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Shifting the Balance of care?

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Title: Shifting the balance of care? A qualitative study of policy implementation in community nursing

Abstract

Aim: This qualitative study examined the interaction between policy implementation and service organisation and delivery for community nursing services.

Background: Leadership in nursing is at the fore front of the policy agenda for shifting the balance of care from hospitals to the community setting and for improving the quality of healthcare services. Yet, little is known about the implementation of policy within the community setting.

Method: A qualitative, interpretive analysis including semi structured interviews with nurse leaders (n=12) and community nurses (n=27) and 3 focus groups (n=13) with community nurses (Total N=39) in three Health Boards in Scotland.

Results: Policy implementation is not adequately integrated between primary and secondary care service at the point of care delivery. The 'top down approach' to policy implementation for shifting the balance of care is currently at odds with the grass roots service organisation and delivery in the community setting

Conclusions: The aspirations of integrated, collaborative health and social care require more clinicians working at the frontline in both primary and secondary care to value more the work of colleagues in the different sectors.

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Implication for nursing management:

The current 'top down approach' to policy implementation encourages resistance in the frontline community nurses rather than commitment. A more 'bottom up' integrated approach to policy implementation is required.

Key words: community nursing, policy, care delivery, service organisation, management,

Introduction

Policy Context-Shifting care into the community

Demographic pressures such as the projected increase in the older population, health service workforce issues, the need to improve health and social care outcomes, and the increasing cost of institutional care signify that current approaches to health care delivery are not sustainable. In the Western world, one of the key challenges for 21st century health care systems is shifting the balance of care from secondary into the primary care sector (Hunter 2008). As the balance of care shifts from hospitals to the community setting the intention is to address these pressures and bring about improvements in service delivery and health outcomes (Department of Health (DoH) 2002, Scottish Executive (SE) 2005, 2006).   Consequently, service organisation and delivery is undergoing rapid change at different levels. Policy implementation aims at

shifting the location of care towards a)the community for quicker, more personal care closer to home, b) shifting the focus of care towards long-term conditions and the promotion of independence, c) changing the roles and responsibilities of patients and professionals (Scottish Government Social Research 2008).

Background

Health policy development in the UK-the impact of devolution

In the United Kingdom (UK), responsibilities for health and social care are devolved to local governments through the Scottish Parliament and through the Assemblies in Wales and Northern Ireland. Devolution in the UK , as Greer (2007, p 87) points out is about *divergence* and over time, devolution created differences in health and social care systems across the UK (Crinson 2009, Maslin-Prothero et al 2008). Whilst some of the differences pre-date devolution, today's UK health service landscape is perhaps better described as 'a family of health care systems' (Jervis & Plowden 2003, Jervis 2008) rendering the one-for-all National Health Service (NHS) a model of the past. For example, personal care for the elderly is free in Scotland but not in England. More recently, the Scottish Government (2012) introduced minimum alcohol pricing to tackle drink related health problems and anti-social behaviour while this is being debated in

England. Differences in health and social care policy reflect different local concerns but also different political values.

Perhaps more fundamentally, in Scotland, the current government (Scottish National Party (SNP)) is committed to retain a health care system that builds on 'existing strengths of NHSScotland – a collaborative, integrated approach built on our traditional values' and 'ensure that NHSScotland remain firmly in the public sector – a public service delivered in partnership with the public' (Scottish Government (SG), 2007, p 3).

In contrast, in England the health care system is based on giving 'the NHS greater freedoms' (Department of Health England (DoH) 2010, p 4) aimed at preventing political micromanagement by devolving 'power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia' (DoH 2010, p 4) which effectively brings to an end a public NHS. The marketization and fragmentation of the NHS in England should not come as a surprise since this process was laid out in successive health policy documents of recent years by successive governments (Leys & Player 2011).

Consequently, whilst the policy of shifting the balance of care from acute hospital (secondary care) to the community setting (primary care) is relevant across the UK, the

implementation of the policy happens in the context of very different health care

systems, resulting in different implications for health care professionals and service

users within the four countries of the UK. As pointed out previously, Scotland is

retaining a public health service (SG 2007) whilst in England community care will be

driven by market forces and a commissioning process led by general practice consortia

(DoH 2010). What was a national health service in the UK arguably, no longer truly

applies due to changes in the organisation of healthcare services taking place and the

different policy making in the four countries of the UK.

