AN ANALYSIS OF POLICY TO PRACTICE DEVELOPMENTS IN NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONS WITHIN SCOTLAND FROM 2005 TO 2010

ZIYING SHUAI

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An analysis of policy to practice developments in Nursing, Midwifery and Allied Health Professions within Scotland from 2005 to 2010

Ziying Shuai (Suzy)

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Abstract

Ziying Shuai (Suzy)

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In the new millennium the Scottish government has been seeking effective practice developments in Nursing, Midwifery and Allied Health Professions (NMAHPs) through setting up numerous policy initiatives to improve patient care both directly and indirectly. Despite the fact that many of these initiatives have been subject to individual commissioned evaluations, to date, no systematic integrative study has been carried out in Scotland. This thesis addresses this deficit with the aim of constructing better understanding of key lessons and issues in regard to policy contexts, processes and outcomes.

Based on a constructivist approach and case study methodology, this study consists of: critical review of literature in relevant cognate areas; critical review of selected commissioned reports and other documentary analysis; case studies of four selected policy initiatives using twenty four in-depth semi-structured interviews; and integrative analysis and synthesis featuring framework analysis and application of relevant theoretical perspectives to enable explanation. At micro level this has provided insight into how and why selected policy initiatives were developed and implemented, based mainly on the perspectives of the various participants involved in the policy initiatives. At macro-level, cross case study enabled identification of key generic lessons such as policy internal and external alignment, good leadership at all levels and effective communication. In doing so the thesis also illuminates relationships between clusters of policy initiatives and their continuous development.

In particular, a new explanatory model of policy to practice change has also been developed in this thesis, building from relevant theoretical perspectives and empirical research. The thesis suggests that the new model will be useful for the analysis of policy through to practice both from 'top down' and 'bottom up' perspectives.

Finally, the findings have significant implications for future policy, education, practice and research. The thesis concludes with a summary of its contributions and related recommendations.

Key words: policy to practice initiatives; nursing; case study; theory; key lessons; Scotland

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Glossary of Abbreviations

RGU	Robert Gordon University
NMAHPs	Nursing, Midwifery and Allied Health Professions
NES	NHS Education for Scotland
SGHD	Scottish Government Health Department
NHS	National Health Service
SE	Scottish Executive
RKE	Research Knowledge Exchange
HIS	Health Improvement Scotland
DOH	Department of Health
HEI	Higher Education Institution
MAPPED	The Model for Analysing Policy to Practice
	Executive Developments

Chapter 1: Introduction to the thesis

1.1. Overview of this chapter

This chapter explains why an analysis of NMAHP policy to practice development is necessary and important by giving an overview of the nature of such initiatives. This establishes a context for explaining the rationale behind the study, the aim and objectives of the thesis and the six core research questions. These questions provide a structure for the research.

1.2. Introduction

Scotland has been experiencing increasing demands on its health services, which have to adapt to the changing needs and expectations of patients, clients and carers, in particular because of an ageing population and the growing burden of chronic disease (Scottish Executive 2005). The health service has had to be reformed to meet these needs, which meant that changes in health policy to improve health care were inevitable and essential. As Professor David Kerr (Scottish Executive 2005) in his report said:

'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 health care needs are changing and we need to act now to ensure we are ready to meet the future challenges.'

This is in common with many developed countries. Accordingly, there is mounting evidence to show that policy plays a particularly vital role in leading health care changes, by determining the power, legitimacy, allocation of resources and the structure of the organisation, and also the direction for service developments which is key (Exworthy 2008; McGinnis, Williams-Russo and Knickman 2002; Buse et al 2005; Hewison 2008; Green et al 2011).

While health policy makers create a number of initiatives which aspire to change practice effectively, developing appropriate policies in healthcare and developing comprehensive and consistent approaches to

patient care is becoming increasingly complex and difficult for care delivery organisations (Jochelson 2006). As Collins and Patel (2009) point out, an effective policy with regulations can be shown to benefit patients, staff and organisations. Conversely, failure to implement a rigorous policy program can be shown to be a weakness in organisations which are identified as poor performers. Furthermore, policy makers also find that it is very difficult to design the programs with clear and certain outcomes, which will be of much greater complexity, uncertainty and risk than ever before. They frequently have unintended consequences, even when the programs are well planned (Hudson and Lowe 2009).

The biggest challenge is how to make the policy work in practice, i.e. how to ensure that the intentions of a policy lead to an effective practice development in the health care service? It seems important to consider whether a policy has worked, is working or would work if implemented and how service users do or might respond and how policies are affected by those responsible for their delivery. This would involve not only individuals, but also the government, and government agencies, policy makers, organizations, policy implementation processes and practitioners. In other words, health care will be influenced by both policy and practice (Lloyd et al 2007).

Practice development in nursing, midwifery and allied health professions has always been intimately connected to health policy changes (MacMahon 1998). It is arguable that the relationship between policy and practice is rarely 'linear', clear or direct. This means that policy guidance cannot necessarily address the individual situation, but tends to provide a principle for implementation (Bergen and While 2005).

Practice change can be characterised by uncertainty and complex situations and therefore progresses at a much slower pace than its initiating policy (Hunter 1993). As such, at the boundary between policy and practice development lies ambiguity of intent and unpredictability

of response, which makes it both complex and problematic (Bergen and While 2005). To tackle these challenges and problems, health policy analysis is broadly acknowledged and perceived as an instrument, which can act on first 'be helpful for' policy to practice development (Sabatier 1998; Sutton 1999; Walt and Gilson 1994). It helps us understand the development and enactment of health policy, how the context of the policy impacts on the health policy process and its consequences. It also seeks to explain why the policy was developed and was implemented in the way it was and throws light on what lessons can be learned from policy to practice (Macduff 2007a; Barker 1996; Brewer and Deleon 1983).

In particular, recent evidence-based policy to practice development has been encouraged to explicitly advise and influence the implementation of policy initiatives. As Pawson (2002) highlights: *'like all of the best ideas, the big idea here is a simple one that research should attempt to pass on collective wisdom about the successes and failures of previous initiatives in particular policy dimensions'* (p 160). This has meant a new phase in the relationship between research and policy making – an innovative milestone which will drive policy and practice in a new way (Nutley and Webb 2000; Bochel and Duncan 2007). The current voice of DOH in the UK specifically emphasises the importance of evidence emerging from health policy research:

'In a difficult financial environment, we need new approaches if we're going to improve quality and productivity. We think we can get more out of health and social care services if we encourage innovation and base more decisions on evidence about what works.' (DOH 2013)

In recent years numerous health policy initiatives in the UK have been set up to target specific issues and problems, including health inequality, patient safety, quality enhancement of health care and health improvement. For instance, Jowell and Britain (2003) presented the report of 'Trying it out, the role of 'pilots' in policy-making'. They suggested that pilots in policy making help not only to inform implementation, but also to identify and prevent unintended

consequences. In effect, piloting of new policies and various individual programs has involved testing, evaluation and adjustment, in order to gain reliable initial evidence of whether policies work, before implementing the new policies nationally (Sanderson 2002). Therefore, analysing policy to practice initiatives is vitally important to provide quality information, based on evidence for policy makers, educators, researchers, practitioners and beyond.

To date, however, the full potential for learning through a systematic analysis of policy to practice in health care is underdeveloped, particularly in nursing, midwifery and allied health professions (NMAHPs) (Ross et al 2011). Literature also suggests that, while some commissioned evaluation studies have been undertaken for individual policy initiatives, policy development has been subject to little critical investigation involving in-depth, systematic cross-case analysis and synthesis.

During the last 10 years, the Scottish government has been developing effective practice in NMAHPs through initiatives designed to improve patient care both directly and indirectly. Many of those initiatives have been subject to individual evaluation. However, literature search suggests that to date, no systematic study has been carried out in Scotland. This is essential, as cumulatively these initiatives involve considerable use of public funds and resources, and critically and systematically learning from the past can contribute towards improving patient care. This drives my PhD project.

1.3. Study rationale

The fundamental reason for this study is to explore systematically and in-depth the key lessons which emerge from policy to practice developments, by studying the different perspectives, views and experiences of key informants involved in the initiatives. This thesis focuses particularly on the Scottish experience, and examines selected policy developments in order that:

- Key contexts, actors, processes, outcomes and the dynamics of policy to practice development can be further explored and better understood.
- Transferable lessons can be systematically learned from this study and used for future health service developments in NMAHP at national level and beyond.

The design of this study will also afford insight into the interaction between government policy and practice development, regarding how policy impacts on local practice, and vice versa.

1.4. Study aims and objectives

This thesis will seek to analyse and synthesise national health policy developments related to nursing, midwifery and allied health professions in Scotland between 2005 and 2010. The Scottish government has developed a range of important initiatives through policy, education and practice in NMAHP within this period. As my doctoral study started in 2010, it seemed appropriate to focus on these initiatives since they had recently been evaluated.

This thesis will examine critically and comprehensively the general issues and lessons learned from this retrospective study by asking mainly *why* and *how* these important national initiatives developed in Scotland. Through critical review and the application of relevant theoretical perspectives and models, the thesis will build up a new model to give a deeper understanding of the variables and the factors involved in going from policy to practice.

The specific objectives of the study are:

- To identify and analyse specific initiatives related to Scottish NMAHPs and to develop case selection strategies.
- To conduct a pilot study of methods and processes, focusing on a local policy to practice initiative.

- To undertake a study of four national initiatives, understanding the nature of the initiatives, and synthesising the key issues and lessons from each case.
- To examine how the Model for Analysing Policy to Practice Executive Developments (MAPPED) model fits each of these cases, in terms of giving potential for prospective planning and retrospective learning.
- To synthesise the main common and particular themes which emerge, and the key lessons learnt across the case studies.
- To consider the findings in the light of relevant theoretical perspectives and to make implications for the development of policy, education, practice and further research.

1.5. Research questions and their origins

Research questions can provide the key to planning and carrying out a successful research project (Denzin and Lincoln 2003; Robson 2011). Denzin and Lincoln (2003) point out that research inquiry comprises a bundle of skills, assumptions and practices as it puts paradigms of interpretation into motion. From their point of view, constructing the initial questions for inquiry, which will guide the study, is critical. The central research questions in this thesis are:

a. Why and how did these particular initiatives emerge?
b. How did each project progress and impact?
c. What has been learned about each particular initiative (e.g. why did it develop as it did)?
d. What has been learned across these initiatives?
e. How can a theoretical model help in understanding these initiatives?
f. What are the key transferable lessons from initiatives of this type?

This research study has arisen from an RGU scholarship, and the key question of what lessons are to be learnt from Scottish policy to practice initiatives comes originally from my supervisor's curiosity and his experience at the conjunction of different national initiatives which seemed to be unrelated. In this context the *why* question (question a)

appeared very pertinent and was central to this thesis and this directed the design and method of research.

This is important because the *why* question was typically not one of those overtly included in the commissioned evaluations of these initiatives. Rather their aims and objectives focused on *how* the policy initiatives developed in terms of their implementation and impact (Gilson and Raphaely 2008; Walt et al 2008). This linked to the second question being addressed and to subsequently learning within and across cases (question c and d) in this thesis. Question *e* comes originally from the study of Macduff (2007a), who created a MAPPED model, drawn from analysing policy to practice change in Scottish family health nursing. The thesis will test the fit of the MAPPED model during this research study, in order to further refine and develop it in terms of enabling a better understanding of the influences, processes and impact of policy to practice initiatives. Finally question f seeks to pull together key lessons that accrue.

From the above, it can be clearly seen how the six central questions evolved naturally. However, these questions need operational research, and this entails appropriate design (Streubert and Carpenter 1995).

1.6. Design structure of the thesis and overview of content

As a result, the enquiry, driven by the six central questions, directed the structure both for the research and its presentation. In total, this thesis comprises nine chapters. Following the introduction in chapter one, a literature review is presented. This consists of three sections. Section one is a critical appraisal of the definitions of policy to practice development and policy analysis, which establishes a set of primary understandings of these concepts. Section two contains a critical and analytical discussion of the relevant theories and conceptual frameworks used for policy to practice development, with a focus on their strengths and weaknesses, in order to help me apply and/or adapt key existing theories of policy analysis. Relevant studies are then extensively reviewed in the last section of this chapter, in relation to

policy to practice in global health care, health care in the UK and Scotland respectively. This provides substantial evidence on what is known about the development from policy to practice, and identifies the need for the present study. Chapter three gives an overview of the research paradigm, case study methodology and philosophical foundation employed in this study. The methodological design of the study, which has four phases, is explained in this chapter. Phase one identifies and reviews Scottish policy initiatives and develops the case selection strategies. A pilot study to test the research processes comprises phase two of the study. Phase three and phase four deal with four case studies and include recruitment, and sample strategies. Ethical issues and how to assess the trustworthiness of this study are also carefully considered in this chapter.

Chapter four concentrates on data collection and a data analysis of both the interview data and documentary data. In order to analyse data critically and precisely, this chapter firstly establishes the strategies for data analysis. Then it applies several analytic approaches to synthesise the different data. Finally three stages of data analysis are presented in this chapter respectively. The first stage of analysis primarily applies content analysis to examine the identified 15 reports, and employs a thematic framework approach to explore raw data of the interviews. It also utilises comparative analysis to compare and contrast the different perspectives across the cases and the views of different groups of participants. This informs a foundational understanding of policy and practice, drawn from the raw data. The second stage of analysis is enhanced by applying different theoretical frameworks, resulting in a deeper and more structured analysis, based on the findings from the primary analysis, in order to better understand the nature of policy to practice development. This also helps to develop a new integrative model to build up the third stage of analysis.

Through a set of systematic analyses, the overall findings of the study are laid out in chapter five, six and seven. The three chapters present the initial findings drawn from the 15 reports and each of four case

studies, then indicates the similarities and differences across the cases and among the different groups of key actors. Based on these findings, discussions are presented in chapter eight. This involves exploring the meaning of these findings, in particular for policy, management, practice in the health service and for education and research also. Concluding the thesis, chapter nine provides a summary of the study, pulling together all the main findings in regard to the study aims and objectives. This chapter highlights the value of the thesis's distinctive approach in exploring the development from policy to practice, it also addresses the limitations related to this study. Finally, chapter 9 presents some implications for policy, practice, education and future research.

Chapter 2: Literature review

2.1. Overview of this chapter

A literature review involves systematically identifying, positioning and analysing documents with information related to the research topic, in order to critically examine and synthesise what is already known, how others have considered and researched the topic and to identify the gaps in knowledge (Berg and Lune 2012; Robson 2011; Gay and Airasian 2003). This chapter starts with the search strategy and the selection of literature. Following this is main body of the literature review, consisting of a critical review of existing literature on what is already known relating to policy to practice development, in order to support and strengthen the study objectives. This will include definitions and particular references, which explore variations in definitions associated with this study. It will highlight gaps in knowledge and identify principal areas of dispute, issues and uncertainty apparent in the literature and thereby explain the need for this study. The structure of the literature review is presented in section 2.3 below.

2.2. Literature search strategy and selection of literature

Initially the literature search strategy needs to focus on the aim of the study identifying key words which reflect the topics of importance. For example, policy, health policy, practice, practice development, policy analysis were systematically noted for exploration. Secondly, terms were identified following the SPIE model (Gerrish and Lacey 2010), which breaks down the key research aim mentioned above into:

Setting (e.g. Scottish health care)

Perspective (e.g. issues, factors and lessons)

Intervention (e.g. policy to practice initiatives)

Evaluation (e.g. strengths and weaknesses/reasons why policy works/does not work)

In this way, a useful structure for listing terms and formulating a search strategy were developed. All searched key words and terms relating to

this study are presented in Table 1. Thirdly, terms, which are very much interrelated and sometimes applied interchangeably in the literature, were also noted. For instance, the term "policy to practice initiative" is sometimes replaced by "policy to practice development/change", the terms of intervention, such as "implementing/performing/transferring policy" with "policy implementation/performance/transfer" are exchangeable, and the terms "analysis, scrutiny, evaluation and examination" etc are used alternatively.

Table 1: A list of searched key words and terms in this study

Key words and terms	Interchangeable terms
Policy; health policy; practice; Health care, Scottish healthcare issues, factors and lessons	"implementing/performing/transferring policy" and "policy implementation/performance/transfer"
Policy initiatives; practice development;	"policy to practice initiative" and "policy to practice development/change"
policy analysis; policy implementation; evaluation	analysis, scrutiny, evaluation and examination

Furthermore, it is vital to take all of the synonyms and alternative spellings for the terms into consideration, in order to be sure not to miss anything important. To this end, word stem truncation (often a *) was used when searching databases. Nevertheless, it is to be noted that searching in this way generates numerous results which may make fleeting reference to the search term but are not fundamentally about that subject (Gerrish and Lacey 2006). Accordingly a combination search technique was used, the Boolean operators (AND/OR) for example, to combine key words and then search results to get relevant literature, then read the abstract for a further selection of literature. Finally, a search was systematically conducted of relevant literature by using the terms above to interrogate the CINAHL, Medline, Science Direct, Cochrane library and Google Scholar online databases, and by hand searching some specific journals such as 'Policy Affair'; 'Health

Policy'; 'Evidence and Policy'. Several official websites including Department of Health (DOH) in the UK, National Health Service (NHS) in UK, NHS Education for Scotland (NES) and Scotland Government Health Department (SGHD) were also searched. In particular I searched my institutional repository (RGU Open Air), national portals (e.g.British Library E-Theses Online Service: ETHOS) and international portals (e.g. Networked Digital Library of Theses and Dissertations; NDLTD) for electronic theses and dissertations relevant to my topic. Moreover, reference lists and bibliographies in books, papers and theses were used as an extra source of literature. It is important to note that apart from a systematic search of the literature, there is sometimes a very practical way to get relevant literature. In this case, several interesting relevant articles were handed to me by my colleagues and my supervisor.

Overall, the search through literature was continuous and was updated on a regular basis in the course of the study. There were also some specific criteria for the inclusion of literature to be searched. The dates of publications were not strictly limited, but the search was restricted to the English language, and the papers for inclusion were limited to those related to policy to practice in health care. However some literature related to policy to practice change in social science was still investigated, in order to broaden the researcher's vision and to adapt existing theories. Duplicates of references and papers reporting similar studies were not considered. In the end, all titles and abstracts of the selected papers were read and entered into Reference Manager Software called Refworks, in order to manage them effectively and appropriately.

The nature of the selected literature

This search revealed a large body of published literature in the field of policy to practice initiatives. However, this literature review includes only those items which, after comprehensive critique and selection, were judged to be relevant to my research questions and aims (Hart

1998). Consequently, only key articles to be reviewed critically were considered, if they pertained to the following categories. They were:

- Relevant definitions of policy to practice development
- Theories relevant to policy to practice change
- Factors influencing policy to practice initiatives
- Lessons learned from policy to practice development
- Approaches used in research design related to policy initiatives in NMAHP
- Evaluation reports related to policy initiatives in NMAHP in Scotland

2.3. The structure of the literature review

The literature reviewed can be placed in four sections. The first section focuses on definitions related to this study. The second section includes discussion of the relevant theories behind policy and practice development. This involves an extensive search of public and social policy analysis, in order to adapt existing theories of policy analysis. The third section includes critical reviews of accounts of research studies relating to policy and practice change in health care. This section is subdivided into three; literature related to policy to practice development in health care from international studies, then narrowed down to the UK and then Scotland itself. The last section examines the 15 selected reports evaluating initiatives in Scottish NMAHPs, which are presented in chapter three. The relevant literature is now reviewed in the following sections.

2.3.1. Relevant definitions of policy to practice change

It is vital to clarify the definitions related to policy to practice. This is not only useful in the development of theory to help understand the nature of policy to practice development, but also in leading the focus of research on how policy influences practice and what works when developing policy initiatives (Unsworth 2002).

2.3.1.1. What is "policy"

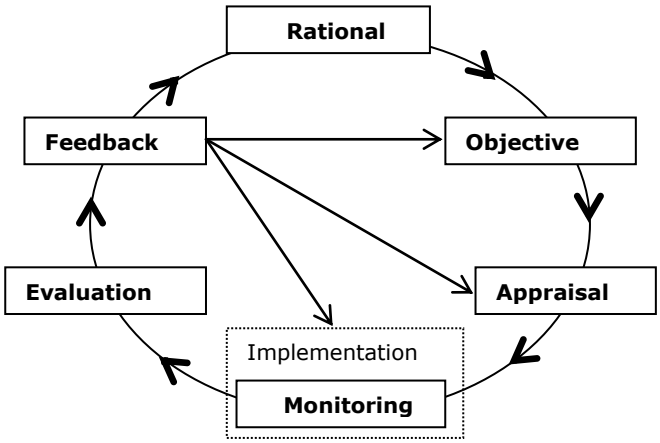
Ball (1994, p15) gives the definition of policy as 'text' and 'discourse' and points out that policies are not only 'things' but also 'processes' and

'outcomes'. However, the term "policy" is used diversely, because it may indicate an overall objective or a principle, or a specific action to be undertaken to help achieve the objective (Wilson 2008).

In effect, Smith suggests that '*the concept of policy denotes…deliberate choice of action or inaction, rather than the effects of interrelating forces'*. He highlights 'inaction' in addition to action and points out that '*attention should not focus exclusively on decisions which produce change, but must also be sensitive to those which resist change and are difficult to observe, because they are not represented in the policy-making process by legislative enactment'* (Smith 1976, P.13).

Guba (1984) declares that policy is the production of a policy-making system like a policy cycle from agenda setting to policy impact. This point appears to echo the ROAMEF cycle, which sees policy as a continual, iterative process, established by HM Treasury's the *green book* (Treasury 2003) (see Figure 1).

Figure 1: ROAMEF model (Adapted HM Treasury Green Book)



This model describes how the policy is informed, what factors will affect it, how the policy is transferred into practice and how it is evaluated and how potential policy change is easily integrated. These logical steps are influenced by each other, interact with each other and are associated with each other. The ROAMEF cycle is based on 'rational' approaches to policy making, which presume that a presented problem

will be addressed through a set of accumulative and logical steps, in search of the best response (Simon, 1945/57,1960). While the policy cycle suggests that it is possible to approach policy making in a systematic fashion, which is helpful, it has been broadly criticized, because the formulation and development of policy hardly ever proceeds in such an orderly fashion. Policy making is a complex process, involving diverse actors and diverse aims, goals and values. In fact, there are various push and pull factors, which are always working for and against each other. For those reasons, it is vital to be aware of the strengths and weaknesses of these tactics (Parsons 1995; Bochel and Bochel, 2004). This is also important for researchers and policy makers, when analysing policy critically, systematically and comprehensively.

From the above definitions, it is clearly seen that the implications of policy influence its own characteristics. Hill (2009) argues that balancing a decisional, top-down perspective on policy with an action-oriented, bottom-up perspective is important. Furthermore, Hill (2009) also emphasises that policy is a continual and iterative process that is developed taking account of context, content, process, power, and different actors, and the interaction between them (Walt and Gilson 1994). This will be further discussed in section 2.3.2.

2.3.1.2. The definition of health policy

The definition of health policy is also challenging, largely because of its different focus (Baggott 2007; Buse, Mays and Walt 2012). However, some authors have made an effort to define health policy. Acknowledging the impact of broader social and economic policies on health, Blank and Burau (2004, p 16) describe health policy as *'those courses of action proposed or taken by a government, that impact on the financing and/or provision of a health service*'. Based on this description, Buse, Mays and Walt (2005, p.6) add *'health policy is assumed to embrace courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health care system'*. They also point out that health policy is intimately associated with politics and depends on who shapes and influences the

policy making, what the policy content is and who it impacts, and how the policy is carried out in different situations (Buse, Mays and Walt 2012). Walt (1994, p.1) claims that *'health policy is directly associated with process and power…it is concerned with who influences whom in the making of policy, and how that happens'*. Thus, health policy may therefore be made within government by different key actors and by external organizations (Walt et al 2008; Exworthy 2008).

2.3.1.3. What is practice development?

As with the concepts described so far regarding policy to practice, it is very important to explore the concept of practice development in relation to policy initiatives. However, practice development is another term which is not clearly defined and is a vague concept that is not used consistently, particularly in the nursing field (Wilkinson 2011; Unsworth 2002; McCormack, *et al* 2004).

Over the past 20 years, practice development has changed in focus. For example, practice development in nursing initially focused on advancing individual patient-centred care, in particular, on improving specific practices, such as pressure damage prevention and pain management and so on. With increased nursing contribution, practice development evolved a different focus, in that the use of systematic approaches and methodological progress would influence other health care professions resulting in improvement of patient care (McCormack, Manley and Titchen 2013).

McCormack and his colleagues (2004, p.316) define practice development as *'a continuous process of improvement towards increased effectiveness in person-centred care. This is brought about by enabling health care teams to develop their knowledge and skills and transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change that reflects the perspectives of both service-users and service providers'.* This concept was widely utilised globally in shaping practice development programmes in national health

care policy at the time (McCormack, Manley and Titchen 2013). For instance, the description of practice development by Scotland (2007) as 'the *term used to describe a collection of processes which enable individuals, teams and organisations by sharing examples of good practice across the organisation as a whole to the benefit of patients and staff'* reflects its principles. This term indicates that policy drives and directs practice development.

