University of Stirling
School of Nursing, Midwifery and Health

A qualitative study of policy and action: How the Scottish Government has implemented self-management support for people with long-term conditions.

Sarah Hilda Annesley

This thesis is presented in fulfilment of the requirements for the degree of

Doctor of Philosophy

Declaration

I declare this thesis is entirely my own work and that it has been submitted only for the degree of PhD.

Sarah Annesley

6th July 2015

TABLE OF CONTENTS

Page

CHAPTER 1: INTRODUCTION

CHAPTER 2: POLICY, POLICY PROCESS AND POLICY IMPLEMENTATION: A LITERATURE REVIEW

Page

CHAPTER 3: CHANGE AND INNOVATION IN THE DELIVERY OF HEALTHCARE: A LITERATURE REVIEW

CHAPTER 4: METHODOLOGY AND METHODS OF THE RESEARCH PROCESS

Page

CHAPTER 7: SYNTHESIS OF FINDINGS

CHAPTER 8: DISCUSSION OF FINDINGS

CHAPTER 9: RECOMMENDATIONS AND CONCLUSION

List of Tables

List of Boxes

List of Figures

Acknowledgements

This research could only have been completed with the support of the participants. I would like to express my gratitude to my research participants. They offered me their time and shared their insight, knowledge and experience. Their willingness to participate made my research a reality.

In particular my grateful thanks go to my supervisors Dr Tom Forbes and Dr Carol Bugge. I am also grateful for the commitment and confidence bestowed on me by Professor Sally Wyke who provided supervision support during her time (and beyond) at the University of Stirling. I am indebted to the support of my work colleagues, both old and new, who have provided guidance, inspiration and wit to sustain my commitment to this thesis.

Finally this is for my son Gavin, my beau Max and my parents, Brian and Carol.

GLOSSARY: Abbreviations

ACF = Advocacy Coalition Framework
CA = Collective Action (NPT)
CHD = Coronary Heart Disease
CHF = Chronic Heart Failure
CHP = Community Healthcare Partnership
COPD = Chronic Obstructive Pulmonary Disease
CP = Collective Participation (NPT}
CQI = Continuous Quality Improvement
DoH = Department of Health
HIC = High Impact Changes
LTCs = Long Term Conditions
LTCAP = Long Term Conditions Action Plan
LTCAS = Long Term Conditions Alliance Scotland
LTCC = Long Term Conditions Collaborative
MCN = Managed Clinical Network
MSP = Member of Scottish Parliament
NES = NHS Education for Scotland
NHSQIS = NHS Quality Improvement Scotland
NPT = Normalization Process Theory
NPM = Normalization Process Model
PDSA = Plan, Do, Study, Act
QI = Quality Improvement
RM = Reflexive Monitoring (RM)
SE = Scottish Executive
SEHD = Scottish Executive Health Department
SLB = Street-Level Bureaucrat
SM-S = Self-Management Support

Chapter 1 Introduction

This chapter provides the background and foundation to the thesis which investigates the process of policy implementation in NHS Scotland. The research problem and methodology are discussed and justification for the study is presented. Thereafter, study definitions and delimitations are identified. Finally, the thesis structure is outlined.

1.1 The field of study

In Scotland during 2005-06, according to Loretto and Taylor (2007: i), 23.6% of adults (aged 16+) reported some form of long-term condition (henceforth LTC). Since 2005 UK governments have sought to introduce health policy, which emphasises concepts of self-management and self-management support for people with LTCs (SEHD 2005a; LTCAS 2008; DoH 2005; DoH 2012). This is a significant policy area designed, where possible, to improve the health outcomes and care experience of patients suffering LTCs (Challis et al. 2010). The current focus on self-management support is associated with policy-makers' desire to change and re-prioritise healthcare services, illustrated by terms such as; '*shifting the balance of care*', '*patient-focused care*', '*patient-participation*', '*co-production of health*', '*patient-engagement*', '*patient-empowerment*', and '*shared decision-making*'. To meet these outcomes governments have sought to introduce self-management initiatives by means of health policy implementation. This research explores how the Scottish Government has tackled the implementation of self-management through policy and action.

Self-management is closely associated with ideas of self-care and self-management support. For the purposes of this work the following definitions are used:

> "*Self-care is what each person does on an everyday basis. This is often compromised for a person living their life with long term conditions.*

> *Self-management is the process each person develops to manage their conditions.*
>
> *Support for self-care and self-management is the responsibility of health and social care providers and unpaid carers.*" (LTCAS 2008: 9)

Significantly, these definitions did not emerge until some three years after the concepts first appeared in policies, statements and other government documents, during which time Government focused on an idea which may not have been understood by those charged with its delivery. These definitions acknowledge that it is common for people to be living with more than one LTC. However, from the outset, policy lacks clarity in the concept it aims to promote, with a potentially significant impact on those who need it most.

1.1.1 Long Term Conditions

Advances in healthcare mean more people are living longer with conditions which previously they might not have survived (Nolte and McKee 2008). They are grouped under the terms chronic disease, long-standing illness or the term used in this research, LTCs. These are recognised as requiring on-going care and support, limiting what people can do and lasting longer than a year (SEHD 2005c). Common LTCs are illustrated in **Table 1-1**.

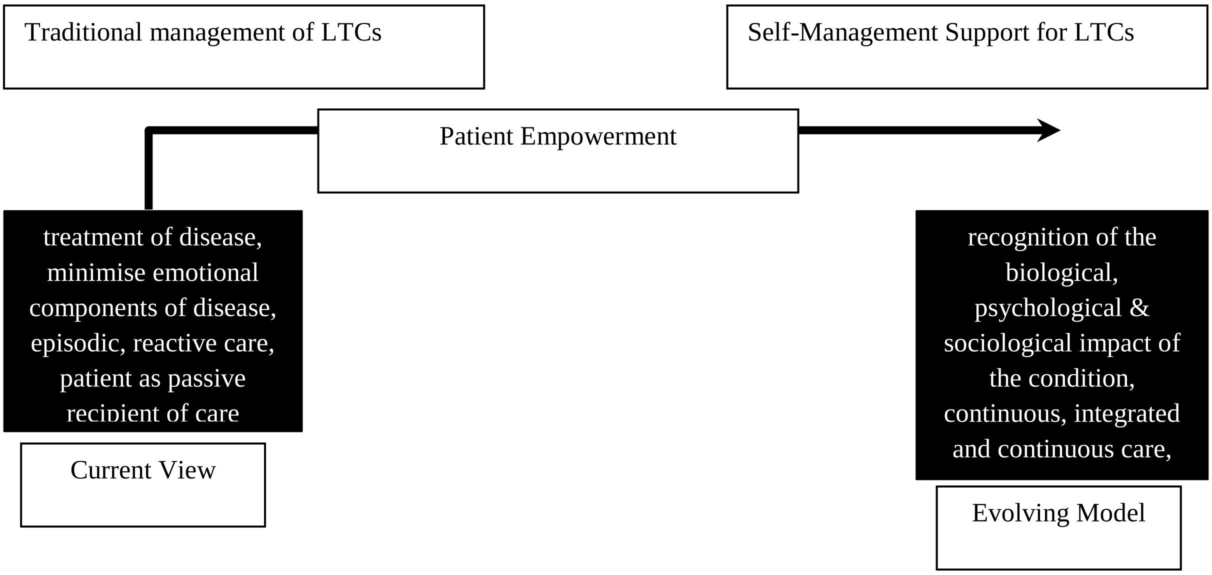
Table 1-1 Common LTCs

Common LTCs	
epilepsy	coronary heart disease
Diabetes	arthritis
chronic pain	inflammatory bowel disease
Cancer	chronic obstructive pulmonary disease (COPD)
multiple-sclerosis	depression

LTCs cannot be cured and so the focus of care shifts to means which enhance functional status, minimise distressing symptoms and reduce exacerbations of the condition through secondary prevention (Nolte and McKee 2008). LTCs are also characterised as common in older people, people living in deprived areas and among the Scottish population (SEHD 2005c; Loretto and Taylor 2007). The picture is further complicated by the prevalence of people living with more than one LTC and the rise in chronic multi-morbidity (Barnett et al. 2012). This epidemiological and demographic shift represents a significant challenge to governments and healthcare providers (WHO 2011).

The challenge for healthcare providers is to improve the management of care of people with LTCs. Traditional healthcare models focus on care for people with individual diseases; people with LTCs need a broader approach (Nolte and McKee 2008; Barnett et al. 2012) whose development has been shown to improve the health of people with LTCs (SEHD 2005c). It should include increasing support for self-management, greater focus primary care, and the recognition and management of vulnerable cases (SEHD 2005c). Greater emphasis on patient empowerment and closer alignment of health services to patients’ needs is being proposed (Barnett et al. 2012). This change in healthcare delivery is illustrated in **Figure 1-1**.

Figure 1-1 Managing LTCs



Informed by SEHD (2005c); Wright (2011)

This thesis is about the process of policy implementation aimed at moving NHS Scotland from the current traditional model of care to a model which promotes self-management support for people with LTCs.

1.1.2 The nature of policy

Policy is generally agreed to be a purposive course of action which reflects decisions and choices made, most commonly, by governments about what should be done to address areas of concern. (Allsop 1995; Anderson 1975). Where policy focuses on health, governments seek to change the practice and delivery of healthcare and direct the activity of different areas of healthcare organisations such as the NHS (Watt et al. 2005). In these interpretations it is implicit that for policy to succeed it must be implemented as planned. Yet there are well-documented difficulties in achieving effective policy implementation (Gunn 1978; Hill 1997; Ham 2009; Hill and Hupe 2009).

Commonly policy implementation is presented as operating in one of two ways: a top-down initiative led by policy-makers who then rely on those doing the job to act as policy-implementers (e.g. Van Meter and Van Horn 1975; Sabatier and Mazmanian 1979). In healthcare this approach focuses on the wide spread dissemination of policy documents, associated initiatives and targets for NHS Chief Executives and managers to implement in their organisations.

In contrast, a bottom-up model argues that a more realistic understanding of implementation can be gained from the perspective of those at whom the policy is targeted and that implementation or the initiation of policy is more successful if the focus is at the point of service delivery where the true policy-implementers can be found (Matland 1995). For close to 40 years this debate between the two different perspectives has continued in the policy literature with no conclusion. It is clear that that commonly the objectives envisaged by policy-makers may not be realised at the point of delivery (Exworthy et al. 2002). To explain why, it is crucial to understand the process of policy implementation from within the system.

Current literature supports the argument that hierarchical models of policy implementation are too simplistic (Schofield 2001). In reality policy implementation requires a range of actors who shape and form an interpretation of policy (Hill and Hupe 2009). But generally, the exact processes by which policy is turned into action are not well-understood (Schofield and Sausman 2004) and what emerges, as Exworthy et al. (2002) define it, is an ‘implementation gap’, an idea supported by other key authors in this area, principally Lipsky (1980), whose work highlights the role of street-level bureaucrats in managing and bridging the gap.

Given UK interest in self-management support and the particular focus identified in Scottish Government policy, this research addresses the processes and actions used by policy-makers and -implementers to deliver self-management in practice. By tracking the processes whereby policy is turned into action it specifically targets the 'implementation gap' between national policy documents and the opportunities created to effect policy implementation.

1.1.3 The countries of the UK: policy response to LTCs

Health policy has been devolved to the four nations of the UK; since 1999 for Scotland and Wales and 2000 for Northern Ireland (Murray et al. 2013). Since then the promotion of self-management support for people with LTCs has been managed separately in the four regions.

The English approach to self-management was initiated by the public health White Paper, "*Saving Lives: Our Healthier Nation*" (DoH 1999) which set out a commitment to patient engagement to improve outcomes for people with LTCs. This commitment was further developed in a 10 year NHS Plan (DoH 2000). More recently the promotion of self-management has focused on the development of services through demonstration of competencies concerning effective communication and empowerment of patients (DoH 2006b). Since April 2013, a new system of public health and health care in England has been implemented as a consequence of the Health and Social Care Act (UK Government (England) 2012). Ideas have evolved and NHS England can now be described as taking a service improvement approach to meet the challenges of managing people with LTCs (DoH 2012).

At a recent conference LTCs (Tackling LTCs 2013) three themes emerged as influencing the future direction of self-management: the importance of an integrated team approach to avoid fragmentation and better reflect a true patient-focused approach to care; greater recognition of the social capital and asset that people themselves present in being able to manage their health; and the importance of risk-profiling to target patients most in need of intervention. A recent external assessment of UK health performance acknowledges supports the good progress being made towards being one of the best health services in Europe for helping those with LTCs (Murray et al. 2013).

In NHS Wales a broader approach is being promoted, targeting health improvement of the whole population through ensuring quality and safety of health services, improving access and patient experience, preventing poor health and reducing health inequalities (Welsh Government 2013). This builds on the work undertaken in NHS England and points to a commonality in the strategic approach adopted in England and Wales.

In 2012 Northern Ireland’s Department of Health Social Services and Public Safety (2012) published a policy framework outlining organisational approaches to be taken to support people living with LTCs. This document focuses on working in partnership, the need to support self-management, providing information for service users and carers, and improving care and services for people with LTCs.

The challenge faced by the rate of growth of LTCs and the number of people over the age of 65 years with one or more LTC is evident across the UK and consequently the policy response, though legislated individually in each of the four countries of the UK, is broadly similar. Ideas of service integration, new models of care, improvement of patient experience and the social capital of people managing their condition are features common to all four policy responses.

My theoretical approach to exposing these elements was initially informed by theories of change as they apply to healthcare. Self-management and self-management support are new ideas, different from current paradigms and thus seen as unique. Their adoption requires fundamental change and adaptation, which draws parallels with theoretical thinking on and the dissemination of innovation (Rogers 1995a; Saetren 2005).

Much of the early discussion in Scottish policy documents addressed the change needed to develop self-management support as a national priority. The Scottish Government's commitment to improving care for people with LTCs was set out in "*Delivering for Health*" (SEHD 2005a) in which clear drivers for change are set out, legitimising and establishing the issues outlined in the document as worthy of attention. Responding to these policy-drivers is the objective of policy-makers and in a top-down model of should also be the objective of policy-implementers. Change and its delivery and management are the underlying frameworks informing how policy should be taken forward. "*Delivering for Health*" (SEHD 2005a) sets out the following drivers: increasing patient expectations, shifting population trends and medical advances. These can only be addressed if health services change. Legitimising self-management has not been established through theoretical ideas drawn from policy implementation literature but through reference to the need to change and modernise:

> "*The NHS in Scotland needs to change. Not because it is in crisis as some would have us believe – it is not; but because Scotland's healthcare needs are changing rapidly and we need to act now to ensure we are ready to meet future challenges*" (SEHD 2005a)

The responsibilities with which government policies charge the NHS demand change. This need for which in the NHS is long-standing (Pettigrew et al. 1992); and as the quotation above shows, there is no sign of the demand for change diminishing. But healthcare, and the NHS in particular, is resistant to change and the influence of new initiatives (Herzlinger 2006). Consequently, understanding how to deliver new ideas in the NHS is a source of much ongoing debate and discussion (May 2013). A perceived lack of success in delivering the objectives of new initiatives causes frustration since, despite the attention which ideas on implementation, innovation and change receive, the NHS remains resistant to new ideas. Even when policy is used to propose organisational change that sets out to improve the efficiency, effectiveness and quality of care, the reality is that uptake of new ideas remains patchy and inconsistent (Exworthy et al. 2002).

Why the adoption of new ideas in healthcare should be so elusive attracts the attention of a number of academic disciplines, including sociology, which offers ideas on diffusion and adoption of innovation (Wejnert 2002). These have been tested and applied in healthcare (Greenhalgh et al. 2008). Healthcare researchers have also sought evidence for what works through approaches commonly associated with management theory (Iles and Sutherland 2001), the application of which to healthcare includes ideas on continuous quality improvement (CQI) methodologies such as LEAN principles to reduce waste of resources in clinical practice, the application of PDSA cycles to test small-scale change and the use of '14-day challenges' (Brennan et al. 2009). Despite an increasing body of research testing these CQI methodologies, uncertainty remains about their effects and the factors which might influence their effects (Brennan et al. 2009).

Other sociologically related work has considered the applicability of social movement theory (Bate et al. 2004), testing unused or under-utilised concepts and theories of change which might make more effective or extend efforts directed at improving and changing the NHS. The net is spread wide in looking for such concepts but high degrees of uncertainty remain in knowing how to manage change effectively.

Uncertainty is a common feature of this literature, reflecting the inherent tensions which exist between the need to improve care and knowledge of how to do it (Auerbach et al.

2007) and between structure and process: the difficulty in overcoming the organisational inertia of the NHS. Such inertia is commonly encapsulated as follows: '*if you always do what you've always done you will always get what you always got*'. The introduction of a new oral anticoagulant (e.g. dabigatran) instead of warfarin to prevent stroke and embolism in patients with non-valvular atrial fibrillation (Health Improvement Scotland 2012) provides a salutary example. NHS services are set-up for the monitoring and support of warfarin treatment. A move to one of the new oral anticoagulants would obviate the need for service support which currently exists for warfarin. A change which meets NHS Scotland's quality ambition to provide the most appropriate treatments, intervention at the right time to those who will benefit as well as avoiding waste or harmful variation (Scottish Government 2010a) ought to be welcomed; but the move from warfarin to dabigatran may not happen because the structures and processes which are in place at present support the traditional and not the recommended treatment – existing structures resist new processes.

Tensions between institutional and individual behaviour are a further barrier to change. This is best illustrated by a seminal work on receptive and non-receptive contexts of organisational change (Pettigrew et al. 1992) in eight health authorities. Pettigrew et al. (1992: 274) identified eight factors which determine an organisation's receptivity to change, ranging from an organisation having a set of values and behaviours which contribute to the achievement of change goals: a '*supportive organisational culture*'; to the importance of having key people leading the change: '*leadership skills*'; and including the need for managers to understand what clinicians value and build on this in a managerial relationship: "*effective managerial clinical relations*" (Pettigrew et al. 1992: 274). This work demonstrates how change should be viewed as a dynamic process where the success or failure of change relies equally on organisational factors as well as key individuals. The probability of these receptive factors being and staying present reflects the fragile boundary between knowing how to change and delivering change in practice.

A third set of tensions exists between aspirations for change or new initiatives (the desired change) and practice (what practitioners are actually doing). Change is often characterised by the "*ambiguity of intent and unpredictability of response*" (Bergen and While 2005: 1), adding to the perception that successful change is complex and problematic. The desired change or outcome of a change initiative is commonly vague and the lack of distinct outcomes is also seen to be true of policy (Exworthy et al. 2002). Consequently, implementation should allow for a degree of adaptation and interpretation by those working in practice with the new idea. In change management literature this is described by the mediating role of professionals (Ferlie et al. 2005), and in policy by the concept of street-level bureaucrats (Lipsky 1980). The importance of both of these is that they can work either to enhance innovation/policy or to slow the spread of innovation/policy.

Greater understanding of how change happens is informed by the exploration of concepts of entrepreneurship, institutional entrepreneurship, and policy entrepreneurs in the management theory literature. For example, management ideas of entrepreneurship and institutional entrepreneurship focus on the work of complex organisations and how such organisations change and evolve over time (Dacin et al. 2002). Institutional theorists focus on complexity and seek to understand institutional and organisational elements, connections and influences which operate during the process of change (Scott et al. 2000). The exploration of entrepreneurship is a key feature in institutional theory.

Entrepreneurship can operate from within an organisation enhancing its functionality; it does not necessarily mean establishing a separate organisation. Equally, entrepreneurship can function at the individual level of an entrepreneur but also at the level of teams or networks displaying entrepreneurial behaviour. From this debate and discussion a new term has emerged: institutional entrepreneurship. This perspective offers a contrast to an organisation simply responding to change as part of its on-going development and growth; it encourages active participation, advocacy, and networking to develop new initiatives and delivery change. From this literature a different way of thinking about change emerges which may have relevance in an NHS context.

Institutional entrepreneurship has been shown to be important in a range of settings, including private and public sector environments. In the healthcare environment there is only a small body of work exploring its application, such as Maguire et al. (2004), who looked at advocacy in HIV. They employed a description of institutional entrepreneurship to capture how individuals applied their skills to transform existing ways of doing things to create a new approach (Maguire et al. 2004) and were able to demonstrate that institutional entrepreneurs could generate new practices in consultation and information exchange. Other work, with its roots in institutional theory, has considered the notion of institutional entrepreneurship in healthcare organisations as it explored how clinical managers, who had undergone education in change management, implemented policy-driven reform in their NHS services (Battilana 2006). Here the individual-level rather than the organisational-level conditions that enabled institutional entrepreneurship were identified, revealing the influence exerted by an individual’s social position within an organisation, which provided an enabling condition for institutional entrepreneurship in the healthcare environment.

1.2 Overview of policy implementation literature

The contrast between the role of the individual and the collective action of an organisation in the delivery of change is also evident in the field of policy implementation. Here there is debate about two roles, which operate at very different points in the policy process: the policy entrepreneur and the street-level bureaucrat.

The actions of policy entrepreneurs operate at the point of initiation: the start of the policy process. These actors insert new ideas into the policy agenda and in turn motivate and initiate the implementation process (Mintrom 1997). They are seen as being good at identifying problems, networking and building coalitions (Kingdon 1995). My research is not directly interested in the initiation of policy, more what happens once it has been initiated, but the terminology overlaps with other theoretical ideas and requires explaining. In addition, policy-entrepreneurs are important actors in 'top-down' models of policy implementation (Van Meter and Van Horn 1975). In contrast, and of more significance to this research, street-level bureaucrats operate at the level of policy implementation and, as Lipsky (1980) argues, they have a significant capacity to change policy, either conforming to its original intentions or re-shaping it and following a different agenda. This places considerable power in the hands of those tasked with ensuring polices are carried out: what I term policy-implementers. Therefore, to understand how health policy is implemented we need to consider how these policy-implementers respond to policy and what work they do to interpret it and apply it to their everyday practice.

The field of study is open to a variety of interpretation and theoretical thinking. These elements contribute to a complex, multi-layered picture, which does not respond to a single approach to understanding implementation processes. Healthcare is recognised as challenging and complex (Plesk and Greenhalgh 2001); there continue to be calls for new ways of conceptualising ideas implemented in healthcare (May 2013), focusing on ideas described as an implementation science. In particular, Normalization Process Theory (henceforth NPT), which sees the adoption of new ideas as a social process. This research uses the theoretical perspective of NPT to explain what is happening in this area of policy implementation.

1.3 The study-aim and objectives of the research

Aim. To explain what processes are used to implement self-management support policy for people with LTCs into the everyday practice of one health board.

The objectives of the research were:

i) To describe the context, content and process of policy-implementation through examination of policy documents promoting self-management for people with LTCs in Scotland;

ii) To investigate how awareness of self-management policy is being transferred from policy-makers to policy-implementers;

iii) To understand the work being used by policy-makers and -implementers to deliver policy in practice;

iv) To account for the factors which support policy implementation and those which inhibit it; and

v) To test the applicability of NPT and its associated constructs of coherence, cognitive participation, collective action and reflexive monitoring as a model to conceptualise the process of policy implementation.

1.4 Personal and professional motivation for the topic

My interest in health policy and change has been motivated by my professional and academic interest in understanding the context within which healthcare is delivered. As a nurse and as a Senior Lecturer I seek to impart this understanding to the practitioners of the future.

My work experience prior to my academic career has been clinically and managerially based. Often in these jobs my work seemed to be reactive rather than planned and organised which caused me frustration. I first began working for the NHS in 1988 and since then the NHS has been characterised by two decades of change and attempts to re-organise it. These attempts were led by the UK Government and then since 1999 following the establishment of the Scottish Government when health became a devolved issue. Reform and re-organisation of the NHS continued in England and Scotland although as (Greer 2004), observed, devolution meant that while the four health systems of the UK faced similar challenges they have approached them with contrasting political solutions. Scotland's approach has been to promote *professionalism,* using clinicians and networks of clinicians to plan resource allocation and agree how care can be rationed (Greer 2004). This engagement with clinicians is a significant part of the policy story in Scotland and one I have both academic and professional interest in exploring.

My interest in this area has also been fuelled by a desire to understand how new ideas can be implemented in the NHS, an organisation with a reputation of resistance to change. Between 2001-2003 I worked on a series of re-design projects in a Scottish NHS Trust. This was a period when the Scottish Government was promoting quality improvement methodologies as a means of delivering changes in the organisation of care. This interest in quality improvement is still evident in NHS Scotland today as represented by '*The Healthcare Quality Strategy for Scotland'* (Scottish Government 2010a). I have drawn on my personal teaching experience with pre-registration nursing students to explore these aspects of change and improvement and to inform the design of undergraduate assessment. Having researched this subject in practice and theoretically through teaching it is clear to me that there is no one solution to understanding the mechanics of change and how processes could be improved. Policy is an important and recognised drive for change; and developments in the organisation and delivery of care are inextricably linked to changes in health and social policy. Furthermore, the changes required commonly fall on the practice of nursing; therefore it is in our professional interest to better understand the solutions which the politicians are imposing on us and to communicate that understanding to policy-makers. It is my intention that this thesis goes some way towards explaining aspects of policy implementation and how policy delivers action in practice.

1.5 Outline of the thesis

Chapter 2 presents a critical review of the literature relating to policy implementation. This is an area of considerable debate, which has undergone ebbs and flows in the amount of interest it receives from researchers and theorists. I have highlighted key points of discussion and identified those, which help to determine how we might better understand the implementation of health policy.

Chapter 3 reviews another important body of literature that addresses ideas of change and the management of change in healthcare. The purpose of Chapter 2 and 3 is to show the close association between policy implementation and concepts of change and innovation. The combination of these bodies of literature is used to provide a rationale for the research questions addressed in this thesis.

Chapter 4 explains the research design and methods used in the research undertaken for this thesis. The aim, objects and research questions are set out and the process by which I sought to answer these questions is described. There is a detailed account of how sampling and the process of data collection were carried out. Ethical considerations and the procedure for acquiring ethical and NHS Research and

Development approval from the chosen health board are set out for examination. Ideas on alternative approaches are discussed; as are my methods for assuring standards in reflexivity, rigour and scholarship.

Chapter 5 is the first of two chapters outlining the findings. In the first of these the findings from my examination of concurrent policy documents are presented. This chapter delineates the policy timeline as it applies to self-management support for people with LTCs. In addition it accounts for the actions and ‘work’ undertaken by policy-makers and expected of policy-implementers. It sets out the link between health policy and the changes expected in practice.

Chapter 6 is the second of the chapters looking at findings. Here the focus is on data gathered from interviews and observation. Using Carl May and colleagues’ (2009) NPT as a conceptual framework, the processes of policy implementation are presented by examining new ways of acting and how work becomes routine, embedded and normalised into practice.

Chapter 7 synthesises the findings to reflect on the significant tensions and conflicts revealed by the findings. Here the discussion explores the meaning of the findings to determine what has been learnt from this research.

Chapter 8 provides detailed discussion of the findings. In addition the strengths and weaknesses of this work are explored and related to other literature. The final **Chapter 9** provides recommendations and concludes the thesis.

Chapter 2 Policy, policy process and policy implementation: a literature review

2.1 Overview of chapter

This chapter synthesises the literature on policy analysis and policy implementation to provide the context and justification for the study. The term 'policy' and the processes of policy-making are defined. Policy, in particular health policy in Scotland, is both the starting point and the object of the study; it is important, therefore, to be explicit about its essential characteristics. Thereafter the chapter considers the policy process: what is written about how policy is made, the use of evidence and other influences on policy and its implementation. The focus of the discussion here is on how actions are taken in the policy process; later chapters of the thesis will analyse the specific content and findings to address the question "*what is being done to implement policy promoting self-management support in Scotland?*"

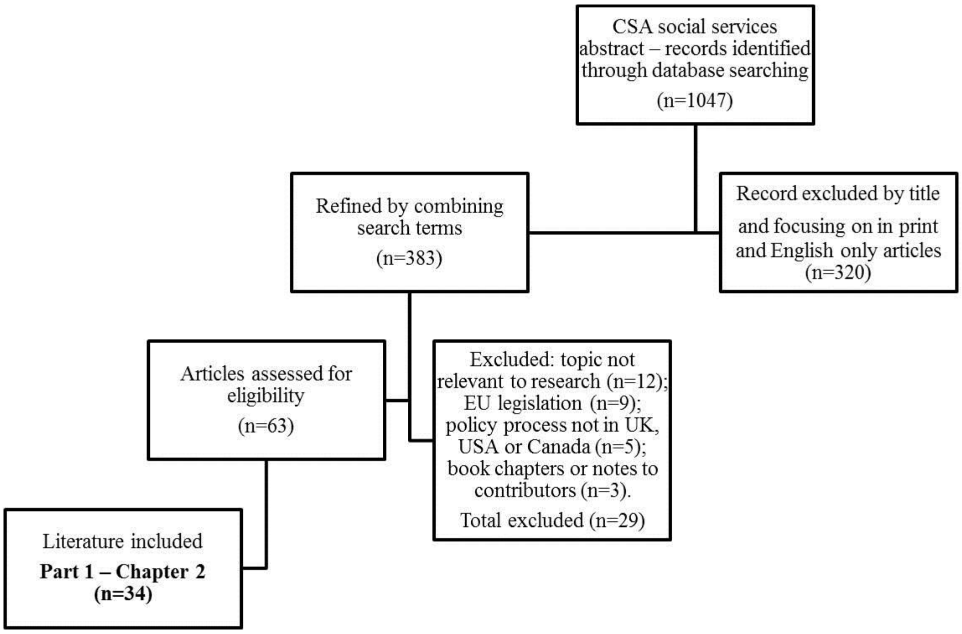
2.1.1 The literature search strategy

My literature search was undertaken in three phases: **Part I** an initial review early on in the research (February-May 2008); **Part II** further refinement of the literature was undertaken in November 2012 and added to in November 2013 on conclusion of data collection and during the final writing-up phase and; **Part III** a targeted literature search in response to examiners' feedback conducted in January 2015.

In Parts I and II searches of the CSA Social Services Abstracts Database were undertaken to identify existing studies exploring the policy process in health and the healthcare environment. **Figures 2-1** and **2-2** represent the process applied at these time points.

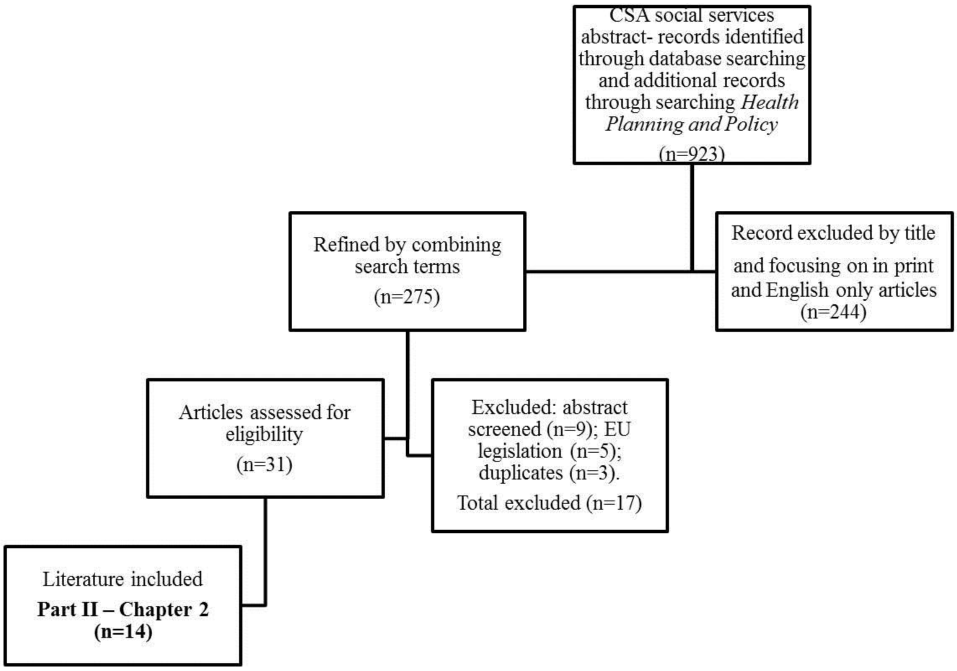
The **Part I** literature search covered 1997-2008. The start date of 1997 was chosen because it matched the political context of my area of policy implementation. My research was conducted in Scotland and the year 1997 marked the establishment of the Scottish Parliament; one of its key areas of devolved power was decision-making on health and health policy. The aim of this initial literature review was to critically interrogate the conditions for the implementation of policy and I wanted literature which matched my areas of exploration: policy, policy-making, policy process, policy implementation, policy change, health, organisations and the NHS. A total of 1047 articles was initially identified. Articles were included using the following criteria: in English; available to download through the University library; I excluded in press, book chapters, duplicates and editorial comment or debate. **Figure 2-1** gives further clarification on the screening process applied.

Figure 2-1 – Part 1 – literature search strategy



Part II of the literature search updated the literature from 2007-2013. In addition to the search terms used previously the literature was refined to include: policy process; health policy process; health policy implementation; power; and networks. In addition I chose articles that were written by authors whom I recognised from previous reading. Finally, by engaging in an iterative process, the range of reading was increased by reviewing references used in a number of the research articles and following these up. Articles were included using the following criteria: a five year timeframe from 2007-2012/13; in English; available to download through the University library and; excluded if in press. The additional sources found at this stage totalled 923. **Figure 2-2** sets out the screening process applied to refine this review.

Figure 2-2 – Part II – literature search strategy

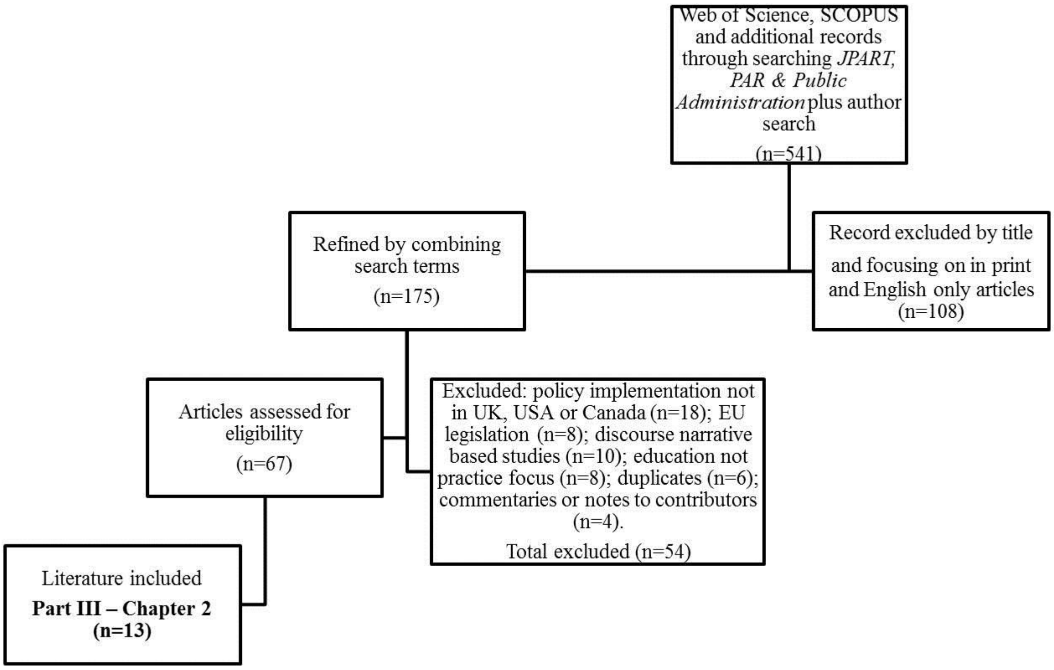


Searching, obtaining and reading literature has been an on-going process further refined and updated in **Part III**. This most recent bibliographic search was completed using Web of Science (WoS) and SCOPUS databases (neither resource is all-inclusive). WoS includes, in its core collection, the Social Science Citation Index (SSCI). In addition, direct searches of the following were undertaken: Journal of Public Administration Research & Theory; Public Management Review (JPART); Public Administration

Review (PAR) and; Public Administration. I added a specific search for articles authored by Sandra Nutley. This approach helped to check the robustness of the literature search.

Part III identified 546 references. The selected search terms included: policy process; health policy process and health policy implementation. Articles were included using the following criteria: a five year timeframe from 2010-2015; in English; available to download through the University library and excluded in press citations. **Figure 2-3** sets out the details of the refinement of the search strategy and how the additional literature was identified.

Figure 2-3 – Part III – literature search strategy



The literature identified from **Part III** search strategy has been incorporated into this revised chapter as well as directly influencing the debate presented in the sections entitled Health Policy and Health Policy Implementation (**Section 2.6.5**) and Evidence in the policy process **(Section 2.6.6)**.

2.1.2 Background

Over the last 40 years there has been considerable academic interest in what is termed '*policy research*'. However, what is debated is as a much about why the topic of policy and policy implementation has gone in and out of fashion as it is about how to undertake policy research, or how successful policy is in delivering the outcomes it envisages. The actions undertaken by policy-makers and policy-implementers are less well understood; in particular, the processes of health policy implementation are still not well studied – whether it is successfully implemented or not.

Furthermore, as a coherent subject area, research on policy and policy implementation does not sit conveniently within one academic discipline: the boundaries are blurred and indistinct covering political science, sociology, institutional theory, organisational theory and public administration. Here I have focused on understanding the nature of policy and policy implementation as it operates within health-care and specifically the delivery of self-management support for people with LTCs.

2.2 What '*policy*' is

Intuitively we might feel that we know what policy is because we have experience of it, or at least its content. For example, consider the Act that implemented the ban on smoking in public places, which became law in Scotland in March 2006 (Scottish Government 2005). We have all felt the impact of this and can describe how the legislation has changed our experience, irrespective of whether we are a smoker or non-smoker. From this we know what policy feels like; we can see that it is something handed down and associated with government or those in authority. In this example the authority of the smoking ban is ensured because it is enshrined in two aspects of the state; government and law, but its experience is also close and personal and this helps us understand what policy is. However, our intuitive understanding based on personal experience only takes us so far. For the purposes of this thesis we need a definition that is more nuanced, in-depth and concrete. We have to look beyond our personal knowledge, to the wider literature, to arrive at a more detailed and comprehensive understanding of what *'policy'* is.

Among analysts there is consensus only that the term policy is difficult to define (Buse et al. 2005; Hill and Hupe 2009; Hogwood and Gunn 1984), so ideas and definitions are often described as broad and diffuse (McConnell 2010). However, despite the repeated refrain that policy is difficult to define it is possible to identify one source from which subsequent debate has flowed. Authors such as Walt (1994); Buse al (2005); and Hill and Hupe (2009) refer above all to James Anderson's (1975) definition. He offers the following definitions:

> "*A purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern."*
>
> And "*Public policies are those policies developed by government bodies or officials*" (Anderson 1975: 3)

So policy is about what is actually done against what is proposed and it is those in authority forming part of a political system who formulate public policy. These distinctions are important in terms of defining my research area since I am interested in public policy, health policy, and understanding what actions are being taken by policy actors, specifically policy-makers and –implementers, to transmit instructions from the political centre to practice or the periphery (Pressman and Wildavsky 1984).

2.2.1 Characteristics of policy – the what and how?

McConnell (2010) suggests that policy comprises multiple entities which constrain its meaning, encapsulate it too tightly distil it down to its essence and preventing it from being studied. He argues that more can be learnt if policy is divided up and the divisions he offers are between "*the what*" – content of policy and "*the how*" – process of policy (McConnell 2010). These divisions are also identified by other authors including Hall and Jenkins (2008). They suggest that policy is commonly defined as decisions and choices made by governments about *what* should be done and *how* actions should be undertaken. Given that policy can be seen as both "*what*" and "*how*" I will consider each in turn.

Contemporary society uses policy to address significant problems facing governments. The "*what*" of policy focuses on content: what decisions should be made about areas of concern. The decisions reflected in policy are important because they also reflect the tools that governments use to tackle perceived problems (McConnell 2010). Having identified areas of concern, policy sets out goals and the means of achieving them, thus seeking to correct problems (Hill and Hupe 2009). The content of policy is about the importance of ideas, philosophies or ideologies, which are presented as purposeful patterns of activity and actions directed towards a goal (Buse et al. 2005; Anderson 1975). This has been termed the "*rational model*" (Gordon et al. 1993: 8).

This commonly held perspective, which is that policy equals decisions, is presented in a variety of writings on policy, public policy and health policy (e.g. Buse et al. 2005; Allsop 1995; Barrett and Fudge 1981; Hill and Hupe 2009). The association of policy with decisions is illustrated by the following definition "*policy is the cognitive act of presupposing what needs to be done and making decisions on that*" (Hill and Hupe 2009: 3). The decisions taken by government can be defined as action, but also involve the use of persuasion, resources, regulation and provision (McConnell 2010).

However, Hill and Hupe (2009) suggest that while policy content reflects a decision to act it can also betray a decision not to act; or to take no action. Hogwood and Gunn (1984) agree that policy includes decisions and actions but also inaction – what is not done is as important as what is done. A current example of action versus inaction is the debate over how to address the relationship between Scotland's population and alcohol and the Bill to impose a minimum price for a unit of alcohol of 50 pence per unit (Scottish Government 2012). The decision to act on and impose this sends a strong message of disapproval. In contrast, the decision not to make this policy, or not to be able to make this policy as a consequence of legal challenge, sends a different message. Not implementing minimum pricing per unit of alcohol sends a more relaxed and pluralist message: that alcohol should be available at a fair price. Both are decisions and both reflect policy but the experience, content and effect of each decision would be very different.

The content of policy also reflects who takes the decisions. Most commonly, policy is associated with government decisions; this is when it becomes public policy (Anderson 1975). This distinction between 'policy' and 'public policy', with public policy having the authority of government - the state - behind it, is significant. It helps legitimise action and supports implementation (Hill and Hupe 2009). This idea, endorsed by Allsop (1995), who observes that public policy is associated with government statements of intent. Similarly, Buse et al. (2005) consider public policy to be made by government since they provide the authority. However, the assumption of public meaning government and therefore no involvement of private or voluntary organisations nor the people on whom the policy is to be enacted - is not necessarily true and public policy does not necessarily exclude these organisations. This adds to the diverse nature of the concept of public policy (Hogwood and Gunn 1984)

Buse and colleagues (2005) explain further that decisions reflected in policy are presented as formal statements applied to a specific "*field of practice*" (Buse et al. 2005: 11). Thus health policy can be defined as the application of decisions taken by government designed to address concerns or problems about health, healthcare and about funding of the health system. The definitional relationship between the terms policy, public policy and health policy appears clearer.

In summary, the content of public policy involves decisions taken (or not taken) by those elected to address public concerns. However, it is argued that characterising policy as relating to decisions is an over-simplification. To fully understand policy we need to account for the "how" and not just the "what" of policy.

As explained by Barrett and Fudge (1981) policy is more than just a starting point delivered by a bureaucratic machine. Any particular set of policies evolves as part of a policy-system. Its nature and essence ebb and flow as it is debated, discussed and moulded beyond the confines of the state or bureaucratic machine and, perhaps, beyond its original intent.

Barrett and Fudge (1981) are not the only authors who feel that just focusing on content as a means of understanding policy is too simple and glosses over its complexity and interrelationships. McConnell's (2010) ideas hint at the potential indefinability of policy, which is not helpful when planning research on the policy process. However, it shows that any definition of policy must more closely reflect the reality of practice. He suggests that to understand policy we need to look beyond the boundaries of what policy is to the system and processes within the system, which support and shape it.

The policy system involves individuals and/or groups as well as governments. These policy-makers, as they are termed, form components which operate on different organisational planes at both macro- and micro-level. Walt (1994) highlights the importance of appreciating the difference between macro- and micro-level actions and the importance of the policy-generating system. She argues that understanding the system within which policy is generated opens up the definition of what policy is and illustrates the role of negotiation and how aspects of power influence policy (Walt 1994). Again, this perspective helps us understand the importance of appreciating that policy is about process – '*the how'* and, not just about its content – *'the what'*.

Investigating how policy is achieved requires closer consideration of the actions and behaviours of those charged with creating or formulating it and those who seek to implement it (Hill and Hupe 2009). Consideration of the '*how*' of policy demonstrates that it is not a single entity; it arises and evolves over time resulting in a 'policy-process' (Jenkins-Smith and Sabatier 1993a). As McConnell (2010) observes, thinking of policy as a process is not new; he argues that it provides a useful way to understand policy, specifically in terms of understanding why policy might succeed or fail in achieving its desired goals.

The policy-process is predicated on the idea that for policy to be achieved a number of key elements are needed: a plan must be formulated about what needs to be done; it requires thinking about how the plan will be undertaken before carrying out the action (Hill and Hupe 2009). Therefore, integral to how policy is achieved is that it must have an outcome - a clear objective (Hogwood and Gunn 1984). Brain Hogwood and Lewis Gunn, two influential public administration scientists, proposed that to a degree the policy-process can be planned and predicted but that, much as the process can be planned, it can lead to unintended consequences.

In addition, these authors argue that while actions designed to achieve a policy outcome may be planned prospectively, they can also be defined retrospectively. The generation of policy involves decisions, choices and actions associated with its content, but these activities are also representative of what happens during the policy-process. Hill and Hupe (2009) argue that this cognitive process results in two groups of questions which highlight opportunities for enquiry in this field.

The first group of questions focuses on "*who is the formulator, who is the decision-maker and who is the implementer?*" in the policy process (Hill and Hupe 2009: 4). The second group of questions concerns whether policy-makers have more power than policy-implementers (Hill and Hupe 2009); and these questions recur in different areas of policy literature. They feature in debates about whether to explore policy implementation from a macro-political or micro-political perspective (Schofield and Sausman 2004) and when trying to use models to explain policy-implementation (Lipsky 1980). The nature of the policy-process is explored in more detail later in this chapter.

In this thesis my interest is specifically in health policy. As with other public policy the decisions reflected in health policy are focused on areas of concern which currently include how to reduce health inequalities; how to tackle increasing levels of obesity; and how to manage the demand created by changing patterns of disease (Buse et al. 2005). Health policy focused on addressing the latter area of concern is central to this exploration of policy implementation.

2.2.2 Characteristics of healthcare policy

Blakemore's (2003) definition of health policy is that it sets out government decisions and actions to address areas of concern and aims to maintain and improve people's health. Taylor (2013) suggests that further distinctions can be drawn between health policy and healthcare policy. The former is about improving health - termed ‘upstream work’ - and the latter relates to government decisions to influence healthcare delivery – ‘downstream work’. For the purposes of this thesis, policy promoting self-management support can be seen as an example of healthcare policy and downstream work. As we will see in **Chapter 5** in this area of policy the Scottish Government is directing the action of healthcare providers (principally the NHS) and healthcare practitioners and in turn influences the health of the populations they serve. To achieve this requires evolution and adaptation to changes in circumstance and environment so that policy becomes inextricably linked with ideas of change and innovation (Sabatier and Mazmanian 1979). Here we are determining if healthcare policy is associated with change and innovation in the Scottish NHS.

2.2.3 The National Health Service

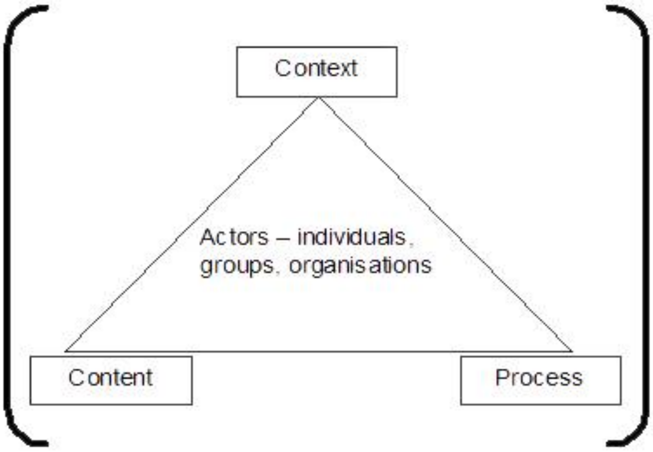
In the UK, government decisions about health, health policy and healthcare policy are taken differently in England, Scotland, Northern Irelands and Wales. All four health systems are based on similar principles, face similar challenges and areas of concern. However, as a consequence of devolution, they have developed different models of delivery (Greer 2004).

The NHS in Scotland has been described as ‘*professionally dominated*’ (Greer 2004: 8) consisting of a tight-knit policy community that relies on a powerful medical infrastructure and universities’ professionals to direct and influence health policy direction. In contrast, NHS England is subject to a broader range of influences and more managerially lead. Greer's (2004) insight into the importance of professionally led groups influencing policy provides a useful starting point from which to understand how policy is made and implemented in Scotland.

2.2.4 The policy triangle

The literature reveals dynamic elements and influences affecting health policy and the complexity of these interrelationships and perspectives is reflected and explored in this research. What Buse and colleagues (2005: 8), specialists in the analysis and exploration of health policy, termed the "*policy triangle*" helps to identify the key elements and their connections. They recognise the importance of four characteristics of policy: policy content, policy process, the actors (those involved) and the context or field of policy. Drawing these elements together into a triangle with the actors at the centre provides a systematic approach to understanding what policy is and forms a useful analytical perspective on the policy context of research into self-management support for people with LTCs.

Figure 2-4 - Policy triangle



(Buse et al. 2005: 8)

Healthcare policy sets the context and provides the impetus and opportunity for policy-implementers to make changes but also allows policy entrepreneurs to mould policy as it is developing (Kingdon 1995). John Kingdon's perspective on policy is seen as pertinent to health policy development (Breton and de Leeuw 2011). His ideas on the importance of policy entrepreneurs link with Hill and Hupe's (2009) question about who holds power – policy-makers or policy-implementers. The degree of control and entrepreneurism that policy-implementers can exercise when turning policy into action is a significant element of this research.

2.2.5 Summary

Policy and its implementation are multidimensional, as the distinction between what (content) and how (process) goes some way to acknowledging. At the same time this distinction helps to identify key characteristics and elements that explain boundaries of policy and the iterative relationship between content and process. The relationship between policy-maker and policy-implementer is blurred and this research has sought to examine and understand this relationship and negotiation in the context of health policy. The policy triangle proposed by Buse et al. (2005) helps thinking about the various elements of healthcare policy and is used later to set out the analysis of healthcare policy documents.

2.3 How policy is made?

Understanding policy-making is difficult and this is particularly true of health policy; there are many overlapping ideas and inter-relationships and unpicking what influences which aspects of policy-making has resulted in different conceptual devices or models. These models seek at best to clarify reality. They are not true representations of what actually happens in practice but help guide thinking and encourage consideration of the many factors that may or may not be at work. There are two broad approaches to representing what Kingdon (1995: 117) describes as the "*policy primeval soup*": a systems models and process models. I consider each in turn.

Conceiving of policy and policy-making as a system (Hill 2005) sees policy as the result of an ‘*input*’ which could be an idea; a political aspiration and/or a topic of public concern. This input is processed by political organisations, commonly governments, who are influenced by situational factors and mechanisms such as statutory consultation, and power. What emerges as an ‘*output*’ is the policy (Buse et al. 2005) (also known as Black Box management, after Henry Ford: the idea is that if you know the input with sufficient certainty, the output is predictable). Systems models as a means of defining policy are criticised for their over-simplicity. Specifically, they are criticised for not creating sufficient distinction between political influence and administration (Hill 2005). Therefore, alternative ideas have sought to take account of both politics and administration but also to reflect more convincingly the complexity of decision-making involved in policy-making. It was against this background that policy production came to be seen as a process (Hogwood and Gunn 1984; Walt 1994; Hill 2005) and ideas of policy stages or cycles of policy-making emerged (Walt 1994).

Analysis of policymaking as a process identifies stages through which ideas, political aspirations, areas of public concern, or perceived need for change may pass before they become policy. Understanding policy implementation as a process allows a mapping of current areas of public concern to resources (Allsop 1995); allows some analytical purchase on policy-making which is consistently described as complex (Walt 1994); and demonstrates that policy-making is not achieved by one action or decision but by a series of actions that overlap and which in reality are difficult to separate (Hogwood and Gunn 1984).

2.3.1 Understanding the process of policy-making

Stages of the policy process, or what has also been called the policy cycle, have been identified to help explain and understand it (Buse et al. 2005). Howlett and Ramesh (1995) take a view informed by the study of public policy and follow a simple model with stages that include problem recognition; proposal of solutions; policy implementation; and policy evaluation. Similarly, Kingdon's political science influenced perspective (1995) highlights agenda setting; specifications of alternatives from which a choice is to be made; an authoritative choice among alternatives; and implementation. In contrast, Hogwood and Gunn's (1984) ideas are influenced by their background in public administration and identify more detail with nine stages: deciding to decide; deciding how to decide; issue definition; forecasting; setting objectives and priorities; options analysis; policy implementation; evaluation; and finally policy maintenance. Political scientists Jenkins-Smith and Sabatier (1993b) also offer a more detailed explanation of the policy process.

Table 2-1. summarises these five approaches to describing the stages of the policy process, ranging from the simplest with four discreet stages to the more complex or detailed. Even though the more detailed suggestions can include up to nine separate stages as presented by Hogwood and Gunn (1984), **Table 2-1** shows that these stages can all be understood within Walt's (1994) four-step framework. So Walt’s model of the policy process may be the simplest but it still covers the essential points that other authors express in more complex models and this observation is identified by the shaded area in **Table 2-1.**

Table 2-1 Different views of the stages of the policy process.

The public administration perspective Hogwood and Gunn (1984)	*The political science perspective* Jenkins-Smith and Sabatier (1993b)	*The health policy analyst perspective* Walt (1994)	*The public administration perspective* Howlett and Ramesh (1995)	*The political science perspective* Kingdon (1995)
Deciding to decide	Policy identification – how issues emerge and get taken up.	Policy identification	Problem recognition,	Setting of the agenda
Deciding how to decide				Specifications of alternatives from which choice is to be made
Issue definition				Authoritative choice among alternatives
Forecasting,	Policy formulation – consideration of who is involved and how policies are communicated;	Policy formulation	Proposal of solutions	
Setting objectives and priorities				
Options analysis				
Policy implementation	Policy implementation – important but often neglected stage	Policy implementation	Implementation	Implementation
Policy evaluation	Policy evaluation – what happens when policy is put into effect	Policy evaluation.	Evaluation	
Policy maintenance				

Although there is broad agreement regarding what stages best represent the policy process, the process or cycle model (Hogwood and Gunn 1984) is linear, implying that each stage is completed before progressing onto the next. In practice policy-making is likely to be iterative and no account is taken of this in current procedural models (Walt 1994). Furthermore, both Walt (1994) and Hill (2005) argue that a linear model makes the presumption that once policy-making has been initiated all stages necessarily follow on. In reality, this is unlikely to happen because, as we have highlighted, policy appears organic with no one organisational level having complete control over each stage. Policy is defined in some ways by the actions or decisions taken by governments but equally by the influence exerted by those charged or who seek involvement in policy implementation. Neither the systems model nor the process model can account for this level of variation.

The stages set out in the various models of the policy-making process also serve to demonstrate that policy can and does originate at different organisational levels and that these organisational levels are important when looking at how policy is implemented. Policy can originate at an international, national or local level (Taylor 2013), initiated by international organisations such as the WHO or the European Union, by the Department of Health, England and by the Scottish Government, Scotland. At the local level, policy is formulated and negotiated with key stakeholders: this is seen as the key organisational context for implementation. The influence that these organisational levels have on the policy process and particularly policy implementation explains why this thesis has sought insight from the national, regional and local organisational levels.

Appreciating the influence of the local organisational level helps explain why the stages of the policy models discussed above might not flow in the predictive manner implied by the stages associated with existing models. Policy implementation does not necessarily follow on from policy formulation. Indeed, the action of policy implementation often shapes how policy is delivered in practice, which might be different from the vision generated when policy is formulated. As Pollitt and colleagues (1979: 139) explain, "*policy-making cannot readily be separated from policy implementation*". This fits with the views of prominent early political science writers Van Meter and Van Horn (1975) that policy implementation should be understood as the actions of people (policy-implementers) directed at the achievement of the objectives set out by a policy directive. The policy process is iterative, and this is illustrated further by the debate between perspectives on policy implementation that explain it as either a "*top-down*" or "*bottom-up*" activity. This raises the question "*how is policy put into effect*?": the important step or process of policy implementation.

2.4 Policy-implementation

Towards the end of the twentieth century a distinct area of policy research emerged, focusing on policy implementation. Initially, it sought to separate policy formulation from policy implementation; what is termed the top-down versus bottom-up theories of policy implementation (Hill 2005). Over time discussion moved to consider what happened during the process of implementation and research explored the role of policy-implementers. By the turn of the century interest in policy implementation had waned, prompting prominent public management scientists Jill Schofield (2001) and Lawrence O'Toole Jr. (2000), to call for more attention to this neglected aspect of the policy process. One explanation for the paucity of interest in policy-implementation is that, as observed at the start of the twenty-first century, there is no well-developed theory of implementation (O'Toole Jr. 2000). This deficit or more specifically the observation that no one theory of policy implementation is suitable for all purposes is still relevant today (Katikireddi et al. 2014). This thesis goes some way to exploring one possible theoretical perspective that might overcome this perceived gap in knowledge. Before proposing the new idea we must first identify what is currently known or debated about policy implementation.

The evolution of the body of literature on the policy process is best understood by considering the early discussion of “top-down” versus “bottom-up” policy implementation (Matland 1995). Policy implementation can be examined from both perspectives, each seeking to represent the influence of the policy-makers and -implementers differently (Buse et al. 2005).

2.4.1 Top-down versus bottom-up ideas on policy implementation

In the 1970s two scholars of public policy Pressman and Wildavsky (1973) heavily influenced discussion on policy implementation and the emergence of top-down models. At the same time Van Meter and Van Horn (1975) presented one of the first models of top-down policy implementation (Matland 1995). The focus of top-down models is on the importance of authoritative decisions and the importance of policy-makers in achieving the desired effect (Matland 1995). The core argument of top-down theorists is based on the assumption that policy implementation should be divorced from policy and that policy-makers must consider how policy should be implemented, it should not be left to chance (Hill 2005). Counter to what might be expected top-down theorists did recognise the importance of understanding how policy could be put into action; but their debate was about who had the power and focused on the policy-maker having more power and influence that the frontline policy-implementers.

As a perspective the “top-down” model of policy implementation has been criticised for predicting a linear relationship between policy formulation and delivery (Sabatier

1986). However, the arguments are more complex: they relate to different schools of thought and different ways of thinking of the world (Hill 2005). In reality the implementation of policy requires a combination of factors operating from both perspectives, top-down and bottom-up, with different stakeholders exercising differing levels of power at different points of time and at different institutional and organisational levels.

The “bottom-up” perspective is heavily influenced by ideas from political science and sees the policy process as iterative, involving negotiation, communication and conflict as policy is translated into practice (Sabatier 1986). Prominent in this debate are the ideas of the political scientist Lipsky (1980) who contests that policy-implementers have significant capacity to either conform to the original policy design or change policy. In contrast, the “top-down” perspective sees control and direction, set by government, as all-important in directing the process of implementation.

A combined approach is most clearly presented in the Advocacy Coalition Framework (ACF) (Jenkins-Smith and Sabatier 1993b) model. It is explored in some detail later but at this stage it is important to establish that it seeks to combine ideas of top-down and bottom-up approaches while also providing an alternative view of policy implementation (Jenkins-Smith and Sabatier 1993b).

Other authors also challenged models of policy-making as a linear process (Barrett 2004; Buse et al. 2005; Hill 2005; and Taylor 2013).Hill (2005) suggests that each stage does not necessarily follow on from the next and Buse et al. (2005) suggests that seeing policy implementation as only ‘top down’, reflects a hierarchical view which is too simple. Barrett (2004) argues that policy implementation should not be seen as a separate stage in the policy process; rather the process is continuous and starts when policy is first identified. Focusing on a top-down only model implies that the policy process operates only at the macro-level where governments and the role of the state dominate (Barrett 2004). These perspectives take too little account of micro-political processes, such as the roles that individuals, groups or organisations take in policy. For policy-making to be truly understood, account must be taken of the content, context, process and actors at all organisational level (Buse et al. 2005). This broad approach to policy-making is not reflected in either ‘top-down’ or ‘bottom-up’ models.

‘Top-down’ and ‘bottom-up’ models of policy implementation are also criticised for taking insufficient account of the range of actors involved in the policy process as well as the influence of factors outwith direct government control (Gilson et al. 2008). The exchange of ideas and information between policy-makers and actors involved in implementation is now so efficient that it further undermines the traditional perspective that the policy process is linear and solely directed from the top-down (Gilson et al. 2008). What emerges is a change in the understanding of how the policy process operates: it is seen as more interactive and iterative and legitimate research in this area has to reflect these changes.

A more fluid understanding of how policy is implemented is needed, one which recognises that policy-makers, such as governments, rarely make policy in isolation and therefore implementation forms a central part of the policy process, not just another stage but broader and integral to the whole (Taylor 2013). A more negotiated and less hierarchical view derives from the perspective that the policy process is influenced by power and networks as much as the desire and will of governments (Taylor 2013; Hill 2005). A more robust argument is to recognise that policy implementation relies on negotiation between those making policy (referred to in this thesis as policy-makers) and those seeking to put it into effect (policy-implementers).

The importance of the level of negotiation and debate between policy-makers and -implementers as part of the policy process is exemplified by Lipsky's (1980) concept of the Street-Level Bureaucrat (SLB) in which he proposed that the degree to which policy is implemented or not depends on those people who actually implement it. Policy implementation is down to those at the front line, such as nurses who, in their work, can exercise the most discretion in how policy is implemented.

For the purposes of this research, the debate about the pros and cons of staged models of the policy process and the debate about “top-down” versus “bottom-up” perspectives of power and control in policy implementation is useful in that it highlights the importance of understanding policy implementation processes as valid areas of study. However, this discussion also serves to illustrate the complexity of the arguments which seek to explain interrelationships of a number of variables and even the nature and meaning of policy. Reconciling and expressing these aspects means that research in this area is fraught with difficulty; consequently, empirical research of the policy process is rare.

2.4.2 Previous studies of the policy process

From the literature review undertaken it can be concluded that research examining the whole of the policy process is rare, probably because the characteristics of the process are hard to define and because each process is unique (Hill 2005) but also because of difficulties in the definition and nature of policy. In addition examination of the policy process is dependent on policy content and the context within which it is enacted (Schofield and Sausman 2004), which mitigates against generalisation. The technical aspects of successful policy-making cannot be defined and are not predictable. Instead, the researcher must take account of the negotiations, perceptions and interests of individual actors in each case studied. Replication or controlled studies are impossible (Gordon et al. 1993); consequently there is no agreement on what makes "*a good process*" and no "*ideal case*" of policy implementation against which subsequent processes can be compared. These factors help to explain why research looking at the whole policy process is rare.

Some lessons have been learned from experience, specifically in relation to policy implementation. Firstly, evidence shows that policy implementation is hard to achieve because policy addresses primarily social problems, whose inherent tensions are difficult to reconcile. Policy implementation also involves layers of government and institution and requires an understanding of the nominalistic world of the policy-implementer whilst reconciling this with the intentionality of the policy-maker (McLaughlin 1987). Other work suggests that ten preconditions need to be met to achieve perfect implementation. This model may be unrealistic but serves to emphasise the complexity of implementation and raises some questions that those focused on improving policy implementation process should consider (Gunn 1978). The following table illustrates the ten pre-conditions as questions.

Table 2-2 Why is policy implementation so difficult?

1) Do circumstances external to the implementing agency impose crippling constraints?	2) How dependent is the programme on getting the co-operation or consent of others and powerful groups?
3) Is there adequate time and sufficient resources available to allow implementation of the programme?	4) Is there complete understanding of, and agreement upon, the objectives to be achieved; and do these conditions persist throughout the implementation process?
5) Will the necessary combinations of resources be available when required?	6) In moving towards the agreed objectives is possible to specify the task performed by each participant?
7) Is the policy to be implemented based upon a valid theory of cause and effect?	8) Is there communication among and coordination of the various elements or agencies involved in the programme?
9) Is the relationship between cause and effect direct?	10) Do those in authority demand and obtain obedience?

(Adapted from Gunn 1978; 170-174)

Policy analysts argue that no single framework can adequately explain or examine this multi-level and multi-actor complexity (McLaughlin 1987). My theoretical perspective goes some way to appreciate the different levels of decision-making as well as taking account of the importance of will and capacity in achieving policy implementation (McLaughlin 1987).

2.4.3 Overview of health and healthcare policy process literature

A wide range of academic disciplines has investigated the policy process, commonly known by the collective term ‘policy analysis’ (Gilson and Raphaely 2008). Of relevance to this thesis is Saetren's (2005) observation that health has become one of the most important fields of study in this growing research literature which comprises either discussion pieces, reviews or, less often, empirical research.

Only a small proportion of the papers reviewed were based on original research. The majority were reviews of theoretical and methodological literature, which drew on the authors' experience to the explore issues and challenges that arise when adopting current approaches to the analysis of the policy process. When original research has been undertaken then qualitative approaches such as case studies, focus groups, observation and analysis of documents dominate (Gilson and Raphaely 2008).

In relation to health policy, the published papers identified for this review focused on a narrow range of aspects of health and healthcare policy. They cover mental health (Brown et al. 2010; Nolan and Hewison 2008; Smith-Merry 2008; MacCourt and Tuokko 2005); drug and addiction (Bergeron and Kopp 2002); nurse implementation of a complex children’s continuing care policy (Noyes et al. 2014); policy implementation by community nurses (Haycock-Stuart et al. 2013); health inequalities (Smith 2007; Bywaters and McLeod 2001; Powell and Exworthy 2001); public health (MacKenzie et al. 2006; and Mackenzie 2008), including the proposed minimum unit price of alcohol in Scotland (Katikereddi et al. 2014); sexual health including family planning and treatment of HIV (Crichton 2008; and Tantivess and Walt 2008) and the control of tobacco use (Cairney 2007; and Breton et al. 2007).

In the following sections I review this literature using four broad headings: firstly, I consider research and analysis of the wider contextual aspects that influence policy-making, what I have termed “why”; secondly the largest group of articles which come under the heading of “how” and cover process in policy-making; thirdly, I consider the literature that focuses on methodological issues and describes how to undertake policy analysis; and, finally, literature reviews and articles that review literature informing policy analysis and concepts relevant to it.

2.5 "Why" – contextual factors which influence policy-making.