Policy implementation

Policy implementation is a complex process and distinct from policy formulation (Hill

2009). In general, two opposite implementation approaches can be distinguished: (1)

top-down and (2) bottom-up strategies. A top-down approach assumes the

implementation of a policy in its totality as a 'one shot' process (Crinson 2009). Top-

down approaches are problematic since implementation is complex and requires

negotiation between the different players, failure to do so will result in implementation

problems (Crinson 2009, Hill 2009). The New Labour government under Blair created in

2001 a 'Delivery Unit' specifically with the remit of implementing government's policies

in education, health, transport and crime. Peck and 6 (2006, p 5) take particular issue

with the word 'delivery' since New Labour's understood implementation problems

'simply as one of unwillingness to "deliver" specific targets' which was rather misguided

and resulted in 'systematically obscure(ing) the nature of the organisational and inter-organisational processes which influence policy adoption and adaptation.' In this context, Oliver and colleagues (2012, p 97) point out that 'NHS re-organisations have been largely expensive, demoralising, and created a downturn in services' which emphasises the importance of including front-line staff for any implementation success.

A bottom-up approach, in contrast, takes account of the complexity of policy implementation, providing more flexibility and integration of those at the front line who actually implement policy (Crinson 2009). This approach does include the possibility of re-creating policy in response to the interactions between different actors and structures in real life (Hill 2009). Whilst this strategy effectively results in shifting goal posts, one has also to consider that this approach to policy implementation might be more realistic since it includes front-line staff and thus builds on their expertise and knowledge leading to real change.

Linked to (successful) policy implementation is policy formulation. The policy making process as being heavily influenced by special advisers, think tanks, lobbyists, pressure groups and so on (Hunter 2008, Leys & Player 2011, Oliver et al 2012) with evidence being used selectively to fit a specific political argument (Hunter 2008, Glasby 2011, Goldacre 2011 a, 2011 b).

Leadership: the key to policy implementation in community nursing?

Nursing leadership in the community health care setting is seeking to bring about

significant organisational change to implement policy such as shifting the balance of

care to benefit patients and carers (DoH 2002, NHS Scotland

http://www.shiftingthebalance.scot.nhs.uk/) whilst addressing the challenges of

delivering high quality care in times of financial constraints (Giordano 2010, Appleby et

al. 2010). Despite nursing in the community being a well-established sphere of nursing

practice, there is a dearth of literature pertaining to policy implementation in the

community.   Community nursing remains relatively under researched when compared

with nursing work in acute care and examinations of policy implementation in the

community context are a rarity.

Poulton (2009) emphasises that changing the practice culture requires effective

leadership and that this has to come from within nursing. McNamara et al. (2011)

concurring with Poulton (2009) suggest that the nursing profession needs to take

responsibility for clinical nursing leadership development suggesting that ownership by

nurses at the frontline of care delivery is key to how policy is interpreted and

implemented to benefit direct patient care. Yet, recent research also from within Ireland

(Casey et al. 2011) which aimed to describe clinical leadership development needs, whilst

not specific to but including community nursing indicates that there is a need to develop

approaches to enhance clinical leaders and leadership at the individual, team and organisational levels. The importance of leadership close to the point of care delivery is likely to be important for the implementation of policy. What appears to be missing from the policy process is the role that nurses in the frontline have on shaping the formulation of policy yet hold responsibility for implementing it.

A key policy development to aid shifting the balance of care in England has been the development of the Community Matron (CM). Whilst this role has evaluated positively (Bee and Clegg 2006, Sargent et al. 2008, Chapman et al. 2009) the evidence highlights that nurses' main function is relieving GP workload as care shifts to the community. This view is substantiated by other studies identifying the substitution of physicians' work in primary care by nurses (Laurant et al. 2007a, b and Kelcher et al. 2009). Clearly, shifting the balance of care policy is shaping the role and responsibilities of nurses in the community. What will be important is how, by commissioning services to the healthcare GPs and their practice teams, community nursing work will be valued in this more fragmented NHS.