Correspondingly, literature suggests that many developments in practice are the result of 'must do' from policy that get the job done, and that this will be most effective at delivering top down policy to practice change (Unsworth 2002). However, it can be argued that top down driven practice change has a negative impact because senior management frequently falls short and this has the potential to create a major pattern of resistance (Westbrook et al 2007). On the other hand, some scholars have identified that the investment of individual groups at street level putting their ideas into action also leads to successful practice development (Garbett and McCormark 2002). It is therefore vital to have congruity between the work being undertaken by practice developers and the practice being promoted by national health policy (Garbett and McCormark 2002). At the heart of these terms, practice development is seen as a complex intervention, rather than a single step collection of interventions across health care teams and interfaces, which involves all internal and external stakeholders. It also emphasises the need for research to advance robust evidence influencing practice development (McCormack, Manley and Titchen 2013).

2.3.1.4. Implementation

Greenhalgh and colleagues define implementation as *''active and planned efforts to mainstream an innovation within an organization''* (2004, p.582). According to Elwyn et al (2008), the process of policy implementation consists of chains of interactions in which a complex intervention is made coherent and performed within an organisation. It is managed through behaviours that convey cognitive contribution by

health professionals and other stakeholders, including service users. At the same time, a series of variables are identified by Durlak and DuPre (2008), which might affect policy implementation. In particular, four aspects are generally seen as main factors influencing on implementation and have become the roadmaps for future research, they are:

- Policy and policy process
- Organisations and their environment
- Agents' preferences and leadership
- Conditions within the implementation

In fact, scholars also view implementation as a policy process in its own right, which has to be mapped and checked to investigate what is happening in practice (Spicker 2006). As such, understanding the process of policy implementation is essential to identify what aspects of the policy work and what does not. This is sometimes regarded as 'implementation science'.

However, seminal literature highlights that the implementers of policy often work under incomplete, inaccurate understandings of what policy means to their everyday practice (Van Horn and Van Meter 1976). This suggests that scholars of policy implementation should focus not only on the relevant structural and organisational variables but also on how implementers understand policy, particularly at the 'street level' (Durlak and DuPre 2008).

2.3.1.5. The definition of policy analysis

Policy analysis is the study of policy concerns, the origins of that policy, its goals and its outcomes (Green and Thorogood 1998; Hudson and Lowe 2009). Walt et al (2008) argue that policy analysis is a multi-disciplinary approach with the aim of explaining the interaction between institutions, interests and ideas in the policy process. They emphasise that doing policy analysis both retrospectively and prospectively is useful in helping to understand policy failures and successes and in planning for future policy development. Based on this, Hill (2009) and

his colleagues view policy analysis as having different modes, they regard policy analysis as puzzle solving, critical listening, policy advice and critique. In other words, policy analysis is trying to establish the criteria by which policies can be weighted, to explore how they perform, and to examine whether policies have the effect they are expected to have (Spicker 2006).

However, it is important to distinguish analysis *of* policy and analysis *for* policy (Hill 2009). While analysis *of* policy is the study of policy content, outputs and the process to further understand the nature of policy, analysis *for* policy is to improve the quality of policy focusing on evaluation, information for policy making, process advocacy and policy advocacy. Therefore policy analysis can be concerned with both ends and means (Hill 2009). In this thesis, the study was involved with both ends and means in order to address the questions of policy development, asking what, who, why, and how policy developed. Nonetheless, this study concentrates more on the process of policy implementation in order to identify the key issues and to draw on lessons learned across those policy initiatives of relevance to Scottish NMAHP.

2.3.1.6. The challenges of studying/investigating health policy analysis and evaluation

As discussed above, definitions relating to policy and practice development vary a lot and are not used consistently. This leads to many challenges and conceptual and practical problems when studying policy and practice development and makes it more complex (Walt et al 2008). Walt and colleagues (2008) have discussed several of these challenges. First on the practical level, since analysing policy to practice development will involve different actors, individuals, groups, organisations/non-organisations, and networks involved in policy processes, there will often be difficulty in contacting the many different groups, because they will be geographically widespread. Consequently, gaining access to relevant documents, papers and recruiting

participants for observations, surveys or interviews can be problematic. This makes data collection and analysis difficult.

On the conceptual level, the carrying out of policy processes is not always obvious or the boundaries of policy stages are not clear and linear, which makes it particularly difficult for researchers to detect. As discussed before, health policy has its own specific features. It is hard to capture those features in a dynamic way, which reflects the weight of historical circumstance as well as contemporary political forces (Baggott 2007). In particular, policy decisions are usually not taking place at a single point in time. This can be specifically difficult to unpack and explain (Exworthy 2008).

Another challenge when carrying out health policy analysis is the tension between the long-term nature of policy development and implementation and the short-term nature both of funding for policy research and of the policy-makers' requests for quick reports and solutions (Walt et al 2008). This has been claimed as the 'curse of temporal challenge' by Hunter (2003). Walt and his colleagues argue that much health policy is driven by practical interests such as the evaluation of existing programmes, and that policy makers expect analysts to produce simply implementable recommendations within a relatively short time, which could lead to reductionism because of the demands of quick policy shots. Such frequent conflict between the demands of the policy cycle on the one hand and rigorous evaluation on the other hand is well recognised (Jowell and Britain 2003). This tension makes both sides feel that their own domain is under threat from the imperative of the other, and this sometimes places the researchers in a difficult position (Mays, Roberts and Popay 2001; Walker, Rahman and Cave 2001). For example, commissioned evaluation researchers at times experience pressure from the funding agencies to provide more positive responses rather than articulate criticism. Researchers are expected to extend and deepen the study, to widen its scope and to be able to report its usefulness beyond its

capacity and the resources available. Practically they are usually given a set of objectives rather than forming them themselves.

It is also difficult for researchers to observe the long term impact of the policy within the restrictions of the timetable for the study. As Jowell and Britain (2003) point out, there is simply no point in studying policy to a timetable, which does not allow time to answer accurately the research questions being addressed. Above all, the most important thing is that these difficulties and tensions challenge the researchers to maintain a balance between detachment and engagement with the subject being studied, and how to build up trust, if the findings are to be taken seriously (Walt et al 2008).

'Power' is a highly disputed concept as a central element in policy to practice development. Oakley (2000) makes the point that the practice of policy analysis takes place within power structures. Taylor and Balloch (2005) argue that the researchers are not simply seeking a more objective study in order to overcome political bias, but rather trying to understand how their work relates to wider issues of power, such as the power relationship between commissioners, policy makers, service providers, service users and researchers. In doing so, policy analysts have to find ways of managing their study rigorously and comprehensively, in order to provide a lens for significant issues, but also they have to explain very complex policy and practice development.

Gilson and Raphaely (2008) have identified that, for the most part, health policy analysis in low and middle income countries is rather intuitive, lacks a systematic plan, and the assumptions on which it is based are rarely recognised. Furthermore, another issue with doing health policy analysis is how the researchers are viewed prior to their involvement in policy communities. It is crucial to consider the standing of the researcher and its possible impact on the research process, which is called as positionality. This is because the process of policy

analysis requires engagement with policy elites (Shiffman and Smith 2007).

2.3.1.7. Positionality and health policy analysis

The obvious questions of who is undertaking the policy analysis, and for what purpose within what context, are clearly relevant in determining what approach is taken when carrying out policy analysis. Thus, information relating to the positionality of the policy researcher and its significance for the policy analysis is vital (Lingard 2013). According to Lingard (2013), positionality has different meanings. The first refers to the actual position of the policy researcher regarding the focus of study. For example, the policy researcher may be an academic researcher, a doctoral student, a commissioned researcher or a policy bureaucrat. Walt et al (2008) describe the policy research team as 'insiders' and 'outsiders', where insiders may be both participants in and researchers of the policy process, outsiders are simply foreign researchers. They point out that insiders might see things differently from outsiders, when interpreting research findings and seeking to understand the complex policy dynamic.

With both groups there are benefits and drawbacks when doing policy analysis. Buse (2008), for instance, suggests that a combination of insiders and outsiders in the research team could engage them in active discussion of the findings at the data collection and analysis stages, which could produce the richest and most comprehensive understanding of the nature of the policy. While outsider policy researchers can be expensive and time-limited, insider policy researchers are difficult to recruit (Walt et al 2008). However, it is recognised that the boundary between the two positions is not always clearly delineated but dynamic. In particular, in some health policy research contexts, one's positionality may also be highly relevant to insider/outsider status in terms of class, gender, age, culture, ethnicity and profession (Merriam et al 2001).

Lingard (2013) explains the second meaning of positionality as the political and theoretical stance adopted by the policy researchers. This meaning implies that different stance of researchers could have a bearing on different research topics, including theory and methodology. Following on from this, Walt et al (2008) claim that research positionality has implications not only for access to data, but also for knowledge construction. They argue that policy research initiated in response to political imperatives leads to a risk of superficial analyses of policy, which only show part of the picture. Likewise, 'position' can also affect the researchers when creating the research agenda and the questions to be asked. Research positionality is perceived to be coupled with the questions of power and resistance (Walt et al 2008).

At a macro level, positionality is closely linked to the features of globalisation. The spatial location of the researcher is of significant concern in the field of contemporary social policy theory and research because of the apparent time/space compression associated with globalisation (Massey 1994). The most important thing to understand then, is that positionality may refer to the national origin of the policy researcher, which influences the nature of the policy analysis done and the theoretical and methodological decisions available. This point has made me very aware of the meaning of positionality in health policy analysis due to my Chinese origin. However, it gives me an opportunity to explore the Scottish health policy initiatives, as an outsider, who is influenced less by a local context. As discussed by Merriam et al (2001):

'*being an insider means easy access, the ability to ask more meaningful questions and read non-verbal cues, and most importantly, be able to project a more truthful, authentic understanding of the culture under study. On the other hand, insiders have been accused of being inherently biased…, the outsider's advantage lies in curiosity with the unfamiliar, the ability to ask taboo questions, and being seen as non-aligned with subgroups.'*

Therefore, Walt and his colleagues (2008) have recommended that to advance health policy analysis on positionality, there needs to be greater reflexivity on the part of researchers, greater attention paid to

the composition and roles of the policy research team, and a long-term approach taken to building policy analytical capacity based on different theories. These recommendations have encouraged me to take a reflexive approach of my research to ensure that the influence of positionality has a useful impact on my research process. For example, my 23 years plus of international nursing experience, as a nursing lecturer, researcher and manager has resulted in my positionality as a policy receiver and giver having a positive impact on my research process. I can also recognise the influence of positionality in the very experienced supervision team, because of their different backgrounds, which has resulted in a strong research team for my research project.

2.3.2. Relevant theories and frameworks used from policy to practice

Having explained the foundational definitions for the thesis, it is now important to consider key theoretical perspectives. Applying theories and conceptual frameworks for policy analysis plays an important role in advancing policy development, by deepening our understanding of policy, and by providing coherence and structure to a fragmented body of knowledge in a more thoughtful conceptualisation of policy process (Walt et al 2008). However, before reviewing the relevant theories and frameworks from policy to practice, it is first and foremost essential to understand the theoretical work undertaken at these three levels in terms of 'frameworks', 'theories' and 'models', as they are often confused with one another (Sabatier 2007) .

A 'conceptual framework' refers to identifying a set of various elements and the relationships between them, which probably equates to a series of phenomena (Ostrom 2007). The development and use of a conceptual framework helps organise an enquiry by identifying the various elements and the relationship between them, which needs to be considered for analysis. However, they cannot in themselves explain or predict behaviour and outcomes (Schlager 2007). In comparison, a 'theory' makes general working assumptions about the elements, which can provide a deeper and more logical coherence to a fragmented body

of knowledge, and enable the analyst to explain a phenomenon, its processes, and predict outcomes (Ostrom 2007). While Frameworks play a significant role in the accumulation of knowledge, theories place value on seeking to explain a fairly general set of phenomena, based on a certain variables identified as critical in a framework (Schlager 2007).

On the other hand, a 'model' represents a specific situation and is much narrower in scope, and more precise in its assumptions than a theory. It is used to explore systematically the consequences of these assumptions and the limited number of outcomes. It also allows analysts to test, revise and further develop theories (Schlager 2007).

Therefore, the terms 'frameworks', 'theories' and 'models' can be visualised, placed along a continuum with growing logical interconnection and specificity but decreasing scope (Sabatier 2007). These conceptual and theoretical practices can help simplify the complex policy process and lead to a better understanding, by viewing it in different ways (Sabatier 2007). However, the boundaries between the three levels are not clearly defined. In particular, many scholars use the terms 'conceptual frameworks' and 'theories' interchangeably, including myself.

The literature relating to policy and practice theories and frameworks is vast, thus it has been necessary to limit the range. Included in this work are a number of widely used frameworks and theories in published public policy literature, in order to appreciate complex policy and practice changes (Gilson and Raphaely 2007). This thesis presents a review of those conceptual frameworks/theories/models which have been utilised most in policy process literature and have been applied in my study (see Table 2).

Table 2: A list of frameworks, theories and models reviewed in this study

Name of framework/theory/ model	Author	Framework	Theory	Model
Policy triangle framework	Walt and Gilson (1994)	√		
Multiple-streams	Kingdon (1984)		√	
Top-down and bottom up implementation	Sabatier (1999)		√	
Strategic change	Pettigrew 1988		√	
MAPPED model	Macduff (2007)			√
NPM model	May (2006)			√
Framework of governance, incentive and outcomes	Ross et al 2011	√		

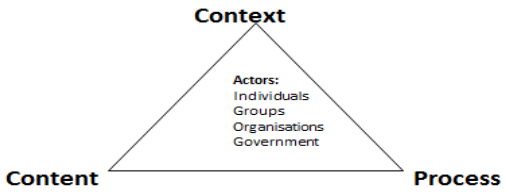
2.3.2.1. Conceptual frameworks

Policy triangle framework

One widely used framework is the policy triangle developed by Walt and Gilson (1994), which is useful especially for health policy analysis, though its relevance expands beyond this field (see Figure 2). This analytical framework focuses on: 1) *policy context*-which policy is initiated and formulated, 2) *policy content*-what the policy consists of, 3) the *process*—the relation to policy implementation and evaluation, 4) the *actors,* who are involved in policy development and implementation, including individuals, groups, organisations and even government, and how the four elements interact with each other (Buse, Mays and Walt 2012).

The policy triangle framework has been employed to analyse a large number of health policy developments in a range of countries (Gilson and Raphaely 2008). It helps to explore and think systematically about all the four different factors that might affect policy, particularly about the somewhat neglected place of politics in health policy. To a certain degree, health policy researchers used to largely focus on the analysis of policy content, neglecting policy context, process and actors. This framework can also prospectively be used to shape existing policy (Walt et al 2008).

Figure 2: Policy triangle framework (Walt and Gilson 1994)



However, the policy triangle framework is a highly simplified approach of explaining complex policy development, and the four factors can be considered separately at a single point of the triangle. This is not what happens in reality. As Buse, Mays and Walt (2012) said, the policy triangle framework is *'like a map that shows the main roads but that has yet to have contours, rivers, forests, paths and dwellings added to it'.* Furthermore, it only implicitly considers the policy impacts and outcomes.

Although the issues of conceptual frameworks remain a problem, some theories have been widely used by way of critical analysis of the policy process. This will be discussed in the next section.

2.3.2.2. Theories

Influential policy theories include the multiple-streams theory (Kingdon 1984), top-down and bottom up implementation theory (Sabatier 1999) and strategic change theory (Pettigrew 1988}.

Multiple stream theory

The theory of multiple-streams was developed by Kingdon (1984) based on the 'Garbage can" model of organisational behaviour. According to Kingdon, the policy process should be viewed as composed of three streams of actors and processes: a problem stream, a policy stream, a political stream.

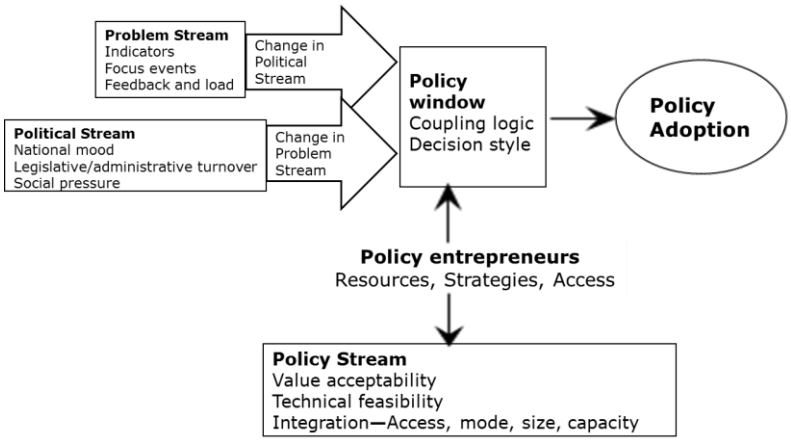
The problem stream represents evidence of the nature of the various issues that may require governmental action. The problem issues can be exposed through indicators such as mortality rates or costs, focus events such as high profile crises, feedback from previous programme and problem load where difficult problems coalesce (Zahariadis 2003).

The policy stream refers to a 'soup' of ideas (e.g. proposals, strategies and initiatives) to address the problem and win acceptance in policy networks. It includes technical feasibility, value acceptability, and integration. Integration is the connection between participants and involves four dimensions: size, mode, capacity and access (Zahariadis 2003; Kingdon 2002).

The political stream includes elements such as public mood, attitude, social pressure and administrative or legislative turnover. Public mood means the general perception of a large number of individuals in a given country and this mood can change as influenced by events and the media. Power, legislative or administrative change frequently affects policy choice (Zahariadis 2003).

In Kingdon's agenda, the policy window is crucial too, since it presents an opportunity to link completely problems, proposals, and politics, and to move a package of the three joined elements up on the decision agenda. The term 'policy window' is defined as 'fleeting' opportunities for advocates of proposals to put forward their pet solutions, or to bring attention to their special problems' when the three streams are coupled together in time (Kingdon 1995, P.165). Also, these three streams basically flow independently until a policy window is opened by events in either the problem or political streams, and then, with the help of a policy, an entrepreneur, an individual or individuals invest their own resources in coupling the streams to advocate a particular policy leading to its adoption (Kingdon 1995; Felix 2007). Figure 3 demonstrates the adapted multiple stream theory.

Figure 3: Kingdon's model (adapted from Zahariadis 2003)



The multiple-stream theory is characteristically seen as an explanation of policy agenda-setting and it can be usefully utilised to explain the entire process of policy formulation. In this context it has been influential on a key nursing policy analysis model in UK: the Context-Convergence-Contingency model developed by Rafferty and Traynor (2004).

However, critics have criticised the multiple-stream theory for making a number of unrealistic hypotheses and for using non specific undetailed processes. Thus, Sabatier (1999) reminds us that multiple stream needs greater clarity and clearer specification of hypotheses. Its strength only lies in its own logic and the conclusions of the original garbage can simulation. In particular, Bendor and his colleagues (2001) complain about the vague logic and confusing language regarding this theory. In the main, multiple stream theory is principally considered important only for the explanation of agendas. It is very limited in analysing policy implementation processes and focuses almost exclusively on the national level.

The top down and the bottom up implementation theories

However, the top down and the bottom up implementation theories (Sabatier 1999) can help explain the process of translating policy to practice. The multiple implementation approach is deeply rooted in the

stages heuristic, which makes a clear distinction between policy formulation and implementation. The benefit of stressing the importance of implementation as distinct from policy formulation highlights the need to examine the process of putting policy into action (Hill and Hupe 2002; Barrett 2004; Hill 2009).

The top downers (e.g. Sabatier and Mazmanian 1980; Dye 2001) emphasise that the essential features of a top down approach start with a policy decision very often by central government and focus on explaining gaps or deficits between the intentions of policy makers and the outcomes of policy.

The two strengths of the top-down approach are stressed by Sabatier (1986). He points out that top down approach is useful when major public programmes in the policy area are under consideration or when the researcher is interested solely in the effectiveness of a programme. Also, the top down approach has a significant effect on making a preliminary assessment about which approach to use. In other words, the top down approach appears to be influential when structuring a piece of legislation. In a sense, top to down implementation of policy to practice can be affected by the central planners responsible for developing policies. However, all decisions can be monitored during the operation process to ensure they are not greatly modified (Dye 2001).

On the other hand, the critics (e.g. Hjern and Hull 1982; Hanf 1982; Barrett and Fudge 1981), argue that the top down approach starts out from the perspective of (central) decision makers and tends to neglect other actors. This means that initiatives coming from 'street level bureaucrats' (Lipsky 1971) or local implementing officials are ignored. They also complain that the top down approach is difficult to use in a situation where there is no dominant policy, but rather a variety of governmental directives and actors. Finally the top downers seem to underestimate the strategies used by street level bureaucrats and target groups to get round (central) policy and/or to bend it to their own purposes.

In contrast, the bottom up theory emphasises the fact that the implementation of policy to practice is highly influenced by front line staff, who can change policies considerably (Hjern and Hull 1985). The bottom up approach begins by identifying the network of actors involved in service delivery at local level with their goals, strategies, activities, and contacts. These contacts are the starting point for the development of a network technique to identify local, regional, and national actors involved the relevant governmental and non-governmental programs. This provides a mechanism for moving from the 'bottom' up (street level bureaucrats) to the 'top' policy-makers (Hjern, Hanf and Porter 1978; Hjern and Porter 1981; Hjern and Hull 1985; Hupe and Hill 2007). The bottom up approach has several notable strengths (Sabatier 1986). First and foremost, this approach puts forward a clear and replicable methodology for identifying a policy network. To some extent, it is able to assess the relative importance of a variety of governmental programmes, using the actor's perceived problems and the strategies developed for solving these problems. Thanks to this, the bottom up approach can clearly foresee all sorts of consequences, in particular, the unintended outcomes, of governmental programmes. Lastly, bottom uppers appear to be better able to deal with strategic interaction because of their focus on a wider range of actors, compared to top downers (Sabatier 1986; 1999; Hupe and Hill 2007).

Although the advantages of the bottom up approach are clear, it is still limited in some areas as far as analysing the policy implementation process is concerned (Sabatier 1986; 1999). For instance, bottom uppers seem to overestimate the power of the peripheral to frustrate the centre. More importantly, while bottom up focuses on the goals and strategies of the vast majority, they seem to undervalue the influence of directives from the centre on those goals and strategies, by means of its power to shape the institutional structure in which individuals work. Furthermore, the fundamental limitation of the bottom up approach is that it relies very heavily on the perceptions and activities of the participants, which can result in it failing to establish a specific theory

concerning the factors which affect its area of interest (Sabatier 1986; 1999).

Strategic change theory

It is important to bear in mind that a range of social science theories from out with the policy studies field have also been applied by researchers to health policy analysis. These have their origins in, sociology, anthropology and organisational management (Gilson and Raphaely 2007), such as strategic change theory (Pettigrew 1988).

The strategic change theory developed by Pettigrew (1988) is drawn from an international research seminar and has been extensively used. Pettigrew emphasises that management of strategic change should involve continuous interaction between the context, the process and the content of change, together with skill in regulating the relationship between the three. He points out that strategic change involves not only consideration of the content of a chosen strategy or the management of the process change, but also the role of context. The role of context is seen as a critical first step in identifying the readiness for change, as well as both the context and the role of individuals within it (Richardson 1999; Harvey, *et al* 2002). The significance of context in mediating change is also demonstrated in studies of change in health care (Pettigrew, *et al*, 1992; Ferlie, *et al* 1998; Iles and Sutherland 2001).

There are two contextual levels, the inner context link and outer context variables. "Outer context" refers to the economic, business, political and social formations. The "Inner context" in the theory refers to the structure, corporate culture and political context within the organisation.

According to Pettigrew (1988), the structure includes not only the formal framework of relationships but also the multiple structures produced by the merged actions of individuals within an organisation. The studies of the relationships between organizational structure and

change have produced inconsistent results (Damanpour and Gopalakrishnan 1998). Some argue that organisational structure can be a barrier or provide few incentives for organisational change (Pettigrew 1985; 1992; Orlikowski 1992; Barrett and Hill 1984; McLaughlin 1990). However Pierce and Delbecq (1977) suggests that the centralised structure of an organisation facilitates adoption and implementation of the change, while decentralisation could be positively related to initiation and implementation of the change. He articulates that the diversity of structural features of organisation could influence the phases of initiation, adoption and implementation of organisational change. Furthermore, Ruef (2002) empirically provides evidence that innovation can be both enabled and constrained by organisational structure.