The formation of policy, and healthcare policy in particular, is influenced by a number of general factors which establish the context against which healthcare policy is made (Buse et al. 2005). The term context includes four factors: situational, structural, cultural and international. A situational factor is a "*focusing event*" (Buse et al. 2005: 11), a one off occurrence, which triggers a new policy – for example, the current debate about press regulation versus press freedom following the News International phone-hacking scandal and the resulting Leveson Inquiry. Structural factors are more permanent and include the political system, economy and demographics of a population. For example, the implementation of a new system of health and public healthcare in NHS England as a consequence of The Health and Social Care Act (2012) (UK Government (England) 2012). Cultural factors include aspects of religion, gender stereotypes and established hierarchies, typified by the debate on minimum alcohol pricing as a means of persuading the public to reduce their alcohol intake. Finally, international or exogenous factors include international investment or global initiatives around particular health issues such as influenza, HIV or tuberculosis.

For Buse et al. (2005) these contextual factors are multi-layered and unique to each health and healthcare policy issue in terms of time and setting; and yet, despite their importance in understanding of the policy process, Gilson and Raphaely (2008) suggest that the contextualisation of research on healthcare policy process is often weak and inadequate.

From the literature I identified four structural elements of policy context that are likely to have a major influence on the policy process: devolution; demographic change; policy trends over time (e.g. the increasing move from paternalistic to consumer-led policies); and financial austerity. Of these, the most important are devolution and demographic change.

2.5.1 Devolution

Scott Greer (2004; 2005) argues that despite UK health systems facing common challenges, devolution in Scotland, Wales and Northern Ireland has resulted in the development of diffuse models of health delivery. In Scotland a model of professionalism has been adopted, with the generation of organisations that reflect existing health profession structures: for example, clinical networks. Greer (2004) suggests that this model promotes the role of the professional in resource allocation by reducing layers of management. Its other distinct characteristic is that the promotion of networks encourages collaboration and cooperation when prioritising and organising health services (Greer 2004). Scotland’s ready adoption of clinical networks is relevant because in the general policy literature (see **Section 0**) the role of networks in implementing policy decisions is highlighted (Brinkerhoff 1999).

Greer (2004) describes Scotland’s approach to the organisation of health as a gamble. In Scotland’s case it is a gamble with professionalism that this model will help balance the challenges of allocating finite resources whilst getting value for money and keeping health professionals onside; and that (principally medical) professionals will provide good advice because in Scotland they are seen as the key policy-implementers (Greer 2004).

Keating (2005) also explores the influence of Scottish devolution on the policy agenda. Like Greer he supports the identification of policy divergence and highlights examples of social care and education where Scotland has sought its own path and set its own priorities (Keating 2005). In Scotland power has been distributed amongst a broader policy community allowing the emergence of distinct policies.

Others argue that policy divergence between the four countries of the UK is less marked. Blackman et al. (2009) compared how three countries of the UK, England, Scotland and Wales, were addressing health inequalities and found that it was the similarities that required explanation rather than the differences and, where there were differences, they were not easily explained by national boundaries. So there is disagreement that the political context of devolution creates the distinctiveness in health policy that is suggested by Greer (2004) and Keating (2005). However, Scotland’s success in implementing a ban on smoking in public places earlier than the rest of the UK can be seen as a distinct national divergence.

It has been argued that the implementation of the smoking ban in Scotland, a successful policy change, is largely attributable to what was termed the “*new politics*” of devolution (Cairney 2007: 73): a 'Scottishness' deliberately distinct from Westminster politics. The first difference is the strength of committee structures that characterises the organisation of both the Scottish Parliament and Government. These committees and groups provide an opportunity for those outwith party politics to meet with decision-makers. It opens politicians to external expertise, and highlights the role of groups of public sector professionals as influencers in policy-making (Cairney 2007).

The second area of difference is the Scottish Parliament’s focus on government by consensus, allowing a more straightforward approach to government where individual

MSPs can have greater success in getting public attention and debate for innovative ideas so they can more directly influence agenda-setting (Cairney 2007). Similar to Keating's (2005) earlier discussion, the significance of the committee structure and the consensual approach to agenda setting is that they represent a broader distribution of power and influence. Just as with networks for policy implementation, power and the distribution of power are important factors in policy-making and -implementation (see **Section 0**).

Given the example of the implementation of the smoking ban in Scotland and my focus on the implementation self-management support policy in Scotland it is clear that any analysis of the policy process must include consideration of structural factors such as devolution and the expectation that Scotland seeks to establish its own health policy agenda.

2.5.2 Demographic change

Demographic change acts as a structural driver of policy-making. The modern European population profile is characterised by an increasing proportion of elderly people as life expectancy rises and birth rates fall (Saltman et al. 2006). This has implications for governments as they must direct their healthcare systems to consider innovative models of health delivery to meet the demands of a changing population and a corresponding rise in dependency. Finding the right model of care is elusive. Health policy-makers have to consider the balance between informal and formal care provision and the double burden of caring for older people and those with chronic conditions (Dargie 2000). In the UK the NHS or private organisations deliver expensive formal healthcare. In contrast, informal care is a system largely unpaid and provided by family and/or close friends, representing less of a burden on the state (Scottish Government

2010b). In work based on Scottish admissions information the combined impact of an ageing population, the demand for formal care and the lack of informal care has been demonstrated to be a contributing factor to the rise in emergency admission rates in those over the age of 65 (Kendrick and Conway 2006). This literature illustrates the impact that changing demographics are likely to have both in terms of demand for informal and formal long-term care and the increased burden of cost to provide it. Negotiating a path through these dilemmas generates three policy drivers, which should lead to transformational change across the UK NHS, with specific resonance in Scotland.

In Scotland it is estimated that by 2035 25% of the population will be over the age of 65; this combines with an estimated 2 million people (40% of the Scottish population) with one LTC plus the cost of providing health and social care for people aged 65 or over in 2011/12 which has been estimated at £4.5 billion – the total budget for the NHS in Scotland for 2010/11 was £11.35 billion – (Audit Scotland 2014). Scotland has, like other European countries, an ageing population, increasing prevalence of LTCs and faces rising costs of formal health and social care. Transformational change is needed to meet these combined challenges and health policy must respond.

As a direct consequence of changing age profiles and current and predicted changes in utilisation of long-term care a number of potential policy responses can be identified:

> - Redesign systems so that long-term care is as efficient and cost-effective as possible.
> - Support for informal carers so that more people take on the role. Shift the demographic profile by increasing the number of younger people in work and or extending the working-life of those in work.
> - Using policy to create "*healthier elders*"
>
> (Saltman et al. 2006: 742).

A number of these policy strands relate directly to policy promoting self-management support for people with LTCs, the focus of this research: the redesign of services; support for informal care-givers; education in prevention; and the generation of healthier elders. These priorities are reflected in Scottish health policy documents.

For policy-making this demographic change has specific implications. Governments must support the increasing proportion of the population that is economically inactive, living for longer with an increased burden of disease (DoH 2012). Government also seeks to offset the financial burden of an ageing population and its associated morbidity and policies to maximise healthy life years.

2.5.3 Future policy trends

Discussion of future policy trends (Dargie 2000) has also been shown to influence policy-making. In work which used ‘futures thinking’ to test how policy-makers could foresee the development of UK health policy (Dargie 2000) six issues were identified, of which the most significant was the impact on health policy of rising public expectation.

The report predicted that changes in public expectation would impact on the direction and focus of health policy in a variety of ways, including demands to increase individual access to health information and an empowered health consumer who has expert knowledge of health, resulting in a change in the relationship between consumer and professional (Dargie 2000). The likely implications for policy-making were an increasing focus on individuals’ responsibility for their own health and the promotion of access to health information (Dargie 2000). As we will see in **Chapter 5** the desire to promote greater personal responsibility for health and the need to make care more individual or person-centred are important drivers behind policy promoting self-management support.

2.5.4 Historical perspective

Previous policies and experiences influence current ideas and those aspects which make it on to the health policy agenda. Bywaters and McLeod (2001) highlight the impact of the Labour government on tackling health inequalities by closer integration of social and health services, which went some way to addressing health inequalities and the needs of vulnerable people. This theme of closer integration between social and health services continues in Scottish health policy.

Literature which has reviewed the NHS over a period of time, such as Gorsky's (2008), maps significant general changes in health policy. Of particular interest to the understanding of policy promoting self-management support is the emergence of ideas on patient choice, the importance of the patient experience and mutuality in healthcare (Gorsky 2008). These new ways of thinking counter the dominant ethos of paternalism - “the professional knows best” and provide a modern focus. Setting out the development of the NHS over the last 60 years shows how different current policy perspectives are from how things used to be (Gorsky 2008). This context helps to explain why policy change is needed in the delivery of the NHS but also why its implementation or realisation is often frustrated.

2.5.5 Summary

This section considered the contextual factors that can influence health policy-making. These include key drivers, concerns and issues that policy-makers are responding to which help explain why policy is made. From the literature four structural factors have been identified as of particular relevance to health policy-making in Scotland today.

These are: the establishment of devolution; the changing age-profile of the population; a corresponding increase in dependency; and future policy trends, particularly the increase in patient expectation and the shift towards patient empowerment and individualised care. In the next section I will consider meso- (organisational) and micro-levels (individual) and explore the literature that explains how the policy process works.

2.6 “How” – the processes which influence putting policy into effect

In this section I examine the literature exploring the processes by which policy is effected – policy implementation. This requires the focus to move away from the contextual or macro-level towards the interaction between those seeking to influence the action of others (policy-makers) and those upon whom influence is being brought to bear to act in a particular way (policy-implementers). This focus can be characterised as meso- and micro-levels (Barrett and Fudge 1981). These comprise ideas on power, networks, entrepreneurial action, policy change and policy-windows which are all used to gain or avoid influence or control in the process of policy implementation.

2.6.1 Power

Power can be understood as the ability to influence, to get things done and achieve an outcome (Buse et al. 2005). In policy-making power is important; it allows people to get involved and influence the policy process. Power can be exerted to impose policies that may be opposed or used to prioritise issues on the health policy agenda (Walt 1994). Furthermore, power, who has it and how it is used, pervades macro-level (governments’), meso-level (organisations), and micro-level (individuals) scales of policy-making (Walt 1994).

Consequently the influence of power in the health policy process is a focus of much policy analysis trying to understand who holds power in the health policy process and whether power lies in the hands of a few or is spread evenly. The latter is referred to as the tension between pluralism and elitism (Taylor 2013). Discussion also tries to understand how power might be distributed differently at each stage or cycle of the policy process. For example, its distribution will be different at the point of policy identification in comparison to policy implementation. This power shift is illustrated by considering Scotland's ban on smoking in public places. When the policy was identified in 2004 the Scottish Executive was considered as very much under the influence of Westminster and a ban was considered unlikely (Cairney 2007). Furthermore, the initial move to enact a smoking ban was proposed by a Scottish National Party MSP at a time of a majority Labour administration. However, by the time of implementation the power had shifted and in March 2006 Scotland became the first nation within the UK to implementation smoking ban (England would not enforce a ban until July 2007) and the success of the smoking ban was attributed to the Labour administration, its early association with the SNP dismissed.

There is no one explanation of power and its influence that explains the actions or importance of power across the policy process (Erasmus and Gilson 2008). What can be distinguished are ideas on how power is distributed to individuals and groups, how this distribution varies and the outcome of this variation. Pluralist ideology considers that power should be evenly spread throughout society with no single concentration (Taylor 2013; Lewis 2006). Pluralists argue that power influences the outcome of policy through several processes: promoting interest groups and negotiation with stakeholders to provide a broad range of influences during the policy process (Walt 1994); promoting participation in policy formation which ensures that politicians cannot ignore the wider concerns of the population; and maintaining state (government) neutrality and thus avoiding bias towards particular ideological interests. Walt (1994) suggests that pluralist policy is balanced and through collective action the public interest is put to the fore. Buse et al. (2005) challenge this understanding, arguing that it is impossible for governments to be neutral. They are subject to lobbying from powerful institutions and so policy reflects the interest of these organisations more than the public good.

Elitism is offered as the opposite of pluralism (Taylor 2013). Walt (1994) and (Lewis 2006) explore elitist theories and suggest that particular groups who are able to exercise more power than others dominate policy-making. Commonly, this view of power uses references to certain classes in society to illustrate that some are able to wield more power than another. Elitists think that pluralists are naive when describing how power influences the policy process. As Walt (1994) suggests, elitists argue that power is retained in the hands of the few; the political elite is narrow and dominated by individuals with the same background and way of thinking. Similarly, interest groups, which are seen by pluralists to mediate policy, are not egalitarian and are dominated by key professionals or businesses: for example, the medical profession, pharmaceutical companies or weapons manufacturers.

Walt (1994) suggests that neither perspective offers a true explanation of power in the health policy process and that it is more realistic to consider both pluralist and elite perspectives and try to understand how they can shed light on the policy itself and its implementation. Therefore, she argues, the distribution of power can move between elitist and pluralist interests depending on the focus of policy (Walt 1994). This compromise is termed "*bounded pluralism*" (Walt 1994: 39) and suggests that elite groups determine policies such as economics, but that domestic and health policy may follow a more pluralistic model. In health policy there is opportunity to participate – indeed this is often encouraged by governments, so there is room for "*pluralistic negotiation on policy*" (Walt 1994: 203). So the elite perspective does not dominate as much as might be expected. Indeed as a view, the elitist perspective can overstate the power that governments or those in control exercise over policy.

Discussion of elite and pluralistic models of power distribution focuses on relationships at the macro-organisational level. Focusing at the meso- and micro-organisational level, as well as its influence at different stages of the policy process, must also be considered when exploring the role of power in policy implementation. Erasmus and Gilson (2008) suggest that a more accurate representation of power is to consider how pluralist approaches operate to support the implementation of policy. They argue that policy-implementers shape and mould policy which challenges the power of the policy-makers. In contrast, at earlier stages of the policy process power is retained by elite policy-makers (Erasmus and Gilson 2008).

From the literature power emerges as an important factor in the health policy process; yet it is rarely explicitly examined in much of the work that tries to analyse health policy (Erasmus and Gilson 2008; Lewis 2006). If power was considered more carefully then this would help understanding of the health policy process, with the potential to improve policy implementation. Power can be decisive in supporting policy implementation but equally exercised to resist policy implementation (Erasmus and Gilson 2008). Understanding how power is exercised is important to policy-making and particularly important with healthcare policy. The spread of power in the health policy process is complex and multi-facetted (Walt 1994) and no single view fully explains the subtleties of who has power or how they exercise power in the health policy process.

Power operates in a variety of ways in this process. Further analysis of its operation focuses on the role of groups, or networks. For example, Lewis (2006) considers how power is exercised through networks and specifically how it is associated with certain professional groups, arguing that in the health policy process it is concentrated in the hands of key networks, specifically the medical profession. They, she argues, form a policy elite.

2.6.2 Policy networks and coalitions

Policy implementation is described as a negotiated process (Barrett and Fudge 1981); the means by which policy is effected relies on the actions, interests and ideas of key individuals (Lewis 2006). This individual activity is often organised into what are termed ‘policy networks or coalitions’ composed of people who know one another professionally and have built a level of understanding and trust (Jenkins-Smith and Sabatier 1993a). These networks use their interconnections to influence policy in a given field by promoting cooperation between organisational levels and using their power to influence the policy process, in particular how policy is implemented (Farquharson 2005; Exworthy 2008; Lewis 2006).

The idea of using networks to influence and effect action is not confined to policy; nor is it new. In healthcare it is recognised that networks within and between organisations may override formal structures and that informal social relationships can achieve an outcome (Ferlie and Pettigrew 1996).

The concept of networks and the associated idea of coalitions in understanding the policy process is most closely associated with the discipline of political science and offers one theoretical lens through which to understand the policy process (Sabatier 2007).

The importance of networks has also been revealed by recent policy research exploring how policy was turned from words to action (Tantivess and Walt 2008). The findings were generated from a qualitative study which analysed the experience of implementing universal provision of anti-retroviral treatment in Thailand between 2001-2004. The authors claim that there has been a shift in focus from government to governance, characterised by an increasingly networked society (Tantivess and Walt 2008). They highlighted the role of networks of non-government actors who proved to be influential not just in the agenda-setting stage of the policy process but in the development and up-scaling of existing policy (Tantivess and Walt 2008). Key to the success of this increase in provision was the influence exercised by a range of policy networks including civil society and non-governmental organisations as well as other specialist groups. This means that whereas decision-making and the control of policy used to be focused on the government or state, the existence of active networks allows for greater recognition of the role of non-state actors (Tantivess and Walt 2008). These non-state actor networks, such as voluntary organisations and professional groups, constitute a policy subsystem that plays a significant role in the health policy process (Baggott 2007). The investigation of networks and particularly non-state actor networks provides key insights into a significant component of policy-making, particularly health policy-making.

The authors conclude by arguing that: "*it would widen our knowledge and understanding of health policy analysis if more case studies could throw light on the role of non-state actors in the policy process*" (Tantivess and Walt 2008: 336). My work includes access to a wider group of individuals who can be described as a non-state actor policy network, members of voluntary organisations such as Arthritis UK, the Pain Association Scotland and local carers' networks. As my findings will demonstrate, these non-state actors have informed the health policy process with regard to the implementation of self-management support in Scotland.

Other authors argue that networks generate foci of activity at both national and local levels. This combination of vertical (top-down) and horizontal (integration across organisational levels) axes gives networks considerable influence in the policy process (Exworthy and Powell 2004). In addition, networks deliver work by promoting inter-connectedness and inter-dependence (Exworthy and Powell 2004). Consequently, to understand implementation it is important to explore the interconnections at a local level as well as centrally.

Lewis (2006) explores further the influence of networks and their associated power in the health policy process. In a paper that analyses the use of personal and positional influence in the implementation of health policy in Australia, she suggests that influence particularly that of the medical profession, is exercised through networks of actors who use it to get an issue onto the policy agenda, promote its importance and ultimately implement it as policy.

Other authors have sought to characterise the types of networks and their influence on the policy process as part of what are termed collectively "*networks models*" (Exworthy 2008) which seek to represent how policy networks connect organisational levels and influence policy implementation. Network models are categorised as either "*policy and issue networks*" or as "*Advocacy Coalition Frameworks*" (Jenkins-Smith and Sabatier 1993b: 2; Exworthy 2008: 332).

In the first model a distinction is made between a policy network and an issue network. A policy network is focused on direct involvement in the policy process. It is an established, stable working group with shared responsibility. In contrast, an "*issue network*" develops around a specific issue on which a number of stakeholders collaborate and seek to raise attention to promote awareness and policy action (Exworthy 2008). An example of a policy network was the collaboration between Labour and the Conservatives in Scotland to promote the concept of 'Better Together' to challenge the SNP's referendum on Scottish independence in 2014. Generally, an issue network is seen to be less integrated than a policy network and therefore is often characterised by restricted power and access to resources, meaning it has less opportunity to influencing the policy process (Tantivess and Walt 2008).

The second network model is Paul Sabatier's *Advocacy Coalition Framework* (ACF) (Sabatier 1986; Jenkins-Smith and Sabatier 1993b). It emerged in recognition of the fact that both top-down and bottom-up models of policy implementation had something to offer in terms of understanding the connection between the influence of networks and policy implementation. The ACF sought to combine the best aspects from each. According to Sabatier (1986) coalitions were made up of actors from both public and private organisations that share beliefs and seek to achieve common goals over time. In contrast to the idea of a policy network, coalitions operated and influenced policy over a longer time scale, perhaps 10-15 years, in comparison to networks, which operate over a shorter time span (4-5 years) (Sabatier 1986).

In work reviewing the theoretical underpinning of the policy process in health promotion, Breton and De Leeuw (2011), argued that the ACF offers one of four theoretical frameworks pertinent to health policy development and developed by political scientists. However, in their review of the literature they concluded that the body of knowledge developed by political scientists has made little impact in health policy research with researchers still relying on what they describe as the "*long-discredited stages heuristic perspective of the policy process*" (Breton and De Leeuw 2011: 88). This work provides further contemporary evidence of the lack of theoretical underpinning of policy process research and a lack of willingness of one discipline, health promotion, to learn from another, namely political science, how it can best influence or improve the policy process.

Contemporary work by public health scientists Katikireddi and colleagues (2014) uses three different policy perspectives in a qualitative study exploring the policy process in Scotland. Again, no one theoretical perspective is deemed robust enough in their examination of the development of minimum unit pricing (MUP) of alcohol in Scotland. Instead they apply in sequence Kingdon's multiple stream model; ideas on punctuated-equilibrium theory and an analytical tool exploring changes in institutional governance (Katikireddi et al. 2014). They conclude that the narrative of MUP illustrates the complexity of the policy process and that by using three perspectives they show how the policy process is influenced by a wide range of variables, including evidence and political and institutional factors. This work shows the benefit of exposing the policy process to a wide variety of theoretical ideas and exploring the particular nature of Scottish politics.

As an alternative to the ACF, networks use other tools, in addition to influence, to control policy-making. These include collaboration between government and non-state actor networks and a more confrontational approach where the network opposes or challenges a government policy decision. This confrontational style in which networks can operate is illustrated by Tantivess and Walt's (2008) description of how Thailand increased access to anti-retroviral medication, but is also represented in work that evaluates the application of '*institutional entrepreneurship*' to direct policy change.

The concept of '*institutional entrepreneurship'* has been found to be important in a range of settings that include private and public sector environments. It is associated with the American sociologist Paul DiMaggio and was developed to describe how actors use resources to create new, or empower existing, institutions to develop new ways of thinking and acting (DiMaggio 1988). Thus interested actors (agents) influence what happens in organisations and their contexts. These agents (who can be individuals or a collection of actors - that is networks or organisations) use resources likely to include agency and social position as well as time, energy and reputation to more closely align services to reflect their interests and shape the character of the changed institution (Kingdon 1995). When applied to policy the term policy entrepreneur is used and shows a cross-over of ideas where political science is learning from institutional theory and vice-versa. Whichever term is used they are both descriptive of the influence some people or collections of people (beyond government) are seen to have over the process of policy-making.

Maguire et al. (2004) investigated how institutional entrepreneurship produced new practices among community organisations and pharmaceutical companies negotiating improved treatment for those diagnosed with HIV. They demonstrated that poorlyresourced community organisations were able to exercise influence over more powerful organisations (pharmaceutical companies) beyond what might be expected from the current understanding of power and networks in the policy process (Maguire et al. 2004). In this context the term was used to describe how a community organisation applied its knowledge of the subject area (HIV treatment) and its close connection with key stakeholders to demonstrate legitimacy and build coalitions to create a new approach (Maguire et al. 2004). Networks also operate through the application of skills or use of tools and these include, as we have seen, influence and challenge but also resource exchange (Tantivess and Walt 2008). Such resources include finance, knowledge, expertise and technology; and the interconnectedness and relationships within networks release these resources to influence policy outcomes. The work of Maguire and his colleagues (2004) adds the concept of legitimacy to help explain the wider processes operating in the generation and implementation of policy.

The actions of groups, whether they are termed networks or coalitions, influence policy process. Some groups are created because of the policy-networks and other groups or coalitions which already exist in areas which then become the focus of policy – e.g. advocacy coalitions focused on the social determinates of health (Exworthy 2008). However groups are thought of in the policy process, their significance lies in their ability to encourage learning and, because their members are grounded in practical experience, they do the job; therefore they are important to implementation. Policy is not just implemented from the top-down, power is not just in the hands of the policy-makers; top-down action is influenced by the actions of those at the front-line – the bottom. These elements foster policy development too (Exworthy 2008). The power and influence of policy networks lies here and this is how networks exercise privilege and power to support the policy-implementation process.

In addition, we have seen that the work by Lewis (2006); Tantivess and Walt (2008); and Maguire et al. (2004) shows that a wide range of actors are involved in the policy process. They operate at different organisational levels but also within levels displaying horizontal influence. The complexity of these interrelationships adds to the challenge when trying to conduct research in this area.

Within policy networks are components that contribute to how policy is implemented; they include different degrees of influence and different levels of operation. The research and debate which explores this aspect of the policy process serves to illustrate how policy-making has broadened from the conceptual frameworks of policy as a rational, hierarchical process to a more adaptive learning process seeking to map and account for the interplay between interested parties. One can conclude that the policy process is broad, complex and no longer under the sole control of governments or the state (Baggott 2007).

The core theoretical ideas evident in contemporary political science influencing perspectives on policy implementation are summarised in **Table 2-3**.

Table 2-3 Summary of political science as a theoretical lens

Policy development frameworks to emerge within the discipline of political science	
Power	A philosophical term not exclusive to political science but used in policy theory to express how ideas are influenced, by whom and through whom, to become policy. Not associated with one theorist but evident in many theoretical perspective on policy implementation.
Network theories including Advocacy Coalition Framework (ACF). (Sabatier 1986; Jenkins-Smith and Sabatier 1993b)	Importance of coalitions and networks, both proponents of policy and opponents.
Entrepreneurial action – policy entrepreneurs and policy change. (Kingdon 1995; and Mintrom 1997)	Individuals or groups in or out of government who use social acuity, clear definition of problems, teambuilding and leadership to generate positive social outcomes through policy implementation.
Multiple streams/policy windows. (Kingdon 1995)	Three separate streams are needed – Problem stream, Policy stream and Politics stream combine to produce the conditions in which the phrase ‘an idea whose time has come’ is best understood or a policy window is created.

2.6.3 Policy change process

The terms 'policy change process' and 'health policy change process's emerged in recent years and add another element for consideration (Breton et al. 2007). Previously, authors referred simply to the policy process or the health policy process; now there is a subtle shift with the inclusion of the word “change”.

Breton and colleagues (2007) use the term in their exploration of public health policy focused on tobacco control. In a context where public policy is increasingly directed to changing the environment and/or individual health behaviour it is argued that policy is used to change behaviour in areas where previously health education programmes were employed (Breton et al. 2007). These authors also argue that, in the area of tobacco control, it is the policy itself which is being changed during the process of implementation (Breton et al. 2007). Policy is open to interpretation and influence and in the end comes down to the people who actually implement it. This influence is reminiscent of Michael Lipsky's concept of street-level bureaucracy (Lipsky 1980).

Using the example of tobacco control policy, Breton and colleagues (2007) suggest that if the dominant view of policy actors is that policy should be used as a means of promoting health then they will support policy that controls tobacco use. If, on the other hand, policy-actors believe that governments should not meddle in health promotion then they will resist policy change because it does not represent their view of what policy should focus on. Achieving policy change and implementation exposes many tensions and this evidence adds depth to both the range of tensions and to understanding them.

Alongside the role of policy actors, Breton et al. (2007) highlight two other opportunities for change or resistance to change in the policy process. Firstly, the broad group of actors who can influence policy includes not just those most obviously seen as policy-makers but also groups that can challenge elite policy-makers. This is a different representation of the idea of *elite* versus *pluralist* power in exercising policy change. Secondly there is a need to acknowledge the impact of previous learning and external factors on the policy process (Breton et al. 2007). These elements provide both the opportunity for policy change and the possibility of restricting the success of policy change. Previous learning, or learning through or as a result of the policy process, particularly the success or failure of previous policy decisions, shapes and moulds policy. External elements, beyond the policy actors' control, include aspects of the current economic situation and public opinion (Breton et al. 2007).

A key example in which public opinion can influence policy is the involvement patients and carers share in the policy process. In researching the Mental Health Act in Scotland (2003) the experience of users and carers during its early implementation was examined (Ridley et al. 2010). Health policy implementation has direct consequences for health services users and their carers, and this is particularly true in mental health policy (Ridley et al. 2010). Therefore, these groups should be seen as legitimate stakeholders, involved and consulted during implementation (Ridley et al. 2010). In reality, the research found that the experience of groups of users and carers is not always positive; they feel excluded and un-supported (Ridley et al. 2010). This failure to adequately meet the expectations of the policy end-user is a frustration because the importance of learning from and engaging with the patient experience is such a heavily-promoted aspect of the health policy process in the UK.

Later work by Veitch (2010) considered patient empowerment in policy implementation. It represents a desired policy outcome, since it fulfils a specific political function that the UK government wishes to address (Veitch 2010), is significant. Patient empowerment is topical and of interest to policy-makers because it fulfils the need to use broader approaches to the governance of health and is a means of addressing the ever-increasing costs of healthcare (Veitch 2010). The promotion of greater individual responsibility in health is not a moral argument but a political technique to manage the economics of a publicly funded health service (Veitch 2010). Patient empowerment promotes the individual's responsibility for their health: if the individual is taking more responsibility they are lessening the burden on the publicly funded NHS and offering the potential to reduce costs (Veitch 2010). Policy-makers endorse self-management support because it promotes greater responsibility, involves patients and empowers them to be more involved in managing their conditions. A more cynical view might be that self-management support is also about using the individual instead of NHS care: an economic argument rather than a moral perspective.

These articles offer slightly different perspectives of the role of the public/patient in the policy process. Ridley et al. (2010) highlight the public/patients as important stakeholders who should be involved at the point of policy implementation because that policy is designed to have the most impact there – policy is being done to them. In contrast, Veitch (2010) presents ideas of patient empowerment as not just a desirable attribute but as a means of achieving policy goals. He argues that the public become both stakeholders and the means of achieving policy goals. The level and degree of public, patient and carer involvement in the health policy process is complex and differs depending on the perspective adopted. However, the findings presented in **Chapter 6** mirror both discussions.

More recent work by Noyes and colleagues (2014) highlights the benefits of facilitation to support policy implementation and thereby achieve policy change. An approach of facilitated implementation was used to support the introduction of complex children’s continuing-care policy. These researchers found benefits in Consultant Nurse facilitators who could adapt the policy to local factors and achieve implementation by generating a best-fit of policy and local circumstances (Noyes et al. 2014). Local circumstances are important in both policy implementation and in the delivery of healthcare change (**Chapter 3**). Noyes and colleagues' work also illustrates the importance of leadership and key individuals to establish trust in a new idea, policy or innovation, a recurring theme in the bodies of literature which have informed this thesis.

The final area of debate to emerge from this expansive literature is the concept of policy streams or windows. Timing and serendipity (chance) determine what direction policy takes and the likelihood of its success.

2.6.4 Policy streams, windows and space

The early stages of the policy process seek to identify how ideas become a concern for policy-makers (Buse et al. 2005) Analysis of this stage has generated a range of descriptions which try to explain how a concern becomes policy. These include the established concepts of policy streams and policy windows, associated with Kingdon's (1995) thinking and the newer concept of policy space (Crichton 2008).

These concepts present a model of how issues get onto the policy agenda and how they are then translated into policy (Kingdon 1995). The opportunity for a policy to take off and be adopted is termed a policy window, which either opens or closes when three policy streams – problems, policies, and politics – combine or separate (Kingdon, 1995). . The significance of the idea of policy windows or streams is that it links contextual elements such as the macro-level political situation with the actions of those operating at a meso- and or micro-level.

Policy-windows suggest that certain combinations of conditions and circumstances tend to align for a short period of time, presenting a window of opportunity which must be taken before it closes (Kingdon 1995). As previously noted, Cairney (2007) highlighted the policy window which allowed the implementation of a smoking ban in Scotland.

The first 'stream' was an awareness of a problem, the public health risk that smoking represented; the second was a policy solution which required active debate around possible responses; and third was the political will to engage in this area of public health (Cairney 2007). In 2006 these three streams came together, opened a policy window and generated action. This combining of streams is referred to as coupling and it is through either coupling or de-coupling of streams that policy is made (Kingdon 1995). As well as influencing policy-making, the contextual climate, previous experience and current conditions affect policy implementation (Gunn 1978).

2.6.5 Health Policy and policy implementation

There is considerable social and political demand to understand how best to organise health systems and deliver services (Fulop et al. 2001). This, combined with rising expectations of consumers and politicians to be more clinically effective and cost-efficient when managing health services, has led to recognition that research on health policy and implementation should be supported. While this is not a new area of study there has been a history of disjointed research causing fragmentation between the disciplines that take an interest in the enactment and delivery of health policy. Since health policy and its implementation are not scientific disciplines in themselves and, therefore, considered to be applied research, they draw on a range of perspectives including anthropology, economics, epidemiology, nursing, medicine, organisational studies and political science. In supporting my thesis, appropriate and relevant theory and research have been sought from both within health policy research and from broader theoretical and organisational perspectives covering the theory and practice of change.

2.6.5.1 Recent studies exploring the implementation of health policy.

Despite (or because of) the wide range of disciplines concerned in the policy process there appears to be little agreement on approaches understanding it (Sabatier 1993). There is a relatively small body of empirical research exploring health policy implementation. The published literature focuses on two approaches: those that test specific theoretical perspectives in understanding implementation of policy or the process of health policy (e.g. sense-making, leadership, policy-entrepreneurship and multiple-lens, diffusion of innovation) and non-empirical research which focuses on literature reviews and glossaries of terms to provide insight into current theories on policymaking acting to promote debate and discussion. The empirical work of the mid 1970s - late 1990s (e.g. Van Meter and Van Horn 1975; Jenkins-Smith and Sabatier 1993 and; Matland 1995) still wields considerable influence over what is known about policy making and policy analysis in general. The incidence of this knowledge and exploration being applied to health policy even after the intervention of the health economist Gill Walt from1994 onwards is limited to, or focused most directly on, health promotion policy or international health policy.

Current understanding of the health policy process in the UK and specifically that of the NHS is based on a limited body of work. Three recent publications have explored what Sabatier (1993: 16) termed "*policy subsystems*" as a means of understanding the process as a whole. Coleman and colleagues (2010) considered why those acting in similar local contexts make different decision in response to the policy innovation of practice-based commissioning. Similar to work by Pope et al. (2006), this research uses the concept of 'sense-making' as an interpretative framework to explore organisational change. Their study (Coleman et al. 2010) was based on empirical research, an unusual feature of this policy literature. Three case studies revealed the importance of local histories in the interpretation of policy initiative. Mapping the impact of past experience of policy initiatives and relationships between the sites influencing the final configuration of policy on the ground (Coleman et al. 2010) was a key component. Coleman et al. (2010) argued that institutional context is as important an influence on sense-making and interpretation of policy as the individual or collective influence of policy-makers and -implementers on the framing and expression of policy. Secondly, the study offered insight into what the authors termed 'distributed sense-making', which highlighted the roles of the subsidiary units which make-up the NHS, including local organisations and professional groups. Those organisations which had been in existence for the longest period of time had the most influence on the interpretation of new policy innovations. They were shown to have particular influence on local interpretations and sense-making of policy.

A study by Haycock-Stuart and Kean (2014), although less theoretically-driven, examined the implementation of health policy from a single perspective: the role of leadership. Within a nursing context (in itself an unusual discipline for study at this level) Haycock-Stuart and Kean scrutinised the ‘shifting the balance of care’ policy initiative in Scotland. Their qualitative study across three health board areas sought to determine if leadership is the key to policy implementation in community nursing. They determined that at the point of implementation policy was open to adaptation, influenced by local context. So although leadership was important it was not the only process involved. Lack of policy ownership, under-resourcing of the policy infrastructure and inappropriate skills and knowledge created an impression that the policy context was disjointed: front-line delivery issues undermined the implementation of ‘shifting the balance of care’.

In studying the Scottish experience of trying to develop and implement minimum unit pricing (MPU) of alcohol, Katikreddi and colleagues (2014) encapsulated a number of broad themes of contemporary literature on policy implementation. First, it is written from within the discipline of public health (within which discipline there is a strong history of seeking to understand the policy process); second, to understand the policy process it applied theoretical perspectives drawn from political science (a discipline which dominates this area of debate); finally, it looked for lessons to be learnt with regard to evidence-based policy-making. Using the Multiple Streams model, Punctuated-equilibrium theory and Multi-level governance, Katikireddi et al. (2014) demonstrated the importance of setting-up and establishing the policy problem. Broader issues, like the role of coalitions in facilitating debate and discussion beyond those expected, affected progress towards policy implementation. Individual influence (policy entrepreneurs: Kingdon 1995) also worked to support policy implementation. The Scottish context and geography in a defined area worked in favour of implementation and adoption of policy. Political and institutional factors, alongside evidence-gathering, were at work. Katikireddi et al.(2014) did not agree which theoretical perspective was best for understanding the policy process but argued that looking at one problem from three perspectives added greater depth to understanding than if a single approach had been taken.

It is clear from these three studies that much is still unknown about the policy process. Models adopted from other disciplines help to clarify it; but it is both complex and heavily contextual: what applies in one case does not necessarily transfer beyond those circumstances.

Henderson et al. (2013), like Coleman et al. (2010), focused his research on understanding the role of front-line policy implementers such as paramedics. Adopting

Lipsky’s (1980) political science perspective of street-level bureaucrats (SLBs) Henderson et al’s. (2013) findings supported several related theories of SLBs. What emerged was how influential professional norms and experiences were in front-line practitioners’ interpretation and implementation of policy (Henderson et al. 2013). Front-line staff are key interpreters of policy because they act as gate-keepers; ultimately their decisions impact directly on patient perception and use of health services. Alongside Coleman’s et al. (2010) and Haycock-Stuart and Kean’s (2014) research, Henderson et al. (2014) study highlights the importance of considering health care reform from the perspective of those required to enact policy in practice.

When the literature review for this thesis was updated careful consideration was given to the journal *Public Administration* in which three important research articles had recently been published. Political scientist Martin Smith and colleagues (2011) considered issues of policy analysis from the perspective of UK street crime and anti-social behaviour. Although the policy context is beyond the remit of this thesis, the theoretical perspective gives valuable insight into how to analyse policy delivery beyond measures to reduce street crime. Smith et al. (2011) contest that policy analysis should give wider recognition to the concept of delivery as a chain with a number of reactions happening within the chain. These reactions include the refraction of policy decisions through individual actors and other agencies involved in the policy area; recognition that those at the front-line are able to use their own knowledge and control over delivery and adjust implementation and rather than thinking of delivery in a hierarchy (top-down or bottom-up) it should be conceived of as a policy field (Smith et al. 2011). Again, there is evidence of complex interactions and influences characterising policy implementation and of the role of different organisational levels. Increasingly it becomes clear that for policy-makers there is little benefit in trying to control or rationalise the processes, influences or fields of policy implementation. It is more important to appreciate the breadth of interactions and work as carefully as possible in context and not seek to exercise too much control or restraint.

Breton and De Leeuw's (2010) work is based on a review of health promotion literature rather than empirical research but it provides an overview of the degree to which research in health promotion has applied (or not) theoretical perspectives derived from political science. Unsurprisingly, Breton and De Leeuw (2010) conclude that its perspectives have made few inroads in health promotion. This evidence supports earlier work by O'Toole (2000) and Schofield and Susman (2004), which similarly identifies a theoretical approach adopted in policy implementation research and the negative impact this has had on the development of understanding or its academic credibility.

Significantly, where Breton and De Leeuw (2010) identified references to theoretical frameworks, the majority were derived from political science and the most consistent choice was Everret Roger's Diffusion of Innovation theory. So although this paper reports on health promotion literature it does highlight the strength in adopting a theoretical perspective to understand the policy process. Breton and De Leeuw's work supports the rationale for adopting a theoretical perspective to examine the policy process in my research.

Work by Pope et al. (2006) and Obron et al. (2011), applied health service researchers rather than political scientists, was identified from *Public Administration*. Pope and colleagues (2006) explore the implementation of NHS Treatment Centres as an example of health innovation, highlighting the close relationship between theoretical perspectives of policy implementation and understanding of organisational change. The researchers, like Coleman et al. (2010), use the work of K. E Weick (an organisational psychologist) to understand the situation and action required to bring Treatment Centres into being. These are a health service innovation derived from policy which requires organisational change to implement it. It spans areas of literature and debate. Pope et al. identify more evidence of the dynamic processes which operate around implementation; principally how much of this action is focused on what they term the "*framing and re-framing of meaning*" (2006: 78). For action to be understood there needs to be greater appreciation that meaning changes over time and that it varies between macro-, meso- and micro-organisational levels. They conclude that there needs to be an appreciation that meaning and interpretation of what a Treatment Centre is, at the micro-level, is subject to local context. This should be acknowledged as providing "*a kind of headroom, which opens up an opportunity for actors at the micro level to construct something of their own*" (Pope et al. 2006: 77). Other organisational levels in turn benefit from the new meaning that emerges as these local solutions feedback to inform understanding at meso- and micro- levels. Consequently implementation, specifically successful implementation, is not best served by rigid interpretation of action from those at the top and enforced on those at the bottom.

Obron et al. (2011) sought to provide empirical evidence of the role of individual agency. Taking the example of policy entrepreneurship and its role in the reform of London health services, they identify how policy entrepreneurship and clinical leadership make policy happen. The role of the individual is a common feature in organisational studies theory and is also represented by the political science concept 'policy windows' attributed to Kingdon (1995). In this paper the researchers examine how ideas of entrepreneurship and leadership combine to allow coalitions to be formed and sustained to deliver policy in practice. What emerges is the importance of a single individual in making policy agendas happen when they were engaged in wider entrepreneurial activity to promote collaboration and partnership with national and local stakeholders. This collaboration was facilitated by individuals' ‘*connectivity*’ (Obron et al. 2011: 340). Of particular note was the connectivity the researchers observed with patients, which were given “*most weight in deliberations*” (Obron et al. 2011: 341). The breadth in the connectivity displayed by the policy entrepreneur concerned was considered a strength and highlights its importance in supporting implementation processes. Similarly, Obron et al. provide evidence of the necessity of clinical leadership in the process of health reform and the implementation of health policy, an important theme in the narrative of policy promoting self-management.

The final article, drawn from Implementation Science, is by Tomm-Bonde and colleagues (2013). Although focused on the area of public health and based on work conducted in Canada, it provides useful insight into the implementation process. Their qualitative study uses Greenhalgh and colleagues’ Diffusion of Innovation framework (2004) to explore the implementation of a policy intervention directed at 21 core public health programmes. This research was written by nurses and close to my area of research.

These authors recognise that implementation is often a long and protracted process and that what influences the adoption of an innovation may change at different points in the process. Tomm-Bonde et al (2013) found that implementation can be negatively impacted if the intervention is perceived as centrally driven, particularly if there is little input from users or a perception that this is what has happened. In addition, they argue that there must be a relative advantage of the intervention to stakeholders for implementation; and that a perceived complexity of intervention will negatively influence implementation (Tomm-Bonde et al. 2013). However, if the innovation can be reinvented (adapted or modified) then implementation is more likely to occur. These aspects fit with what might be expected to happen from Greenhalgh et al. (2004) and Pettigrew et al.’s work (1992); Tomm-Bonde and colleague’s (2013) observation that a period of negotiation was essential to enable the adaption needed to allow for implementation, was new.

Other evidence of what worked to support implementation included incentives and mandates at the policy-making level. These incentives were seen to work alongside strong leadership, clear strategic vision and communication of this vision to front-line staff (ibid). Tomm-Bonde and colleagues concluded that “*implementation remains the Achilles heel of innovation*” (2013: 69), and recommended that implementation should be planned and should use theoretical frameworks such as the Diffusion of Innovation prospectively, not retrospectively.

Policy, the policy process and policy implementation are difficult concepts to unpack. Ideas are mutually 'entangled' and not confined to a single stage. In applying a systematic approach to analysis the core concepts and arguments do not fit neatly; rather than simplifying the argument the discussion appears more, not less, complicated.

2.6.6 Evidence and the policy process

Traditionally, policy has been lead more by politics than evidence (Nutley and Webb 2000). However, because of the increased importance attributed to scrutiny and accountability in government there has been an observed rise in the demand that evidence should play more of a role in policy (Davis et al. 2000). This demand is driven not least by the observation that un-tested policy may be disastrous for patients – witness the recent failure of the Liverpool Care Pathway. Since evidence should play a role in the policy process there is benefit to exploring the possible relationship between policy and evidence, the focus of this section.

The link between evidence and policy is not straightforward and one of its complexities lies in the assumption that the need or desire for evidenced-based policy making fits with a rationale model of policy-making (Nutley and Webb 2000). In Sanderson's words (2006: 115) the importance of evidence in policy-making is linked to "*the modernist faith in progress informed by evidence*". However, over reliance on rationale models of policy-making have been subject to some criticism (as presented earlier in the Chapter). In contrast the consideration of the policy-process from a pluralistic perspective opens a more incremental view of evidence-based policy making (Nutley and Webb 2000). It is the concept of evidence and policy in pluralist models of the policy process which is of most relevant in this research.

Nutley and colleagues (2010) show that there is both international interest in the relationship between research evidence and policy-makers and that this is particularly true in areas like healthcare, where it is considered important to encourage policy-makers and practitioners to look for the best available evidence to enhance accountability and promote improvement (Nutley et al. 2010; Sanderson 2002). More significantly, and in line with constructivist concepts of policy-making, is an appreciation of the relevance and importance of evidence being used to demonstrate what works (Sanderson 2002). This less directive approach incorporates ideas of interaction and learning: less top-down and more bottom-up.

General agreement emerges from the literature, over the last decade or more that evidence is important in the policy process (Nutley et al.. 2010). However, there remains considerable debate about what is the most useful form of evidence. Sanderson (2002) argues that it should focus on learning from what works in practice rather than applying the evidence that is available. However, in practice what emerge are differences in the interpretation of the nature of evidence – what is being used but also the fact that there is little opportunity for evidence relevant to policy-making or implementation to be generated through evaluations of whether policies work.

Research is not the only relevant form of evidence. The complexity of the policy environment requires a flexible rather than fixed view of what evidence works or is needed for policy implementation (Sanderson 2006). Indeed work, undertaken recently by Evans and colleagues (2013) exploring the nature of evidence used in implementation suggests that those who operationalize policy take a broader view of what evidence is routinely acted on at the level of implementation.

Evans and colleagues (2013) found that when implementing new policies a range of information and evidence was used to make decisions about policy implementation; research did not dominate (Evans et al. 2013). Furthermore, the NHS Wales respondents recognised that they should be contributing information through their experience of policy implementation to further policy and service planning but were not doing so. What emerged is recognition that the relationship between policy and evidence is not linear, with policy-implementers' adoption of policy influenced by requirements for negotiation and consideration of the local situation and patient need. Consequently, a tension existed between the expectations of policy-makers and -implementers (Evans et al. 2013). A key recommendation from the work by Evans and others (2013) was for local implementers to be allowed to build local evaluation and not rely on centrally driven ideas of how performance and accountability can be improved by evidence, thereby highlighting the importance of building on the use of research evidence whilst supporting local evaluation into policy implementation.

The findings from Evans et al. (2013) in turn reflects assertions by Nicolas Mays et al. (2005) when they sought to determine the range of evidence that might usefully inform policy making in the health field. In both pieces of work, although it was recognised that policy-makers and mangers need high-quality evidence, it emerged that diverse forms of evidence existed and there was no consistent approach to how this evidence could be applied to policy and support implementation (Mays et al. 2005). There is a tripartite paradox: a desire for evidence to inform policy, a complex evidence landscape and a failure to allow time for evaluations of policy to prove that what works.

2.7 Conclusion to chapter

In this chapter policy, health policy and healthcare policy have been defined with difficulty because they are contested terms, open to different interpretations. It is agreed that policy is a statement of government intent and carries an element of authority. As the debate about definition appears contested and circular, the chapter moved to consider how policy could be analysed. Here a number of conceptual models drawn from the different academic disciplines were used to explain the processes of policy-making and its implementation. These models and various academic perspectives on them highlight the complexity of the debate on the policy process, its implementation and how policy happens in practice. Among the most dominant theorists are those who suggest that the policy process is hierarchical and characterised by a number of steps to be processed in sequence. In contrast other theorists, such as Sabatier (1986) and Jenkins-Smith and Sabatier (1993a) argue for a less restrictive interpretation of the policy process, presenting it as an adaptive environment where policy-makers engage with policy-implementers to learn and mould policy to best reflect each other's perspective and knowledge. These contrasting perspectives are characterised by a debate between top-down versus bottom-up policy implementation.

To help unpick the issues and identify what is known about the policy process and policy implementation I have used Walt and Gilson's (1994) ‘*Policy Triangle’* to structure an examination of the literature which has sought to examine ‘why’ (what contextual factors influence policy implementation) - and ‘how’ (what processes and actors drive, shape and control policy implementation). Policy-making and its implementation are broad concepts, not easily defined in stages. They are complex and subject to the influences of organisations and stakeholders beyond those traditionally seen to wield power. They are not under the sole control of the state.

Understanding of policy implementation as an adaptive, iterative process has directly informed this thesis. Contemporary understanding of policy implementation in general highlights ideas of power, individual and organisational networks and the role of evidence. In relation to the implementation of health there is a much smaller body of work, which still serves to highlight the role of sense-making, leadership and policy-entrepreneurship as well as the benefits of adopting a theoretical perspective. These are significant areas of theoretical debate, which will be shown to resonate with the findings generated from this research.

Finally, this Chapter identified policy implementation and specifically health policy implementation as a legitimate area of research.

Chapter 3. Change and innovation in the delivery of healthcare: a literature review

3.1 Overview of chapter

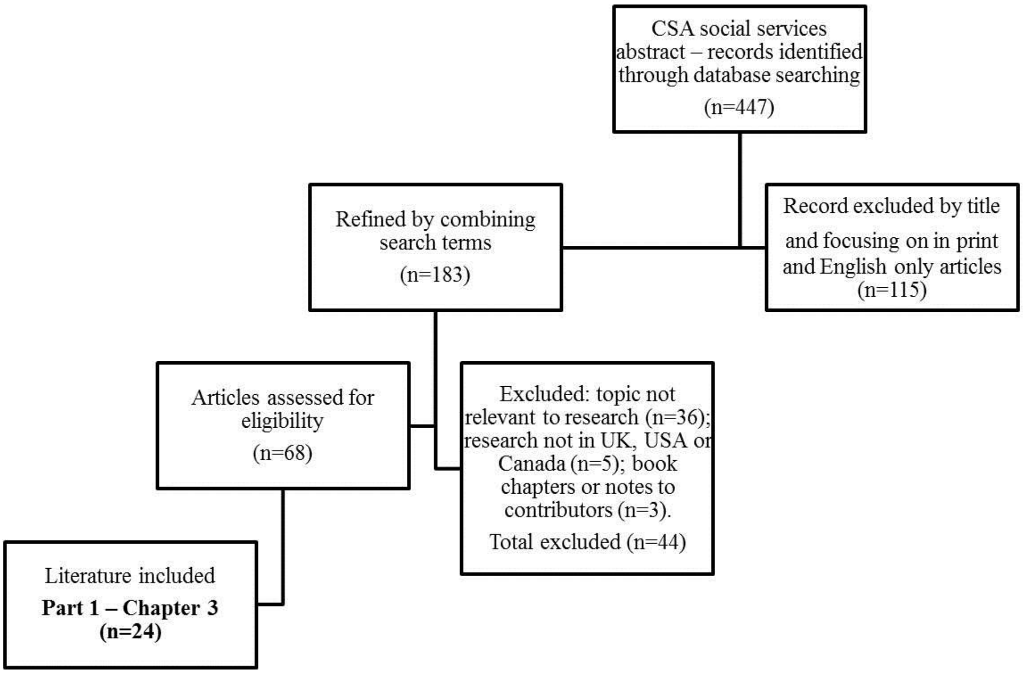
As we have seen in **Section 2.6.3**. the implementation of health policy involves strategies designed to change the way healthcare organisations operate, which in turn means changes in the way healthcare practitioners work.

3.1.1 The change and innovation literature search strategy

Again, identifying literature to inform this chapter has been an on-going process completed in two stages. Initially the focus was to identify work highlighting understanding of change and innovation in healthcare organisations and in relation to policy implementation. Literature was collated from a range of sources including books and articles, as well as being informed by discussions with prominent researchers in the field. In **Part I** an initial review was undertaken (from May 2009 onwards) and in **Part II** a targeted literature search in response to examiners' feedback was conducted in January 2015.

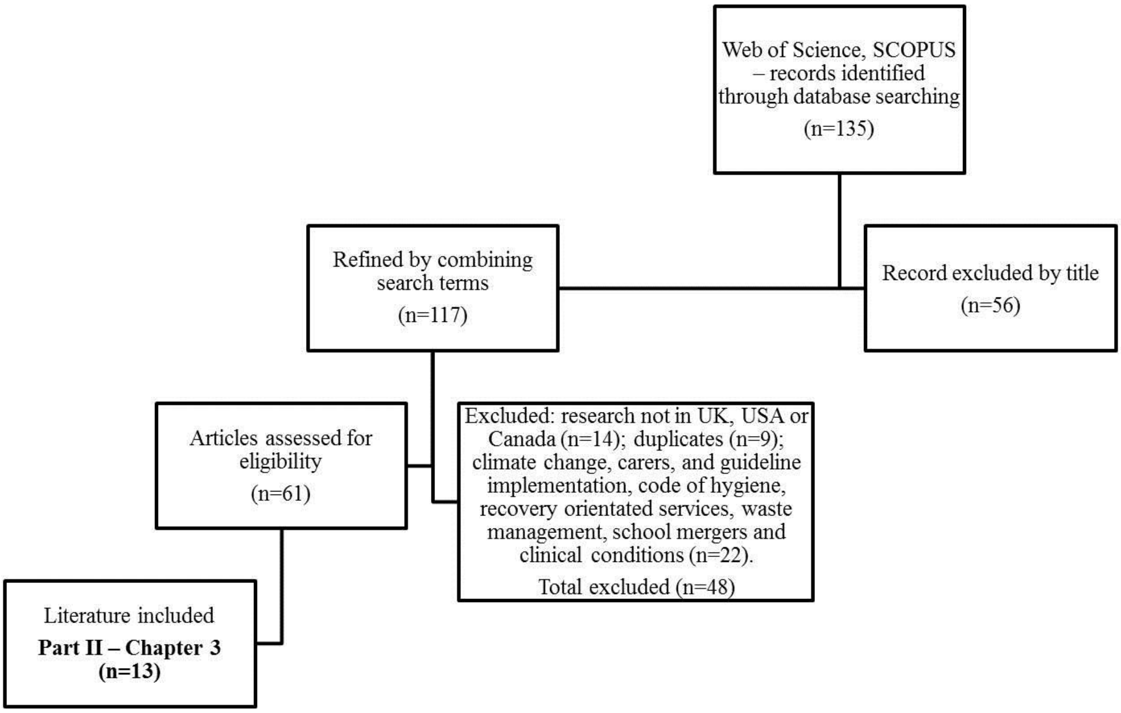
In **Part I** the CSA Social Services Abstracts Database was searched using the following terms: "change management", "organisational change", "diffusion of innovation", and "implementation of change" and a specific search was made for articles related to Normalization Process Model/Theory. A total of 447 articles was initially identified. Articles were included using the following criteria: in English; available to download through the University library, and excluded if in press, duplicated, editorial comment or debate. **Figure 3-1** diagrammatically presents the process applied at this time point.

Figure 3-1 - Part I - literature search strategy



A second search of the literature (**Part II**) refined and updated the bibliographic sources search. Part II search used Web of Science (WoS) and SCOPUS databases, identifying 135 references in total. Selected search terms included change, organisational change, healthcare and a specific search for articles related to NPT. Articles were published in the last five years in English, accessible through the University library and excluded in-press papers. See **Figure 3-2** for further details on the refinement of the search strategy.

Figure 3-2 - Part II - literature search strategy



The literature identified from the **Part II** search strategy has been incorporated into this revised chapter as well as directly influencing the debate presented in the sections entitled NPT (**Section 3.5.3**).

3.2 Background

Within organisational analysis processes of change are a key strand of debate, and directly relevant to policy and policy implementation (Fulop et al. 2001). The literature on organisational change is multidisciplinary and wide-ranging, so; this review has taken a structured approach to including and excluding literature. Papers about individual motivation to change that draw from psychology, or ideas from education that link to organisational learning and continuous professional development are excluded because they are less relevant to the subject of "*policy implementation*". For similar reasons papers exploring social marketing and communication as a means of eliciting change were omitted.

To further structure the discussion, and following Balogun and Hope Hailey's (2008) assertion that there is no single 'best way' to change, that no single model of organisational change will suffice and that research will not tell us how to manage change but only the factors that need to be considered to facilitate change (Balogun and Hope Hailey 2008), I have distinguished three strands of approaches to its understanding:

- Those that identify models of organisational change attempting to inform managerial efforts to drive change.
- Those that explore the why, how and what of organisational change, identifying features of the organisational environment that promote or inhibit changes.
- Those that focus on how individuals act to implement new ideas or technologies within organisations.

As Bamford and Daniel (2005) suggest, change is a constant feature of the UK healthcare sector. The NHS provides the ideal environment in which to study organisational change and yet, as Pettigrew et al. (1988) argue, even though it has attracted a diverse range of analysts, the study of change in the NHS remains a significant challenge.

The drivers for change in the NHS are numerous, including advances in medical technology, changes in the economic, political and social environment in which the NHS operates; and cumulative and incremental changes in the research evidence on how healthcare can best be delivered (Ashford et al. 1999). Strategies for change are necessary but desire for change and a clear strategy do not guarantee success. How best to achieve successful change in the NHS remains elusive (Herzlinger 2006; Effective Healthcare 1999; Rogers 1995b). One approach to creating a strategy for change is for management to plan it through the implementation of a model of change.

3.2.1 Models of organisational change

A seminal review by Ilse and Sutherland (2001) attempted to draw together ideas and models on understanding organisational change in healthcare. It aimed to help mangers identify tools for change and distinguished different ways of thinking or interpreting change, including contrasting planned change with emergent change; episodic versus continuous change. It drew distinctions between developmental, transitional and transformational change.

3.2.1.1 Planned versus emergent change

Planned change is deliberate and directed by decisions about what should be altered or replaced (Iles and Sutherland 2001). It is structured and organised with a clear start and finish point. Even so, the authors recognise that the complexities of achieving change mean that the two kinds of change often co-occur: "*organisational change is not fixed or linear in nature but contains emergent elements*" (Iles and Sutherland 2001; 14).

The idea and model of planned change is most closely associated with the work of the American psychologist Kurt Lewin. His work and ideas have been described in detail by Bernard Burnes (2004) and I have drawn heavily on this summary.

Lewin proposed a number of elements of planned change, including Field Theory; Group Dynamics; Action Research and, his most significant contribution,, the 3-stage model (Burnes 2004). These elements combined to provide what Burnes describes as an elaborate and robust approach to planned change. Central to Lewin's idea was the recognition that for a new behaviour to be adopted, the old way of doing things has to be discarded; only will change be achieved (Bamford and Daniel 2005).

Burnes suggests that Field Theory was Lewin's attempt to understand group behaviour and how it played out in the complex dynamic of the field or situation in which it took place. He was particularly interested in understanding how group behaviour exerted forces to maintain the status quo, resulting in barriers to change. To achieve change, he argued, one needed to understand the forces at work in the field or context, since these explained both group and individual behaviour (Burnes 2004). This thinking formed the basis of Lewin's Force Field Analysis, still advocated as a tool for planning change management (Iles and Sutherland 2001).

Burnes identified Lewin as the first author to consider the importance of group dynamics in the management of change (Burnes 2004). He argued that the nature of a group and the relationships between its individuals exerts a strong influence on behaviour, suggesting that understanding the group characteristics and the dynamics they display is more important than focusing on individual behaviour. The influence of this thinking is reflected in other approaches to change that highlight the importance of individual and collective action to implement new ideas, work that has explored the importance of networks in facilitating or inhibiting change (Ferlie and Pettigrew 1996; see Section 3.4). Lewin's idea of Action Research showed that successful change requires a recognition that action is needed and careful analysis of the situation to inform action (Burnes 2004).

Leading on from Lewin's ideas on Field Theory, Group Dynamics, and Action Research was his three-stage model (Burnes 2004) which suggested that change be viewed as a process that moved an organisation, team or service from the current state through a transition to a desired state (Iles and Sutherland 2001). Change was achieved by un-freezing, moving and then re-freezing through planned action (Burnes 2004). This idea has proven durable, and is highlighted widely in contemporary change-management literature (Hayes 2007).

Although Lewin's ideas still influence much of the current writing on change they suffer from recognised limitations. His model of planned change is seen as an over-simplification

(Burnes 2004), as too prescriptive and unrealistic because, as in arguments about the policy process and policy implementation, change is rarely linear (Hayes 2007). If change is linear then that assumes that everyone involved in achieving change will share the same goal and as Bamford and Daniel (2005) argue this is a false assumption. Furthermore, Hayes (2007) suggests that Lewin's model of planned change only succeeds in delivering short-lived change.

In contrast to planned change, commonly described as linear and predictable, emergent change highlights unpredictability and the multiple variables that impact on the shape and success of change (By 2005). Emergent change is seen to more closely reflect reality by taking account of the internal and external environments that influence an organisation's response to change. The application of emergent change means that models have to stress the importance of aspects such as strategy, people and culture in organisations and how these can exert inertia and block change or act as levers to support change processes.

An emergent approach to change reflects more of the reality of what actually happens in practice. In contrast, the planned approach sets-out the theoretical discussion that is needed to win people over to a new idea – to sell a change. This is reflected in work undertaken by Bate (2000) who argued that organisational change is a non-linear process. Bate's (2000) case study focused on understanding how a culture in a hospital could be changed. He observed that this was not implemented from the "*top-down*" – management driven – nor was it "*doing change*" where an approach that has worked elsewhere is imposed as a solution in a different context. Change was achieved by encouraging ideas and solutions to emerge from within – as Bate (2000: 509) termed it "*home-grown*". Top-down or doing change can be seen as aspects of planned change; in contrast, approaches that allow ideas to be generated in an inclusive, collaborative manner echo the concept of emergent change. Bates's (2000) study shows that an emergent approach offers a more sustainable model of how to succeed with change in healthcare organisations. Generally, the ideas that change can be implemented by will from those perceived to be in a position of authority is counselled against because it is seen as ineffectual (Iles and Sutherland 2001).

3.2.1.2 Episodic versus continuous change

Other authors, such as Weick and Quinn (1999), have tried to move the debate forward by undertaking a detailed analysis contrasting episodic with continuous change. Episodic change is "*infrequent, discontinuous and intentional*" (Weick and Quinn 1999; 365). It is often associated with key initiatives or actions that can be internal to the organisation, such as changes in the leadership, or external, such as a technological innovation. This way of modelling or understanding change could be described as "top-down". Episodic change tends to occur slowly, infrequently and formally (Weick and Quinn 1999). The role of the change agent, the *"...prime mover in creating change*" is also seen as a distinguishing feature (Weick and Quinn 1999: 373).

Continuous change is "*ongoing, evolving and cumulative*" (Weick and Quinn 1999: 375). It is most closely associated with the idea of the learning organisation, a popular area of discussion for promoting change in the NHS (Davies and Nutley 2000). Organisational learning promotes engagement and develops both individuals and organisations to deliver improvements and changes in performance (Davies and Nutley 2000).

Continuous change is seen as an ideal state for an organisation to aspire to, but it requires the natural inertia within organisations to be overcome (Weick and Quinn 1999). So change is not a one-off phenomenon but ongoing, and spiral rather than linear. Promoting a continuous approach to change is considered a less dramatic approach than episodic change but is considered to achieve more sustainable results and create a supportive culture promoting on-going change (Balogun and Hope Hailey 2008).

3.2.1.3 Change as a "punctuated equilibrium"

A third term used in this discussion of models of change is to see change as "*punctuated equilibrium*" (Balogun Hope Hailey 2008). This view sees change as a stepped process – linear again – but rather than incremental, as in planned change, the desired outcome is described as "*frame-breaking*" or "*quantum*" (Greenwood and Hinings 1993: 1052). Over time in an organisation there are periods of adaptation and adjustment around existing ways of doing things, interspersed with short episodes of evolutionary change – when things have to change. Punctuated equilibrium likens the development of an organisation to a life-cycle with spurts of growth or "*upheaval*" balanced with periods of convergence and stability (Greenwood and Hinings 1993). This discussion is closely associated with the debate led by organisational theorists and its practical application can be hard to determine. Its purpose, though, is to emphasise the importance of studying organisations over time to fully understand how change is achieved – hence the idea of life-cycles. This area of debate also serves to highlight the importance of adopting a holistic approach to understanding how change is implemented, and as we will see in the second section of this chapter it is a point that other theorists also emphasise (e.g Pettigrew et al. 1992).

3.2.1.3 Summary

This discussion of different models of change appears useful, particularly as a management tool. However, we must be aware that, as identified by Balogun and Hope Hailey (2008), there is no empirical evidence to support any of these models of change as more successful or a better representation of reality. Their role is to provide ideas relevant to different organisations and different points in time. However, it is a source of frustration, particularly in the NHS, that there is little agreement on the most effective approach to the management of change (Bamford and Daniel 2005).

What we can learn from exploring different models of change is to appreciate that the change process is continuous and at different points in time different models may apply. Models seek to apply a vertical perspective of what is needed for change to occur; but change does not just happen through vertical co-ordination. It is also necessary to account for the ways in which change happens – the actions needed laterally – to develop our understanding of successful change.

3.3 The what, why and how of change in organisations

The second broad approach to understanding change is informed by both empirical research and reviewed organisational research undertaken by a number of leading authors. Collectively this writing allows us to identify features of the organisational environment that inhibit or facilitate change and these ideas are summarised in **Table 3-1**. The distinction that these authors make between content (the *what*); context (the *why*) and process (the *how*) of change, is key.

Table 3-1. Discussion that focuses on understanding how organisational change happens

Armenakis and Bedeian (1999: 295)	**Pettigrew, et al. (1988: 301)**
Content - “*the what of change*”;	Content of change - the nature of the idea;
Context – recognising the conditions that exist in an organisation’s internal and external environment;	Context - identified as outer and inner, which contribute to understanding the **why** of change;
Process – refers to what is done to achieve an intended change;	Processes – identified as the **how** of change.
Outcome – or criterion issues deal with the outcomes assessed to determine the success or not of organisational change;	
Behavioural issues – importance of highlighting the affective reaction to change.	

The ideas that Pettigrew, McKee and Ferlie worked on from the mid 1980’s have contributed much to our understanding of organisational change in general and specifically in relation to organisational change in the NHS. Two models remain analytically useful today. The first is their combination of context, content and process into an analytical triangle (Pettigrew et al. 1988), which they use to contend that research on change should recognise the interplay of these three elements. The second analytical contribution from Pettigrew and colleagues was their idea of understanding organisations’ receptivity to change and what factors facilitate or inhibit this receptivity. Initially I will explore their ideas on the importance of content, context and process and also draw on the work of others who explore change from these distinct perspectives. The elements of receptivity will be explained in **Section 3.3.2.**

Explanations of how policy is implemented identify the importance of considering the content of policy, the process of policy-making, the context surrounding policy-making and the actors influencing policy implementation (Walt and Gilson 1994). In both literatures the interaction and influence of these elements is presented as a triangle designed to encourage systematic thinking about change, as with Pettigrew, et al. (1988: 301) or policy implementation as with Walt and Gilson (1994: 354). The focus in this next section is to explore how ideas of content, process and context help our understanding of how change happens.