In contrast, in Scotland, clinical leadership roles close to the provision of care at the frontline have emerged, but these roles appear to be less about role substitution and are more about implementing the organisational strategy, providing primarily clinical

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leadership to the nurses delivering direct patient care (Haycock-Stuart and Kean 2011, 12 Kean and Haycock-Stuart 2011, Kean et al. 2011, Haycock-Stuart et al. 2010 a, b). Recent research examining the policy of implementing a more generic community nursing model in Scotland (SG Social Research 2012) indicates the limitations of policy which does not adequately involve the frontline nurses at which the policy is directed, in the policy development. 'There was a strong sense that the new Community Nurse role was introduced from the top and had not fully considered the views of nurses to which it was directed. Thus many felt the need for greater consultation before new policies are introduced' (SG Social Research 2012, p 34).

Purpose of the analysis

 Data analysis aimed at examining the implementation of policy, particularly the shifting the balance of care policy, and changes in service organisation and delivery within the community nursing.

Method

The Research and Development Departments of the three Health Boards and the Research Ethics Committee approved the study. The study design involved mixed qualitative methods including focus groups and individual interviews to explore a) how community nurses co-constructed the meaning of policy implementation and b) what the

every-day experiences of service organisation and delivery change as a result of the policy implementation was on a group and individual level. While focus groups allow access to the co-construction of meaning and processes within groups, individual interviews provide data on personal experiences and insights (Barbour 2007, Kitzinger 1996). This approach allowed us to cross-reference emerging themes and probe in subsequent interviews and focus groups. The underlying epistemological assumption was constructionist in that we assumed multiple realities (Harris 2008, Charmaz 2006) of leadership and policy implementation.

Data Collection and Sample

Information about the study was snowballed through Nursing Directors within the three Health Boards in Scotland to lead nurses and community nurses to recruit participants. The study involved 29 nurse leaders and nurses working in the community setting in 31 semi-structured, individual interviews (the nurse directors were interviewed twice, at the beginning and end of the data collection). Three focus groups were also held. In one remote area, some of the same people were involved in the focus group and the individual interviews. Box 1 indicates the questions asked of participants and the main themes identified which are considered in the findings section of this paper. A total of 39 participants (Table 1) were involved in the study between April and December 2009.

This time period reflects that key policy around organisational change for shifting the balance of care has had time to embed in practice.

Box 1 A sample of semi-structured interview and focus group questions focusing on policy and the 4 themes considered in this paper.

1.1 Examples of interview & focus group questions:
- What is shaping the leadership in your organisation/ health board?
  - Policy agenda
  - Health board agenda
  - Personal agenda

- What is the impact of the leadership policy agenda on leadership in practice?

- How does policy influence practice, specifically community nursing? (Prompted with specific policy if required)

- How is the integration of different professional teams supported? (Social work and nursing integration policy e.g. joint futures)

- What is your view on the modernising community nursing agenda? (Prompted with specific policy if required)

- How is the policy agenda shared with you and your more junior colleagues?

Initial questions for individual interviews and focus groups probed and changed over time in accordance with emerging insights.

1.2 The 4 Policy themes discussed in this paper:
Policy into Practice-Shifting Care into the Community

Integrated services-but not integrated policy implementation?

The conflict between policy and 'reality' in community nursing

The disconnection between policy and practice

Table 1: Participants in the study

District Nurse	8
Community Staff Nurse	12
Health Visitor	3
School Nurse	0
Nursery Nurse	2
Health Care Assistant	2
Team Leader (TL) (3=DN, 2=HV)	5
Lead Nurse (LN)	3
Acute Care Managers for Community Sector	1
Assistant Nursing Director	1
Director of Nursing	2

Data Analysis

This mixed methods study represents a single-paradigm method design (QUAL + qual)

(Morse 2010) and therefore allowed for a concurrent approach to data analysis across

individual and focus group data (point of analytic inference) (Creswell & Plano Clark 2011). All semi structured interviews and focus groups were digitally recorded, transcribed verbatim and managed within the Nvivo8 software. Data analysis focused on generating concepts reflecting patterns and processes in both data sets (Bryman & Burgess 1994, Charmaz 2006). Coding moved from open coding to higher levels of abstraction, leading to the development of coding trees under which categories and subcategories were subsumed. Data transcripts were analysed independently before being discussed between the authors, this is what Saldaña (2009) calls 'a reality check' that facilitated discussions beyond the individual's analytical lenses.