Organisational culture refers to the beliefs, values, meanings and rationales utilised for the action, together with the language, codes and rules that inform those actions. Evidence shows culture affects many aspects of health care including performance and the use of research (Scott-Findlay and Estabrooks 2006; Mannion, Davies and Marshall 2005; Scott et al 2003; Sheaff et al 2003; Hyde and Davies 2004). For example, in Ruef's (2002) study, the results illustrate the significance of organisational culture impacting on the innovation. He points out that the internalisation of norms and ideas cannot be neglected in predicting the capability for creative action.

The politics of an organisation refers to both the internal distribution of power and the number of challengers involved. In particular, vertical and horizontal integration is a crucial feature of distribution of power (Pettigrew 1985;1992). The perceptive idea of integrating vertical and horizontal dimensions has a clear connection with policy implementation. For example, Young (2002) identifies the impact of vertical interaction between policies located at different spatial scales of governance, and horizontal interplay between policies at the same level of governance.

To some extent, it can be clearly seen that the three elements of inner context can have a significant effect on implementing policy to practice initiatives within organisations. This is because each element has a direct or indirect influence on viable performance, in that they shape organisational strategies, either in their origins or their implementation (Pettigrew 1985;1992). Overall this theory is valuable in helping us understand what policy to practice initiative change is, how it changes and why. Yet, it does not fully investigate how the key actors affect the processes of strategic change.

Thus, paying specific attention to the development of theories can be beneficial when systematically analysing policy to practice, by giving a deeper understanding of the variables and the factors involved in going from policy to practice. This would go beyond merely 'stating the facts" and provide a more thoughtful conceptualisation of the process from policy to practice (Walt et al 2008). These will be returned to in the discussion section/in analysis of my study findings.

2.3.3. Relevant studies from policy to practice development in health care

Having critically discussed pertinent concepts and theories from policy to practice, this section reviews studies relating to policy to practice initiatives in health care. However, Maxwell (2006) emphasises the importance of *relevant* studies for this task instead of attempting comprehensiveness. He highlights '*relevant works are those that have important implications for the design, conduct, or interpretation of the study, not simply those that deal with the topic, or happen to be in the defined field or substantive area, of the research*' (p.28). Therefore, according to literature search strategies and the criteria for literature selection mentioned above, a range of studies relating to policy to practice change were carefully selected, and organised into three sub-sections according to their different orientations. This provides a broad overview and discussion of current debates relating to policy to practice developments, in order to emphasise the need for this study and to

guide the methodology of this study. The following section begins by reviewing international studies attached to policy and practice change.

2.3.3.1. Literature relating to policy to practice change in healthcare from international studies

Concerning relevant literature, this section includes a great number of global studies, which identify and examine the factors influencing health policy to practice development (see Figure 5), in its different stages (policy formulation; policy translation process and the outcomes), in a large array of countries dealing in particular with the factors, which hinder or facilitate the implementation of health policy to practice change, such as the study by Watt et al (2005) and Green et al (2011).

The study by Watt et al (2005) focused on analysing the barriers to and the facilitators for achieving practice change. Watt and his colleagues employed a mixed method with a longitudinal design to investigate how a health policy initiative operated in two different sectors with a view to shortening the length of the postpartum hospital stay. They pointed out that policy, as a tool for practice development, must place emphasis on the organisational, professional, and social context within which the policy is to be implemented. These contexts may either support or hinder policy implementation.

The study of Watt et al (2005) provides a good evidence of how implementing policy intended to change post-natal care practices reflects the different impact of various contexts on policy performance. However, the drawback when considering the applicability of this work, is that the study is very limited, in that it only deals with one initiative based around the Canadian health care system. In addition, this study did not provide insight into why things happened as they did in implementing the policy initiative.

A comprehensive study was carried out by Green and his international colleagues (2011) using a multi-method approach, retrospective and comparative study, to evaluate and understand the policy processes in

nine case-studies of maternal care in China, India and Vietnam from 1999 to 2008. This paper provides convincing evidence for enhancing policy processes and concludes that evidence-based, systematically planned policies appear to be implemented more successfully and to be more effective in reaching their goals.

However, this work based on information from low and middle income countries makes comparison with Scottish health policy difficult, not only because of the different geography, culture and policy, but also due to the different health care system and management structure. Nevertheless, this study can be very useful, when analysing policy initiatives for the purpose of gaining a better understanding of the nature of policy to practice developments and of the key issues emerging from those initiatives. In particular, the methodological triangulation of this research design and the developed conceptual framework set a good example for similar studies.

Finally, the studies which identified lessons learnt from policy to practice initiatives (see Figure 5) have also been reviewed in depth such as the study by Williams et al (2004). Williams et al (2004) conducted a historical review of archival documents and multiple in-depth case studies in four countries (Tanzania, South Africa, Kenya and Peru). The data collection for the case studies came from individual interviews and focus groups, with key informants being identified by a combination of purposive sampling and "snowball" sampling. The key lessons learned from this study indicated that key stakeholders should be identified and engaged in the policy change process early, and improved communication is needed on all levels.

This research project through intra and cross-case studies presents its successful strategies using rigorous evidence; presenting arguments for change and developing regional approaches, instead of focusing solely on the home country. Moreover, it shows the benefit of operating purposive sampling and snowball sampling in multiple case studies. This provides a clear idea of how to identify the key lessons learned

from health policy to practice change. Clearly, this study is limited to specific malaria treatment policy in four African countries, where there is a lack of an adequate national health care system.

This review section has critically evaluated several studies using diverse methods in different countries. These studies focused on what happened from policy to practice, what impact the policy had, and why things happened as they did. In particular, they sought to explore the factors influencing health policy to practice by identifying the barriers and facilitators for implementing health policy and practice. Here both their strengths and weaknesses have been critically reviewed, and how they shed light on my study. However, they are limited by focusing only on one or two individual policy initiatives or on specific fields within policy to practice development in health care. They also limited in terms of theory test and development. These limitations suggest that a systematic investigation of initiatives from health policy to practice needs to be considered. The next section presents a review of studies relating to health policy to practice development in the UK.

2.3.3.2. Literature relating to policy to practice change in healthcare in UK

There are a limited number of studies which focus on explaining what happens from policy to practice in health care in the UK, particularly limited regarding Nursing, Midwifery and Allied Health Professions (NMAHPs) (May 2006; Holme 2009; Moore et al 2010; Hunter 2010; Ross et al 2011). And in these, they are limited in the systematic analysis of policy to practice developments in NMAHPs.

One key relevant study of policy to practice in health care in the UK is May (2006), who developed a theoretical framework for the Normalisation Process Model (NPM), through systematically analysing and synthesising an extensive series of qualitative studies of telemedicine initiatives. This model was consequently refined and expanded to assess and evaluate the enactment of complex interventions in health care (Murray, May and Mair 2010).

Normalization is referred to the routine embedding of a complex intervention in health care (May 2006)

The Normalisation Process Model is defined as four theoretical constructs: *IW* (interactional workability); *RI* (Relational integration); *SSW* (skill-set workability) and *CI* (contextual integration) (see Table 3). Table 3 illustrates the components of NPM.

Table 3: The components of the Normalisation Process Model (May 2006)

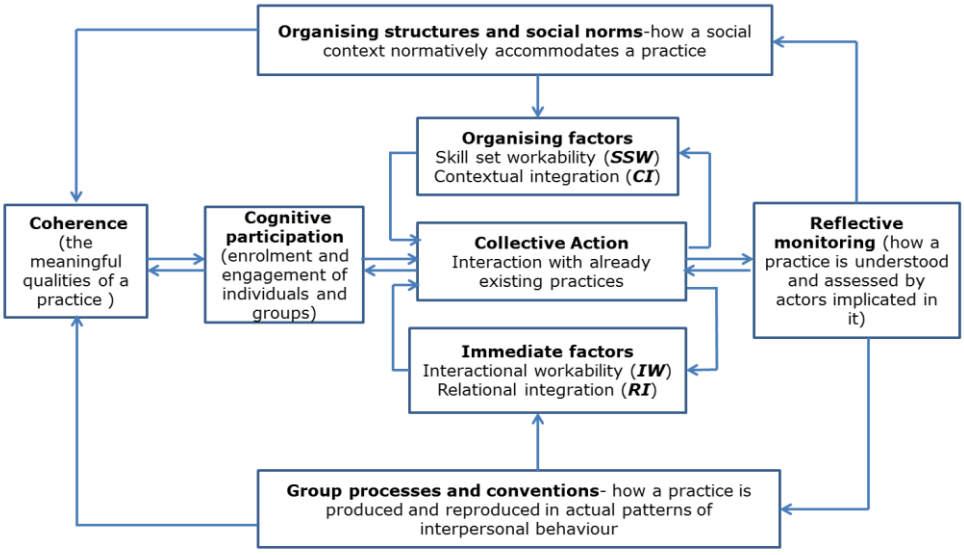
NPM	**NPM dimensions**	
Interactional workability (IW)	Congruence	co-operation
		Legitimacy
		Conduct
	Disposal	Goals
		Meaning
		Outcomes
Relational integration (RI)	Accountability	Validity
		Expertise
		Dispersal
	Confidence	Credibility
		Utility
		Authority
Skill-set workability (SSW)	Allocation	Distribution
		Definition
		Surveillance
	Performance	Boundaries
		Autonomy
		Quality
Contextual integration (CI)	Execution	Resourcing
		Power
		Evaluation
	Realization	Risk
		Action
		Value

IW refers to the immediate factors in which complex interventions are operationalized, including two dimensions: *congruence and disposal*. ***RI*** refers to the network of relations between professionals and patients by means of knowledge and practice relating to a complex intervention,

characterised by two dimensions: *accountability and confidence*. On the other hand, ***SSW*** refers to the formal and informal divisions of labour in the field of health care, including *allocation* and *performance* dimensions. ***CI*** points to the capacity of an organisation to implement a complex intervention with the dimensions of *execution and realisation*.

To thoroughly understand the four constructs is essential. The reason is that these constructs are extremely useful in providing a conceptual framework for characterising policy to practice initiatives, which propose a working model of implementation, embedding and integration in conditions marked by complexity and emergence (see Figure 4). Figure 4 presents a model of Normalisation Process.

Figure 4: A model of the Normalisation Process Framework (May and Finch 2009)



The framework of NPM explains why some policy processes lead to a practice becoming normalized while others do not. It provides an explanatory framework for exploring the routine embedded practice in the policy context. It also engages with why things happen as they do. Therefore, it can be helpful in understanding the factors that facilitate and impede the routine incorporation of complex healthcare interventions in practice. As such, this model offers a framework for

characterising the 15 identified Scottish health policy initiatives (See Chapter three).

However, the language in this model is very technical, since it uses theoretical vocabulary within the statements, explanation and beyond. Some individual statements do not make the meaning clear and overlap, which is confusing for the users. Moreover, this approach focuses solely on the policy intervention process with no concern for the policy formulation process (Elwyn et al 2008; May et al 2011).

Another key relevant study was carried out by Hunter (2010), where a national policy initiative was implemented to support normal birth within Wales maternity care. He used a range of qualitative methods to explore the real life experiences of those involved in policy development and performance, and to gain further insight into the perceptions of those key informants. More importantly, this study critically analysed policy formulation and implementation stages, including how the ideas were formed, the processes of the steering group and implementation and, what impact it had on midwives, doctors and mothers. In this wider national policy initiative study, Hunter states that the national policy has been interpreted at a local level, with variations in its usage, reflecting local culture. The study also indicates a number of unexpected consequences for the working practices of midwives and midwife-doctor relationships.

According to Hunter (2010), taking the various critical issues into account is of the greatest importance when developing policy, especially at a national level. Firstly, managing the particular challenges of national policy formulation and implementation is critical, due to the large scale. For instance, how to ensure effective communication with all concerned parties requires every process to be in place. Secondly, it is essential to acknowledge that consultation with all stakeholders is vital in order to diminish feelings of exclusion and disaffection. For example, an effective steering group with members from clinicians needs to be created, extra time must be given to these people instead

of adding to existing workloads. Thirdly, policy should be appropriately evidence-based and be realistic and achievable, in order to ensure on-going commitment and motivation. Last but not least, continued leadership to support the new policy is required after the initial implementation. Rigorous evaluation tools are also required, because policies as they are carried out in practice may be very different from the initial intent of the policy.

This study shows clearly the important lessons to be learned from implementing a national policy initiative, and this is included in my study aims. Besides, it demonstrates the importance of exploring the perspectives of different stakeholders through an in-depth study. My research project can benefit from these strengths. In spite of this, it is very much limited to one specific case within a particular locality of Wales. Scottish culture is significantly different from Wales, and they also have their own health policies and health care system, though both are in the UK. Most importantly, there is lack of a systematic research examining health policy to practice initiatives. These deficiencies remind us that an in-depth systematic study is clearly necessary, in order to obtain robust convincing evidence for health policy development.

Significantly, one of the few relevant studies in the nursing field is Ross et al's (2011) recent retrospective study, analysing four completed national and regional nursing studies carried out in England. Applying the framework approach (Ritchie and Lewis 2003), they thematically explored the four cases, adapting theoretical perspectives from Davies et al (2005) and Read et al (1999) to generate a thematic framework (see Table 4), in order to provide a comprehensive understanding of policy and practice development in nursing. Through this theoretical approach, Ross and her colleagues established a structured critique of the impact of contextual, professional and personal factors on nursing policy to practice change. For example, at the contextual level, the common themes emerging from their findings across case studies include:

- Connections between organisational aspects and personal relationships that make organisations work.
- Support and commitment in terms of strategic leadership and colleagues relations
- A combination of contextual and individual behaviours is crucial
- Leadership is an important theme at different levels, providing support, expertise, access to resource and legislation.

Table 4: Conceptual framework of governance, incentive and outcomes adapted from Ross et al (2011)

A conceptual framework of governance, incentive and outcomes--Adapted from Ross et al 2011			
Governance	**Implementation of policy to practice initiative**		**Impact**
Contextual features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Policy context			
Resources and budget			
Support and sustainability			
Patterns of working			
Influencing governance mechanism, e.g. market, hierarchical, network			
Personal features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Preparation for the role			
Career aspirations			
Professional features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Professional implications of development			

The findings provided strong evidence of innovation in nursing, which addressed various policy concerns. However, one of the limitations of

this work is that it is based solely on documentary analysis of cases that they were personally involved in evaluating. This strongly suggests that a further in-depth systematic empirical study by an external researcher who was not involved policy to practice developments and evaluations in NMAHPs would be useful. Nevertheless, the study of Ross et al (2011) provides the background for my PhD research project, giving insight into key lessons learned from NMAHPs policy to practice initiatives in the UK.

2.3.3.3. Literature relating to policy to practice change in nursing, midwifery and allied health professions in Scotland

There appears to be a dearth of literature relating to policy to practice in NMAHPs in Scotland. However, the study of Macduff (2007a) is very relevant to my study, in particular his MAPPED model (see Appendix 1). This model is top down in nature and is drawn from analysing policy to practice change in Scottish Family Health Nursing.

MAPPED model was developed based on several relevant theories: Kingdon (1995)'s agenda setting model; Bergen and While (2005)'s model of practice response to policy change in community nursing; Rafferty and Traynor (2004)'s Context-Convergence-Contigency (C-C-C) model and May et al (2003)'s contingency model. The MAPPED model was seen as relevant for analysis of initiatives with four main characteristics: (i) 'top to down' in nature; (ii) incorporated an educational program and (iii) a commissioned evaluation; and (iv) involved regional health boards in associated translated activities (Macduff 2007a). These elements will be main criteria for my initial case study selection in order to systematically analyse policy initiatives.

Essentially, the model can help to explain and understand the structures, processes and any impact from policy to practice developments. Using it as a tool can also help to explore the weak links and blocks in the processes of policy to practice initiatives. However, the language in the model may be too academic for general use. Besides, the study is limited to national level and new role development,

which encompasses education and research evaluation. Furthermore, it is restricted to a "top down" method of policy to practice, without an effective feedback procedure. Thus, testing the fitness of the MAPPED model to policy and practice development forms part of my study.

Overall, by critically reviewing relevant studies I have gained more clarity, a broad overview and understanding of issues relating to current debate and uncertainty. This helps me understand the context, process and outcomes of policy to practice, and exposes the main gaps in knowledge of policy development, which require further study (Robson 2011; Gerrish and Lacey 2006; Ritche et al 2014). One of the main gaps is lack of in-depth systematic studies that span policy formulation through to implementation and evaluation. It also provides a clear critique of the strengths and weaknesses of the different methodological approaches, and it can be seen that this informs the selection of theories, methodologies and instruments (e.g. interview schedules) for my PhD research study. For example, the application of in-depth multiple case studies by Green et al (2011), Williams et al (2004) and Ross et al (2011) has strongly shown the strengths of case study methodology for analysing policy to practice. Lastly, this review of relevant studies helps me to identify general patterns within the findings from multiple studies in a similar area (Robson 2011; Ritche et al 2014) and these inform the comparisons and discussion in my study. The findings focus on the factors which are said to either influence health policy development or to facilitate or hinder the process of implementing policy change, and on the critical lessons learned from policy initiatives. Figure 5 summaries key findings extracted from relevant studies through this literature review.

Figure 5: Extracted findings from relevant studies

Factors influencing policy to practice

I. Governance characteristics
- Politics
- Policy
- Funding
- Connection between organisational aspects and individual relationships

II. Organisational characteristics
- Acceptance: perceived the needs and benefits
- Resources: staffing, timing and cost
- Infrastructure and capacity of organisation
- Organisational culture or climate and norm
- Integration of new programmes
- Shared vision

III. Individual characteristics
- Professional knowledge and skills
- Value and beliefs
- Behaviour and enthusiasm
- Commitment
- champions

IV. Policy initiative
- Capability
- Adaptability

V. Specific policy processes and practices
- Collaboration and partnership
- Effective engagement
- Effective communication
- Leadership
- Support at different levels
- Training and technical assistant

Barriers hindering policy to practice

1. Organisational context, resources were not available
2. Professional context: negative attitudes and behaviours
3. Social context: patients lacked of knowledge
4. Difference in pace
5. Staffing difficulties, resources, cost
6. Unsustainable governmental roles
7. Poorly designed payment schemes
8. Patient's trust crisis
9. Lack of management support,
10. Limited education and skills
11. The absence of systematic protocols for interventions
12. Institutional culture

Lessons learned from policy initiatives

1. Managing challenges
2. Evidence-based and achievable policy
3. Be aware of contextual variation
4. National policy imperatives are not always translated into practice
5. Effective engagement
6. Tensions in governance arrangements
7. Conflicts between decentralised decision-making and the need for overall
8. Political preference
9. Issues for meeting national priorities and targets
10. Confusion over the different ways in understanding, operating and priorities
11. Need more transparency and accountability
12. Communication strategies
13. Effective leadership
14. Development of practice guidelines
15. Discretionary and inconsistent implementation
16. How the findings contribute to health policy decision-making process

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2.4. Summary

The literature review chapter has discussed the initial strategy for searching and selecting relevant literature. Following this, it has critically reviewed relevant theories and studies, including key concepts relating to this study. This review has provided not only an overview of

what is already known about the factors and lessons emerging from previous studies, but has also given a great deal of information about the possible structure of this study (e.g. the study by Ross et al 2011), and has identified the gaps in knowledge of policy to practice development. Both the literature and the gaps in the range and scope of the studies available suggest that what is needed is in-depth systematic study from policy formulation through to implementation and evaluation. A range of methods has been recommended, such as in-depth semi-structured interviews, focus groups, case studies and mixed methods, to explore the issues and lessons from policy to practice developments. However, one very clear message from the studies reviewed is that systematically investigating health policy change is complex and critically challenging, in particular regarding research design. In the next chapter I will discuss research design in more detail explaining the rationale for selection of and application of the research methodology.

Chapter 3: Study methodology, design and methods

3.1. Overview of this chapter

This chapter explains the methodology and methods developed and used in this thesis. Initially the study of the philosophical root of the methodology itself is considered, which leads to an explanation of the epistemological and ontological foundations of this study. The case study methodology at the heart of the enquiry is explained. The chapter explains the four phase research design, and the methods used to address the six central questions that drive and link each of part of the study. In doing so, the chapter also considers ethical issues and, the criteria for assessing trustworthiness.

3.2. Overview of key concepts and relationships

Before considering the nature of interpretation and explanation of health policy initiatives, it is important to understand the research paradigms. A paradigm is defined as *'a systematic set of beliefs, together with their accompanying methods'* (Lincoln 1985, p15).

Quantitative and qualitative research have traditionally been considered as different research paradigms, in that they are underpinned by distinctive belief systems (Kuhn 1996; Kuhn 2012). In general, a quantitative researcher uses numerical data, and statistical analysis in order to test hypothetical generalisations (Hoepfl 1997). Social researcher doing a qualitative study relies on textual data and analysis of these data in their textual form, seeking to understand the meaning of human action (Schwandt 2001). In doing so, qualitative inquiry can explore in-depth the complex and dynamic nature of the social world (Cronbach, 1975; Hoepfl 1997), and is therefore particularly suited to analysis of policy initiatives (Murphy et al 1998), as it has been seen from the literature review

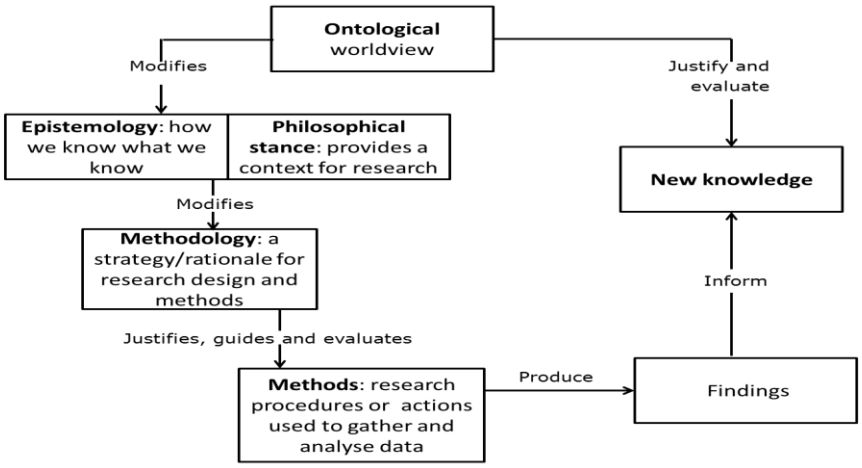
The differences between quantitative and qualitative research paradigms are substantially influenced by a range of factors (Ritchie et al 2014). The main factors include beliefs about the nature of the social

world and what is known about it (ontology), and the nature of knowledge and how we come to know it (epistemology), as well as those factors particular to the study, including the aims and objectives of the research, the characteristics of the funders and study participants, and the researcher's experiences and beliefs. For example, employing the typical features of the qualitative paradigm with its uniqueness and usefulness in my study can enable me to address my study aims and objectives by

- ❖ providing in-depth understanding and interpretation of policy initiatives;
- ❖ using small purposively selected samples;
- ❖ interacting with participants to elicit the issues;
- ❖ collecting wide and rich data;
- ❖ employing an analytical process with detailed descriptions and creative development of themes (Snape and Spencer 2003).

The above elements of ontology, epistemology, methodology are related to each other and illustrated by Figure 6 below.

Figure 6: The relationship between ontology, epistemology, methodology and methods (adapted from Carter and Little 2007)



While the ontological worldview determines the philosophy of knowledge (epistemological stance) and philosophical stance,

epistemology guides methodological choices and is visible in the method, particularly in the interaction between participant and researcher, in the assessment of the quality of research, and in the opinion given in analysis and writing. Meanwhile, methodology shapes and is affected by research aims, questions, study design and methods. In a certain sense, method is confined by but also shows the methodological and epistemic choices made (Carter and Little 2007; Krauss 2005).

The relationship presented here between elements of research paradigms has helped me understand how to develop my research study. And a qualitative design with case study methodology seemed the most appropriate approach to take, in order to achieve the study aims and to answer the research questions.

3.2.1. Philosophical underpinnings of this study

Before explaining case study methodology in more detail it is useful to consider the philosophical underpinnings of the study.

3.2.1.1. Ontological worldview

Ontology deals with enquiries into *what the nature of the world is and what we can know about it* (Lincoln and Guba 1985; Crotty 2005). One possible philosophical stance is realism, which views the world as *reality* (Robson 2011). In fact, realism has various names, such as *objective realism and subtle realism* amongst others, each of which emphasise specific features (Robson 2011). While '*Objective realism' viewed by positivists* asserts that there is a tangible reality, and experience with it can result in knowing it fully, this attracts criticism from subtle realism. Subtle realism perceived by naturalists argues that ontologically, reality is seen as something that exists independently of those who observe it, but is only accessible through the perceptions and interpretations of individuals or groups (Ormston et al 2014; Lincoln and Guba 1985).