3.3.1 Content

Understanding the content of change helps to assess how closely the agenda for change fits with the local situation. Generally, it is agreed that the closer the fit the more relevant the change will appear. However, Greenwood and Hinings (2006) identify a paradox. While there does seem to be a need for some understanding of content to support the case for change, some imprecision is necessary so that there can be local interpretation. They suggest that intent can be shaped and implementation responsive to allow ideas on how change would be implemented to emerge from local experience and knowledge. This reflects ideas of "bottom-up" change and supports the need for local interpretation so that a change becomes real and meaning is attributed through its implementation (Marshall and Olphert 2008). This discussion is similar to ideas on emergent change but is also reflected in wider discussion on how policy is implemented. The opportunity for local interpretation and adaptation during implementation is presented as *incrementalism*, the fine-tuning of policy (Theodoulou 1995).

The content of a change should also be seen to fit with current priorities or reflect issues that are seen to be causing a problem or creating a pressure for change (Pettigrew et al. 1988). This is linked to NHS management's requirement to achieve outcomes and seek improvements in patient care through policy initiatives and in the case of the present study the content of change is determined by the content of policy promoting self-management support for people with LTCs. Thus it is tied into ideas of patient empowerment and the promotion of greater personal responsibility for health and wellbeing. Alongside the challenge of an ageing population, these Government drivers for change inform policy content, which becomes management's means to an end and makes changes initiated from it more likely to be acted on.

So for change to happen the content must have relevance, but also allow some local interpretation so that those charged with change feel in control and not disenfranchised.

3.3.2 Context

Research focused on context highlights the importance of understanding an organisation's external and internal environment and how these influence the success or otherwise of change (Armenakis and Bedeian, 1999). Its importance was established and developed by Pettigrew (1987). These researchers defined context as referring to national political, economic and social forces operating external to the organisation (outer contextual issues). These in turn shape the inner context, embracing management and strategy. The relationship between outer and inner context was considered important because, as explained by Greenwood and Hinings (2006), excessive pressure externally can drain or deflect the energy that helps shape the internal context. Lack of drive and focus internally will result in unsuccessful change: the external context directly affects the internal.

Pettigrew (1987) identifies two particularly important features of the internal context: leadership, which helps to challenge traditional ways of thinking and acting; and a supportive culture in which an organisation is open to innovation and flexible. These features, in combination with other aspects, generate what Pettigrew and colleagues (1992) termed an organisation’s receptivity to change.

Pettigrew et al. (1992) later identified receptive contexts that facilitated change and non-receptive contexts, which inhibited change. Receptive contexts included “*management action*” which was shown to be “*favourably associated with forward movement*” (Pettigrew et al. 1992: 268). In contrast non-receptive contexts, those seen to be “*associated with blocks on change*” (Pettigrew et al. 1992: 268) might include the absence of “*key people leading a change*” (Pettigrew et al. 1992: 278) or leadership that was present but not sustained.

In total eight factors (**Table 3-2**.) were identified, a mixture of content and contextual factors; but as illustrated the importance of the latter dominates. The interaction of these factors created energy and enthusiasm for change and were associated with an organisation's receptiveness to change. Pettigrew et al. (1992) were clear that these factors could be associated, but would not in themselves cause successful change.

Table 3 -2. Eight receptive factors associated with change

Factor	**Definition**
1. **Content:** Quality and coherence of policy	The extent to which goals and methods of implementation are linked
2. **Content:** Simplicity of goals	Establishing the key priorities for the change agenda and maintaining them
3. **Context:** Key people to lead change	Having continuity of leadership skills
4. **Context-:** Long-term environmental pressure	Awareness of external factors in triggering change
5. **Context:** Supportive organisational culture	Having a set of values and behaviours which contribute to the achievement of change goals
6. **Context:** Effective managerial-clinical relations	Managers understanding what clinicians value and clinicians thinking managerially
7. **Context:** Co-operative inter-national organisational networks	Productive relations with related social services and voluntary organisations.
8. **Context:** Priorities and fit between change agenda and its locale	Awareness that particular features of the locality may inhibit or accelerate change

(Adapted from Pettigrew et al. (1992: 276))

The idea of receptivity and non-receptivity has proven useful to researchers either in determining readiness to change and/or identifying barriers to change (Newton et al. 2003). Work undertaken by Newton and colleagues (2003) used the receptivity model to both collect and analyse data to evaluate the implementation of Personal Medical Services (PMS) in GP practices in England. This PMS project was initiated to promote the development of innovative approaches to the delivery of primary healthcare. They concluded that the receptivity model was useful and in their application they were able to refine and operationalise each of the receptive factors. This enabled them to both describe the experience of change that their case-studies underwent but also interpret what was happening and compare this with what might be considered the ideal. Significantly, Newton and colleagues (2003) found that two of Pettigew and colleagues’ (1992) factors had no influence on the achievement of change in their case study: Environmental factors (**Table 3-2**: item 4) and Change agenda and locale (**Table 3-2**: item 8). Their work also illustrated a change of influence of factors over time as the project developed and embedded, demonstrating that a realistic model of change cannot itself be static.

Newton’s application of the receptivity model identifies the important considerations for achieving successful change in the NHS. Whilst ‘top-down’ support (e.g. “quality and coherence of policy”) is needed, it does not necessarily exert consistent influence throughout a project – in their case study it was shown to be more important at the beginning than at the end. Other factors are at play, including the importance of bottom-up actions (e.g. “key people to lead change”). Second, the factors are wide-ranging, suggesting that change has to be facilitated by considering a variety of different perspectives and that actions are necessary at different levels within an organisation and at different times during a project (Newton et al. 2003).

Pettigrew and colleagues' (1992) ideas have been used effectively by Newton and colleagues to understand an event – the testing of PMS in primary care. Furthermore, their perspectives continue to influence thinking, as we will see later in this chapter.

3.3.3 Process

From the previous discussion it is clear that appropriate content is needed to achieve a change. In turn, managing the context in which ideas are introduced is key to successful implementation. What is less well explained in empirical research is the process of change. Process is defined as the *"....actions, reactions and interactions of various interested parties as they seek to move the district [service, organisation] from its present to future state*" (Pettigrew et al. 1988: 301). This is the crux of a change, and yet it is the least developed aspect in the literature, which offers widely differing interpretations of what constitutes change. Some research looks at discrete medical interventions; other work addresses means of achieving whole-system change and re-organisation. It seems that change and process of change in each circumstance is different; extrapolation and distillation of the actions of successful change differ too, depending on content and context (Pettigrew et al. 1988).

A process-focused approach to change has established the importance of the role of change-agents (Armenakis and Bedeian 1999). Understanding how to achieve change requires consideration of the actions and behaviours of individuals. Whilst it is recognised that no one person or group of people can make change happen the actions of those initiating a change are key (Bate 2000). Change-agents are those that respond positively to the need to implement change (Ashford et al. 1999). Weick and Quinn (1999) also identify the importance of change-agents by their ability to influence those individuals who are needed to make the change happen as well as making-sense of what the new initiative is and where it is heading.

The behaviour and actions of the change-agents are important, but so is the impact of individual behaviour of those who are not change-agents. In the NHS the behaviour of individuals by whom the change is being delivered can create a significant area of resistance, a barrier to change (Ashford et al. 1999). The degree to which individual actions and behaviours influence how change is enacted is analysed by Brooks and Brown (2002), who highlighted the way work relationships in healthcare created what they termed ritualistic ceremonies that created barriers to change. Specifically, they highlighted strict ward routines including early wakening of patients and rigid demarcation of roles and what is seen as nursing work.

Similarly, Bate (2000) identified how a culture of tribalism, individualism and conservatism undermined organisational change. These cultural perspectives contributed to what he called a fear of disappointment, which meant that staff were no longer prepared to commit to change for fear of further disappointment and failure; it was easier not to change (Bate 2000). In qualitative work by Marshall and Olphert (2008) the impact of organisational change on staff was evaluated and showed that the process commonly had a negative rather than a positive effect on staff. Commonly, this meant that staff felt let down by change, became cynical and doubted the strategic planning behind it. Marshall and Olphert (2008) conclude that this behavioural response is particularly important to consider when suggesting alterations to NHS organisations. They argue that staff are loyal to the ethos of the NHS, their patients and employing organisation and any change that erodes these relationships potentially results in negative behaviour that can limit its success (Marshall and Olphert 2008).

3.3.4 Summary

Change and ideas on change are large themes in the social science literature, an important theme in organisational theory and the focus of detailed debate in relation to implementing new ideas on the delivery of healthcare. So far, this chapter has outlined key models of change and considered how it can be achieved. It is clear that there is no neat solution. The closest area of agreement is the set of factors that appear to facilitate success: a balance between planned and emergent change; a model that provides some framework but is also responsive to emergent ideas and local strengths to support change. As well as models to help managers understand the process we must also be aware of how factors interact to both support and inhibit it, which highlights the importance of content, context and process. Of these, the context, principally the importance of receptivity, appears the most developed area of understanding. The least well-understood, but arguably the crux of the issue, the process, remains elusive.

Much of the empirical work presented here is over 20 years old and it is important to consider new ways of thinking about the process of change in healthcare. This current work looks at change as a form of innovation, which Rogers (1995b: 325) defines as an idea perceived "*as new by an organisation or individual*". How an innovation is taken up and used is the focus of current research as a means to understand healthcare responses to change initiatives. This more recent work added detail to understanding the process of change: what needs to happen. This is the third area of literature that I will discuss.

3.4 Diffusion as an approach to understanding change

The discussion to this point has dealt with traditional ideas of change. Diffusion, which is the spread of an idea or innovation, offers an alternative interpretation of how it can be delivered. The concept of diffusion was initially an evolutionary theory of the 19^{th} C, adopted by social scientists and anthropologists like the social theorist Everett Rogers, who explained that the uptake of new ideas should be likened to a social change relying on communication and networking to overcome the barrier of uncertainty (Rogers 1995a). The following section will consider the diffusion model of innovation and how this might operate in a healthcare setting. It goes on to consider the similarities between the components of different frameworks for understanding how change happens using thinking that has been informed by Rogers' ideas.

3.4.1 Definition of diffusion

Diffusion is seen as both a planned and spontaneous spreading of an idea. Diffusion encourages the adoption of an innovation into practice through communication and imitation

(Rogers 1995a; Greenhalgh et al. 2004). Rogers (1995a) suggests four essential elements to diffusion: the innovation, communication channels, time and the social system. The innovation is an idea or practice perceived as new by an individual or organisation. It is the individual’s reaction to that idea which determines whether it is seen as new and defined as an innovation. Communication channels are identified as the process through which participants create and share information to generate understanding of the new idea. Behaviour and reaction to innovation changes with the passage of time; and finally the social system is the set of interrelated units that work to solve problems and attain a common goal. This system is engaged in trying to make the innovation work. Each of the four elements has a number of subdivisions that provide further context to how these broad aspects support diffusion, described in **Table 3-3.**

Table 3-3. Elements of diffusion (adapted from Rogers 1995a pp 10-31)

The innovation	**Communication Channels**	**Time**	**A Social System**
Technological innovations, information and uncertainty – new ideas are commonly associated with technological innovation.	**Heterophily and diffusion** –Where participants are heterophilious, (similar in terms of beliefs, education, and social status, and sharing common meanings) communication likely to be more effective. Commonly the nature of communication with regard to innovation means that participants are not necessarily matched. The change agent who has the influence to stimulate the relationship between the CA and decision-makers. is likely to have more technical knowledge than the participant, creating a mis-match and a potential barrier to diffusion.	**Innovation-Decision process** – participants seek to decrease uncertainty about an innovation so they look for knowledge to help with the decision process.	**Social structure and diffusion** how units (for example people and who we know support promotion or job opportunities) in a social system are arranged and how this arrangement can facilitate or impede the spread of innovation.
Technology clusters – innovations are adopted more readily if ideas are packaged together.		**Innovativeness and adopters** – categorises members of the social system as one of 5 adopter categories – *innovators, early adopters, early majority, late majority* and *laggards*.	**System norms and diffusion** – established patterns of behaviour or norms can act as a barrier to the spread of innovation.
Characteristics of an innovations *relative advantage* – the greater the perceived relative advantage the more rapid the rate of adoption; *compatibility* – an idea consistent with existing values and norms is easier to adopt; *complexity* – if an innovation is easily understood then uptake will be more rapid; *trailability* – if the innovation can be experimented upon then it is perceived as less uncertain and uptake will be easier; *observability* – if others can see the impact of an innovation then it is more likely to be adopted.		**Rate of adoption** – refers to the relative speed with which an innovation is adopted. When a new idea is adopted quickly it is worth exploring to apply the lessons to a different innovation.	**Opinion leaders and change agents** – commonly those seen as most innovative are also deviant to the norm. Therefore one person does not impact on the uptake of innovation what matters more are opinion leaders and change agents.
			Types of innovation – decisions003A collectively the social system can decide to adopt or reject an innovation. The social system exerts an influence beyond that of an innovator.
			Consequences of innovations – consequences of adopting an innovation are weighed up. If desirable then the uptake of new idea is more likely.

Rogers has applied his ideas on diffusion to many subject areas, including the uptake of public health measures in Peru (Rogers 1995a) and the spread of new ideas in healthcare (Rogers 1995b). His work highlights the importance of social contact, particularly with peers, and the use of word of mouth in the adoption of a new idea. For example, he discusses the prescription of a new drug amongst physicians and argues that peer communication is a significant driver behind its rapid adoption in a social system traditionally seen as hard to change in terms of acting on new ideas (Rogers 1995b).

3.4.2 Diffusion of innovation in healthcare organisations

Historically, diffusion research has been most closely related to sociology. Its connection with the organisation of healthcare is relatively recent. Rogers (1995b) used healthcare examples in work published in the 1990's but there was no direct connection between ideas of diffusion and change in healthcare until Greenhalgh and colleagues, in 2004, published a systematic review of the diffusion of service innovations. This far-ranging review identified 13 research traditions that bore some relevance to diffusion of innovation. From their analysis of the literature within each of these traditions Greenhalgh and others generated a list of key components determining the success or otherwise of the diffusion of an innovation in healthcare organisations (detailed in **Table 3-4.**). Although this team examined research from traditions as diverse as Marketing and Knowledge Utilisation and Communication Studies and Health Promotion, the conceptual model that they developed is very heavily influenced by Rogers' (1995a) elements of diffusion presented above in **Table 3-3.**

The initial conceptual framework presented in Greenhalgh's work in 2004 was set out as a diagram with interlinking ideas presented within frames and distinctions made between ideas that they associated with the inner and outer context. Greenhalgh and others (2005) subsequently refined this complex diagram into a series of seven key dimensions identified from the literature, distilled from the 13 research traditions.

Table 3-4 Dimensions of diffusion of innovation

1. **Innovations** – how can innovations in healthcare be perceived as more advantageous than existing practice?
2. **Adopters and adoption** – the role of the individual in the uptake of a new idea
3. **Communications and influence** – what is the nature of interpersonal influence in adoption of new ideas in health services?
4. **The inner [organisational] context** – to what extent does the internal structure support the adoption of new ideas?
5. **Systems' readiness for change** – the steps that an organisation can take to determine the impact of an innovation;
6. **The outer [environmental] context** – can external "pushes" (such as policy) overcome and organisations resistance to change?
7. **The implementation process** – how are innovations sustained?

Adapted from Greenhalgh et al. (2004); Greenhalgh et al. (2005: 421)

Subsequently Greenhalgh and her team developed and tested these dimensions by interpreting them within a multi-level theoretical framework and then applying this framework to the uptake of a complex intervention in a healthcare organisation: electronic patient records in England. Her case study identified 4 primary care settings seeking to implement a shared electronic patient record. In each location data included staff interviews, observation and records of focus groups with patients. The experience of implementation was then explained with reference to the dimensions of diffusion that Greenhalgh and her team had been working on since 2004. The previous seven dimensions (**Table 3-4**.) were expanded to 9 (Greenhalgh et al. 2008), detailed below. These "material properties" appear specifically to influence the adoption of innovation in healthcare, and relate closely to Rogers' (1995a) original ideas outlined above in **Table 3-5.** In addition their proposals compare closely with Pettigrew et al.'s (1992) ideas of receptive factors, set out in **Table 3-2**.

Table 3-5 Nine components of diffusion of innovation in healthcare

1. **Material properties of the technology**: functionality and efficiency of use under real conditions.
2. **Attributes of the technology** : the new idea must have an advantage distinct from existing technology.
3. **Concerns of potential adopters** –adoption requires engagement of key individuals over a period of time and support to ensure the innovation is sustained.
4. **Communication and influence** – adoption relies on published material and the influence of key individuals to shape people's attitude in a positive manner to new ideas.
5. **Organisational antecedents for innovation** – differences within organisations mean that some are more or less willing to adopt new ideas. Leadership, a positive management culture, and an environment supportive of risk-taking create capacity to absorb new ideas.
6. **Organisational readiness for innovation** –Timing is important: new idea must coincide with an organisation being ready
7. **The implementation and routinisation process** – procedural aspects are clear; examples of good practice.
8. **Linkage** – innovation supported by early communication, particularly during developed process.
9. **Wider environment** – importance of innovation fitting with socio-policy climate, other initiatives and incentives. Adapted from Greenhalgh et al. (2008: 1788).

Greenhalgh et al. (2008) concluded that the success or failure of a new idea such as electronic patient records is determined by the exertion of influences at micro-, meso-and macro-level. Once again the process of how to deliver change cannot be distilled in a straight-forward manner and although this research team looked widely to better understand the uptake of new ideas, their conclusion and ideas still rely heavily on the work of Pettigrew, Ferlie et al. (1992) and Rogers (1995a).

3.4.3 Normalization Process Theory (NPT)

Around the same time that Greenhalgh and colleagues were developing their ideas, another research team were seeking to understand how new and complex interventions become embedded into healthcare practice. This work, led by the sociologist Carl May, has developed into NPT (May and Finch 2009; May et al. 2009). Like Greenhalgh et al.'s (2004) Diffusion of Innovations Model, NPT provides a framework for understanding, evaluating and thinking through the process of implementation, embedding and integrating complex interventions in healthcare. NPT encourages researchers to look at what people actually do and how they work. It focuses on the collective and coordinated actions required for people and organisations change (May 2013).

Greenhalgh et al. (2005) used their components of innovation to argue that "*the success of implementation (and the chances of sustainability) are critically dependent on the attributes of the innovation, the behaviour of individual adopters, the nature of communication and the influence, and various structural and sociological features of the organisation and its wider environment*" (Greenhalgh et al. 2005: 176). In contrast, proponents of NPT argue that 'normalization' of a new practice in healthcare is characterised by three core processes: implementation, embedding and integration (May and Finch 2009; May et al. 2009). According to May and colleagues *implementation* is the social organisation required to bring practice into action; *embedding* focuses on explaining the processes through which a practice becomes (or does not become) routinely used by individuals and groups; and *integration* is the process by which a new way of working is reproduced and carried forward in an organisation. These three processes are mapped onto four mechanisms: coherence, cognitive participation, collective action and reflexive monitoring (May and Finch 2009).

i) **Coherence:** action which defines and organises the objects of the new practice, such as what the new practice means, what benefits it may bring and how it differs from how things have been done before;

ii) **Cognitive participation:** work which defines and organises the enrolment of participants in a practice to gain engagement and 'buy-in' to the new practice;

iii) **Collective action:** work which defines and organises the enacting of a practice and explains how a new initiative is operationalised;

iv) **Reflexive monitoring:** what appraisal is being done of a new initiative, to assess whether it is worthwhile or not. (May and Finch 2009; May et al. 2009).

Both Greenhalgh's and May's ideas have been employed as theoretical perspectives to understand issues relating to change and implementation in healthcare (e.g. Greenhalgh et al. 2008; Finch et al. 2012; Mair et al. 2012). In these examples the research teams use their different paradigmatic perspectives to understand the spread of an e-health innovation. Taking their determinism-influenced perspective on the diffusion of innovation, Greenhalgh et al. (2008) consider the spread of e-health records in community practice. Mair et al. (2012) use NPT influenced by organisational and management theory and focus on the process of implementation of e-health and the readiness of adoption (Finch et al. 2012). By adopting their different philosophical positions each research team provides an alternative view of how change is implemented in healthcare. To date neither has been proven more effective than the other but both theoretical frameworks have been tested beyond e-health initiatives: for example (as discussed in **Chapter 2 Section 2.6.5)** health policy implementation of twenty one public health interventions in Canada (Tomm-Bonde et al.. 2013). Our purpose here is to explore the health research which has used NPT as a theoretical framework and highlight the insight this evidence reveals.

The testing and application of NPT in healthcare has been far-reaching. Early applications focused on specific aspects of teleheath, used earlier interpretations of May's ideas known as the normalization process model (NPM) and was led by a member of the original NPM/NPT research team (May et al. 2007). They included integration of e-health services (Mair et al. 2007); normalization of teledermatology (Finch et al. 2007 and; Finch 2008); the implementation of decision-support technology (Elwyn et al. 2008) and telecare in chronic lung disease (Mair et al. 2008).

However, later work applied NPT to a wider selection of implementation issues, of which I have been able to identify eight research projects between 2011-2014. This later empirical research informs our understanding of contemporary issues in healthcare implementation and supports my rationale for applying NPT as an analytical tool (see **Chapter 4**).

Most of the recent published literature on NPT focuses almost exclusively on its retrospective application as a theoretical framework to support data analysis. Some of this work still draws on ideas from early versions in which normalization was seen as a model rather than a theory. Deborah James considered a review of services for children with speech and language needs and concluded that much could be learnt from the social process used to support implementation rather than focusing exclusively on the benefits and barriers to new service models (James 2011). Like other research reviewed here, James's work applied NPT retrospectively and was selective in the constructs it applied, focusing on two out of four.

MacFarlane and O’Reilly-Brun (2012) also adopted a selective and retrospective interpretation of NPT (and, again, concepts close to NPM) for a paper in which they provide a reflexive account of their qualitative evaluation of general practitioners' uptake of language interpreting services in the Republic of Ireland. They concluded that the practical value of NPT lies in its ability to enhance the understanding of the manner in which new ways of thinking, acting and organising become embedded in health care systems (MacFarlane and O’Reilly-Brun 2012). In addition, the theoretical perspective offered by NPT encouraged analysis of experiences across a wide stakeholder group and provided a standardised and systematic approach to understanding implementation (MacFarlane and O’Reilly-Brun 2012). However, although NPT was seen to advance levels of understanding there were issues in how it was operationalised and they reported that they did not feel completely comfortable in their interpretation of the constructs (MacFarlane and O’Reilly-Brun 2012).

Two studies by Gallacher and colleagues (2011 and 2013) used all four NPT constructs to describe the treatment burden and work associated with being a patient with chronic heart failure (CHF) (Gallacher et al. 2011) and following a stroke (Gallacher et al. 2013). This empirical research illustrated a novel application of NPT. In each paper NPT constructs were applied retrospectively to the work of patients: what patients needed to do to manage their condition and to better understand the treatment burden they face (Gallacher et al. 2011; 2013). The retrospective analysis revealed that for patients with CHF coherence was a challenge and highlighted the importance of information and good communication needed to help patients make sense of their condition (Gallacher et al. 2011). Similarly, cognitive participation or engaging work was difficult and could explain non-adherence to treatment. To support collective action (enacting work) patients engaged in very specific tasks to ensure that they managed their symptoms. The weakest area of work was reflexive monitoring (Gallacher et al. 2011). According to Gallacher and team (2011) NPT could not account for all the work that patients engaged in; specifically, it did not account for the emotional burden of living with a chronic condition, a significant aspect of patient experience.

Gallacher et al.'s (2013) paper systematically reviewed literature relating to patient experience of the treatment burden following a stroke, analysed in relation to those articles which presented information fitting NPT's four constructs. This was not empirical research; even though it revealed what current research highlighted in relation to the burden of care faced by stroke patients, it is not so applicable to understanding the implementation processes revealed by NPT as when it is used in relation to empirical service-orientated research.

More relevant was empirical research undertaken in the Netherlands which reported the use of all NPT constructs to explore the implementation of a stepped-care approach for depression in a multidisciplinary, primary care setting (Franx et al. 2012). Franx and colleagues' use of NPT to understand the process of service organisation is a very different application to the work of patients as explored above and reveals a number of issues. For each of the four NPT constructs they identified the barriers and facilitators to delivering the stepped-care approach, demonstrating that although all four constructs operated concurrently, coherence and cognitive participation appeared to be crucial drivers (Franx et al. 2012); if shared understanding is absent, delivering a new idea will be difficult.

In addition, the researchers found that introducing a new way of working into healthcare practice was time-consuming and dependent on the interaction of complex factors with facilitators and barriers working at different levels (the individual, the professional, the patient; the social, organisational and economic and political contexts). In their final discussion, with regard to the contribution made by NPT to their understanding, they concluded that implementation projects should pay particular attention to local problems with regard to coherence and cognitive participation, arguing that if implementation is too targeted towards action then clinicians will not engage (Franx et al. 2012). Their conclusion that systems of reflexive monitoring were not implemented and that this needed to be addressed (Franx et al. 2012) demonstrates the power of their analysis. This is a significant study: the first empirical research to apply NPT prospectively rather than retrospectively, and to a service organisation issue other than telehealth. Consequently, it reveals important insight into both the strengths and limitations of NPT, which to this point had largely been absent from the literature.

Two papers published the following year also applied all four NPT constructs. Lloyd and colleagues (2013) used NPT in a longitudinal study which at two time points used interviews to explore how a multi-faceted, shared decision-making implementation programme in the UK was progressing. Like Franx et al. (2012) and other researchers, they found that coherence was a key theme to emerge from the data, with many teams still struggling with the meaning of shared decision-making nine months after the programme started (Lloyd et al. 2013). Coherence was critical if normalization of shared decision making was to be achieved and this emerged as more complex than previously anticipated. However, Lloyd et al. (2013) also found that increased understanding did not necessarily lead to wide-spread agreement as to the desirability of shared decision-making. These researchers observed the three other constructs of NPT but found that coherence appeared to be the prerequisite for successful normalization of shared decision-making.

A third 2013 paper reported research undertaken in Scotland to assess general practitioners' perspectives on the implementation of electronic medical records (Bouamrane and Mair 2013). All four NPT constructs were used by Bouamrane and Mair (2013) as a conceptual framework to support the interpretation of interview data. They found that to facilitate adoption of the new technology, practitioners needed to be able to make sense of electronic systems and this in turn was dependent on an understanding of the rationale for change and wider-organisational effort to sustain and communicate support for this cultural change. GP or user buy-in was not evident through traditional methods of collaboration and participation but was achieved by financial incentives and linking the new technology to perceived patient benefits (Bouamrane and Mair 2013). In common with other applications of NPT they found that most organisation of the work of implementation of the new technology was directed at collective action with particular focus on the impact of the new technology on workflows and roles, responsibilities and training (Bouamrane and Mair 2013). In both situations the innovation was seen to impact negatively and as a factor hindering the work of GPs. The fourth area hindering GP interaction with the new technology was the lack of evidence or reflexive monitoring. This absence of work to appraise effectiveness of an innovation is a consistent finding to emerge when NPT is applied; one that significantly hinders embedding and sustainability of innovations.

Contemporary research using NPT highlights a number of significant foci when seeking to understand the success or otherwise of interventions designed to improve healthcare practices. Overall, implementation processes are time-consuming, complex and contextually dependent, so policy-makers, policy–implementers and change agents need to pay particular attention to them. The importance of coherence – sense-making shared understanding – consistently emerges as both an area of considerable work and where differences can undermine the success of change. Similarly, acknowledging the appraisal work people need to undertake and process is not given the recognition it deserves and inhibits the achievement of successful change and innovation.

NPT's strength lies in its ability to explain what people do and consider this from both an individual and organisational perspective (Mair et al. 2012). NPT is explicitly process-oriented. In contrast, Greenhalgh et al.'s (2004) Diffusion of Innovations model considers the flow of ideas and what makes them more or less attractive to adopters (May 2013). It also encourages a tight focus on the importance of antecedent conditions and the influence of individual attitudes and beliefs, and thus approaches innovation and diffusion from a narrower perspective. In this thesis NPT was chosen as an analytical framework for the breadth in understanding it offered. The details of this rationale are explored in **Chapter 4** (section 4.2.2).

3.5 Conclusion to chapter

Examination of the literature related to change and innovation reveals a body of complex and multi-layered work, characteristics which can also be attributed to healthcare. Consequently, no one approach to change and innovation emerges as offering the solution to change in the NHS. The literature highlights a breadth of accumulated knowledge from a variety of disciplines, that helps to explain what factors can make the adoption of new ideas successful and what potentially undermines new initiatives:

- Importance of planning change so that it is sustained over a sufficient period of time to demonstrate benefit;
- Models of change appear useful as a management tool;

- Understanding the organisational environment, both internal and external, and the influence these aspects can exert on the achievement of change or innovation;

- The content of change should be relevant and make sense to implementers;

- Aspects of the internal organisational culture such as leadership, a positive management culture and an environment, which supports risk-taking, and the testing of new ideas, are seen as helpful.

- NPT reveals that for implementation to work it is important to build coherence, facilitate participation and buy-in, adapt to new working practices and commit to the benefits of monitoring and reflecting on the value of innovations.

Current thinking around change in healthcare focuses on testing new ideas on the work of implementation of innovation and takes a detailed approach to understand processes which operate both at the individual and organisational level.

Chapter 4: Methodology and methods of the research process

4.1 Introduction: a qualitative approach

This chapter sets out the methodology and methods deployed at each stage of the research process. Drawing on Denzin and Lincoln's (2005) thesis that qualitative research is interpretative, guided by beliefs and feelings, I will demonstrate how these influence the study.

The study design, set-out in **Section 4.2**, outlines the study design and justification for the qualitative approach and the use of a single case to contextualise conditions and represent the views of policy-makers and -implementers on their experience of policy implementation (Yin 2009). In **Section 4.3** I give an account of the data collection process and **Section 4.4** describes how the research was conducted. **Section 4.5** outlines the ethical issues and data handling approach. Section 4.6 explores data analysis to show how the findings presented in **Chapter 5** and **6** were generated. **Section 4.7** explains the reflexivity during the research. A conclusion to the chapter is presented in the final section (**Section 4.8**).

4.2 The study design - philosophical stance

Research should be relevant, credible and develop new knowledge. To ensure relevance, Depoy and Gitlin (1994) argue, research should be able to demonstrate the reality of the situation it seeks to describe or define. Its Credibility is achieved by methodologically sound planning and undertaking (Cutcliffe 2000). The researcher must also show a process of learning and the development of new knowledge. The process of exploring and testing “*how we know what we know*” is considered by Crotty (1998: 3) as a basic element.

I am interested in studying the human and social world to understand and interpret the relational dynamics between and within the Scottish Government and a local health board as healthcare policy is enacted. My thesis considers applied health service research driven by a desire to generate relevant, naturalistic research, a perspective strongly associated with qualitative approaches to inquiry (Silverman 2001).

Qualitative research is defined as "*development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of the participants.*" (Pope and Mays 1995: 42). Qualitative research techniques have evolved from a number of research traditions or epistemological perspectives, of which the most significant is interpretivism (Miles and Huberman 1994). It is most closely associated with the German philosopher Immanuel Kant (1724-1804), who suggested that there were ways of knowing about the world other than just observing it and that meaning could be created by people interpreting, experiencing and understanding the world around them (Snape and Spencer 2003). Interpretivism thus assumes an ontological perspective on the nature of reality. Constructivist ontology fits with interpretivists' desire for social reality to be understood best through examination of social relationships and interactions (Schwandt 2003). They bring object and meaning together as a way of understanding the social reality of a situation (Crotty 1998). Rather than seeking to avoid or control human interpretation or interaction when trying to understand the objective truth of a situation, constructivists take account of the need to understand objects within their social context, adopting a 'realistic' as opposed to a 'materialistic' position (Snape and Spencer 2003). Constructivism also recognises that to understand an object one must see how that object is experienced, which in turn influences how its meaning is constructed. So, constructivists argue, nothing exists in isolation and human experience is essential to understand meaning (Schwandt 2003).

In this study I wanted to present a realistic understanding of policy implementation as understood and constructed by those who make it: the policy-makers and those who are charged with implementation: policy-implementers. Interpretivism and constructivism fit this aim and have guided the research design and data analysis.

The qualitative approach is multi-dimensional and diverse, making it particularly relevant to understanding the context, people and interactions commonly featuring in health research (Yin 2011). Qualitative research in health helps particularly to explain how contextual factors – economic, political, social, environmental, and organisational – operate in this complex, multi-layered, human environment. It also plays a role in understanding people by exploring how they make sense of their experience of health and disease; and focussing on ways in which actors involved in different organisational health activities interact with each other. Of most relevance to this research was determining how contextual factors influenced health and specifically health policy-implementation, and what interactions and actions were taken to ensure that implementation of health policy focused on self-management support for people with LTCs. The multiple dimensions of qualitative research fit the main purpose of this study.

4.2.1 Qualitative stance

Qualitative research, broadly defined, is "*any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification*" (Strauss and Corbin 1990: 17). The distinctiveness of a qualitative approach is that it explores the richness, depth, and complexity of phenomena within its natural setting. Its perceived weaknesses include the difficulty of reproducing results independently; the evident potential for witness bias and researcher prejudice; and a lack of statistical rigour (Yin 2009).

Qualitative research is associated with intense contact in the field; it provides insight through discovering meanings by improving our comprehension of the whole. It is the researcher's role to gain this multi-dimensional view which, in qualitative research, is achieved by capturing the perceptions of participants from close to the source of the phenomena or, as Miles and Huberman put it (1994: 6) '*from the inside'*.

Qualitative research exists alongside other social science research methods (Yin 2011). "*Nonqualitative methods*" (Yin 2011: 282), including surveys, experiments and cohort studies, are best seen as alternative approaches with similarities to qualitative methods rather than polar opposite perspectives.

Parallels include the qualitative researcher's closeness to the data collection, referred to as their reflexive role, and the potential for the "*experimenter or Hawthorne effect*" (Fincham and Rhodes 1992: 168) where the action of taking part in an experiment was enough to generate a positive effect. In addition both research traditions have concerns over validity and the use of triangulation to promote rival thinking to strengthen the quality of the research (Yin 2011). Analytically there are also similarities: the use of matrices in qualitative research as advocated by Miles and Huberman (1994) is comparable to the reassembly of quantitative data. What differs is that qualitative data consist of words and narratives and quantitative data consist of numbers.

Qualitative research focuses on the collection of data in the field with the researcher as the main research instrument (Yin 2011). The range of research methods is generally broad and the focus is on collecting rich data that provide adequate explanations of the context being explored (Yin 2011). In my research I sought to capture this richness of experience through interviews, analysis of policy documents and the observation of meetings. I spent 18 months collecting data and engaged in my field of study. The engagement with these richly complex sources generated a ‘closeness’ with the data and encouraged thinking about observations and experiences to formulate understanding and meaning (Snape and Spencer 2003). A key factor informing my methodology is the way in which people in a particular setting come to account for, take action on and manage their day-to-day situation. . For interpretation, qualitative research relies on analysis of the organisation of words which, with thinking and through the application of theoretical ideas and patterns, allow meaning to be conferred on them.

Further support for a qualitative approach is provided by considering my research objectives and how other research in policy implementation has been undertaken. Qualitative research methods were appropriate to address the particular objectives:

> (i) to describe the context, content and process of policy implementation through the examination of policy documents;
>
> (ii) to investigate how awareness of policy promoting self-management was being generated;
>
> (iii) to understand the work of policy-makers and -implementers to deliver policy in practice;
>
> (iv) to account for factors which promote or effect policy implementation and those which inhibit or obstruct it.

The literature review in **Chapters 2** and **3** demonstrates that qualitative approaches have often been successfully employed to research policy implementation, for example Jill Schofield's (2004) work which used interpretative ethnography to examine how public service managers operationalize new policy initiatives.

4.2.2 Justification for the use of the case approach

Qualitative research has no single agreed approach to study design. There are five commonly associated qualitative study designs:

> i) *Ethnography*, a portrait of people developed by studying the story and culture of a group to understand cultural awareness;
>
> ii) *Phenomenology*, the study of lived experience through events and taking the individual's perspective e.g. the experience of patients with ulcerative colitis;
>
> iii) *Grounded theory*, which seeks to go beyond what is already known about a subject and develop a new theory;
>
> iv) *Participatory action research*, which involves individuals and groups researching their own personal setting and socio-cultural experience;
>
> v) *A case study approach*, an in-depth approach to understanding a small number of units or individuals diachronically, for example in the evaluation of health service policy implementation (Cresswell 2007).

The approach adopted here has the advantage, according to Stake (2005) and Yin (2009) of allowing the study of processes and actions in detail and the investigation of interactions between organisational levels. This fitted with the focus and aim of my research. In addition, these methodologists argue that the necessary detail can be achieved by the study of a single case and that the inclusion of additional cases can dilute the attention applied and level of understanding generated (Stake 2005) This produces a true ‘holistic’ study: that is, something which is complete in itself, has its own sub-parts but which is part of something larger: an entity in a hierarchical organism (Koestler 1978). Furthermore, the case focuses on understanding the dynamics of everyday life from the perspective of individuals, groups and/or organisations in a single setting (Eisenhardt 1989). It allows more intense contact with the field of study than a multiple case scenario. I knew I had limited resources for fieldwork and had to balance breadth versus depth in data collection: a case approach provided this level of detail while concentrating my time in one geographical location.

A case study approach also provides a means of investigating how things get done, particularly in relation to systems (Stake 2005). Here I am interested in understanding the process of policy implementation, which 'behaves' like a system. In addition I wanted to map the interaction between different levels of the policy system; from national to regional to local; and vice-versa: hence ‘holistic’.

Importantly, the case approach allowed me to investigate policy implementation in discrete organisational contexts, revealing the contrasting paths and *work* of policy-makers compared to policy-implementers. By considering three different contexts (national, regional and local), I have also been able to compare contexts to explain the significance of national mechanisms and local circumstances in securing policy change. This has enabled me to test a framework for implementation - NPT which was chosen to take account of what Mazmanian and Sabatier (1983) identified as the most important perspectives in a policy implementation framework:

i) knowledge of the characteristics of the society within which implementation takes place;

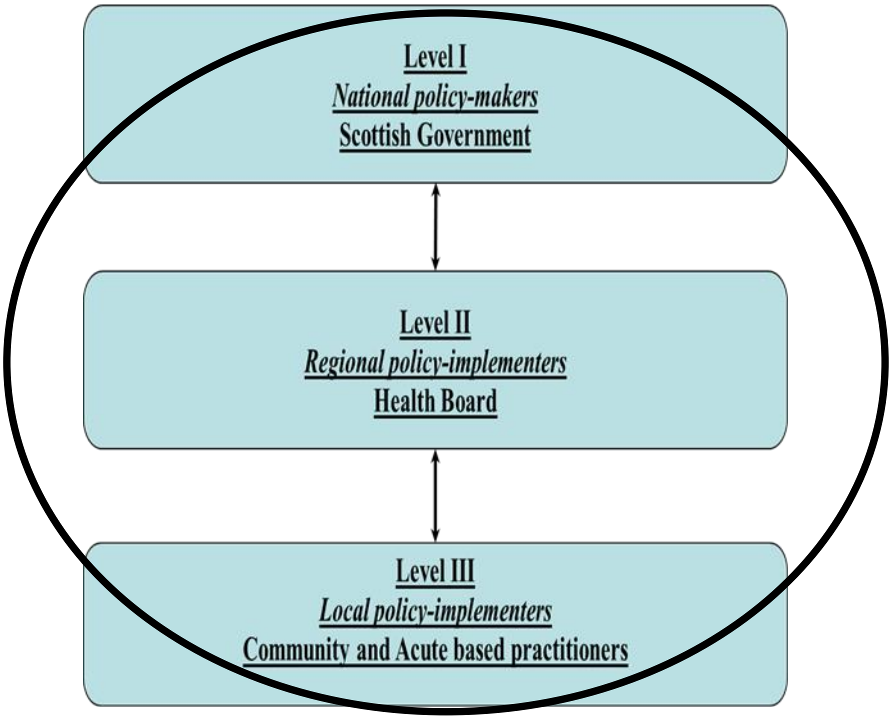
ii) identification of where policy-makers and -implementers can best influence the course of events;

iii) recognition of what cannot be changed and what is amenable to intervention.

NPT is a more detailed and context-sensitive framework than simply considering policy implementation from the perspective of “top-down” and “bottom-up” or the consideration of policy content versus policy implementation, both previously examples of debate in the study of policy implementation (O'Toole 2004). I have undertaken a case study of policy implementation which applied a more nuanced theoretical framework to explain practice. This level of study is acknowledged by O'Toole (2004) as a rare undertaking.

I combined individual levels and associated data collection into a single case of policy implementation, a bounded, tight design exposing the complex and under-researched nature of policy implementation (summarised in **Figure 4-1).**

Figure 4-1 A case-approach to understanding policy implementation.



4.3 Data collection

Denzin and Lincoln (2005) outline many different methods by which data are collected in qualitative research. These include archival study, observation, interviews, documents and focus groups. Of these, I applied three methods (justification for which is provided in **Section 4.4**):

i) review and analysis of policy documents
ii) interviews with policy-makers and -implementers;
iii) observation of meetings.

This triangulated approach of three methods of data collection allowed the verification of ideas which emerged from policy documents, through interviews and observation of committee discussion; this ‘*confirmability*’ is seen to improve the validity and reliability of the findings, an important element when using a single case approach (Eisenhardt 1989; Bowling 2002) and consistent with an interpretivist perspective of multiple realities differing across time and place (Miles and Huberman 1994).

4.3.1 Sampling

Creswell (2007) identifies data collection as a series of interrelated activities which include: sampling; locating the site and individuals; gaining access and forging rapport; collecting data; recording information; resolving field issues; and storing data. This section addresses the ways in which these activities were mapped onto the data-collection phase of my research, conducted from December 2008 to May 2010.

The delivery of this complex project required flexibility and responsiveness to sampling so that I was able to adapt to emerging ideas and contacts.

4.3.1.1 Selection of NHS Board

Sampling was initially directed towards the choice of a single NHS board for study. From preliminary discussion it was evident that some health boards were emerging as early implementers of self-management policy and so leading the process of policy implementation. Robson (2002) advocates sampling a ‘*critical case*’ which represents a good learning environment and allows in-depth exploration of the questions of interest. I used the following criteria to determine which health board best fitted the demands of the strategy:

i) An NHS Board recognised as an '*early adopter*' and thus seen to be providing leadership in this area of policy delivery;

ii) A context which was recognised as exemplifying the main objectives set out in the policy-makers' vision of how programmes to improve self-management could be applied in practice;

iii) A setting where a range of programmes at different stages of development were operating.

These criteria combined to frame a setting which fulfilled the objectives of the case study and provide a richness of data both seen as important aspects in case selection (Stake 2005; Miles and Huberman 1994).

Three NHS Boards met the criteria. My final selection was determined by accessibility in terms of agreement to support the research and ease of travel from my work base. Such pragmatic considerations are recognised as an appropriate influence when choosing the research setting (Hammersley and Atkinson 1983). From a possible three NHS Board areas one was chosen as the setting for the Level II and III data collection. To anonymise participants and location, it is referred to as NHS Kuzburgh.

4.3.1.2 Selection of participants for interview

At Level I – National policy-makers – the first three participants were approached for interview using purposive sampling. This strategy is seen as resource-efficient but has been criticised for being poor at eliciting sufficient information and lacking credibility as it relies on the researcher's existing networks (Creswell 2007). In recognition of its limitations this strategy was used in combination with snowball sampling which uses initial participants to identify other people involved in the same area of study and have knowledge which could add to the information and enrich the data collected. In my interviews I applied chain sampling by asking, at the end of each interview, the following question: "*Is there anyone that you feel it would be particularly helpful for me to approach for interview*?" The success of snowball sampling depends on careful selection of the initial participants as they have a strong influence on who the researcher approaches next (Miles and Huberman 1994; Bowling 2002). There is an acknowledged risk of weighted selection here which is highlighted in **Chapter 8** where the limitations of the study are explored.

The purposive selection of initial participants risks limiting the richness of the data; so considerable preparation was undertaken before initial individuals were approached for interview. The first step in this preparation, part of Creswell's (2007: 118) '*gaining access and forging rapport*' stage, was initiated by meeting, on two separate occasions, between June 2008 and October 2008, with a contact working to support the Scottish Government's LTC Unit which aimed to promote self-management support for people with LTCs. I was able to establish that, as well as the unit; there was a series of working groups associated with policy promoting self-management for people with LTCs, linked to activity directed by the LTC unit. I was then able to identify and locate key individuals. In November 2008 I attended a national event to mark the launch of the Government's Long Term Conditions Collaborative (LTCC) initiative. A number of the identified individuals presented papers on self-management, its policy drivers and ideas on how change in clinical practice could be achieved. This allowed me to learn more about the roles of key players in this policy area and their involvement in policy-making. It also allowed me to introduce myself and my research. This combination of networking at a national event and the knowledge shared by the members of the LTC Unit proved useful in identifying initial participants and subsequently in securing my first three national interviews. These first contacts came from different professional backgrounds and organisations, offering a range of perspectives beyond that of the Scottish Government.

From December 2008 to April 2009, using a combination of purposive and snowball sampling, twelve policy-makers were approached for interview. Of these, eleven accepted my request to participate and agreed to an interview. The one refusal was from a Government minister and explained on the basis that as a Member of the Scottish Parliament they did not agree to any individual interviews. In the letter of refusal, the respondent identified someone whom he thought would be a useful contact and potential interviewee, someone that I had already interviewed, confirming that I had included the right policy-makers at this organisational level and that my selection of initial participants had been effective.

I employed similar sampling strategies when choosing potential participants at Level II – Regional – Health Board members and executive leads and Level III – local – practitioners within NHS Kuzburgh. I again had initial the assistance of a local contact whom I met and discussed my research proposal with in June 2008.

On the conclusion of my interviews at Level I and, after I had successfully secured NHS Research Ethics and NHS Research Governance approval [**Appendix 1**: REC reference: 08/S10001/71], I held a further meeting with my health board contact. From this second meeting I was able to identify a purposive sample of health board directors, managers and leaders of local voluntary agencies who were seen to be taking an active role in the delivery of policy to promote self-management. This initial group of four participants was contacted during May 2009 and all were interviewed between May 2009 and July 2009. **Table 4-1** provides a description and timeline of the interview participants.

Table 4-1: Timeline, sequencing and description of interview contacts

Pseudonym	Position	Organisation	Date	Level
Dom	Clinician	Scottish Government (LTC Unit)	Dec/2008	***Level I - Policy-Maker (P-M)***
Gayle	Director	Voluntary Organisation	Dec//2008	
Bobbi	Clinical Lead for self-management	Scottish Government (LTC Unit)	Jan/2009	
Charlie	Director	Voluntary Organisation	Jan//2009	
Emroy	National Programme Manager	Specialist HB	Feb//2009	
Alex	Chief Executive	Voluntary Organisation	Feb//2009	
Finlay	Civil Servant	Scottish Government (LTC Unit)	Feb//2009	
Harper	Programme Manager	Specialist HB	March/2009	
India	Clinical Manager	Scottish Government (LTCC)/clinician seconded from NHS Kuzburgh.	March/2009	
Jay	Senior Programme Manager	Scottish Government (LTCC)/clinician seconded from NHS Kuzburgh	April//2009	
Marley	National Director	Voluntary Organisation	June//2009	
Kris	Nurse lead	NHS Kuzburgh	May//2009	***Level II - Regional Policy-Implementer (P-I)***
Lennon	MCN, Co-ordinator (diabetes)	NHS Kuzburgh	June//2009	
Nell	Regional Director	South Kuzburgh Carers	July/2009	
Oakley	MCN, Co-ordinator (CHD	NHS Kuzburgh	July//2009	
Paul	Director CHP	NHS Kuzburgh	July/2009	
Quinn	Associate Director	NHS Kuzburgh	July//2009	
Reece	Regional Programme Manager (LTCC)	NHS Kuzburgh	Aug//2009	
Sidney	Associate Director	NHS Kuzburgh	Sept/2009	
Taylor	Director NHS Board	NHS Kuzburgh	Sept//2009	
Rylee	Manager	North Kuzburgh Carers	Dec//2009	
Jamie	Link Worker	North Kuzburgh Carers	Dec//2009	
Pat	Regional Project Manager (LTCC)	NHS Kuzburgh	Sept/2009	***Level III - Local Policy-Implementer (P-I)***
Vaughan	GM - Locality Manager	NHS Kuzburgh	Nov/2009	
Lou	GM - Locality Manager	NHS Kuzburgh	Nov/2009	
Fran	LTC lead	NHS Kuzburgh	Nov//2009	
Blake	Nurse – Team leader	NHS Kuzburgh	Feb//2010	

Pseudonyms	Position	Organisation	Date	Level
Casey	Specialist Nurse	NHS Kuzburgh	Feb/2010	***Level III - Local Policy-Implementer (P-I)***
Berni	Specialist Nurse	NHS Kuzburgh	March/2010	
Eddi	Nurse - Team Leader	NHS Kuzburgh	April/2010	
Logan	Nurse - Team Leader	NHS Kuzburgh	April/2010	

Snowball sampling was used to identify other managers and clinical leaders seen as important in the regional and local policy implementation process. This led to a further twelve contacts, eleven of whom agreed to participate; the one who declined did so because of workload pressure. This, like Level I, reflected a high response rate and overall recruitment progressed more easily than had been anticipated.

I believe that recruitment was straightforward because the research focus was topical and fitted well at the time people were approached for interview. Initial contact was by email (see **Section 4.4),** an effective and time-efficient means of communicating with potential participants, contributing to the high response rate. A third reason, I believe, lay in the ground work and positive engagement secured through the two key ‘gatekeepers’ (Creswell 2007). Their inside knowledge and assistance in identifying likely participants proved an effective combination, with due consideration of the risks implied.

Level II interviews were concluded during September 2009 but it was clear that the majority of respondents were experienced in a single geographical location, the area served by Community Health Partnership 1 (CHP-north). Mindful of the importance of using sampling to generate a broad and balanced perspective on the detail of what is going on, I agreed, following discussion with my supervisors, to modify my sampling strategy. From September 2009 onwards, as Level III – local - interviews started, I used my interview contacts, as well as seeking guidance from my initial local contact, to identify potential participants of interest both in respect of the research topic and among those who had experience of working in a different CHP. This ability to shift and change the sampling method during fieldwork is an adaptive feature of qualitative research (Miles and Huberman 1994). Creswell (2007) also advocates the importance of being flexible in the sampling strategy and this change helped to open up the participants beyond one geographical location but still within the health board area.

Level III – local – interviews began at the end of September 2009 and were concluded by April 2010. During this time a total of eighteen participants were approached, of whom nine agreed to interviews and nine (50%) refused. In comparison to recruitment at Level I and II this was the hardest level at which to recruit participants. Of the nine who refused to participate, five cited reasons for refusal. The reasons given for not participating included one respondent who was on long-term sick leave and one who offered to provide a written response to my interview schedule. The remaining three replied that their current job positions were under review due to internal re-organisation and they were in the process of having to re-apply for their jobs. In the light of this additional work pressure they felt unable to contribute.

In qualitative research sample sizes tend to be small and are often not pre-specified at the start of the research (Miles and Huberman 1994). In this work, at each level, interviews with ten participants were planned, giving a target number of thirty. There is benefit, in a qualitative case approach, for sampling to build on variety and respond to the opportunity for further in-depth study (Stake 2005). Therefore, although a target number had been agreed there was some variation in the total number of interviews conducted (final total 31). The table below summarises the numbers of participants approached for interview at each level and those who agreed to be interviewed (see **Table 4-2**).

Table 4-2: Number of interview participants

	Approached	Accepted
Level I – National – Policy-makers	12	11
Level II – Regional – Policy-implementers	12	11
Level III – Regional – Policy-implementers	18	9
	Total	***31***

4.3.1.3 Selection of meetings for observation

The second data collection method was the observation of meetings. Field notes were taken while observing the topics of discussion and interactions between those attending meetings at organisational Levels I and II, chosen using a combination of purposive and opportunistic sampling.

Purposive sampling directed the first choice of meeting at Level I. Here I aimed to observe a national meeting which would provide a rich source of data on progress in and future plans for self-management and how policy was being implemented. I was able to seek guidance from my national-level contact who worked for the LTC Unit. This conversation was also informed by responses from Level I interview contacts, an iterative aspect of qualitative methodology. During my discussion with interview participants, there were frequent references to programme boards and steering groups established to support strategic decisions relevant to self-management support and implementation plans. This information generated leads to further meetings most relevant to my purpose. I was successful in securing the observation of one national meeting in September 2009 and a second meeting in May 2010.

Similarly at Level II the sampling of meetings for observation was guided by information from the responses of the interview participants. In addition, if other project groups were mentioned when I was observing a meeting I used this information to generate other leads. My first request to observe a meeting at Regional Level II was accepted and from my observation here I identified a further three leads for groups to observe. Two out of the three observation requests were refused. The reason for refusals for one group was because they were facing the termination of funding which had significant implications for staff and specific work streams, and due to the sensitivity of the discussion it was not felt to be appropriate to have an observer present. The second group was in the process of establishing itself, so again it was not felt to be appropriate to have an external observer.

Consequently at Level II two meetings were observed, one in December 2009, the second in April 2010. I had planned observations of two committee meetings per level. However, in practice there were no relevant committee discussions taking place at Level III, so across the case study a total of four rather than six meetings was observed (see **Table 4-3**).

Table 4-3 Number of meetings observed

	Approached		*Accepted*
Level I – National – Policy-makers	2	**Observation 1** – Self-Management Strategy Group **Observation 2** – Long Term Conditions Collaborative (LTCC) – team meeting	2
Level II – Regional – Policy-implementers	4	**Observation 3** – Long Term Conditions Programme Board **Observation 4** – Care Management Steering Group	2
Level III – Regional – Policy-implementers	No requests made		
	6	***Total Sample***	***4***

Further details of the meeting observed and the attendees is given in **Chapter 6**.

4.3.1.4 Selection of policy documents

A purposive and convenience sampling strategy was used to identify policy documents to be included on the basis of comprehensiveness, detail and accessibility (Miller and Alvarado 2005). To further inform the sample the following inclusion criteria were used: those published by the Scottish Government Health Department (previously the Scottish Executive Health Department) published from 2004-2010, just before the publication of Scotland's National Framework for Service Change (SEHD 2005b). This document was the first to highlight to NHS Scotland the significance of support for self-management as an aspect of systematic high quality care for people with LTCs. Alongside policies, documents and guidance directed at specific actions associated with LTCs, self-care and self-management including Health Department Letters (HDLs) (previously Management Executive Letters - MELs) were also included. Finally, interview participants were asked which policy documents they felt were most relevant to self-management. Analysis of responses to this question also helped determine the sample of policy documents included in collection. In total 14 documents were selected by this sampling approach.

4.4 Conducting the research

4.4.1 Use of policy documents

The first source of data was policy documents, broad statement of goals and objectives as policy-makers see them, providing a framework outlining the activity policy-implementers are expected (by policy-makers) to undertake. For example, consideration of key policy statements offers insight into what policy-makers say self-management support is, what they want to happen and how they expect policy to be implemented. Such texts provide what is termed an "*official version*" (Silverman 2001: 119) to be tested against what is observed or reported through interviews. Here I was using policy to compare the official version to what was reported to be happening. Analysis of policy informs conclusions drawn in relation to the following research objectives: (i) to describe the context, content and process of policy implementation through the examination of policy documents; (ii) to investigate how awareness of policy promoting self-management was being generated and; (iii) to understand the work of policy-makers and -implementers delivering policy in practice.

4.4.1.2 Inclusion of policy documents

Data were collected from relevant Scottish health policy documents to determine how the Scottish Government sees self-management support and how it promotes policy implementation (Green and Thorogood 2009). A data extraction form was completed (**Appendix 2**) recording the author, date, title, process and purpose of each policy document. These headings were used to generate summaries of each policy document (**Section 5.2.1**).

Documents are summarised chronologically from 2005-2010, providing a realistic trajectory of policy ideas as they emerge and how the Scottish Government sees them being translated through different organisational contexts. This '*policy timeline*' highlights the emergence of self-management in policy and tracks its evolution over a five-year period (**Table 5-1**).

4.4.2 Use of interviews

I wanted to understand the perspectives of individual policy-makers and -implementers: those people who were most closely involved in the writing and delivery of policy. What Barrett (2004: 3) termed the '*policy-action relationship*' could have been evidenced in a number of different ways: for example by post or phone interviews, through a questionnaire, or through discussion in focus groups with a number of policy-makers and -implementers. My choice was to undertake face-to-face semi-structured interviews.

To achieve my research objectives, in particular objective (ii) to investigate how awareness of policy promoting self-management was being generated; objective (iii) to understand the work being used by policy-makers and -implementers to turn policy into action; and objective (iv) to account for the factors which support policy-implementation and those which inhibit, it were best addressed by individual interviews. These are subtle ideas which I felt had to be gathered in a natural, confidential setting where people felt at ease to present what was 'really going on'. The face-to-face interview provided the right environment. Furthermore, in the NHS and within the civil servant/government community, individual meetings are a familiar means of doing business and eliciting information.

Face-to-face interviews allowed data to be collected close to the situation; in qualitative research this proximity adds to what Miles and Huberman (1994: 10) refer to as "*local groundedness*". Interviews involve asking questions, listening to and recording responses from individuals on, in this case, a semi-structured questionnaire in an in-depth manner. These interview attributes provided the best means of generating data related to concepts and opinions and suited my research objectives (Yin 2011). Furthermore, it was my aim to explore the process of policy implementation, and interviews provided a longer and extended period in which to do this. Face-to-face interviews allowed for iterative questioning, for the generation of new information and ideas not anticipated in the planned questions, so that nuance and depth could be explored in real time.

The use of interviews rather than focus groups or questionnaires provided a snapshot: what was happening at a particular point. These approaches would not provide the necessary insight in terms of understanding the slowly-emerging processes of policy implementation and delivery of change in practice.

4.4.2.1 Process of conducting the interviews

Although interviewing is one of the most common and powerful methods of qualitative data collection it is also considered to be much more challenging than it may first appear (Fontana and Frey 2005).

To help ensure the success of my interviews a number of stages was defined: an initial approach to potential participants; securing permission to interview; making arrangements to visit and conduct the interview; confirming arrangements; forwarding transcripts after the interview; and, finally, a follow-up and letter of thanks.

The initial approach was made, in all but one case, by email. The one exception was the request made to the Member of the Scottish Parliament by letter, because email contact to him was through a general email box that was tried with no success. At the start of the research I was unsure how an email by an unknown contact would be viewed by my potential participants. In the event and, as supported by the high recruitment discussed earlier, the doubt was groundless. In my initial email I set out that this was a research request and that I was seeking interviews with key stakeholders involved in the area of policy promoting support for self-management for people with LTCs. I attached an information sheet [**Appendix 3**] which provided further information on the study and indicated how they could get in touch with me if they were willing to participate. I detailed that if I did not get a response by phone or email within 10 days then I would follow-up my initial contact with another email. In this second email I asked if they had been able to consider my request and asked that they let me know whether they were willing to participate or not. Participants were assured that if they indicated that they were not willing to participate then there would be no further contact. Most respondents replied to at least the second email and for those that did not then, if a contact phone number was available, I was able to phone and determine their response.

Once the initial approach had been made, and a participant indicated that they were willing to be interviewed, a further email exchange agreed a date, time and convenient venue. Approximately five days before the interview was due I sent an email confirming final arrangements, and included an outline of the main areas to be covered during the interview [**Appendix 4**.].

I arrived promptly for each interview and was prepared with all the required paperwork, including the written consent forms for signature. Following introductions, participants signed two consent forms. One was a copy for the participant to retain and the second was for my records. The consent form [**Appendix 5**.] requested that participants confirm that they had read the information sheet, that they were aware they had agreed to a recorded interview and that the information gathered would be used for research purposes.

I opened each interview by covering the same introductory information which I set out in the interview checklist [**Appendix 6**.]. This ensured that all participants were aware who I was, which institution I was from, what the research was about and that the interview was being recorded. Once this formal introduction was completed the interview progressed by following the interview schedule [**Appendix 7**]. This approach ensured that all the individual interviews covered the same topics and were undertaken within a reasonable time period of around one hour. The same interview schedule was used with all interview participants irrespective of their organisational level.

The interview schedule was designed around a series of open questions which enabled the discussion and exploration of topics in as much detail as possible. It ensured that all areas of questioning were covered with each participant but as the interview was conducted face-to-face there was also the opportunity to modify the line of enquiry and respond to significant points, generating an extra tier of data-richness.

All interviews were digitally recorded. The average time for each interview was approximately 60 minutes. Two interviews were around 45 minutes and five were just over an hour and 15 minutes long. To test my interviewing technique I undertook one practice interview with an ex-work colleague from a local health board. I wanted to see if I was encouraging my interviewee to talk freely, listening more than I was speaking and asking the questions in a straightforward and comprehensible manner. This initial practice interview was not reviewed by my supervisors. As explained by DiCicco-Bloom and Crabtree (2006), interviewing is difficult to do well. The use of a practice interview helped refine my approach: ‘on the job’ reflection.

The audio file for each interview was transcribed. I undertook the transcription of the first four interviews which helped me to become familiar with the interview schedule and my approach to interviewing. I subsequently made a request for the cost of professional transcription to be covered and this was granted as part of the support I received from the Department. Thereafter all interviews were professionally transcribed, saving time and generating a much more accurate and better-presented transcript.

To ensure the accuracy of the typed transcript I returned it electronically to the interviewee for confirmation that it was a true reflection of the interview. I highlighted passages where a point might not have been clear, commonly an acronym or discussion of local practices or where the interviewer had implied that they might be giving information of a sensitive nature by using a qualifying statement such as ‘*perhaps I should not be saying this but…*’. Often the transcripts were long; so I explained that if I did not receive any notification to the contrary by a given date then I would assume that they accepted the accuracy of the transcript. Once this process of final checking with participants was complete the transcript was ready for analysis.

4.4.3 Use of observation

Interviews are limited because they only provide access to what people say they do; not what they actually do (Green and Thorogood 2009). In contrast, observational methods allow the researcher access to what people are actually doing: to understand the work policy-makers and -implementers undertook to deliver policy in practice (objective (iii)). In government and healthcare organisations one of the most common activities consists of arranging and attending meetings: they become part of the job. Policy implementation involves many meetings, so their observation was an important means of identifying the exact nature of what was happening on the ground in comparison to statements of intent as revealed by policy documents.

Observation of meetings also provided insight into a more naturally occurring situation. An interview, by necessity, is staged. , By observing policy-makers and - implementers in discussion the researcher comes closer to understanding the actual processes of policy implementation. The participants at a meeting had commonly also participated in the interviews so observation added to the reliability and validity of both data sources. So although observation is time-consuming Green and Thorogood (2009), it added another dimension to understanding policy implementation processes and their actors.

4.4.3.1 Process of conducting observations

The meetings on which observation was conducted were identified by the opportunity to witness detailed discussion on how policy was being implemented and what future plans were being made. The aim was to note details of actions; assessment of outcomes; what obstructions were anticipated; and what planning was undertaken to overcome potential barriers to implementation, all key features in understanding such a complex process (Bowling 2002).

An outline of the structured observational tool used is presented in **Appendix 8**. Bowling (2002) comments that observation is a difficult technique to master; however the tool provided a useful reference framework within which to record relevant aspects of the observation.

The process used to identify targeted meetings is set out in **Section 4.2.1**. Gaining access and consent to observe a meeting was mediated through the local “gatekeepers” or the chairperson if they had been an interview participant. The initial approach came by email from the researcher. To support this request an information sheet detailing the purpose of the study, what the observation would include and how confidentiality of the data would be assured was provided [**Appendix 9**]. In the initial contact the researcher asked the chairperson if they would support the observation of the meeting. If they agreed then the researcher requested that the chairperson take the information sheet to the next scheduled committee meeting and seek verbal agreement from all committee members for the researcher to attend and observe a subsequent meeting. Once this was agreed then the researcher attended the next convenient meeting and observed discussion.

Individual signed consent from all participants was not sought, since it would have been problematic and time consuming. It proved sufficient to seek the permission of the chairperson in consultation with those attending a meeting, reassured by the fact that the researcher was taking notes of the broad areas of discussion and not the precise details of what was being said or identifying individual members. I discussed consent to observe meetings with other organisational researchers and determined that this procedure was consistent with standard ethical practice.

Following the observation I typed up notes by completing the observation sheet [**Appendix 8**]. This was emailed to the chairperson for final confirmation and approval and, as with the interview transcripts, once the content of the observational notes were approved these data were ready for analysis.

Details of how the data derived from policy documents and data generated from interviews and observations were analysed are presented in **Section 4.6**.

4.5 Ethical issues

In addition to the requirement to ensure informed consent (discussed in relation to interviews **Section 4.4.2.1** and observations **Section 4.4.3.1**), other ethical considerations informed the research processes so that it was safe and minimised risk to participants. These considerations include confidentiality, data protection, data-handling, potential benefits and potential harm (Royal College of Nursing 2007).

4.5.1 Confidentiality and data protection

The process of interviewing and accessing documentation results in the researcher being given information in confidence. Participants required assurance that the information they shared would be treated in confidence and that when reported it was presented anonymously. Each participant was assigned a gender neutral pseudonym. Most participants were female. No biographical data was collected on participants.

Given the nature of the likely interview targets and the location of the data collection, protecting anonymity of participants and the study site was acknowledged as challenging. The protocols were set out in the NHS Research and Ethics application and in the participant information sheets [**Appendix 3** and **Appendix 9**].

It was explained to potential participants that although every effort would be made to ensure confidentiality and anonymity, this could not be guaranteed and this was set out in all participant information sheets. In an effort to allay concerns, participants were offered the opportunity to review a transcript of their interview, at which point they had time to consider the information they had given and how it had been anonymised. If, at this point, they had any queries or requests for information to be withdrawn then this was addressed prior to analysis.

4.5.2 Data handling

It was necessary to ensure that the handling of data was in line with the Data Protection Act (1998) (NHS Scotland 2003). This requires that data are securely stored for an appropriate time and that there is respect for the participants and their privacy (Kalra et al. 2006). This research deals with data in three forms: policy analysis, which requires completion and storage of a data-extraction form as well as the original document; interviews, which were digitally recorded and then transcribed; and notes detailing the broad discussion during the observed meetings.

4.5.2.1 Policy documents

A data-extraction form was used to distil relevant information and summarise the content of documents relevant to the research objectives. These are public documents and freely available; their storage is not ethically-challenging.

4.5.2.2 Interview recordings and transcribing

Recordings and transcripts of all interviews were stored securely as digital files on a password protected PC. These recordings were used to generate a verbatim transcription, then destroyed on conclusion of the data analysis stage (January 2013). During the preparation of the transcripts any identifiable data, such as names and locations, was anonymised by use of an alpha-numerical code. To protect the integrity of the data, the names of specific groups, commonly national groups, were left in. To ensure that participants were aware of this they were offered a copy of the transcription to review prior to it being submitted as a final data source. Supervisors read only anonymised transcripts.