Findings

A major analytical theme relates to policy implementation particularly policy pertaining to the shifting of the balance of care from the hospital to the community and is presented here, Box 1 indicates the themes discussed in this paper. An overview of the main study themes presented elsewhere are summarised in Table 2 and reported in detail in earlier papers (Haycock-Stuart and Kean 2011, 2012, Kean and Haycock-Stuart 2011, Kean et al. 2011, Haycock-Stuart et al. 2010 a, b).

Table 2: Overview of the study themes reported elsewhere

Theme	Relevance

'Nursing leadership and quality of care' *'Leading' for quality versus 'delivering' for quality'* *'Perceived quality of care, patient experience and outcomes'*	Highlights the challenges of meeting the quality agenda for nursing leadership (Haycock-Stuart and Kean 2011a).
'Organisational decision- making and skill mix for quality care'	Exemplifies the tensions between front-line nurses and senior nurse leaders in organising services for high quality care (Haycock-Stuart and Kean 2011a).
'Emotional labour within community nursing leadership' *'Managing emotions at work'* 1) *Keeping up appearances-working at masking emotions* and 2) *the sacred and the profane - balancing work as a team leader*	The emotional challenges for nurse leaders when working with colleagues to deliver high quality care in the community setting. Two dimensions of this process emerged (Haycock-Stuart et al. 2010b)*.*
'following' and 'followership' (1) *socially co-constructing leaders*,	Followership as a major theme of nursing leadership in the community. Four dimensions of processes by which

(2) *doing following*, (3) *standing by*, and (4) *resisting following*	followers co-construct leadership became apparent (Kean et al. 2011a).

Policy into Practice-Shifting Care into the Community

Meeting the policy agenda of shifting the balance of care has necessitated change at several levels and put simply these can be considered shifting the **location of care,** shifting **the focus of care** and **changing roles and responsibilities** (SG Social Research 2008) for community nurses, but as our data indicates, these are inextricably linked. The evidence we present indicates how to meet the challenges of shifting the balance of care, a shift of human resources-particularly the nursing resource was seen as key to implementing change for addressing the policy agenda as this Nurse Director explains:

> *We decided that it would be more appropriate for the associate nurse director to*
>
> *operationally manage all the nurses within her directorate primarily to support shifting*
>
> *resources in terms of shifting the balance of care rather than have artificial barriers*
>
> *between the community and the hospital. We've tried to wrap our management*
>
> *structures around the patient journey. So we didn't want to artificially separate - and*
>
> *particularly here the community nurses perhaps rather than the health visitors - we*

didn't want to artificially separate the community nurses because we saw a big role for them in terms of long term care and condition management. We're now looking at the virtual ward, thinking about shifting the balance of care, how do we actually both have early discharges and prevent admissions. We saw that at some stage we would probably want to shift the hospital resources into the community and if we had 2 senior managers with budgets, we felt that on balance that could be a barrier to change……. I think the management of the nursing resource in total needed to be kept together. (Nurse Director 2.2)

The organisational infrastructure and service delivery is adapting to meet policy agendas and the reorganisation of the nursing work force is central to the organisational change. However many community nurses described being challenged by the change required in shifting the balance of care from hospital to the community. Sometimes nurses described a lack of integration between the primary and secondary care services for changing the roles and responsibilities necessary for increased nursing care in the community.

Integrated services-but not integrated policy implementation?

An illustration of the lack of co-ordination for shifting the location of care is given here and it is evident that moving patients out of hospital quicker and sicker not only changes the location of care, but the nature of the nursing work in the community setting. Yet this is, by their accounts, poorly understood by acute service colleagues. The acute hospital

personnel implementing the policy, seem not to appreciate the challenges their discharge patterns can have on community nurses work load and responsibilities. As this District Nurse Team Leader explains:

'Nobody phones us in advance and says, "look w are going to be doing 20 hips next week, can you cope with it in community, have you got the right staff and the right resources"? It's done in isolation, there's no link up, there's no communication. "Oh, we are going to do a pile of cataract operations, so that means we'll have 12 patients out in the community needing their eye drops done".…….There's no forward planning. There is from the acute side's point of view because they'll make sure that they've got enough theatre staff, they'll make sure that they've got their beds to accommodate that. But the turnaround is so high, they're straight out to the community and come to us and I think what they're not realising... is that we don't just take referrals from the acute services, we take referrals from General Practitioners, from Social Work, self-referrals and from other hospitals. (Team Leader 1.3)