Thus subtle realism directly addresses the issues of 'how' and 'why' something happened which is not necessarily tangible. Moreover, subtle

realism provides a way of approaching research in an open, uncontrolled situation, which is close to the real world, research which takes place in a 'field', rather than laboratory situation (Robson 2011). The philosophical stance of subtle realism is particularly useful to my study, because it provides me with a basis to explore issues from policy to practice change, that are not necessarily externally tangible other than through the perceptions of different participants. However, those can be viewed as reflective of a reality wherein factors influence policy development. So much so, the next section will discuss the epistemological stance in detail.

3.2.1.2. Epistemological stance

Having established subtle realism as useful ontology, it is important to investigate the epistemological stance in qualitative research. Epistemology is concerned with ways of knowing and learning about the world. It focuses on issues such as: how we can learn about reality; what information can be considered; the nature of the knowledge we can acquire and how we can know and learn about the social world (*of policy to practice change*) (Ormston et al 2014; Crotty 2005; Robson 2011). These issues can be explored through analysing the relationship between the researcher and the researched and how this influences the connection between 'facts' and 'values'.

At the heart of this, reflexivity in qualitative research is considered particularly important (Ormston et al 2014). For example, 'positionality', as discussed before, has an effect not only a personal and professional commitment to this study but also on the importance placed on contextual and social influences in analysing policy and practice. Thus, reflexivity makes explicit the ontological and epistemological stance of the researcher, who must be reflexive about her own beliefs and values influencing the research process (Mauthner and Doucet 2003; Holloway and Wheeler 2010).

However, knowledge of the world in qualitative research is based on 'understanding' and reflecting on the human interpretation of the social

world. The significance of both the participants' and the investigator's interpretations is important when trying to understand the phenomenon being studied (Ormston et al 2014). This is known as the interpretivist position, which stresses the importance of interpretation as well as observation in understanding the social world (Holloway and Wheeler 2010). The methodology in my thesis is essentially *interpretive,* underpinned by philosophical assumptions that characterise the interpretivism position on knowing within health policy to practice development.

To a large extent, interpretivism has been viewed as essential to the qualitative tradition (Holloway and Wheeler 2010). Another related movement is constructivism, takes the view that '*all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essential social context'* (Crotty 2005, p42). Here, what constructivism emphasises is that meaning (truth) is constructed by human beings as they engage with the world they are interpreting. It would seem to be very useful for my thesis to apply constructivism for epistemological considerations focusing exclusively on the meaning–making activity of the individual mind (Crotty 2005). The study enquiry involved the perceptions of policy makers, educators, research evaluators, practice managers, practitioners, patient representatives and a wide range of textual materials. Through a process of interpreting the meaning of these, using research theory, and bringing personal accumulated knowledge to bear, a new interpretation and explanation can be created and constructed (Macduff 2007a).

Thus the thesis is grounded in what Ormston and colleagues (2014) would call 'constructivist thinking' i.e. that the mind is active rather than passive, which helps construct an explanation of how policy initiative developed, why it developed in the way it did, and what the key factors are that influence policy to practice change as developed from the thought of those who participated (Macduff 2007a).

Furthermore, the use of constructivism, where the focus includes the collective generation (and transmission) of meaning (Crotty 2005), is helpful for ensuring that my study is trustworthy (see Section 3.3.2).

Unsurprisingly, constructivism still has its limitations. For example, it is linked with the phenomenon of *reification, which* refers to understandings being transmitted unknowingly and gaining a place in our view of the world. In this way, our sedimented cultural meanings may serve as barrier between us and realities (Crotty 2005). For instance, there is a sedimented cultural view that prescribing should be done by doctors instead of nurses. Such a phenomenon limits constructivism greatly in its attempt to view the real world as it is limited by '*the range or scope of information available to a constructor, and the constructor's sophistication in dealing with that information'* (Crotty 2005). Discussing the weaknesses of constructivism is fundamental, as it helps me consciously to reflect on my study.

Robson (2011) suggests that rapprochement between what might be termed constructivism and subtle realism seems feasible while Nightingale and Cromby (2002) argue for 'critical realist' constructivism as more credible, of great value and closer to a 'truth' than a range of alternatives. Accordingly a subtle realism ontological worldview and an interprevism/constructivism epistemological stance, underpin my qualitative design, based purely on case study methodology.

3.2.2. Case study methodology

The section above discussed the philosophical stances of ontology and epistemology. These help me to establish my research stance, which shapes the way in which I see things (even the way in which I feel things!), and gives me an explicable view of the world. Now it is time to discuss the case study methodology used in this thesis.

3.2.2.1. Rationale for case study methodology

It is challenging to identify a research design which is rigorous and systematic but flexible enough to integrate various perceptions and

comprehension both in the process and the outcomes (Payne et al 2007). In particular, analysing policy to practice in NMAHPs remains challenging and complicated (Walt et al 2008). While each research strategy has specific advantages and disadvantages, case study methodology is the preferred strategy when "how" and "why" questions are being asked, when the researcher has little control over events, and when the direction of study is focusing on a contemporary phenomenon within some real-life context (Yin 2009).

Case study methodology originally came from social science research and relies on the principles of real-life inquiry (Descombe 2003). Case study methodology has roots in the epistemological and ontological perspectives of ethnography (Bailey 1997). The case study approach is defined as an attempt to systematically investigate an event or a set of related events with the specific aim of describing and explaining these phenomena (Bromley 1986).

Robert Yin in 2003 wrote that, "*A case study is a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence*" (p 16-17). Gerring (2007) also described a case study as "*…the intensive study of a single case where the purpose of that study is at least in part to shed light on a larger class of cases; case studies enjoy a natural advantage in research of an exploratory nature*" (p20). Thus, case study approach has been used to aid understanding of the many layers of policy and practice.

The strength of case study methodology is that it is pluralistic in nature and can enable supporting studies which are descriptive, exploratory, illustrative and explanatory to be undertaken (Stake 1995; Yin 2003; Gerring 2007). Yin (2014) highlights the features of case study research which lie particularly in the use of multiple and complex sources; using triangulation and a protocol to guide data collection and analysis. He further identifies that the use of multiple cases builds the development of converging lines of inquiry within an in-depth, detailed

study of a phenomenon. While some scholars argue that the purpose of case study is to offer a rigorous analysis of a single case or a set of cases, the attributes of which can be disseminated to other similar conditions (Payne et al 2007), others such as Yin (1994) posit evidence from case studies using multiple sources to be more robust than from those that relied on only single sources of information creating a 'replication logic' (Yin 1994).

The evidence shows that most investigations for health policy analysis are case studies, whether or not researchers identify them as such (Gilson and Raphaely 2008; Ha et al 2010; Cooke and Hurley 2008; Cowley et al 2000). When considering a study of policy and practice development, case study methodology was selected to provide in-depth data and detail of the 'fine details' of the policy context, content and process. These have also been viewed as interaction elements to produce practice change (Palmer and Dunford 2002). This is important, given that a great deal of information about policy to practice development already existed, but that an in-depth systematic understanding of policy initiatives from empirical study was essentially lacking.

Consequently, multiple case study methodology has been selected as an appropriate approach for this study, since it offers advantages when:

- There is a need to answer the questions of 'how' and 'why'
- Situations are complex;
- The real-world context of policy and practice is central
- Multiple perspectives are required
- Flexibility is desirable
- Research needs to study something in-depth
- There is a need to undertake contrast and compare the phenomenon in different policy initiatives, in order to facilitate the development of an in-depth systematic understanding of policy to practice change.

3.2.2.2. Limitations of case study methodology

Despite the appropriateness of case study methodology, it is very important to recognise its limitations and take account of them in the study design. The case study analysis is limited mainly by the representativeness of the 'cases' and by how and why they are selected. The most critical view is that the case study analysis provides a limited basis for traditional 'scientific generation', which means that the evidence from case studies is largely restricted to generalization regarding other similar events (Yin 1994; Remenyi 1998). However, case study methodology is suited to offering in depth analytical data of complex context and processes, even though it cannot provide statistical evidence which can be used to make general statements representative of particular populations (Stake 1995; Wood, Ferlie and Fitzgerald 1998).

Sometimes, in health care it is easy to be confused by the use of the term 'case study', particularly for the more common *clinical case studies,* which focus on discussing a specific patient, and because of the use of the term as a method of learning and teaching in NMAHPs (Yin 2003; Vallis and Tierney 2000).

In addition, a qualitative case study analysis may be seen as suffering from bias, as a result of 'subjective' judgments which are made during the stages of data collection, analysis and reports, which could cause conclusions to be invalid (Amaratunga and Baldry 2001). At the same time, Bromley (1986) found that researcher bias had an impact on internal validity. Becker (2008) also points out that investigators may have 'feelings' for the subject they are studying, which means that the conclusions drawn lack complete reliability.

Accordingly, some researchers are concerned that case study methodology potentially results in a lack of rigor and in problems, as a result of the large amount of subjective data, which are gathered in conducting the study (Yin 2003). Therefore, it is important to pursue rigor in qualitative research in particular, to ensure the quality of the

case study approach. The next section will discuss the key points needed to ensure rigor in qualitative studies, and in particular with respect to case study methodology.

3.3. Rigour in qualitative case study research

3.3.1. Introduction

Demonstrating rigor in qualitative research studies is challenging as the criteria for assessing it are still debated (Horsburgh 2003; Dixon-Woods et al 2004; Rolfe 2006; Parahoo 2006). The criticism is that methodological rigour in qualitative research is confused by the diversity and lack of consensus about methods assessing trustworthiness (Sandelowski 1986; Murphy et al 1998). Other critics also debate whether criteria should be utilised at all, and if so, which criteria should be employed, and how these should be judged within a qualitative research study (Murphy et al 1998).

The core issue is that using criteria, in particular those of validity and reliability, is perceived as inappropriate, since these have been designed for use with quantitative methodologies. Originally, the concepts of validity and reliability were also applied as fairly standard terms to measure the rigour in qualitative research (LeCompte, Preissle and Tesch 1993). However, they are generally questioned by quantitative scholars because their ideas of validity and reliability cannot be addressed in the same way as a qualitative paradigm. While some qualitative scholars still insist that the standard terms should be utilised to assess qualitative studies (Miller 1986), opponents maintain that it is impossible to produce criteria of judgment shared by both qualitative and quantitative paradigms (Smith 1984), since they have different philosophical stances. For instance, Morse (1999), and Mays and Pope (2000) argue that the criteria selected to assess the rigour in qualitative studies should be fit for the paradigm and not be borrowed from the quantitative paradigm, otherwise they can suggest that the research is not robust (Horsburgh 2003; Cutcliffe and McKenna 1999).

Qualitative scholars have proposed the use of different terminology to replace validity and reliability, which are more suited to a qualitative paradigm. This is known as trustworthiness (Shenton 2004; Tobin and Begley 2004; Lincoln and Guba, 1985). Lincoln and Guba (1985) list the four criteria of credibility, transferability, dependability and confirmability, in order to establish the trustworthiness of a qualitative study (Beck 1993; Koch 2006). The four criteria are presented in Figure 7 where they are compared with the traditional criteria.

Figure 7: Four criteria for trustworthiness of qualitative paradigm

Traditional standard criteria criteria		**Constructivist paradigm**
Truth value	Internal validity	Credibility
Applicability	External validity	Transferability
Consistency	Reliability	Dependability
Neutrality	Objectivity	Confirmability

3.3.2. Strategies for enhancing trustworthiness

Therefore, these criteria of trustworthiness (see Figure 7) were employed in this study. In keeping with the appropriate criteria for trustworthiness of the qualitative paradigm, strategies for enhancing the rigour of my study have been built up (see Table 5). This can help to ensure rigor of the study, in particular, to ensure that the design and conduct of this study makes the final emergent findings as robust as possible.

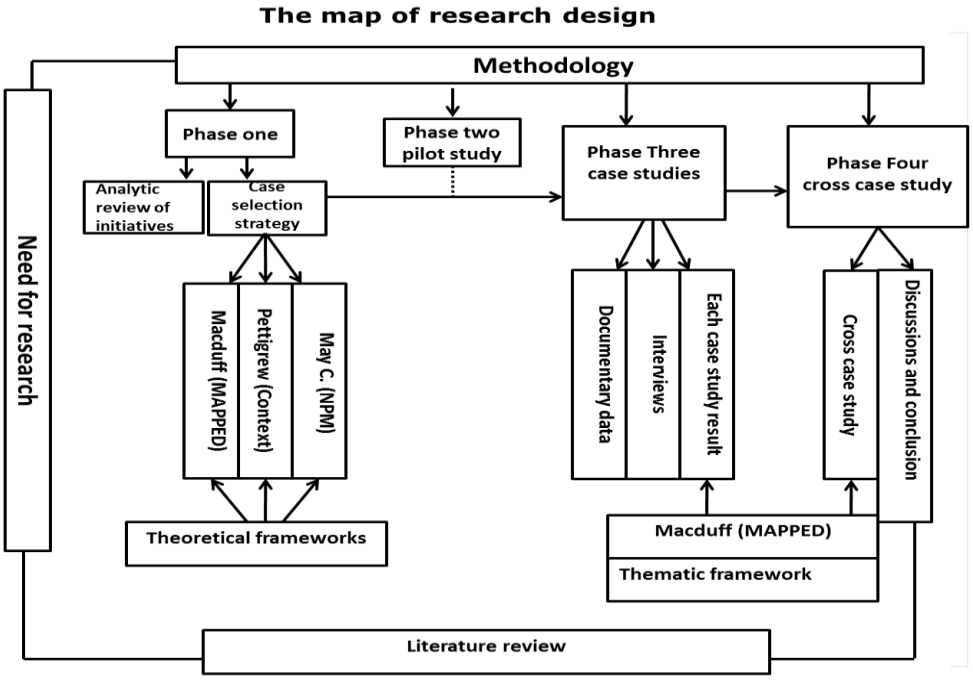
Table 5: Strategies for enhancing the rigour of the study (Miles and Huberman 1994; Yin, 2003; Murphy et al 1998; Koch 2006)

Issues of rigour	Strategies for enhancing the rigour of the study
Credibility	• Using activities such as prolonged engagement; peer debriefing and reflexivity to enhance the credibility • Using triangulation: multiple case studies; theories, multiple data sources and analysis to establish a chain of evidence. • Making contrasts and comparison analysis across cases. • Critical thinking- the possibility of rival explanations and systematically analysing data including positive and negative findings, using theoretical frameworks to facilitate a comprehensive portrayal of the research findings.
Transferability	• Weighing up the evidence by considering data from within and across cases against literature, and research design as a systematic in depth study. • Replicating a finding by using several data sources and multiple cases.
Dependability	• Keeping the transparency of analytic claims by ensuring the account "rings true", ensuring all emerging themes are rooted in raw data, to enable verification for the reader. • Developing a comprehensive research protocol and case study database. • Application of a computerised analysis packages e.g. NVivo 9 enabling an audit of decision processes and signposts
Confirmability	• Triangulation, in-depth description • Using audit processes: testing interview schedules; checking of the recordings and transcripts by others; making analytical checks on the research process (e.g. coding, charting, mapping) and bias checks. • Peer reviews; supervisor reviews.

3.4. Research design and methods

Having presented the rationale of my methodological approach, which is rooted in subtle realism, interpretivism and a constructivism philosophical stance, and having discussed criteria for the trustworthiness of my research design, I will now give in Figure 8 an overview of the study design with its four phases, which will be explained individually.

Figure 8: The map of research design



3.4.1. Methods for phase one

Phase one involves identifying and systematically reviewing relevant initiatives and developing useful case selection strategies.

3.4.1.1. Identifying initiatives

This stage of the study is grounded in earlier work, which developed an explanatory model (MAPPED, Macduff 2007a) as a result of analysing a policy to practice development in nursing. This is because his study and model relate to the type of initiatives that have become very prevalent in the UK and Scotland in particular. Therefore based on the MAPPED model, the criteria for systematically searching policy initiatives for my study should comprise: (i) focus on one or several NMAHP group(s) (ii) policy initiative of national scope with aspiration to impact on practice and patient care (directly or indirectly) (iii) involvement of an educational programme or framework (iv) involvement of a commissioned evaluation.

According to these criteria, I have first of all found all the relevant published initiatives from 2005 to 2010 by searching through the publications of NES, Health Improvement Scotland and the Scottish Government website to identify the initiatives from policy to practice developments in Scottish NMAHPs. In doing so, a total of thirty one initiatives were initially identified. However, only fifteen initiatives (see Table 6) were found to meet the four criteria mentioned above. The initiatives which were not for national NMAHPs, did not transfer to practice, were without an educational program or without a completed commissioned evaluation were excluded. Several large initiatives, such as Community Health Nursing, Leading Better Care were on going at the time, with evaluations still in progress. Therefore these were omitted. Table 6 lists the 15 initiatives identified as satisfying the four relevant criteria adapted from the MAPPED model.

Table 6: 15 identified initiatives

Name of project	**Four characteristics adapted from MAPPED model (Macduff 2007a)**			
	Agency	Training /education	National policy to practice	Commissioned evaluation
Allied Health professions support and development scheme (Kazia Solowiej 2006)	AHP	√	√	√
Advanced Practice Succession Planning Development Pathway (Currie K.2010)	Nursing	√	√	√
An education programme for staff working with acutely ill and injured children and young people (English C. 2009)	Nursing	√	√	√
The establishment of the Practice Education Facilitator role project (Carlisle C. et al 2008)	Nursing	√	√	√
Evaluation of flying start NHS (Banks P. et al 2010)	NMAHP	√	√	√
The Impact of Educational Resources to Support Values-Based and Recovery-Focused Mental Health Practice (Macduff C. et al 2010)	Mental health nursing	√	√	√
NM in Scotland: being fit for practice (Lauder W. et al 2008)	Nursing and Midwives	√	√	√
Clinical leaders for the future (ECCF) (Pearson P. and Machin A.2010)	NMAHP	√	√	√
Scotland Cleanliness Champions Programme (Macduff. C. et al 2009)	NMAH	√	√	√
A Pilot program for the role of Maternity care assistant in Scotland (Gibb S. et al 2008)	Midwifery	√	√	√
Evaluation of the Extension of Independent Nurse Prescribing in Scotland (Watterson A.et al 2009)	Nursing	√	√	√

Midwife Prescribing Project (Shaw H. et al 2008)	Midwifery	√	√	√
Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards (Birch A. and Martin C. 2009)	Nursing	√	√	√
The succession planning development pathway for consultant nurse, midwives and AHP (McCreaddie M. et al 2006)	NMAHP	√	√	√
Mellow Babies(Puckering C. et al 2006)	NM	√	√	√

Focusing on the 15 evaluated initiatives, the next step was to critically review the studies.

3.4.1.2. Critically reviewing the 15 identified initiatives

All of the identified 15 initiatives were commissioned evaluation research. Evaluation research is a type of study that employs standard social research methods for evaluative purposes, as a specific research methodology, and as an assessment process for the social programs (Powell 2006). The purpose of an evaluation is usually to gauge the effects and effectiveness of something, in particular, some intervention, policy and innovation or service etc (Robson 2011). The focus of most of evaluation, however, falls on impact and outcomes which does relatively little to provide insight into the process of programme implementation. Furthermore, evaluation of policy is based on a particular political context, which is often to check whether the outcomes of programme are consistent with the aims. As such, evaluation research should be understood as inherently political (Spicker 2006).

Thus, critically reviewing these policy evaluation studies can provide a basis for the development of policy initiative study by mapping the work already undertaken, by gaining important insight into the processes of policy initiatives and by critically assessing these studies in terms of focusing on methodological approaches and findings (Gilson and Raphaely 2008). However, my research found no extant validated tool suited to critical appraisal of these evaluation studies. I had to develop this myself, informed by the best available principles and

related tools. Due to constraints of space, the development and application of my approach to appraisal of quality and categorisation of type is presented in Appendix 2.

The systematic critical review in Appendix 2 gives a complete picture of the 15 evaluation studies including features of their methodological approaches, policy initiative types and stages, research stance, and overall quality of each evaluation report. These features are useful for my study. They enable me to compare the research strategies and to benefit from lessons emerging from those initiatives. A systematic synthesis of the findings of the 15 policy evaluations in terms of key lessons and recommendations is presented in Chapter 5.

However, due to the limitation of the scope of a PhD study, not all 15 initiatives can be analysed in depth and there was a need to select a smaller number of cases for such study. The next section will discuss case selection in more detail.

3.4.1.3. Developing case selection strategies

The case selection in this study incorporated three strategies by applying a systematic approach. Firstly, the relevant documentation (e.g. project summaries/evaluation reports) pertaining to each of the 15 initiatives was read and critically analysed. Secondly, relevant policy analysis and knowledge transfer literature was analysed in order to identify the most relevant theoretical perspectives (See Chapter 2, Section 2.3.2) that could be applied to these 15 cases to enable the study of a key subset. Lastly, the practical issues were also considered. These are now explained (see Table 7 for summary).

Table 7: 15 identified initiatives and criteria used for further case selection.

Name of project	Outer context: Ostensible driver PI-Political imperative L-Legislation WDR-Workforce development resource WDS-Workforce development standard	Inner context: Ostensible driver Leading agency	Most prominent Normalisation Model characteristic IW-Interactional workability RI -Relational integration SW-Skill-set workability CI-Contextual integration	Type of Project New role; Ext/expand/enhance role; General education framework	Scope All Health Board's or only selected	Pre-existing research supervisor links VS--very strong S--substantial L-- A little N- -None
Advanced Practice Succession Planning Development Pathway	WDR	Nursing	RI	Ext/expand/enhance role	selected	L
An education programme for staff working with acutely ill and injured children and young people	WDS	Child Nursing	SW	Ext/expand/enhance role	All	S
The Impact of Educational Resources to Support Values-Based and Recovery-Focused Mental Health Practice	WDS	Mental Health Nursing	RI	Ext/expand/enhance role	All	VS
Evaluation of the Extension of Independent Nurse Prescribing in Scotland	L	Nursing	SW	Ext/expand/enhance role	All	L
Midwife Prescribing Project	L	Midwifery	SW	Ext/expand/enhance role	selected	N
Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards	WDS	NMAHP	SW	Ext/expand/enhance role	selected	N
Mellow Babies	WDS	Health visitor	SW	Ext/expand/enhance role	selected	N
The establishment of the Practice Education Facilitator role project	WDR	NM	IW	New role	All	L
Scotland Cleanliness Champions Programme	PI	Nursing	IW	New role	All	VS
A Pilot program for the role of Maternity care assistant in Scotland	WDR	Midwifery	SW	New role	selected	S
The succession planning development pathway for consultant nurse, midwives and AHP	WDS	NMAHP	SW	New role	All	L
Allied Health professions support and development scheme	WDS	AHP	RI	General education framework	selected	N
Evaluation of flying start NHS	WDR	NMAHP	RI	General education framework	All	L
NM in Scotland: being fit for practice	WDS	NM	RI	General education framework	All	L
Clinical leaders for the future (ECCF)	WDS	NM	RI	General education framework	selected	N

In Table 7, the 15 initiatives are categorized according to six different characteristics. The first two of outer and inner context, ie, the ostensible drivers for the 15 initiatives are based on Pettigrew's theoretical framework (1988) (See Section 2.3.2). According to Pettigrew, the context of any policy can be described as having two levels, namely the inner and outer contexts. Considering the background of the policy drivers, four characteristics of the outer context of the identified initiatives have been classified. They are: *PI*-Political imperative; *L*-Legislation; *WDR*-Workforce development resource; *WDS*-Workforce development standard. However, several of the four characteristics can be seen concurrently within each initiative. Therefore it was decided to categorise by the one which is the most dominant in each initiative. On the other hand, the inner context of the ostensible drivers has been categorised according to the different leading agencies such as: nursing, midwifery, allied health professionals.

The third characteristic is derived from another theoretical framework which is the Normalisation Process Model (NPM) developed by May (2006) (See Section 2.3.3.2). May (2006) defines NPM as four constructs: *IW* (interactional workability); *RI* (Relational integration); *SSW* (skill-set workability) and *CI* (contextual integration). Thus, another four attributes of the initiatives have been categorised, according to the constructs of NPM which helps to examine the intervention processes of the fifteen initiatives. From a practical point of view, it is often difficult to decide which construct belongs to the initiatives implementation process as some of them overlap each other. For the purposes of selecting cases to study, it is sufficient to choose the most dominant construct. This study has also examined the connection between the fifteen initiatives and their different intended outcomes (e.g. role development), named as the fourth characteristic. For example, the initiatives are either a new role development, an extended/expanded/enhanced role or a general educational framework, while these are sometimes difficult to define operationally and exactly.

In addition to the theoretic perspective drawn from the literature, it has also been useful to consider practical issues such as the scope of each initiative (e.g. does it apply to all health boards or only some) and the degree of pre-existing links between the RGU research supervisor (Dr. Macduff) and the particular initiatives. These are categorised as: VS- very strong; S- substantial; L- a little and N- none. The scope of the initiatives and the pre-existing links with the research supervisor comprise the fifth and sixth characteristics of the 15 initiatives respectively.