4.5.2.3 Notes from observation

During the observations detailed field notes were taken. These notes did not detail the specifics of "*who said what*" and due steps were taken to preserve the identity of those contributing to the discussion. Following each observation the notes were typed up and all paper copies were destroyed as confidential waste.

4.5.2.4 Archiving

All electronic data were stored in a secure file facility for automatic electronic back-up. In line with guidance from the University of Stirling's Research and Enterprise Office, primary data will be retained for a period of five years following completion of the research.

4.5.3 Potential harm/potential benefits

During the process of acquiring informed consent, the potential benefits and harm of involvement were made clear to participants (Royal College of Nursing 2007). This research did not involve any clinical intervention; the potential harm concerned aspects of inconvenience, most noticeable in the imposition on gatekeepers' and participants' time and good faith in helping with access and agreeing to an interview. Requests for participants to review transcripts, provide additional clarification or expand on contacts suggested generated some extra work for them. Issues concerning protection of anonymity could also be perceived as harmful and were explained before consent was given.

The potential benefits to participants of taking part in this research were hard to quantify and, given the area of study, are longer-term. To encourage participation, potential benefits were outlined: the opportunity to discuss work that participants are involved in and to reflect on their experience was seen to provide a sense of satisfaction (Robson 2002). In addition, involvement in the research offered the potential to contribute to the understanding of the process of policy implementation, the opportunity to highlight good practice and provide participants with a forum to share their ideas on the delivery of policy.

4.6 Data analysis

Specific features which set the qualitative analytical process apart include close interaction between the researcher and data and an acknowledgement that data-collection and analysis can occur simultaneously (Yin 2011). Qualitative analysis is iterative and progressive, operating in a circular rather than linear manner (Yin 2011). The engagement of the researcher in the process is complete, and qualitative analysis actively encourages the researcher towards a process of reflexivity. The strength of qualitative data lies in their ability to present real life by focusing on events in their natural setting with an emphasis on a single 'case': *"a focused and bounded phenomenon embedded in its context*" (Miles and Huberman 1994: 10). This allows development of a contextual understanding, providing potential for meaningful description and explanation of actions and their consequences.

Here I account for the exact process of analysis to reflect on and justify how the collected data were analysed and findings derived (Bryman and Burgess 1994). Qualitative data are not immediately accessible for analysis; some processing is required, involving data reduction and display to maximise observable patterns, analyse them and determine conclusions (Miles and Huberman 1994).

Qualitative research is characterised by methods which capture large amounts of detailed, complex data. This is a common ‘*problem*’ identified in qualitative data gathering (Bryman and Burgess 1994: 216). Others argue that the detail and depth generated by qualitative data is part of its strength. For example, Miles and Huberman (1994) talk of the richness and multi-dimensional nature of qualitative data. It is the purpose of data analysis to reveal this richness in an accurate and vivid manner. The data consist of ideas, descriptions of processes and events, all expressed in words. In effective qualitative analysis there is a strong emphasis on setting data in context, in this case Scotland and in particular one health board area, but also in terms of time and place. Consequently I present the diversity and complexity of the factors being explored whilst providing explanations which have meaning within the context in which the research was undertaken.

To represent the process of data analysis used in this research I have chosen to follow Miles and Huberman's (1994: 10) components of data analysis: data reduction; data display; and conclusion-drawing with verification. These ideas link with the concept of case analysis.

4.6.1 Analysing policy documents

Data reduction required abstraction and simplification. For all data this began with familiarisation, re-reading policy documents, listening to and reviewing all interview data and reviewing the notes taken during observations. Through this I was able to develop sensitivity to the data and identify which ideas fitted with existing theoretical thinking.

Subsequently, a more detailed approach to data analysis could begin. Two approaches were for data analysis, one for policy documents and one for the interview and observational data.

Policy documents were initially analysed with the help of a policy table and, subsequently, further reduction was informed by the use of Walt and Gilson's (1994: 354) '*policy analysis triangle*': context, content, and process forming the points with actors located in the middle. These authors argue that traditional policy analysis has focused on the content of policy and failed to understand the significance of the context within which it is developed or the processes and action of policy implementations such as sufficient resources, clear understanding of the objectives to be achieved, strong communication and co-ordination and the need for those in authority to command sufficient co-operation to overcome recalcitrance to change (Gunn 1978). The policy analysis triangle encourages consideration of the practical and contextual aspects of policy implementation, leading to greater insight. In my analysis the following definitions of context, content, process and actors, as informed by Buse and colleagues (2005), have been applied:

i) *Context* – when, how and why the promotion of self-management emerged in Scottish health policy documents;

ii) *Content* – how self-management has been conceptualised;

iii) *Process* – what policy says about how to deliver self-management, what areas for changes are identified and what levers for change are being used by policy-makers;

iv) *Actors* – who are the actors and how are they directing, influencing and implementing policy promoting self-management support for people with LTCs (adapted from Buse et al. 2005:8)

This analysis generated a detailed description of the circumstances and key organisations and players in this area of policy implementation.

Using these four headings in combination with the documentary analysis template [**Appendix 2**] policy documents were reviewed and reduced to provide context for the detailed data analysis which was to follow. The findings from this analysis are presented in **Chapter 5**.

4.6.2 Analysis of observations

Observational data are useful for comparison. In interviews respondents can feel pressurised to give information which they think the interviewer wants. Observation can reveal the extent to which what you have been told is what is actually happening. In this research it proved a useful means of comparison and support for findings. At the outset of the study it was anticipated that the observational data would be analysed separately and that the same themes and sub-themes as those employed to analyse the interviews would be applied to these data. But the process of analysis required some revision. The final agreed approach was to combine observational with interview data and code using NPT as described in **Section 4.6.3**. This was undertaken and the findings supported by data from the observations are included in **Chapter 6**.

4.6.3 Analysis of interview and observation data

Data reduction and analysis involved the generation of codes to synthesise and determine meaning. A code is defined as:

> "*a word or short phrase that symbolically assigns a summative, salient, essence-capturing and/or evocative attribute for a portion of language-based data*" (Saldana 2009: 9).

Codes were generated in one of three ways:

i). *in vivo*/inductive which use the language of the participants;

ii). emergent or inductive which the researcher generates from the data;

iii). *a priori*/deductive which are derived from theory, literature and/or policy sources in advance of analysis (Saldana 2009).

I have used ideas and theories derived from the literature to generate codes which have then been applied to these data, and *a priori*/deductive analysis (Green and Thorogood 2009).

The deductive approach was employed because it was concerned with the real-world, complex phenomena of policy implementation to which I aimed to apply structure. Beginning with an organising framework of codes in this way is perceived as a top-down approach to data reduction (Bradley et al. 2007). In contrast, an inductive or bottom-up approach to analysis involves allowing concepts to emerge from the data, thus codes reflect what emerges (Bradley et al. 2007). My choice of a deductive approach offered a means of applying insight from what is already known about the field of policy implementation and then later refining this interrogation of the data with insights from different but related fields: namely, processes of implementation, embedding and integration (May and Finch 2009). Having noted this, I recognise that a deductive approach to qualitative data analysis has limitations which include suggestions that the data can be forced to fit the structure being imposed (Glaser and Strauss 1967). However, drawing ideas from related literature provided greater insight into an area of practice which had not previously been examined in such detail. Therefore, I would argue that there were combinations of inductive and deductive approaches underway simultaneously as I immersed myself in the data.

Data-reduction by coding was conducted using the computer-assisted qualitative data-analysis software QSR (NVivo10). Once completed, all data coded by association with one theme was displayed, reviewed and refined to check how well the codes fitted the data.

Following the coding of the interview and observational data a framework approach was used to assess the processes and work being undertaken by policy-makers and -implementers when implementing policy promoting self-management. This framework analysis used the four core constructs of NPT (Coherence; Cognitive participation; Collective action and Reflexive monitoring) and the four individual components of each of the four constructs (May and Finch 2009). The application of this framework approach is illustrated by a sample of data analysis in **Appendix 10.** NPT provided a good match with my desire to examine the effort and work of implementation beyond simply identifying what worked (facilitators) and what did not work (barriers) in policy implementation.

4.6.2.1 Rationale for using NPT as a theoretical framework to support analysis

There is a well recognised need for greater use of theory to address research translational gaps and NPT is one such sociological framework (McEvoy et al. 2014). Equally, it is important for researchers to give a rationale for their choice of framework. This section identifies the reasons why NPT was chosen.

In qualitative research the use of theories is more varied, than in quantitative research (Creswell 2014). Here NPT has been used as a lens that has shaped the interpretation of the data. As established in **Chapter 2** policy implementation is an applied science which draws on perspectives from a broad range of academic disciplines consequently this thesis could have adopted one of a number of relevant theories. I have chosen a theory of sociological origins (NPT); within sociology there are many theoretical frameworks that could have been used, for example the Theory of Planned Behaviour Change (Ajzen 1991) or the theory of Diffusion of Innovation (Greenhalgh et al. 2004, 2005). NPT emerged as the preferred approach because, and as supported by McEvoy et al. (2014), it recognises the significance of what people do when they implement complex health interventions and this level of clarity and practice focus was highly relevant to my research. In contrast other theoretical perspectives focus on attitudes and beliefs (e.g. Ajzen 1991) or the flow of innovation (e.g. Greenhlagh et al. 2004), which can be perceived as more subtle and less applied concepts.

Further justification of the use of NPT emerges when its strengths are explained. NPT has a breadth of coverage. It is best described as a meso-level theory, linking micro and macro-levels (Crewell 2014). This breadth is important when seeking to explain the complex phenomenon of policy implementation. The focus of NPT is on the work and collaboration needed to implement or normalise a new idea (May et al. 2010). Consequently, NPT gives strong recognition to understanding stakeholder involvement and the work that policy-makers, implementers, clinicians and patients have to do. It focuses on understanding these individual responses but also on the collaboration needed between stakeholders which reveals how ideas, knowledge and understanding is passed on and shared in a complex environment.

NPT also recognises the need to identify the processes that promote and inhibit implementation of complex interventions (May et al. 2010). This attribute directly linked to research objective 4 and consequently represents a significant benefit in using NPT.

Here NPT and its four related constructs have been applied; such comprehensive use of NPT is unusual. For example McEvoy et al. (2014) identified only 11 out of 29 papers they reviewed that utilized all four constructs. So a comprehensive interpretative scheme has been applied to interview and observational data. This approach was chosen to provide an exploration of the work involved in implementation and the actions of individuals and groups in making-sense of, engaging with ; enacting and appraising policy promoting self-management for people with LTCs (May et al. 2010). These phenomena and processes are not well covered by existing sociological theories and highlight a particular strength of the thesis, contributing to the body of knowledge about how theory may benefit policy implementation (Finch 2015).

For the purpose of this research the four constructs of NPT have been operationalised using the following descriptions:

Coherence – sense–making work (see **Section 6.3.1**) This mechanism was used to summarise accounts of what participants said they understood self-management and self-management support to be, or how they explained what self-management is. Data relevant to coherence were commonly elicited when asked "*What does the term self-management mean to you*?"

Cognitive participation – relationship work (see **Section 6.3.2**) This mechanism was used to summarise accounts which described how self-management policy was being promoted and the emphasis was on notions of legitimation and buy-in.

Collective action – enacting work (see **Section 6.3.3**) This was applied to data which emphasised work and resources used by individuals, groups of professionals or organisations to operationalizing self-management policy: for example, accounts of what respondents had done to try to implement self-management policy.

Reflexive monitoring – appraisal work (see **Section 6.3.4**) This was applied to accounts of the ways policy-makers, managers and other users appraise the implementation of self-management.

In turn, each of these mechanisms is seen to have four components, detailed as a set of questions and illustrated in **Table 4-4.**

Table 4-4: Summary of the four mechanisms and their components.

	Mechanisms			
	Coherence	**Cognitive Participation**	**Collective Action**	**Reflexive monitoring**
Components	Differentiation ~ what work is directed at making sense of self-management support?	Enrolment ~ do individuals 'buy-into' the idea of self-management?	Skill-set workability ~ how does the initiative of self-management support affect roles and responsibilities or training needs?	Reconfiguration ~ do people try to alter self-management support?
	Communal specification ~ do individuals have a shared understanding of the aims, objectives and expected benefits of self-management support?	Activation ~ can individuals sustain involvement?	Contextual integration ~ is there organisational support of the new initiative?	Communal Appraisal ~ how do groups judge the value of self-management support?
	Individual specification ~ do individuals have a clear understanding of their specific tasks and responsibilities in the implementation of self-management support?	Initiation ~ are key individuals willing to drive the implementation?	Interactional Workability ~ Does self-management support make people's work easier?	Individual Appraisal ~ how do individuals appraise the effects on them and their work environment?
	Internalization ~ do individuals understand the value, benefit and importance of Self-management	Legitimation ~ do individuals believe it is right for them to be involved?	Relational Integration ~ Do individuals have confidence in self-management support?	Systematization ~ How are the benefits or problems with self-management identified or measured?

(Adapted from May and Finch, 2009: 547; Mair et al. 2012: 359).

Finally, there is little current research on understanding the policy process. The approach applied in this thesis was to use NPT as an analytical framework to explain the translational gap between policy and practice. As presented in **Chapter 3** (**Section 3.4.3**) research using NPT has been applied to elements of e-health, patient work and aspects of service re-organisation but not to the implementation of health policy. In addition NPT encourages systematic and detailed mapping of concepts, which allowed a full exploration of the processes of policy implementation across organisational levels. A full account of the mapping of all four NPT constructs and the findings generated using this deductive approach to analysis is presented in **Chapter 6.**

4.6.4 Data display

To help make sense of large amounts of data Miles and Huberman (1994) recommend the use of matrices during the analytical process, helping to order those data through slow non-linear emergence of ideas from qualitative data (Yin 2011). One matrix has been used here on data from the policy documents (see **Chapter 5**), creating a time-ordered display starting with the policy document where self-management first appeared and continuing to cover all the policy documents which provided the context to the data collection, up to 2010. A second matrix was used to summarise interview and observational data that matched the components of NPT [**Appendix 10**]. In both cases these displays were used to guide the researcher through large volumes of data; draw different types of data together and avoid duplication and repetition of ideas. This systematic approach helped to provide some early indications of what was happening in policy implementation and proved a useful interim stage to help establish why things were happening as they were.

4.6.5 Conclusions and verification

The process of data-reduction, through coding and preparing the data displays described above, led naturally to the presentation of findings and, in turn, helped me to prepare the final discussion and conclusions chapter. My experience of analysis was iterative and I sought to learn as the process evolved. I tested reduction tools which worked for some data but which, when tested on the interview and observational data, proved inadequate. This required further review and reading and so my analysis, rather than being conducted in a distinct phase, was continuous, evolving and refined up to the point of verification and conclusion-writing.

4.7 Reflexivity

My experience of undertaking this research has been a struggle, not least through the process of understanding and applying methodology and analysis. I know, from discussions with fellow PhD students, that this process of self-reflection is an important aspect of the qualitative research experience, a key component of ‘reflexivity’ (Finlay 2003). I have also struggled with reconciling the tensions between my roles as a lecturer focused on undergraduate nurse education, researcher PhD student and mother over a long period, like Carolan (2003). Reflexivity, its meaning and typology are variously debated in the literature. Of the possible variants of reflexivity Finlay (2003) identifies five (introspection, inter-subjective reflection, mutual collaboration, social critique and ironic deconstruction). I am most interested in what can be learnt from the process of self-reflection and introspection to help understand what I have learnt about the process of qualitative research. I further divide this into three distinct stages: data collection, making sense of the data and conducting data analysis.

Of the three data collection activities, interviewing and observation are most open to reflexivity because the data have been generated for the purpose of the research (Yin 2011). In contrast, policy documents are objects created for a purpose other than the research, in this case advising and directing NHS Scotland and associated organisations. Including such objects reduces some of the potential pitfalls of reflexivity; only the choice of documents has been influenced by the research (Yin 2011).

During the process of generating data through interviewing and observation I kept a reflexive journal and after each interview or observation I recorded what was and what was not so successful about my interaction. Using this thinking I was able to inform subsequent interviews or the way I approached an observation. My focus was to learn from people but my experience during interviews was that it was hard not to intervene in the questioning as a way of showing what I knew rather than giving space to participants. My success at being nondirective and allowing participants to present themselves was greater in some interviews than others. Due to the constraints of time and word count I have chosen not to reveal all the detail of this self-refection in my discussion of the process of data collection but the reflexive diary did help to account for the contextual issues I encountered during data collection and helped me to learn on the job and improve my interview technique. Equally, recalling specific interviews and referring to my diary of the events was useful when undertaking data analysis to help articulate my findings. There is a balance between self-reflection and subjective introspection, which has been termed "*keeping the reflective self under control*" (Yin 2011: 272). If the self-reflection is effective it will lead to re-interpretation and insight (Finlay 2003).

Reflexivity was also evident during the process of data analysis, particularly when trying to reassemble and interpret the data. As explained in previous sections, this has been attempted twice, first using the policy triangle (Buse et al. 2005) and then, when this appeared superficial and descriptive, seeking guidance from Mair's interpretation of NPT (Mair et al. 2012). My choice to highlight the reflexive aspects of data interpretation shows that I struggled with this aspect in comparison to other stages of the research process. This analytical struggle is not confined to novice researchers like myself. Harper (2003: 79), for example, identified that he "*often felt at sea*". I started out on one analytical path and then changed direction and blamed the analytical framework for not producing the depth and detail of meaning that I thought my data deserved. I decided to change direction, and I have justified this choice; but it has potentially compromised my findings by curtailing the time I had to review them. I had to ask myself if the choice of NPT restricted my findings. This experience is explored further in **Chapter 8** where the limitations of the research are explored.

I have offered some insight into how I have approached reflexivity. I have presented it as something which I have done alone. However, my final observation is that the discussion and debate I have had with my supervisors has also been a reflexive process which has helped shape this research and my response to it. This collaborative approach has been most helpful and sustained me to complete this thesis.

4.8 Conclusion to chapter

This chapter provides a detailed exploration and justification for the qualitative stance taken in this thesis. In addition it accounts for the study methods, selection of participants and policy documents, ethical considerations and the approach to data analysis.

In the later sections an explanation of the qualitative analytical process has been presented with justification for and with discussion of how the process of data analysis changed and evolved over the course of the study.

It is important to acknowledge that the way research is designed, how data are collected and analysed, has an impact on the findings generated; and here I have presented one approach. In addition there are close links between each stage with one decision influencing the next in an iterative process.

A methodological strength of this research has been the application of NPT to support data analysis. NPT recognises the significance of what people do when they implement complex health interventions and this level of clarity and practice focus was highly relevant to the research (McEvoy et al. 2014). NPT provides insight into the tasks of implementation and therefore takes us beyond implementation as the end point. NPT highlights embedding through innovations becoming routine and integration by the sustainability of innovation into the social context (Mair et al. 2012). In addition NPT provides a theoretical perspective in an area of research which is commonly seen as '*theory-lite*' or lacking in current, relevant and useful theoretical perspectives: policy implementation.

Chapter 5 Findings from health policy documents

5.1 Overview of chapter

This chapter considers how the Scottish self-management policy story has influenced the effectiveness of policy change. It analyses the content of thirteen Scottish health policy documents from 2005 to 2010 to clarify the sequencing of policy ideas and determine the actions stated to meet the policy goal. This analysis provides insight into a wider debate and frames the findings from interview and observational data presented in **Chapter 6**. In addition the findings presented here provide a context for policy implementation both nationally and locally.

I will sett out chronologically Scottish health policy documents alongside important developments promoting self-management in **Table 5-1**. The next section considers their context and addresses the question ‘why self-management and why now?’ This is followed by a review of policy document content. **Section 5.5** focuses on the details of what policy says about how self-management should be delivered. It considers the processes advocated by policy documents to promote policy implementation and what levers of change policy is advocating to encourage the implementation of self-management support.

Table 5-1 Timeline of milestones and the development of policy promoting self-management for people with LTCs

Date	Event
May 2005	'A national framework for service change in the NHS in Scotland' published;
Nov 2005	'Delivering for Health' published;
Nov 2006	First conference on self-management and the Long Term Conditions Alliance Scotland (LTCAS) launched;
Feb 2007	Long Term Condition Toolkit to allow CHPs to benchmark work to support people with LTCs published;
March 2007	HDL strengthening role of MCNs in promotion of self-management for people with LTCs published;
June 2007	HEAT targets directed at improving the management of people with LTCs were introduced, for implementation in 2008/09;
Dec 2007	'Better Health Better Care' the first health policy by Scottish National Party (SNP) minority government published;
April 2008	Long Term Conditions Collaborative (LTCC) established;
Oct 2008	''Guan Yersel' The self-management strategy for long term conditions in Scotland' published;
March 2009	'High Impact Changes' first formal guidance from LTCC published;
June 2009	'Improving health and wellbeing of people with long term conditions' an action plan setting out the opportunities for NHS Scotland to improve the health for people with LTCs published;
June 2009	HEAT targets directed at improving the management of people with LTCs increased from three to five for implementation 2009/10;
Sept 2009	Self-management fund with a total of £4m used to fund self-management initiatives over 3 years established;
Nov 2009	'Improving self management support' second formal guidance from LTCC published;
March 2010	'Improving care pathways' third formal guidance from LTCC published;
May 2010	'The Healthcare Quality Strategy for NHS Scotland' which up to May 2013 was the key policy document directing NHS services in Scotland;
July 2010	'Improvement approaches for people with Long Term Conditions' fourth formal guidance from LTCC published;
March 2011	LTCC ended and;
May 2011	SNP elected as majority Scottish Government.

This timeline illustrates that the concept of self-management has emerged and developed over a period of five years but that there was a significant concentration of activity and policy between 2008-2010. This corresponded directly with the period during which data was collected for this research.

5.2 Context: policy documents

Here the thirteen policy documents that have most directly influenced the promotion of self-management support for people with LTCs are explored (summarised chronologically in **Table 5-2,** which details their process of development and purpose).

This approach offers insight into why self-management became such a strong focus of Scottish health policy from 2005-2010.

Table 5-2 Scottish health policy documents promoting self-management support for people with LTCs 2005-10

Author/Date	Title	Process of Development	Purpose
SEHD 2005b.and 2005c	*A National Framework for Service Change in the NHS in Scotland. Building a Health Service – Volume 1 and 2. (hereafter FSC).*	Commissioned in 2003 by the first Labour administration of the Scottish Parliament and undertaken by an external advisor, clinical Professor David Kerr, Fellow of Corpus Christi College, Oxford. The framework document was generated through a number of advisory groups and an extensive public and professional consultation exercise.	A review of the NHS in Scotland to provide a 20- year plan to deliver a modern NHS. The *FSC* proposed a model of healthcare delivery seeking to 'shift the balance of care' by moving from acute focus to local, community care; from episodic, reactive interventions to preventative and anticipatory approaches; from patient as passive recipient to patient as partner in care and from where self-care is infrequent to where self-care is encouraged. The *FSC* recommendations are heavily influenced by the dual challenges of an ageing population and the rising prevalence of LTCs. Ideas of self-care, self-management and support for self-management are emphasised and seen as key to informing the delivery of a modern Scottish health service.
SEHD 2005a.	*Delivering for Health (hereafter DfH).*	This was the first health policy statement issued by the Labour administration. It set out the government's response to the FSC. Developed in a traditional manner by policy-makers with little consultation, it was presented as a statement of what NHS boards should do to meet the vision of a modern Scottish NHS presented in the FSC	This policy interpreted the recommendations made in the *FSC*. It charged Health Boards to recognise the need for change so that health services could keep pace with population trends, patient needs and medical advances. The purpose of *DfH* was to establish priorities: greater involvement of people in the future development of services; help to achieve reduced waiting times by streamlining patient journeys; improving services quality and integration; and encouraging effective use of resources, especially the workforce. The aim was to 'shift the balance of care' away from the acute setting towards community based services. *DfH*, in line with *FSC*, also established that the area where these priorities were seen as most needed was in the care of people with LTCs.

Author/Date	**Title**	**Process of Development**	**Purpose**
LTCAS 2006.	*"Gaun Yersel". The Voluntary Sector's Approach to Self-Management Conference.*	A report produced following a conference on self-management, issued by the newly-established Long Term Conditions Alliance Scotland, which had been identified as an action in *FSC*. The conference was hosted by the voluntary sector and included representation from government health department, local authorities and people with LTCs.	To highlight the importance of the voluntary sector and what could be learnt from their experience of working with people with LTCs. The conference also included the use of personal experience to demonstrate what self-management means to people with long term conditions.
NHS Scotland (NHSS) 2006.	*Delivering Care, Enabling Health (hereafter BHBC).*	Seen as a Scottish strategy for nursing this document was developed by the Chief Nursing Officer's policy forum and then refined through national workshops and consultation with professionals.	Building on the core principles of professional nursing practice – which include care and compassion - this policy sought to highlight nursing's contribution to implementing *DfH*. It also explained the contribution of nurses and allied health professionals to meeting the needs of the Scottish population and the competencies required to meet the challenges of the future. Established the priorities of an increasing proportion of elderly people in the population, rising prevalence of LTCs and the need to deliver care closer to home. It suggested that how these priorities are met will require transformational change so that nurses become enablers and supporters of service users rather than providers of care.

Author/Date	**Title**	**Process of Development**	**Purpose**
Scottish Executive (SE) 2007a.	*Community Health Partnerships (CHP) Long Term Conditions Toolkit (hereafter THDL).*	In February 2007, this Health Department Letter (HDL) was issued for action by all NHS board chief executives and CHP clinical leads and general manager. The development of this "toolkit" was identified in *DfH* and its use is described as mandatory.	The purpose of the *Toolkit* was for all CHPs to develop an action plan to ensure that services and care are integrated, responsive and of high quality. The toolkit was designed to allow CHPs to benchmark what work they are currently engaged in to improve care for people with LTCs and where improvements and developments can be made. It was designed as a self-reporting exercise with the submission of completed tool-kits to the DoH by April 2007. Following this there would be an independent review with reference to two marker conditions: Chronic Obstructive Pulmonary Disease (COPD) and rheumatoid arthritis.
Scottish Executive (SE) 2007b.	*Strengthening the role of Managed Clinical Networks (MCNs) (hereafter MHDL).*	In March 2007, a second HDL was issued in response to *DfH* which identified that it was time to strengthen the role of MCNs and seek to enhance the support they could give in the care of people with LTcs. The content and advice contained in this HDL was generated and refined through a process of consultation with existing Lead Clinicians for MCNs.	MCNs were established networks providing a useful vehicle for delivering the "*whole system change*" (letter), reflected many integration priorities and a broad range of stake-holders, and committed to providing anticipatory care local to service users. Here was a model in which the balance of care could be shifted and focused more effectively in the community with support needed from acute/ specialist clinicians. They were seen as consistent with NHS reforms, offering a way of "*delivering the future*" (SE 2007:7). The guidance strengthened reporting relationships between MCNs, NHS Board and CHPs; strengthened leadership and management arrangements; and promoted patient and carer involvement and use of IT. Its aim was to encourage the "*continuing development of managed care networks*" (letter)[1]. MCNs were identified as key to the development and implementation of the approaches to LTCs set out in *DfH*.

---

[1] This HDL uses both the terms Managed Clinical Networks and Managed Care Networks

Author/Date	**Title**	**Process of Development**	**Purpose**
Scottish Government (SG) 2007.	*Better Health Better Care: Action Plan. (hereafter BHBC)*	*BHBC* was the first health policy issued by Scottish National Party led administration. The policy was informed by a process of consultation which extended from August until the publication of the action plan in December 2007. During the consultation great effort was made to include the views of a diverse range of the Scottish population as well as staff and NHS professionals. Involvement, participation and representation were important themes in this policy statement right from its inception.	*BHBC* set out a 5-year programme of work directed at one of the Scottish Govt's 5 strategic objectives – *"help people to sustain and improve their health, ensuring better, local and faster access to healthcare."* (SG 2007:1). Three key action areas were set out: *"towards a mutual NHS; helping people to sustain and improve their health; ensuring better, local and faster access to healthcare"* (SG 2007:iii). The *BHBC* aims to establish "*A mutual NHS*" to encourage 'ownership', foster a common sense of purpose and distinguish the Scottish NHS from other UK service-delivery models. The term "*co-production of health*" (SG 2007: 5) reflects the Govt's commitment to greater public involvement, enhancing patient experience and rights. Targeting health improvement and access to better local services recognised the needs of those with LTCs and those facing deprivation. Actions focus on people's capacity to improve their health and well-being, including mental health, the promotion of enablement, confidence, and the ability to make healthy choices (SG 2007:21). Actions to achieve better local services develop the importance of quality, patient-centred services. Self-management shows how the NHS can develop patient-centred care. *BHBC* highlighted other initiatives refined and expanded upon in other policy documents including: strengthening the role of LTCAS which will include the development of a self-management strategy; the concept of care or case management incorporating the use of Scottish Patient at Risk of Readmission and Admission (SPARRA) risk-prediction tool; and establishment of the LTC Collaborative (LTCC).

Author/Date	**Title**	**Process of Development**	**Purpose**
LTCAS 2008.	*"Gaun Yersel!" The Self Management Strategy for Long Term Conditions in Scotland (hereafter SMst).*	As agreed in *BHBC* and following the conference in 2006 the Long Term Conditions Alliance Scotland (LTCAS) worked in partnership with the Scottish Government to produce *"Gaun Yersel!" The Self Management Strategy for Long Term Conditions in Scotland*. Working with an external agency and one that represents the voluntary sector and people with long term conditions was an unusual and innovative approach to policy-making. This was deliberate and, as stated in the foreword, designed so that policy-makers could "*learn from people's own experience*".	To demonstrate NHS Scotland's commitment to self-management to improve the care of people with LTCs. *"Gaun Yersel!"* explains what self-management means and uses case studies to illustrate the perceived benefits of self-management. In addition the strategy sets out the interventions supposed to be needed to make self-management happen. The first was the establishment of the self-management fund – "*LTCAS seeks £2million per year for a period of three years*" (LTCAS 2008: 28). This fund was to be administered by LTCAS and directed at funding voluntary organisations to establish self-management initiatives. Second was the establishment of the "*long term conditions Hub*" (LTCAS 2008: 23), a physical meeting point and resource centre to support the voluntary sector in developing its capability with regard to support for self-management. The policy targets the voluntary sector showing its existing strengths in this area but recognises what else is needed to develop the capacity and capability to meet public and policy-makers' expectations with regard to self-management. As importantly, *"Gaun Yersel!"* sets out the role of the NHS and health professionals with regard to self-management. The policy emphasises the importance of the individual but shows what the NHS and health professionals who care for people with LTCs need to do to deliver self-management.

Author/Date	Title	Process of Development	Purpose
Scottish Government (SG) 2009.	*Long Term Conditions Collaborative (LTCC). High Impact Changes (hereafter HIC)*	First formal guidance to be issued by the LTCC; contains seven improvements that NHS Health Boards are expected to make to improve the way people with LTCs self-manage and experience NHS care. The development was informed by members of the LTCC; the content and approach is heavily influenced by the tools and techniques advocated by quality improvement methodologies.	HICs are set out and the policy directive explains the improvement actions required to achieve each of seven HICs linked to five domains: service organisation, self-management support, delivery systems design, decision support and information systems. To help Health Boards make sense of these changes each domain was listed as part of the *"CHP Toolkit"* issued in 2006 and mapped to existing HEAT targets and Community Care Outcomes. In so-doing the Scottish Govt is setting measureable outcomes against which to determine the success of policy to promote self-management and make Health Boards and their Chief Executives accountable for meeting (or not) these targets. The HICs are a policy incentive.
NHS Scotland (NHSS) 2009a.	*Improving Health and Wellbeing of People with Long Term Conditions in Scotland. A National Action Plan (hereafter NAP).*	Issued, as a Chief Executive Letter (CEL), this *Action Plan* was directed to Health Boards, Local Authority staff and the voluntary sector. The plan was developed in response to an action detailed in *Better Health Better Care*. The content and scope were informed by a wide range of stakeholders and discussion at an open forum event lead by the LTCC.	To set out how the 7 *HICs* - set out in *HIC* - would be implemented, who is responsible and the timescale on which each should be achieved. The *Action Plan* outlines key opportunities available to NHS Scotland to improve the health and well-being of people with LTCs including: integration of services; use of managed clinical/care networks; importance of workforce development so staff are "*prepared and equipped for new roles and approaches to care*" (p14); the emergence of Telehealthcare to allow remote monitoring, and effective use of information systems to allow risk stratification of patients to help prioritise care. The *Action Plan* focuses tightly on delivery, highlighting the levers of change being used to support imple-mentation. For the first time, the *Action Plan* sets out 5 (out of 30): Health; Efficiency; Access; and Treatment (HEAT) targets applying to the management of those with LTCs. Other levers include the use of the LTCC as a national quality-improvement programme targeted at improving care for people with LTCs.

Author/Date	**Title**	**Process of Development**	**Purpose**
NHS Scotland (NHSS) 2009b.	*Long Term Conditions Collaborative. Improving Self Management Support. (hereafter ISMS)*	Generated by the Collaborative with the support of the Scottish Government's Long Term Conditions Unit and the voluntary sector through the LTCAS. This policy builds on the information set out in HIC identified earlier in the year.	This document sets out 'what can be done' and the actions needed to improve self-management. Specifically, *ISMS* identifies how quality improvement methodologies, such as Plan Do Study Act (PASA) cycles and lean-thinking can be used to deliver the *HICs*. Individually the 10 changes are explored through the use of discussion to explain the meaning of each term plus the presentation of examples of good practice. The focus is on implementation and raising awareness so that the *Action Plan* and the *HICs* can be turned into reality.
NHS Scotland (NHSS) 2010.	*Long Term Conditions Collaborative - Improvement approaches for people with Long Term Conditions (hereafter ILTC).*	Generated by the Collaborative this policy is defined as a resource to support practitioners to recognise the importance of enabling and anticipatory approaches.	The purpose is document is to define how the delivery of healthcare in Scotland is changing for the whole population and not just those with long term conditions. To do this *Collaborative - Making the Connections - Food For Thought* sets out key challenges that need to be addressed and examples of initiatives that are working to overcome these challenges. The challenges highlighted include health inequality; health literacy, moving to community-led health; supporting people to return to or remain in work; maximising benefits and financial health; and mental health improvement. The focus of this document is on prevention and anticipation of need as well as interventions needed once people have become unwell. It also highlights the linkages between the Scottish Government's policy work streams – Keep Well and LTCs initiatives.

Author/Date	**Title**	**Process of Development**	**Purpose**
Scottish Government (SG) 2010.	*The Healthcare Quality Strategy for NHS Scotland (hereafter HQSt).*	Issued in May 2010, after an extensive period of consultation with the NHS, members of the public and other stakeholders, this is the current key policy document directing NHS services in Scotland.	The purpose of *The Healthcare Quality Strategy for NHS Scotland* is "*to deliver the highest quality healthcare service to the people of Scotland and through this ensure that NHS Scotland is recognised by the people of Scotland as amongst the best in the world*" (SG 2010: 1.). A total of 6 priorities is identified: caring and compassionate staff; clear communication and explanations; effective collaborations; clean and safe care environment; continuity of care and clinical excellence (SG 2010: 1.). In addition to these 6 priorities the *Quality Strategy* highlights 3 quality ambitions which are mutually beneficial partnerships; no avoidable injury or harm; and the most appropriate treatments, interventions and support services will be provided (SG 2010: 6.).

5.3 Context: why self-management?

As we see in **Table 5-1** and **5-2**, the concept of self-management began with "*A National Framework for Service Change in the NHS in Scotland. Building a Health Service"* (SEHD 2005b). Commonly referred to as the Kerr Report, it was an independent review whose motivation and direction was drawn from a similar English review of health services, produced three years earlier, by Derek Wanless and entitled "*Securing our Future Health: Taking a Long View*" (Wanless 2002).

The Wanless Report is an evidence-based assessment of the long-term resource requirements of the NHS in England. Wanless considered a number of influences which would impact on the NHS up to 2022: the desire to improve the quality of NHS care; changing public and patient expectations; advances in medical technologies and the changing health needs of the population (Wanless 2002). He argued that for the NHS to survive it must learn to balance increased demand against the need for reform to ensure effective resource use. A significant call was for improvement to people's engagement so that their health status rises and they use primary care resources more appropriately - an early reference (though not named as such) to self-management (Wanless 2002: 5).

Like Wanless, Kerr focused much effort on defining and explaining the 'drivers' for change to show why healthcare cannot stay the same. These 'drivers' set the context for '*why self-management?*' and were discussed in a document accompanying Kerr's overall report (SEHD 2005b), entitled "*Drivers for Change in Health Care Scotland*" (SEHD 2005c). Nine drivers were outlined; five are considered most closely related to the promotion of self-management:

> (i) changing population and patterns of illness with a shift away from acute conditions to long term conditions;
>
> (ii) continuing heath inequalities;
>
> (iii) higher patient expectations;

(iv) improvement in medical science and technology; and

(v) increasing power of information and communication technology.

In the following section each driver will be taken in turn.

Changing population and patterns of illness - Like other developed countries, Scotland's population is ageing as life expectancy increases and the birth rates decline (SEHD 2005c). An ageing population means more people with greater levels of dependency experience ill-health amongst this sector of the population. According to Kerr the consequence of this population shift on demand for health services will depend on the availability of other forms of care such as the informal care supplied by family and/or volunteers (SEHD 2005c). He argued that the NHS, in its present form, cannot meet the increase in dependency. A compounding factor is a change in patterns of illness, specifically the rise in incidence of chronic LTCs. Changing health needs and increasing life expectancy are drivers which are not exclusive to Scotland (Wanless 2002). However, the '*Scottish effect'* (SEHD 2005c: 10) adds to the urgency for NHS reform. This is the acknowledgement that Scotland's population experiences higher levels of deprivation than other areas of the United Kingdom and as a consequence its population is affected by more ill-health (SEHD 2005c). Kerr used the poor health of the Scottish population to argue for an improved Scottish health service, but this on its own was insufficient. The Scottish health service must focus on prevention as well as cure and target closer integration and partnership if it is to tackle this concern:

> "*An improved health service can undoubtedly make a contribution but the solution is more likely to be found in preventative action*" and "*In terms of the public health policy response there is a recognition that 'health' will only be improved when organisations work in partnership*" (SEHD 2005c: 11).

Kerr acknowledged that the rise in prevalence of LTCs was already having an impact on NHS Scotland, principally that services were focused on learning how to deal with more emergency admissions. This model of care was un-sustainable because it relied on in-patient hospital-based care, and he advocated an integrated system which worked to keep people out of hospital and not assume that admission was the best solution. This could be achieved by closer co-operation between health and social care systems and by strengthening the role of primary care to create a service which is more co-ordinated and orientated to prevention (SEHD. 2005c).

Health inequalities - Health inequalities which exist in the Scottish population are well-documented. Kerr (SEHD 2005c) advised that any future health service will have to ensure that resources are targeted at improving the general health of the population and tackling health inequalities. This is particularly important for those with an LTC, since they have been shown to be more socially and economically disadvantaged (Loretto and Taylor 2007).

Patient expectations – Patient expectations are an important driver to motivate modernisation and change in healthcare delivery, reflected in the political requirement for greater public accountability, more efficient use of public services and a demand for more recognition of patients' perspectives in informing healthcare delivery (SEHD 2005c). The future NHS must be more responsive and provide patients with opportunities to exert more control and exercise more choice. The Kerr Report suggests that the patient is "*moving towards the centre and the healthcare system and those working in it [are] moving towards backstage and supporting roles*" (SEHD 2005c: 39). Consequently, the patients of the future would become "*decision-makers, case-managers and co-producers of health*" (SEHD 2005c: 39). These aspects emerged in later policy documents as roles and responsibilities promoted for patients in relation to self-management (Scottish Government 2010c).

Improvements in medical science **–** Advances in medical science would continue to improve outcomes for patients (SEHD 2005c). Of particular relevance to policy directed at improving care of people with LTCs are genetic advances which may prevent chronic disease, and the technology which could sustain an ageing population in ways which avoid hospital admission (SEHD 2005c). Overall, the key benefits of medical advances would be in their ability to prevent ill health so that the ageing population does not generate the burden of disease forecast by the shift in Scotland's demographics.

Information and Communication Technology – The Kerr Report (SEHD 2005b) acknowledged that uptake and use of information and communication technology is poor in the NHS and that Scotland is no exception. For a modern NHS to support the efficient passage of patients, quick access to information is essential. Kerr identified a number of key information technologies, including clinical systems and telemedicine, as means of providing more efficient care models.

Clinical systems allow patient information to be shared between sectors and/or professional groups and can be used to prioritise services and plan more effective service delivery. Telemedicine allows healthcare to be delivered remotely by supporting remote consultation and networking. It can also be used to delegate tasks such as symptom monitoring to patients, promoting independence. The Kerr Report highlights the importance of both applications to ensure a health service '*fit for the future*' (SEHD 2005c: 78).

The five drivers above have been set out individually because they have most impact on the broad policy context to this research. They also establish the emergence of ideas which have had a lasting influence on health policy in Scotland since 2005. Kerr established key concepts and social imperatives: importance of patient-centredness; closer involvement of people in their care; moving care away from hospitals and avoidance of unnecessary hospital admissions; better co-ordination of care through partnership; closer team-working within healthcare and other agencies; use of information systems; and the inclusion of the voluntary sector (SEHD 2005b). These ideas are all reflected in the concept of self-management, what it means and its importance in relation to the care of people with LTCs. Kerr's recommendation to target Health Boards to introduce systematic approaches to caring for people with LTCs and offer support for patients and their carers to take responsibility for their health (SEHD 2005c) were additional key areas of influence.

Subsequent to the Kerr Report the Scottish Executive published *Delivering for Health* (SEHD 2005a). This was trailed as the Scottish Executive's response to Kerr's recommendations for change. In *Delivering for Health* the importance of health boards systematising care for people with LTCs was emphasised:

> *"Long-term conditions can be better managed through increasing support for self-care; strengthening and extending primary care; offering integrated and responsive specialist care and managing vulnerable cases by anticipating need."*(SEHD 2005a: 17).

Much of the discussion within "*Delivering for Health"* was cross-referenced to the "*National Framework*" and a number of Kerr's recommendations were approved. The "*National Framework*" suggested the establishment of a Scottish Long Term Conditions Alliance – similar to one in England. "*Delivering for Health"* agreed to the formation of this organisation to provide focus and representation for a number of voluntary bodies. The new Long Term Conditions Alliance Scotland (LTCAS) features heavily in the interview accounts and observational data which I present below. A Community Health Partnership self-assessment tool kit became formalised in "*Community Health Partnerships (CHP) Long Term Conditions Toolkit*" (Scottish Executive 2007a) and the role of Managed Clinical Networks, identified in "*Delivering for Health*" was issued as a formalised policy directive in 2007, along with strengthening the role of Managed Clinical Networks (MCNs) (Scottish Executive 2007b). The role of the MCNs and CHPs in the promotion of self-management for people with LTCs is reflected in interview accounts (**Chapter 6**).

5.3.1 Summary - context

Important policy documents moulding future ideas on self-management emerged in 2005 with the Kerr report (SEHD 2005 b & c) and the Scottish Executive's response "*Delivering for Health*" (2005a), which established the importance of promoting the public's engagement with health as a means of responding to changing population profiles, patterns of illness and promotion of general good health. Partnership, responsiveness, patient control and individual choice, also represented in these early documents, continue to influence later policy statements.

5.4 Content: How self-management is defined

What policy documents say about 'self-management', and how it is defined, provides information which enables those implementing policy to understand the *idea* and help plan how self-management can be applied in practice. The literature shows that policy content is key in determining willingness or unwillingness to implement it (Tummers et al. 2012). Understanding the content of a change initiative has also been shown to influence willingness to implement it (Ajzen 1991). The meaning of policy is best understood by considering relevant policy documents, analysis of which documents also showed how the conceptualisation of self-management has changed over time.

5.4.1 Self-management and 'shifting the balance of care'

When self-management first emerged it was closely aligned to policy-makers' desire to '*shift the balance of care*' (SEHD 2005a and 2005b), an idea presented as a new way of delivering healthcare which moved the culture of the NHS away from its traditional focus on episodic care to a model engaged in continuous care (SEHD 2005b). A number of areas for work were identified: care of people with LTCs; a closer focus on prevention; consideration of the patient as partner; involvement of carers; and development of facilitated approaches to encouraging self-care (SEHD 2005b), all designed to move care away from the traditional primacy of in-patient services and the belief that the practitioner knows best. To deliver on these the NHS needs to adopt new ways of working, new skills and new thinking. Furthermore, Kerr argued for specific focus on the needs of those with LTCs; one way to achieve this was to promote a system that supported self-management.

> "*Self-management ……takes place in the context of a recognised medical condition and will normally include a level of formal health service input often focused on patient education, monitoring of disease indicators and skills mastery*" (SEHD 2005c: 4)

In these early policy documents self-management was presented as: the patient recognising their role as self-managers; being aware of their disease; monitoring symptoms and learning new skills to improve outcomes; and having the confidence to fulfil this role. The role of unpaid carers and the voluntary sector, who could provide additional support, advice and information sharing, is also embedded in concepts of self-management (SEHD 2005c).

In summary, Kerr presents self-management as a means by which the NHS can '*shift the balance of care*' and encourage a move away from episodic to integrated and continuous care with patients, unpaid carers and the voluntary sector taking a greater role. In effect it is a deficit model which sees patients, NHS staff and other partners in care as deficient in self-management skills. The proposal is to change ways of working, develop new skills and introduce new ways of thinking with patients, staff and wider organisations, leading to the emergence of new healthcare models, a '*shift in the balance of care*' and the creation of a more sustainable, efficient and patient-focused NHS.

5.4.2 Self-management and mutuality

In later policy documents an additional political element emerges: self-management as '*mutuality*', with both political overtones and personal connotations of power and respect. This association is aligned to a change in political leadership from Labour to the Scottish

National Party (SNP), which occurred in 2007 when a minority SNP administration was elected in the Scottish Parliament. Subsequently a majority SNP government was elected in May 2011; since then the desire for mutuality and empowerment in healthcare has evolved further, becoming what has been termed an "*alternative paradigm in healthcare*" (Howieson et al. 2013: 163).

The desire to create "a *mutual NHS*" (Scottish Government 2007) is presented in the SNP's first health policy document *Better Health Better Care.* Mutuality incorporates ideas of inclusiveness, partnership, and co-production of health. As an idea mutuality is promoted across NHS Scotland but is specifically linked to the promotion of self-management support for people with LTCs because it provides the socialist values of co-operation and collaboration fundamental to the political beliefs of the SNP government and implicit in the ideals of co-production of health (Howieson et al. 2013). It is a persuasive mix.

"*Better Health Better Care"* established that the government wanted to build a mutual NHS through cooperation and collaboration, setting out the government's desire to create a sense of ownership amongst patients and the public, acknowledging that with this ownership comes rights and responsibilities (Scottish Government 2007). Key aspects to mutuality are accountability and partnership:

> *"We need to move towards an NHS where ownership and accountability is shared with the Scottish people"* (Scottish Government 2007: 5) and *"The concept of a mutual NHS reinforces and extends this commitment to partnership"* (Scottish Government 2007: 12)

These ideas of partnership and active involvement in care – developing the idea of 'being in it together' - are linked to self-management:

> *"we will also encourage patients and carers to be genuine partners in the delivery of their care through the commitment to patients' rights and active involvement in self-management"*(Scottish Government 2007:v)

The idea of mutuality recurs in other policy documents, such as the 2009 "*Action Plan*" which highlights the Government's commitment to "*mutual care models for long term conditions*" (NHS Scotland, 2009a). Mutuality is developed in the SNP's most recent policy document "*The Healthcare Quality Strategy for NHS Scotland"* (Scottish Government 2010a) in which its ongoing commitment to the idea is presented in the context of improving the quality of care linked to supporting patient-centredness and achieving one of the Government's three stated 'Quality Ambitions': "*mutually beneficial partnerships*" (Scottish Government 2010a: 6):

> *"A mutual NHS is an underpinning requirement of person-centred healthcare, so we will continue to pursue this as part of this Quality Strategy."*(Scottish Government 2010a: 5) and **"Quality Ambitions** - *Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making*." (Scottish Government 2010a: 7).

The emphasis on mutuality is linked to two important political messages. First, that the NHS and health goes beyond the organisation and the staff involved in it – we all have a responsibility and must accept that responsibility through self-care and self-management. Second, that the future of the NHS in Scotland is firmly placed within the public sector and that Scotland will be distinctive in not seeking a more market-orientated approach such as that being pursued in England (Scottish Government 2007).

5.4.3 Self-management and why it is important

Successive policy documents developed and explained in more detail what was meant by the term 'self-management'. The policy which added most to establishing the distinctiveness of self-management, and took its definition beyond that in the Kerr Report, was *"Gaun Yersel!" The Self Management Strategy for Long Term Conditions in Scotland"* (LTCAS 2008).

Through the use of case studies *"Gaun Yersel!"* showed how self-management could promote and enhance the independence and wellbeing of people with LTCs. It placed the patient firmly at the centre of the policy discussion by using people's own experience, demonstrated by the decision to write *"Gaun Yersel!"* in partnership with the Long Term Conditions Alliance Scotland (LTCAS):

> "*The Long Term Conditions Alliance Scotland (LTCAS) was asked by the Scottish Government to develop a strategy for self management. This reflects recognition both of the considerable contribution self management can make and of self management as a movement driven not by policy makers but by people themselves*."(LTCAS 2008: 5)

Whereas the Kerr Report emphasised self-management as part of 'shifting the balance of care', *"Gaun Yersel!"* suggested that the promotion of self-management does not mean that patients are happy to accept this responsibility without support from the NHS and healthcare practitioners. It shows that healthcare professionals, government and policy-makers also have a responsibility:

> *"Self management is the responsibility of individuals. However, this does not mean people doing it alone. Successful self management relies on people having access to the right information, education, support and services. It also depends on professionals understanding and embracing a person-centred, empowering approach in which the individual is the leading partner in managing their own life and condition(s)"* (LTCAS 2008: 8).

So "*Gaun Yersel*!" argues both for the importance of the individual and for the demands expected of professionals. As well as promoting better information and education, it argues that government and policy-makers should help to change attitudes and cultures so that the ethos of self-management becomes integral to care systems (LTCAS 2008).

"Gaun Yersel!" also served to highlight, in the most direct manner, the role of the voluntary sector in the promotion of and support for self-management. This commitment to fostering wider partnerships and growing the "*third sector*" is also a strong feature of "*Better Health, Better Care*". In this 2007 policy, health boards were directed to identify local voluntary organisations and collaborate with them to improve services. Similarly, in policy guidance issued by the Long Term Conditions Collaborative (LTCC) "*Improvement approaches for*

people with Long Term Conditions" (NHS Scotland 2010), the NHS was urged to build community and voluntary sector capacity to better support people with LTCs (NHS Scotland 2010) and to develop awareness that supporting self-management for people with LTCs cannot just rely on health. Therefore, the NHS is advised to focus on involving the voluntary sector and then providing advice to people on how to access these services (NHS Scotland 2009b).

A broad range of voluntary organisations is referred to in the policy documents. Some of them focus on the needs of people with specific conditions; others work to support carers of those with LTCs. The inclusion of carers and their representatives is another important element in the Government's drive to enhance self-management and bring maximum benefits for people with long- term conditions (LTCAS 2008):

> "*The unpaid carer's role is also vital to the ability of people with long term conditions to self-manage.*" (LTCAS 2008: 52).

The first and second of seven '*High Impact Changes*' identified by the LTCC in 2009 include carers:

> No. 1. "*empower people living with LTCs, their carers and the voluntary sector, to be full partners in planning, improving quality and enhance the experience of care*" and No. 2. "*we support people with LTCs and their unpaid carers to be involved in patient-centred care planning*" (The Scottish Government 2009: 5)

The lead set by *"Gaun Yersel!"* emphasised that in order for an individual to manage their LTC they and their carers will need support, advice and information which can best be accessed through health professionals, NHS or the voluntary sector, signifying that the debate was directed not just at self-management but at establishing the need for self-management support. *"Gaun Yersel!"* defined and established the distinction between these two ideas:

> "*Self-management is the process each person develops to manage their conditions*."

And: "*Support for self-care and self-management is the responsibility of health and social care providers and unpaid carers*." (LTCAS 2008: 9).

The subtlety of self-management, alluded to in Kerr's definition of four years earlier, has been refined with the idea of self-management as two separate concepts. Here LTCAS has chosen to separate out the expectation on the individual and explain this as self-management, name the expectations of health and social care providers as support for self-management, giving both the individual and existing service providers roles in self-management delivery.

5.4.4 Summary - Content

It is important that policy, any policy, is clear about its content and what it says, since this influences the willingness (or unwillingness) of policy-implementers (Tummers et al. 2012). Self-management as a concept and the policies that support it have evolved with its promotion as an idea and ultimately what it requires to change. Initially, self-management was heavily influenced by the desire to shift the balance from the traditional focus of in-patient care as first choice and professional knowing best. This distinction or desire is perhaps too extreme and so, in consequence, a softer approach has emerged with greater emphasis on mutuality as a way of presenting self-management more as a concept of public good.

Mutuality is also represented by the co-authorship of the Scottish Self-management Strategy, whose symbolism showed how partnerships between voluntary agencies and government could work to communicate to the Health Boards and wider NHS that partnership was possible and could bring benefits to the partners and those they represented.

5.5 Process: What do policy documents reveal about how self-management should be delivered?

The various policy documents propose that LTCs can be better managed by increasing support for self-management which, in turn, should be achieved by strengthening and extending primary care, offering integrated and responsive specialist care and managing vulnerable cases by anticipating need (SEHD 2005c). To meet the expectation of self-management, changes in the way services are organised and delivered are required. Policy provides guidance on how these changes can be achieved in the form of suggested approaches to service organisation and the use of specific levers of change. Both areas were concerned with clarity about how self-management can be delivered in practice.

5.5.1 Approaches to the organisation of services

Policy provides evidence of three approaches that Health Boards should use to encourage services to be more patient-centred: an increased role for community health partnerships and Managed Clinical Networks MCNs to promote multi-disciplinary and multi-agency working; the promotion of home-based information technology - Telehealth - to deliver care more efficiently and closer to home; and the use of case/care management supported by risk stratification to help prioritise the delivery of community care to those patients in greatest need.

Multi-disciplinary and multi-agency working Changes to the health services require health professionals to work together, integrate across separate areas of health and social care, collaborate with local authorities and encourage closer working relationships with the voluntary sector (SEHD 2005a). Generally, it is recognised is that the NHS cannot deliver self-management on its own and a model of close partnership working is reiterated across the documents, cross-cutting between patients, health professionals and unpaid carers as well as between health and social care delivery organisations in state and third sectors. Its importance is emphasised:

> *"Change 5. Introduce a systematic and integrated multi-agency approach across CHPs to provide better local and faster access to services for people with long term*

> *conditions who require proactive and co-ordinated support"* (NHS Scotland 2009a: 24)

Multi-agency working is seen to support smoother referral pathways between social and health services; and better care co-ordination (LTCAS 2008) is expected to offer the potential for faster access to services, helping to ensure that people get the right help at the right time (Scottish Government 2009).

The importance of multi-disciplinary working in the promotion of self-management has focused on two existing models of service delivery: the Community Health Partnership (CHP) and the MCN. As **Table 5-2** shows, HDL 10 2007 (Scottish Executive 2007a) and HDL 21 (Scottish Executive 2007 b) promoted the role of the MCNs and CHPs as the most important organisations through which integrated working could be established in local Health Board areas.

The third means of promoting a truly multi-agency approach to self-management is the involvement of the voluntary sector or, as it is termed in policy documents, the "*third sector*" (Scottish Government 2007), a unique aspect of Scottish health policy. The level of engagement and working that the Scottish government expects with the voluntary sector is illustrated by the establishment of the LTCAS which was proposed in "*Delivering for Health*" (SEHD 2005a). As **Table 5-2** shows, the following year this voluntary sector umbrella organisation organised a conference exploring self-management which served to highlight its importance to people with LTCs.

Since 2006 LTCAS has highlighted what it knows about the challenges faced by people living with an LTC and the benefits of self-management (LTCAS 2006). It has demonstrated how it can represent and involve people with LTCs in the delivery of policy. The importance of this model of involvement and the representation of people's personal experience through stories and personal accounts is recognised by policy-makers. The collaboration between the Scottish Government and LTCAS shows how the Government wants to be seen to learn from people's experiences to improve care (LTCAS 2008) as the opening pages of the '*Self-Management Strategy for Scotland*' show:

> *"The self-management strategy that follows is a unique document, in that it has been developed not, as you might expect, by the Scottish Government, but by the Long Term Conditions Alliance Scotland. This was a deliberate decision, in keeping with our overall approach to long term conditions management, where we want to learn from people's own experience of living with these conditions" (LTCAS 2008: 2)*

The inclusion of voluntary services and the importance of multi-disciplinary team working to meet the expectation of self-management is emphasised as an action for change.

Telehealth The promotion of home base information technology, commonly referred to as Telehealth (literally: *health at a distance*) is advocated as a means of supporting self-management. Its use to improve self-management for people with LTCs appears across the policy documents. "*Gaun Yerself*" advocates Telehealth because:

> *"Technology can support individuals with better information and minimise unnecessary face-to-face contact with health services"* (LTCAS 2008: 56)

Telehealth fits with many of the requirements of self-management because it allows care to be delivered in the least intensive setting possible and enables remote monitoring of symptoms, promoting patient empowerment and control of their condition (SEHD, 2005c). Telehealth also anticipates problems and helps to manage exacerbations, obviating unnecessary hospital admission (NHS Scotland 2009b):

> *"A 'telehealthcare' package, available in a person's home, can improve a person's experience of care by reducing the need for travel to major cities and hospitals to receive care and treatment"* (NHS Scotland 2009b: 16)

Analysis of policy documents showed that there is considerable interest in using telehealth as a cost-effective addition to the standard support and treatment available to people with LTCs.

It was seen as means of off-setting the financial burden associated with a predicted rise in prevalence of LTCs and the burden of demand this places on current and future models of care (DoH 2012).

Case/care management supported by risk stratification Telehealth exemplifies ways in which information technology can provide support for self-management. Improving NHS Scotland's use of patient data was also promoted from 2005 onwards. Kerr (2005) argued the importance of good information systems, echoed in the National Framework:

> *"Information systems should be able to support the three functions of assessment of need, care planning and co-ordination and evaluation of the quality of care."(SEHD 2005a; 57)*

Information systems were to be key elements in the delivery of self-management, helping to promote an anticipatory as opposed to a reactive approach to care.

Risk stratification was strongly advocated in later policy statements to ensure that all people with an LTC are on an information system so that the health service can ensure regular review and recall (NHS Scotland 2009b). Specific advice was offered on how to use information services, advice focused on the identification of at-risk patients and specifically those at risk of admission or re-admission to in-patient care, with the knowledge that many of these patients are likely to have an LTC.

To help target them, policy advocates that health boards should incorporate the use of Scottish Patient at Risk of Readmission and Admission -SPARRA - data to target resources and services to those in most need. Its use, and the benefits of integrated information systems, were highlighted specifically in the Long-Term Conditions Action Plan (LTCAP):

> *"ISD is continuing to develop the SPARRA (Scottish Patients at Risk of Readmission and Admission) risk prediction tool, which is currently based on hospital admissions data, including exploring the possibility of incorporating risk factors present in other datasets such as primary care, social care and prescribing data. ... .An essential part*

> *of this strategy will be to design, develop, and implement a system which delivers the information management functions that support a personal health record or electronic care plan to enable engagement, self management, risk prediction and clinical information support for long term conditions."* (NHS Scotland 2009a: 14)

Policy is focused on using data such as SPARRA to support the review of people with multiple conditions and enable sharing of data across relevant care partners (NHS Scotland, 2009a). This encourages services to systematically promote efficiency and effectiveness. One example of this integration is termed variously case or care management. Having identified at-risk patients, care management can be used to help high-priority patients try to break the cycle of admission, readmission and crisis management. The LTCAP sets out what case/care management is and whom it should be used for;

> *"for those with particularly complex needs who require a more intensive level of care, often referred to as 'case / care management', a co-ordinated and proactive approach to improve health and help them avoid being admitted unnecessarily to hospital."*(NHS Scotland 2009a: 12)

The integration of SPARRA (or risk predictor tools) and case/care management was included as one of the actions under the seven high impact changes:

> *"Target case/care managers to assess those identified by risk prediction tools as at high risk then tailor care for individuals through a case / care management approach using multidisciplinary teams which work closely with social services."* (NHS Scotland 2009a: *13).*

The process of delivering self-management in practice includes a wide variety of actions; efficient and intelligent use of information systems promotes care targeted at the most vulnerable patients.

5.5.2 Levers for change

As well as direct actions and examples of organisational elements, the analysis of policy reveals a number of levers for change used to encourage the process of self-management implementation. These are top-down ideas that focus on key outcomes such as: NHS performance management targets known as HEAT; protected financial investment; staff education and the use of quality improvement methodologies. The evidence from policy that supports each of these levers for change will be presented.

Performance Management HEAT targets, defined as H – health; E – efficiency; A – access; and T – treatment are used to support NHS performance management. Their strength is their ability to motivate action, since they are set for all NHS boards and their achievements are publicly measured (Scottish Government 2007). They are not exclusively associated with the delivery of self-management but in '*Better Health, Better Care*' actions associated with an enabling health service and, in turn, ideas of self-management were used to refine the HEAT targets of 2008/09:

> *"NHS Scotland is uniquely placed to provide services and support which build people's capacity to improve their health and wellbeing. This is an enabling role: to help create the conditions in which people have the confidence, motivation and ability to make healthy choices and to provide professional support and advice when required. This has been recognised more clearly in the HEAT targets for 2008/09, which provide a clearer specification of the distinct contribution that NHS Scotland will make towards the Scottish Government's strategic objectives."* (Scottish Government 2007)

In two later policy documents (Long-Term Condition Collaborative 'High Impact Changes' (Scottish Government 2009) and the Scottish Government's LTCAP (NHS Scotland 2009a) there was further refinement of the self-management delivery processes. In the later document the management of LTCs was mapped to five out of thirty HEAT targets set for 2009-10:

> T6: Reduce long term conditions admissions/bed days
> T7: Improve quality of health care experience
> T8: Increase Complex Care at home
> T10: Reduce rate of attendance at A&E
> T12: Reduce 65+ emergency bed days (NHS Scotland 2009a: 15)

Seven '*High Impact Changes*' were identified and linked to two core aspects of performance management, first existing HEAT targets and then Community Care Outcomes. Each high impact change was therefore made up of "*a bundle of improvement actions*" (Scottish

Government 2009: 5) linked to the HEAT target and Community Care Outcome theme. HICs required that:

> "*we empower people living with long-term conditions, their carer and the voluntary sector to be full partners in planning, improving quality and enhancing the experience of care*" (Scottish Government, 2009: 5)
>
> and it was mapped to; "*HEAT Target: T7 – improve quality of healthcare; and Community Care Outcome Themes: User satisfaction; support for carers*" (Scottish Government, 2009: 6).

Later in the same year the LTCAP emphasised the five HEAT targets that applied to LTCs and the requirement of the 14 Health Boards to report progress against these targets because:

> *"Scotland's integrated performance framework helps focus investment and action on improving health, wellbeing and outcomes for people with long term conditions"* (NHS Scotland, 2009a; 14)

As well as establishing the role of performance management in driving forward policy delivery, the LTCAP outlined further work under way to amend and develop new targets:

> *"Amended targets will give consideration to targets that: focus on improvements to services for people with long-term conditions; and reflect the role of NHS Boards in empowering and enabling people with long term conditions to manage their own condition"* (NHS Scotland, 2009a; 15).

NHS performance frameworks have evolved to be more closely associated with the actions needed to implement policy supporting self-management, a process still developing with further refinement of targets and outcomes planned. Policy provides evidence that performance management is a key lever of change used to encourage Health Boards to implement self-management.

Financial investment Policy documents provided evidence of financial support to promote the delivery of self-management. First is the Scottish Government's provision of a 'Self-management fund' of £2m per year for 3 years (LTCAS 2008) to be administered by the LTCAS to encourage wider availability of self-management programmes. A key aim was to increase capacity within the voluntary sector to provide support and advice for patients on self-management:

> *'To begin to establish the self-management agenda, initially LTCAS seeks £2 million per year for a period of three years.'*

Later in the report further details are provided:

> '*We suggest that the agreed budget is set up in a fund, to be managed by LTCAS. Organisations will then be supported to make bids for self-management initiatives set against criteria agreed with LTCAS and the Scottish Government'.* (LTCAS 2008: 28)

By the time this policy statement of financial support of £2million per year for 3 years reached the LTCAP it had been reduced to *'£2m p.a. for two years from April 2009-March 2011*' (NHS Scotland 2009a; 20), although other financial promises to promote self-management had been honoured: the commitment set out in '*Delivery for Health*' to establish the LTCAS in 2006 was fulfilled. Later, in *'Better Health, Better Care',* further statements of government support of the work of the LTCAS was outlined with financial support for the development of a LTCs 'Hub', described as: "*a resource centre for smaller member organisations*" (Scottish Government 2007: 52). The development of the LTCC was also set out in *'Better Health, Better Care'* and was established and funded by the government from 2008-11.

Other targeted financial support was set out in the '*Long Term Conditions Toolkit'* which provided a one off payment of £10,000 for each Community Health Partnership to '*help in the initial stages of completing the Toolkit'* (Scottish Executive 2007a: letter).

Between 2005 and 2010 targeted financial assistance was invested to develop capacity through the self-management fund and support the establishment of the LTCC. The focus of both initiatives was to promote policy prioritising self-management for people with LTCs.

Promotion of quality improvement methodologies - Further incentives for change and service re-organisation were driven by quality improvement methodologies most closely associated with the work of the LTCC, established in 2008 to support NHS Scotland, the policy-implementers, to "*deliver sustainable improvements in patient centred care*" (Scottish Government 2007: 53):

> *'The three year national programme will engage all 14 territorial NHS Boards and the focus will be on clinical systems improvements to improve access, reliability, safety and patient experience. There will be a regional management infrastructure to support the use of technical and behavioural management tools and techniques' (Scottish Government 2007: 53)*

In '*High Impact Changes*' the improvement methodologies LTCC would use were clarified and encompassed:

> *'PDSA cycles, lean-thinking, theory of constraints, as well as context specific improvement knowledge to reduce mortality, improve flows, and increase productivity through our the system'* (Scottish Government 2009: 2)

The delivery of the seven '*High Impact Changes'*, all of which targeted improving care for patients with LTCs, was linked to improvement technologies in an approach that would encourage the sharing of innovative practice across Scotland.