With limited integrated discharge planning across the primary and secondary care interface, despite the health board having an *'integrated, one system approach to the organisation,'* (Nurse Director 1.1) the community nurses describe being ill prepared for the shift in the balance of care. Nurses working in the community understood and valued the need for the shifting the balance of care policy, but considered the implementation

lacking in strategic balance between the primary and secondary care sectors. It seemed that the acute services were driving the strategic and actual shift to care for more people in the community, but with the community setting having limited opportunity to plan, prepare and mobilise resources to safely respond to the increased care in the community.

The conflict between policy and 'reality' in community nursing

The following extract from a remote and rural context further illustrates the tensions for nursing leadership when working to provide high quality care and demonstrates how the implementation of policy can be a major challenge in the community with limited resources. It also shows how the reality of service organisation and delivery at the frontline often conflicts with different policy agendas. Here the team leader illustrates the challenges of meeting policy agendas around living and dying well (SG 2008), person-centred care (SG 2010a, McCormack and McCance 2010) and shifting the balance of care to the community setting.

'Oh, it's so frustrating. It's terrible. I used to think, crikey, it's just me but it is a lack of resources. I mean, we had a lady who expressed a wish to die at home and the family's expectation was that we would put in a nurse every night and we could not meet that. I mean, I explained that, you know, I'm sorry we can't do it. "Well, Dr so and so said that we would get it", so because the doctor had said it, the expectation was there. We took the lady home but she ended up getting re-admitted and I thought

> *that was a real failure, you know, in the services but there's nothing you can do about*
>
> *It'. Team Leader 2.1*

Despite the shift in balance of nursing care from the hospital to the home environment (DoH 2002, Scottish Executive (SE) 2005, 2006), and the Living and Dying Well action plan (SG 2008, SG 2010b) to ensure that good palliative care and end of life care is available for all patients and families in a consistent, comprehensive, appropriate and equitable manner across all care settings, the community nurses found themselves depleted of the organisational resources needed to fulfil the policy agendas and compassionate care as is expected (DoH2012). The nurses were willing to work with the policy agendas, but found the resources to support the policy in practice were often not available, be it human resource, educational or knowledge or skills resources and their frustration is evident at feeling unable to meet the quality strategy agenda (SG 2010a). The reality of implementing the policy and the strategic direction were often in conflict and nurses often did not feel ownership of the policy and the changes being implemented.

The disconnection between policy and practice

This Lead Nurse working closely with frontline practitioners delivering the nursing care explains the disconnection between policy making and policy implementation in

community nursing and the sense that policy making is not connected to the reality of service delivery for the type of organisational change needed to implement policy.

> *'We had a discussion at our planning day last week where the health board came in and talked about the kind of implementation plans for the next 3 years and it very quickly came round that how policy and planning are actually quite remote from the interface. [ ] We do live in a very disconnected world..........The world of Joint Futures, no matter how well intentioned, did not, in my view, build in the human dynamic of power, authority and what you've got is a local structure where you have local politics and you have a health background which is centralised in its government politics.'' Lead Nurse 3.1*

This lead nurse is alluding to the political tensions in health care delivery. In Scotland policy is developed around the integration of health and social care services and the expectation of co-operation and collaboration between these services. Policy makers however had not adequately considered the dynamic of *human power* at the point of implementation and how this shapes the interpretation of policy into practice. The result is that policy is adapted at the point of implementation to fit the context or not implemented at all when frontline people are not involved in the policy making process.

This disconnection between policy and practice at the point of implementation is further illustrated in the way nurses perceive their clinical leadership roles emerging and their work role and responsibilities changing in response to shifting the balance of care. These frontline nurses with relatively new leadership roles described juggling the clinical 'hands on' component with patients with the more 'distant' aspects of leadership which involved attending meetings taking them away from patient care.