Thus, the mapping of Table 7 enables the selection of a sub sample for closer study that will give best potential for insight across the key criteria. At this point, the focus is on selecting eight cases which will cover most of the factors and provide the greatest balance. Even though Stake (1995) states that selection for multiple-case studies by sampling of attributes should not be the highest priority, nevertheless the balance and variety are critical and opportunity to learn is of primary importance. How to select eight cases to balance the six characteristics is challenging. The next section will explain this in detail.

3.4.1.4. The initial selection of eight cases to balance the different characteristics

As shown in Table 7, each initiative has different characteristics overall. The principal question in the selection of the eight cases is what combination of initiatives could provide a useful range and balance of the different factors for investigation. Clearly, it is impossible to select eight cases randomly and get a balance and variety of cases. Therefore in order to select eight cases which provided this balance, a chart was compiled coding the 15 initiatives with the capital letters A to O, and with the six categories subdivided into 22 sub-elements, calculated as numbers (see Table 8).

Table 8: A chart showing 22 sub-characteristics of the 15 cases

Coding Projects	WDR	WDS	L	PI	Nursing	NM	NMAHP	M	AHP	IW	RI	SW	CI	New role	Exist role	Education	All	Selected	VS	L	N
A	1				1						1				1			1		1	
B		1			1							1			1		1				
C		1			1						1				1		1		1		
D			1		1							1			1		1			1	
E			1					1				1			1			1			1
F		1					1					1			1			1			1
G		1						1				1			1			1			1
H	1					1				1				1			1			1	
I				1	1					1				1			1		1		
J	1							1				1		1				1			
K		1					1					1		1			1			1	
L		1							1		1					1		1			1
M	1						1				1					1	1			1	
N		1				1					1					1	1			1	
O		1				1					1					1		1			1
Total cases / Cases Selected	WDR	WDS	L	I	Nursing	NM	NMAHP	M	AHP	IW	RI	SW	CI	New role	Exist role	Education	All	Selected	VS	L	N
	4	8	2	1	5	3	3	3	1	2	6	7	0	4	7	4	8	7	2	6	5
A	1				1						1				1			1		1	
C		1			1						1				1		1		1		
D			1		1							1			1		1			1	
F		1					1					1			1			1			1
H	1					1				1				1			1			1	
I				1	1					1				1			1		1		
L		1							1		1					1		1			1
M	1						1				1					1	1			1	
Total selected cases	3	3	1	1	4	1	2		1	2	4	2	0	2	4	2	5	3	2	4	2

Table 8 gives a picture of the weighting for the 15 initiatives, using the 22 sub-characteristics to select the cases. In this case selection, the different elements within the cases provide a balance relative to each other, rather than according to an exact mathematical calculation. The first consideration was of the different elements based on Pettigrew's policy context theory and the Normalisation Process Model (NPM), after that the other domains were considered.

Bearing in mind uncertainties about which initiatives would be feasible to study, a pool of eight cases was purposively chosen according to the selection criteria strategies. These eight cases (see Table 9 and highlighted initiatives in Table 7) can potentially cover all the key aspects in the various columns of Table 8. These served as the pool, from which the final four case studies would emerge. Table 9 is a sampling frame of eight selected cases aiming for balance of coverage of the main factors, based on theoretical and practical considerations. In Table 8, two characteristics have been added, 'relationship to patient care' and 'commissioning organisation'.

Table 9: Eight selected cases and their characteristics

Name of project	Outer context: Ostensible driver PI-Political imperative L-Legislation WDR-Workforce development resource WDS- Workforce development standard	Inner context: Ostensible driver Leading agency	Most prominent Normalisation Model characteristic IW-Interactional workability RI -Relational integration SW-Skill-set workability CI-Contextual integration	Type of Project New role; Ext/expand/enhance role; General framework	Relationship to patient care D-direct I-indirect	Commissioning organisation SG-Scottish Government NES-National Education for Scotland HIS-Healthcare Improvement for Scotland	Scope All Health Board's or only selected	Pre-existing research supervisor links VS--very strong S--substantial L-- A little N- -None
A	WDR	Nursing	RI	enhance role	I	NES	Selected	L
C	WDS	Mental Health Nursing	RI	enhance role	D	NES	All	VS
D	L	Nursing	SW	Ext/expand/ role	D	SG	All	L
F	WDS	NMAHP	SW	Ext/expand/ role	D	SG	Selected	N
H	WDR	NM	IW	New role	I	NES	All	L
I	PI	Nursing	IW	New role	D	NES	All	VS
L	WDR	NMAHP	RI	General framework	I	NES	All	L
M	WDS	AHP	RI	General framework	I	NES	Selected	N

3.4.1.5. The final four cases for in-depth study

In order to optimise viability, it was essential to screen the eight cases extensively, so that they could become an effective 'mini' four case study.

On a practical level, my initial plan was to send invitation letters with detailed information sheets to key actors by using purposive and snowball sampling techniques within the eight selected cases. The cases which emerged as being the most feasible to study would be those where the most key actors agreed to participate. On this basis a number of cases would be consciously selected for in-depth case study. At the same time, in the selection of the final four cases, there was particular concern to achieve coverage of four main types of initiative namely: (i) new role (ii) extended/expanded role (iii) enhanced role (iv) general education framework. However, this would ultimately be dependent on the response to the invitations sent to potential participants.

In the end, according to the responses and study concerns, the final four cases were selected for further in-depth case study named as Case 1, 2, 3, 4 (See Table 10).

Table 10 : The final four cases

Name of project	Outer context: Ostensible driver PI-Political imperative L-Legislation WDR-Workforce development resource WDS- Workforce development standard	Inner context: Ostensible driver Leading agency	Most prominent Normalisation Model characteristic IW-Interactional workability RI -Relational integration SW-Skill-set workability CI-Contextual integration	Type of Project New role; Ext/expand/ enhance role; General framework	Relationship to patient care D-direct I-indirect	Commissioning organisation SG-Scottish Government NES-National Education for Scotland HIS-Healthcare Improvement for Scotland	Scope All Health Board's or only selected	Pre-existing research supervisor links VS--very strong S--substantial L-- A little N- -None
Case 1	L	Nursing	SW	Ext/expand/ role	D	SG	All	L
Case 2	WDR	NM	IW	New role	I	NES	All	L
Case 3	WDS	AHP	RI	General framework	I	NES	Selected	N
Case 4	WDS	Nursing	RI	enhanced role	D	NES	All	VS

3.4.2. Methods for phase two-- a pilot study

Pilot studies play a vital role in health research in that they can yield information on both process and potential outcomes in preparation for the major study (Burns and Grove, 2009). Well-designed and well-conducted pilot studies can be used to test the feasibility of the research protocol with a small sample and to pre-test the particular research instrument such as the interview schedule (Leon, Davis and Kraemer 2011).

To test the methods and processes used in this study, a small external pilot study was conducted in conjunction with a local policy to practice development ("Back to the Floor") by seeking to interview three people who were involved in different positions within the initiative (See Appendix 3). The "Back to the Floor" initiative was implemented in NHS Grampian in 2007 with coaching/counseling interventions, and it has been externally evaluated, making it broadly similar to the national initiatives that formed the core of the main research study.

The pilot study was helpful in four ways:

- To test and refine the interview schedule
- To assess and develop the research process
- To identify practical issues in the data collection process
- To develop interview skills of the researcher

Furthermore, several modifications were made to the interview schedule.

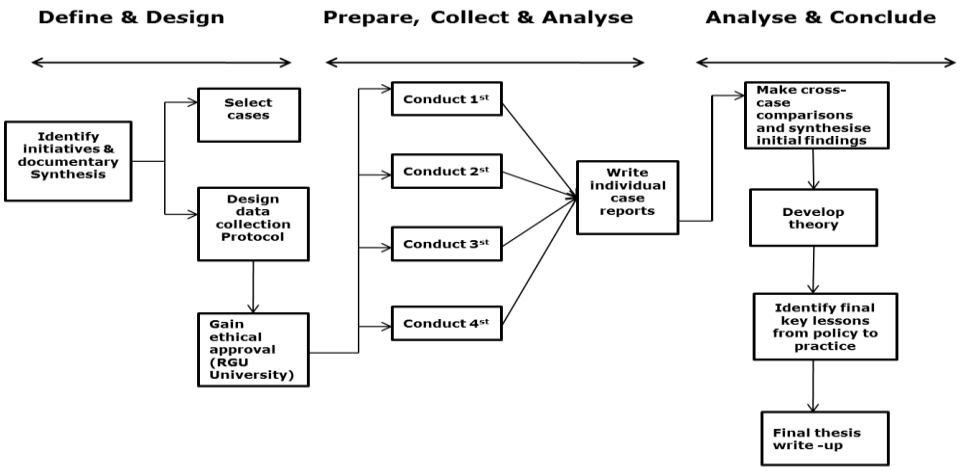
- Breaks were placed in the schedule to allow the interviewee to rest.
- Some questions were placed in a different order to improve the flow.
- The choice of questions was tailored somewhat to the participants' role in the initiative.

3.4.3. Methods for phase three--four case studies

Phase three aimed to explore the nature of initiatives by interviewing key actors in each development, with a view to further identifying the

main factors impacting on each of the four initiatives (see Figure 9) and the related main lessons.

Figure 9: The case study process (adapted from Yin 2003)



3.4.3.1. Recruitment for case studies

Recruiting appropriate target participants for case studies is challenging as the investigator must consider a rationale for identifying the target population practically and theoretically in each case (Berg and Lune 2012). In this research project, I sought to interview the following key actors within each selected case, in order to explore different perspectives regarding policy development:

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

Interviews were in-depth, digitally audio recorded, semi-structured in nature. As such the aim was to recruit 24 participants in all.

Some of the informants in this target population were identified purposively as gatekeepers through publically available sources and professional networks as having involvement in the particular initiative(s). Relevant informants were invited to take part by means of a letter, information sheet and consent form (See Appendix 4). In the recruiting process, limited snowball sampling was also used, whereby those who accepted might also indicate other potential contacts who could be approached to take part (Berg and Lune 2012). For example, these actors were also invited to pass on a web link designed by myself and checked by my Principal Supervisor, giving details of the study to other relevant colleagues whom they viewed as key actors in the six categories given. In this way an element of 'snowball' sampling was combined with a purposive approach as one of my sampling strategies. The next section explains this in more detail.

3.4.3.2. Sampling

In qualitative research, the sample is not intended to be statistically representative, but the characteristics of the target population should be used as the basis of selection, and the samples are usually small in size and based on the study aims and objectives (Ritchie et al 2014; Berg and Lune 2012). In this study, the participants needed to cover a range of perspectives from different roles within the policy initiative, in order to enable detailed exploration and understanding of the central themes and questions which the researcher wishes to study (Bryman 2012). Here, the two approaches of purposive sampling and snowball sampling were applied to the four case study interviews.

Purposive sampling means the selection of participants and, settings is criterion-based or purposive according to the study aims (Mason 2002; Patton 2002). In this thesis, six key informants of a sample in each case were chosen to represent a particular type, in relation to the key criterion discussed in Section 3.4.3.1. This enables that key informants relevant to the subject matter are covered, and ensures that differences in perspective between various groups could be explored (Ritchie et al 2014).

Snowball sampling is known as respondent-drive sampling or chain referral sampling, driven by the referral of one respondent by another (Penrod et al 2003; Heckathorn et al 2002; Berg and Lune 2012). Snowball sampling is sometimes the best way to locate subjects with certain attributes and characteristics, when studying hard-to-reach populations (Lee 1993; Berg and Lune 2012). In this study, some key actors who were involved in the policy initiatives were identified and interviewed, then they were asked to refer other potential participants who could meet the research sampling criteria. By combining purposive sampling and snowball sampling, the planned interviews of 24 key informants were successfully completed by early 2014 (see Table 11). Details of data collection and data analysis approaches will be explained in Chapter 4.

3.4.4. Methods for phase four: Cross case studies

Phase four consists of cross-case analyses, using a thematic framework (Spencer et al 2003), contrasting and comparing the differences and similarities within the findings across all cases. The comparisons of this study included:

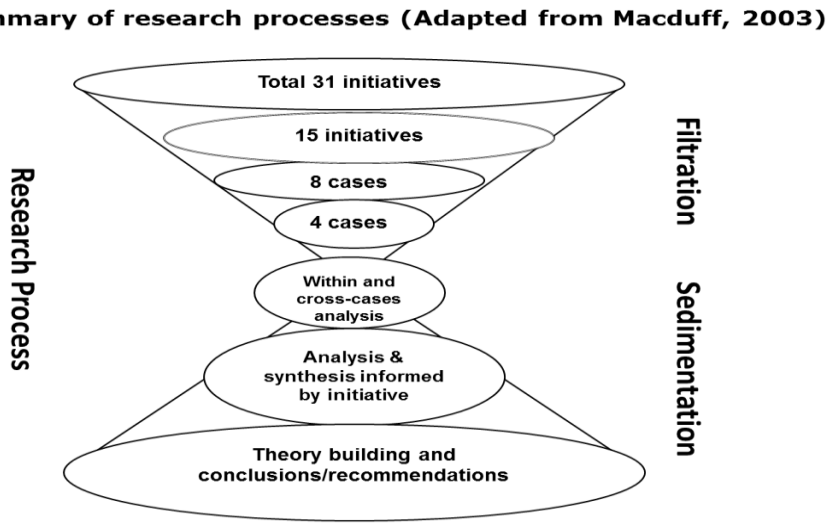
- key issues and lessons emerging from each case and their relationship to commissioned reports
- key issues and lessons emerging from different groups of key informants
- key issues and lessons across case studies: commonalities and differences

Originally the study sought to follow the initial cross case analysis with a *Research Knowledge Exchange event (RKE)* to be held in Edinburgh in June 2013. The rationale was to invite wider participation from the key groups of stakeholders identified (i.e. practitioners, service users, managers, educators, evaluators and central initiative staff). These groups would have been invited to consider an initial synthesis across cases, possibly to be informed by theory, and to generate further thoughts and ideas.

There was an intention to capture wider views from practitioners. However an advert in the RCN's on-line bulletin failed to attract any response. When only one positive response was forthcoming from members of the evaluation teams involved in the 15 initiatives listed in Table 6 and 7, it was concluded that the planned event was not viable. In consultation with the supervisory team it was concluded that the literature review, empirical research and secondary template analyses would yield sufficient material to sustain the thesis, and that the aspirations related to this planned event might be better realised through post-doctoral work.

On the whole, the research design process has been narrowed down from a wider perspective to focus on four case studies, then develops from the micro level to general policy to practice development. Figure 10 illustrates the complete project process.

Figure 10: A summary of the research processes (Adapted from Macduff and West, 2003)



3.5. Ethical considerations

3.5.1. Introduction

Ethics refers to rules of conduct that conform to a code or set of principles (Berg and Lune 2012). It is vital to follow ethical codes and

guidelines when carrying out a social research project, as social scientists delve into the lives of other human beings (Israel and Hay 2006; Berg and Lune 2012). Concerns about research ethics involve a range of issues, such as harm, consent, privacy and the confidentiality of data (Punch 1994; Punch 2005). Substantially, ethical considerations, when carrying out social research involving people, require avoiding potential for harm, stress and anxiety (Robson 2011).

Following ethical guidelines, this study was reviewed and approved by the School of Nursing and Midwifery Ethics Review Panel in RGU before the pilot study and main case studies were conducted. NHS ethical permission was not required but this study was reviewed by the Research Advisory Group in NES. Potential concerns raised by them included: informed consent, confidentiality and in particular anonymity of the participants and to an extent, the cases themselves. Procedures were set in place to allay these concerns throughout the methods of recruitment, data collection and analysis processes and in writing the final reports. I also attended the NHS course on 'Good Clinical Practice for Researchers'.

3.5.2. Informed consent

Informed consent means that participants should be given sufficient information to enable them to make a decision about whether or not to take part in a study (Rithcie et al 2014; Robson 2011). The procedures of informed consent used for participants in this study include the following:

- ❖ the potential participants' details were recorded in the case study databases
- ❖ an invitation letter along with written and detailed information explaining the project research (a well-designed web link including information sheet, consent form and researcher contact details, see Appendix 4) was sent separately to all potential participants by email.
- ❖ those who expressed interest in participating were contacted. The project was explained further and all enquiries relating to this study

were clarified. If the participant wished to continue, a face to face interview time and venue were negotiated and planned for future.

❖ interviewees were informed again and the researcher answered any enquiries before starting the interview. It was also important to ensure at the start of the interview that the interviewee had not changed his/her mind. In addition, the researcher again gave an assurance of confidentiality and anonymity verbally, and explained the need for audio-recording. If the interviewee was convinced and still willing to contribute to this study, the consent form was given to the participant to sign and this was countersigned by the researcher.

❖ all the signed consent forms were securely stored in a folder in the university.

3.5.3. Confidentiality

The study had initially planned to give participants the choice to be named in reporting their interview or to be anonymous, but this was changed to promote anonymity in response to NES Group concerns that this might bring its own difficulties and discourage participation. Thus, there was concern to keep job titles generic, to further protect the identity of participants. Therefore, the different roles of participants involved in the initiatives were given as "educator", "evaluator", "practitioner", "manager", "service user representative" and "central initiative staff".

In addition, the cases were each characterised generically according to primary interest of the study. Hence, the four cases are described as follow: case 1 as "extended role", case 2 as "new role", case 3 as "general educational framework" and case 4 as "role enhancement" etc.

Finally, all the participants' information was stored in a confidential process according to RGU confidentiality policy and the NMC code of conduct. Raw data was normally accessible only to the researcher, supervisors, individual interviewees and the transcribing secretary. All the audio-taped records and transcripts were located in a password

protected computer behind the RGU firewall and these will be destroyed 10 years after completion of the project.

3.6. Summary

This chapter has given a detailed account of the methodology and methods used in conducting this study grounded in an ontological worldview of subtle realism and epistemological interpretivism /constructivism. It has discussed the suitability of multiple case study methodology for this research and has shown that the methods designed are consistent with this. Furthermore, the triangulation data sources fit the methodology and have the potential to provide rich and robust data in relation to policy to practice initiatives.

The issues of rigour were identified and have been addressed. A particular strategy for evaluating quality of 15 reports and an appropriate sampling strategy were developed and applied. The roles of potential participants in the policy initiatives were the most relevant aspect in seeking to achieve the study aims and objectives regarding policy to practice development. Ethical considerations were also explained. In order to complete explanation of the methods used in the study, the following chapter details data collection and analysis approaches.

Chapter 4. Data collection and analysis

4.1. Overview of this chapter

Having established the strategies to be used for research design and methods, this chapter now focuses on methods for gathering and analysing the data.

4.2. Data collection

'*Data are not viewed as given by nature but as stemming from an interaction between the inquirer and the data sources. Data are, so to speak, the constructions offered by or in the sources'* (Lincoln and Guba, 1985, p.332). This thesis involved two kinds of data collection: documentary data and interview data.

4.2.1. Collecting documentary data

Documentary data cover a very wide range of resources, typically text-based, e.g. they consist of words, such as minutes of meetings, letters, diaries, newspapers and articles etc. (Berg and Lune 2012; Bryman 2012; Atkinson and Coffey 2011). The main documentary data in this study comprised 15 selected Scottish evaluation research reports, some programme summaries, minutes of meetings and presentations. The 15 reports were all available from the website of the publications of NES and the Scottish Government (see Section 3.4.1.1).

Apart from the final 15 reports, some additional information was obtained from those official websites relating to the 15 policy initiatives. The type of documents comprised local and national policies, guidelines, annual reports, minutes of meetings, presentations, and staff newsletters. These were categorised as focal, related or contextual documents (Macduff 2007a) according to their relevance for understanding specific initiatives. All the various documents illustrated have been considered proper types of data for understanding policy to practice change (Bryman 2012; Atkinson and Coffey 2011).

4.2.2. Collecting interview data

Interviewing is defined simply as a conversation with a purpose which is specifically to gather information (Berg and Lune 2012). The type of interview used in this study was in-depth individual face to face and semi-structured in nature. In-depth interview is a powerful approach for producing a description and interpretation of people's social world and is a core qualitative research approach (Ritchie et al 2014). Rubin and Rubin (2011) emphasise the power of in-depth interviews:

'*When using in-depth qualitative interviewing…researchers talk to those who have knowledge of or experience of the problem of interest. Through such interviews, researchers explore in detail the experiences, motives, and opinions of others and learn to see the world from perspectives other than their own (p.3)*.'

It has long been claimed that face to face interviewing provides a strong basis for the establishment of a good rapport between the researcher and the participant. It helps to create an environment where the researcher is able to take non-verbal communication into account and to probe further information, and where the interviewee can respond in a free and full way (Yeo et al 2014). On the other hand, face to face interviewing is limited by certain situations, e.g. busy participants, a scattered sample or a budget or a timetable. These can make the interview process time consuming.

Semi-structured interview involves the implementation of a number of predetermined questions and special topics, in order to seek insight into participants' views via the active verbal communication of an individual interview (Ritchie et al 2014; Robson 2011; Berg and Lune 2012).

The in-depth semi-structured face to face interviews in this study were guided by an interview schedule (see Appendix 5) which was developed by myself and reviewed by my Principal Supervisor, informed by Macduff's MAPPED model and the questions informed by the literature review. The interview schedule served as a checklist of topics to be covered and a default wording and order for the questions (Robson

2011; Ritchie et al 2014). It was initially tested and modified after the pilot study (See Section 3.4.2). Then, it was utilised as a guide rather than an inflexible instrument during the case study interviews (Robson 2011). The interview schedule focused on the key topics, but the order of questions was not fixed. In this way, it allowed the participants scope to give information they felt important and relevant to the research inquiry. It also enabled a more flowing and conversational interaction and allowed the researcher to probe for further information.

The interview data, including the pilot interview data and the case study interview data was obtained from the in-depth semi-structured individual face to face interviews, the audio-recordings, the complete transcripts and the notes taken during the interviews.

4.2.2.1. Pilot interviews

As discussed in Section 3.4.2, the pilot interviews were valuable as a means of testing the research processes and refining the interview schedule. The pilot interview data and its documentary data were used for pilot data analysis.

4.2.2.2. Case study interviews

This study conducted 24 in-depth, semi-structured face to face interviews with key informants in different roles involved in the four policy initiatives. The 24 interviews were audio recorded and transcribed verbatim. These recordings, transcripts and some notes taken during the interviews formed main sources for the case studies. Table 11 presents the details of the participants interviewed in the four cases.

Table 11: Details of participants interviewed in the four cases

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

As can be seen in Table 11**,** Case 3 had a high number of central initiative staff. This is because there was some difficulty in establishing the best people to interview, as this initiative combined three different elements. Two participants requested to be interviewed together. Hence there was a high number of central initiative staff in this case.

However, the roles of the participants interviewed were the same in each case, consistent with the strategies of recruitment, but the numbers of interviewed participants were slightly different across cases, due to difficulties of access. All the interviews were in-depth, face to face, individual and semi-structured in nature, except for Case 3, where two participants requested to be interviewed together. The length of the interviews varied from 45 minutes to 120 minutes. All interviewed participants received the same information, a research information sheet and the information about MAPPED model, no less than 24 hours prior to interview. This allowed them more time to consider the interview and their responses before interview.

For precision, all the interviews were audio-recorded, which provided a permanent record and allowed me to concentrate on conducting the interview, prompting and probing where necessary (Silverman 2000; Robson 2011). No participants declined the audio-recording, and no one

asked to review the notes of their interview in this study. Each of the recordings was then transcribed verbatim.

4.2.2.3. Gaining entry and access

Access to a target population who are willing to participate in research can be extremely difficult. Hayes (2005) describes gaining access to data sources as a 'long and winding road'. Reflecting on Okumus, Okumus and McKercher (2007) case study experience, they highlight that many external factors are beyond the researcher's control. Therefore, it is vital to be organised, self-motivated and persistent before and during the study.

However, Robson (2011) emphasises that the researcher's agenda is important, if he or she is to gain access. For example, a research agenda, which is clear about the research intentions with a tight, pre-structured and good design makes things easier. Developing a collaborative relationship with health and social care and, higher educational professionals, along with academic research, was vitally important in terms of facilitating access to this study. NES were helpful in facilitating participant recruitment, as were a number of academic colleagues with knowledge of recent initiatives.

4.2.2.4. Reflections on the interviewing process

Reflecting on my interview process, it was challenging and exciting. A productive and successful interview greatly depends on the personal and professional qualities of the individual interviewer because the process of interviewing is a demanding one-cognitively, intellectually, psychologically and emotionally (Kvale and Brinkmann 2009; Rubin and Rubin 2012; Silverman 2010). The researcher and the researched are both potential sources of bias since the interviewer is responsible for taking decisions, asking questions and interpreting answers, and the interviewee is responsible for answering the questions and expressing their personal perspectives and experiences relating to the questions (Patton, 2002).