Subsequent to '*High Impact Changes*' (Scottish Government 2009), the LTCAP (NHS Scotland 2009a), '*Improving Self-Management Support'* (NHS Scotland 2009b) and '*Making Connections - Food for Thought*' (NHS Scotland 2010) provided further practical advice on how to deliver policy to support self-management. These documents represent a significant move away from large overarching policy statements such as *Delivering Care, Enabling Health* (NHS Scotland 2006) and *Better Health Better Care* (Scottish Government 2007). They are designed to be more accessible and contain detailed actions to guide policy-implementation. However, as starkly illustrated by my interview data, policy-implementers are more aware of large policy statements, and reference was not made to these ‘*policy-lite*’ documents as examples of current policy.

Education and training - The fourth lever of change to emerge from this analysis consists of two elements: a focus on the importance of education for staff – the health professionals who work with people with LTCs; and policy identifying the importance of education for self-managing patients.

The commitment of healthcare professionals is vital for successful self-management, so health professionals need opportunities to develop their skills and experiences. Policy states that education supports staff to be ‘*agents of change*’ (Scottish Government 2007; 12). Ideas on self-management may not seem new but some of the skills that professionals need to promote interactions empowering and engendering a sense of control or to tackle psychological as well as physical symptoms will be new. This is recognised as a particular challenge. Professionals must move from helper to enabler and education is needed. Self-management requires a shift in thinking and transformational change so that health professionals can become effective supporters of patients (NHS Scotland 2006):

> *‘NMAHPs* [Nurses, Midwives and Allied Health Professionals] *must undergo transformational change in delivering the new health agenda by becoming first and foremost enablers and supporters of service users’ self-care an self-management abilities’* (NHS Scotland 2006: 32)

Other policy documents acknowledge that professionals need opportunities to learn how to promote and support patients to self-manage. Education will help staff develop their knowledge and skills and in turn enable patients to self-manage and live better with their condition (Scottish Government 2009). To meet this outcome specific policy targets have been set with the fourth ‘High Impact Change’:

> ‘*we train staff to have the right knowledge, skills and approach to long-term conditions care.’* (Scottish Government 2009; 5)

Policy also encourages the NHS to recognise the value of patient education programmes which can be generic or condition specific, professionally-led, lay-led or patient-led. Who leads the programme or whether the programme is condition specific or generic is unimportant: these programmes foster the patient as expert and promote ideas of wellbeing, enablement and control (SEHD 2005a). On a practical level engaging people in set programmes so that they learn how to self-manage is reported to reduce pain, improve mental wellbeing and, for some conditions, reduce complications (LTCAS 2008).

The promotion of patient-education on '*how to self-manage*' is identified as a policy target in - '*HIC*': Target 3:

> *"we commission peer support groups for people with long term conditions and their carers* and *provide relevant, accessible information"* (Scottish Government 2009; 5)

The NHS has been directed to ensure that voluntary groups are supported and that patients with an LTC can find out about national and local support groups. Education for professionals and for people with LTCs was recognised as an important driver for change and policy encouraged Health Boards to address this for both groups.

5.5.3 Summary - Process

A number of procedural elements emerged from the analysis of policy documents designed to promote the implementation of policy supporting self-management. Health Boards are encouraged to review the organisation of service and focus on greater partnership and collaboration so that the burden of care is shared more equitably across health services (primary and community), shared with social care and in greater partnership with the voluntary sector. This multi-agency working was detailed in the text of policy documents, but the Scottish Government also led by example and by role-modelling the partnership through their work with the LTCAS (now called Health and Social Care Alliance Scotland).

Telehealth was heavily promoted in policy documents. Remote monitoring supplementing usual care was seen as a means of helping patients to recognise and manage their symptoms to prevent exacerbations that might precipitate emergency admission to hospital. At the time of this research Telehealth represented the proactive engagement of patients in their chronic condition and suggested a more cost-effective approach to monitoring symptoms with less direct professional engagement. Current evidence, however, does not support the assertion that telehealth has this desired affect; indeed patients who have access to usual care appear to do just as well as those with access to telehealth in addition to their usual care (Henderson et al. 2013).

The promotion of quality improvement methodologies, which were used to direct the work of the LTCC, continues to influence care today. The work streams initiated through this organisation and the use of improvement methodologies encouraged policy adoption, combined with financial incentives and performance targets to form a persuasive argument in support of policy promoting self-management – an argument which health boards could not ignore.

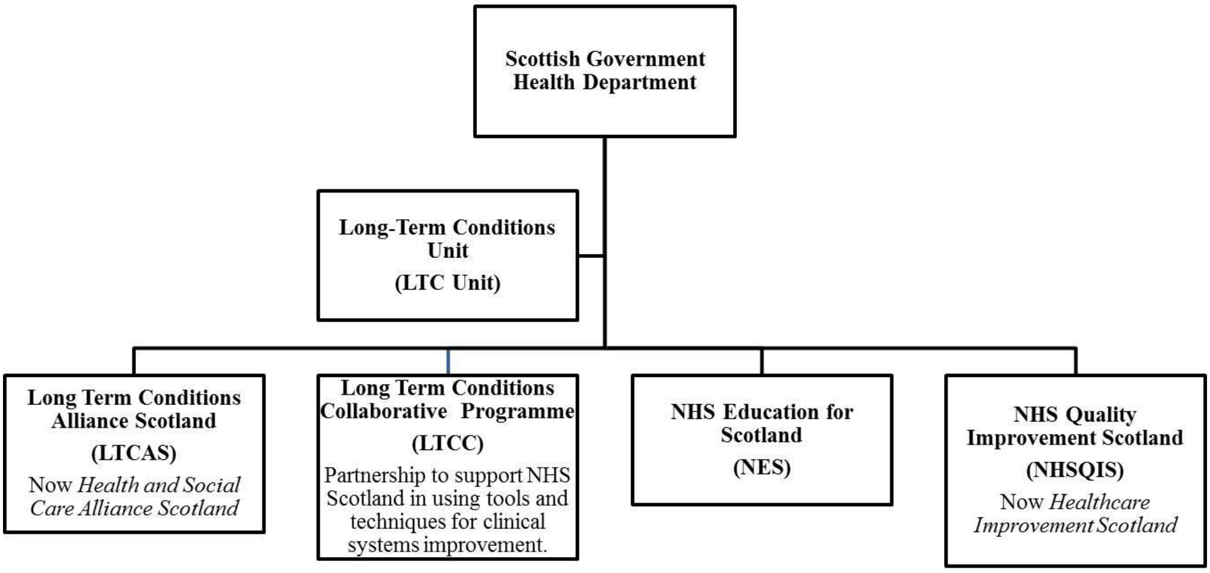
5.6 Actors: who is involved in directing, influencing and forming policy promoting self-management

In this analysis the actors involved in making policy are organisations rather than individuals. The key national organisation is the Scottish Government's Health Department, the source of the principal documents shaping policy in this area. As the policy has evolved the Health Department has directed the establishment of other organisations who have subsequently informed policy. For example, the actions and contribution of the LTCAS were formally recorded in '*Better Health, Better Care*' (Scottish Government 2007); and the establishment of the LTCC was also noted in '*Better Health, Better Care*':

> *"A new, dedicated Long Term Conditions Collaborative is being developed to support NHS Scotland."* (Scottish Government 2007: 52).

Other key national organisations include NHS Education for Scotland and NHS Quality Improvement Scotland. **Figure 5-1** sets out these national actors.

Figure 5-1 National actors



Policy also sets out the key local actors: NHS Boards, Local Authorities, CHPs, MCNs, carers' organisations and local voluntary groups. Those actors and their relationships specific to NHS Kuzburgh are presented in **Chapter 6.**

Contributions from Arthritis Care Scotland, Diabetes UK Scotland, Pain Association Scottish and the Thistle Foundation were all evident in the policy documents reviewed. The inclusion of these charities, many of whom have worked with people with LTCs and disability for a significant period of time, helped bring strong focus on learning from people's experience. This was a unique aspect of this area of policy implementation and a particular attribute of the policy story which emerged from interview and observational data.

5.7 Conclusion to chapter

From the outset policy distinguishes between self-management and self-management support. Self-management actively encourages people to manage their health and, when necessary, their ill health. It also seeks to develop an individual's capacity to cope with chronic ill-health such as that associated with LTCs. Self-management support is a collaboration between patients and healthcare practitioners that ought to provide basic information, emotional support and strategies for living with a chronic illness. It helps people to define problems, set priorities, establish goals, create treatment plans and solve problems along the way (SEHD 2005b).

To realise this vision there is a need for recognition and support for the role and responsibility of the patient or person with a LTC to self-manage; for re- organisation of services; to promote multi-agency working, particularly the inclusion of the voluntary sector; and for training and education that supports health professionals with the skills to help their patients self-manage.

Policy analysis has revealed various factors that provide a context within which policy is implemented at Health Board level. An important aspect of this policy analysis are incentives to encourage policy implementation. The promotion of self-management attracted a large number of policy incentives including financial as well as management performance in the form of HEAT targets. The impact of these drivers on the dynamics of policy implementation in practice is presented in **Chapter 6**.

Chapter 6 Findings from interview and observational data- *‘the storyline of policy implementation’*

6.1 Overview of chapter

This chapter uses NPT: see **Chapter 3**, Section 3.4.3; **Chapter 4**, Section 4.6.2 as a conceptual framework to help present the findings from interview and observational data, accounting for ways in which policy-makers and -implementers (actors) have sought to embed and ‘normalise’ support for self-management into routine healthcare practice.

Each of the four NPT constructs, and the findings generated, is presented in turn with further discussion of findings using the four components belonging to each construct (see **Chapter 4 Table 4-4**).

Although the mechanisms of NPT are listed as four discrete components, May and Finch (2009) accept that implementation is rarely experienced quite so discreetly and argue that the process of policy implementation is dynamic and fluid. The categorisation and sub-categorisation, which proponents of NPT suggest, should be seen not as what actually happens but rather as a representational model of the dynamic and fluid processes at work when trying to operationalise new practices (May and Finch 2009). This fluidity explains why I, like other researchers, encountered difficulties in applying NPT concepts to the data. This was the experience of MacFarlane and O’Reilly-Brun (2012) who noted that they did not always feel confident or comfortable in the use of this conceptual framework. Similarly, overlap between the constructs for example determining what might be classified as cognitive participation in comparison to collective action proved challenging. Franx et al. (2012) shared the difficulty in discerning between mechanisms. What proved helpful in this research was reference to the four components within each mechanism to determine the meaning of each NPT construct and therefore ‘fit’ the data appropriately.

6.1.1 Participants

Thirty-one people took part in this research: 11 national policy-makers (P-M) and 20 policy-implementers (regional and local, P-I). For ease of reference a description of each participant's job role and their role as either P-M or P-I is provided below. This table should be read in conjunction with **Table 4-1**.

Table 6-1 Participants and associations

Pseudonym	*Position*	*Pseudonym*	*Position*
Dom	Clinical Manager LTC unit (P-M)	Paul	Director CHP (P-I)
Gayle	Director LTCAS (P-M)	Quinn	Associate Director (P-I)
Bobbi	Clinical Lead LTC unit (P-M)	Reece	Regional Programme Manager (P-I)
Charlie	Director Voluntary Agency contributed to policy documents (P-M)	Sidney	Associate Director (P-I)
Emroy	National Programme Manager (P-M)	Taylor	Director NHS Board (P-I)
Alex	Chief Executive Voluntary Agency contributed to policy documents (P-M)	Pat	Regional Project Manager (P-I)
Finlay	Civil Servant Health Department SG(P-M)	Vaughan	GM - Locality Manager (P-I)
Harper	National Programme Manager (P-M)	Lou	GM - Locality Manager (P-I)
India	Clinical Manager – LTCC (P-M)	Fran	LTC lead (P-I)
Jay	Programme Manager –LTCC (P-M)	Jamie	Link Worker - voluntary agency(P-I)
Marley	National Director Voluntary Agency (P-M)	Rylee	Manager - voluntary agency (P-I)
NHS Kuzburgh		Blake	Nurse - Team leader (P-I)
Kris	Nurse lead NHS Kuzburgh (P-I)	Casey	Specialist Nurse (P-I)
Lennon	MCN, Co-ordinator (P-I)	Berni	Specialist Nurse (P-I)
Nell	Regional Director (P-M)	Eddi	Nurse - Team Leader (P-I)
Oakley	MCN, Co-ordinator (P-I)	Logan	Nurse - Team Leader (P-I)

A number of these participants operated across the boundaries, acting as both policy-makers and -implementers. For example India and Jay were seconded from NHS Kuzburgh where they had clinical roles as well as acting as P-M as part of their roles within the LTCC.

6.1.2 Coherence – sense-making work

In NPT coherence is action which defines and organises the object of the new practice, such as what the new practice means, what benefits it may bring and how it differs from how things have been done before (May et al. 2009). There is evidence that interviewees were sensitive to coherence, that they recognised the value of working to understand the meaning of policy implementation (see **Chapter 7** and **Chapter 8** for further discussion).

Coherence is mapped through five types of data-generated sense-making work activities:

i) Use of policy documents to help understand self-management;
ii) Understanding how self-management is linked to the wider agenda;
iii) Generation of personal understanding to guide meaning;
iv) Understanding self-management through the tasks expected and the benefits for people with LTCs; and
v) Defining self-management through negative perceptions (setting-out what it is not as a means of establishing what it is).

The length and detail of responses generated by the question "*What does the term self-management mean to you*?" and the frequency with which respondents returned to this topic at other points in the interview demonstrated the importance of understanding the meaning of self-management. Firstly, self-management is different from the usual culture of care for people with LTCs and fundamental to the success or otherwise of implementation:

> *"I don't think that self-management is a natural idea to people who have been working in the health service for a long time…it is so alien to what so many people are doing."* (Sidney P-I: 84)

6.1.2.1 Use of policy documents to help understand self-management

In articulating coherence respondents referred to, or used the content of, policy documents to help explain important points, suggesting their key use in helping participants understand self-management.

In response to the question "*What does the term self-management mean to you*?", policy-makers referred to documents that they had helped to write. Alex (P-M), who was involved in writing '*Gaun Yersel*!' (LTCAS 2008), referred to:

> "..*self-management in the values-based way that it's written in this document"* [holds up a copy of *'Gaun Yersel'*]. (Alex P-M: 58)

Policy-implementers also looked to policy documents to provide specific ideas which would help them define, interpret and implement self-management, employing specific terminology contained in policy documents. Quinn said:

> "*Self-management is very much a partnership approach and really endorses what was said in 'Better Health, Better Care'…in terms of a mutual thing, rather than [the] sort of paternalistic approach…that health has perhaps had in the past, is saying, the patient has an equal part to play and giving them the support and knowledge to be able to take that forward*" (Quinn P-I: 32).

Policy-implementers also described how they used diagrams in documents to explain self-management. The 'Kaiser Permanente pyramid', first presented in 2005 in the 'Kerr report' (SEHD 2005b) and further endorsed in the 2009 National Action Plan (NHS Scotland 2009a), was specifically cited in a number of accounts. Paul (P-I) said:

> "*we have used to develop our Long Term Condition Strategy, we used …the pyramid, Kaiser Permanente pyramid sort of thing with the various tiers in it. And very much say that at the bottom tier, that was a whole range of, for long term conditions…people with long term conditions, you know, health improvement, and to self-care and self-management. …And, I guess the definitions that we're sort of using around that was the provision of education, training, support mentoring, etcetera, to patients within specific groups in order to better allow them to manage their condition.*" (Paul P-I: 26).

So for policy-implementers, policy documents and diagrams offered useful guidance on what self-management is and how to deliver it.

As Tummers et al. (2012) identified, one of the key factors in policy implementation is the perception of '*meaningfulness*'. This awareness was revealed across all organisational levels. For example:

> "*I think we've been going through a journey, and I think the biggest penny dropping moment really was the publication of the National Framework for Service Change, because I think that really forced health boards to re-look at their core principles and shift from a very reactive approach to care, to a much more proactive approach to care"* (Kris P-I: 26).

However, although awareness of policy document content was widespread, there appeared to be confusion over the exact content or function of the policies. This was highlighted by those policy-implementers who worked most directly with patients. For example a specialist nurse, Casey:

> "*I think most of* [self-management] *came out in that recent Scottish Government documentation it mentions it in some shape or form. Better Health, Better Care, shifting the balance of care and all that sort of stuff. I know that there's the work with the Long Term Conditions Collaborative. I'm not wholly sure of what they're doing. I know that they've got the "Gaun yersel" strategy. But to be honest I haven't actually seen that. I don't really know what it says."* (Casey P-I: 64)

It seems, therefore, that having a policy document in itself is not sufficient to make things happen. Implementing self-management in practice requires work from policy-implementers and the content of the documents was not necessarily seen as helping with implementation. For example:

> *"I attended that launch of the Self-Management Strategy but I've never heard anything about it since. I mean the document's sitting there and I do actually sometimes go back to the document for references and things but that's where the sort of policy ends if you like and our development of it begins" (*policy-implementer *Eddie P-I: 27)*

This suggests that, as predicted and suggested in Chapter 2, the line from policy-maker through policy documents to policy-implementer to practice is not straightforward and involves interpretation and negotiation.

Observational data provided further evidence that policy documents were used as a point of reference to understand self-management but that the implementation of the ideas they contained remained problematic. In **National Observation 1- (**a policy-implementers' meeting – convened as a regular forum to oversee the implementation of '*Gaun Yersel*' (LTCAS 2008), discussion of the LTCAP (NHS Scotland, 2009) the Action Plan was seen as an important approach to raising awareness of self-management and self-management support. However, concern was expressed that the breadth of actions implicit in both the

LTCAP and '*Gaun Yersel*' were barriers to implementation. Policy-implementers felt that there was too much to do and a consequent danger of paralysis or lack of focus. For example:

> *The breadth of the actions highlighted in the self-management strategy could be a potential obstruction – where to start or what to prioritise?* (Note from: **National Observation 1**).

Determining who was responsible for the actions implicit in policy documents also caused policy-implementers concern. For example:

> *The group recognised the importance of providing regular updates on progress though appeared unclear as to exactly how to do this. Issue of responsibility – who is responsible at an individual Health Board level? Question not easy to answer.* (Note from: **National Observation 1**).

Policy documents, therefore, while providing key support to implementers of health policy change, create problems of both interpretation and implementation, a tension explored further in **Chapter 7**.

6.1.2.2 Understanding how self-management is linked to the wider agenda

Respondents engaged with a wide range of contextual drivers of self-management policy and articulated their understanding of it. The most important were: changing demographics; the desire for Scotland to maintain a separate identity for the NHS; and a societal shift in expectations which sought to promote health through greater personal responsibility.

When discussing the meaning of self-management, policy-makers and -implementers commonly cited wider issues in relation to caring for people with LTCs, describing self-management in a broader context as part of a larger agenda and intimately linked to other contemporary policy issues such as the Keep Well initiative, the patient safety agenda and models of co-creating health (interview Dom, LTC unit). Respondents identified such issues as an explanation of the importance of taking action to change current NHS provision. Here a policy-maker explains the impact of an ageing population, higher incidences of LTCs and the potential impact on the NHS as a whole:

> *"We have to make sure that the NHS can still support people with long-term conditions because, as you know, there'll be more people over the age of 60 than under 60 in 2031, predicted anyway. There will be people living longer and when people live longer there's a high instance of cancer. You've got people living with one or more long term conditions. So you've already started to get a picture of complex needs developing. People living longer with complex needs and different variances of complex needs and cancer, so essentially I think it's about maintaining the NHS actually, and I know that this is also something not just unique to Scotland or the UK but also to western countries too. So it's a problem."* (Harper, P-M : 33)

The national political context was also recognised. Although the concept of self-management was introduced into Scottish health policy under a Labour administration with the publication of the Kerr Report (SEHD, 2005b) (**Chapter 5**), the Scottish National Party (SNP) gave it additional emphasis and encouragement for implementation from 2006 onwards. For example, one policy-maker said:

> *"I guess since the Kerr Report and Delivering for Health, long term conditions have been clearly identified as being a priority within the health services and the sort of scale of the challenge that they present has been recognised so I think that in itself is really crucial, and since the change of administration as well with the SNP coming in that has continued across so the emphasis is still very much on long term conditions"* (Gayle, P-M; 42)

Respondents found it reassuring that support for a policy promoting self-management has evolved over time and survived changes in political leadership. Respondents argued that Scotland's status, as a devolved country of the United Kingdom was important:

> "*where health is a devolved issue we can make the changes in our health system because we have the control to do that….tailoring things to the people of Scotland"* (Bobbi, P-M; 276).

A key consequence of the devolution of control is a scale and unity of operation that fosters an integrated, purposeful set of policies. For example:

> *"I think one of the main factors that helps in all this is the kind of health system that we've got in Scotland. I think having a unified system that is based on health*

> *insurance rather than private insurers, that has integrated health systems so that we don't have separate commissioning and provider organisations, all really help"* (Finlay, P-M: 104).

So the political and economic context helped people to see how self-management '*fitted in*' and became congruent with the overall political vision.

The emergence of self-management in policy was also attributed to a societal shift:

> "*I think there is a whole issue of the population in society taking more of a responsibility for their own health and their own healthcare needs, so that people see it as their responsibility to do something about their health.*" (Reece P-I: 55).

Policy-makers want to create an NHS that encourages more personal responsibility and is more inclusive: (Finlay P-M: 106) and:

> *"...the government's view is about a health system and service which is more mutual, people feeling that they are more involved and engaged with services.*" (Bobbi, P-M: 110).

This interpretation is used to encourage stakeholders to embrace its role in supporting management of LTCs.

Economic pressures reinforce mutuality. Respondents linked their understanding of self-management to a political desire to make the NHS more sustainable and efficient. Self-management policies were seen to provide a focus for such change. The status quo was no longer an option; self-management had to be turned into tangible policies and practices. For example, Finlay (P-M): 28:

> "*I think that the other comment that people make frequently is that self-management is an idea whose time has come. That there has been a long gradual process of change that has paved the way for the work that we are doing now. So I hope that that's another factor that will help make these changes. But I think none of us are under any illusion that while we may have reached something of a tipping point, it is not going to happen automatically or speedily*".

The levers behind this *'tipping point'* included a need to address people's learned dependency and over-reliance on the NHS, to move patients away from '*models of being sick*' (Marley, P-I: 44) and challenging ideas of '*learned helplessness*' (Charlie, P-M:; 208).

Mutuality and economics cannot be disassociated from the Scottish Government's priority to improve overall public health. Here was an opportunity for the NHS to shift its focus on ill-health to adopt a more positive view of health for all, even those with an LTC:

> "*There does seem to be a real enthusiasm for promoting health. Not just the management of ill health, but the promotion of health.*" (Sidney, P-I: 15).

6.1.2.3 Generation of personal understanding to guide coherence

Discussion also focused on the personal interpretation policy-makers and -implementers applied to self-management – how they made sense of it – to allow them to do their job.

Differing ways in which policy-makers and -implementers expressed their understanding of self-management and its support had significant implications for coherence (see **Chapter 7 and 8**). Policy-makers approached the concept in general terms. For example: "*... at one level self-management is whatever someone says it is in terms of helping"* (Bobbie, P-M: 32). Some policy-makers found the notion of self-management difficult to articulate, resorting to broad, abstract statements which could apply to any discussion of healthcare. As illustrated by Bobbie, a policy-maker:

> "*So self-management I see as a very all encompassing concept and a definition, it really it [..pause] can't be imposed. If somebody says that something is a dimension of [...pause] a response to an issue for themselves, then by definition it's self-management*" (Bobbie: 34).

Others described self-management as far-ranging, huge, a "*spectrum of things*" (Dom, policy-maker: 12). Its breadth and abstraction prevented clear definition, as Emroy, a policy-maker, working in specialist health board testified:

> *".*. [self-management is] *something to do with people feeling enabled to do what they feel they need to do for their health…it's around some of the psychological and more emotional elements of care. ...Around people being able to identify the impact that say a long term condition has, but then manage everything that comes with that, as opposed to just managing symptoms."* (Emroy, P-M : 30).

Consequently, at the level of policy-making, it was hard to identify a shared sense of what self-management meant. In contrast, policy-implementers focused on its practice and were more specific and direct about what it meant and how it differed from existing practices:

> [Self-management] *" is about working in partnership with patients, discussing with them what their disease means, that they are still a person, and yes they happen to have this long term condition but all the things that they can do to remain well, to manage their symptoms, to be in control, to work in partnership with me and other health professionals, that we're all there to support them to minimise the impact of their diagnosis and symptoms from that on them."* (Logan, P-I: 22)

Policy-implementers were keen to translate abstract ideas of self-management from policy (described in **Chapter 5**) into practical knowledge and found it easier to describe. For example, Nell (P-I), who both worked for a local carers' organisation and was herself a carer, thought self-management was '*self-explanatory*' (Nell: 29) but went on to say:

> [Self-management] *"is about people with long term conditions. If they manage their condition properly, and that would include a carer, then you're in a situation where you reduce the admissions to hospital, early discharges... It means that they are advised and informed about their condition, they know how to manage it.*" (Nell: 31)

Other policy-implementers described supporting self-management as part and parcel of their job, so they became the means by which self-management was translated into practical knowledge:

> "*I see the development of self-management approaches across a whole range of clinical modalities as being one of the key components of this job.*" (Vaughan, P-I: 62)

So, while some policy-makers were engaged in abstract discussion and others thought carefully about what self-management meant, those charged with policy-implementation wanted to generate more practical knowledge. Overall, the extent to which 'self-management' as a term and a practice makes sense to people varied across organisational levels. Policy-implementers use more practical and applied examples to describe their understanding; policy-makers offer more generalised explanations.

6.1.2.4 Understanding self-management through the tasks and benefits expected for people with LTCs

Generally, self-management required encouraging people to "*cope well with their condition*" (Dom, P-M: 16) and promoting confidence:

> *"…I think it's about building up a network of people who have the confidence to manage their own condition.*" (Quinn, P-I:101).

Characterisation of self-management as improving choice and facilitating greater personal responsibilities was common amongst both policy-makers and -implementers:

> "*I think if* [people with LTCs] *are aware of their condition, if they are aware of the choices that are available to them, I think they will engage in the management of their own condition. I think they'll take responsibility for their own condition"* (Kris, P-I: 22).
>
> And: *"….making sure that you're enabling people to contribute to their care planning and to have that power and understanding and choice*." (India, P-M: 56)
>
> And:*"…if you can do it yourself you've got control, you're enabled, you're empowered, you've got choice. All those things. And I think it helps you understand your condition*." (Rylee, P-I: 43)

Staff participation was also a key factor in success:

> *"On the other side of the coin, I think there's something that we have to do for professionals to promote and create an environment which allows that to happen and move away from the traditional, paternalistic, 'Doctor knows best' culture to a more negotiated and partnership approach to the management of that condition*" (Kris, P-I: 22).

Self-management was defined, then, as a focus on the individual balanced with professional support and partnership. Critically, it meant encouraging patients to take decisions, prevent crises, manage their symptoms and taking medication:

> "*it's about starting to educate them to know what their symptoms are. when to recognise their symptoms and when to start taking their medication*" (Oakley, P-I: 65).

Respondents gave examples of specific technical or condition-specific skills that they saw as important for self-management:

> "*So self-management is knowing how to get information, knowing how to process it, make use of it, how to conduct yourself in a consultation with a health professional confidently so you know how to ask questions, which questions to ask and it's about monitoring…some conditions like diabetes you need to be looking after your blood glucose and perhaps peak flow readings for respiratory diseases. There's a lot of management of more technical things.*" (Dom, P-M: 14)

Three of the policy-implementers interviewed, who were carers and/or classed themselves as having an LTC, offered particularly valuable perspectives, drawing on their own experience to outline the tasks required to self-manage successfully; they emphasised the need for support, improving patients' sense of control, taking responsibility and preventing hospital admission. For example, talking of her son, Jamie (P-I) said:

> "*we have carers there, we have a good care package from social work so I have that back up from them, but I also have the learning disability team and I can link to them at any time and if I have problems with different things I can get support from them without troubling consultants or getting him admitted*" (Jamie: 29).

Other practitioners felt that self-management could/should be taught to patients. NHS Kuzburgh's Chronic Obstructive Pulmonary Disease (COPD) network manager described the benefits of a disease-specific programme of self-management:

> *"So to me it is about educating them. But it's not just about giving them the information or the education, it's about actually taking them on the journey from being dependent to taking responsibility for their own care. With the example of COPD which is the one I've been working on mostly, recently"* (Oakley, P-I: 63)
>
> And "*... it's also about giving them some education to make their quality of life more...fulfilling. To hopefully enhance their functional independence, to make them more independent and for them to understand what they can do for themselves"* (Oakley, P-I: 65)
>
> Finally *"....So what we've tried to do within, COPD is combine the physical activity aspect of it, with the education part. So it's been... it's quite a, it's quite a large programme they've put together."* (Oakley, P-I: 71).

Expectation of patient buy-in and potential self-education, then, is high. Unsurprisingly, this features in policy documentation. For example, LTCAS states in '*Gaun Yersel!*'- (LTCAS 2008), that:

> "*self-management…places people not only at the centre of services but puts them in the driving seat*" (LTCAS 2008: 10).

As early as 2001 self-management was being promoted through programmes of education, specifically the Expert Patient Programme (EPP) (DoH 2001). Initially, these self-management programmes were generic. Latterly, focus has shifted to establishing the effectiveness of disease-specific programmes of self-management. These condition-specific programmes are seen to be more effective in improving patient outcomes; but reality of practice is not always so straightforward: '*getting patients to actually do for themselves*' is counter to the usual role of the nurse (Blake, P-I: 41). Nurses tend to do things *for* patients, promoting dependence rather than enabling independence. A more nuanced view of how to engage patients with LTCs came from this district nurse team leader:

> "*…our remit now should be looking at how can we go into these patients and actually encourage, involve the family, the patient, to take care of their own health with us as a support mechanism. So it's getting away from the culture of it being easier to go in and do the job. Now we have to sit down and say right, it's going to take us a wee bit of time, but the end result will be that a patient will be able to live a bit more independently than they had before*" (Blake, P-I: 42)

The extent to which these varying expectations of patient buy-in have been met is discussed in **Chapter 8**. Policy-makers argue that, as well as educating patients in the skills required, there is a more strategic, wide-ranging purpose to self-management: creating a more patient-focused approach to care. Specifically, respondents discussed how self-management would foster a health service that was tailored more to the needs of patients. For example:

> '*self-management places the person at the centre of the service and gives them the respect, and gives them the support that they need.*'. (policy-maker A06; 88). And: '*we're also focusing on moving towards patient-centred outcomes, so it's what the person themselves wants to achieve whilst living with that condition'* (Kris, P-I: 40).

Anecdotal evidence of being involved in a self-management course called ‘Challenging Arthritis’, showed positive results from patient buy-in:

> *“the course seemed to change something in themselves about how they dealt with and coped with their condition. People who had done the 6 week self-management course seemed, two inches taller, they walked straighter, d’you know they seemed more in control”* (Charlie, P-M: 10).

Self-management has the ability to transform perspectives and improve the quality of people’s lives, this was presented as evidence that it was worth doing.

> *“..I’ve heard or picked-up on again and again from people about the difference self-management makes, because a lot of times people talk about it transforming their lives, transforming is a word they use a lot”* (Gayle, P-M: 32)
>
> And: “*I think the outcome in terms of people’s health is better. I think they are much more able to ask questions appropriately, and I don’t mean that it’s wrong for people to ask questions, but people will now feel that they can ask the right questions to the right people. I think it will give people much more ownership of their own health, so they will take more responsibility and will have less of this reliance on the sort of nanny state for want of a better description.*” (Vaughan, P-I: 113).

Recognition that the gap between expectation of patient buy-in and the long-term reality were more nuanced was also available:

> *“I think unfortunately sometimes self-management is seen as – oh another skill, oh we’ll teach people to self-manage – and I don’t believe you can do that. I think self-management is something that comes partially from the relationship with the clinician, but it’s an internal process. And if we can help people to get to that internal process and understand that then I think it does make people more in control and have more say over their health.”* (Emroy, P-M: 40).

So policy-makers argue that self-management support is effective in improving patient-centredness. This closer modelling of services to patient needs, particularly those with an LTC, could be achieved by promoting key skills so patients felt better able to cope with their condition, negotiate health services and make healthcare work for them. These are skills and benefits worth striving for. However, implementers emphasised that the expectations placed on patients to negotiate, take control and be more involved might not be achievable for all patients with an LTC, a critical finding.

For the greatest impact self-management should work for those with the greatest needs: older patients with an LTC; less well-educated patients; those with more than one LTC; and those who live in socio-economically deprived situations, without easy access to information or on-line material. This exposes a complex reality:

> "*I don't think* [self-management] *is inclusive, I think there will always be people that won't ever manage to get all services…one of the difficulties we see, is not everyone is able to do and manage their own self-care, a lot of people are particularly dependent*" (Fran, P-I: 36).

This lack of inclusivity or understanding how self-management could be inclusive was a barrier to people developing a shared view of its purpose. If self-management does not meet the needs of those least able to help themselves, then the concept appears flawed (see Chapter 8 and 9).

The accounts here show that policy-makers and -implementers generally present a positive image of self-management that brings benefits to patients and is worth working towards. However, there was a tension between this desire to promote individual personal responsibility and concern over how self-management could help the most needy patients.

6.1.2.5 Defining self-management through negative perceptions (setting out what it is not as a means of establishing what it is)

There are potential negative perceptions of shifting the burden of care from the NHS to people and families. Using this some respondents articulated their understanding of self-management by what it was not, or how it might be perceived negatively, as a means of distinguishing change from current practice.

One manager who worked closely with the Coronary Heart Disease and Respiratory Managed Clinical Networks (MCN) offered a negative definition:

> *"…*[self-management] *is not about taking the health service away from them, it's about getting them to be more responsive to their own disease."* (Oakley, P-I: 65).

Other practitioners were keen to describe how self-management could be integrated with existing NHS services to avoid the perception that it meant taking services away from people:

> '*self-management's about having pathways in services available so that patient, before they reach any acute situation, can anticipate and get some help to manage their care, either at home or with the right professionals that may prevent an exacerbation or an admission*' (Fran, P-I: 34).

This point, as we have seen in **Chapter 5**, was emphasised in '*Gaun Yersel!*':

> *"Self-management is the responsibility of individuals. However, it does not mean people doing it alone. Successful self-management relies on people having access to the right information, education, support and services. It also depends on professionals…."* (LTCAS 2008; 8).

The fear of misinterpretation was expressed through discussion of the terminology used in policy documents, and scepticism of the true motivation behind self-management. In particular, policy-makers expressed strong opinions about the terms 'self-management' and '*Gaun Yersel*!' (LTCAS 2008).

> *"I suppose we had a slight concern about calling the document "Gaun Yersel" was that it has the rubric added to it saying that it does not mean going it alone, it comes back to the point that I made earlier about not abandoning people"* (Finlay, P-M : 28)

The term self-management was felt to imply negative connotations: saving money, the NHS shutting down and people having to go it alone. Another policy-maker felt there was a lack of coherence between the concept and the terminology used in policy documents, which could cause confusion. She thought there was too much explanation required and that the sense of partnership, which should be explicit within self-management, was missing:

> *"so the idea that self-management...it's about coping with, living with, dealing with, supporting you to live with. It's a different sense from "Gaun Yersel". I think the idea that the word 'with' is quite key and it's missing in self-management."* (Harper, P-M: 73).

One member of a patient organisation expressed particular scepticism of the purpose of self-management:

> "*I get the impression what they would like to achieve is that people would self manage to reduce the strain on the health services, and on social services, I get the impression that's where ideally they would like to take this…..*" (Marley, P-M: 56).

6.1.2.5.1 Summary

Overall, respondents seemed to have a coherent understanding of self-management, despite significant differences between policy-makers and -implementers in how they expressed this understanding. Policy-makers understood the concept in more general terms than policy-implementers who gave more specific and practical examples of self-management and how its support differed.

Self-management depends on active engagement in health and its management by patients with a different type of input from current practices: ideas of person-centred care and the promotion of individual responsibility. Overall, respondents presented it as a positive concept that brings benefits to people with LTCs; but there were also barriers to patient buy-in, especially for those patients in greatest need or with the severest conditions.

Observational data showed there was concern in understanding what self-management was because it was seen as covering so much; an all encompassing term which might overwhelm those trying to implement it. Interestingly, in the policy documents reviewed there is only one clear statement of how to define self-management; self-management support and self-care. This is contained within "*Gaun Yersel*" (LTCAS 2008) and although there was widespread awareness of this policy document the meanings it set out appear to be insufficient or not go far enough to inform practice.

No single coherent view on the nature of self-management and self-management support emerged. There was a lot of personal interpretation, with people trying to negotiate how this concept could work for them. In the process, both policy-makers and policy-implementers highlighted a paradox in the promotion of self-management which focused on the need to promote personal responsibility and yet not make people with LTCs feel abandoned, or left to fend for themselves. There is further critical discussion of sense-making and its importance in policy implementation respondents in the synthesis of findings **Chapter 7**.

6.1.3 Cognitive Participation – relational work

According to NPT 'cognitive participation' is work which organises the enrolment of participants in a new practice with the purpose of gaining engagement and ensuring buy-in (May et al. 2009). This collaboration and communication is a recognised facilitator of success in the delivery of change and innovation in healthcare practice (Grol 2005). NPT adds more detail to the work people engaged in: what worked and what was less successful.

Evidence is presented here that maps cognitive participation in four areas of work:

i) The creation of organisational structures to promote policy implementation;

ii) The use of quality improvement initiatives to ensure ‘buy-in’;

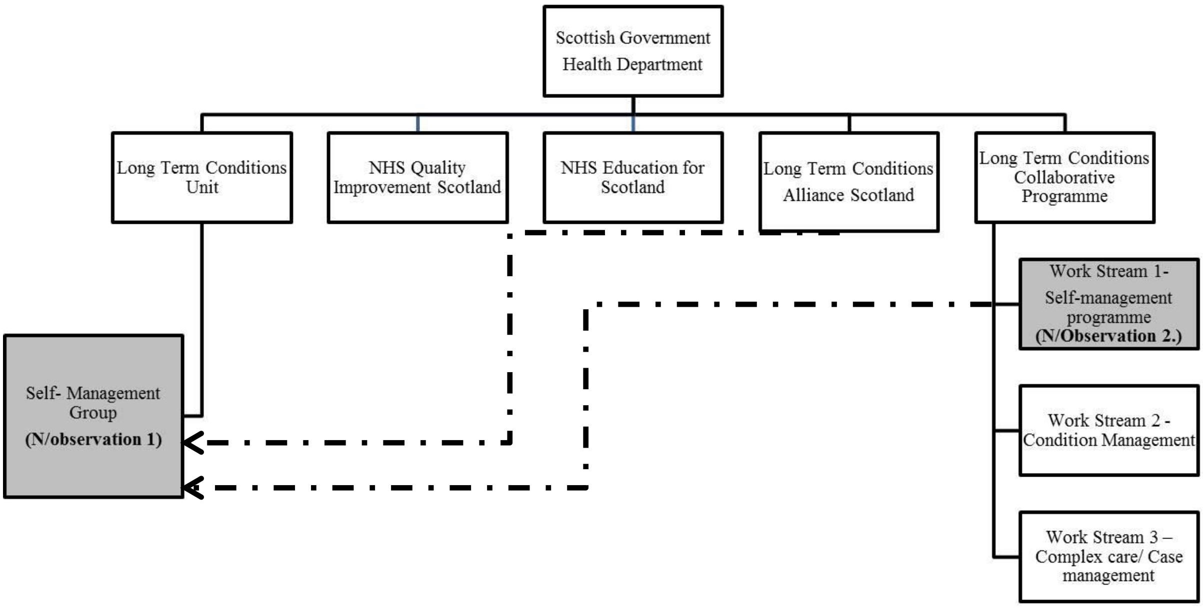
iii) Engaging with key individuals at different organisational levels; and

iv) The novel use of the LTCAS as policy-makers to ensure legitimation.

6.1.3.1 Enrolment - creation of organisational structures to promote policy implementation

As presented in Chapter 5, Scottish policies resulted in the creation of a flat organisational model to support the implementation of self-management policy. But most of the work of national policy implementation was observed in an additional organisational layer. **Figure 6-1** details the national actors and their associated organisational bodies with the observations observed identified in the shaded boxes. The dashed lines indicate which actors/organisations were represented at each meeting.

Figure 6-1 National organisational structure and observations



This structure was mirrored by that of NHS Kuzburgh which is presented later in (**Figure 6-2**).

The LTCU was the key government organisation which, alongside specialist health boards like NHS Education for Scotland and NHS Quality Improvement (now known as Healthcare Improvement Scotland), provided a focus for engaging others and for mobilising resources towards promoting policy implementation, helping to integrate the idea of self-management into practitioners' everyday work. Commonly, the same individuals may sit on more than one of these groups; the overlap of ideas, influences and remits is striking. This was particularly true of the Self-Management Group as indicated by the dashed lines showing that membership was composed of LTCU, LTCAS and LTCC. This was not reciprocated by the Self-Management Programme meeting which was just LTCC staff.

The LTCC, set up in 2008, was seen by policy-makers as the main organisation through which support for the implementation of self-management was driven. It was expected to operate through demonstrations of self-management delivery in practice:

> *So they have been powerful and gone up and down the country with regional events talking about self-management and suggesting ways that they can encourage people to work in a different way and how to change their systems of working"* (Dom, P-M: 136).

It also aimed to guide actions at local levels through quality improvement measures and establish clear lines of communication:

> "*to try and map some of that and make sure that those who are doing well, are spreading and sharing. And those who are not doing so well: get a bit of a boost to lift up. Specifically what we've developed is a small set of improvement measures about self-management to try and get people on a monthly basis starting to lever and drive performance around self-management.*" (India, P-M: 81).

The LTCC mapped the extent of initial enrolment with self-management support through small improvement measures:

> "*And the collaborative sometimes give you fourteen day challenges and, again, it's almost like a reality check and where are we? What's going on? And sometimes you can be quite surprised at the amount of activity that's actually going on in that area so it can be quite beneficial…being able to meet the challenges and recognition of all the work that is going on and being able to capture that, it is beneficial because it keeps the focus and it also communicates the activity to our Long Term Conditions Executive leading sponsor…*" (Kris, P-I: 114)

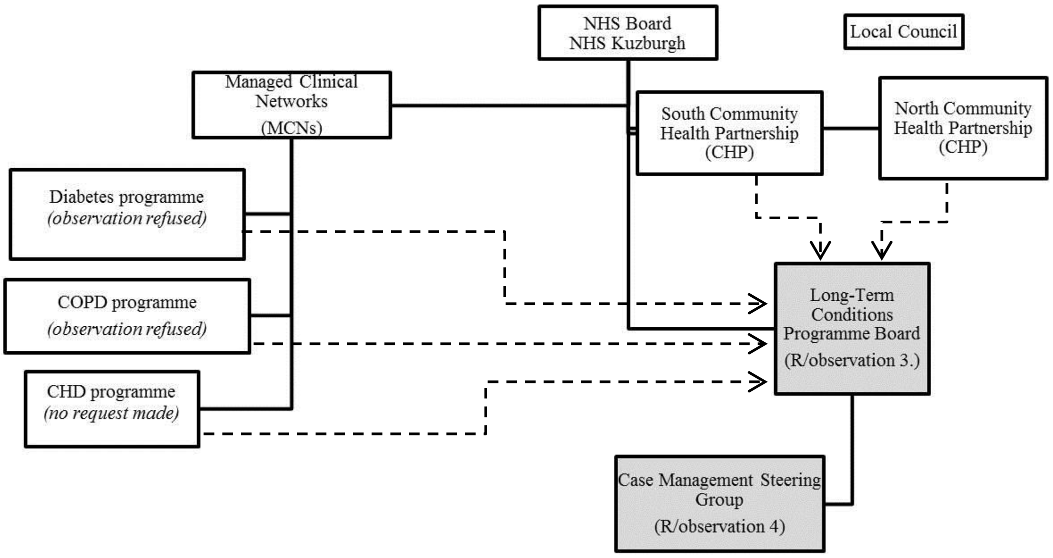
Its success in supporting enrolment was evident from interviews with policy-implementers who frequently cited ideas generated from the Collaborative to guide local activities or monitor progress on actions. For example:

> "*And then when the Long Term Conditions Collaborative came along, I think we've embraced it really enthusiastically, because we were kind of starting from scratch with some of these things, and what's been really interesting to see is when we benchmark ourselves using things like the Toolkit, or our progress in the Collaborative with other health systems, we seem to be doing reasonably well…*" (Paul, P-I: 59).

Local policy-implementers helped shape the LTCC programme. For example, two respondents based within the health board at regional level were employed as Programme and Project Manager respectively, giving the LTCC good reach into local health systems; but this came at the cost of employment of two individuals, for only a three years life span . This meant a financial dependency for the HB.

Figure 6-2 details the organisational structure operating at the regional and local level. The dashed lines again show where representation was shared between groups.

Figure 6-2 NHS Kuzburgh's organisational structure and observations



The LTCC supported the enrolment of health boards in policy implementation through work-streams, and local implementers reported back as members of the LTCC network and in response to 14-day challenges. These tools were used to determine the extent of policy implementation at the regional level:

> *"Nationally the long term conditions collaborative is really key to policy promotion. I'm part of [it], so we kind of nationally report back to them with figures, but locally*

> *I'm employed by NHS Kuzburgh...they've got three work streams: self-management, supported self-management and complex care"* (Pat, P-I: 110).

Participation by health boards was a requirement: LTCCs represented a top-down approach to enrolment and policy implementation.

There is, however, a paradoxical degree of over-organisation deployed to ensure enrolment. The author attended a meeting of the *national* LTCC Team and its members **(National Observation 2)** at which the focus was on local organisations' engagement with self-management. One initiative scrutinised the use of the Boys' Brigade to raise awareness of self-management with young people. The practical element comprised a questionnaire and training towards a Boys' Brigade badge. From this most local level the meeting then addressed the use of one health board area as a site where techniques and applications to improve self-management support could be tested. This demonstration site would provide examples of good practice and enable the sharing of practice from one area to another. This apparent disparity of focus raises significant issues: is this an appropriate use of time, focus and funds?

Regional enrolment initiatives were observed and reported in interview data. The first, already in place before this policy programme, were the Managed Clinical Networks (MCNs) in NHS Kuzburgh, seen as potentially important to enrol clinicians in support for self-management. In total there were three important MCNs – diabetes, COPD and Coronary Heart Disease (CHD). The second, an LTC Programme Board and an associated Steering Group (see **Figure 6-2**), were newly established to monitor local activity supporting self-management, so that local work and progress could be planned, monitored and reported back at national level.

The MCNs were established across NHS Scotland in the early 2000s to promote vertical and horizontal integration of clinical and social care services for patients with one condition across community and acute care settings. By streamlining the delivery of care, MCNs seek to improve its quality, build a multi-disciplinary network to support patients and maximise the use of existing resources. In addition, MCNs are charged with delivering clinical change and service improvement (Scottish Executive 2007b); they perform a role in supporting self-management policy implementation and provide a focus and environment in which self-management might flourish:

> *"…the self-management aspect over the years has emerged naturally, in a sense because I think one of our strongest MCNs is in diabetes and we have been working with patients and families with diabetes self-management programmes. So in a sense these programmes have evolved naturally but nationally policy has now really shifted the focus and highlighted the importance of self-management."* (Kris, P-I: 74).

Existing MCNs were seen to provide an established organisational structure and means of communication which could support enrolment and 'buy-in' within a health board area.

Accounts of the role of the LTC Programme Board in NHS Kuzburgh demonstrated what policy-implementers were doing to support self-management, establishing responsibilities, providing a focus for work and a forum in which to persuade and encourage 'buy-in' though the use of leadership and key champions. Here Paul, a policy-implementer in one of the CHPs, describes the local Project Board:

> "*We have a Project Board for the Collaborative… and we've got a range of people who then are interfacing with national groups. So we've got people like [I09], …people like [J10] of the National Programme, who attends our Long Term Conditions Programme Board on a regular basis and tests stuff out with us. So there's been, you know, there's… certainly our Long Term Conditions Programme Manager is kind of leading the way across the West of Scotland in relation to a range of issues."* (Paul, P-I: 74)

Furthermore, observational data from both regional meetings (**observation 3 and 4**) further highlighted the reach of national initiatives both those directed through the LTCC but also work targeting anticipatory care plans and promotion of ideas of enablement.

In summary, both national and local structures, through existing organisations such as MCNs and the newly established LTCC and NHS Kuzburgh's Programme Board, were seen to be important in facilitating enrolment and 'buy-in' with ideas of support for self-management.

In enrolment there was a high degree of top-down influence supporting policy-implementation, balanced by local interpretation and assessment within which existing organisational structures and networks could be deployed. But elements of micro-management and the spurious creation of new initiatives when the potential of existing frameworks was not being maximised reveals tensions between structure and functionality.

6.1.3.2 Activation - how participation in the policy programme is sustained

If enrolment is key to establishing the potential for self-management of LTCs, then its sustainability is the test of ultimate success. Alongside enrolment, the LTCC supported 'buy-in' to policy supporting self-management through the use of Clinical Quality Improvement (CQI) strategies. The LTCC was a 3-year (2008-2011) quality improvement initiative established to change the way care is provided for people with LTCs including the promotion of self-management. It advocated the use of practical methods and tools to deliver improvements, used by policy-makers to encourage health board participation:

> "[LTCC] *is a specific improvement programme. It uses improvement methodology and continuous quality improvement. And the delivery is about small tests of change and rapid tests of change"* (Jay, P-M :68).

If the LTCC could be criticised for operating in a top-down manner, respondents did not reflect such attitudes. A national leader of the LTCC argued that their approach was not about imposing ideas; it would only work if there was support and direction from the local policy-implementers:

> *"It's crucial that the improvements are developed and shared by the local teams, but supported through the national programme. I think it's always a balance…and it*

> *needs to come from the ground up, or it wouldn't ever work, it wouldn't ever work if it was coming from the top down. It's not a mandatory programme..."* (Jay, P-M : 86).

Three CQI strategies, that Brennan et al. (2009) suggest are commonly used in healthcare to change practice and systems, were identified: LEAN principles to reduce waste in clinical practice; the use of PDSA cycles to test out small incremental changes; and the implementation of LTCC's '14-day challenges' targeted at patient-care. Their effectiveness was acknowledged by policy-implementers:

> "*And sort of steps for change using the 14 day challenges that we keep getting and that keeps you on the ball and you've got to get that done. Plus we have taken on elements of the LEAN approach and the PDSA cycles. We've actually put two district nurse teams, who are keen for change and put them through LEAN as promoted by the collaborative*" (Quinn, P-I: 206)

For practitioners such as this District Nurse team leader the experience was positive:

> *"Here in Carwell we have been 'LEANed' and I have to say it has been the best thing since sliced bread. It's given us the opportunity to see the time we've wasted...and basically that's time we can put back into the patients. It has also allowed us to challenge our case loads"* (Blake, P-I: 115).

Here are examples of policy-implementers, including local practitioners, using ideas initiated by policy-makers, to test and implement change. Policy-implementers described clear links between organisational levels and ideas-sharing, reflecting the means by which inert policy ideas were turned into action. This is a positive example of the process of policy implementation; but these are short-term initiatives, unrepresentative of the embedding or sustainability of new policy. The LTCC was in place for 3 years and the challenges were to be delivered over 14-days; but there was no evidence that the changes tested lasted beyond these timeframes. This concern over the short-termism was evident in regional observation data. For example, at the Care management steering group (**R/observation 4 March/2010**) attendees discussed the work to meet 14-day challenges as drivers for change and action; but queried how could these ideas be sustained and embedded into practice. The extent to which these findings impacted on the embedding and integration of policy.

6.1.3.3 Initiation – are key individuals willing to drive the implementation?

The importance of key influential individuals in engaging with implementation is recognised in NPT, where their involvement helps to demonstrate the workability of a new initiative (May and Finch 2009). Similarly, in academic debates of change, management and policy implementation, individuals' willingness or resistance to lead or champion new initiatives is central to policy success or failure (for example, Pettigrew et al. (1992), and Everet Rogers (1995a)) and pinpoints the importance of "*early-adopters"* in the diffusion of innovation. Weick and Quinn (1999) highlight the role of change-agents, the '*prime movers who create change*' (Weick and Quinn 1999: 366). Lipsky's (1980) theory of street-level bureaucrats identifies the power local implementers can exert on policy-implementation, for success or failure. More recently Tummers and colleagues (2012) show the need for professionals to be willing to implement to achieve policy performance.

In these data the importance of leadership, champions and local interpretation of policy by key individuals was a frequent theme. Recognition that key individuals should have expertise in self-management is common. However, policy-makers wanted a distributed approach to leadership: one not solely associated with the Scottish Government. They sought to involve both national leaders and other sponsors and to use this network to establish leaders in each health board:

> *"I think it has to be a very distributed form of leadership for change. And I think we're looking at the national leaders, such as [Charlie] and [Dom] in here, Long Term Conditions Alliance leads, the Alliance for Self Care research leads. But I think the collaborative has a role, although I don't have the same level of expertise in self-management. We have a role of spreading that expertise. But at a health board area, then we're looking at having, and the model I've been punting, is the model of distributed leadership, where you've got a lead for long term conditions in a board area."* (India, P-M: 52).

At a local and regional level this distributed leadership was implemented through a local programme manager (Reece) and project manager (Pat) placed to support the work of LTCC in NHS Kuzburgh.

Local implementation of self-management policies was reinforced by new leaders in NHS Kuzburgh acknowledged as bringing clear direction:

> *"P16 came to us two or three years ago from Wales. And he came in with a fresh look alongside a new Chief Executive, [name of Chief Executive]. Now they came in with a fresh look at Kuzburgh, came in with no pre-conceived ideas."* (Nell, P-I: 273).

The local model of distributed leadership was encouraged from the top and supported by targeted funds. Financial support allowed two clinicians to be seconded from NHS organisations to the Scottish Government LTC Unit:

> *"You need a range of leaders. And I think it's really helpful that we have a national clinical lead for self-management in the Scottish Government as well, who is somebody who is there to give expert advice and support and guidance as well."* (Jay, P-M: 96)

Clinical leadership has brought a degree of expertise and credibility which has helped win people over. In work by Ham and colleagues (2003), examining the implementation of NHSEngland's national booked admissions programme, clinical champions were shown to be effective in winning over reluctant colleagues. My data show that clinical leaders wield significant influence which persuades others to 'buy-in' and support self-management:

> *"I'm thinking about the, two COPD/cardiac and diabetes self-management programmes, were both mainly led by clinicians. They were seen as someone who had credibility among their colleagues' to be able to develop that understanding and that this was the right direction to go in, but was also leading the MCN who could be the vehicle to pull together what was needed to deliver self-management"* (Reece, P-I: 117)

As well as leading by example, clinical leaders understand the system and are able to exert influence when securing funding. As one MCN manager explained:

> *"*[name], *who was having these big stakeholder meetings, had said we need more of this self-management stuff, and getting the ear of the right people and persuading them that funding should be made available. And not everybody would sign up, the funding comes from a number of different places, and not everyone was amendable to that funding to be put into the pot. So that was a difficult negotiation."* (Lennon, P-I: 106).

The extent to which clinical leadership which can also be translated as policy entrepreneurs (Oborn et al. 2011) is discussed in **Chapter 8**.

Leaders were identified by name in interviews and respondents explained their role: for example, chairing project boards or executive-level responsibility for 'LTCs care' and/or 'self-management':

> *We have a Long Term Conditions Programme Board which is chaired by our CHP director and executive lead for long-term conditions, and I think having that level of support and leadership highlights the importance of the long term conditions work and how it is absolutely integral to core business."* (Kris, P-I: 28).

By involving managers in leading self-management a positive organisational culture emerges, enhancing engagement and promoting policy implementation. Through formal authority, control of resources and possession of information and expertise, managers were shown to promote or block change. In these data, managers were seen to be useful in promoting policy-implementation.

Manager's role in engaging front-line staff and local champions was also important:

> '*Well I think if you don't have champions it will never work, you know, if you keep doing what you've always done you'll get what you always got, kind of stuff, so there's no doubt we do have a number of champions in the system*.' (Vaughan, P-I: 77).

These data provide evidence of leadership, particularly that of strong clinical leadership amongst policy implementers.

6.1.3.4 Legitimation– do people believe it is right for them to be involved?

NPT suggests that for people to engage in a new practice they should identify it as: legitimate; conforming to their standard; offering a high degree of quality, and worthwhile (Mair et al. 2012). Policy-makers and -implementers taking part in this study saw self-management as entirely legitimate; that it was '*right and proper*' for them to be involved.

Self-management policies were described as a needed change where a high level of awareness was reported:

> "*I think that there's an increasing awareness of self-management as a policy, I think generally clinicians in services and other people working in services are very aware of the need to be supportive of people who want to and can self-manage. ... I think our experience working with this programme has been that this is not a new idea to people. But it's something that they're grappling with in terms of how do, I change my practice.*" (Jay, P-M: 38)

Legitimation was achieved by involving policy-makers beyond the cohort of civil servants. Inclusivity was a key feature of the primary policy statement *'Gaun yersel!'*:- (LTCAS 2008), authored by a voluntary sector membership organisation, LTCAS - now Health and Social Care Alliance Scotland - which does not provide services but acts as an intermediary between people with LTCs and the Government. This novel approach was significant in establishing the legitimacy of the Scottish Government's initiative, exemplified by the genesis of *'Gaun yersel!'*:

> "*The CMO* [Chief Medical Officer] *has been keen that we try to do this in an innovative and imaginative way and not just set up expert groups that produced worthy reports that then nobody paid any attention to. So when he took up post he was very keen that we should organise these open space events that took place with the help of the Alliance And out of that came our report called Living Well with Long Term Conditions, which sets out the general principles about the kind of approach to long term conditions management that people with those conditions are looking for. Self-management was part of that. And stemming from that we very much encouraged the Alliance to think about developing national strategy for self-management specifically and they were very pleased to do that. So we now have this strategy called Gaun Yersel!"* (Finaly, P-M: 26).

Policy-implementers appreciated the less formal approach to policy which '*Gaun Yersel!'* represented (LTCAS, 2008). It appeared to make it easier for them to involve others and '*sell the idea*'.

> *The significant problem that you've got this sort of top down stuff and you've got to shove the ideas into the organisations and there's a few ways of trying to do that and it's sort of publicly publishing something called* Gaun Yersel*, you know, which…, it's not a professional language that that's in. …And that sort of drives it down towards people and it gets you away from this sort of official governmental-ees*" (Sidney, P-I: 72).

However, local policy-implementers' accounts varied. Those involved in central policy development or who worked at the executive level felt that self-management was easy to legitimate, whereas those who had not were more equivocal. Some local policy-implementers within the NHS Kuzburgh appeared disenfranchised:

> "*there was another Scottish Government document came out, "Gaun yersel" I attended that launch but I've never heard anything about it since… I mean the document's sitting there and I do actually sometimes go back to the document for references and things but that's where the sort of policy ends if you like and our development of it begins. There's nobody really asking us now…*" (Berni, P-I: 85)

Observational data highlighted how contradictions between policies, particularly those which appeared to be on the boundary between social and health care, also undermined legitimation. At the Care management steering meeting (**R/observation 3 April/2010**) attendees felt that they were being asked to implement one policy which appeared to contradict another, creating a barrier to implementation.

In contrast the experience of local policy-implementers working in voluntary organisations revealed close engagement and a belief that their involvement helped secure the buy-in; they felt able to contribute to the local process of implementation. They were represented on project boards and were sought for their expert knowledge and local contacts:

> *"We have a local health board who are trying very hard to work along with the Carer Information Strategy and they're achieving - we are achieving together. We've got*

> *databases in there now which can tell us, the age range of the carers, what their roles are, who they're looking after, how long have they been doing it. How it affects their health."* (Nell, P-I: 63)

Legitimation was high among policy-makers and regional level policy-implementers within the NHS and voluntary stakeholders. Front-line clinicians and local policy-implementers felt disenfranchised and confused by prioritisation and here legitimation was weaker. At this level the advantages and effectiveness of self-management were less apparent, seen as a potential implementation weakness (Greenhalgh et al. 2004).

6.1.3.5 Summary

Interview and observational data illustrates how work aligned to NPT's 'cognitive participation' sustained staff involvement in implementing policies for self-management support through different actions. These included the use of CQI strategies designed and initiated through the LTCC and which, although associated with a national organisation – LTCC – was not seen as didactic. Regional and local policy-implementers found the LTCC guidance helpful and considered it more facilitative than instructional. The tools and techniques suggested by the LTCC were used actively in NHS Kuzburgh.

Leadership sustained involvement and was seen to be important to the implementation process, providing support and advocacy for the new idea and generating awareness which promoted 'buy-in'. National policy-makers and regional policy-implementers recognised the importance of leadership, promoting its importance.

Policy-makers were successful in ensuring that legitimation embedded self-management beyond policy documentation. They talked of "*running self-management principals through all standards and guidelines*" (Harper, P-M: 27). This re-enforced a positive view of self-management at policy-making level but clarity and participation were weaker at the implementation level. Here involvement was frustrated by practical barriers such as contradictions between policies and a perception of short-termism.

The LTCAS's authorship of the Self-Management Strategy for Scotland (LTCAS 2008) ensured wider participation in the initiative by bringing the voice of people with LTCs to the heart of policy-making helping to make it less formal and more usable.

Regional policy-implementers recognised this approach to policy-making and appreciated its legitimation of the concept. However, local policy-implementers, specifically clinicians, were less impressed. Although they felt included when the idea of self-management was debated at the outset, as the initiative gathered importance and became part of the management agenda, they felt disconnected and less inclined to participate. This barrier to implementation was hidden from policy-makers.

6.1.4 Collective Action - enacting work

Francis Mair and colleagues (2012) define collective action as the work performed by individuals, groups of professionals or organisations to bring a new idea into operation. Interview and observational data show that enacting work focuses on organisational issues, with additional work directed at patient engagement and increasing staff skills to deliver self-management.

In NPT four components of collective action are identified: skills-set workability; contextual integration; interactional workability; and relational integration (Mair et al. 2012).

6.3.3.1 Skills-set workability – how does self-management affect roles and responsibilities or training needs?

A model based on self-management requires care to be organised differently from traditional practitioner-led, episodic approaches (see **Chapter 1Figure 1-1**). It necessarily affects the roles and responsibilities of practitioners and patients; and training is needed to adapt to changes.

Implicit in the concept of self-management support is an expectation on patients to contribute directly to their health status: patients need information, support and motivation to do this effectively. Here Emroy as policy-maker in a specialist health board illustrates these general changes in the responsibilities of a patient with a LTC:

> "*Self-management is about people developing their own problem-solving approaches. Now, they might still need that assistance in terms of managing a particular symptom, but then managing the other aspects around that will have to be problem-solving and motivational stuff coming from themselves, and I think that's where self-management becomes a bigger thing than it's often acknowledged as*." (Emroy, P-M : 56)

Policy-makers identified changes in the patient role in terms of motivation, empowerment, confidence, decision-making, responsibility and enablement, often encapsulated as '*helping people to live with a long term condition*' (Finlay, P-M: 20).

The broad argument presented by policy-makers did not articulate in detail the exact nature of the role or responsibilities expected of a self-managing patient. In contrast, policy-implementers were working in practical ways to help patients become more proactive partners in care, helping them to learn about their condition, manage their symptoms and understand what to do if their condition deteriorated.

The use of the diabetes patient education programmes was particularly helpful and an example of policy in action:

> "*For individuals I think self-management programmes can be transformational, … In Kuzburgh we're running the DAFNE programme for type 1 and XPERT programme for people with type 2 diabetes. They seem to give them, I'm not fond of the word, 'empowerment', but it really does empower people to take control and then they become the experts in their own healthcare and the management of their own condition.*" (Lennon, P-M: 22)

Policy-implementers' translation of policy into action included initiatives to support pulmonary rehabilitation programmes and a telehealth pilot, both for people with COPD.

If practical support given to patients was valued by regional policy-implementers, these initiatives were not available to all eligible COPD patients across the health board area and the funding on which they operated was short-term. Consequently, their reach was limited and, even though they were seen as helpful, their continuation is uncertain. These data highlight both important challenges in policy implementation and considerations for sustaining and embedding policy longer term.

Practitioners were trying to deliver new models of care but were frustrated and disappointed because these initiatives did not appear to be sustained or embedded:

> **Interviewer: What will happen to the pulmonary rehabilitation programme?**
>
> *We'll continue it in some shape or form but the community classes will be cut. So we're hoping to maintain one community class per hospital site, so there will be a hospital class and a community class. A disappointment to everybody* (Casey, P-I: 102).

Respondents also reiterated that staff would need support to develop their skills and roles to support self-management. Policy-makers suggested up-skilling in relation to improved communication with patients and the management of consultations:

> *".. there are a lot of things that we want to do, whether it’s around the training that the health professionals get in terms of managing a consultation with somebody with LTC or allowing people access to their medical records and their care plans ... To support this the Alliance is planning to have a small number of strategic grants which could be as much as £150,000 a year. .. So that's the main piece of work that we're doing around promoting the policies.*" (Finlay, P-M: 46).

Recognition of the importance of collectivity is apparent in some of these processes; for example, educational support; but, for example, work to promote clinical engagement received less consideration despite its recognised importance:

> "*I think we need to support it* [self-management] *educationally …, so both NES and Quality Improvement Scotland have a role in supporting the education and practice development for staff to empower and support people*." (India, P-M: 14).

Further evidence of training support is provided by my observation of the 'Self-management Strategy Group' **(N/Observation 1 Sept/2009**) which focused on training for staff and how, in current projects, it could be supported. The group discussed specific examples, including NHS Education for Scotland undertaking a learning needs assessment; financial support of up to £10,000 per Health Board to promote training in 'communication and human relationship skills'; and an e-health portal designed to allow patient access to information on medication, requests for repeat prescriptions, input personal data and request appointments. This was being tested with two groups of patients, one with diabetes and one with COPD in a single health board area, as an example of good practice. The need for changing roles, particularly those of clinical staff, and relevant training in clinical engagement, was well understood by policy-makers:

> "*One of the most important things is clinician engagement. We need nurses, AHPs, GPs, staff in the NHS to really understand the difference it* [self-management] *can make. If they – if they can grasp what a powerful thing it is to work with patients alongside them and to, and to shift the balance in a face to face consultation*." (Dom, P-M: 82).