'The other thing that I think everybody would say is – the dichotomy between practice and team leader, she (Lead Nurse) sometimes doesn't get. So she'll ask me to do things at quite short notice and I've got patients booked and sometimes I have to change the patients or cancel them and, really, I shouldn't do that. I should say," I'm sorry, I've got have patients who have to come first."' Team Leader 1.2

The nurses with the clinical leadership roles described the tensions of meeting immediate 'hands on' patient clinical needs and working toward more 'distant' strategic development, both of which are necessary for high quality care. The challenge is there for nurses with new roles and responsibilities to prioritise work especially when their value base is patient driven, but the new work responsibilities seem to detract from patients as they become more strategic workers and less clinically focussed. This was a particularly challenging aspect of the new clinical leadership roles as the community setting has fewer

nurses than the acute setting and very limited nurses available to 'step in' and care for

patients in the same way as the nurses in the acute hospital can move from ward to ward.

Importantly, the shifting the balance of care policy is resulting in fewer beds in hospitals,

shorter hospital stays, resulting in patients with greater health care needs in the

community. In response to the shift in location of care more extra resources are being

put into the community, but in addition the roles and responsibilities of the nurses in

the community are changing with the patients being discharged sicker and quicker from

hospital. As these focus group participants debate the impact of policy on their caring

work:

> *Interviewer: So what's setting the agenda?   You're saying there's a lot of*
>
> *change but what's setting the agenda for all that change? [ ]*

> *Participant 4:   Well, there is changes because they have built a new hospital and*
>
> *there is going to be a new health centre and they are changing the way I suppose*
>
> *primary care is going to work in (*name of location*).   There is going to be 2 new*
>
> *health centres and I think that is their opportunity to save some money (LAUGHS)*

> *Participant 3:   And the new hospital - The new hospital has got like 400 less beds,*
>
> *so we are going be more involved in the community. People are going be discharged*
>
> *a lot quicker from hospital, so we will be more involved with their care.*

> *Participant 5:   ( ) a lot of nurses are travelling in to the same area from different practices, they are trying - for 2 areas – they are cutting our travelling time, hopefully maybe see more patients and* (spend*) more time with patients rather than travelling back and forward.*

Shifting the balance of care policy is implemented through reducing acute care beds with little negotiation or consultation with frontline community nurses about how they would need to change their working patterns to care for an increasing number of acutely ill patients. The lack of negotiation about how the policy is implemented with the frontline community nurses indicates the failings in shifting the balance of care policy implementation. The community nurses see policy as very important for driving these changes, not only the shifting the balance of care policy, but also the releasing time (SG 2010c) to care strategy which aims to enable nurses working in the community to have more direct patient care contact time. Shifting the balance of care is requiring nurses to work differently and some nurses are resistant to the policy as it is changing the nurses' roles and responsibilities with their existing and new, acutely ill patients. In addition, for some community nurses the policy is making them break long established working relationships with patients and families as they move to more geographically focussed work to reduce travelling time.

Discussion

Top down policy implementation and community nurses lack of policy ownership

Data analysis indicates how community nurses believe their quality of care was at times

compromised as a result of implementing the shifting the balance of care policy.

Predicting and balancing workload in the community setting is recognised as being a

challenge (Haycock-Stuart et al 2008). The lack of joint decision making between

primary and secondary care about discharge planning is a major challenge to ensuring

the ambitions of the *Scottish Government Quality Strategy* (SG 2010a) for high quality

and safe care as shifting the balance policy is implemented (SG and NHSScotland 2011,

DoH 2012). Despite the aspirations of the Scottish Government (SG, 2007, p 3) to retain

a health care system that builds on 'existing strengths of NHSScotland – a collaborative,

integrated approach built on our traditional values' there is evidence that there are

challenges to this approach for shifting the balance of care in community nursing.