As a novice qualitative researcher, I undertook extensive preparation involving a formal training course in qualitative interviewing and analysis, practice interviews with friends and colleagues and the pilot study interviews. This proved useful in increasing my confidence and skills for the main study. However, I did sometimes feel challenged during interviews, particularly with senior professionals, who had extensive experience of policy and practice contexts and content.

Furthermore, some interviewees needed more encouragement during interviews than others, and at times greater clarification in some questions was necessary. Sometimes, interview recordings were replayed prior to carrying out further interviews, in order to enable me to address specific issues regarding the interview schedule, before continuing with other participants. I found that it was helpful to signal the approach of the end of interview, to encourage the interviewee to raise anything important not yet discussed. Sometimes, in this way, I was surprised by the extra useful information.

The recordings from the interviews were transcribed verbatim in full, which significantly minimised the possibility of misunderstanding the participants' perspectives. It also helped provide evidence for an audit and peer review, in order to ensure the trustworthiness of the study (Bryman 2012).

4.3. Data analysis

4.3.1 Introduction

Data analysis is a systematic search for meaning through in-depth examination of relevant text generated within the research study (Coffey and Atkinson 1996; Hatch 2002). The aim of qualitative data analysis is to detect, portray and explain the world views of people included in the study (Coffey and Atkinson 1996; Ritchie and Lewis 2003). In particular, qualitative data analysis places emphasis on detecting themes and patterns within the data by means of systematic and comprehensive procedures, which identify essential features and relationships. It is a challenging and exciting task that requires a blend

of creativity, a combination of inspiration and diligent detection (Ritchie and Lewis 2003). The process of qualitative data analysis is not a distinct stage of research, rather it is a cyclical, continuous and iterative process along with the data collection process, since the two processes inform each other or even drive each other on (Miles and Huberman 1994; Ritchie and Lewis 2003; Pope and Mays, 2006; Silverman 2010). At the same time, managing the data in case studies is potentially difficult and challenging, particularly considering the large reams of collected qualitative data (Burns and Grove 2001; Yin 2003; Parahoo 2006). There is arguably a certain difficulty in analysing qualitative data in case studies, because techniques are seldom fully operationally defined (Murphy et al 1998). Furthermore, while there is now more transparency about how qualitative data are 'managed', there may remain little explanation of how the results are produced from the data collected (Ritchie and Lewis 2003).

Following the development of computer-assisted qualitative data analysis software (CAQDAS), we can clearly see the main benefits which this method offers the analyst in the handling of large amounts of data namely: improvement in rigour; consistency of approach; and relative ease of navigation and linking of data (Weitzman 2000). Also, CAQDAS provides a better view of how the unwieldy and tangled raw data is managed and analysed. However, criticism is evident in the literature at both technical and epistemological level. For example, Coffey and Atkinson (1996) object that some computer packages encourage tagging and retrieval of segments, removing them from their context. There has also been concern about the risk of losing data through operational mistakes and also the implementation of individual software can lead to difficulties (Murphy et al 1998).

In order to avoid these pitfalls, an important approach is to have a clear strategy for data analysis organised prior to the beginning of analysis and to choose suitable analytic tools (Yin 2003; Ritchie and Lewis 2003). The following section will provide a detailed outline of the strategy for data analysis and the analytic approaches applied in this study.

4.3.2. Data analysis strategy in this study

The strategy of data analysis in this study involved six steps:

- General analysis of different types of contextual and related documents (e.g. local and national polices and guidelines)
- Specific analysis of the 15 focal reports, based mainly on their findings and recommendations
- Analysis of the transcripts from each individual interview
- Analysis of each individual case, and summarising main themes
- Cross case analyses
- Finally, the analysis and synthesis of the findings in relation to appropriate literature, seeking to construct a new explanatory model.

This analytic structure is guided primarily by Yin's case study strategy (2003), which provides clear steps for data analysis (see Figure 9). Initially each interview data set was analysed individually, then allocated to each case, and then contrast and comparative analysis was undertaken comprehensively and systematically across all cases. The analytical approaches used in this study are presented in the next section.

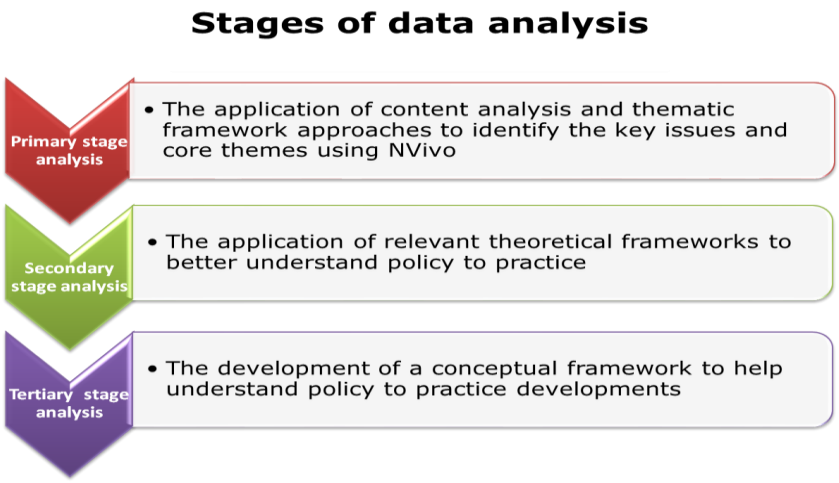
4.3.3. Analytical approaches applied in this study

It is important to emphasise that whatever approach is used, qualitative data analysis is a very time-consuming process. Any approach needs to include certain features, regarding ordering of the data within and between case searches, in order to maximise the potential for a full and reflective analysis; allowing flexibility and transparency for the external reader; and allowing emergent ideas, concepts, patterns etc. to remain rooted within the raw data (Ritchie and Lewis 2003).

Equally important, as Leech and Onwuegbuzie (2007) state, using more than one approach of data analysis, called data analysis triangulation, can strengthen the rigor and trustworthiness of the findings, and can lead to a deeper and fuller understanding of policy to practice development research and beyond.

Bearing in mind these principles, this study was developed for data analysis in three stages, utilising several approaches to systematically analyse and synthesise the collected data resulting in the development of a conceptual framework for analysis (see Figure 11). The three stages of data analysis are discussed critically below.

Figure 11: Stages of data analysis



4.3.3.1. Primary stage analysis

Primary stage analysis included critically analysing and synthesising documentary data and interview data. The following section will discuss how the two types of data were investigated.

4.3.3.1.1. Content analysis

After a general analysis of contextual and related documents (e.g. policies, guidelines) by reading, understanding and extracting key material for exemplar quotes, the main documentary data, comprising 15 reports, was subject to a more formal analysis of content.

Content analysis is defined as a careful, detailed, systematic investigation and interpretation of particular material in an effort to identify patterns, themes and meanings (Leedy and Ormrod 2005; Berg and Lune 2012). It is typically carried out using a range of text including various written documents, pictures, video or audio tapes. Robson (2011) and Berg and Lune (2012) have analytically shown the

advantages and disadvantages of content analysis for documentary data. The advantages are:

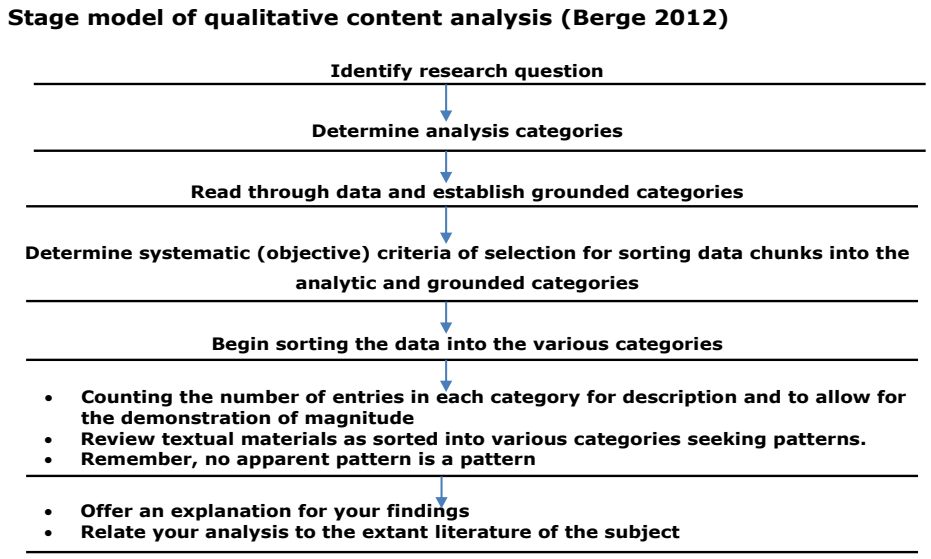
- It can be virtually unobtrusive when based on existing documents.
- It allows for reliability checks and replication studies, because the data are in permanent form and it can be subject to reanalysis.
- It is cost effective when a run or series of documents of a particular type is available.
- It offers a means by which to study a process that takes place over a long period of time, and that may reflect trends in a society.

The disadvantages are:

- The documents available may be limited and partial.
- It is difficult to allow for the biases or distortions of the documentary data, which others have decided were worth preserving.
- It is ineffective for testing causal relationships between variables.

The process of content analysis for the identified 15 reports was the model offered in Figure 12.

Figure 12: Stage model of qualitative content analysis



Following the above stage model, the analysis started with the research questions:

- What common issues and lessons emerged from the 15 reports?

- What were the common recommendations for policy makers, educators, practice developments and researchers?

The next step was to read the fifteen identified reports thoroughly to gain a general understanding. This was a time consuming process as the reports were quite broad in nature and provided quite different sources for the detailed data. Then all of the findings and recommendations had to be combined to form the raw data. When combining the literature and the research questions, a number of analytic categories were developed by establishing the content of the findings and recommendations of the 15 reports (Berg and Lune 2012). After establishing the analytical and grounded categories (see Table 12), the next step was to read through all the findings and recommendations, and to highlight the relevant category headings for sorting the data chunks. After sorting or locating data chunks, a pattern was established by coding similar categories and also by recording the number of reports in different categories. Thus, categorical patterns were identified.

The extraction of the common issues, lessons and recommendations was fairly straightforward in terms of content analysis of manifest findings (Graneheim and Lundman 2004), and there was general checking of this by my Principal Supervisor who was familiar with the findings and recommendations of the reports. Moreover, these documents are publically available for verification of interpretation. Table 12 is an example of how the 15 reports were recorded.

Table 12: An example of applying content analysis to 15 evaluation reports

Factors impact on policy to practice		Currie et al	English et al	McDuff (2010)	Watterson et al	Shaw et al	Birch& Martin	Puchering et al	Carlisle et al	Macduff et al (2009)	Gibb et al	McCreaddie et al	Solowiej	Banks et al	Lauder et al	Pearson et al
Key themes	**Original statement**															
organizational and administrative support	support from line management/ Board/national approach			yes						yes						
	key organisational contacts, LHBCs and managers were positive about Cleanliness Champions															
individual support	For senior managers, this was viewed as an essential part of effective clinical governance.			yes	yes		yes		yes							
	the majority of PEFs were working at Grade G															
	Flying Start NHS is well regarded and seen as a valuable initiative, with Practice Education Facilitators playing a major role in promoting and supporting this course.															
	support from team colleagues; line management/supervisor															
	The Code of Conduct for Healthcare Support Workers was unanimously supported by healthcare support workers, workplace supervisors and employers. The Code of Practice for NHS Scotland Employers was supported by the majority of															
variations in training and culture in terms of personal values and beliefs	The main factors which helped respondents to progress values based and recovery focused practice were: resonance with personal values;			yes												yes
	Considering environment, some areas were very supportive - valuing the rich resource the process could bring for making service improvements to care.															
	Cascade training varied															

In effect, this part of the study is primarily a systematic synthesis, placing the identified 15 reports together to find the common issues which emerge from these initiatives' findings and recommendations, in order to provide clear evidence for policy makers, educators, and practitioners and to direct my further in-depth study.

4.3.3.1.2. Thematic framework analytic approach

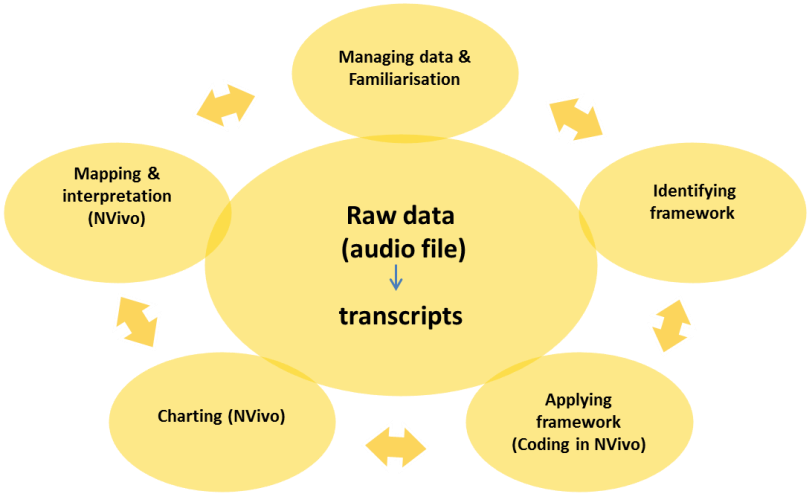
The approach for analysing interview data was different from that of documentary data. This will now be discussed and illustrated.

When starting to analyse each individual data set (i.e. each interview transcript), this study initially applied the method of thematic framework analysis, which was developed at the National Centre for Social Research (Spencer et al 2003), and is now widely employed by qualitative researchers. It is particularly geared towards generating policy and practice-orientated findings (Green and Thorogood 2009). This approach offers analysts a rigorous and transparent data management system, based on a matrix analytical method, so that all analysis steps involved can be systematically carried out. It also permits the researchers to move backwards and forwards between different phases of analysis without losing the original record of the raw data (Ritchie and Lewis 2003). This process of framework analysis is viewed as being similar to thematic analysis but it is more explicit and more informed by prior reasoning (Pope and Mays 2006). It is characterised by five key steps:

- Familiarisation
- Identifying a thematic framework
- Indexing
- Charting
- Mapping and interpretation

The five steps of framework analysis should be based on original raw data, and each step should be a dynamic and interactive process, which builds up convincing and rigorous evidence from policy to practice (see Figure 13).

Figure 13: The process of primary stage interview data analysis



Primary data analysis
(Applying framework approach)

Step one: Managing qualitative data and familiarisation

At the start of data analysis, managing the qualitative data is substantial as qualitative material is likely to be highly rich in detail but unstructured and unwieldy in content (Ritchie and Lewis 2003; Bryman and Burgess 1994). Therefore the first step of data analysis includes data management and familiarisation.

Managing qualitative data

It is inevitable at the first stage that several hundred pages of transcripts and 24 audio-recordings would seem quite daunting. However, this was made significantly easier by applying NVivo to organise the data effectively (Bazeley 2006; Bazeley and Jackson 2013). NVivo requires the analyst to code data, which then permits easy identification, indexing and retrieval of data (Wong 2008; Auld et al 2007). This will be described in more detail in step three. The use of this software product can reduce technical difficulty and enhance the process of qualitative data analysis (Wong 2008; Auld et al 2007), particularly when dealing with multiple case studies to create cases in NVivo (Gibbs 2002).

To manage 24 sets of individual face to face interview data including audio-recordings and transcripts in NVivo, I organised the four case studies named as case studies 1,2,3,4 into different folders under internal sources, and imported the interview recordings and transcripts into the sub-folders under each case (Figure 14). In addition, when importing every transcript, it was vitally important to subdivide the sources into different cases and to use person node classification for future analysis of cases, cross-cases and different key actors (Figure 14, 15).

Figure 14: Folders for Sources with node classification in NVivo

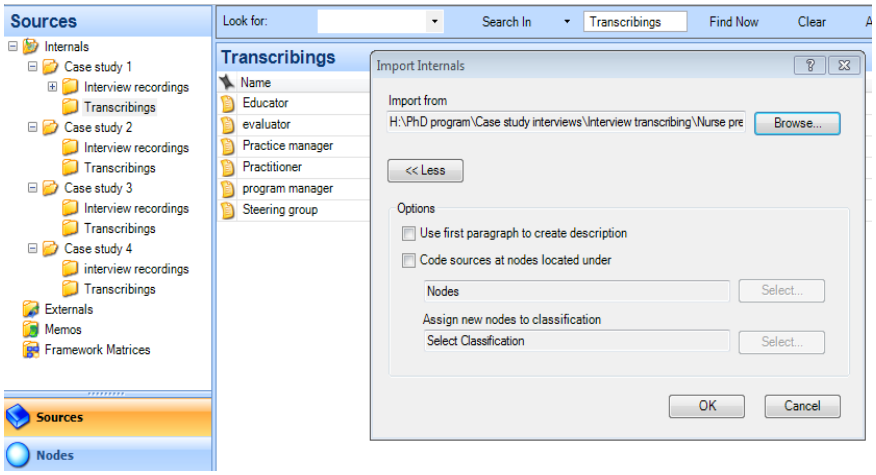
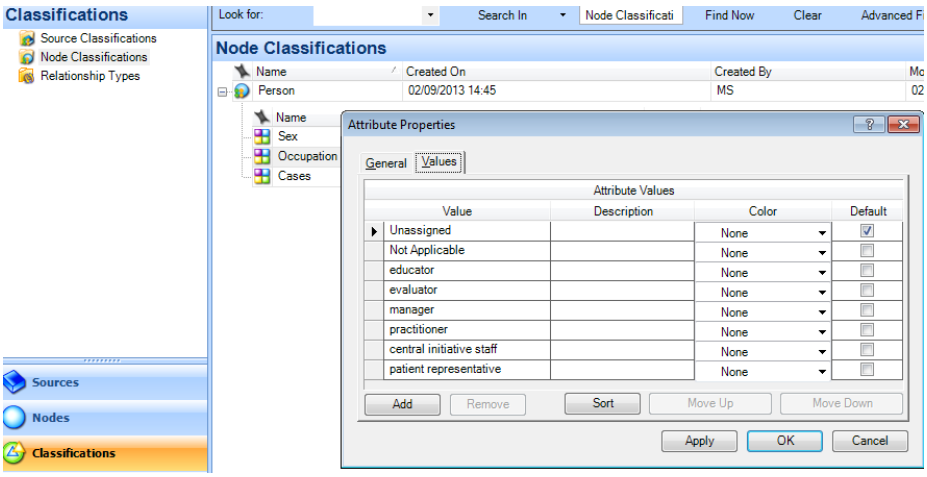


Figure 15: Person node classification in NVivo



Thus a mass of unwieldy, tangled data could be simply managed with NVivo. This helped me keep track select an appropriate subset of sources

for particular analyses. However, the NVivo software applied in this study crashed regularly, and I had on-going problems saving data. This impeded the fluency and momentum throughout my work, which frustrated me.

Familiarisation

Familiarisation is a crucial activity at the beginning of analysis, because the process of familiarisation is akin to building the basis of the structure for the thematic framework (Ritchie and Lewis 2003; Pope and Mays, 2006). It is claimed that the selection of a set of data for review during the process of familiarisation is possible despite the limitations of time and resources (Ritchie and Lewis 2003). This study started with case study 1, therefore, after each set of data in case study 1 was collected by semi-structured interview, the process of transcribing audio-taped recordings was scheduled immediately. All the interviews were transcribed verbatim and imported to NVivo 9, which facilitated familiarization with the data. By listening to the recordings, reading the transcripts over and over again, and sifting and highlighting important ideas and recurrent themes, the process of immersion and familiarisation with the raw data was begun. The process of familiarisation continued until there was a sense that all the various circumstances and characteristics within the data set had been unpacked (Ritchie and Lewis 2003). This allowed an understanding of experiences from the different perspectives of those involved in the policy to practice initiatives.

At this stage the original proposal was reviewed to identify and review the main aims and objectives and map them to the analysis (Ritchie and Lewis 2003).

Step two: Identifying a thematic framework

After gaining an overview of the richness, depth and range of diversities in the data coverage, and becoming thoroughly familiar with the data set, the second phase was to identify a thematic framework for the study.

The thematic framework enables the organisation and classification of data according to core themes/ concepts and the development of categories,

which can be sorted hierarchically into main and sub-themes (Ritchie and Lewis 2003; Pope and Mays, 2006). The process of developing a conceptual framework involved critically reading and re-reading each interview transcript in case study 1 (a total of six transcripts) over and over, highlighting the key statements and grouping recurrent and core themes and ideas which emerged from the raw data. In this way, each individual transcript in case study 1 was systematically investigated. Once the recurrent and core themes had been noted, drawing both upon core themes raised by the interviewees themselves and views and experiences that recurred in the data, and upon key issues introduced into interviews through the topic guide (Ritchie and Lewis 2003), these themes were then sorted and classified under a smaller number of broader, higher order categories or 'main themes' and placed within an overall framework (please see Table 13). This framework was a detailed index of the data, which helped labelling the data into manageable chunks for subsequent retrieval and exploration (Ritchie and Lewis 2003). At the same time, this step also involved logic and intuitive processes (Bryman and Burgess 1994). Furthermore, the pilot analysis also helped me to develop the framework. In particular, getting my supervisor's support and advice was significantly helpful in reviewing and revising the initial framework.

After reviewing and editing the primary framework, the final thematic framework was applied at the same point in each case study for labelling or tagging each raw data set. However, each case study had different subthemes which emerged from their raw data. Importantly, it was necessary to allow the dynamic of the framework, which could be managed, to add in the new key themes which emerged from other cases. There are five broad categories with 21 main themes and subthemes within the final framework, including a labelled 'others' category for significant but unrelated main themes (see Table 13).

Table 13: A thematic framework for data analysis

A thematic framework presenting categories of main themes and sub-themes regarding initiative development	
Categories/main themes	**Subthemes**
Formulation of initiative (1)	
Drivers of initiative formulation	External drivers
	Internal drivers
	Key people
Purpose of the initiative	
Relationship with other initiatives	
Triggers for initiative emerge	
Planning initiative enactment	
Support and resistance	Support
	Resistance
Risks and benefits	Risks
	Benefits
Key influential factors	positive influences
	negative influences
Expectations	
Progress of initiative development (2)	
Education or training process (2.1)	purpose of education
	role of educator
	theoretical framework
	Main issues emerging
	impact and outcomes of education
Initiative translation process (2.2)	Key project roles
	Context, culture and individual influence
	Communication strategy
	Monitoring and feedback
	Balance between central control and local implementation:
	Main issues and key factors emerging
Formal Evaluation of initiative (2.3)	The purpose of Evaluation
	Role of evaluators
	Methodology of evaluation
	Main issues emerging
	Quality related to the evaluation report
	Key factors
	Impacts and outcomes of Evaluation
Impacts and outcomes of initiative (2.4)	on the delivering services
	on the receiving services
	within relevant community

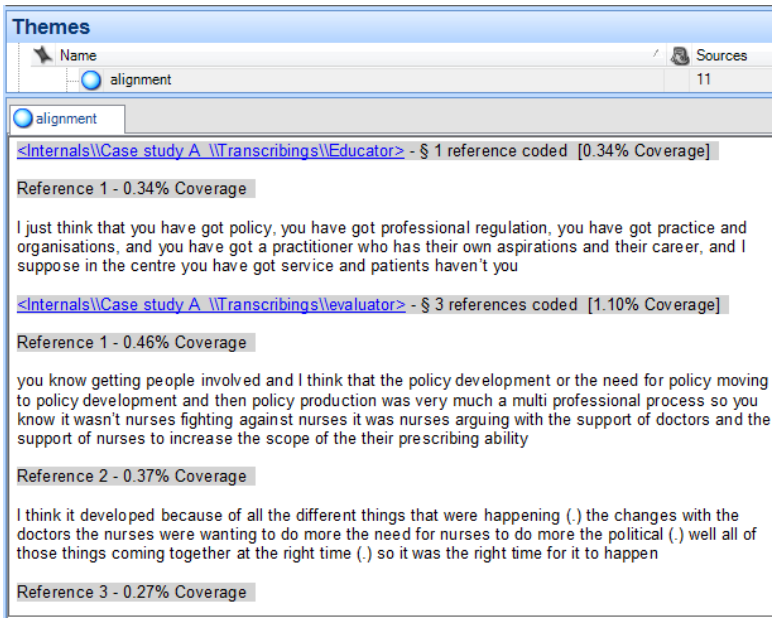
	success and difficulties
Lessons learnt from initiative development (3)	
Sustainability	evidence
	strategies
Dissemination	
Individual, Culture and organisational Changes	
Key issues	Positive
	negative
Key lessons	
Mapped model (4)	
Nature of the model	
Need to be further developed	
Feedback	
Others (5)	

Step three: Indexing: coding the nodes in NVivo 9

This step involved incorporating the structured framework above into NVivo 9 as a 'coding framework' called parent nodes, that could be used to code the data systematically for each interview transcript. This helps annotate the transcripts with various coding nodes, which are most often supported by a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute to a piece of data (Saldaña 2013). This process advanced my familiarisation with the data as a whole, since it involved reading and interpreting each phase, sentence and paragraph in detail, making sense of 'what is this talking about'. The different coding nodes in each data set were called child nodes (or sub-themes) which built up a rich, robust and colourful landscape for each case. Bear in mind, coding in NVivo does not mean that NVivo codes the data, this task is the responsibility of researcher, but NVivo does efficiently store, organise, manage and reconfigure the data to enable analytic reflection (Saldaña 2013). NVivo can import and handle documents saved in rich text format, can allow the use of supplementary coding devices such as coloured fonts, bold type and italics. In this way, every coded child node can be traced back to the original data through NVivo. It also permits revision of the coding, the application of more than one code to the same message and the easy insertion of annotations or analytical memos linked to a particular code.