Policy-makers wanted to draw practitioners in to create collective action at practice level through education and training; and policy-implementers also recognised that they needed new skills to make self-management work: brief interventions and motivational interviewing (Lennon, P-I: 68); carers' awareness training for staff (Nell, P-I: 95); training in care management for District Nursing Staff (Eddi, P-I: 27) and additional courses around specific LTC such as COPD (Logan, P-I: 114). Local policy-implementers record that this type of training and knowledge supported change:

> " *...I've had a girl in my team who went on to do her diploma in COPD. Another girl went on to do her certificate in cardiac rehab. So these people who have done*

> *training of more recent times definitely have…you know, they're contributing towards the change.*" (Logan, P-I: 114).

Further evidence of training or up-skilling, improving awareness of and collaboration in self-management, is provided by the author's observation of the 'NHS Kuzburgh's LTC programme board' **(R/Observation 3 Dec/2009)** at which seven projects and their work plans were reviewed. Three specifically targeted training or information-sharing to promote self-management: a 'Kuzburgh Directory of Services', an online resource designed to provide practitioners with a central point of advice on local services in the care and management of long term conditions; training delivered by the Pain Association Scotland; and a self-management toolkit called 'the pain companion'. These initiatives plus the work mentioned previously for patients with COPD and diabetes show how policy-implementers used opportunities for training and education to promote self-management in this Health Board area.

Evidence for effective collective action in developing skills is yet to be assessed by evidence-based research. This has implications for sustainability. In addition, a complex relationship between policy goals and reality offers lessons for all stakeholders.

6.1.4.2 Contextual integration – is there organisational support?

Accounts from policy-implementers demonstrate a high degree of organisational support for the idea of self-management in contexts where inertia might have been anticipated. Furthermore, a number of contextual aspects relevant to NHS Kuzburgh also ensured that enacting work was more easily undertaken.

According to O'Toole Jr. (2000), policy implementation or "*action on behalf of policy*" is affected by a number of context-specific issues which emerged from regional and local accounts reflecting 'top-down' drivers from policy-makers and 'bottom-up' issues specific to time and place. Informed by the accounts and observations, I identified four influences of particular significance

i) Historical context: previous efforts to re-organise health services;

ii) Geographical context: the physical landscape of the health board area;

iii) Societal context: changing population needs;

iv) Organisational context: influences specific to NHS Kuzburgh.

Historical Context: Between 2005 and 2007 NHS Kuzburgh underwent a complicated and ultimately unsuccessful internal health strategy review. The review's purpose had been to encourage services to focus more on health improvement; review who delivers care, specifically encouraging more of a partnership approach; and deliver more services locally. Although NHS Kuzburgh’s review was unsuccessful because of political objections to the plans for centralising of services, accounts indicate that policy-implementers were still looking for ideas and actions which would help meet these goals; and the implications of the experience of 2005-2007 were still being felt. Interviewees referred to NHS Kuzburgh being “..*‘strategy free’, not quite sure what direction it was actually going in*.” (Paul, P-I: 116).

Respondent P16 went on to explain how the Kuzburgh board responded, to assert a strategy in the local healthcare system;

> *“…And I think that raised the profile of the fact that there was a need for a strategy. And I think that brought both general practitioners, district nursing teams, health visiting teams along, and there was a need to up the game, and in upping the game, resources will start to become available, so actually you could start to switch the balance between acute services and primary care services.”* (Paul, P-I: 116).

But a local policy-implementer recorded mixed success:

> *"We are bringing some services out of hospital. A lot of the resources are not shifting and that is a frustration"* (Pat, P-I: 240).

Having experimented unsuccessfully with promoting better use of resources, improving patient experience and reducing infrastructure costs, NHS Kuzburgh seemed to be looking for ideas to help promote patient independence and maximise effective resource use in other ways. Self-management was identified as a solution and a policy which emerged at the right time, in the right place.

Geographical Context: NHS Kuzburgh serves a mixed urban and rural population so that access to services is not spatially consistent. The organisation wanted to demonstrate how it was working to enhance community infrastructure and improve access to services over its whole area. The impact of local geography influenced the responses and uptake of policy:

> "*there's quite a big urban community and there's quite a large rural area which is relatively under-populated. And I think these towns stuck out in the middle of nowhere have an identity whereas places like East Quarter and Home Town, they are bigger and they don't have much of an identity, people don't have an attachment to these places and have a poor social view of themselves… things don't develop so well in areas with a poor identify of themselves."* (Sidney, P-I: 258)

The organisation had to recognise the impact of local economic geographies on demand for services in developing a new system:

> *"One of the things we've worked very hard at in Kuzburgh over the last two or three years is integration of services, and it's an integrated approach both from acute and CHPs making sure that we work together. Within this we have to recognise that the west Kuzburgh CHP is more affluent than the east and with a different, less illness burden, but even within the west there are areas with high disease burden as well."* (Taylor, P-I: 147).

Reconciling these geographical differences seems to motivate local implementation of self-management policy, as a driver encouraging collective action and supporting implementation.

Societal Context: For regional policy-implementers, the ageing population within NHS Kuzburgh and beyond also represented a drive for collective action. Realisation that the status quo was no-longer an option was an important influence on self-management policy:

> *"we've got an ageing population, there's no getting away from that and.. we have to target resources appropriately. I think resources are going to be so stretched that you couldn't… we probably can't survive if we had the traditional way of managing people with long term conditions."* (Quinn, P-I: 72).

A disparity has emerged between priorities expressed by policy-makers and regional and local policy-implementers who identified a growing and ageing population with LTCs and potentially too few people to deliver the care. For the latter, concern over health inequalities and the poor health of certain populations was a stronger contextual influence. The implications of this point of contention between policy-makers and policy-implementers is discussed in **Chapter 8**.

Organisational Context: A key organisational feature to emerge from policy-implementers was the importance of leadership, evident in accounts identifying executive team leadership and that provided by the MCNs. As noted previously local MCNs were identified as potentially important to the enrolment of clinicians in support for self-management and as influential through the clinical leadership they represented.

The leaders in the executive team were new at the time of the interviews and brought clear direction and innovative ideas:

> *"P16 came to us two or three years ago from Wales. And he came in with a fresh look alongside a new Chief Executive, [name of Chief Executive]. …, came in with no pre-conceived ideas."* (Nell, P-I: 273).

Alongside this new team was an established pattern of network care delivery through two MCNs which, as well as being important to contextual integration, were also relevant in promoting enrolment.

Discussion of the importance of the new team and the citing of the work directed by the MCNs illustrates that people did not always reflect on new work to illustrate how policy was being integrated. The appointment of the management team and the role of the MCNs were in existence before policy promoting self-management. Instead, they reflected on how they sought to match policy ideas to projects or activities which clinicians or managers were already doing. This was most obvious when discussing how the MCNs built and developed the idea of self-management which appeared as a 'close fit' with work they were already engaged in:

> *"I think the local context for us was more important than the national strategy, I think that was more of a driver. I think it was nice that this was all happening, and we stood up in public and told people about the diabetes self-management programme and made it look like it fits, but that's one of the tricks of management in the NHS"* (Lennon, P-I: 106)

P16 recounted how certain ongoing initiatives fitted with the promotion of self-management. He talked of the importance of "*tying-up ideas*" (Paul, P-I: 38). Seeking the best fit and working to adapt with what is available emerged as an important response to policy implementation.

In contrast, local policy-implementers, those in practitioner roles, did not see the organisational context as quite so conducive to the adoption of policy as the regional respondents. Of particular concern, and reported by two of the District Nurse Team leaders, was a change in the CHP management structure which was ongoing at the time of the interviews. This added an air of uncertainty which directed peoples' focus elsewhere:

> *"So we've got these General Managers and there'll not all be jobs for them and we've got Service Development Managers, there's twenty odd of them and there's only going to be x amount of jobs. So there's a lot of discontentment on the ground."* (Blake, P-I: 191).

Policy-implementers wanted to explain the local context. They described the uniqueness of NHS Kuzburgh in terms of both what had gone before (previous attempts to review local healthcare strategy), its geographical differences and their receptiveness to implementing policy promoting self-management. In addition, day to day organisational matters were recognised as important, some in a positive way (leadership and the role of MCNs) but some as barriers to implementation of self-management policy (e.g. service re-organisation). Significantly, the influence of organisational issues on the integration of self-management policy appears more complex for regional and local implementation than for national policy-makers.

6.1.4.3 Interactional workability – does self-management make people's work easier?

In NPT the term interactional workability refers to 'ease of use' (Mair et al. 2012) a concept specifically tailored and tested in relation to e-health systems onto which self-management is not easily mapped; it is a more diverse concept, but accounts from policy-makers revealed that work was being undertaken to demonstrate how self-management could be supported and made easier to implement. The data revealed three initiatives:

i) Patient experience and the use of people's 'stories';

ii) Targeted financial investment;

iii) Promoting examples of good practice from other health board areas.

Patient experience and the use of people's 'stories': Scottish self-management policy was significantly influenced by the experiences of people LTCs:

> *"In Scotland our policy is being driven along for long term conditions by people who have got a long term condition*" (Dom, P-M: 74).

The Government's close collaboration with organisations such as the LTCAS revealed its commitment to using patient experience to influence and drive policy. Patient narratives demonstrated the personal impact of current service organisation and highlighted the importance of seeking alternative approaches:

> "*… to hear scenarios of 'I went there and then there and then there and then the bus fares', you know the detail of how it really impacts on peoples' lives is very important and when that is delivered in a powerful way with, well the members of the board that we have contact with, they are fantastically eloquent. And when they are delivering that message at the board and with the Chief Medical Officer sitting there it does have a big impact"* (Dom, P-M: 76).

The experience of voluntary sector partnership and use of personal testimonies became powerful, albeit non-traditional, levers of change:

> *"We've been explicit all along that we want to draw on the direct experience of people living with these conditions as one of the most powerful levers for producing change. I think we shouldn't underestimate the power of people's stories"* (Finlay, P-M: 60).

This experience was reinforced by India, a policy-maker:

> *"I think what makes the biggest difference, is hearing lived experiences of people with long term conditions"* (India, P-M: 46).

Patient testimony generated a high level of interest for both policy-makers and -implementers, drawing an emotional response which prompted policy-implementers to believe that self-management was workable and worth pursuing.

The involvement of patients and their stories was widely observed in accounts from regional and local policy-implementers:

> *"I think it's easy for clinicians to sit and try to paint a story for other people, but actually when you hear it from a patient, it is ten times more powerful…Its been a really important lesson for me seeing how important the voice of the patient is in spreading the message"* (Taylor, P-I: 173)

In a later account Paul, a CHP Director, was clear that this personal insight was an instrument for change:

> *"I think one of the most interesting mechanisms in changing practice are these digital stories that we are seeing"* (Paul, P-I:136).

Through patient involvement and stories policy-makers and -implementers were able to promote the workability of self-management. These stories were from people who had benefited from self-management initiatives and provided evidence that it worked. This approach offered a novel opportunity for evaluation which could have been developed to support, sustain and embed self-management. Evaluation and determining what works or does not work is explored further in **Section 6.3.4**.

Financial investment: Policy-makers were aware that with targeted financial support self-management could be implemented. At the policy-making level the main beneficiary of this investment was the LTCAS, which was able to increase its capacity to support the organisations it represents. It also received Government support in the form of a '*Self-Management Fund*' directed to increasing capability within the voluntary sector to support self-management skills. A member of the LTCAS acknowledged how it helps them to deliver the strategy set out in '*Gaun Yersel*':

> *"Well, I mean, they're* [Scottish Government] *very supportive of our organisation; they've funded [us] to deliver the self-management strategy and in itself, I think, is a huge thing really, because they're committing to that partnership"* (Alex, P-M: 222)

So financial backing from the Scottish Government was a means of getting people to "*buy into the idea of self-management*" (Charlie, P-M: 128). In turn, policy-makers recognised financial support as an important component in supporting policy implementation; here it was being used in a very direct and targeted manner.

At a meeting of the national 'Self-Management Strategy Group' (**N/Observation 1 Sept/2009**) the author observed that the focus of discussion was the 'self-management fund', cited as an action in the Self-Management Strategy. The fund was an allocation of £4 million over 2 years designed to promote capability and capacity within the voluntary sector to provide self-management support and education. Access was achieved through a competitive bidding process which considered proposals led by either a voluntary sector organisation individually, or in partnership with a social or health service team. Evidence from policy-makers showed good engagement in this initiative from the voluntary sector but less from health and social care representatives. Although it was designed to generate awareness, promote partnership working and show the benefits of self-management, its reach was limited by restrictions imposed on the application process:

> *"… we did explore it [the self-management fund] with a couple of individuals … but they weren't actually a recognised group. They would have been keen to work with us if we had taken the lead on it, but we couldn't do that because of the bidding process… which was really unfortunate, because we're keen to push and drive self-management, but the nature of that bidding process, meant that couldn't"* (Reece, P-I: 92).

This narrow uptake was felt to act as a barrier to implementation: an important lever of change was not having the desired impact.

Examples of good practice: these were used to demonstrate the possibilities of self-management, to illustrate what was possible and show how self-management approaches could best be used. As one policy-maker from the LTCAS explained, it was:

> "*a bit like showing what self-management would be like if it succeeded*" (Alex, P-M:56).

Key to demonstrating good practice were the actions directed by the LTCC, who identified one of their roles as sharing and spreading good practice as set-out in the policy document "High Impact Changes" (Scottish Government 2009). It contained ten desired changes and illustrated the actions needed by reference to practical examples.

Accounts from policy-makers working in the LTCC provided further support for the use of examples of good practice as a means of promoting self-management:

> *“…. it’s still pockets of good practice, so we’ve still got the challenge of scaling that and spreading it. But in every health board area now there’s examples of good practice, it’s not spread across all conditions. Somewhere there’s good practice in a single condition, and our challenge is to move that from the local champions to…that’s just the way we do our business.*” (India, P-M: 44)

Policy-makers hoped that presenting examples of good practice would induce what they termed “*cross-fertilisation*” (Finlay, P-M: 42): change would be supported by showing cases where self-management had worked well and ideas would spread from one area to another. The use and impact of drivers and incentives supporting policy implementation was an important aspect of this policy story.

6.1.4.4 Relational integration – do individuals have confidence in self-management?

Elwyn and colleagues (2008) argue that, for a new initiative to be fully integrated into routine practice , health professionals and others need confidence in new ways of working. Where it is lacking practitioners are reluctant to integrate the new practice (Mair et al. 2008). In my data weak evidence supporting the efficiency of self-management is cited as a serious challenge.

> “*The evidence base for self-management ... is in reality less well developed than it is for other areas of health and that is something that acts against taking forward change in this area, particularly for people who have a more medical model of research and looking at evidence*” (Jay, P-M: 136.)

Implementers shared concerns on the lack of evidence:

> “*And if you have this blanket belief that self-management works and therefore you don’t have the critical faculty which says, actually, we’ve got to look at how that intervention is delivered and what it is….You’ve got to prove it works.*” (Sidney, P-I: 206)

Policy-makers committed to self-management wanted to promote a different kind of evidence to support and raise confidence in implementation:

> “*I think we need to be very careful in that some of the clinical community historically looked at randomised controlled trials at that kind of evidence base. I think we’re looking at much more action research and lived experience and sharing what works*

> *at a personal level. So while we're keen to help support and implement evidence based practice, it doesn't have to be based on randomised controlled trials.*" (India, P-M: 139)

The absence of robust evidence was recognised as a barrier to successful integration of self-management.

Confidence in self-management was also said to be weakened by practitioners' concerns over its safety. Practitioners were anxious to balance promotion of independence with the need to ensure no harm comes to patients:

> "*It shouldn't be a one size fits all, because I think we would all recognise, as clinicians, that the patients have different strengths and some have a better understanding than others and some are able to manage, and I think particularly where there's really complex co-morbidities, we shouldn't assume that patients are going to be able to self- manage as effectively. ... It's something about a safety net, making sure that we have a safety net so practitioners are still picking up signs that need medical attention."* (Taylor, P-I:55).

To some, supporting self-management represented a loss of power for clinicians:

> *"I think there is something about clinicians… it is really to do with perhaps medical clinicians thinking that if this gets managed by non-medical people and we allow the patients to look after themselves then they won't do it as well as I can… So there's that loss of power" (Sidney, P-I: 304).*

One can see an analogy in the way that legal justice works and in policing, with increasing use of civilian, non-specialist workers such as Community Police officers: more tensions and perhaps defensive occupational behaviour.

A new initiative, such as self-management, which challenges existing practice, requires clinicians onside for it to be integrated and embedded in healthcare delivery. Grol et al. (2005) and Greenhalgh et al. (2004) acknowledge the influence that target groups of professionals have on the success of change or innovation. Their buy-in is a positive and significant factor in the adoption of a new idea (Greenhalgh et al. 2004). Here clinicians were concerned about safety and the dynamics of the patient-practitioner relationship, a barrier to successful policy implementation.

6.1.4.5 Summary

These data show the significance of collective action in the process of policy implementation and reflect that it was an area of considerable implementation work.

For both policy-makers and policy-implementers, action focused on training and skill updates, targeted at increasing the skills of practitioners, but also comprised initiatives to help patients understand more about their condition and manage symptoms through education programmes. Government funding was an important driver used to encourage health boards to improve training. Collaborative approaches to training were also promoted with the inclusion of other organisations, principally the voluntary sector. Financial support and collaborative approaches to education revealed that change was being driven and policy-makers and -implementers were trying to prepare both practitioners and patients with the skills needed to self-manage.

Collective action was also influenced by contextual elements specific to NHS Kuzburgh: the impact of previous efforts to re-organise health services explained the current interest in self-management; the geographical context and landscape of the health board area influenced implementation; societal context and changing population were drivers for change and support for self-management; and the organisational approach specific to NHS Kuzburgh affected buy-in and sustainability. The role of these drivers was more important to policy-implementers than policy-makers.

Other levers of change included: patient experience; financial investment and examples of good practice, used to show how self-management support could reduce complexity and improve patient experience without increased resources. Of these the most significant was the use of patient experience which simplified the message about what self-management is and improved confidence in the concept.

Accounts from policy-makers suggested that self-management was instinctively worthwhile in spite of a lack of evidence for its success. In contrast, policy-implementers and ultimately users of self-management expressed reticence, recognising the lack of evidence to support the benefits of self-management and identifying further concerns around patient safety and a perceived loss of professional power. These perceptions were not recognised or addressed by policy-makers. The extent to which this ultimately hinders sustained and embedded policy implementation is discussed in **Chapter 8**.

6.1.5 Reflexive Monitoring – appraisal work

According to Mair and colleagues (2012), to understand and evaluate the implementation of a healthcare intervention in practice users must appraise the intervention as "*worthwhile or not*" (Mair et al. 2012). The process can be considered within four domains: reconfiguration; communal appraisal; individual appraisal and systematization.

6.1.5.1 Reconfiguration - do individuals try to alter self-management support

Reconfiguration and altering, so that policy is made as worthwhile as possible, is enabled by engagement. Participants determine or appraise the '*worthwhileness*' of a new idea by the degree to which they are engaged in the process of development and refinement of a new initiative, later described as "*user-produced knowledge*" (Mair et al. 2012: 361). Mair's account illustrates the importance of close involvement by users of and stakeholders in policy at the levels of both implementation and policy-making.

Recent literature on policy implementation recognises the importance of stakeholder involvement. Traditionally it was seen as top-down process: policy-makers decided policy and -implementers were expected to implement as directed. Current thinking encourages a more iterative process, responsive to the interpretation and insight which policy-implementers contribute. Tummers and colleagues (2012) argue that if policy-implementers are willing to engage and reconfigure a policy idea, it has a higher chance of being seen as a policy success. In **Chapter 5** a review of the policy documents revealed that the Scottish Government's approach to developing self-management policy recognised the importance of including stakeholders in shaping and configuring it, as well as involving them in policy delivery. This generated stakeholder willingness to be part of the policy process. Here, for example, is a member of the LTCAS:

> *"... I mean I guess very much from our point of view of what's been incredibly kind of heartening and refreshing is the role that the Alliance has been asked to play in the policy development.*" (Gayle, P-M: 42)

Involving the LTCAS from the outset helped the Government ensure that self-management support reflected patient and carer perspectives. Arthritis Scotland was also part of the team which contributed to the self-management strategy for Scotland (LTCAS 2008):

> *"…the Alliance certainly grew this* [self-management] *and when we were asked to write the strategy, it was be careful what you wish for... it took us by surprise."* (Charlie, P-M: 124).

So these policy-makers welcomed their inclusion in the review but recognised that with this consultation came additional responsibilities. From the policy-implementers' perspective there was discussion of the close working relationship between the Government and Health Boards. Policy-makers actively sought the experiences of practitioners and used it to improve final policy guidance:

> **Interviewer:** - ***So you feel policy is being driven from the bottom-up or, just top-down?***

> *"I think there is a two way communication, because we are given … a stream of information that would come down, but we have the chance to discuss it and amend it and change it and feed that back. I know that with the National Delivery Plan, … the collaborative were able to offer us early sight of that to make comment on, which we, our core group within the programme Kuzburgh did and fed back and when it was actually launched, we saw that some of the changes that we had asked for, had been incorporated and we've worked on a couple of national pieces of work … so I think they are willing, they appreciate the benefit of front line practitioners commenting, to see if things are fit for purpose."* (Reece, P-I: 100).

National stakeholders and those charged with policy-implementation were both actively engaged and willing to be involved in the policy process, an important illustration of what Brinkerhoff (1999) termed inter-organisational co-ordination.

The use of clinical staff on secondment offers a more strategic opportunity to engage practitioners and foster 'willingness' in policy development, an approach used to support the work of the LTCU and the LTCC. To make self-management more acceptable to clinical staff and increase the likelihood of its up-take secondees were encouraged to contribute their clinical experience. They could '*sense-check*' ideas and add clinical credibility to new ideas and policy directives. A strong association with clinicians was seen to support policy-implementation. For example:

> '*We've also appointed a Lead Clinician for self-management, [B03], who is working on that two days a week. We also have a Practice Nurse in on secondment, [G02] who again is focussing on self-management.'* (Finaly, P-M: 46).

Here accounts illustrate that the worthwhile-ness of self-management was determined by the close involvement of users and stakeholders in the policy process, including engagement across different organisational levels. These examples show a general willingness on behalf of both policy-makers and -implementers to learn from each other, which was pursued formally through clinical secondments to policy units.

6.1.5.2 Communal appraisal - how do groups judge the value of self-management support?

While the benefits of such informal appraisal are evident from the above accounts, respondents also emphasised the importance of more formal approaches to appraisal and monitoring to support the process of policy implementation. This commonly relied on matching initiatives and work to existing NHS targets. Indeed this discussion links to previous data on the need for evidence to support policy implementation, the implications of which are discussed in **Chapter 2 Section 2.6.6**.

A principal lever of change in NHS Scotland is setting, achieving and measuring demonstrable targets such as HEATs, against which the performance of all health boards are measured (see previous definition **Chapter 5**). Policy-makers and -implementers recognised the significance of performance measures and targets in implementing policy:

> *"it's my understanding that there will probably be HEAT targets for boards to help develop self-management. Without these there is no impetus. Health boards deliver, as you know, to meet their HEAT targets and they have to deliver on that. If there are soft things around like self-care, self-management but there's no target then there's no impetus."* (Harper, P-M: 38).

Policy-makers were clear that they needed a framework against which to match delivery. For example, the LTCAP (NHS Scotland, 2009) was referred to, alongside the inclusion of self-management in HEAT targets:

> *"When the delivery plan comes out and HEAT targets are identified, if it* [self-management] *doesn't sit with that it will go nowhere. So you always have to match opportunities with actions that are identified from policy"* (Harper, P-M: 51).

And:

> *"if we're going to have any kind of HEAT targets around self management, then those are the kinds of things that we need to be focussing on. And that's building the capacity around things like communication skills, motivational interviewing. And the context that will help support and enable self management"* (India, P-M: 72).

Linking policy to existing outcome assessment frameworks was identified as an important means of promoting policy change. Observational data from both national and regional meetings provides evidence of the work being undertaken to communally appraise the effectiveness of policy implementation.

The national Self-Management Strategy Group (**N/Observation 1Sept/2009**) considered how to monitor and appraise the success of the self-management fund. Committee members were anxious to be able to demonstrate progress on both the impact of the strategy and its funding. LTCAS members attached considerable importance to effective appraisal; and to provide a formal evaluation they had approached a private consultancy firm to carry out a far-reaching and extensive evaluation three areas: the LTCAS as an organisation; the impact of the self-management fund; and the Scottish self-management policy. **N/Observation 2** (May/2010), a meeting of the LTCC team that focused specifically on the activity of the self-management work stream, provided further evidence of work being undertaken to appraise its effectiveness. I observed that appraisal activity was closely target-driven and directed towards assessing the implementation of two documents: *LTCAP* (NHS Scotland 2009a) and *LTCC: High Impact Changes* (Scottish Government 2009). Much discussion addressed the use of a self-assessment tool which would allow Health Boards to analyse how they were doing with regard to self-management services.

At Health Board level observational data provided evidence of policy-implementers' communal appraisal work. In **R/Observation 3** the focus was appraisal of a number of local self-management initiatives: a diabetes self-management programme; a COPD supported self-management trial; and a self-management resource to help patients in chronic pain.

If, in theory, communal appraisal was recognised as key to implementation, the difficulty in undertaking effective evaluation of new initiatives at this level of policy-implementation was striking. For example, NHS Kuzburgh's diabetes self-management programme had received £50,000 from the LTC Programme Board. At the time of observation the programme manager was seeking additional funding to continue this programme and the project was trying to evaluate its impact in terms of improved patient outcomes. The programme seems to be a good example of policy in action; yet poor evaluative data were presented during **R/Observation 3.** Three hundred patients had enrolled on the diabetes self-management programme and baseline data had been obtained from them; and yet follow-up data after 12-months was only obtained from 7 of the initial 300. There was frustration with the failure to provide an informative approach to monitoring. Policy-implementers knew they needed hard evidence to secure further investment but seemed unable to enact robust procedures to generate the evidence. The implications of this gap and missed opportunity in terms of evaluation and collation of evidence to support policy implementation is discussed in **Chapter 8**.

At **R/Observation 3** there was also discussion of a COPD supported self-management programme comprising pulmonary rehabilitation and a telehealth project to support home management of people with COPD. Both elements were due to have their funding reviewed in three months' time. The pulmonary rehabilitation element was evaluated at the end of the six-week supported exercise sessions and by a further questionnaire six weeks after the end of the exercise block. It was reported anecdotally that patients felt better and enjoyed the peer support provided, but there was no objective evaluation to determine the degree to which their symptoms were improved or controlled more effectively. The appraisal, as it was reported, appeared limited and insufficiently robust to argue for sustained long-term commitment.

In contrast, assessment of the COPD telehealth project was thwarted by a lack of uptake by GPs who were required to refer patients to the scheme. The number of patients participating was small and although outcome data were collected and represented a positive trend, the scale of the evaluation meant that no conclusive benefits could be proven.

In reviewing these disappointing results, committee members acknowledged the importance of linking outcomes to existing performance targets or priority areas. For example, a reduction in GP prescribing of antibiotics would be a positive achievement for the COPD telehealth project. Similarly, linking the benefits of the diabetes self-management programme to HEAT targets with ‘shifting the balance of care’ was identified but no actions were planned to modify the evaluations to better measure performance.

These observational data give evidence of the work being undertaken to communally appraise the programmes in place. However, attempts at appraisal seemed superficial and flawed by a number of limitations: lack of uptake (e.g. COPD telehealth initiative); poor follow-up of patients as a consequence of staffing issues (e.g. diabetes self-management programme); and missed data-collection opportunities (e.g. Pulmonary Rehabilitation classes).

Frustration over poor assessment of effect and long-term sustainability of initiatives was reflected in interviews with policy-implementers. They wanted good evidence but could not provide it, which meant that self-management projects were being dropped as other priorities took over or money ran out: [with the telehealth project] **..**

> “*we didn’t get the recruitment for that. It was not very good. But there were lots and lots of issues … I think the* telehealthcare *project was definitely a longer term project. I think it should have been looked at over five years and not just a year and a half. But again the figures are starting to go up now and people are now starting to self-manage their exacerbations a lot better. But it’s too little too late I think. The service will stop”* (Casey, P-I: 124)

Lack of time for evaluation, for new practices to bed in and to win over recalcitrant practitioners appears to have undermined attempts to appraise and monitor these self-management initiatives.

6.1.5.3 Individual appraisal - how do individuals appraise the effects on them and their work environment?

Policy-makers did not discuss how they expected health professionals to appraise their experience of enacting self-management. This lack of appreciation of the importance of understanding the dynamic nature of implementation and of individual appraisal of self-management for policy-implementers was a notable absence which highlights barriers to policy implementation where more could be done to support policy-implementation.

When policy-implementers explored their experience of implementing self-management they cited the obstacles they faced, such as a lack of training, competence in key skills, and competing aspects of their role:

> *"…so I feel self- management, we want to do it, we really do want to do it and we want to do it properly but the idea…we've not been trained right, we don't have the competencies to listen to a chest properly, we don't have the time because, in my job, as a team leader, I've got the management side, I have a clinical case load.*" (Eddi, P-I: 71).

Entrenchment of working practices of colleagues and rigid perceptions of the role of the patient and/or carers were also part of their experience and impacting on their appraisal of self-management and it achievability. For example:

> *"…especially here in areas like this, .. 'Oh I can't do that, I can't give my mother insulin, oh no, no'. So it's trying to encourage it and it's education so, again, it's something we're very active in doing … but it's the attitudes of both the population, the public and also nursing staff.*" (Blake, P-I: 43)

Other policy-implementers, working higher up the organisation, although committed to the implementation of self-management, were concerned at delivery within current financial restrictions. So any individual appraisal of self-management must be judged in line with the financial targets it had to operate in:

> *"…and me personally, I think one of the things I will be trying to promote and push is how do we try and identify where some of this utilisation of self- management has reduced the pressure on hospital in such a way that we can try and maximise that resources so that we're still keeping some of that self- management stuff going on in the community. Because if we don't we'll fail.*" (Vaughan, P-I:52)

For policy-implementers the experience of enacting self-management was judged against what they were expected to do in their roles as clinicians and managers. It would be judged by proving its worth in financial terms: it had to help them manage finite resources more effectively. They appeared uncertain that the implementation of self-management would deliver this expectation, a potential barrier to policy implementation.

6.1.5.4 Systematization – identification of the barriers to systematization

Assigning data to the NPT concept of "*Systematization*" was difficult for an inexperienced researcher. My difficulty and concern that I was not assigning data correctly is shared by other NPT users, who found overlap between constructs and difficulty in discerning between constructs (Franx et al. 2012). Similarly, I found that data could be assigned here had been reported against other NPT mechanisms (for example clinical leadership is reported in relation to initiation and legitimation and the importance of evidence to support implementation and sustainability of policy has been assigned to relational integration). The fluidity and flexibility acknowledged as inherent in NPT can also explain my difficulties; they highlight the challenges and strengths of NPT as a theoretical framework, discussed in **Chapter 8.** As the disentangling of the data proved challenging, I have chosen to highlight what emerged as factors hindering policy implementation which have not previously been highlighted.

New from the policy-makers were the following issues:

i) the scale of the task which faced them;

ii) a lack of clarity around exactly what is being asked of people; and

iii) a poor level of public awareness of what self-management is.

Perception of the scale of the task was experienced as a potential barrier to implementation. Policy-makers, in particular, were conscious about the number of projects and initiatives going on simultaneously, and imagined that clinical staff would feel overwhelmed and unsure of where or how to start. One national-level respondent said:

> *"I think the policy environment in Scotland ... it's incredibly complicated. And I don't know how you're meant to navigate it. And I dread to think what it must be like if you're out there as a Charge Nurse"* (Emroy, P-M: 92).

In a later interview a second policy-maker explained that the scale of the change which self-management represented meant it could appear unachievable:

> "*... it's a huge culture shift for a lot of people within services, you know, whether they're at Health Centres or Social Care Services, to understand what that* [self-management] *really means.* (Alex, P-M: 96)

A lack of clarification of exactly what is being asked of people was identified as a possible hindrance to implementation. Policy is often vague on detail; this is seen as par for the course (Sanderson 2006). Furthermore, as presented in **Section 6.3.1** the coherence of self-management and how things fit together is important; and if there is a lack of understanding of self-management between one level and the next (i.e. policy-maker to -implementer), this will discourage action or engagement with the policy directive. Policy-makers identified their perspective and level of expertise with regard to self-management but this understanding was not necessarily shared by practitioners:

> *"... what we now have is the gulf between the clarity that we have among the groups around, presented within the Alliance and the enthusiasm, and the expertise ... Which is at odds with the majority of front line NHS clinical staff.*" (Bobbi, P-M: 80)

Failure to achieve a shared vision between organisational levels was exacerbated by a perceived lack of evidence of improvement resulting from change and doubts that the implementation of self-management would bring real patient benefits. Policy-makers expressed concern over the level of public awareness of what self-management meant, paralleling the misinterpretation and coherence between organisational levels, where a lack of understanding could hamper policy implementation. For example:

> "*I would imagine if we went out here now and went down to* [name of town] *and said to people in the street, are you aware that there's a problem with long term conditions, are you aware there's a collaborative in the government who are looking at this, or there's an alliance for the voluntary organisations, I think you'd be lucky if you got one person all day that could say, oh yeah, I'm conscious this is going on."* (Marley, P-M: 292)

Possible public misinterpretation was cited as a barrier which needed to be overcome if the policy was to be systematized into the NHS in an organised and meaningful manner:

> "*I think for me it's probably more people's perceptions and fears and a lack of understanding, a lack of confidence. I think there is a public awareness challenge that we need to be quite clear this isn't about devolving responsibility. This is about empowering people but continuing to have a shared responsibility to support their needs. It's about that mutual approach to care, doing with rather than doing for. I think there's probably…there is a public awareness and a social marketing challenge around that stuff.*" (India, P-M: 20).

The concern was that the public would misinterpret self-management as healthcare on the cheap; a downgrading of the health service rather than an improvement.

Policy-makers identified a range of barriers restricting the implementation of self-management policy. Policy-implementers identified similar issues but here some of the barriers were identified in approaches taken by policy-makers to facilitate and promote implementation rather than restricting its success. Policy-implementers were also concerned at the potential impact of a lack of evidence. On the one hand they highlighted the positive impact of financial support but also the restriction that limited the impact of policy implementation and sustained change:

> "*There are certain annoying things going on. The annoying policy of the government or health department or whatever in terms of putting blobs of money and saying, here is a blob of money which can be used for certain things, it gets people thinking creatively*." (Sidney, P-I: 272).

The implication was that self-management initiatives had to end, often before they could demonstrate patient benefit, this caused frustration:

> *"And particularly with time limited money, here's a certain amount of money for three years and you think, well what happens at the end of three years.*" (Sidney, P-I: 276)

6.1.5.4 Summary

Policy-makers acknowledged the difficulty of demonstrating how self-management would be an improvement beyond qualitative sentiment. The lack of, or at best weak, evidence was identified as a real barrier to embedding self-management. Systematisation of the concept was also limited by a perception amongst policy-makers that self-management was hard to deliver to those patients who needed it most, limiting its overall effectiveness. People with LTCs are more likely to be disadvantaged over a range of social indicators, yet these indicators mean that they are less likely to engage with practitioners in a way that would reflect self-management. This concern was illustrated by one policy-maker, who said:

> *"in my worst days…I think self-management is probably only going to work with people that it would have worked with anyway."* (Emroy, P-M: 157).

Policy-implementers believed it would be beneficial to systematically assess the benefits of self-management but acknowledged that such appraisal was missing and they were unsure how best to address it. National targets – e.g. HEAT targets helped policy-implementers plan how to evaluate the benefits and problems associated with the concept. Small-scale systematization were underway but were insufficient to provide a robust appraisal which could be built on. There was a degree of frustration amongst policy-implementers at the lack of interest in pursuing appraisal work.

The accounts show where there was co-production of policy with the close engagement of policy-makers and –implementers plus patient experience, which supports Tummers and colleagues' (2012) idea that close personal involvement in policy makes implementation more likely. Providing opportunities for policy-implementers to exercise discretion fosters policy adaptation. When they act in this way they are termed 'street-level bureaucrats' (Lipsky 1980), and their actions are recognised as generating higher policy performance.

According to the policy-makers interviewed here, policy implementation should be linked to NHS performance targets such as HEAT measures. This was confirmed by the observations made of policy-makers discussion at national meetings. Policy-implementers also used their meetings to discuss monitoring, what to monitor and how to assess impact. In particular, observation of the LTC Programme Board revealed how NHS Kuzburgh was investing heavily in terms of time and money in initiatives to support policy implementation. However, the projects were not able to produce robust data to prove their effectiveness or how their approaches were improving patient outcomes. The frustrations and limitations of this lack of effective monitoring were reflected right through the organisation and particularly amongst front line staff who felt new practices never had the chance to prove their worth before the agenda shifted and managers moved on to the next thing.

Individual appraisal of self-management was positive, but it was balanced by concern over the reality of implementation. Policy-implementers faced practical issues over integration ranging from perceptions of what roles were suitable for patients and family members to reluctance by nursing staff to relinquish their traditional paternal relationship with patients. Significantly, managers appraised self-management as interesting but lacking sufficient financial benefit to pursue it in a systematic manner.

6.3 Conclusion to chapter

The objective of this chapter was to set out the findings from the interview data generated from policy-makers and -implementers. Using NPT I have mapped the key processes of implementing policy promoting self-management support for people with LTCs. This has highlighted a number of expected areas of tension and barriers to implementation; but also areas where expected problems have not materialised, where new initiatives have been implemented successfully and identified areas of unanticipated barriers.

The NPT framework has brought into sharp focus key areas for discussion which have been referenced throughout the chapter and which will be synthesised in **Chapter 7**.

Chapter 7 Synthesis of findings

7.1 Introduction to chapter

This research has enhanced understanding of implementation processes in response to policy direction. Its purpose was to explain them in the context of self-management policy for people with LTCs, offering an important perspective on health policy in practice.

A complex picture emerged from three organisational perspectives: policy-makers reflecting national policy direction; insight into regional policy-implementers operating within a health board area; and the experience of local practitioners focused on translating policy into better patient outcomes. My research has generated a unique narrative explaining the experience of making, implementing and sustaining health policy.

This chapter synthesises findings (see **Chapter 4** for methods) beginning with a series of statements drawing together data from policy documents, observation and interviews. These are presented as a list of broad tensions characterising the work of policy implementation. I highlight their significance and new areas of learning which emerge from them.

7.2 Key findings

Data analysis from documents, interviews and observation revealed five key findings:

Finding 1-a shared understanding was needed for policy implementation;

Finding 2-involving stakeholders helped drive forward policy implementation;

Finding 3- work promoting collaboration and participation was the most detailed and important in the processes of policy implementation;

Finding 4 - the course of policy implementation was affected by factors facilitating or inhibiting stakeholder acceptance of self-management and;

Finding 5 - NPT fostered key analytical insights.

7.2.1 Finding 1- A shared understanding between all stakeholders is needed for policy implementation

Policy documents raised awareness of self-management and the need to promote it for people with LTCs, but these documents were insufficient to confirm meaning and create a shared purpose. Policy-implementers were required to undertake further work to interpret self-management from policy documents and implementation required on-going negotiation and interpretation. This was work that policy-makers did not have to engage in since their level of understanding and meaning was theoretical rather than applied.

Negotiations over key terms such as ‘self-management’, ‘support for self-management’ and ‘self-care’ exposed a lack of input from practitioners. Self-management is a new way of working, different from the usual care for people with LTCs; and this was recognised by policy-makers and -implementers. However, this caused uncertainty about how best to interpret and apply policy in practice to benefit patients. Policy-implementers, therefore, experimented with service models to establish which worked best and how they could demonstrate self-management being used in everyday practice. These models included: telehealth and pulmonary rehabilitation for COPD; pain manuals for patients with chronic pain and bought-in self-management education programmes for people with diabetes. My observations are supported by public administration literature such as Van Meter and Van Horn (1975) who observe that implementers often have to work with incomplete information and make the best of a situation. This ‘making do’ was evident in the data.

From this we can deduce that the implementation of self-management policy in Scotland is an interpretive process operating at what Paul Sabatier termed the “*policy subsystem*” (Sabatier 1986: 40), and should not be limited to top-down or bottom-up interpretations of policy implementation. The details of the nature and influence of the policy subsystem are explored in **Chapter 8**.

7.2.2 Finding 2: Getting stakeholders involved helped drive forward policy implementation.

I found evidence of awareness, commitment and motivation amongst relevant stakeholders: people were working together to promote policy implementation. Synthesis from policy, interview and observational data showed involvement was achieved through the use of opinion leaders, particularly those with clinical or patient expertise. They are variously described in the literature as change-agents, change leaders or champions; and successful change depends on them (Molinsky 1999). A receptive social setting and the use of networks that supported policy implementation by getting people to work together enhanced involvement, as I showed in NHS Kuzburgh. Leadership, receptiveness and networks are recognised within the literature as mechanisms that ensure success (Battilana 2006; Erasmus and Gilson 2008; Pettigrew et al. 1992; Grol et al. 2005).

Further evidence of the level of involvement promoting policy implementation is provided by NHS Kuzburgh’s use of MCNs. From the interview data it was clear that a number of clinical networks (MCNs in diabetes, COPD and Coronary Heart Disease) ensured that all key players and organisations were involved in self-management initiatives. Within these MCNs clinicians knew each other and had established working relationships which they used to support the legitimation of self-management policy. Furthermore, once the policy could be directed to specific medical conditions it came under the influence of clinicians, ensuring enrolment and legitimation. It gained clinical credibility, an important factor in bridging the gap between policy and practice.

Clinical credibility was additionally revealed by policy-makers seeking to establish a distributed approach to leadership, best represented through the use of clinical secondments which supported the work of the LTC Policy Unit in the Scottish Government as well as leadership in the LTCC. The replication of clinical leadership worked as a mechanism to support successful policy implementation at all organisational levels right down to front line policy-implementers. These ideas are supported by literature which suggests that leaders wield key influence in the establishment of new ways of working (Ham et al. 2003).

I also found that the legitimation of self-management policy was promoted through the use of policy-makers, beyond the usual cohort of civil servants. The collaborative approach to policy-making is best illustrated through the partnership of the Scottish Government and LTCAS in their document '*Gaun Yersel*!' (LTCAS 2008). However, when this idea was mapped to data from regional and local policy-implementers its translation to front line clinical policy-implementers was more problematic. Clinical staff felt disenfranchised from the concept of self-management, which could ultimately compromise its success.

7.2.3 Finding 3: Work promoting collaboration and participation was the most detailed and important in the processes of policy implementation

The policy story of self-management revealed that most implementation activity was attributed to the work engaged in by policy-makers and -implementers to promote collaboration and participation. Specifically, I was able to identify a series of unique examples of constructive collaboration with patients with LTCs. The Long Term Conditions Alliance Scotland, authors of '*Gaun Yersel*' (LTCAS 2008), representing the patients' perspective, is a non-traditional policy author. It wrote the central policy statement and therefore acted as policy-maker. Using a patient organisation in this way promoted participation and ultimately policy implementation. Prioritising collaboration through patient engagement, patient-empowerment and patient-choice are important ideologies within contemporary health policy (Crinson 2008). '*Gaun Yersel*' (LTCAS 2008), was an exemplar of patient engagement delivered by allowing patients to become policy-makers. This level of engagement is new. The document uses colloquial language (best illustrated by its title) and patient narratives explain self-management in accessible terms. Simplification of the message encouraged stakeholders to learn about and implement self-management policy. Policy-makers saw '*the lived experience*' as a powerful learning tool, motivating change and the integration of new ways of delivering care. Patients had a central role as both policy-makers and -implementers.

7.2.4 Finding 4: The course of policy implementation was affected by factors facilitating or inhibiting stakeholder acceptance of self-management

Policy implementation success was critically dependent on a range of resources: stakeholders needed an organisational framework; time; the development of skills and knowledge; management targets and financial support. Some of these were recognised by policy-makers; others were given less attention. Where they were addressed, the factor acted as facilitation (e.g. financial support through the self-management fund) but where they were limited or overlooked then they were shown to act as an inhibitor (e.g. time or, more specifically, lack of time).

There was a clear national structure promoting self-management policy implementation (e.g. LTCC and the LTCs Unit). Formal organisations helped regional policy-implementers learn about self-management policy and encouraged them to report examples of policy implementation back to policy-makers whilst also sharing examples of best practice with other implementers. A clear organisational context demonstrates organisational (Grol et al. 2005) and political support (Sabatier and Mazmanian 1979), the combination of which creates a receptive context, as I found in NHS Kuzburgh.

The establishment of organisation structures such as the LTCC can be interpreted as formal government-sanctioned programmes, a top-down approach to policy implementation (Sabatier 1986) through which the implementation process is structured by government to enhance compliance and overcome resistance. Testimony showed that this alignment and close association with government was seen as helpful by regional policy-implementers but less so by District Nurses, who felt disenfranchised and failed to interpret the legitimation of policy; this despite their interest in and motivation to promote self-management for their patients.

Financial and management incentives and resources facilitated policy implementation. Commonly, a lack of money or resources is seen as a practical barrier to change or the adoption of a new idea (NICE 2007). My data reveals that access to dedicated financial support (e.g. the Self-Management Fund; ring-fenced special projects money), supported implementation. However, these financial resources were administrated and allocated under tight restrictions that compromised their effectiveness in sustaining implementation. For example, the funding support for NHS Kuzburgh's pulmonary rehabilitation services was described as '*blobs of money*' (Sidney P-I: 272), only available for short periods (18-months). In practice, policy-implementers could not sustain initiatives that showed policy was hard to embed and integrate so initiatives were discontinued when the money ran out, causing frustration (Sidney P-I: 276). If inadequate financial support is a barrier to changing practice (Grol and Wensing 2005) my data also showed that providing the wrong type of financial support generated uncertainty, compromising the sustainability of a new initiative and ultimately limiting its long-term embedding.

My data revealed the importance of recognising skills and knowledge for successful policy implementation. Interview and observational data showed that stakeholders were concerned about skill and knowledge deficits amongst those required to deliver policy (clinicians) and among patients, who must know how to self-manage. Practitioners were expected to enact a new model of care and needed to know how. At the same time self-management placed different demands on patients, so they needed new skills and knowledge to become effective ‘self-managers’. Policy-makers and -implementers knew that this knowledge and skill would be difficult to acquire. For practitioners and patients it meant a change in mind-set and thinking so that people with LTCs would engage with the health service in a different way and healthcare professionals would evolve their care to develop greater patient empowerment. A skills gap, which meant that policy-implementers knew what the policy entailed in broad terms but lacked the knowledge to undertake its delivery in practice, was a barrier to successful policy implementation.

Policy-makers and -implementers were concerned that the interpretation of self-management would not fit all patients in all circumstances. Specifically, self-management must help those in greatest need. Those with LTCs are more likely to be both socially and economically disadvantaged (Loretto and Taylor 2007) and there is a fear, amongst policy-maker and -implementers, that it would not benefit those that needed it most.

More subtle barriers to policy implementation included concerns that policy promoting self-management was exclusive rather than inclusive; there was insufficient evidence to show that the new care model was effective in improving patient outcomes.

Policy-makers recognised that they needed evidence of effectiveness to generate trust in the new idea and break down inherent scepticism. This requires both generation and the application of evidence. My analysis showed that policy-makers were using evidence in its broadest interpretation but policy-implementers were struggling with the generation of evidence. I found that policy-makers were reliant on narratives of patient experience to show that self-management worked. This evidence operated at an emotional level to gain buy-in and challenge natural clinical scepticism to the new care model and represented a significantly beneficial approach to change and implementation.

In contrast policy-implementers, who also understood that evidence of effectiveness must be generated, were frustrated. They collected and appraised data to try to demonstrate impact and patient benefit but their efforts were often thwarted by short-term funding and short timescales. Insufficient time and money was made available to generate any useful appraisal of their effectiveness. Consequently, self-management initiatives had been implemented but they were not sustained or embedded; indeed, many were ended after 18months. Providing clear means of generating evidence to illustrate the impact of policy in terms of improved patient outcomes is essential for successful sustainable implementation.

7.2.5 **Finding 5: NPT models fostered key analytical insights.**

The application of NPT as an analytical framework has identified what processes in policy implementation worked and what processes require more work or attention (where it did not work). NPT has revealed the ongoing work and processes in four areas: the role of meaning (*coherence*), involvement (*cognitive participation*), getting the work done (*collective action*) and evaluation (*reflexive monitoring*). Elements of these four areas are discussed in the headed sub-sections in the next paragraphs and the new knowledge is illustrated in the four diagrams which end this chapter. My analysis has revealed the meaning of self-management: the importance of stakeholder engagement and how this has been done; what processes were being used to get the work done (or the policy implemented); and identified where evaluation and monitoring was occurring or otherwise.

NPT has been less useful in revealing some of the more nuanced and complex contextual issues. For example, the influence of NHS Kuzburgh’s inner organisational context and their experience of organisational change prior to implementation of self-management policy, explored in **Chapter 8**.

Coherence: understanding of self-management was not shared with all stakeholders. There was little communal specification between policy-makers and -implementers but evidence of individual specification, particularly by policy-implementers (Mair et al. 2012). This insight links to **Finding 1** (see above) revealing the analytical insight generated through the application of NPT.

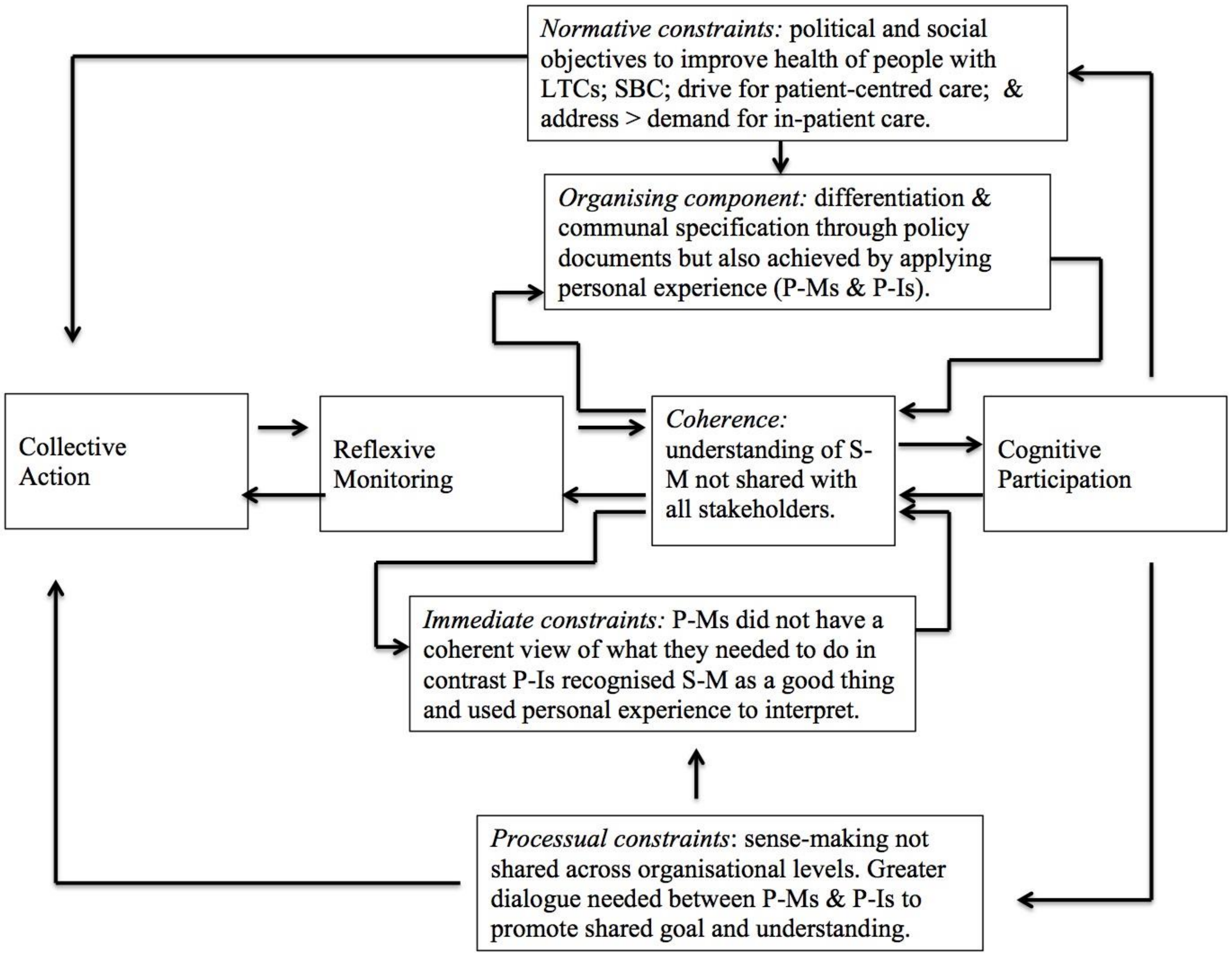
Cognitive Participation (CP): Policy-makers and -implementers are willing to work together to implement self-management. This level of patient participation is new and these mechanisms worked by promoting enrolment and legitimation (Mair et al. 2012). The importance of participation leadership and a willing-ness to work together link to **Finding 2** (see above).

Collective Action (CA): The work of self-management happened but sustaining and embedding it was harder because of skills deficits restricting the workability of policy promoting self-management (Mair et al. 2012). There was also concern that it would be selective in its workability - help those that could help themselves and not those who need self-management the most. Thus contribute to health inequalities rather than producing health equality.

Reflexive Monitoring (RM): Evaluation self-management was happening but people were frustrated by shifting priorities which meant policy was not given time to embed and become sustained. This proves a known barrier to implementation in the NHS. Success and evaluation of patient outcome is key but given little attention meaning new initiatives are commonly not sustained or attention shifts to the next priority.

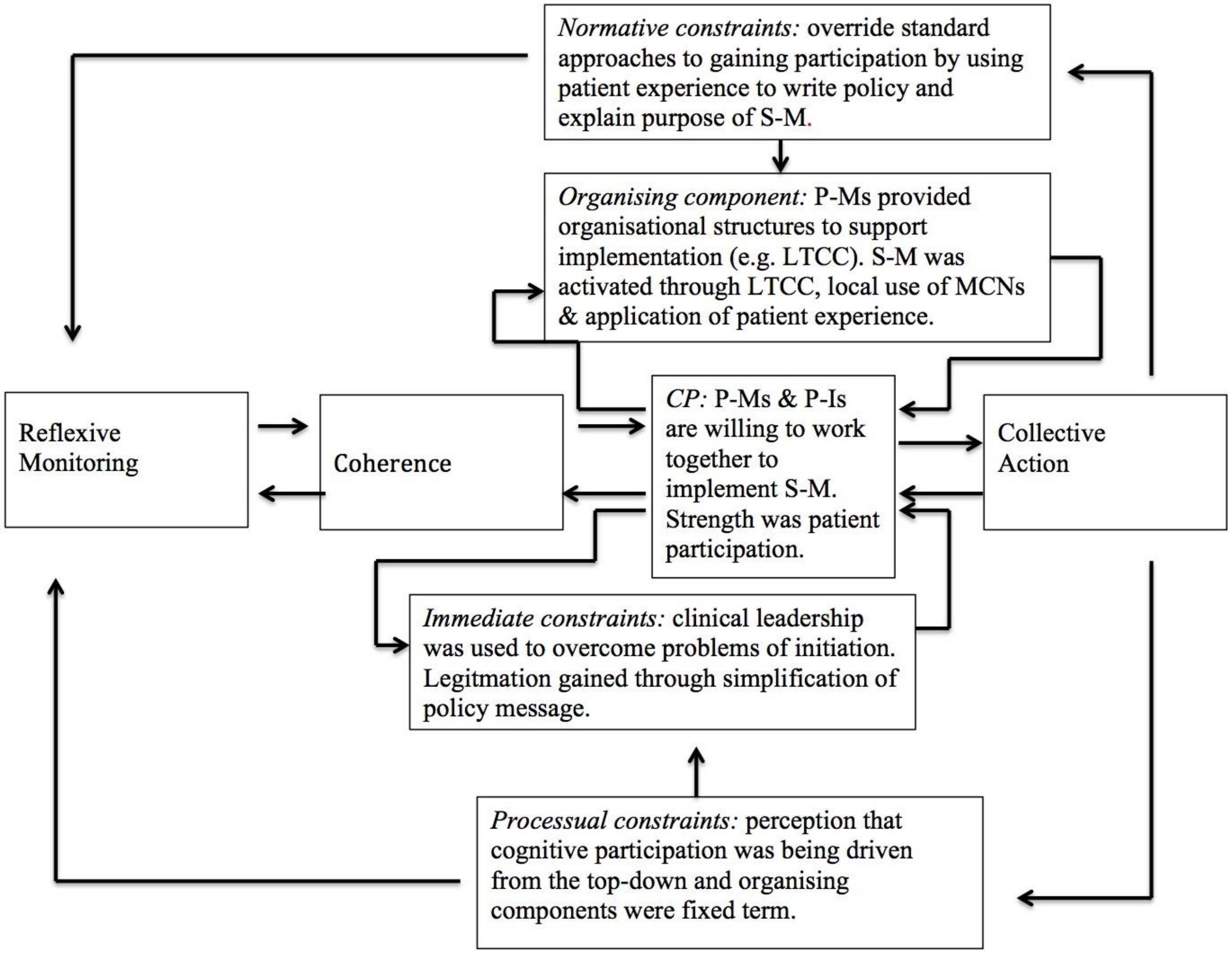
The following diagrams summarises the constructs, components and constraints impacting on policy promoting self-management support for people with LTCs as revealed by the analytical framework of NPT (May et al. 2010).

Figure 7-1 Coherence: analytical model



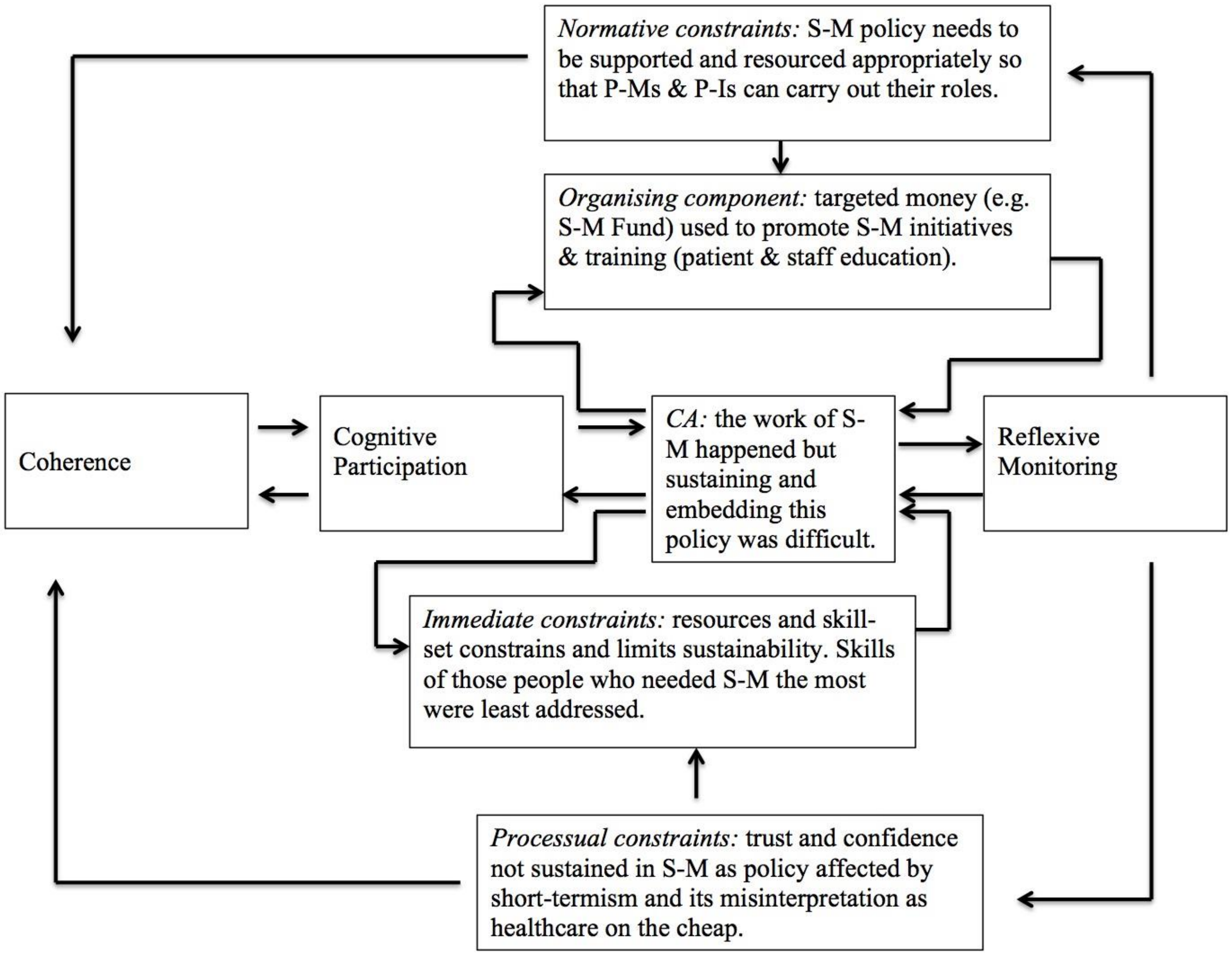
Informed by MacFarlane et al. (2014); May et al. (2010).

Figure 7-2 - Cognitive Participation (CP): analytical model



Informed by MacFarlane et al. (2014); May et al. (2010).

Figure 7-3 Collective Action (CA): analytical model



Normative constraints: S-M policy needs to be supported and resourced appropriately so that P-Ms & P-Is can carry out their roles.

Organising component: targeted money (e.g. S-M Fund) used to promote S-M initiatives & training (patient & staff education).

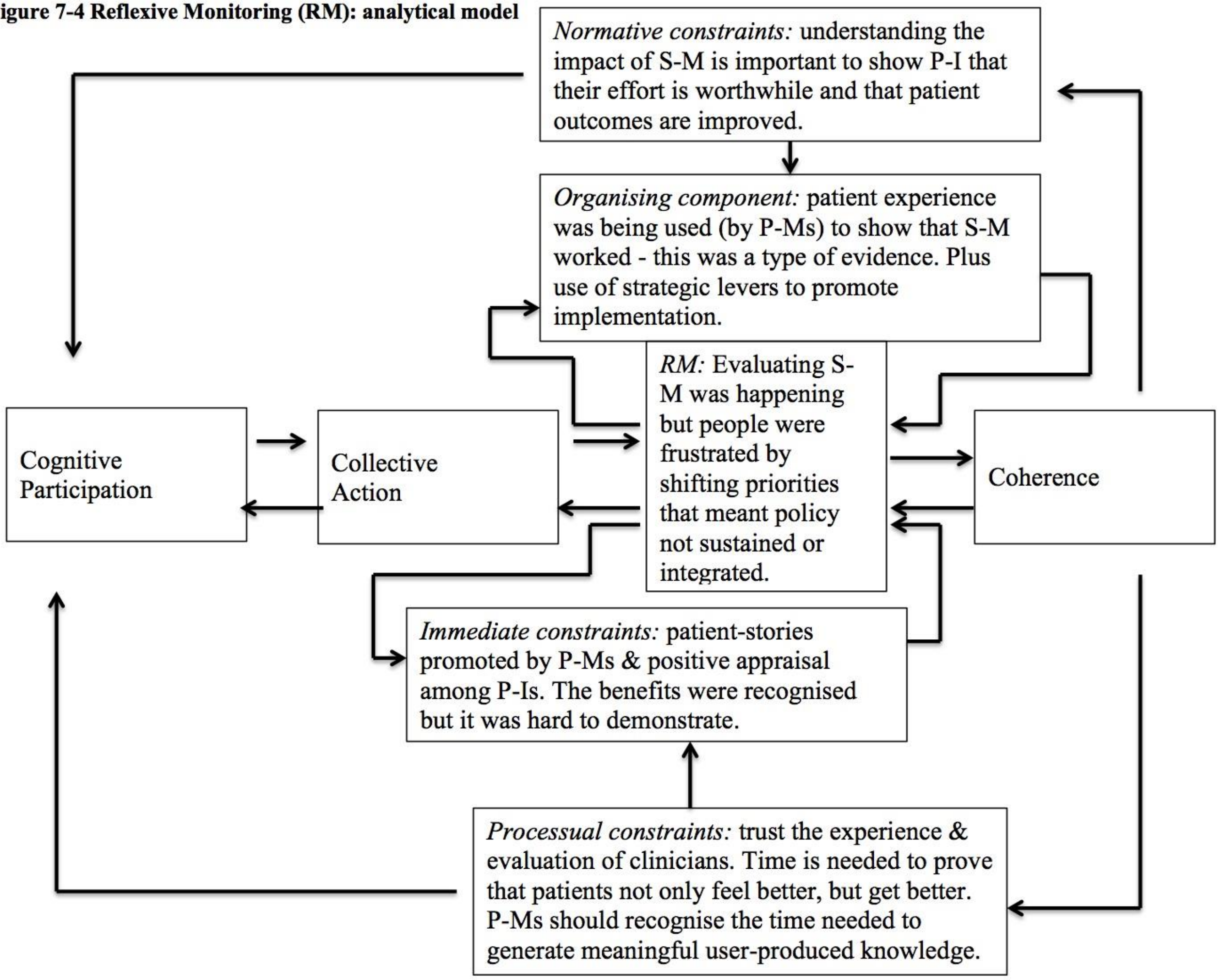
CA: the work of S-M happened but sustaining and embedding this policy was difficult.

Immediate constraints: resources and skill-set constrains and limits sustainability. Skills of those people who needed S-M the most were least addressed.

Processual constraints: trust and confidence not sustained in S-M as policy affected by short-termism and its misinterpretation as healthcare on the cheap.

Informed by Macfarlane et al. (2014); May et al. (2010)

Figure 7-4 Reflexive Monitoring (RM): analytical model



Informed by Macfarlane et al. (2014); May et al. (2010)

7.3 Chapter summary

There is little current research on understanding the policy process. The approach applied in this thesis was to use NPT as an analytical framework to explain the translational gap between policy and practice. As presented in **Chapter 3 (section 3.5.3)** existing research using NPT has been applied to elements of e-health, patient work and aspects of service re-organisation but not to the implementation of policy. NPT encourages systematic and detailed mapping of concepts, which allowed a comprehensive exploration of policy implementation processes across organisational levels and methods of data collection.

This chapter has set out a synthesis of the main findings and identifies the new areas of knowledge that have been revealed in relation to understanding the process of policy implementation. The significance of these findings will be explored in the **Chapter 8** Discussion of findings.