The lack of integration for the implementation of policy across the primary and secondary

care settings evident in the data suggests that there is a strategic misconception that

nurses in the community are able to absorb the relocation of caring work that occurs

when increasing numbers of acutely ill patients are discharged into the community. The

data reveal a dominant top-down approach to policy implementation (Crinson 2009, Hill

2009). This approach has important implications for leadership and followership in

community nursing, the evidence suggests a shared vision is important for success around

policy implementation. A lack of negotiation and integration between primary and secondary care services-particularly between nurses in the frontline of care delivery in both the acute and community setting resulted in policy implementation problems in the community. A lack of appreciation as to 'the nature of the organisational and inter-organisational processes which influence policy adoption and adaptation' (Peck and 6, 2006, p5) mean that shifting the balance of care policy is often perceived as problematic by community nurses rather than as a constructive process for improved patient care. The need for better integration between primary and secondary care at the front line by those who actually implement policy (Crinson 2009) is evident if policy implementation is to be improved when seeking better care for patients in the community. As Hunter (2008) indicated, successful policy implementation is 'seriously impaired if those working on the front line are not signed up to the changes and seek to contest, or undermine, them' (Hunter 2008, p 34).

The conflict between policy implementation and service organisation

Nurses in this study illustrated how implementation of the shifting the balance of care has necessitated change for them at several levels including those identified in earlier research such as shifting the ***location of care,*** shifting ***the focus of care*** and ***changing roles and responsibilities*** (SG Social Research 2008). Our data illustrates how these changes at several levels are inextricably linked. The evidence also highlights how current service organisation and delivery at the frontline often conflicts with the

different policy agendas. For many nurses working in the community, implementing different policies and their strategic direction were often in conflict with the existing organisational services and resources available. The community nurses often did not feel ownership of the policy and the changes being implemented.

Frontline nurses often felt frustrated that they were unable to implement the care in accordance with policies, such as person-centred care (SG 2008, DoH 2012) for better quality care (SG 2007, 2010a). Tensions were evident between implementing policy to provide high quality care without appropriate resources whether these were human resources, education, knowledge or skills resources that were lacking. Giordano (2010) and Appleby et al. (2010) highlight the challenge for nursing leadership of organisational change for high quality care in times of limited resources. This challenge is not just for the nurse leader, but also the frontline nurses who need to deliver the care directly to the patients and families, the care they believe they are entitled to within the policy context. There is evidently a responsibility in policy making to ensure that the resources are available to nurse leaders and community nurses to enable them to meet the policy agendas.

Conclusions

Nurses working in the community considered the implementation of the policy to be
lacking integration between primary and secondary care. The approach taken to policy
implementation can be seen as top down (Crinson2009, Hill 2009) and as such lacks the
integration of those at the frontline. The organisational infrastructure of community
nursing was at times not adequately prepared, resourced or responsive enough around
implementing the policy agenda to shift the balance of care to the community setting.
Community nursing lacked not only adequate numbers of staff at times, but also
appropriate education for good knowledge and skills. Whilst there was an expectation to
move nurses from the hospital to the community to meet the demands for patient care
there was little recognition by nurse leaders of the need for educational preparation for
working in the different context of the community setting. There was pervasive evidence
that the policy context was disjointed from the context of frontline care delivery and this
led to community nurses often feeling demoralised in their work with colleagues and
patients.

Implications for Nursing Management

 Some nurses with new leadership roles felt challenged by the desire and expectation to
provide immediate high quality care to patients whilst also being expected to undertake a
more 'distant' long term strategic role to improve community nursing services for
patients. Such new roles and responsibilities evolve gradually as the process of de-

normalisation of practise takes time. However, policy makers and to some extent senior nurse leaders expect swift change in response to policy, but there needs to be acceptance by nurse leaders that change processes often need time.

Developing a bottom up approach to the formulation and implementation of policy (as opposed to the current top down approach evident in this research), is more likely to positively engage frontline community nurses when implementation of the policy is required thus leading to a more successful integration of policy into practice. Heeding the 'simple rules' of Best et al. (2012) are likely to help when developing and implementing policy as 'change requires human input and human qualities such as energy, commitment, some understanding, a sense that one is doing the right thing and acting reasonably in the circumstances, and a belief that what one is doing will be worthwhile, effective, and appropriately rewarded' (Best et al. 2012, p443). A more realistic approach to the policy making and implementation process would be to include front-line staff by building on their expertise and knowledge as well as involving senior nurse leaders. This approach can mean that some involved in the policy process might not feel the 'ideal' is being developed-but at least the policy is more likely to be 'owned' and to be realistic when it comes to implementation in the community setting. A more bottom up approach would have allowed frontline nurses to explore and negotiate with senior leaders in the organisation the deployment of resources and educational development to prepare for the implementation of the policy and changes in the organisation.

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