However, when starting the process of coding the original transcripts in case study 1, I firstly coded hard-copy printouts, not via a computer system, because manipulating qualitative data on paper and writing codes in pencil gave me more control over and ownership of the work (Saldaña 2013). After I had expanded my basic understanding of the principles of qualitative data analysis, and had gained some experience by hard-copy coding, in particular, I enrolled in a two day workshop for NVivo, facilitated by master teachers. I then recoded each data set in case study 1 by employing NVivo 9 based on the thematic framework. An example of coding a transcript in regard to an emergent theme entitled 'alignment' is given below in Figure 16

Figure 16: Coding transcripts in NVivo



Nevertheless, coding is a cyclical and spiral act involving recoding the qualitative data to further manage, filter, highlight and focus on the prominent features for generating categories, themes, and concepts, grasping meaning, and/or building theory (Saldaña 2013). The coding process continued until all the transcripts were coded exhaustively and almost every statement had been investigated. However, within the coding process, the 'coding framework' was still dynamic with the potential to be modified and added to, if and when new themes arose from other cases. At the same time, it was vitally significant to keep the nodes stable and

flexible because the coding nodes organize principles that are not set in stone, they are creations and tools to think with. They can be expanded, changed or argued with while developing ideas through continual interaction with the data (Coffey and Atkinson 1996). Based on this idea, I refined the coding for each original interview transcript through NVivo 9, after constantly consulting with my Principal Supervisor, who reviewed the coding nodes. Refining the coding involved analytically interrogating the nodes, jumping ahead and returning to transcripts to exact new ideas. This enabled me to modify the nodes according to how I understood the data. This was critically important in assessing the trustworthiness of this study (as discussed in section 3.3).

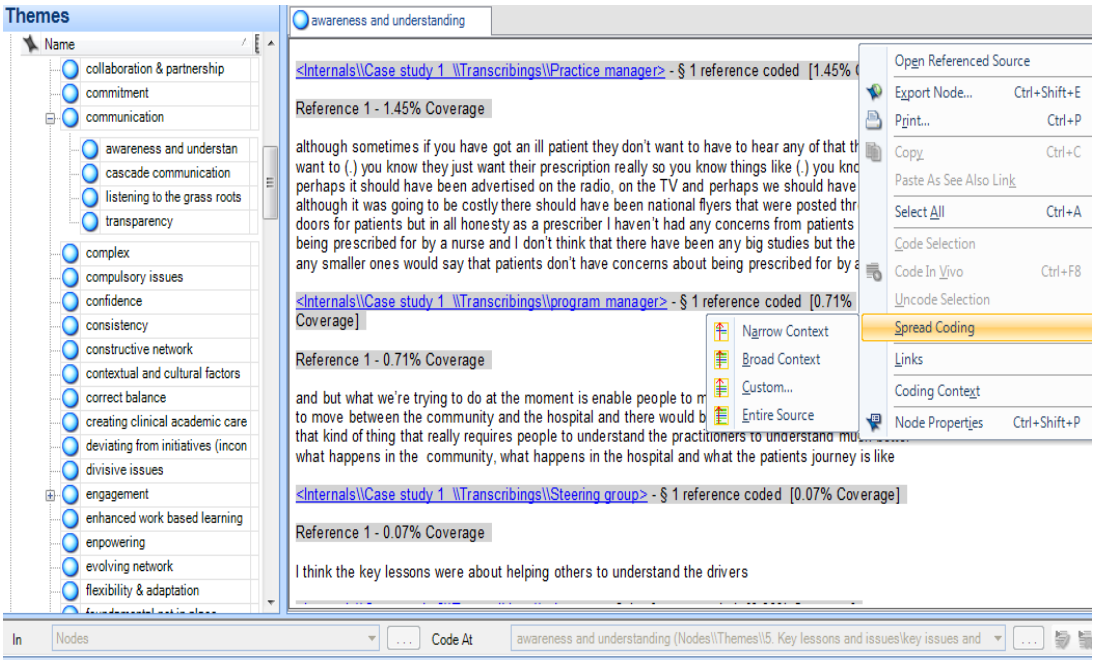
Step four: Charting in NVivo

Following coding nodes in NVivo, the next step was to sort or order the nodes in NVivo by cutting, pasting or merging nodes into related categories, so that material with similar content or properties was located in the same place. As Charmaz (2006) described the process of coding "it generates the bones of your analysis, then integration will assemble those bones into a working skeleton". For example, 'time, funding, people and infrastructure' are all grouped under resources. Another example is coding child nodes under 'strategy' so that some similar/overlapped sub-themes get further organised and sorted (see Figure 17). This step involved abstraction and synthesis (Bryman and Burgess 1994; Pope and Mays 2006). However, I found it particularly challenging when I was faced with the vast amount of information contained in the nodes. How to assemble the bones into a working skeleton was challenging. Bearing the challenges in mind, I regularly consulted my Principal Supervisor to discuss how to sort the nodes, and continually consulted relevant literature with my research questions and objectives, because these always point the way forward for analysis. This was a significant help in bringing me back to read, synthesise and interpret each participant's perspective regarding policy to practice initiatives under each theme, before summarizing the details under the appropriate parent nodes. This led to a complete synthesis of each key informant's views regarding the lessons learned from national initiatives. Besides, NVivo helps sort the data into different categories by

cutting, pasting or dragging/merging and changing the nodes without losing access to original transcripts, by allowing a reference to be opened at any time (see Figure 18). This can be vitally important in allowing the tracking or auditing of significant statements in the original transcripts, while referencing sample passages for use as possible quotations at a later stage of analysis (see Figure 18).

Figure 17: charting and sorting sub- nodes into main themes

Figure 18: Charting nodes with reference text and showing retrieved (broad) context.



Step five: mapping and interpretation

This stage involved summarising or synthesising all the data after shifting/sorting the entire data set according to appropriate themes. It is critically useful to work through the data systematically finding and searching for, patterns and relationships within and between themes/ sub-themes and cases (Ritchie and Lewis 2003), gathering insight into the different key actors' perceptions, opinions, accounts and experiences regarding policy to practice initiatives, related issues and lessons. Thus apparent characteristics, opinions and experiences regarding policy to practice development related issues and lessons learned from key actors were drawn together to form a bigger picture (Bryman and Burgess 1994). During the process of interpretation, the question was how best to retain the context and essence of the point without losing the voice of the respondent. This requires care and sensitivity when making a decision about the amount and content of material to map (Ritchie and Lewis, 2003). Also, the emphasis is on how to interpret the data in depth, so that the analysis of qualitative data is enriched. Bearing these points in mind, I applied annotations, models and queries in NVivo to synthesise and interpret the data effectively. At the primary analysis stage, I employed comparison and pattern approaches to refine and relate categories or themes arising from the four cases and from the divergent views from different groups of participants through NVivo.

As discussed before, I started coding the themes manually in case study 1. After charting and shifting the data, I read down the views relating to different perspectives, based on the initial themes/sub-themes arising within five interviews, analytically extracting, merging, synthesising and interpreting the initial themes/sub-themes. The final synthesised and summarised themes/sub-themes are presented in Table 14.

Table 14: Mapping and interpretation (Using Case 1 as example)

Extract of the thematic framework presenting categories of main themes and sub-themes regarding initiative development	
Categories/themes/sub-themes	**Explicit/implicit interpretation.**

Formulation of initiative		
Drivers of initiative formulation	External drivers	Changes of demographics, workforce and service delivery; legislation
	Internal drivers	Professional readiness; changes of nursing model and teams.
	Key people	Champions; key stakeholders
Purpose of the initiative		Expand competencies; improve patient care
Key processes that advanced the initiative		Lobbying, a functional network at different levels; fund; law
Relationship with other initiatives		Change in nurse grade and in GP contracts; nurse led services.
Triggers for initiative emerge		Legislation; doctors' role change
Planning initiative enactment		Knowledge preparation; build up standards
Support and resistance	Support	Evidence-based; support from key stakeholders and politicians; policy environment
	Resistance	Professional challenges; challenges for online learning; organisational structure and system; lack of motivation.
Risks and benefits	Risks	Unsure; Opaque; time and resource wasted; inconsistency; incompetency
	Benefits	Improve quality of service; good for career progression and workforce development
Key factors	positive influencing	Nursing organisations; key people; political support; collaboration; readiness and willingness; law; professional accountability
	negative influencing	Cheap labour; lack of confidence; no motivation; no enthusiasm
Expectations		Not be supportive, stressful; job satisfaction
Progress of initiative development		
Education or training process (2.1)	purpose of education	Building up accountability and expanding knowledge
	characters of education programme	Complex; incremental course; tightness; robust; generalist; strict admission criteria; blended learning.
	Main issues emerged	Varied knowledge; time; recruitment; challenges for course design (consistency; strategic plan; entirety; repetitive; challenge for service user involvement; difficult content; imbalance; legal aspects); resource wasted; learning methods.
	Key factors	National policy; standards; aspiration; interrelation; governmental funding;
	impacts and outcomes of education	RCN accreditation; postgraduate certificate or diploma; improve cv.
Initiative translation process (2.2)	Key project roles	A lead at national and local levels; a lead in connection with government and local board; a course lead; student individuals and groups to transform service; peer support groups;
	Context, culture influential	Attitudes; good relationship; different strategies in each board;
	individual influential	Attitudes of local nursing director; local champions; individuals' willingness
	Communication strategy	Top-down communication strategy; methods of communication
	Monitoring and feedback	Audit; peer review;
	Key factors	Leadership; engaged stakeholders; monitoring;
	Balance between central control and local implementation:	Gaps of expectations between centrally and locally; detached support linkage between centrally and locally;

	Main issues emerged	Need to change in system; challenge for secondary care; administrative management; audit; conflict opinions; less guidance; resource wasted.
Formal Evaluation of initiative (2.3)	The purpose of Evaluation	Understand the acceptance
	Role of evaluators	Evaluate different perspectives
	Methodology of evaluation	Qualitative case studies,
	Main issues emerged	Difficult study; how to identify participants; how to access get rich data; interim report not fully published.
	Quality related to the evaluation report	Good report; more positives than negatives; some key issues not detailed.
	Key factors	Collaboration with sponsors; consistency; recruitment strategy
	Impacts and outcomes of Evaluation	Provide evidence; firewall; justify and support;
Impacts and outcomes of initiative (2.4)	on the delivering services	Service redesign; time management; relationship with patient; career progression; job satisfaction; patient safety.
	on the receiving services	Meet needs; improve access to medicine; patient satisfaction;
	within relevant community	Enhance the range and the quality of the services; incremental change; public awareness
	success and difficulties	Right intervention; global health experience and health assessment; health approach; exciting shift; limited disseminations; failing; dilemma; workforce challenge.
Lessons learnt from initiative development		
Sustainability	evidence	Levelling out; positive attitude; students continue to come; need qualification; a good example; a major policy initiative; funding from government;
Dissemination		Wide geographic spread; heightened awareness; limited access; dissemination strategies.
Individual, Culture and organisational Changes		Work ways and experiences; working life; job satisfaction; good prototype; increase credit; role progression; law changed.
Key issues	positive	Leadership; collaboration; feedback; enthusiasm;
	negative	Willingness; problem solution; mismatch; mobilisation; management process; recruitment; balance learning and practice; confusion; role development;
Key lessons		Leadership; network; Ownership; recruitment and admission; time; good guidelines; collaboration; enthusiasm; organisational structure; early identify key stakeholders
Future research		A longitudinal case studies; comparison study
Mapped model		
Understanding the nature of the model		Monitor initiative processes; showing weak links or blocks; use for macro and micro initiative change; constraint perspectives.
Need to be further developed		Key individual power; evidence-based; simple language;
use of Feedback/loops		For future use; not sure
Others		

However, to start meaningful analysis of systematically synthesising and interpreting the data in NVivo, I applied the analytical question 'what were the key themes relating to lessons and issues which emerged from the study'. To answer this question, the process of interpretation involved dragging across and synthesising all existing sub-themes relating to the factors, issues and lessons from the coding framework. This was completed using a new parent node in NVivo, named as "the key issues and lessons emerging from four cases". This map was able to give a complete picture of key themes/subthemes for the main lessons which emerged from the data within the 24 interviews, i.e. fulfilling the goal of cross case analysis. With the analytic question of 'what were the key themes relating to lessons and issues which emerged from each case study', using matrix coding queries through NVivo, I filtered out the themes relating to issues and lessons emerging from each case and from different groups of participants. In the same way, this singled out the key themes relating to common issues and lessons emerging from the four case studies (see Chapter 7). This systematically mapped a complete picture of the main issues and lessons learned from policy to practice, which emerged from the 24 interviews.

Accordingly, the process of mapping and interpretation also caused me to reflect on the original research aims and objectives, when synthesising the themes which emerged from the collected raw data (Pope and Mays, 2006). This was of particular help in deciding the amount and the content of data to be mapped.

In addition, in order to establish and develop interpretive rigour, the transcripts and key coding themes in the pilot study, Case 1 and Case 2, were subject to detailed critical review by my Principal Supervisor. This helped me to develop the thematic framework. Moreover, the key themes linked to the quotations and transcripts regarding lessons learned across case studies were also checked and verified within my supervisory team.

4.3.3.2. Second stage analysis

The second stage of analysis involved the application of relevant theoretical frameworks in order to probe further into an understanding of policy to practice developments. This was of significant help in exploring how the findings might be illustrated through relevant conceptual frameworks. It was challenging to determine which theoretical frameworks to select. However, the strategy for identifying relevant frameworks has evolved, based on criteria from an intensive review within nursing and more generally from public policy literature. The criteria focus on:

- Relevance to primary questions and findings
- Concerned with the dynamics of policy to practice developments, and with potential for application to NMAHPs.
- Addressing some of the emergent themes/sub-themes within this study
- fitting into the multi-cultural world of UK NMAHP policy

This led to the selection of two models including governance, incentive and outcomes, adapted from Ross et al (2011) and May's (May 2006) Normalization Process Model (NPM). The two conceptual frameworks have been discussed before. Here, they were employed as analytical templates to further explore the perceptions which had already arisen from the initial stages in analysing 24 interviews data and fifteen reports (Crabtree and Miller 1992). This meant the systematic analysis became much deeper and more meaningful, seen from different angles using different lenses (see Chapter 7).

Analysing the data from the four cases based on the two models, involved the processes of extraction, interpretation, contrast, integration and illustration from raw data, and deep consideration in the light of prior findings at the first stage of analysis (Macduff 2007a). In order to critically and systematically fulfil the requirements of the structured analysis, I had sometimes to check original reports or transcripts to get a meaningful overview of the whole process while it was valuable to go through the findings from first stage analysis. The result is presented in Chapter 7.

The Ross framework seemed helpful in providing an overall picture of the impact of policy to practice initiatives on a range of outcomes, although it is rather "top heavy" in orientation. By contrast, the NPM model seemed to offer more scope for examining the factors that promote or inhibit operating and embedding complex interventions in practice. Moreover the Macduff "MAPPED" model was an explicit part of the interview schedule (see chapter 7).

4.3.3.3. Third stage analysis— the development of an integrated model

The third stage of analysis leading to my synthesis of an integrated model is explained in context in Chapter 7.4.3.

4.4. Summary

This chapter explained the process of data collection and how it was dealt with. In this study the data consists of documentary data and 24 in-depth semi-structured face to face interviews. The chapter has reflected on the interview process and measures taken to enhance the credibility of this study. The data analysis included an analysis of the 15 identified evaluation reports which was undertaken by applying content analysis. A thematic framework was used to analyse and synthesise the raw data gathered from 24 interviews within the four case studies, along with the support of a computer package (e.g. NVivo) to effectively manage data and help data analysis. This study has, in addition, applied May's NPM model and Ross et al's model to explore the four policy to practice initiatives. This will lead to the development of a new integrated model for analysing policy to practice initiative. The next chapter will explain the findings from the 15 commissioned evaluations.

Chapter 5: Findings from 15 commissioned reports

5.1. Overview of this chapter

Prior to presenting synthesis of the findings, it is necessary to outline the aims and objectives of the 15 reports, in order to clearly understand what the commissioned evaluators were being asked to do by the policy makers (see Table 15). In effect, Table 15 shows that the main requirements of the commissioners are largely about evaluating operation/implementation and impact, and identifying key influencing factors.

Table 15: Overall the aims and objectives of the 15 evaluation reports

Name of evaluation reports	Aims and objectives	Methods of evaluation
Advanced Practice Succession Planning Development Pathway	To concurrently evaluate the impact of the pilot advanced practice succession planning development pathway on individuals' learning, development of advanced practice attributes, service delivery/development and patient outcomes.	Case study, questionnaire and tel-interview
An education programme for staff working with acutely ill and injured children and young people	To evaluate the NES tiered education programmes for all healthcare staff who deal with acutely ill and injured children and young people; the impact of the NES tiered education programme for the care of acutely ill and injured children and young people, on the patients themselves, and on the individuals and teams who received the tiered education programme, as well as the service they provide.	Case study, questionnaire and interview
The Impact of Educational Resources to Support Values-Based and Recovery-Focused Mental Health Practice	To explore the experiences of those involved in the regional training (i.e. the commissioned trainers and the first wave trainers) To examine the planning, delivery and sustainability of further dissemination within specific organisational contexts To explore the experiences of mental health workers who received training To synthesise lessons learned	Case study, questionnaire; semi-structured interview; focus group
Evaluation of the Extension of Independent Nurse Prescribing in Scotland	To provide evidence on how nurse prescribing has operated in Scotland since 2001, how nurse prescribers were prepared for their role, what effects such prescribers have had on patients, fellow health professionals and NHS organisations. Objectives were to examine • The implementation and operation of the extension of nurse prescribing; • The impact of nurse prescribing on the appropriate use of nurses' skills; • Patient benefit from nurse prescribing and patients' perceptions of their experiences of care; • Measure the impact of nurse prescribing extension on workloads; • Assess the extent to which public health and patient safety are safeguarded; and • Different approaches to nurse prescribing training.	Case study, questionnaire; semi-structured interview; focus group and documentary analysis

Midwife Prescribing Project	• To audit the current status of midwifery practice in order to establish benchmark figures to be used as points of comparison in future impact evaluations • To identify additional educational elements that could be incorporated into a module that contextualises prescribing for midwives. • To develop a module descriptor which includes learning outcomes, competencies, and appropriate assessment strategies specifically for midwives • Evaluate the outcomes of this specific module for midwives, on completion of a programme which would commence in Sept 2007	Audit
Mellow Babies	To measure change in maternal depressive symptoms and the quality of interaction between mothers and babies.	RCT, questionnaire
The establishment of the Practice Education Facilitator role project	The overall aims of the project were to: • Evaluate the impact of the new posts in terms of the perceived quality of support for mentors; • Explore the impact on the quality of the clinical learning environment in terms of students' experience; • Identify the number of students that can be accommodated in both acute hospital and community placements; • Identify examples of innovative practice which act as barriers/facilitators to the learning environment; • Identify strengths and weaknesses of different models of implementation and development of posts; • Explore inter-professional learning developments in practice.	Case study, questionnaire; focus group
Scotland Cleanliness Champions Programme	•To evaluate the role of NES in terms of its development of the programme, its strategy for supporting implementation, and congruence between intention and enactment. • To evaluate the educational programme curriculum in terms of its content, formats and related processes. • To evaluate the experiences of the students who undertook the programme, their mentors, and key health service managers who were involved in implementing the programme. •To make informed initial judgement in regard to the programme's overall fitness for purpose.	Questionnaire and interview
A Pilot program for the role of Maternity care assistant in Scotland	To investigate: • The effect MCSW posts are likely to have on future maternity workforce planning. • The extent to which MCSWs have been accepted and integrated into maternity teams. • The perceptions of MCSW staff themselves of the role and the extent to which it is meeting their career aspirations.	Case study, questionnaire; Semi-structured interview; focus group

The succession planning development pathway for consultant nurse, midwives and AHP	• To identify the extent to which the succession planning development pathway for consultant nurses, midwives and allied health professions has contributed to an increase in numbers to the recruitment pool for these senior posts across NHS Scotland; • To ascertain the usefulness of the process (particularly the Development Needs Analysis Tool as a mechanism to identify personal strengths and areas of potential development); and • To identify the potential of transferability of this model to other staff groups.	Case study, questionnaire; Semi-structured interview
Allied Health professions support and development scheme	To assess the impact of the scheme on the: • recruitment and retention of AHPs; • career development of AHPs; • factors leading to successful outcomes for individuals and teams in NHS Scotland.	questionnaire and Tel-interview
Evaluation of flying start NHS	To evaluate the impact and effectiveness of Flying Start NHS in supporting the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland.	questionnaire; interview; focus group
NM in Scotland: being fit for practice	The Aims: • To identify the extent of and perceived impact of increased flexibility, achieving fitness for practice and partnership working on the skills and competence of newly qualified nurses and midwives • To evaluate the one-year development programme for practitioners qualifying from September 2005 • To further construct an evidence base and research platform on which to build and develop appropriate nurse and midwife education programmes which reflect and meet modern health care needs The objectives: •To evaluate the influence of flexibility and Fitness For Practice educational processes within programmes •To describe the relationship between flexibility, Fitness For Practice curricula and 'fitness for practice' outcomes • To identify and evaluate changes to the way in which partnership working has been developed between HEIs and service providers • To evaluate the impact of the programmes in NHS Scotland in terms of perceptions of fitness for practice • To evaluate the impact of the one-year development programme for newly registered nurses and midwives	questionnaire; interview and systematic review

Clinical leaders for the future (ECCF)	To systematically evaluate key features (contexts), activities (mechanisms) and outcomes of the Early Clinical Career Fellowships Pilot in order to make recommendations for future programme development. The specific objectives: • To describe and develop an understanding of the contexts of the ECCF Project. • To describe and develop an understanding of the structure, organisation and running of the programme. • To explore the perceptions of stakeholders involved To identify, describe and assess the perceived outcomes of the programme	questionnaire; focus group
Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards	To assess the implementation, operation and potential impact of the pilot. The overarching aim was to assess whether the model of employer-led regulation with the addition of a central occupational list had potential to enhance patient safety and public protection.	Case study, questionnaire; interview

Although it was difficult to characterise the findings of the reports because they involved 15 national policy initiatives, reading through synthesised data, following leads along the way, and studying designs were productive. Miles and Huberman (1994) said: *"The researcher must weave these webs… see the links and draw the threads together, often by creative leaps of imaginative analogies (p170)"*. Now, it is time to weave the webs to link the common themes through a critical review of the fifteen reports. The common themes arising from the 15 reports were based on their findings and recommendations. These aspects are presented separately in detail in the following two sections.

5.2. Shared findings across the 15 reports

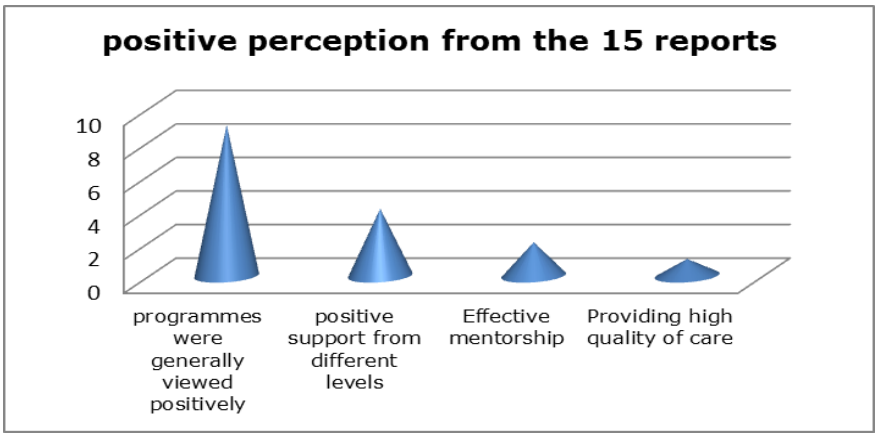
The common findings across the 15 reports highlighted the six issues shown below, which are explained individually.