Chapter 8 Discussion of findings

8.1 Introduction to chapter

Policy-makers need to understand policy implementation (Smith et al. 2011). Policy implementation studies are needed to bridge the translational gap of policy into practice (O'Toole 2004; Schofield 2001), and are therefore of contemporary and on-going relevance. This research combines ideas on policy implementation with a contemporary theoretical framework to explain those processes by which new ways of thinking in healthcare (May and Finch 2009; McEvoy et al., 2014) are implemented, embedded and integrated. Insights generated by this approach offer a significant new perspective on health policy implementation in practice.

In examining the action of policy-makers and -implementers in response to health policy direction five objectives were identified:

i) To describe the context, content and process of policy-implementation through examination of policy documents promoting self-management for people with LTCs in Scotland;

ii) To investigate how awareness of self-management policy is being transferred from policy-makers to policy-implementers;

iii) To understand the work being used by policy-makers and -implementers to deliver policy in practice;

iv) To account for the factors which support policy implementation and those which inhibit it and;

v) To test the applicability of NPT and its associated constructs of coherence, cognitive participation, collective action and reflexive monitoring as a model to conceptualise the process of policy implementation.

The implications of my findings, outlined in **Chapter 7**, summarised for reference in the following box (see **Box 8-1**), will be discussed here.

Box 8-1 – Principal findings

Finding 1- A shared understanding is needed for successful policy implementation (links to Objective i.)***;***

Finding 2- Getting stakeholders involved helped drive forward policy implementation (links to Objective ii, iii.);

Finding 3- Work promoting collaboration and participation was the most detailed and important in the processes of policy implementation (links to Objective ii, iii.);

Finding 4- The course of policy implementation was affected by factors facilitating or inhibiting stakeholder acceptance of self-management (links to Objective ii, iii & iv.) and;

Finding 5 – An NPT framework fostered key analytical insights (links to Objective i, ii, iii, iv & v.).

In this chapter I use Doherty and Smith's (1999) suggested structure for discussion of scientific papers under the following headings: principal findings; strengths and weaknesses of the study; comparisons with existing literature; and implications for policy-makers and practitioners (policy-implementers). Chapter 9 will consider recommendations and conclude.

8.2 Principal findings

The implementation of health policy is much more complex than modelling just the what, the where and the who of policy implementation (Haycock-Stuart et al. 2013), or indeed notions of policy stages (Exworthy 2008), approaches adopted by other studies to conceptualise the policy process in healthcare. Modelling these processes requires perspectives from organisational theory and implementation science literature. These enabled me to analyse how the policy process unfolds and account for the work that policy-makers and -implementers engage in to implement policy promoting self-management in Scotland. I have shown that policy processes require intensive work to clarify their meaning; that there is legitimate and nuanced debate about their comprehension. The reality which emerges does not fit with traditional top-down models (Matland 1995).

In order to drill down into the reality of key elements of the discussion, I posit a series of hypothetical scenarios, based on evidence amalgamated from the data. I want to explain why the reality of implementing policy on self-management for LTCs is sufficiently complex that no one layer of organisation can understand it fully without a more comprehensive analysis, as I have undertaken.

8.2.1 Understanding self-management to promote policy implementation

Whilst policy documents are not the starting point of policy implementation (Allsop 1995) they provide a common purpose, clarify roles and responsibilities and will be understood by both policy-makers and -implementers (Hill 2005). The importance of shared meaning is reflected in shaping successful change in practice as a result of policy, and where there is an absence of a '*shared world view*' then inertia to change is commonly observed (Pettigrew et al 1992: 277). Research studies suggest that meaning and understanding are required for policy-implementers so that they know what to do to implement policy – and why (Walt 1994). Others argue that focusing too much on definition and meaning implies that policy-implementation is a 'top-down' process in which policy is set before it is implemented; that there is more to be gained from conceptualising policy as a non-linear, iterative process (Hill 2005). I found that the line from policy documents through policy-makers to practice involved complex, iterative processes of negotiation and interpretation (see Chapter 6 Section 6.1.2).

Policy-makers were making considerable effort to build and disseminate the concept of self-management nationally. However, interview and observational data revealed a more complex interpretation of self-management between policy-makers and -implementers. There was widespread awareness of relevant policy documents but this was insufficient to confirm shared meaning and understanding.

> *To illustrate this dynamic I will take a hypothetical policy-maker: 'Dom', who works with the LTC Unit, Scottish Government, and who contributed to the development of 'Gaun Yersel' (LTCAS 2008). She knows that self-management is a new way of working, regarded as something different from the 'usual'. She recognises it as a broad concept which for patients means that they should be supported to develop their knowledge on their LTC; that it allows patients to develop confidence in health consultations as well as being able to monitor their conditions and understand the significance of, for example, their blood glucose in diabetes or peak flow readings in COPD. Self-management for patients means new knowledge, technical skills as well as a psychological adjustment, in terms of their role and the relationship they have with the healthcare team. Equally, self-management for practitioners' means new knowledge and it is not always clear how they can facilitate self-management effectively for their patients. This creates uncertainty and a degree of fear and resistance between policy-makers and -implementers because it is not always clear how patients can be meaningfully involved in their management of LTCs. Should the focus be on developing patient skills and knowledge, or on the practitioners and how they relate and engage with patients?*

> *'Dom', as a policy-maker and with a healthcare background, works with civil servants to show them the way and provide clinical insight that she hopes will overcome the tension between policy-maker and -implementer. Her role is to actively engage in policy to understand and resolve issues of implementation in relation to self-management interventions and practices. This is what she does to impart understanding and meaning through policy documents, at meetings and networking opportunities and events. However, she recognises their remains confusion and seeks to engage with policy-implementers and look for examples of good practice as a means of showing what self-management is and sharing this understanding "you've got to get out there, get out of this office, they call it horizon scanning".*

This lack of understanding creates uncertainty and tension between policy-makers and -implementers as to where the emphasis should be. As it is not always easy to understand the work involved (or meaning of) in self-management there is scope for dialogue and discussion between policy-makers and -implementers to better explain the need for new service provisions whilst also targeting improved health and well-being for patients with LTCs.

At each level I found quite distinctive approaches to the understanding of policy:

- National policy-makers were committed to the policy promoting self-management. It had a prominent status, which legitimised it as an intervention and approach to care worth promoting. However, they were less clear about what the concept of self-management meant in practical terms.
- Regional policy-implementers recognised their responsibility for transforming policy into something deliverable, were aware of key policy documents and the significance of some of them in creating a momentum for change and they wanted to respond positively to national policy priorities;
- Local policy-implementation: those working with policy and using policy on a daily basis undertook further work to interpret policy. This additional work was

> informed by their professional experience and subject to interpretation and negotiation within their working context.

This debate about meaning and the work to make sense of a new idea as an important aspect of the implementation process is similar to that expressed by Lloyd and colleagues (2013) who found divergent attitudes to the concept of shared decision-making created a barrier to the normalization of the practice.

As a consequence of this lack of clarity around what self -management meant I found that many policy-implementers appeared uncertain about how best to interpret and apply self-management in practice to benefit patients. However, they were also observed to be motivated to experiment with service models to establish which worked best. The contradiction between a lack of clarity and positive action highlights the importance of work by Van Meter and Van Horn (1975) who found that implementers often have to work with incomplete information and 'make the best' of a situation.

8.2.2 Stakeholder involvement promotes policy implementation

Processes of stakeholder involvement were well-developed and organised effectively. In this study the mechanisms and components of these influences comprised leadership, using high levels of clinical credibility; the use of networks to create an organisational culture; and a receptive social setting. Leadership, networking, coalitions and receptivity emerged as important influences on policy implementation (see Chapter 6 Section 6.1.3).

The role of sets of actors, policy networks and coalitions are recognised mechanisms in the policy process, a lens through which it can be understood (Sabatier 2007). They are associated with a combination of top-down initiatives raising issues of command and control (e.g. the LTCC) and the encouragement of local autonomy (the role of local MCNs).

One might expect that successful policy implementation would depend on the suppression of local autonomy (Smith et al. 2011). However, what emerged here, as a consequence of the insight provided by NPT, was the importance of the involvement of policy-implementers who facilitated policy legitimation: people believed it was right for them to be involved (Mair et al. 2012). Long-term this would be more successful than a command-driven process, since it is only through local autonomy that the organisational and cultural change needed to implement self-management can be achieved.

The importance of champions or street-level bureaucrats (SLBs) is evident in both the policy and change literature and in my data. The objects of change or policy process play a key role in the adaptation of an organisation to new ideas or ways of working (Pettigrew et al. 1992). In these data 'Paul' and 'Sidney', both regional policy-implementers, were a positive example of the importance of the SLBs role in my policy story.

> *Paul was a director of one of the two CHPs in NHS Kuzburgh, so as well as responsibility for operational day-to-day delivery of services within the CHP, he was responsible for the delivery of improved services for people with LTCs. Sidney was the associate medical director, GP, lead clinician of the MCN (diabetes) and chair of the LTC Programme Board (regional observation* 1). *Both held important leadership roles in the local NHS hierarchy and used their leadership and clinical and managerial responsibility to drive forward self-management policy. These regionals organisational actors used leadership and power to exert influence that moulded practice, inspired change and identified resources to support new initiatives. They were able to overcome immediate*

> *constraints by using their experience and existing networks like the MCNs to tap into resources of time, motivated individuals and financial support. The experiences of SLBs like 'Paul' and 'Sidney' show that leadership helps change attitudes, motivates and empowers, helping people embrace new ideas and mobilise resources (Grol et al 2005; Vangen and Huxham 2003).*

In addition NHS Kuzburgh team members were commonly highlighted at national and local level as providing strong leadership; and we know that such individuals support wider diffusion processes (Rogers 1995a). Leadership, specifically clinical leadership and champions of change, are a significant part of the process of policy implementation.

Other factors influencing participation and supporting these policy-implementers included the use of policy documents to help illustrate what self-management encompassed but also the priorities and targets policy established and how they could use this to improve services. They valued the "*Scottish approach*" welcomed the use of the LTCC and the tools they brought and the inclusion of HIPC document (NHS Scotland 2009b).

The nationally established networks, as illustrated by LTCC programme, although welcomed, also created a tension as a consequence of its focus on central control versus the desire for local ownership. This tension was exacerbated by a perception at the delivery-end of short-termism. Many national initiatives led by policy-makers to promote policy were time-dependent. The LTCC was in place for 3 years and the challenges it set for policy implementers to work on were to be delivered over 14 days; there was no evidence that the changes tested lasted beyond these timeframes. So, although the LTCC promoted involvement they did not embed and integrate policy sufficiently. Clearly, implementation is not sufficient; policy must be sustained and embedded to achieve the organisational change expected. In addition participation must extend beyond national initiatives and involve practitioners as well as patients.

In many ways local organisational models like MCNs were more successful because they showed the benefits of promoting local autonomy and networks. MCNs focused on specific clinical conditions and provided an area of clinical control for policy-implementers. Within these networks policy-implementers could adjust the work they were doing to meet their understanding of self-management. MCNs provided an established, stable working group with shared responsibility focused on a shared issue and used these strengths to promote collaboration, attention and promote action.

> *In addition the involvement of SLBs like 'Paul' and 'Sidney' brought their knowledge of the local context and the specific needs of the patient population and this was an important influence on self-management policy implementation. For example, 'Paul' and 'Sidney' knew that this health board faced particular difficulties due to the significant numbers of the population with more than one LTC, high admission rates for patients with LTCs and the high levels of deprivation and geographical isolation, which characterised NHS Kuzburgh. These high levels of ill-health and areas of social isolation meant they were motivated to improve and drive forward self-management and wanted to demonstrate positive patient outcomes. 'Paul' and 'Sidney' wanted to work with others to implement self-management.*
>
> *At the same time there were frustrations. SLBs, like 'Paul' and 'Sidney' knew about strong self-management initiatives in their health board but they found it hard to spread these initiatives even from one hospital to another or from one CHP to the next. Spreading the idea of self-management amongst the patients*

> *who might benefit was also a frustration and patients appeared reluctant in some geographical areas to work together and collaborate to improve their health. So those personnel helped promote self-management policy through their job responsibilities and leadership roles. The influence of SBLs was ultimately restricted by the level of personal commitment patients were prepared to engage in.*

8.2.3 Collaboration and participation promotes policy implementation

I have highlighted issues concerning the focus on getting the work of policy delivery done and the approaches used to secure stakeholders' collaboration and participation. Most significant was the blurred line between policy-maker and –implementer, best illustrated by the collaboration between the Scottish Government Health Department (traditional policy-makers) and LTCAS in the production of the central policy document ‘Gaun Yersel!’(LTCAS 2008). This can be interpreted on a number of levels. Policy-makers were role-modelling to health boards how collaboration could be done; political ideologies were enacted in health priorities such as patient engagement, patient choice and patient-centred care (SEHD 2005c; Scottish Government 2010a and 2010b). It was evidence of policy in action by policy-makers and the operationalisation of contemporary health policy themes. In these data ‘Charlie’ was an example of effective and unique collaboration and participation to secure policy implementation.

> ‘*Charlie’, a policy-maker contributing to “Gaun Yersel!”, but also a patient with a LTC and an executive director of a national voluntary agency was pre-motivated to self-management. Her position, personal experience and application of self-management gave her significant credibility both amongst fellow policy-makers but also bridged the gap between levels as she engaged*

> *with SLBs. She was able to show the potential impact of self-management to policy-makers which was interpreted as a type of evidence. She was the link in the chain from 'Dom' as a policy-maker to front line staff providing the face of self-management whilst also simplifying the policy message.*

Patients' roles, at different points in the policy process, were as suppliers of anecdotal, persuasive, evidence of self-management success. The participation of patients in this manner can be seen at a more profound level than those of SLBs. Patients with LTCs were both determining what the policy should be and being used to bolster the delivery of policy to practitioners, through illustrations of best practices. Previously, patients have been observed acting in an advocacy role to change HIV/AIDs policy in Canada (Maguire et al. 2004). This example focused on a defined patient group known to be politically active. In contrast, I found a policy story being influenced by a disparate and generally disenfranchised group (people with LTCs), a unique observation not previously revealed by other work exploring health policy implementation.

Furthermore, this level of patient engagement has to be shared with other patients, as peer-to-peer participation, to show how policy can be enacted by those it is targeted at. This sharpens the discussion in Section **8.2.1** about showing patients the social capital they have within them to manage their LTC. This cannot best be done by professionals and maybe of most influence if led by other patients.

Traditionally policy implementation literature has focused on understanding government controlled agencies (Hill 2005). Here the inclusion of patients, who are the object of the policy, was a process used to facilitate policy implementation by ensuring collaboration and participation, echoing the literatures theoretical stance that stakeholders and service users should be central to any change or improvement initiative (Fauth and Mahdon 2007). I have found that policy-makers were explicit that they were using engagement and consultation with the objects of the policy - in this case patients with LTCs - and these patient stories provided a powerful influence on implementation for both policy-makers and -implementers.

8.2.4 Policy implementation was affected by factors which facilitated or inhibited stakeholder acceptance of self-management

To get the work of policy implementation done a number of processes have to happen at the level of patient care delivery. This is the front-line - policy-implementers need resources in the right combination: financial support; the development of skills and knowledge; management targets; and evidence to promote improvement. Where they were addressed they acted as facilitators (e.g. financial support through the self-management fund); where they were limited or overlooked then they were shown by the data to act as inhibitors (e.g. lack of evaluation to demonstrate success or failure).

Policy-implementers had access to a dedicated financial fund, which should have facilitated policy implementation, or at least not acted as a barrier to success. The self-management fund acted as a strong incentive, one designed to ensure compliance and recognised as an approach used by government to promote policy implementation (Smith et al. 2011). However, the financial resources associated with self-management initiatives were administrated and allocated under tight restrictions which compromised their effectiveness in sustaining implementation. It was a model of short-term funding which created a shifting socio-economic background at the level of policy-implementers and this has been shown to destabilize policy implementation. My findings reinforce Sabatier and Mazmanian’s (1979) observation that the allocation of resources should provide a stable operational environment in order to create positive conditions for effective policy-implementation. Uncertainty, here in the form of short-termism, created the conditions for a dysfunctional system.

Patients also need resources, and this was recognised by policy-implementers because their absence created barriers to embedding the concept of self-management. Policy-implementers wanted to promote self-management to their patients but they felt frustrated by the patients' lack of willingness to accept the demands this made on them. Interview data revealed that self-management policy expected patients to accept greater personal responsibility, enablement and empowerment and the creation of an environment which moves away from the usual paternal relationship. Local policy-implementers, most notably DNs, told me that some of their patients with LTCs lacked confidence in the new intervention. They were concerned that self-management would not reach those patients who needed it most: the elderly, those with more than one LTC and those living in poor social and economical circumstances. These factors represented a DN's 'typical' patient and also recognised as a significant proportion of the Scottish population (Loretto and Taylor 2007). This creates a policy paradox with policy designed to support the most in need having greatest impact for those who can help themselves and least on those who might benefit the most.

To illustrate this let us consider the following hypothetical NHS Kuzburgh patients. Given NHS Kuzburgh's industrial past, COPD and diabetes were common LTC.

> *'Jane' lived in a rural location 20 miles south of two larger towns. She was 77 years and immobile due to obesity. She had a history of COPD as a consequence of smoking and for the last 10 years suffered from Type I diabetes. She required a DNs visit twice a day for her insulin to be administered. Despite encouragement from the DN team both 'Jane' and her family would not take on*

> *the task of insulin administration. In addition, though there was a local diabetes self-management programme run in the health centre Jane could not leave the house easily and therefore could not benefit from peer-support and training in balancing carbohydrate intake and her does of insulin. Consequently, 'Jane' was receiving on-going DN* support and frequent admissions due to exacerbation of her COPD.
>
> *In contrast 'Fred' was a 49 year old, employed brick-layer who had had severe asthma all his adult life. He attended his GP surgery every 6 months for a respiratory assessment and recorded his peak flow measurements and what medication he took daily in a diary. He had recently completed a 6-week pulmonary rehabilitation programme and his exercise tolerance had increased. He felt motivated and in control of his condition and his health and well-being were good. His contact with the DNs or practice nurse was infrequent, more a partnership than a patient-carer relationship. He has benefited from the promotion of self-management policy in NHS Kuzburgh.*

Healthcare policy should focus on the patient experience and start with an understanding of who the policy might help the most and build policy to meet the needs of the most complex patients and not the easiest, but as *'Jane'* and *'Fred'* show policy-implementers like the DNS Debbie had to work with both realities. Despite her best efforts '*Debbie*' could not persuade '*Jane's*' family to engage in self-management, the family saw it as Jane's right to have healthcare delivered that relied on practitioners and the NHS. They were not going to engage in self-management because it was not their responsibility. Consequently, policy was not reaching those that need it most and despite '*Debbie's*' effort to promote self-management policy with '*Jane*' she resisted, and with no engagement the effort made by '*Debbie*' was lost and no evidence collected to show what might have been or how patients like '*Jane*' could become self-managers of their LTC.

Management targets were another important driver in policy implementation. Targets work because policy-implementers, particularly health service managers, recognise that they must generate evidence to demonstrate government effectiveness and facilitate policy implementation by promoting accountability (Sanderson 2006). However, such top-down incentives ultimately led to frustration amongst policy-implementers. They were blunt instruments, failing to reflect the true impact of self-management: helping patients with LTCs to feel better. HEAT targets focused on reducing hospital admissions or patient length of stay; in contrast, self-management was not interpreted in such crude target-driven terms by policy-implementers. There was a tension between the policy-makers' focus on the use of top-down measures of performance to drive implementation and the desire for policy implementers to show patient improvement. This highlights the difference between evidence that promotes accountability versus evidence promoting improvement (Sanderson 2006). Both forms of evidence are important in the process of policy implementation and evidence of promotion improvement is essential to sustain and embed policy.

Improving the quantity and clarity of evidence contained within policy documents is widely recognised as a key to sustaining and embedding initiatives. It would support the policy's purpose and implementation (Ham et al. 1995; Mays et al. 2005; Sanderson 2006; Sanderson 2002). However, the poor effort to collect evidence to promote improvement was a striking feature of my research. Attempts at gathering evidence which promoted improvement were undermined by weak performance. Without a clear approach to generating evidence policy is not carried forward and in turn no evidence is created: a downward spiral of implementation failure characterised by poor sustainability. Why is this?

Evidential failure was best illustrated by the limited evaluation of a self-management programme in diabetes. Practitioners collected baseline data on 300 patients who enrolled on the programme but only collected post-programme data on 7 patients: so no impact/outcome could be determined. The reasons for such poor follow-up are hard to explain but appear to relate to administrative issues with a number of personnel changes, a lack of clarity around approval for new funded posts and confusion as to whose responsibility it was to collect this data. These practical issues impact on continuity and progress. In the sense that they are context-dependent they are hard for policy-makers to foresee and plan for; but ultimately they seriously compromise policy-implementation. And such contextual issues can at least be anticipated in their generalities: my research shows that they are likely to occur. My example shows that there are real obstacles to the generation of evidence and that these are contextual and not just intellectual (knowing what evidence is where and how to use it) (Finch et al. 2012). Policy-makers must support implementers to tailor delivery; and assessing impact has to be context specific.

8.2.5 Analytical insights of the policy process as revealed by NPT

During analysis the application of NPT has enabled some key questions to be asked of these data which better explain the process of policy implementation. These questions provide a sociological perspective on what should be happening and as much is learnt from what work is evident as what is absent (Finch 2015). NPT, by working with the complexity of policy implementation and appreciating that implementation is non-linear, has revealed strong collaboration and participation in the work used by policy-makers and -implementers when delivering self-management policy (May et al 2010). The richness I have revealed through this theoretical perspective has not previously been explored in relation to the process of policy implementation.

Breton and De Leeuw (2011: 83) argue that:

> "*a good theory of the policy process should explain goals and perceptions, actions and events, among potentially hundreds of stakeholders in the process, leading to specific sets of policy outcomes*".

NPT provided an explanatory framework helping to identify these factors: the coherence, cognitive participation, collective action and reflexive monitoring required for successful policy implementation. It predicts that where there is strong coherence, good collaboration, focused work on participation and organised work on monitoring then an idea will be implemented (May et al 2010). Where these effects are weak or not evident there will be barriers to implementation, embedding and sustainability of a new initiative.

NPT has helped raise the most important questions with regard to the importance and influence of context. Healthcare is phenomenally complex: the implementation of new ideas into practice is influenced by multi-faceted relations between behaviours and individuals (Finch et al. 2012). NPT allows appreciation of the importance of social context (Finch et al. 2012); but this is only one contextual element and my analysis of NHS Kuzburgh has revealed that other contextual aspects are also important in determining the likelihood of policy implementation. Specifically, the historical context and this health board's experience of previous unsuccessful change initiatives meant policy-implementers were proactively motivated to do things differently. Lloyd et al.

(2013) also showed the impact of a past-experience on the uptake of a new initiative and adds further weight to developing greater contextual sensitivity.

It is difficult to account for all contextual conditions of a particular phenomena, since they differ from situation to situation (Fulop et al. 2001). What we can do is use this research and others to highlight what contextual aspects provide the most useful insight and from this generate insights which can be applied across settings. We can generalise from the particular to show in what ways contextual factors most often impact on policy implementation.

Analysis using the frameworks of NPT has shown that social context is important, and provides for this. But in addition there is evidence that historical perspectives and previous experience are also important influence on receptivity to implementation.

Contextual influences unique to NHS Kuzburgh are its geography, which is diverse and covers rural and urban areas. Its industrial past, based on coal mining and steel production, has impacted on the long-term health of the population. In turn these contextual aspects have impacted on patient engagement in self-management and create both physical and geographical barriers to policy implementation. The difficulty is that these contextual elements are different from one health board to another; and yet each theme (history, experience, population, geography) are common to the experience of all. NPT has enabled an accurate picture of events and influences on policy (self-management) and this context (NHS Kuzburgh) it provides internal validity. It does not have the ability to provide external validity across all populations, all new initiatives or all organisations (Ferlie 2001). A next generation of NPT theorists needs to address this lacuna in its theoretical power to explain.

8.3 Strengths and weaknesses of the study

The strengths of this research were: the worth and relevance of the study; its the depth and detail; the high level response rate to interview requests; its unique focus on understanding the experience of policy-makers and -implementers in the act of policy implementation and its application of a sociological theory to understand the translation gap of policy implementation, recognised as an important and expanding evidence base in implementation science (McEvoy et al. 2014).

The worth and relevance of this study can be gauged by considering the extent to which self-management is a good exemplar from which to consider the process of policy implementation and the extent to which the findings are applicable beyond Scotland.

Policy promoting self-management support for people with LTCs is a priority for the NHS across the UK. It must rise to the combined challenge of an ageing population and the rising prevalence of long-term disease. How to manage these factors presents a global challenge and, therefore, an area of global debate (WHO 2011). Self-management policy in Scotland is seeking to rise to this challenge: its implementation is an important and topical area to explore. The focus of this debate is how to use policy to tackle LTCs and meet the challenge. Of equal relevance is the observation that much of the policy presented in this research focuses on doing things differently to improve the quality of healthcare being delivered. This type of clinically focused improvement and change is notoriously difficult in the NHS (Boaden et al. 2008). Therefore, careful examination of a policy which is a driver for change and improvement provides valuable insight into both areas. It extends the application of my findings to a global context. Self-management policy is recognised as an area where Scotland is perceived as being “ahead of the game” - providing leadership and testing ideas from which other areas of the UK can learn(Tackling Long Term Conditions 2013). This is particularly true of aspects such as: integration of care; social capital and patients as assets; and approaches to risk-profiling as a means of targeting resources to those who need services most (Tackling Long-Term Conditions 2013). Given this acknowledgement there is something that the wider NHS can learn from through this exploration of Scottish policy and the findings are not restricted to one part of the UK.

The depth and detail of the research was ensured by applying three approaches to data collection and this, combined with consideration of three organisational levels, allowed a detailed examination of policy process at the time of the event - in real-time. In addition my high response rate ensured depth, breadth and quality of data (Cleary et al. 2014).

This research has generated new understanding of the experience of policy-makers and -implementers in the act of policy implementation. My research in this field is unique and contributes to a recognised gap in the policy implementation literature. Traditionally, the policy implementation debate was focused on “top-down or bottom-up” models with contributions from Sabatier (1986), Lipsky (1980) and Barrett and Fudge (1981). During the 1990s, the debate about policy implementation stalled until the early 2000s when there were calls for a revival and new research (Schofield 2001; Barrett 2004; O'Toole Jr., 2000). My research has bridged this lacuna in the development of new ideas and our understanding of the process of policy implementation.

I have undertaken research in a complex area – policy implementation – and in a dynamic and complex environment - the healthcare system. This is an important research problem (May 2013) but one that requires considerable skill to operationalise in the complex adaptive system which, is modern healthcare (Plesk and Greenhagh 2001). NPT has provided a useful framework with which to set boundaries and apply clarity of vision to the interacting systems which operate at national, regional and local health policy levels.

The novel use of the sociological theory NPT to understand the translation gap between policy-making and the actions or work of policy-makers is a further strength. NPT represents the use of a theoretical perspective in an area of literature, which has been criticised for lacking theoretical structure (Matland 1995). Secondly, using NPT fits with the growing interest in its application and testing, which has emerged recently (McEvoy et al. 2014).

NPT is a new theory and this research has added to its expanding evidence base. When originally conceived, it was applied to e-health and telehealth. My research goes beyond these original areas of interest and applies NPT to qualitatively analyse the implementation of policy in healthcare: a complex intervention in a complex and highly contextual setting. . Unlike the he majority of NPT testing (prior to 2012) I have tested all four constructs (e.g James 2011; MacFarlane and O' Reilly-de Brun 2012). Where all four constructs have previously been tested, research commonly relied on secondary data analysis (e.g. Gallacher et al. 2011). I have tested them with primary data. The application and testing of in such a robust manner with empirical data adds further strength and demonstrates the robustness of my research.

The weaknesses and limitations of this work are methodological, and consequently impact on the perceived quality of the research. Mays and Pope (2000) state that the quality of qualitative research is influenced by a number of factors and these provide a framework from which to explore the areas of weakness. Of particular relevance are sampling, data collection and analysis, contextual descriptions and reflexivity of the researcher.

Sampling in my research was conducted by a mixture of purposeful and snowball sampling. It could be argued that the scope of cases was not as extensive as possible, limiting the opportunity for conceptual generalisation (Cleary et al. 2014). It could also be argued that this approach does not extend the sample to data that might highlight negative cases (Mays and Pope 2000) as the focus is on following networks whose participants are more likely to identify future participants with similar views to themselves.

One of the principle data collection tools were semi-structured interviews recognised as one of the most familiar and yet hardest qualitative research tools to apply (DiCicco-Bloom and Crabtree 2006). Consequently, limitations such as investigator and observer effects (Fontana and Fray 2005; Fincham and Rohdes 1992) may have played a part in the character of the collected data. My inexperience as a researcher might have meant that my personal bias and lack of interview skill distorted the data and this is obvious in some of the early interviews where there are examples of leading questions. Similarly, my respondents could be perceived as giving a largely positive account of policy implementation and so subject to the observer effect by revealing what they believed was socially or politically desirable – what the researcher wanted to hear (Fincham and Rohdes 1992).

Another area of methodological weakness lay in the sampling strategy. Snowballing depends on careful selection of the initial participants, since they have a strong influence on who the researcher approaches next (Miles and Huberman 1994; Bowling 2002). Consequently there is an acknowledged risk of weighted selection in favour of participants who have similar ideas. On reflection, to address the potential risk of snowballing sampling there would have been benefit in asking a supplementary question such as: '*and why do you think they would be useful?*' to help avoid bias towards positive views of self-management possible issues. However, I am generally satisfied that the advantages in my approach, as described in **Section 4.3.1**, fully justify the potential risks.

Data analysis procedures could also be identified as an area of weakness, particularly in relation to the retrospective application of NPT as an analysis framework. Ideally, NPT should have been agreed prospectively as the framework to data analysis. Prospective application of NPT would allow true testing of the impact of all four constructs in an implementation journey and/or to reveal if one or other construct emerges as more important in supporting implementation than the other (McEvoy et al. 2014). The application of NPT in this way is underway (Finch 2015). However, I would argue that its retrospective application ensured that data collection was not biased towards NPT applicability.

In addition, interpretation of the four NPT constructs during data analysis was difficult, and there was a tension between the pre-determined constructs and associated mechanisms. Seeking to interpret the data but yet not force the data where it did not fit was a challenge, which I, and other NPT researchers report (MacFarlane and O'Reilly-Brun 2012). In addition I added to this challenge by having to 'get it right' not just for the four mechanisms - knowing what was collective action and what was cognitive participation - but down to the level of skill-set workability or communal appraisal. Subsequent discussion of the application of NPT revealed that the expectation is that all

16 elements do not need such consideration (Finch 2015). I argue, however, that on balance those tensions benefited the sensitivity of my analysis and my reflexivity.

Healthcare is by its nature context specific, an area which causes difficulty and limitations for many applied healthcare researchers. Consequently, it is important to describe the setting adequately so that a judgment can be made as to how my research findings relate to other settings (Mays and Pope 2000).

My research was focused on one health board and it could be contested that it was restrictive, limiting its applicability. The nature of qualitative research is to focus on "*the concrete and the particular*" (Yin 2011: 211) so it can be hard to argue that findings from qualitative research are applicable beyond the circumstances in which they were generated. However, I have sought to off-set any criticism of too narrow a focus by including different organisational levels and considering both the perspective of policy-makers and -implementers. This has generated a broad understanding of the process of policy implementation. In one sense, the sensitivity to the individual context of NHS Kuzburgh is itself applicable on the national and global scale.

Additional credibility has been added to my findings through the close parallels which can be drawn between what I have found, and existing research on policy implementation and the delivery of change in healthcare. It has been challenging to combine these two bodies of literatures but there is benefit in acknowledging their interaction and close association. Furthermore, given the complex and difficult nature of healthcare it is unlikely that one perspective on change will be sufficient (Plesk and Greenhalgh 2001). I have shown that a combination of ideas and perspectives is the best means of understanding the process of policy implementation in healthcare.

Throughout my research I have sought to apply reflexivity. The degree to which this is perceived as adequate or not may been seen as limitation. I am an in-experienced researcher, I was a single researcher, not part of a research team, and the complexity of the topic and research context have demanded much resilience and perseverance to conclude this study.

8.4 Comparison to existing literature

The findings from this study deepen our understanding of the policy process from the existing published work. Rationale models of policy, the policy process and implementation have dominated this academic discipline for over 30 years (Hogwood and Gunn 1984; Jenkins-Smith and Sabatier 1993; Kingdon, 1995) and yet do not adequately reflect the lived experience of policy-makers, policy-implementers and practitioners (Katikireddi et al. 2014). This research goes some way to bridging the gap between theory and practice, by revealing a detailed account which highlights the interplay of the individual and organisational mechanisms operating when self-management policy is being implemented. The research shows how these mechanisms operate in a non-linear manner and confirm the importance of policy-implementers in making sense of self-management; how they operationalise engagement, get the work done and seek to evaluate impact and outcome shows how dynamic, self-aware and proactive their role is.

Researchers recognise that work like this study is needed to enhance practitioners' and researchers' engagement and understanding in the policy process (Katikireddi et al. 2014). The analytical insight provided by NPT reveals what work policy-makers and -implementers were using across the policy process. In previous studies exploring policy implementation the importance of one or two elements in the policy process emerged, such as clinical leadership (Haycock-Stuart and Kean 2014); or the influence of power (Taylor 2013); the role of networks and the co-operative capital they possess (Tantivess and Walt 2008); and ideas on entrepreneurship and its role in the generation of new practices (Maguire et al. 2004); or the nature of evidence used in healthcare policy implementation (Evans et al. 2013). My research has considered the translation of policy from a broader, more holistic perspective, to reflect the complex nature of modern health policy and the multiple agencies involved in its implementation.

Consequently, I have been able to reveal to importance of understanding health policy implementation from the front-line. Like other researchers (Tomm-Bonde et al. 2013) I have found a mismatch between policy-makers and -implementers in conceptualising self-management. Policy-implementers focused on what they were being asked to do and so interpreted self-management as the closest fit to their personal perspective and knowledge of their patients, and were frustrated by the policy-makers' and managers attempts' to direct and control implementation. In my research, where implementation worked best where policy-implementers were in charge of ideas and responded to patient need, implementation was not integrated or embedded because of unsustained top- down interventions. Tomm-Bonde and colleagues (2013; 69) observed that "*implementation is the Achilles heel of innovation*"; my research adds that policy-makers must also consider integration and embedding of policy if implementation is to be achieved.

The focus on health policy implementation adds to a body of specialist knowledge and demonstrates the applicability of policy implementation studies on different areas of policy, such as crime (Smith et al. 2011). My research demonstrates that policy operates at different levels (National, Regional and Local); but the relationship between these levels is not linear and ideas are refracted and operationalised to meet local contexts and the knowledge of local practitioners. The process of policy implementation with the analytical insight of NPT is better conceived as a number of cognitive mechanisms culminating in collective action or enacting work (May 2013).

8.5 Implications for policy-makers, -implementers and researchers

For policy-makers an important implication to arise from this work is that they should consider the prospective use of implementation frameworks, like NPT, in the policy process. Researchers have observed that theoretical frameworks are rarely used in relation to policy delivery or, when used, are applied retrospectively rather than prospectively (Breton and De Leeuw 2011; Tomm- Bonde et al. 2013). Planning policy implementation with the support of implementation frameworks would help policy-makers take account of the dynamic elements of the systems within which policy operates and plan important aspects of understanding, involvement, participation and evaluation, all revealed by NPT.(May 2013).

In addition, policy-makers need to recognise the actions associated with developing a shared understanding of the intention of policy as part of the policy implementation process. Policy-makers would do well to recognise the influence policy-implementers have on developing shared understanding, and not focus just on policy documents. These documents provide a dominant discourse, allowed it to develop over time and set out guidance in broad terms of the policy direction. However, they are not sufficient in themselves to implement or embed policy I have shown that the work that regional and local policy-implementers do to make sense of policy and policy-makers involves local knowledge, networks and leadership.

The importance of participation is another area of recommendation to emerge for policy-makers and researchers. There is value in policy-makers seeking to ensure active participation to get the work of policy implementation done. Specifically, the participation of those not traditionally part of the policy process, such as patient organisations or the use of patient stories, helped implementation and delivery. Patient involvement provided evidence of what the policy meant but also why it was worth working towards. The patients' voice emerged in my research as a powerful driver of implementation and change and this is an area worth closer scrutiny.

The key message for policy-makers and -implementers is to look at what is already going on and how new policies might fit with existing work. Policy-makers could use this information to align initiatives rather than appear to be introducing concepts that are all new or removed from existing clinical networks, organisational structures and leadership. This avoids the conception that policy implementation is hierarchical and provides a more sustainable model of how policy can be embedded and integrated beyond implementation. Consequently, greater recognition of local context should be made by policy-makers and for researchers in this field the influence of context on policy implementation should be given closer attention

Finally, this work recommends that policy-makers take time and effort to support policy-implementers more effectively to determine the impact of policy. Policy-makers must support policy-implementers to have the time (not assess impacts over too short a time period) find what work is needed to demonstrate impact and what outcomes health policy reveals for patients. Without evidence of what is working or not then future policy-implementers will be reluctant to contribute to policy change, there will be less management buy-in and more scepticism about who might benefit most from policy.

However, evidence-building in policy is a journey which starts with evidence which promotes the initiation of policy and then moves to evidence which supports implementation. However, for policy to be integrated and embedded the nature of the evidence changes. The process explained here reveals a broad interpretation of evidence (e.g. use of digital stories, colloquial language) but a lack of detailed and sustained evidence to support embedding, with particular concern that the patients who benefit from policy implementation are not those who need it most. The changing relationship of evidence as the policy process evolves and how health policy can best target those who need it most, are both areas for future research.

The recommendations that emerge from the use of NPT, other than its prospective use, include wider testing of its mechanisms to topics beyond those of its traditional focus in e-health. This level of scrutiny will allow researchers to evaluate how successful NPT is in determining implementation processes and recommending how to make implementation and policy change more successful. Potentially, NPT offers scope for bridging the translational gap between what makers of policy want to happen and how policy-implementers might achieve policy change. This work might demonstrate that it truly is a theory of implementation and not simply a heuristic device (May 2013; McEvoy et al. 2014).

8.6 Summary

Policy promoting self-management for people with long-tem conditions was implemented in a complex environment which presented significant research challenges. There was a responsiveness beyond what might have been expected given the potential weariness one might expect among NHS staff subjected to what appears almost constant change and re-organisation (Boaden et al. 2008). This might best be explained by considerable work to promote participation and collaboration which ensured positive communication and a strong patient focus to the concept of self-management. In addition, leadership was evident at macro, meso and micro levels. In this narrative considerable effort was placed on the importance of leadership, with different approaches used. Patients and the voluntary sector through LTCAS provided leadership in partnership with traditional policy-makers. In addition, at the national level, effort was made to bring in clinicians to provide clinical leadership, again in partnership with policy-makers. These clinical leaders were known and recognised at health board and practice level, providing an important bridge between policy-maker and -implementer. This leadership at the policy-implementation level operated individually and collectively with a strong sense of team spirit.

This largely positive story is off-set by an apparent failure to sustain the initiatives which appear most directly to represent policy in action. Insufficient consideration was given to monitoring and provision of adequate resources. This non-sustainability was, in effect, built into the system. At policy-making level initiatives such as the LTCC and the Self-Management Fund were only established for set periods of time (3 years). Without adequate time to prove its worth self-management was perceived as desirable but frustrating, since its potential benefits could not be sufficiently demonstrated to ensure on-going support. Self-management at the level of policy implementation became one of many competing priorities.

The analysis of policy implementation process is as important as identifying the approach taken - be it top-down or bottom-up. Research exploring policy implementation process is a legitimate area of study and NPT has proved a useful analytical framework with which to identify potential barriers and facilitators for the process.

Chapter 9 Recommendations and conclusion

9.1 Introduction

This last chapter makes final recommendations and concludes the thesis.

Traditionally, the view of policy making is that the people who make it have little understanding or regard for how the policy will work in practice. I have confirmed that there was a discrepancy of understanding between those making policy and those implementing it and the balance of meaning and understanding lay with those operationalising policy; policy-implementers. High levels of consultation facilitated this implementation process and strong efforts to promote participation were well conceived and executed. Most noticeable was the vernacular voice offered to engage and participate with those people who had an LTC. The level of patient engagement in the policy process was significant and unique. As identified by the implementation literature the role of leadership and particularly clinical leadership were given considerable attention and this worked to support the process of policy implementation. Similarly, generating and linking new organisational structures enhanced the implementation process. Alongside these organisational frameworks support was provided by the use of financial drivers and management targets. These worked to an extent but short-termism and shifting priorities undermined their long-term impact. Most significantly, the need for evaluation and monitoring was not fulfilled or carried through. Consequently, there was little evidence generated to show that this process of policy implementation was attaining the patient outcomes needed to ensure it would be carried forward. The evidence generated was experiential which did not provide the robust data to prove that policy impacted on financial or management targets. Furthermore, there was insufficient evidence that the policy directly benefited those who needed it most (socio-economically deprived patients and those with more than one LTC). Consequently, scepticism that this policy would only help those that can already help themselves and not have the wider impact in addressing the needs and improve the health of the most vulnerable persisted; a serious hindrance to the success of the self-management policy process.

My research has generated a unique narrative explaining the experience of making, implementing and seeking to embed health policy in Scotland. It has mapped the collaboration and communication evident from three distinct perspectives: policy-makers reflecting national policy direction (in this case what the Scottish Government thinks should be done to meet the challenge of the rising prevalence of LTCs); insight into the regional/executive policy-implementers operating in one health board; and the experience of local practitioners focused on translating policy into better patient outcomes. Investigation of macro- and meso-levels of policy implementation is unique (Fulop et al. 2001) and has proved a challenging undertaking.

9.2 Recommendations

A more specific evaluation of the implementation of self-management policy is necessary. So, in contrast to looking at the implementation of self-management policy at an organisational level (the focus of this research) I recommend consideration of the insight NPT might bring to self -management policy in relation to, for example, people with diabetes compared to people with COPD. This would be an important new area of research, which would build on our understanding of NPT as a general theory of implementation (May 2013). In addition it would add to the growing evidence base testing NPT and may identify which, if any, are its most important mechanisms. Evaluation the implementation of healthcare policy in this manner would be helpful to relevant mangers and policy-makers as well providing greater consideration of patients and the work they have to do to operationalize self-management on a daily basis (May 2013).

I recommend more detailed examination and understanding of the work or effort required to embed and sustain policy implementation, given that coherence and expectations of policy are important to support effective implementation. Understanding how to improve this aspect, perhaps through communication and good information, is an area worthy of further exploration.

Further work to understand the best and most effective means of appraising the impact of policy also emerged as an area for future research. Assessing impact or providing robust evidence to sustain and embed new policy initiatives emerges as an area worthy of further research. In my examination of the policy process effort was made to assess impact of new initiatives. However, I have shown that work to appraise policy impact was undertaken too soon to show the consequences on patient outcome. This and other evidence, including work by Wandersman et al. (2012) reveals that we are still unable to define what works best because appraisal work is not carried through to a useful conclusion.

Further research and testing of NPT in the areas of policy implementation is required. NPT was developed to address the observed difficulty of implementing and integrating new treatment and ways of organizing care in the health service setting. (May et al. 2009). It was not developed with policy implementation in mind but there has been, and continues to be, an interest in implementation and specifically how it can learn from other disciplines (Schofield and Sausman 2004; May 2013). Further testing of NPT would help refine this area of thinking. This research has effectively demonstrated the social nature of policy implementation and how positively people engage with it even when barriers, which impede the success and sustainability of implementation, frustrate them. To understand policy implementation and the delivery of change in health care practice requires detailed exploration of the behaviours of organisations and individuals. NPT provides insight into the social context of how new initiatives are implemented (Finch et al. 2012). However, wider contextual aspects such as geography and location of organisations, population need and an organisations previous experience of dealing with change and or policy change are less well captured by NPT. This work reveals that these wider contextual aspects are important factors influencing the integration and embedding of a new initiative. Developing the contextual sensitivity of NPT would add to its validity as a theory of implementation.

Greater understanding of the process of assessing policy outcomes is also recommended by this work. The demonstration of successful implementation is such an influential aspect of all healthcare interventions (policy or change) and yet remains illusive. Work on this aspect would be an important area of theoretical debate and promise practical relevance for practitioners, policy-makers and researchers.

The field of policy implementation is a potentially rich area of research and, given the scope and challenges of health policy, its implementation should be the focus of more studies.

9.3 Conclusion to thesis

Policy and its objectives must be defined if the desired actions are to be achieved. Understanding the process of policy implementation has proven to be complex and multidimensional, with some aspects working well and other aspects not. With regards to policy promoting self-management for people with LTCs I found a willingness to implement and enact it. There was a strong sense of collective responsibility at all organisational levels. Professional leadership was strong and effective and organisational structures existing and new created effective administrative authority. The most noticeable characteristic of the policy implementation process was wide participation, which extended beyond the traditional stakeholders of Government and Health Boards. Self-management policy in Scotland is policy for people with LTCs by people with LTCs.

References

Ajzen, I. (1991). The theory of planned behavior. *Organisational Behavior and Human Decision Processes, 50*, 179-211.

Allsop, J. (1995). *Health policy and the NHS towards 2000* (2nd ed.). Essex: Longman.

Anderson, J. E. (1975). *Public policy-making*. New York: Praeger.

Armenakis, A. A., and Bedeian, A. G. (1999). Organizational change: A review of theory and research in the 1990s. *Journal of Management*, *25*(3), 293-315.

Ashford, J., Eccles, M., Bond, S., Hall, L., and Bond, J. (1999). Improving healthcare through professional behaviour change: Introducing a framework for identifying behaviour change strategies. *British Journal of Clinical Governance, 4*(1), 14-23.

Audit Scotland. (2014) *Reshaping care for older people.* Edinburgh, Audit Scotland. Retrieved 02/15, 2014 from http://www.audit-scotland.gov.uk/docs/central/2014/nr_140206_reshaping_care.pdf

Auerbach, A. D., Landefeld, C. S., and Shojania, K. G. (2007). The tension between needing to improve care and knowing how to do it. *New England Journal of Medicine, 357*(6), 608-613.

Baggott, R. (2007). *Understanding health policy*. Bristol: The Policy Press.

Balogun and Hope Hailey, J., and Hope Hailey, V. (2008). *Exploring strategic change* (3rd ed.). London: Prentice Hall.

Bamford, D., and Daniel, S. (2005). A case study of change management effectiveness within the NHS. *Journal of Change Management, 5*(4), 391-406. doi:10.1080/14697010500287360

Barrett, S. M. (2004). Implementation studies: Time for a revival? personal reflections on 20 years of implementation studies. *Public Administration, 82*(2), 249-262.

Barrett, S. M., and Fudge, C. (1981). Examining the policy-action relationship. In S. M. Barrett, and C. Fudge (Eds.), *Policy and action. essays on the implementation of public policy* (pp. 3-38). London: Methuen.

Barnett, K., Mercer, S. W., Norbury, M., Watt, G., Wyke, S., and Guthrie, B. (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. *The Lancet, 380*(9836), 37-43. doi:http://dx.doi.org/10.1016/S0140-6736(12)60240-2

Bate, P. (2000). Changing the culture of a hospital: From hierarchy to Networked Community. *Public Administration, 78*(3), 485-512. doi:10.1111/1467-9299.00215

Bate, P., Bevan, H., and Robert, G. (2004). *'Towards a million change agents'. A review of the social movements literature: Implications for large scale change in the NHS.* London: NHS Modernisation Agency.

Battilana, J. (2006). Agency and institutions: The enabling role of individuals' social position. *Organisation, 13*(5), 653-676.

Bergen, A., and While, A. (2005). "Implementation deficit" and "street-level bureaucracy": Policy, practice and change in the development of community nursing issues. *Health and Social Care in the Community, 13*(1), 1-10.

Bergeron, H., and Kopp, P. (2002). Policy paradigms, ideas, and interests: The case of the french public health policy toward drug abuse. *The Annals of the American Academy of Political and Social Science, 582*, 37-48.

Blackman, T., Harrington, B., Smith, K., Hunter, D., Marks, L., McKee, L., . . . Williams, G. (2009). Health inequalities in England, Scotland and Wales: Stakeholders' accounts and policy compared. *Public Health, 123*(1), e24-28.

Blakemore, K. (2003). *Social policy. an introduction* (2nd ed.). Buckingham: Open University Press.

Boaden, R., Harvey, G., Moxham, C., and Proudlove, N. (2008). *Quality improvement: Theory and practice in healthcare*. Coventry: The University of Manchester. Manchester Business School.

Bouamrane, M. -.M, & Mair, F. S. (2013). A study of general practitioners' perspectives on electronic medical records systems in NHSScotland. *BMC Medical Informatics and Decision Making, 13*(58) http://www.biomedicalcentral.com/1472-6947/13/58

Bowling, A. (2002). *Research methods in health. investigating health and health services* (2nd ed.). Buckingham: Open University Press.

Bradley, E. H., Curry, L. A., and Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research, 42*(4), 1758-1772.

Brennan, S., McKenzie, J., Whitty, P., Buchan, H., and Green, S. (2009). Continuous quality improvement: Effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews,* (4) doi:10.1002/14651858.CD003319.pub2

Breton, E., & De Leeuw, E. (2011). Theories of the policy process in health promotion research: A review. *Health Promotion International, 26*(1), 82-90. doi:10.1093/heapro/daq051

Breton, E., Richard, L., and Gagnon, F. (2007). The role of health education in the policy change process: Lessons from tobacco control. *Critical Public Health, 17*(4), 351-364. doi:10.1080/09581590701549527

Brinkerhoff, D. W. (1999). State-civil society networks for policy implementation in developing countries. *Review of Policy Research, 16*(1), 123-147. doi:10.1111/j.1541-1338.1999.tb00844.x

Brooks, I., and Brown, R., B. (2002). The role of ritualistic ceremonial in removing barriers between subcultures in the National Health Service. *Journal of Advanced Nursing, 38*(4), 341-352.

Brown, L. D., Isett, K. R., and Hogan, M. (2010). Stewardship in mental health policy: Inspiration, influence, institution? *Journal of Health Politics, Policy and Law, 35*(3), 389-405. doi:10.1215/03616878-2010-004

Bryman, A., and Burgess, R. G. (1994). Reflections on qualitative analysis. In A. Bryman, and R. G. Burgess (Eds.), *Analyyzing qualitative data* (pp. 216-226). GB: Routledge.

Burnes, B. (2004). Kurt lewin and the planned approach to change: A re-apprasial. *Journal of Management Studies, 41*(6), 977-1022.

Buse, K., Mays, N., and Walt, G. (2005). *Making health policy*. Maidenhead: Open University Press.

By, R. T. (2005). Organisational change management: A critical review. *Journal of Change Management, 5*(4), 369-380. doi:10.1080/14697010500359250

Bywaters, P., and McLeod, E. (2001). The impact of new labour health policy on social services: A new deal for service users' health? *British Journal of Social Work, 31*(4), 579-594.

Cairney, P. (2007). Using devolution to set the agenda? venue shift and the smoking ban in Scotland. *British Journal of Politics and International Relations, 9*(1), 73-89. doi:10.1111/j.1467-856x.2007.00259.x

Carolan, M. (2003). Reflexivity: A personal journey during data collection. *Nurse Researcher, 10*(3), 7-14.

Challis, D., Hughes, J., Berzin, K., Reilly, S., Abeil, J., & Stewart, K. (2010) Self-care and self-management in long-term conditions: The effective management of critical interfaces. SDO Project (08/1715/201) Southampton: HMSO. Retrieved 06/23, 2008, 02/27, 2014 from http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0014/64310/FR-08-1715-201.pdf

Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: Does size matter? *Journal of Advanced Nursing, 70*(3), 473-475. doi:10.1111/jan.12163

Coleman, A., Checkland, K., Harrison, S., & Hiroeh, U. (2010). Local histories and local sensemaking: A case of policy implementation in the English National Health Service. *Policy and Politics, 38*(2), 289-306. doi:10.1332/030557309X462547

Creswell, J. W. (2014). Research Design. Qualitative, Quantitative & Mixed Methods Approaches. (4th Edition). London: Sage Publications Ltd.

Creswell J., W. (2007). *Qualitative inquiry and research design. choosing among five approaches* (2nd ed.). Thousand Oaks: Sage Publications.

Crichton, J. (2008). Changing fortunes: Analysis of fluctuating policy space for family planning in kenya. *Health Policy and Planning, 23*(5), 339-350. doi:10.1093/heapol/czn020

Crinson, I. (2009). *Health Policy a critical perspective*. London: Sage

Crotty, M. (1998). *The foundations of social research. meaning and perspective in the research process*. London: Sage.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476-1484.

Dacin, T., Goldstein, J., and Scott, W. R. (2002). Institutional theory and institutional change: Introduction to the special research forum. *Academy of Management Journal, 45*(1), 45-56.

Dargie, C. (2000). Policy futures for UK health. *Foresight, 2*(4), 401-409.

Davis, H., T., O . Nutley, S and Smith, P., (2000) Introducing evidence-based policy and practice in public services. In H. T. O. Davies, S. M. Nutley & Smith P. C. (Eds.), *What works? evidence-based policy and practice in public services.* (pp. 43-68). Bristol: The Policy Press.

Davies, H. T. O., and Nutley, S. M. (2000). Developing learning organisations in the new NHS. *British Medical Journal, 320*(8 April), 998-1001.

Denzin, N., and Lincoln Y., S. (2005a). The discipline and practice of qualitative research. In N. Denzin, and S. Lincoln Y. (Eds.), *The sage handbook of qualitative research* (Third ed., pp. 1-32). London: Sage Publications.

Department of Health, Social Services and Public Safety. (2012). *Living with long term conditions. A policy framework*. Northern Ireland: Department of Health, Social Services and Public Safety Retrieved 01/13, 2014 from http://www.dhsspsni.gov.uk/living-longterm-conditions.pdf

Depoy, E., and Gitlin, L., N. (1994). *Introduction to research. multiple strategies for health and human services*. St. Louis: Mosby.

DiCicco-Bloom, B., and Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314-321. doi:10.1111/j.1365-2929.2006.02418.x

DiMaggio, P. (1988). Interest and agency in institutional theory. In L. Zucker G. (Ed.), *Institutional patterns and organisations: Culture and environment*, pp. 3-21). Cambridge, MA: Ballinger.

Docherty, M., & Smith, R. (1999). The case for structuring the discussion of scientific papers. BMJ: British Medical Journal, 318(7193), 1224-1225. doi:10.1136/bmj.318.7193.1224

DoH. (1999). *Saving Lives: Our Healthier Nation*. Retrieved 03/10, 2015 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265576/4386.pdf

DoH. (2000) The NHS plan. A plan for investment. A plan for reform. London: Stationery Office. Retrieved 03/10, 2015 from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4002960

DoH. (2001). *The expert patient- a new approach to chronic disease management for the 21st century*. London: DoH. Retrieved 06/23, 2008, 02/27, 2014 from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018578.pdf

DoH. (2005). *Self care - A real choice* (1st ed.). London: DoH. Retrieved 06/23, 2008 from http://www.dh.gov.uk/assetRoot/04/10/08/92/04100892.pdf

DoH. (2006a). Our health, our care, our say. London: DoH. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453.

DoH. (2006b). *Supporting people with long term conditions to self care: A guide to developing local strategies and good practice*. London: DoH. Retrieved 06/23, 2008, 02/27, 2014 from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm

DoH. (2012). *Long term conditions compendium of information. third edition*. London: DoH. Retrieved from 06/23, 2008 02/27, 2014 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

Effective Health Care. (1999). Getting evidence into practice. *NHS Centre for Reviews and Dissemination Http://Www.York.Ac.Uk/Inst/Crd/Pdf/ehc51.Pdf, 5*(1), 1-16.

Eisenhardt, K., M. (1989). Building theories from case study research. *Academy of Management Review, 14*(4), 532-550.

Elwyn, G., Legare, F., Weijden, T., Edwards, A., and May, C. (2008). Arduous implementation: Does the normalization process model explain why it's so difficult to embed decision support technologies for patients in routine clinical practice. *Implementation Science, 3*(1), 57.

Erasmus, E., and Gilson, L. (2008). How to start thinking about investigating power in the organizational settings of policy implementation. *Health Policy and Planning, 23*(5), 361-368. doi:10.1093/heapol/czn021

Evans, B. A., Snooks, H., Howson, H., & Davies, M. (2013). How hard can it be to include research evidence and evaluation in local health policy implementation? results from a mixed methods study. *Implementation Science, 8*(1), 17-25.

Exworthy, M. (2008). Policy to tackle the social determinants of health: Using conceptual models to understand the policy process. *Health Policy and Planning, 23*(5), 318-327. doi:10.1093/heapol/czn022

Exworthy, M., and Powell, M. (2004). Big windows and little windows: Implementation in the "congested state" *Public Administration, 82*(2), 263-281. doi:10.1111/j.0033-3298.2004.00394.x

Exworthy, M., Berney, L., and Powell, M. (2002). 'How great expectations in westminster may be dashed locally': The implementation of national policy on health inequalities. *Policy and Politics, 30*(1), 79-96.

Farquharson, K. (2005). A different kind of snowball: Identifying key policymakers. *International Journal of Social Research Methodology, 8*(4), 345-354. doi:10.1080/1364557042000203116

Ferlie, E., and Pettigrew, A. (1996). Managing through networks: Some issues and implications for the NHS. *British Journal of Management, 7*(Special issue), S81-S99.

Ferlie, E., Fitzgerald, L., Wood, M., and Hawkins, C. (2005). The nonspread of innovations: The mediating role of professionals. *Academy of Management Journal, 48*(1), 117-134.

Ferlie, E. (2001). Organisational studies. In Fulop, N., Allen, P., Clarke, A. & Black, N. (Eds), S*tudying the organisation and delivery of health services. Research Methods* (pp. 24-39). London: Routledge.

Finch, T. (2015) Personal Communication. Institute of Health & Society, Baddiley Clark building, University of Newcastle. Tuesday, 13/01/15.

Finch, T., Mair, F., O'Donnell, C., Murray, E., & May, C. (2012). From theory to 'measurement' in complex interventions: Methodological lessons from the development of an e-health normalisation instrument. *BMC Medical Research Methodology, 12*(1), 69. doi:10.1186/1471-2288-12-69

Finch, T. (2008). Teledermatology for chronic disease management: Coherence and normalization. *Chronic Illness, 4*(June), 127-134.

Finch, T. L., Mair, F. S., & May, C. R. (2007). Teledermatology in the UK: Lessons in service innovation. *British Journal of Dermatology, 156*, 521-527.

Fincham, R., and Rhodes, P. S. (1992). *The individual, work and organisation. behavioural studies for business and management* (2nd ed.). London: Butler & Tanner.

Finlay, L. (2003). The reflexive journey: Mapping multiple routes. In L. Finlay, and B. Gough (Eds.), *Reflexivity. A practical guide for researchers in health and social sciences* (pp. 3-20). Oxford: Blackwell.

Fontana, A., and Frey, J., T. (2005). The interview. In N. Denzin, and S. Lincoln Y. (Eds.), *The sage handbook of qualitative research* (Third ed., pp. 695-727). London: Sage Publications.

Franx, G., Oud, M., de Lange, J., Wensing, M., & Grol, R. (2012). Implementing a stepped-care approach in primary care: Results of a qualitative study. *Implementation Science, 7*(8). doi:10.1186/1748-5908-7-8

Fulop, N., Allen, P., Clarke, A. & Black, N. (2001) Issues in studying the organisation and delivery of health services. In Fulop, N., Allen, P., Clarke, A. & Black, N. (Eds), S*tudying the organisation and delivery of health services. Research Methods* (pp. 1-23). London: Routledge.

Gallacher, K., May, C. R., Montori, V. M., and Mair, F. S. (2011). Understanding patients' experiences of treatment burden in chronic heart failure using normalization process theory. *Annals of Family Medicine, 9*(3), 235-243. doi:10.1370/afm.1249

Gallacher, K., Morrions D., Jani, B., Macdonald, S., May, C., Montori, V.M.; Erwin, P.J., Batty, G.D; Eton, D.T., Langhorne, P., Mair, F.S.; (2013). Uncovering Treatment Burden as a Key Concept for Stroke Care: A Systematic Review of Qualitative Research *PLoS Medicine, 10(6), Art. No.: e1001473 10.137journal.pmed1001473*

Gilson, L., Buse, K., Murray, S. F., and Dickinson, C. (2008). Future directions for health policy analysis: A tribute to the work of Professor Gill Walt. *Health Policy and Planning, 23*(5), 291-293. doi:10.1093/heapol/czn025

Gilson, L., and Raphaely, N. (2008). The terrain of health policy analysis in low and middle income countries: A review of published literature 1994–2007. *Health Policy and Planning, 23*(5), 294-307. doi:10.1093/heapol/czn019

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research* (Reprinted 2006 ed.). New Bruswick: Adeline Transaction.

Gordon, I., Lewis, J., and Young, K. (1993). Perspectives on policy analysis. In M. Hill (Ed.), *The policy process: A reader* (pp. 5-9). London: Harvester Wheatsheaf.

Gorsky, M. (2008). The british national health service 1948-2008: A review of the historiography. *Social History of Medicine, 21*(3), 437-460. doi:10.1093/shm/hkn064

Green, J., and Thorogood, N. (2009). *Qualitative methods for health research* (2nd ed.). London: Sage.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., and Kyriakidou, O. (2004). Diffusion of innovations in service organisations: Systematic review and recommendations. *The Millbank Quarterly, 82*(4), 581-629.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., Kyriakidou, O., and Peacock, R. (2005). Storylines of research in diffusion of innovation: A meta-narrative approach to systematic review. *Social Science and Medicine, 61*, 417-430.

Greenhalgh, T., Stramer, K., Bratan, T., Byrne, E., Mohammad, Y., and Russell, J. (2008). Introduction of shared electronic records: Mulit-site care study using diffusion of innovation theory. *Br.Med.J., 337*(7677), 1786-1795.

Greenwood, R., and Hinings, C. R. (1993). Understanding strategic change: The contribution of archetypes. *Academy of Management Journal, 36*(5), 1052.

Greer, S. L. (2004). *Four way bet: How devolution has led to four different models for the NHS*. London: UCL Constitution Unit.

Greer, S. L. (2005). The territorial bases of health policymaking in the UK after devolution. *Regional and Federal Studies, 15*(4), 501-518. doi:10.1080/13597560500230672

Grol, R., (2005). Effective organisation of the implementation. In R. Grol, M. Wensing and M. Eccles (Eds.), *Improving patient care. The implementation of change in clinical practice* (pp. 208-219). Edinburgh: Elsevier.

Grol, R., Wensing, M., Hulscher, M., and Eccles, M. (2005). Theories on implementation of change in healthcare. In R. Grol, M. Wensing and M. Eccles (Eds.), *Improving patient care. The implementation of change in clinical practice* (pp. 15-40). Edinburgh: Elsevier.

Grol, R., and Wensing, M. (2005). Effective implementation: A model. In R. Grol, M. Wensing and M. Eccles (Eds.), *Improving patient care: The implementation of change in clinical practice* (pp. 41-57). Edinburgh: Elsevier.

Gunn, L. A. (1978). Why is implementation so difficult? *Management Services in Government, 3,* 169-176.

Hall, C. M., and Jenkins, J. (2008). *Tourism and public policy* (Oxford ed.) Blackwell Publishing Ltd. doi:10.1002/9780470752272.ch42

Ham, C., Hunter, D. J., & Robinson, R. (1995). Evidence based policymaking. *British Medical Journal, 310*(6972), 71-72.

Ham, C., Kipping, R., & Mcleod, H. (2003). Redesigning work processes in health care: Lessons from the NHS. *The Millbank Quarterly, 81*(3), 415-439.

Ham, C. (2009). *Health policy in Britain* (6th ed.). Basingstoke: Palgrave.

Ham, C., Kipping, R., and Mcleod, H. (2003). Redesiging work processes in health care: Lessons from the NHS. *The Millbank Quarterly, 81*(3), 415-439.

Hammersley, M., and Atkinson, P. (1983). *Ehtnography: Principles and practice*. London: Tavistock.

Harper, D. (2003). Developing a critically reflexive position using discourse analysis. In F. Finlay, and B. Gough (Eds.), *Reflexivity. A practical guide for researchers in health and social sciences* (pp. 78-92). Oxford: Blackwell.

Haycock-Stuart, E., & Kean, S. (2013). Shifting the balance of care? A qualitative study of policy implementation in community nursing. *Journal of Nursing Management, 21*(6), 867-877.

Hayes, J. (2007). *The theory and practice of change management* (2nd ed.). Basingstoke: Palgrave Macmillan.

Health Improvement Scotland. (2012). *Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation.*. Edinburgh.: NHS Scotland. Retrieved on 06/23, 2013; 02/27, 2014 from http://www.healthcareimprovementscotland.org/our_work/cardiovascular_disease/stroke_and_systemic_embolism/stroke_and_systemic_embolism.aspx

Henderson, A. C. (2013). Examining policy implementation in health care: Rule abidance and deviation in emergency medical services. *Public Administration Review, 73*(6), 799-809. doi:10.1111/puar.12146

Henderson, C., Knapp, M., Fernández, J-L., Beecham, J., Hirani, S. P., Cartwright, M., . . . Newman, S., P. (2013) Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial. *BMJ* 346(7900) doi:10.1136/bmj.f1035 9 (Published 22 March 2013)

Herzlinger, R. E. (2006). Why innovation in health care is so hard. *Harvard Business Review, 84*(5), 58-66.

Hill, M. (1997). Implementation theory: Yesterday's issue? *Policy and Politics, 25*(4), 375-385.

Hill, M. (2005). *The public policy process* (4th edition ed.). Harlow: Pearson Education.

Hill, M., and Hupe, P. (2009). *Implementing public policy* (2nd ed.). London: Sage.

Hogwood, B. W., and Gunn, L. A. (1984). *Policy analysis for the real world*. Oxford: Oxford University Press.

Howieson, B., Sugden, R., and Walsh, M. (2013) Mutuality in Scottish healthcare: leading for public good. *Leadership 9(2) 162-179.* doi:10.1177/1742715013475563

Howlett, M., and Ramesh, M. (1995). *Studying public policy*. Oxford: Oxford University Press.

Hupe, P. L. (2011). The thesis of incongruent implementation: Revisiting pressman and wildavsky. *Public Policy and Administration, 26*(1), 63-80.

Iles, V., and Sutherland, K. (2001). *Organisational change. A review for healthcare managers, professionals and researchers*. London: NCCSDO. Retrieved 06/23, 2008 02/27, 2014 from http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1001-001_V01.pdf

James, D., M. (2011). The applicability of normalization process theory to speech and language therapy: A review of qualitative research on a speech and language intervention. *Implementation Science*, 6, 95. Doi:10.1186/1748-5908-6-95

Jenkins-Smith, H., C., and Sabatier, P., A. (1993a). The dynamics of policy-orientated learning. In P. Sabatier A., and H. Jenkins-Smith C. (Eds.), *Policy change and learning* (pp. 41-58). Boulder Colorado: Westview Press.

Jenkins-Smith, H., C., and Sabatier, P., A. (1993b). The study of public policy processes. In H. Jenkins-Smith C., and P. Sabatier A. (Eds.), *Policy change and learning. an advocacy coalition approach* (pp. 1-9). Colorado: Boulder.

Kalra, D., Gertz, R., Singleton, P., and Inskip, H. M. (2006). Confidentiality of health information used for research. *British Medical Journal, 333*(7560), 196-198.

Katikireddi, S. V., Hilton, S., Bonell, C., and Bond, L. (2014). Understanding the development of minimum unit pricing of alcohol in Scotland: A qualitative study of the policy process. *PLoS ONE, 9*(3), e91185. doi:doi:10.1371/journal.pone.0091185

Keating, M. (2005). Policy convergence and divergence in scotland under devloution. *Regional Studies, 39*(4), 453-463.

Kendrick, S., and Conway, M. (2006). Demographic and social change: Implication for use of acute care services by older people in scotland. *European Journal of Population/Revue Europeenne De Demographie, 22*(3), 281-307. doi:10.1007/s10680-006-9002-9

Kingdon, J. (1995). *Agendas, alternatives and public policies* (2nd ed.). New York: Harper Collins.

Koestler, A. (1978). *Janus: A summing up*. London: Picador.

Lewis, J. M. (2006). Being around and knowing the players: Networks of influence in health policy. *Social Science and Medicine, 62*(9), 2125-2136. doi:10.1016/j.socscimed.2005.10.004

Lipsky, M. (1980). *Street-level bureaucracy. dilemmas of the individual in public service*. New York: Russell Sage Foundation.

Lloyd, A., Joseph-Williams, N., Edwards, A., Rix, A., & Elwyn, G. (2013). Patchy 'coherence': Using normalization process theory to evaluate a multi-faceted shared decision making implementation program (MAGIC). *Implementation Science, 8*(102). doi:10.1186/1748-5908-8-102

Loretto, W., and Taylor, M. (2007). *Characteristics of adults in scotland with long-term health conditions (no. 59/2007)*. Edinburgh: Scottish Government Social Research. Retrieved from http://www.scotland.gov.uk/Resource/Doc/201268/0053757.pdf

LTCAS. (2006). *"Gaun yersel". the voluntary sector's approach to self-management conference.* Edinburgh: Long-Term Conditions Alliance Scotland. Retrieved from. http://www.nhstayside.scot.nhs.uk/ltc/ltc12_alliance/Conference%20Report.pdf:

LTCAS. (2008). *"Guan yersel!" the self management strategy for long term conditions in Scotland*. Glasgow and Edinburgh: LTCAS and Scottish Government. Retrieved from http://resourcelists.stir.ac.uk/items/2808955C-5278-A85F-5945-7A46B50904D1.html

MacCourt, P., and Tuokko, H. (2005). Development of a seniors' mental health policy lens: An analytical tool to assess policies and programs from a seniors' mental health perspective. *Canadian Journal of Community Mental Health, 24*(2), 35-53.

MacFarlane, A., and O'Reilly-de Brun, M. (2012). Using a theory-driven conceptula framework in qualitative health research. *Qualitative Health Research, 22*(5), 607-618.

MacFarlane, A., Tierney, E., & McEvoy, R. (2014). *A framework for implementation of community participation in primary care.* A University of Limerick and Health Service Executive Collaboration.

Mackenzie, M. (2008). 'Doing' public health and 'making' public health practitioners: Putting policy into practice in 'starting well'. *Social Science and Medicine, 67*(6), 1028-1037. doi:10.1016/j.socscimed.2008.05.021

MacKenzie, M., Blamey, A., and Hanlon, P. (2006). Using and generating evidence: Policy makers' reflections on commissioning and learning from the scottish health demonstration projects. *Evidence and Policy, 2*(2), 211-226.

Maguire, S., Hardy, C., and Lawrence, T. B. (2004). Institutional entrepreneurship in emerging fields: HIV/AIDS treatment advocacy in canada. *Academy of Management Journal, 47*(5), 657-679.

Mair, F. S., May, C., Finch, T., Murray, E., Anderson, G., Sullivan, F., . . . Epstein, O. (2007). Understanding the implementation and integration of e-health services. *Journal of Telemedicine and Telecare, 13*(suppl 1), 36-37. doi:10.1258/135763307781645112

Mair, F. S., Hiscock, J., and Beaton, S. C. (2008). Understanding factors that inhibit or promote the utilization of telecare in chronic lung disease. *Chronic Illness, 4*(June), 110-117.

Mair, F., S, May, C., O'Donnell, C., Finch, T., Sullivan, F., and Murray, E. (2012). Factors that promote or inhibit the implementation of e-health systems: An explanatory systematic review. *Bulletin of the World Health Organization, 90*(5), 357-364.

Marshall, J., and Olphert, A. (2008). Organizational change in the national health service: Lessons from the staff. *Strategic Change, 17*(7-8), 251-267. doi:10.1002/jsc.831

Matland, R. (1995). Synthesizing the implementation literature: The ambiguity-conflict model of policy implementation. *Journal of Public Administration Research and Theory, 5*(1), 145-174.

May, C., and Finch, T. (2009). Implementing, embedding, and integrating practices: An outline of normalization process theory. *Sociology-the Journal of the British Sociological Association, 43*(3), 535-554. doi:10.1177/0038038509103208

May, C. R., Mair, F., Finch, T., Macfarlane, A., Dowrick, C., Treweek, S., . . . Montori, V. M. (2009). Development of a theory of implementation and integration: Normalization process theory. *Implementation Science : IS, 4*, 29-36.

May, C., Murray, E., Finch, T., Mair, F., Treweek, S., Ballini, L., Macfarlane, A. and Rapley, T. (2010) *Normalization Process Theory On-line Users' Manual and Toolkit*. Available from http://www.normalizationprocess.org [Accessed on 4th March 2015].

May, C. (2013). Towards a general theory of implementation. *Implementation Science, 8*(18), 18-32. doi:10.1186/1748-5908-8-18

Mays, N., Pope, C., & Popay, J. (2005). Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *Journal of Health Services Research & Policy, 10*, S6-S20.

Mazmanian, D. A., and Sabatier, P. A. (1983). *Implementation and public policy*. USA: Scott, Foreman and Company.

McConnell, A. (2010). *Understanding policy success. rethinking public policy*. Basingstoke: Palgrave Macmillan.

McEvoy, R., Ballini, L., Maltoni, S., O'Donnell, C. A., Mair, F. S., & MacFarlane, A. (2014). A qualitative systematic review of studies using the normalization process theory to research implementation processes. *Implementation Science, 9*(1). 2-14.

McLaughlin, M., W. (1987) Learning from experience: Lessons from policy implementation. *Educational Evaluation and Policy*, 9(2), 171-178.

Miles, M. B., and Huberman, M. A. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). London: Sage.

Miller, F. A., and Alvarado, K. (2005). Incorporating documents into qualitative nursing research. *Journal of Nursing Scholarship, 37*(4), 348-353.

Mintrom, M. (1997). Policy entrepreneurs and the diffusion of innovation. *American Journal of Political Science, 41*(3), 738-770.

Molinsky, A. L. (1999). Sanding down the edges: Paradoxical impediments to organisational change. *Journal of Applied Behavioral Science, 35*(1), 8-24.doi: 10.1177/0021886399351002

Murray, C. J., Richards, M. A., Newton, J. N., Fenton, K. A., Anderson, H. R., Atkinson, C., Davis, A. (2013). UK health performance: Findings of the global burden of disease study 2010. *The Lancet, 381*(9871), 997-1020. doi:http://dx.doi.org.ezproxy.stir.ac.uk/10.1016/S0140-6736(13)60355-4

Newton, J., Graham, J., McLoughlin, K., and Moore, A. (2003). Receptivity to change in a general medical practice. *British Journal of Management, 14*(2), 143-153. doi:10.1111/1467-8551.00271

NHS Scotland. (2003). *NHS code of practice on protecting patient confidentiality*. Edinburgh: SEHD. Retrieved 02/15, 2013 from http://www.confidentiality.scot.nhs.uk/publications/6074NHSCode.pdf

NHS Scotland. (2006). *Deliverying care, enabling health: Harnessing the nursing, midwifery and allied health professionals contribution to implementing delivery for health in scotland.* Edinburgh: Scottish Executive. Retrieved 02/15, 2013 from http://www.scotland.gov.uk/Resource/Doc/152499/0041001.pdf

NHS Scotland. (2009a) (CEL 23, 10 June). *Improving health and wellbeing of people with long term conditions in scotland. A national action plan*. Edinburgh: Director-General Health and Chief Executive NHS Scotland. Retrieved 02/15, 2013 from http://www.scotland.gov.uk/Resource/Doc/294270/0090939.pdf

NHS Scotland (Health Delivery Directorate. Improvement and Support Team). (2009b). *Long term conditions collaborative. improving self management support*. Edinburgh: Scottish Government. Retrieved 02/15, 2013 from http://www.scotland.gov.uk/Resource/Doc/274194/0082012.pdf

NHS Scotland Health Delivery Directorate. Improvement Support Team. (2010). *Long term conditions collaborative making the connections - food for thought: Anticipatory care, self management and community-led health improvement approaches for people with long term conditions*. Edinburgh: Scottish Government.

NHS Scotland Quality Improvement Hub. (2012). Long term conditions collaborative: About. Retrieved 02/15, 2013, from http://www.qihub.scot.nhs.uk/programmes/outpatient-primary-and-community-care/long-term-conditions-collaborative.aspx

NICE. (2007). *How to change practice: Understand, identify and overcome barriers to change*. London: National Institute for Health and Clinical Excellence.

Nolan, E., and Hewison, A. (2008). Teamwork in primary care mental health: A policy analysis. *Journal of Nursing Management, 16*(6), 649-661.

Nolte, E., and McKee, M. (2008). Caring for people with chronic conditions: An introduction. In E. Nolte, & M. McKee (Eds.), *Caring for people with chronic conditions. A health system perspective.* (pp. 1-14). Maidenhead: Open University Press.

Noyes, J., Lewis, M., Bennett, V., Widdas, D., and Brombley, K. (2014) Realistic nurse-led policy-implementation, optimization and evaluation: novel methodological exemplar. Journal of Advanced Nursing 70(1), 220-237. doi:10.1111/jan.12169.

Nutley, S., & Webb, J. (2000). Evidence and the policy process. In H. T. O. Davies, S. M. Nutley & Smith P. C. (Eds.), *What works? evidence-based policy and practice in public services.* (pp. 13-41). Bristol: The Policy Press.

Nutley, S., Morton, S., Jung, T., & Booz, A. (2010). Evidence and policy in six European countries: Diverse approaches and common challenges. *Evidence and Policy, 6*(2), 131-144.

Oborn, E., Barrett, M., & Exworthy, M. (2011). Policy entrepreneurship in the development of public sector strategy: The case of London health reform. *Public Administration, 89*(2), 325-344. doi:10.1111/j.1467-9299.2010.01889.x

O'Toole Jr., L. J. (2000). Research on policy implementation: Assessment and prospects. *Journal of Public Administration Research and Theory, 10*(2), 263.

O'Toole, L. J. (2004). The theory-practice issue in policy implementation research. *Public Administration, 82*(2), 309-329.

Pettigrew, A., Ferlie, E., and Mckee, L. (1992). *Shaping strategic change - making change in large organizations. the case of the national health service* (1st ed.). London: Sage.

Pettigrew, A., McKee, L., and Ferlie, E. (1988). Understanding change in the NHS. *Public Administration, 66,* 297-317.

Pettigrew, A. M. (1987). Context and action in the transformation of the firm. *Journal of Management Studies*, *24*(6), 649-670.

Plesk, P., and Greenhalgh, T. (2001). The challenge of complexity in health care. *British Medical Journal*, *323,* 625-628.

Pollitt, C., Lewis, L., Negro, J., and Patten, J. (1979). Policy implementation. introduction. . In C. Pollitt, L. Lewis, J. Negro and J. Patten (Eds.), *Public policy in theory and practice* (pp. 139-141). Sevenoaks, Kent: Open University Press.

Pope, C., Robert, G., Bate, P., May, A. L., & Gabbay, J. (2006). Lost in translation: A multi-level case study of the metamorphosis of meanings and action in public sector organizational innovation. *Public Administration, 84*(1), 59-80.

Pope, C., and May, N. (1995) Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health service research. *BMJ*, 311(6996), 42-45.

Powell, M., and Exworthy, M. (2001). Joined-up solutions to address health inequalities: Analysing policy, process and resource streams. *Public Money and Management, 21*(1), 21-26.

Pressman, J.L., and Wildavsky, A. (1984). Implementation. How great expectations in Washington are dashed in Oaklands (3rd ed.). Berkley: University of California.

Ridley, J., Hunter, S., and Rosengard, A. (2010). Partners in care?: Views and experiences of carers from a cohort study of the early implementation of the mental health (care and treatment) (scotland) act 2003. *Health and Social Care in the Community, 18*(5), 474-482. doi:10.1111/j.1365-2524.2010.00920.x

Robson, C. (2002). *Real world research* (2nd ed.). Oxford: Blackwell Publishers.

Rogers, E. M. (1995a). *Diffusion of innovation* (4th ed.). New York: Free Press.

Rogers, E. M. (1995b). Lessons for guidelines from the diffusion of innovation. *Joint Commission Journal on Quality Improvement, 21*(7), 324-328.

Royal College of Nursing. (2007). *Research ethics. RCN guidance for nurses* (revised from 2004 ed.). Retrieved 02/05, 2013 from http://www2.rcn.org.uk/__data/assets/pdf_file/0004/56695/researchethicsmay07.pdf. London: RCN:

Sabatier, P., A., and Mazmanian D., A. (1979). The conditions of effective implementation: A guide to accomplishing policy objectives. *Policy Analysis, 5*, 481-504.

Sabatier, P., A. (1986). Top-down and bottom-up approaches to implementation research: A crtical analysis and suggested synthesis. *Journal of Public Policy, 6*(1), 21-48.

Sabatier, P., A. (1993). Policy change over a decade or more. In P. Sabatier A., & H. Jenkins-Smith C. (Eds.), *Policy change and learning. An advocacy coalition approach* (pp. 1339). Oxford: Westview

Sabatier, P., A. (2007). The need for better theories. In P. Sabatier A. (Eds.), Theories of the policy process (2nd ed.) (pp.3-18). Boulder Colo: Westview

Saetren, H. (2005). Facts and myths about research on public policy implementation: Out-of-fashion, allegedly dead, but still very much alive and relevant. *Policy Studies Journal, 33*(4), 559-582. doi:10.1111/j.1541-0072.2005.00133.x

Saldana, J. (2009). *The coding manual for qualitative researchers*. London: Sage.

Saltman, R. B., Dubois, H. F. W., and Chawla, M. (2006). The impact of aging on long-term care in europe and some potential policy responses. *International Journal of Health Services, 36*(4), 719-746.

Sanderson, I. (2006). Complexity, 'practical rationality' and evidence-based policy making *Policy & Politics, 34*(1), 115-132.

Sanderson, I. (2002). Evaluation, policy learning and evidence-based policy making. *Public Administration, 80*(1), 1-22.

Saunders, M., Lewis, P., and Thornhill, A. (2003). *Research methods for business students* (3rd ed.). Harlow: Prentice Hall.

Schofield, J. (2001). Time for a revival? public policy implementation: A review of the literature and an agenda for future research. *International Journal of Management Reviews, 3*(3), 245-263. doi:10.1111/1468-2370.00066

Schofield, J. (2004). A model of learned implementation. *Public Administration, 82*(2), 283-308.

Schofield, J., and Sausman, C. (2004). Symposium on implementing public policy: Learning from theory and practice. *Public Administration, 82*(2), 235-248. doi:10.1111/j.0033-3298.2004.00392.x

Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry. In N. K. Denzin, and Y. S. Lincoln (Eds.), *The landscape of qualitative research. theories and issues* (2nd ed., pp. 292-331). London: Sage.

Scott, W. R., Ruef, M., Mendel, P. J., and Caronna, C. (2000). *Institutional change and healthcare organizations. from medical dominance to managed care*. Chicago: The University of Chicago Press.

Scottish Executive. (2007a). *Community health partnerships (CHP) long term conditions toolkit - HDL (2007) 10*. Edinburgh: Scottish Executive Health Department.

Scottish Executive. (2007b). *Strengthening the role of managed clinical networks.* (No. HDL (2007) 21). Edinburgh: Scottish Executive. Retrieved from www.jitscotland.org.uk/

Scottish Government. (2005) Smoking, Health and Social Care (Scotland) Act 2005. Retrived from http://www.legislation.gov.uk/asp/2005/13/contents.

Scottish Government. (2007). *Better health, better care: Action plan*. Edinburgh: Scottish Government. Retrieved from http://scotland.gov.uk/Resource/Doc/206458/0054871.pdf

Scottish Government. (2009). *Long term conditions collaborative. high impact changes*. Edinburgh: Scottish Government. Health Delivery Directorate Improvement and Support Team. Retrieved from http://www.scotland.gov.uk/Resource/Doc/263109/0078695.pdf

Scottish Government. (2010a). *The healthcare quality strategy for NHS Scotland*. Edinburgh: The Scottish Government. Retrieved from http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf

Scottish Government. (2010b) *Caring Together. The Carers Strategy for Scotland. 2010-2015*. Edinburgh: The Scottish Government. Retrieved 01/08, 2012 from http://www.scotland.gov.uk/Resource/Doc/319441/0102104.pdf.

Scottish Government. (2010c). *Long term conditions collaborative. improving care pathways*. Edinburgh: Health Delivery Directorate and Support Team. The Scottish Government. Retrieved http://www.scotland.gov.uk/Resource/Doc/309257/0097421.pdf

Scottish Government. (2012a) Alcohol (minimum pricing) (Scotland) act 2012 (Asp4), ActU.S.C. (2012). Retrieved from http://www.legislation.gov.uk/asp/2012/4/contents/enacted

SEHD (2005a). *Delivering for Health*. Edinburgh: Scottish Executive. Retrieved 01/08, 2012 from, http://www.scotland.gov.uk/Resource/Doc/76169/0018996.pdf

SEHD (2005b). *A national framework for service change in the NHS in scotland. building a health service fit for the future. volume 1*. Edinburgh: Scottish Executive. Retrieved 01/08, 2012 from, http://www.scotland.gov.uk/Resource/Doc/924/0012113.pdf.

SEHD (2005c). *A national framework for service change in the NHS in scotland. building a health service fit for the future. volume 2. A guide for the NHS*. Edinburgh: Scottish Executive. Retrieved 01/08, 2012 from, http://www.scotland.gov.uk/Resource/Doc/924/0012112.pdf.

Silverman, D. (2001). *Interpreting qualitative data. methods for analysing talk, text and interaction*. (2nd ed.). London: Sage.

Smith, K. E. (2007). Health inequalities in Scotland and England: The contrasting journeys of ideas from research into policy. *Social Science and Medicine, 64*(7), 1438-1449. doi:10.1016/j.socscimed.2006.11.008

Smith, M. J., Richards, D., Geddes, A., and Mathers, H. (2011). Analysing policy delivery in the United Kingdom: The case of street crime and anti-social behaviour. *Public Administration, 89*(3), 975-1000. doi:10.1111/j.1467-9299.2010.01892.x

Smith-Merry, J. (2008). Improving mental health and wellbeing in Scotland: A model policy approach. *Australian E-Journal for the Advancement of Mental Health, 7*(3)

Snape, D., and Spencer, L. (2003). The foundations of qualitative research. In J. Ritchie, and J. Lewis (Eds.), *Qualitative research practice. A guide for social science students and researchers* (pp. 1-23). London: Sage.

Stake, R., E. (2005). Qualitative case studies. In N. K. Denzin, and Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 443-466). Thousand Oaks: Sage.

Strauss, A., and Corbin, J. (1990). *Basics of qualitative research. techniques and procedures for developing grounded theory*. Thousand Oaks: Sage.

Tackling Long Term Conditions. (2013). *Conference Proceeding May 16th*. London: Barbican Conference Centre

Tantivess, S., and Walt, G. (2008). The role of state and non-state actors in the policy process: The contribution of policy networks to the scale-up of antiretroviral therapy in thailand. *Health Policy and Planning, 23*(5), 328-338. doi:10.1093/heapol/czn023

Taylor, G. (2013). *Using health policy in nursing practice*. London: Sage. Learning Matters.

Theodoulou, S. Z. (1995). How public policy is made. In S. Z. Theodoulou, and M. A. Cahn (Eds.), *Public policy. the essentail readings* (pp. 86-96). New Jersey: Prentice Hall.

Tomm-Bonde, L., Schreiber, R., Allan, D., MacDonald, M., Pauly, B., Hancock, T., & on behalf of the RePHS,Research Team. (2013). Fading vision: Knowledge translation in the implementation of a public health policy intervention. *Implementation Science, 8*(1), 59. DOI: 10.1186/1748-5908-8-59

Tummers, L., Steijn, B., and Bekkers, V. (2012). Explaining the willingness of public professionals to implement public policies: Content, context, and personality characteristics. *Public Administration, 90*(3), 716-736. doi:10.1111/j.1467-9299.2011.02016.x

UK Government (England).(2012). The Health and Social Care Act (2012). Retrieved 01/08, 2014, from http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

Van Meter, D. S., and Van Horn, C. E. (1975). The policy implementation process. A conceptual framework. *Administration and Society, 6*(4), 445-488.

Veitch, K. (2010). The government of health care and the politics of patient empowerment: New labour and the NHS reform agenda in England. *Law and Policy, 32*(3), 313-331.

Walt, G. (1994). *Health policy. an introduction to process and power*. London: Zed Books.

Walt, G., and Gilson, L. (1994). Reforming the health sector in developing coutries: The central role of policy analysis. *Health Policy and Planning, 9*, 353-370.

Watt, S., Sword, W., and Krueger, P. (2005). Implementation of a health care policy: An analysis of barriers and facilitators to practice change. *BMC Health Services Research, 5*, 53.

Wandersman, A., Chien, V. H., and Katz, J. (2012). Toward an evidence-based system for innovation support for implementing innovations with quality: Tools, training, technical assistance, and quality assurance/quality improvement. *American Journal of Community Psychology, 50*(3-4), 445-59. doi:http://dx.doi.org/10.1007/s10464-012-9509-7

Wanless, D. (2002) Securing our future health: Taking a long-term view. London: HM Treasury. http://webarchieve.nationalarchieves.gov.uk/20100407/http://hm-treasury.gov.uk/consult_wanless_final.htm

Weick, K. E., and Quinn, R. E. (1999). Organizational change and development. *Annual Review of Psychology, 50*(1; 1), 361.

Wejnert, B. (2002). Integrating models of diffusion of innovations: A conceptual framework. *Annual Review of Sociology, 28*(1), 297-326. doi:10.1146/annurev.soc.28.110601.141051

Welsh Government. (2013). A framework for delivering integrated health and social care. Cardiff: Welsh Government. Retrieved 01/08, 2014 from http://wales.gov.uk/docs/dhss/consultation/130823consultationen.pdf .

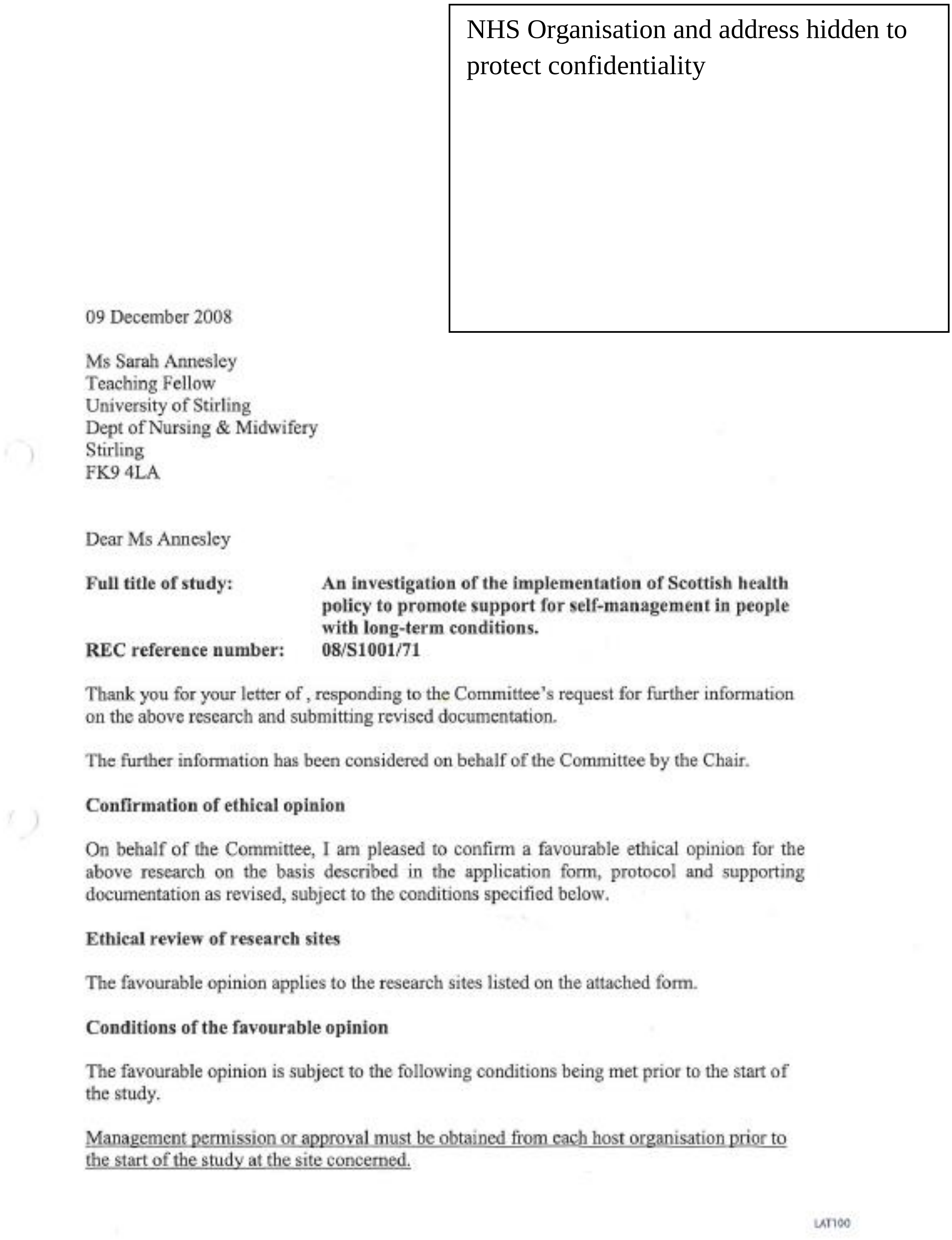
WHO. (2011). *Global status report on non-communicable diseases 2010: Description of the global burden of NCDs, their risk factors and determinants.* Geneva: World Retrieved 03/06, 2014, from Health Organisation. http://www.who.int/nmh/publications/ncd_report2010/en/

Wright, K. (2011). Changing approaches to the management of long term conditions. In L. Meerabeau, & K. Wright (Eds.), *Long term conditions: Nursing care and management* (pp. 36-44). London: Wiley-Blackwell.

Yin, R. K. (2009). *Case study research. design and methods* (4th ed.). London: Sage.

Yin, R. K. (2011). *Qualitative research from start to finish*. New York: The Guilford Press.

Appendix 1: REC Letter



NHS Organisation and address hidden to protect confidentiality

09 December 2008

Ms Sarah Annesley
Teaching Fellow
University of Stirling
Dept of Nursing & Midwifery
Stirling
FK9 4LA

Dear Ms Annesley

Full title of study:	**An investigation of the implementation of Scottish health policy to promote support for self-management in people with long-term conditions.**
REC reference number:	**08/S1001/71**

Thank you for your letter of , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

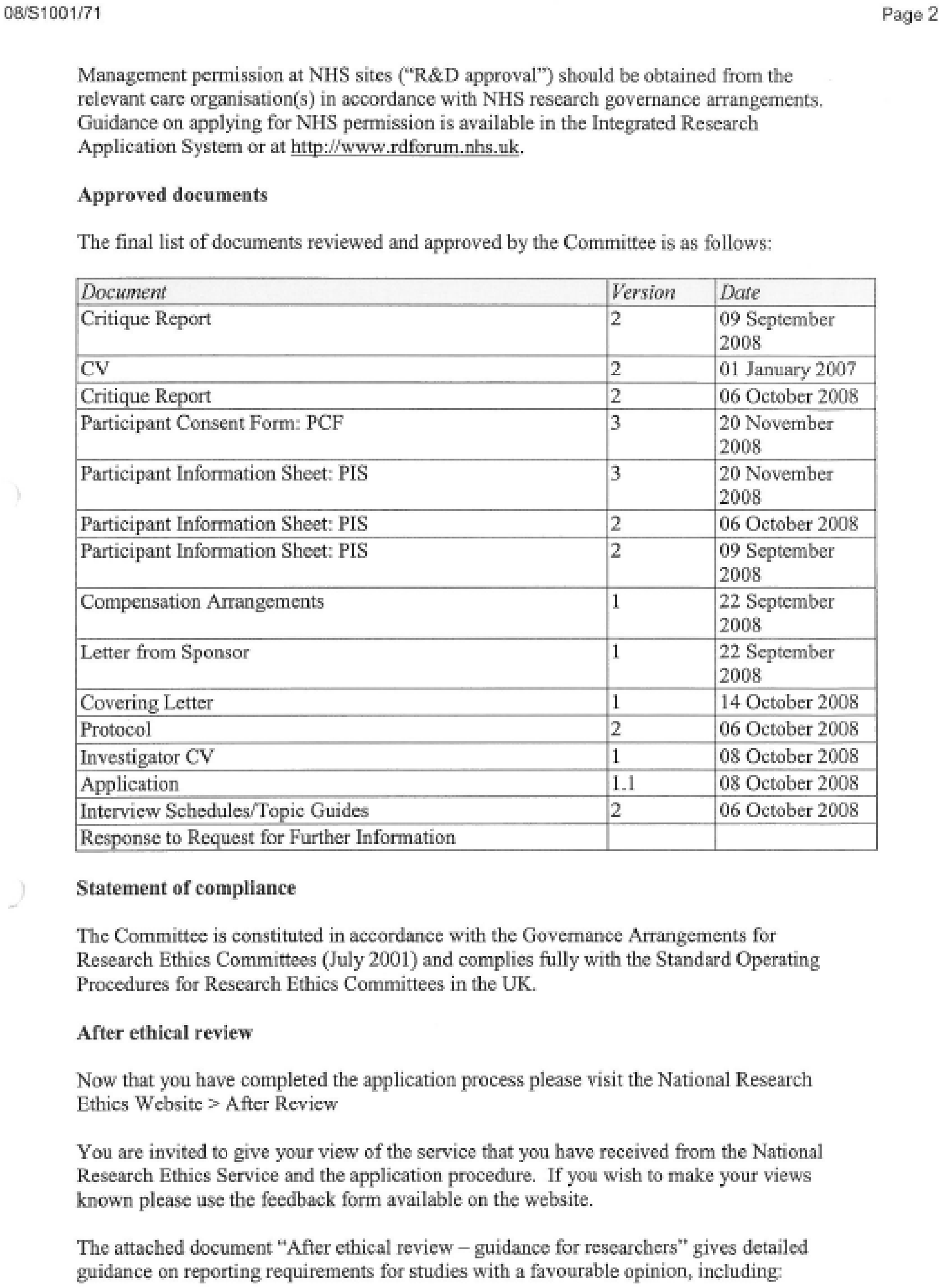
The favourable opinion applies to the research sites listed on the attached form.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

LAT100



Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Critique Report	2	09 September 2008
CV	2	01 January 2007
Critique Report	2	06 October 2008
Participant Consent Form: PCF	3	20 November 2008
Participant Information Sheet: PIS	3	20 November 2008
Participant Information Sheet: PIS	2	06 October 2008
Participant Information Sheet: PIS	2	09 September 2008
Compensation Arrangements	1	22 September 2008
Letter from Sponsor	1	22 September 2008
Covering Letter	1	14 October 2008
Protocol	2	06 October 2008
Investigator CV	1	08 October 2008
Application	1.1	08 October 2008
Interview Schedules/Topic Guides	2	06 October 2008
Response to Request for Further Information		

Statement of compliance

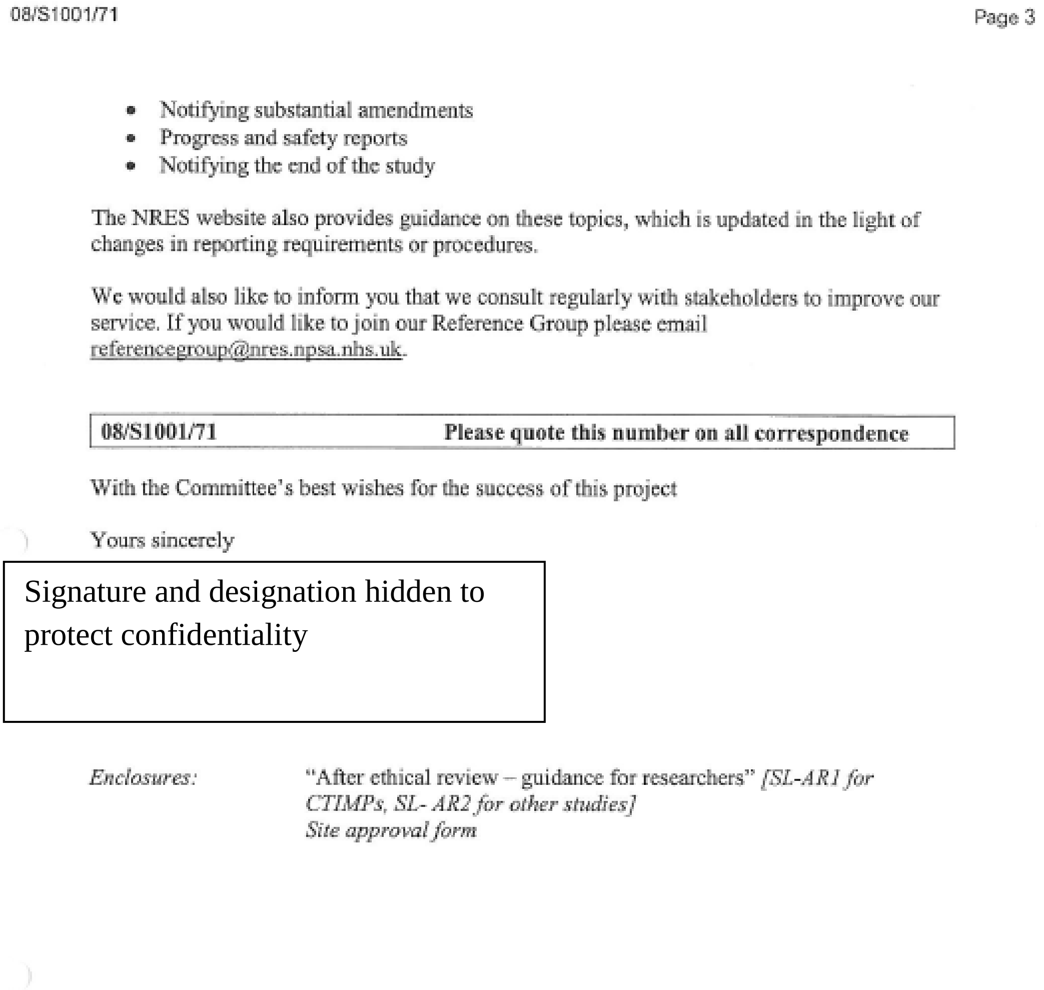
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:



- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

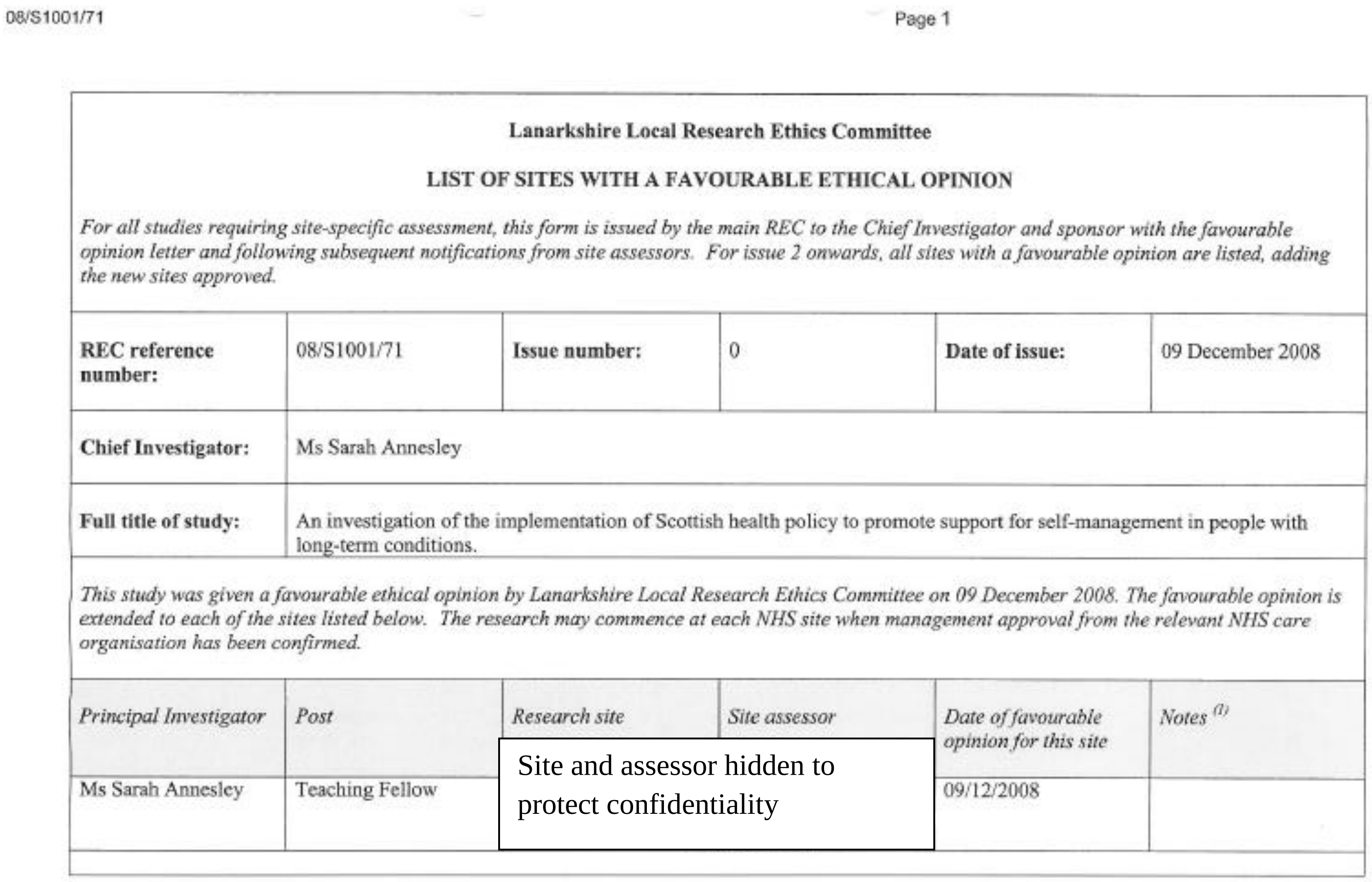
08/S1001/71	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Signature and designation hidden to protect confidentiality

Enclosures: "After ethical review – guidance for researchers" *[SL-AR1 for CTIMPs, SL- AR2 for other studies]*
Site approval form



Lanarkshire Local Research Ethics Committee

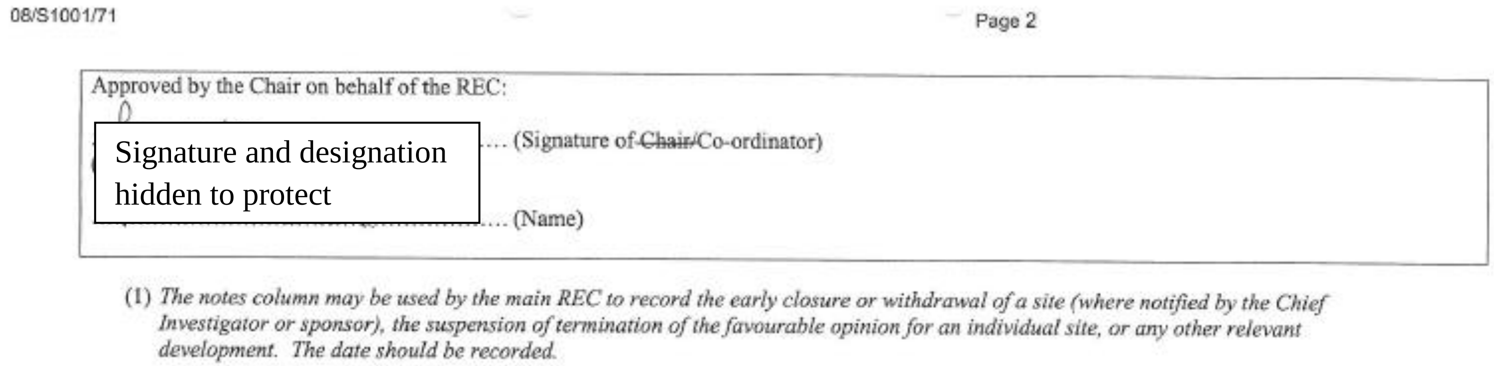
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	08/S1001/71	**Issue number:**	0	**Date of issue:**	09 December 2008
Chief Investigator:	Ms Sarah Annesley				
Full title of study:	An investigation of the implementation of Scottish health policy to promote support for self-management in people with long-term conditions.				

This study was given a favourable ethical opinion by Lanarkshire Local Research Ethics Committee on 09 December 2008. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	*Post*	*Research site*	*Site assessor*	*Date of favourable opinion for this site*	*Notes* [1]
Ms Sarah Annesley	Teaching Fellow	[redacted] Site and assessor hidden to protect confidentiality	[redacted]	09/12/2008	



08/S1001/71 Page 2

Approved by the Chair on behalf of the REC:

Signature and designation hidden to protect

…… (Signature of ~~Chair/~~Co-ordinator)

…… (Name)

(1) *The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.*

Appendix 2: Information sheet for individual participants approached for interview[2]

UNIVERSITY OF
STIRLING

DEPARTMENT OF
NURSING AND MIDWIFERY

ALLIANCE for SELF CARE RESEARCH
"Enhancing self care"

An investigation of the implementation of Scottish health policy to promote support for self-management in people with long-term conditions.

You are being invited to take part in a study that is investigating how people working in NHS Scotland are responding to health policy designed to support self-management for people with long-term conditions.

Before you decide whether to become involved, it is important that you understand the purpose of the research and what you are required to do.

Please take time to read the following information carefully. Feel free to discuss this study with your peers or colleagues before you decide.

Why is the research being done?

This research will investigate the implementation of national health policy to promote self-management for people with long-term conditions (LTCs) in Scotland. The study aims to investigate the mechanisms through which policy is implemented and the context in which changes in practice, in relations to programmes supporting self-management for people with LTCs are achieved. Through feedback, dissemination and discussion of the results we hope that this understanding will contribute to improved policy development and implementation in Scotland. The research is being undertaken as part of a doctoral study.

How is the research being done?

The study is designed as a case study in three phases; national, health board and CHP using three methods of data collection. We will interview key people; observe some meetings and analyse relevant policy documentation. You are being asked to participate in an individual interview.

Why have I been chosen?

---

[2] **Version 4** 12 01 09

You have been identified as having a key role in the development and use of policy in your organisation. We want to interview people who have knowledge of this area and are actively involved in shaping and implementing the programmes to support self-management for people with long-term conditions. Your knowledge and expertise in this area will help us because you can tell us how policy was developed and is being implemented; we are interested in your views, ideas and opinions on the programmes being developed, implemented and evaluated and what you think are the important mechanisms for change. We hope to interview around 30 people like yourself at different organisational levels.

Who is running the study?

The study is being funded by the Department of Nursing and Midwifery and is supported by the Alliance for Self Care Research, both based at the University of Stirling. It is being conducted by me, Sarah Annesley, as part of a doctoral research degree

Do I have to take part?

No. It is up to you to decide whether or not you take part. You do not have to take part. You can have time to think over whether you take part or not. I will contact you over the next few days by email or telephone to see if you are interested in taking part. If you are *not* interested just tell me and I will not contact you again. Alternatively, you can contact me yourself to tell me your decision. My contact details are at the bottom of this information sheet.

What will happen next?

As I said, I will telephone or email you to find out if you are interested in taking part in the research. Once I know that you *are* interested in taking part we will arrange a suitable meeting date, convenient for you to have our face-to-face interview. This can take place, at your place of work or an alternative venue whichever is most convenient for you.

Can I change my mind?

Yes. If you agree to take part in this research and then change your mind, then you are able to withdraw at any time without giving a reason. There is no sanction if you withdraw or decide not to take part in the first place.

What will taking part mean for me?

Taking part will mean that you agree to a face-to-face interview with me. This interview will be digitally recorded and explore a number of themes. The interview will last for up to 1 hour. Following the interview I will type up a transcription of our discussion and return this to you so that you can review the information you gave. At this point you can clarify any points, or ask for information to be removed. Once the data from the interview has been analysed I may need to come back to you with a phone call or second interview to ask your opinion on our developing analyses.

As well as an interview, depending on your situation and what we have discussed, I may ask if you could provide any supporting documentation to show how your organisation is using health policy to improve care for people with long-term conditions. As a participant I may also ask if you would be willing to let me observe any meetings that you think would be useful to help me understand what is happening in your area.

Are there any risks involved in taking part?

It is very unlikely that you will come to any harm as a result of taking part in this research. Participation may bring some inconvenience by imposing on your time and good faith. In addition there may be requests for further information or permission to access meetings and this may generate extra work for you but every effort will be made to limit this inconvenience to a minimum. If you do have any concerns about how you are treated during this research, please contact Dr Ruth Jepson, Post-Graduate Tutor Dept of Nursing and Midwifery, University of Stirling, FK9 4LA. Phone: 01786 466402 email: ruth.jepson@stir.ac.uk

Will I benefit from taking part?

I cannot promise that taking part in this research will be of any direct benefit to you. However, by agreeing to be involved you will have an opportunity to share your opinions and discuss work that you are involved. This may provide a useful opportunity to reflect on your experience which might provide some sense of satisfaction in your achievements. In addition participation provides a chance to highlight good practice and the potential of your experience to inform future policy implementation. These are long-term benefits but would we hope provide some sense of achievement.

Will my taking part be kept confidential?

Any information that is collected about you will be kept confidential. Your personal details will be removed and pseudonyms will be used to identify you and your location to protect your identity. However, given the nature of the participants and the specialist area of policy being explored it might be possible to deduce locations and likely participants. Every effort will be made to ensure that confidentiality and anonymity is preserved and only the immediate research team will have access to precise details of locations and participant. To further protect participants we will change the gender of respondents which has worked well in previous studies. Most information will be held securely for a period of 5 years following the end of the study. Digital recordings of interviews will be destroyed as soon as the research is complete.

What will happen to the results of the study?

The results of this research will be used to write a doctoral thesis for submission to the University of Stirling. In addition the findings will be used to prepare presentations and articles for publication in academic journals and will be widely disseminated in policy circles also. We will prepare a summary of the findings which will be sent to participants. Please tell us if you do not want to receive the summary

If you would like more information about the study, and are interested in being interviewed then please contact:

Researcher's Contact Details: Sarah Annesley, Dept of Nursing and Midwifery, University of Stirling, FK9 4LA.

Phone: 01786 466110

email:

sarah.annesley@stir.ac.uk

If you would like some independent advice about whether you should take part in this research, please contact:

External Contact: Dr Andrew Watterson, Director of Research, Dept of Nursing and Midwifery, University of Stirling, FK9 4LA.

Phone: 01786 466283

email:

a.e.watterson@stir.ac.uk

Thank you for taking the time to read this information sheet.

An investigation of the implementation of Scottish health policy to promote support for self-management in people with long-term conditions.

NHS REC Ref. 08/S1001/71

NHS RandD Ref. L08048P

Appendix 3: Documentary analysis template

Author/Date	Title	Process of development	Purpose
		In whose name is the documents/statement written? What goals/outcomes are revealed? (related to context) How/what methods/actions are proposed to achieve outcome?	Key elements of content and who is represented as carrying out the actions referred to? Where does the action take place?

<u>(Version 1. 25/06/09)</u>

(Adapted from Robson 2002; 355)

Appendix 4: Interview themes

Information about yourself, including your current role and the responsibilities that you have for supporting self-management.

Ideas on what you think self-management is and how it might help people with LTCs.

Identify key national and local policy documents promoting support for self-management.

How policies in this area are being promoted at the moment.

Discussion of what you see as the desired outcomes from policy emphasising support for self-management.

What are the mechanisms (ideas, opportunities or actions) that are being used to encourage the implementation of policy, and your views on whether these mechanisms are helping to deliver change in practice.

The individuals and organisations that you consider to be key in delivering the implementation of policy in this area.

The factors that are helping and those that may inhibit the delivery of policy promoting support for self-management.

Other circumstances (contextual elements) that are important in facilitating or preventing the effective implementation of policy in this area.

Discussion of key areas of national activity and local activity – what is being done locally to improve care for people with long-term conditions

Other comments and a request for suggestions on future interview contacts.

Appendix 5: Participant consent form

An investigation of the implementation of Scottish health policy to promote support for self-management for people with long-term conditions.

Researcher: ***Sarah Annesley***
Tel: 01786 466110
Email: sarah.annesley@stir.ac.uk

Address: *Dept. of Nursing and Midwifery*
University of Stirling
Stirling, FK9 4LA

Please read the 6 statements below, ticking each box and signing at the bottom if you agree:

1. I confirm that I have read and understand the Study information sheet (Ver 4 12 01 09) and I have had an opportunity to ask the researcher any questions.	☐
2. I understand that my participation is voluntary, that I am free to withdraw at any time without giving any reason and that there will be no detriment to me for doing so.	☐
3. I understand that I will take part in a face-to-face, recorded interview as well as be asked to provide any supporting documentation and access to meetings for observation.	☐
4. I understand that any information that I give will be treated in the strictest confidence and every effort will be made to preserve my identity. This information will be kept securely, will only be available to the research team and destroyed after 5 years from the end of the study	☐
5. I give permission for the information I provide to be used for research purposes (including doctoral thesis, publications and presentation) with strict preservation of my anonymity.	☐
6. I agree to take part in the above study	☐

____________________ __________ _______________

Participants Name **Date:** **Signature**

____________________ __________ _______________

Researcher **Date:** **Signature**

1 copy for participant; 1 for researcher

Appendix 6: Interview checklist

Date __________________Location_________________

1. Thank you giving formal signed consent to be interviewed. My name is Sarah Annesley and I am a research student at the University of Stirling. As explained in the information sheet I am interested in how health policy, focused on supporting self-management for people with long term conditions, is being implemented in Scotland.	☐
2. In this interview it is your opinions and ideas that I am interested in – there are no right or wrong answers. And anything you say will be treated as confidential with every effort made to maintain your anonymity.	☐
3. As you can see the interview is being recorded and from this I will prepare a typed transcript of the interview. Once I have done this I will forward this transcript to you. You can then review a typed version of our discussion, make any amendments and/or remove any items that you do not want included before the data is analysed.	☐
4. The transcription will be verbatim and presented as we both speak and so will include pauses…errs etc. This may come as a surprise when you read it back but it is so that the data is kept free from interpretation.	☐
5. Are you happy that the interview is being recorded?	☐
6. The interview will cover 3 general areas – policy, implementation and key areas of health board/local activity	☐
7. Is there anything you would like to ask me before we start the interview?	☐
8. Would you like to receive a summary of the research findings?	☐

Appendix 7: Interview Schedule

Q1. Can you tell me a little bit about yourself?

> What is your professional background,
> What is your current role?
> What responsibilities do you have for developing/implementing support for self-management for people with LTCs?

Q2. Can you give me your ideas on what you think self-management is?

> How might self-management help people with LTCs?

Q3. Can you identify the key national policy documents seeking to promote SM for people with LTCs that you are aware of in this area?

Q4. [Do you have any local policies or documents that are seeking to do this? Can you give me any other examples? (used to inform the policy analysis) **only for HB and CHP** interviews]

Q5. How do you see policies to encourage self-management for people with LTCs being promoted at the moment?

Q6. In your opinion what outcomes does health policy to promote support for self-management for people with LTCs intend to achieve?

> Are there any other outcomes that you anticipate (positive or negative outcomes)?
> How achievable are these outcomes?

Q7. What mechanisms are being used to achieve these outcomes? (by mechanism I mean ideas, opportunities or actions)

> Are these mechanisms being directed nationally or locally?
> What other mechanisms could be used?

Q8. Are these mechanisms helping to deliver change in practice?

> If yes, how are they helping?, Can you tell me about a programme that is using [*name mechanism identified*]?

Q9. Which individuals are key in delivering the implementation of policy to promote support for self-management?

> Who is leading change in this area, what is their position?
> At what organisational level do these individuals operate – national or local?
> Is there anyone else who could be involved but is not?

Q10. Which organisations are key to the delivery and implementation of policy to promote support for self-management?

> Which organisations are leading changes in this area?

At what organisational level does this organisation operate – national or local?
Is there any other organisation that could be involved but is not?

Q11. What factors are helping to promoting self-management for people with LTCs? And what factors are inhibiting the development of new practises in this area?

Q12. Are there any particular circumstances (contextual elements) that you feel are important in facilitating or preventing the effective implementation of policy in this area? – by this I mean, cultural, organisational factors.

Q13. Thinking of a key area of national activity can you highlight a project/programme that you feel is promoting support for self-management effectively?

Q14. Can you tell me a bit more about this programme/project?

a). What problem was it seeking to address?	d). How will you know that it has worked?
b). What are its aims?	e). Whose ideas were these?
c). What is it doing to address the concern/problem?	f). Why is (area) being focused on this at the moment?

Q15. Do you have any other comments on this area of current health policy or the topics we have discussed?

Q16. Is there anyone that you feel it would be particularly helpful for me to approach for interview? – are you able to give me a contact email or phone number…

Concluding Statement That concludes all the formal interview questions but for my records can I seek clarification on two points.

As outlined in the participant's information sheet I will be forwarding a verbatim transcript of this interview. During the process of typing up the transcript and the analysis of the data there maybe some queries that arise. Therefore, can I ask if I can come back to you with a phone call or request for a second interview to seek your opinion on our developing analyses? If you are able to agree to this then you would be contributing to the findings of the research and may then be interested in receiving a copy of the research summary once the project has concluded – would you like to receive a summary of our findings?

Finally thank you for agreeing to be interviewed and I am most grateful to you for giving me this opportunity. Your comments and insight on this area of policy is greatly appreciated.

Appendix 8: Observation sheet

Meeting name: _

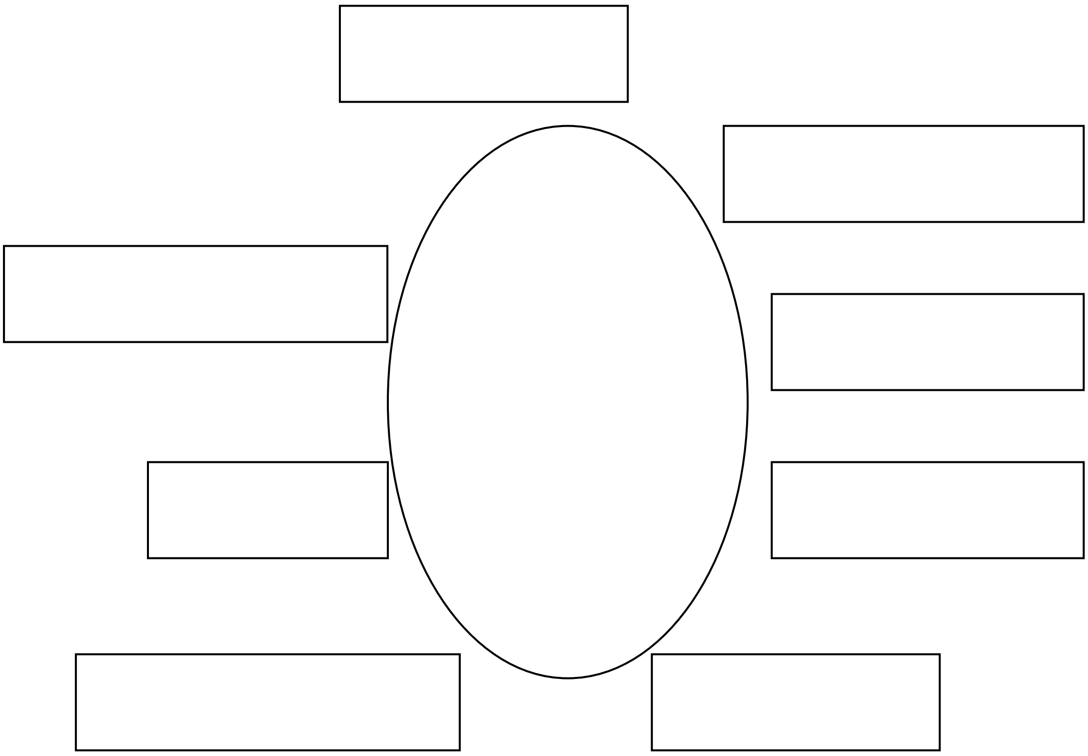
Date:_

Location: _______________

Actors present (codes):

Topic/Focus of meeting:

Arrangement of Group: (where people are sitting illustrated by diagram)



Notes:

Key documents:

What programmes/projects are being discussed?	
What problem are the programmes/projects trying to address?	
What positive ideas- suggestions, actions, attempting to problem solve are being offered?	
What is the programme/project trying to achieve?	
What specific action(s) is the programme/project using to achieve goals?	
How will outcomes be assessed?	
How will the success or failure of the programme/project be gauged?	
What obstructions/barriers to implementation are highlighted?	
What drivers/facilitating factors are present and what are suggested?	
What information is presented and by whom?	
Other comments (challenges identified, issues and areas of caution)	

(Adapted from (Saunders et al. 2003)

Appendix 9: Information sheet for committee members attending an observed meeting[3]

UNIVERSITY OF STIRLING
DEPARTMENT OF NURSING AND MIDWIFERY

ALLIANCE for SELF CARE RESEARCH
"Enhancing self care"

An investigation of the implementation of Scottish health policy to promote support for self-management in people with long-term conditions.

You are being invited to take part in a study that is investigating how people working in NHS Scotland are responding to health policy designed to support self-management for people with long-term conditions.

Before you decide whether to be involved, it is important that you understand the purpose of the research and what you are required to do.

Please take time to read the following information carefully. Feel free to discuss this study with your peers or colleagues before you decide.

We plan three phases; one at each level of policy making and implementation:

1. **Phase I** (the national level) will consider the work of the Scottish Long Term Conditions Unit and associated working groups;
2. **Phase II** (the regional level) will focus on how policy is interpreted and translated into programmes in one Health Board;
3. **Phase III** (the local level), will focus on programme development and implementation in practice in one Community Health partnership (CHP).

Why is this research being done?

This research will investigate the implementation of national health policy to promote self-management for people with long-term conditions (LTCs) in Scotland. The study aims to investigate the mechanisms through which policy is implemented and the context in which changes in practice, in relations to programmes supporting self-management for people with LTCs are achieved. Through feedback, dissemination and discussion of the results we hope that this understanding will contribute to improved policy development and implementation in Scotland. The research is being undertaken as part of a doctoral study.

What would my involvement be?

---

[3] Ver 2 09/09/08

I am sending this information sheet to you because you are a member of a committee or group at which the researcher would like to be present and observe what is going on. This is part of the data collection phase and is designed to learn how policy is turned into action. Only a few meetings are being observed and I hope that this will help to understand what people are doing to improve the care of people with long-term conditions and how they are doing it.

Who is running the study?

The study is being funded by the Department of Nursing and Midwifery and is supported by the Alliance for Self Care Research, both based at the University of Stirling. It is being conducted by me Sarah Annesley, as part of a doctoral research degree

Do I have to take part?

No. It is up to you to decide whether or not you agree to let the researcher observe this meeting. You do not have to agree to this and you can have time to think over whether you agree or not.

What will happen next?

Once you and your fellow committee members have indicated that you are willing to let the researcher observe this meeting, this decision will be feedback to the researcher by the committee’s chairperson. I will then attend the next convenient meeting.

During the process of observation I will sit discreetly in the room during your discussion. During my observation I will take notes detailing the programmes of work discussed and general observations. There will be no digital recording of the discussion.

Can I change my mind?

Yes. If you agree to take part in this research and then change your mind, then you are able to ask the researcher to withdraw at any time without giving a reason. There is no sanction if you request the withdrawal of the researcher or decide not to take part in the first place. Any data collected to this point will be destroyed and not included in the final analysis.

What are the potential risks and benefits for people taking part in the research?

It is very unlikely that any participants will come to any harm as a result of taking part in this research. Participation may bring some inconvenience by imposing on your time. There may be requests for further information and this may generate extra work for you or another committee members but every effort will be made to limit this inconvenience to a minimum.

Equally, taking part in this research may not be of any *direct* benefit to any participant or their organisation. However, by agreeing to be involved participants have an opportunity to share opinions and discuss the work that they are involved in. This may provide a useful opportunity to reflect on experience which might provide some sense of satisfaction in their or the organisation's achievements. In addition participation provides a chance to highlight good practice and the potential of experience to inform future policy implementation. These are long-term benefits but we hope they will be sufficient to encourage people to participate in the research.

What are the ethical and confidentiality issues likely to arise from the research?

Any information that is collected during the observation process will be kept confidential. All personal details will be removed from data and pseudonyms will be used to identify individual participants and locations. However, given the nature of the participants and the specialist area of policy being explored it might be possible to deduce locations and the likely identity of participants. To further protect participants it might be necessary to change the gender of respondents, which has proven successful in other studies.

Every effort will be made to ensure that confidentiality and anonymity is preserved and only the immediate research team will have access to precise details of locations and participants. Most information will be held securely for a period of 5 years following the end of the study. Hand written notes from the meetings observed will be destroyed as soon as the research is complete.

What will happen to the results of the study?

The results of this research will be used to write a doctoral thesis for submission to the University of Stirling. In addition the findings will be used to prepare presentations and articles for publication in academic journals and will be widely disseminated in policy circles also. We will prepare a summary of the findings which will be forwarded to the committee chairperson. Further copies of this summary document will be available on request.

Researcher's Contact Details: Sarah Annesley, Dept of Nursing and Midwifery, University of Stirling, FK9 4LA. Phone: 01786466110 email: sarah.annesley@stir.ac.uk

or

Professor Sally Wyke, Alliance for Self Care Research, University of Stirling, FK9 4LA.
Phone: 01786466110 email:

sally.wyke@stir.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 10. Factors that promote or inhibit the implementation of policy promoting SM_S for people with LTCs

NPT provides a robust analytical framework for understanding 3 interrelated processes – implementation – *def*. organisation and operational tasks; - embedding - *def*. how tasks are made routine and; integration - *def*. how embedded tasks are sustained in the social context.

Could do 2 or 3 frameworks one for the macro level – policy-makers and 1 for meso-level & micro-level – policy-implementers? 2 frameworks presented here.

Table 1 - NPT analysis of marco-level (national) – policy-makers

Coherence – ***sense-making work*** ~ work undertaken to determine whether users see self-management support as differing from existing practices, have a shared view of its purpose, understand how it will affect them personally and grasps its potential benefits. **[POLICY]**	**Cognitive participation –** ***relationship work*** **~** this focuses on the work undertaken to engage with potential users and get them to 'buy-into' the new system. Highlights the recruitment of local champions as a means of doing this. **[LTCC & LTC unit]**	**Collective action –** ***enacting work*** ~ in this domain the emphasis is on the work performed by individuals, groups of professionals or organisations in operationalizing the new idea. [I think I have lots of data on this construct]. Respondents at all levels spent most of their time talking about enacting work.	**Reflexive monitoring –** ***appraisal work*** **~** ways in which managers and other users appraise whether self-management support intervention is worthwhile or not.
Differentiation ~ *what work is directed a making sense of self-management support?* – the production of policy statements/guidance these seek to differentiate SM-S[i] as such they represent the work policy-makers have undertaken to differentiate S-MS from exiting ways of delivering care for people with LTCs.	**Enrolment ~** *Do Individuals 'buy-into' the ideas of S-MS?* Policy-makers presented SM-S as a positive concept one worth working at to ensure health professionals 'buy-in' to the concept. Enrolment work included the development of a collaborative – LTCC. The purpose of this initiative was to actively involve HBs in work that that promoted the integration of	**Skills set workability ~** *how does S-MS affect roles and responsibilities or training needs?* Policy-makers were aware that significant work was needed to meet the training needs of practitioners to enable them to enact S-MS – skills like motivational interviewing, goal setting were mentioned even skills to set-up different appointment schedules or periods of	**Reconfiguration ~** *Do individuals try to alter S-MS?* Through a series of policy documents (presented elsewhere) policy-makers were trying to set the configuration that they saw as best for the implementation of S-MS. The opportunity for re-configuration was through the close working relationship the Scottish Government sought to establish with HB areas. This

	SM-S.	consultation were mentioned. S-MS was seen to represent a significant change in how practitioners operated. There was also recognition that S-MS required patients to have a different skill set. Respondents highlighted that they would need training so that they would view the consultation differently, and use skills of negotiation to exercise more control over their consultation. This would take time and be more work for the patients. Other skills such as knowing where to go for help through the use of online directories was also cited. Patients would also be encouraged to recognise that a wider range of services could help them – not to see the NHS as always the first source of guidance. This would need skills to negotiate - are patients ready for this work?	allowed the sharing of information on S-MS prior to publication which allowed some shaping of ideas before set as policy. Other opportunities to re-configure was through the use of clinical staff on secondment – this approach was used to support the work of the LTC unit & LTCC. These individuals could work, using their clinical experience, to re-configure S-MS so that it was acceptable to clinical staff this would help uptake. Reconfiguration was also worked on through the close engagement with patient & carers groups – LTCAS etc. They worked to ensure that S-MS reflected the patient & carer perspective.