- ❖ Positive perceptions from participants involved in these initiatives
- ❖ Negative perceptions from participants involved in these initiatives
- ❖ Beneficial impacts through initiatives
- ❖ Drawbacks related to initiatives
- ❖ Key factors enabling enactment of initiatives
- ❖ Barriers hindering policy to practice

5.2.1. Positive perceptions from participants involved in these initiatives

The main positive perceptions from the 15 initiatives are illustrated in Figure 19.

Figure 19: Positive perceptions from 15 reports



The strongest finding is that the programmes in the reports were generally viewed as positive and successful. For example, Carlisle et al (2008) in their report concluded that "*the role of the PEF has been accepted widely across Scotland and that where the role works well, it is seen as a valuable addition to the support and development of a quality clinical learning environment for pre- and post-registration students".*

Across the fifteen reports, the other major views from contributors in these initiatives included positive support from different levels; effective mentorship and provision of high quality care. These are discussed in the following paragraphs.

Some reports found the staff had very positive support from different levels. For instance, Pearson and Machin (2010) in their reports said "*A majority of managers were felt to be supportive*" and they also quoted the voice of respondents "*The support I have received from my own health board employer has been fantastic and very, very supportive*". Another report by Birch and Martin (2009) clearly supported the above views: "*The induction standards for healthcare support workers were supported by participating HCSWs (82%) and Workplace Supervisors (84%) with workshop delegates (72%) supporting mandatory status".* Likewise, Macduff (2010) cited the opinions of trainers' "*Supportive from start, including line manager support, head nurse support and support from administration (clinical governance)*".

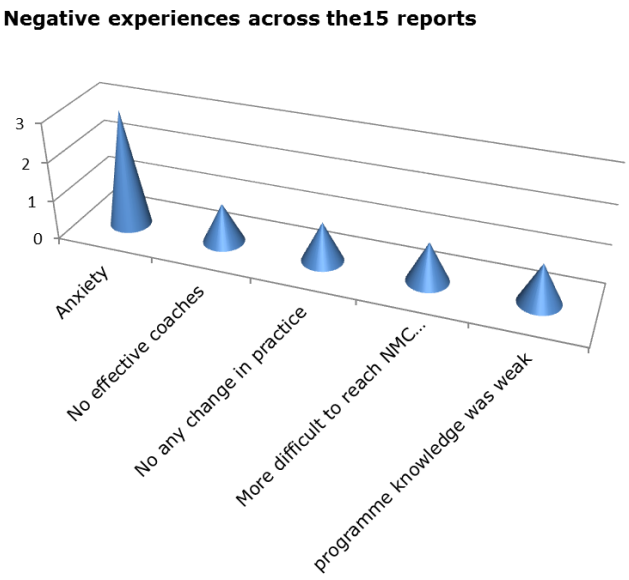
At the same time, one of the positive views that comes from the findings is effective mentorship, which can be found in the reports of Pearson and Machin (2010) and McCreaddie et al (2006). They agree that *"A majority of fellows had mentors , and more than half were felt to be effective"; "Mentors perceived the purpose of mentorship as raising or encouraging political awareness, signposting, 'prodding' or 'toughening up' the mentee for the rigours of a post at a perceptibly more strategic level".*

While the positive voices are always foremost in these reports, some disapproving voices are heard.

5.2.2. Negative perceptions from participants involved in these initiatives

In comparison to the positive views, there were relatively few negative experiences highlighted. Figure 20 outlines the more negative experiences across the 15 reports.

Figure 20: Negative experiences across the15 reports



Some participants had experienced various degrees of anxiety when new initiatives were introduced. Carlisle et al (2008) stated in their report "*Some PEFs had concerns around ways to retain their own clinical competence, particularly as their role did not involve any direct patient contact or clinical skills teaching remit"*. Some staff were also concerned

about their competence on key topics. Shaw et al (2008) found "*students who undertook this mode found it challenging and perceived disadvantages with some anxiety of 'missing' out on key topics".*

Other negative perceptions were reported by Pearson and Machin (2010), who found that there were no effective coaches, little change in real practice, and that program knowledge was also weak. Additionally, Shaw et al (2008) reported that it was difficult to reach the NMC standard. They stated "*Students found it more difficult to address competence within the NMC Standards or the Prescribing Centre approach to prescribing"*.

It is valuable to look at the reported impact of those initiatives. This includes the beneficial effects and the drawbacks regarding the 15 policy initiatives.

5.2.3. Beneficial impact of the initiatives

The main benefits recognised across the findings of the fifteen reports are:

- Effectiveness of learning
- Improvement of role and professional development
- Positive changes in behaviour, practice and environment
- Effectiveness of practice
- Motivation provided for recruitment
- Raising awareness of issues related to policy and practice
- Benefits for the service user and public health
- Evidence-based practice

Within the 15 reports, the most frequently expressed positive impact from the implementation of an initiative, was that it encouraged effective learning. There are six reports which strongly agree with this point. For instance, McCreaddie et al (2006) quoted the interviewee on how to learn critical thinking via the program: "*That gave me confidence and made me feel as though I could critically analyse issues. The ALS contributed to this development* (NP73; 443)." Similarly, Pearson and Machin (2010) states '*Action Learning Sets were seen as particularly helpful in preparing Fellows for some of the challenges of practice, with patients but also in working*

with colleagues. Master classes were found to be useful, enjoyable and easy to apply to practice for the majority".

The second most frequently expressed view was that the policy led to an improvement of role and professional development and positive changes in behaviour, practice and environment. Five reports support these views. In particular, Macduff (2010) quoted a staff member, who said "*By role modelling and encouraging people to accept that change need not be feared. Introducing small changes can lead to a huge difference for people"*. Another report from Currie et al (2010) concurred with this view "*looking at examples of how other people have managed issues in their areas has made me reflect more critically on my own leadership skills and make changes".* Watterson et al (2009) also reported positive changes in practice. They said: "*the professional benefits associated with nurse prescribing related to increased satisfaction, improved professional development and a related increase in professional recognition and respect"*.

However, only three reports mentioned the benefit of effective practice as a result of the initiatives. Watterson et al (2009) claimed that "*The benefits from the program included building inter-professional working, enabling effective use of medical staff time, and maintaining public health standards*".

Two of fifteen reports highlighted benefits for the service user and for public health. In Macduff (2010)'s report, one of the interviewees commented *"Great patient involvement-patients as participants in care, not recipients of care".* Watterson et al (2009) also showed that patients found quicker and easier access to treatment to be the most beneficial aspect of nurse prescribing. They found patients and carers reported that relationships with the nurse prescribers led to patients having confidence in the prescriptions given. Two other groups felt the initiatives would help staff in raising awareness of issues related to policy and practice. Macduff (2009) quoted from a senior charge nurse*: "Colleagues are more aware of good practice and of doing it. This is due to hand hygiene cascade trainers".*

Another important point is that the enactment of initiatives can provide excellent opportunities for evidence-based practice, even though only one report mentioned such a view.

5.2.4. Drawbacks related to the initiatives

Critical problems highlighted in the 15 reports included:

- A rush to invest without adequate prior planning
- Monitoring processes causing a burden in terms of resources
- Variable or poor management and deployment of policy change
- Excessive travelling times to fulfil obligations

Throughout the fifteen reports, some researchers pointed out the deficiencies of initiatives, though these are relatively few, compared to the benefits side. One example can be found from within McCreaddie's report (2006). They stressed that "*a rush to invest in visible Consultant NMAHP posts might have led to a dilution of the role via the appointment in some instances of less able and/or qualified individuals"*.

Another problem of poor management of policy changes has been pointed out in Shaw's report (2008). They said "*midwives do not appear to be focusing on the recent policy changes"*. Finally, a somewhat stronger criticism is related to travelling. Pearson and Machin (2010) pointed out "*In other areas the experience was not so positive. Travelling, especially from remote and rural areas created problems for some Fellows"*. The same problem was mentioned by (Currie 2010): "*Gaps in the geographical distribution of participants are noticeable"*.

Drawing on the effects of the 15 policy initiatives, the next section presents the factors emerging from these reports, which may facilitate or hinder policy development.

5.2.5. Key factors enabling enactment of initiatives

A number of factors were found, which impact, to some extent, on the implementation of policy to practice development. They focus on:

- Support from the organisation, administration and individuals

- Culture and personal values and beliefs

The reports showed clearly what issues were significant in facilitating policy to practice developments. Specifically, organisational, administrative and individual support was the most important factor. Macduff (2010) summarised the findings "*the main factors which helped respondents to progress value-based and recovery focused practice were: support from team colleagues; line management/supervisor support; and support from Board/national approach"*. Watterson et al (2009) contained similar findings: "*Peer support was considered to have a positive effect on prescribing work by just over half of the respondents*".

At the same time, another positive factor influencing policy to practice, was culture and personal values and beliefs. Pearson and Machin (2010) reported "*Considering the environment, some areas were very supportive--valuing the rich resources the process could bring to making improvements to care services*". Macduff et al (2010) also mentioned that the main factor which helped the initiative progress was resonance with personal values.

5.2.6. Barriers hindering policy to practice

- Inadequate support and direction
- Lack of time
- Poor staffing levels/resources
- Personal and professional attitudes

On the other hand, a lot of barriers were found to impede the deployment of the initiatives (see above). A common complaint was poor staffing levels /resources. The reports found that the factors which hindered progress were poor resources, staff shortages and lack of time. Again, Watterson et al (2009) argued that "*the age profile of the nurse prescribing workforce may prove problematic and may be more difficult to address, but that is part of a wider debate about the workforce planning in Scotland"*. Shaw et al (2008) quoted feedback from students "*Students stated that it was very difficult to obtain up to date midwifery specific textbooks, incorporating the latest changes in legislation and practice guidelines*", and Macduff (2009)

stated in his conclusion; "*Although lack of time was mentioned as a problem by some participants, it is significant that many more saw lack of equipment and poor environmental facilities as hindering progress"*.

The other common difficulties were lack of support and direction, as well as personal and professional attitudes. There is a quotation from the Pearson and Machin (2010) report that supports this viewpoint: "*My manager does not understand the ECCF and does not appreciate the long hours of study I put in, travel time and commitment. He fails to understand the benefits to the ward, my students and colleagues. This is the most challenging aspect of the program"*. Another report by Watterson et al (2009) claimed that some GPs thought nurse prescribing would possibly increase the cost, and the GPs were convinced that nurse prescribers were under-trained in diagnostic practice, which led some GPs to be concerned that nurse prescribing would move away from specific areas of competence and into general areas.

So far, all the common themes emerging from the findings of the 15 reports have been discussed. The next section presents the common recommendations across these reports.

5.3. Common recommendations across the 15 reports

According to the synthesis of recommendations from the fifteen reports, this section has been divided into three parts based on the target population, such as policy makers, education and practice development. They are all dealt with separately.

5.3.1. The key common recommendations for policy makers and top managers are:

- Continuing development, delivery and sustainability of initiatives
- Improving management systems and processes
- Building up systems and processes for monitoring
- Generating more support from sponsors and host organisations, including financial support
- Developing information sharing systems

- Leadership development
- Role development
- Fostering and enhancing motivation

Table 16 shows details of the common recommendations for policy makers and their occurrence.

Table 16: The common recommendations and reoccurrences for policy makers and managers

Key themes:	Currie et al	English et al	Macduff (2010)	Watterson et al	Shaw et al	Puchering et al	Birch and Martin	Carlisle et al	Macduff et al (2009)	Gibb et al	McCreaddie et al	Solowiej	Banks et al	Lauder et al	Pearson and Machin et al
Continuing and developing the initiatives	yes	yes	yes	yes	yes				yes	yes	yes	yes			
Improving the process of management system			yes	yes	yes			yes			yes				yes
Building up monitory process system				yes	yes		yes				yes		yes		yes
Need support from sponsor, organisation and financial side				yes							yes		yes	yes	yes
Information sharing system		yes	yes				yes								yes
Role development							yes				yes		yes		
Leadership development			yes	yes											
Promote motivation							yes							yes	

Perhaps unsurprisingly, given the commissioned nature of these evaluations, a large number of researchers are in favour of continuing and supporting the development of initiatives. As Table 16 shows, nine out of fifteen agree with this. Improvement of management process beyond the initiative's deployment is also advocated by six reporters. They speak with one voice: *"Introduce managerial supervision for PEFs"*; "*Health boards should enact processes to develop and integrate the Cleanliness Champions' role more fully into local infection control planning and practice"*.

In addition, there are six recommendations which suggest a need to build up a monitoring system for the initiatives. Watterson (2009) advised "*Demonstrated and regularly reviewed and monitored good governance related to nurse prescribing practice across Scotland is needed"*.

Again, the need for more support from sponsors and organisations and financial support to deploy the initiatives was strongly supported by five reports. Three examples are: Bank et al (2010): "*There should be equity of support between NHS Boards, and acute and community settings*." Pearson and Machin (2010):"*A board level champion in each NHS Board would help in ensuring provision of essential organisational support."* Watterson et al (2009)*:"Further development and underpinning of appropriate nurse prescribing support and networking groups is needed".*

Accordingly, setting up an information sharing system from policy to practice is also broadly perceived as essential. There are five reports which point this out. For example, Macduff (2010) recommends "*Enabling local practice development networks to share good practice*"; *"There needs to be an effective administration and information sharing system"* (Pearson and Machin et al 2010).

Interestingly, only two reports highlighted leadership development through the initiative programs. They recommended *"Identifying a high-visibility mental health leader with executive responsibility for strategic implementation of the initiative"; "Promoting participation from a wider*

range of healthcare workers, especially those in a particular position to lead and influence such as executives, medical staff, and clinical managers" (Macduff et al 2010). *"Further development of strategic leadership and champions to carry through prescribing in midwifery and mental health, which is seriously under-developed would be worthwhile"* (Watterson et al 2009).

Another two research groups from Birchand Martin (2009) and Lauder et al (2008) also stated "*Consider motivating factors for staff groups where regulation is not part of the existing culture and prepare such groups for undertaking assessment". "Award for excellent work in Scotland in relation to assessment and development of numeracy skills in NM education."*

5.3.1. Common themes for education:

- Continuing and developing the courses
- Improving educational delivery processes
- Enhancing learning material preparation
- Enhancing course assessment
- Curriculum development
- Improving learning methods
- Flexible course design

Table 17 displays the main themes for education, which emerged from the recommendations through the fifteen reports.

Table 17: The common recommendations for the educational system and occurrences

Key themes:	Currie et al	English et al	Macduff 2010	Watterson et al	Shaw et al	Birch and Martin	Puchering et al	Carlisle et al	Macduff et al 2009	Gibb et al	McCreaddi et al	Solowiej	Banks et al	Lauder et al	Pearson and Machin et al
Continue and develop the course	yes	yes		yes		yes			yes				yes		
Improving Education delivery process			yes	yes		yes					yes	yes	yes		
Learning material preparation			yes	yes	yes						yes		yes	yes	
Course assessment				yes	yes						yes				yes
Curriculum development				yes									yes	yes	
Improving learning methods					yes				yes						
Flexible course design				yes										yes	

According to Table 17, the three pieces of advice most frequently mentioned are 'Further developing the courses'; 'Improving educational delivery process' and 'Learning material preparation'. Each topic is mentioned by six research groups'. The suggestion for further developing the courses can be found in the six reports. For instance, Macduff (2010) advocates that NES should continue to promote the integration of the 10 Essential Shared Capabilities and Realising Recovery training in relevant undergraduate curricula.

Another six reports stated that improving the educational delivery process is important. An example from McCreaddie et al (2006) points out: "*Education training could operate on an 'open' call for individuals with specific expertise and capability, wishing to apply independently and on a 'closed' call strategically supporting identified NHS service needs e.g. a meritocratic approach.*"

Understandably, the other six reports felt that it was vital to prepare the learning materials well. For example, Banks et al (2010) said "*Information is available relating to what a Flying Start portfolio should be; NQPs are aware of the links to PDP and KSF which are clearly signposted; NQPs have a clear understanding of what completion looks like and who will assess and sign off their portfolio.*"

Four research groups placed the course assessment on the agenda. Shaw et al (2008) suggested that "*Contextualisation of education programme components to midwifery practice to be further monitored. Whilst generic exam questions have been of use thus far, a bank of standardized midwifery specific exam questions to be developed which incorporates current legislation aspects on midwives powers in supply, prescribing and administration of medicines.*"

Table 17 shows that three reporters highlight the development of the curriculum. For example, one of the reports recommended developing a new core module for carer and service-user involving self-management and

self-care, and changing the curriculum to reflect new evidence on teaching and learning (Lauder et al 2008).

However, concerns about learning methods and flexible course design should not be neglected, though only two reports mentioned these. While Watterson et al (2009) stressed ways of customising the course to the needs of different specialities. Shaw and colleagues (2008) emphasised the importance of an inter-professional learning method. They said "*Inter-professional learning should be available on the programme to enable midwives to learn from other prescriber practitioners and to assimilate knowledge about developments in modern medicines management and collaborations within the NHS.*"

5.3.2. Common recommendations for practice development

Continuing the theme of practice development in the recommendations of the fifteen reports, a number of key common recommendations emerged as below (illustrated in Table 18).

- Effective management for practice developments
- Fostering motivation for practice development
- Developing collaboration for practice development
- Addressing the impact on service development and patient outcomes
- Supporting practice development at different levels
- Developing standards for practice development

Table 18 : The common recommendations and reoccurrences for practice development

Key themes:	Currie et al	English et al	Macduff 2010	Watterson et al	Shaw et al	Birch and Martin	Puchering et al	Carlisle et al	Macduff et al 2009	Gibb et al	McCreaddie et al	Solowiej	Banks et al	Lauder et al	Pearson and Machin et al
effective management for practice development				yes	yes			yes	yes				yes		
to motivate for practice development		yes	yes								yes	yes	yes		
to develop collaboration for practice development			yes	yes	yes								yes		
to address the impact on service development and patient outcomes	yes		yes						yes						
to support practice development in different level			yes					yes						yes	
to generate best practice development			yes					yes	yes						
to track the process of the practice development				yes							yes		yes		
to build up standards for practice development						yes			yes					yes	

Table 18 shows the suggestions with the most support concern effective management of practice development and consideration of motivating factors. The two key themes were reported by five research groups. While some of the first group recommended developing the clinical infrastructure and national priorities and an implementation plan, some emphasised improving links with participants through practice processes, inclusion in audits, feedback of results, and forward planning.

The last five groups suggested how to motivate staff groups. For example, Macduff (2010) recommended that Health Boards should consider promoting wide spread integration of the training and practice development work into staff Personal Development Plans and clinical supervision processes (individual and group/whole team).

Not surprisingly, the next best supported suggestion is build up collaboration for practice development. There are four reports that highlighted such a point of view. Watterson et al (2009) suggests that "*close collaboration between post holders such as the chief medical officers and chief pharmacists and lead nurse prescribers should be encouraged and linked to effective management systems.*" Macduff et al (2010) also strongly advocates developing a multidisciplinary managerial steering group with service user representation to plan strategies with other national and local mental health initiatives and with an overseas connection.

Looking at Table 18, we see that the other five common recommendations are the following:

- To address the impact on service development and patient outcomes;
- To support practice development in different level;
- To generate best practice development;
- To track the process of the practice development
- To build up standards for practice development

These five common suggestions are each mentioned in three reports and by different research groups. Now the shared recommendations for policy

makers, educators, managers and practice development have been fully examined.

5.4. Summary

This chapter provides insight into what commissioners require to be done i.e. an evaluation of the operation, its impact and the identification of any influences. However, it is interesting and also important to consider what is not being asked explicitly. For example, there is no direct question asking why the initiatives were initiated.

Through this synthesis of findings and recommendations of the 15 commissioned reports, there are a lot of similarities and it might be argued a natural inclination to positives, given that the funders commissioned the reports. Although at one level this synthesis of findings from the reports may seem unsurprising and straightforward, it is nevertheless important. To my knowledge this has not been done before and this pooling of knowledge is useful for apprehending the bigger picture. In the next chapter more in-depth of insight will be gained through the selected case studies.

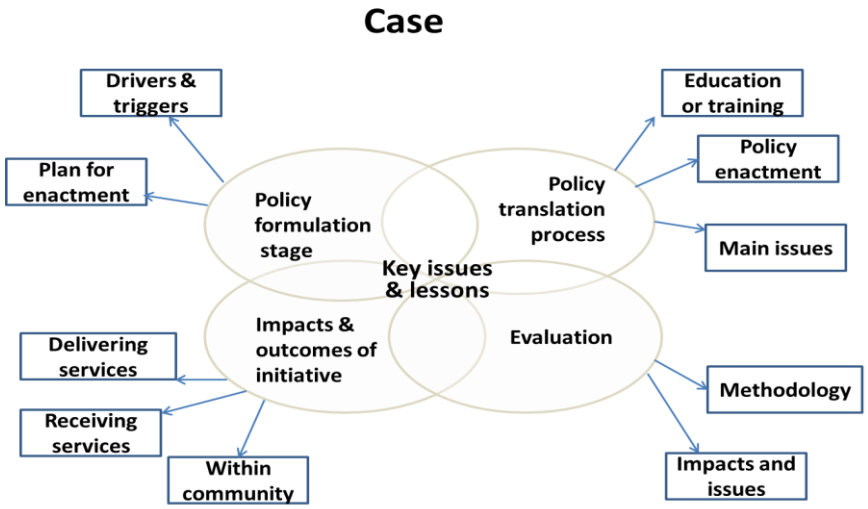
Chapter 6. Findings from each case study

6.1. Overview of this chapter

The case study findings from data analysis are presented in this and the following chapter (Chapter 7). The two chapters focus on exploring the views of different stakeholders on policy to practice initiatives, and draw on the rich qualitative data generated within and across the four case studies. However, presenting qualitative evidence which conveys the depth and richness of qualitative data, requires considerable thought (Ritchie et al 2014). How to report findings gained from raw data comprehensively yet concisely is challenging.

In order to present the case study findings coherently, this chapter will deal with the findings on a case by case basis to enable holistic understanding of each case, with contrast and comparison. Each case will begin by describing the main data sources and the features of the case, regarding policy *context, process, outcome,* drawn from the documentary data and the interview data. Next, the key themes emerging from the case will be presented, based on the MAPPED model (Macduff 2007a), exploring the processes behind policy formulation, implementation and impact. Finally, the central themes relating to lessons learned from the policy initiative will emerge (see Figure 21). Each of the four cases will be presented in turn.

Figure 21: Framework for presenting the findings in each case



6.2. Case 1 (extended role)

6.2.1. Main data sources

The main sources of data used in the construction of Case 1 study were: the commissioned report; 6 face to face in-depth case study interviews. They are summarised in the box below.

Table 19: Main data sources in Case 1

Main data sources in Case 1
The commissioned report
Six interviews: one central initiative staff, two managers, one educator, one evaluator, one practitioner

6.2.2. The features of Case 1

Case 1 is an initiative concerned with the development of an extended role for the nursing workforce. It has evolved over time since 2001. The features are dealt with according to policy context, process and outcomes, using information drawn from both documentary data and interview data. They are presented below.

Table 20: Features of Case 1

Features	Case 1 (extended role)
Context	**Outer context:** . European working directives led to a change in GP contracts. . Law passed **Inner context:** . Development of an out of hours service increased nurse-led services. . Each NHS health board was encouraged to establish an effective network with support from national level.
Process	. The Scottish government provided adequate funding to support training and implement change. . A steering group was established for the initiative at the strategic level, which involved policy maker, education, research and practice. . A training programme including special skills training consisting of 26 days of study, a programme of 72 hours supervised learning in practice, along with a competency-based assessment was designed and implemented. . A range of staff who met the criteria for the training were recruited. . Qualified prescribers took full responsibility for patient care. . A leading practitioner in each board was pointed to link the local board with national government. . A fair and structured monitoring process was available such as peer review system. . During the implementation process, practitioners had support from different levels and good leadership. However, it was difficult to find a designated medical practitioner and to keep the database alive as people moved. In particular, there were delays in getting prescribing pads due to administrative issues at early stage. . Education and practice worked collaboratively
Outcomes	.The initiative improved the range and the quality of services for patient care, in particular by providing quicker and safer access for patients. . It is a good example of an initiative that has evolved over time. . The extended role caused minimal/no disruption and had dedicated funding and support. . The initiative was successfully developed and sustained by the programme carried out in Scotland. . A challenge for the NHS and their workforce . Very high level of professional and organisational commitment.

However, deeper and richer information was obtained from six in-depth case study interviews, drawing on contributions from the different stakeholders. They gave valuable insight into experiences of the policy to practice initiative. The following sections discuss the interview findings in more detail.

6.2.3. Interview findings

The interview findings were drawn from the initial thematic framework analysis of the interview data, which investigated the processes of policy formulation, implementation and impact based on Macduff's MAPPED

(2007) model. A complete list of the key themes and sub-themes for Case 1 is provided in Appendix 6 to exemplify the analysis process for a case (similar listings are not shown for case 2-4). The following sub-sections provide a summary of these themes with indicative quotes from participants to enhance meaning.

6.2.3.1. Themes relating to policy formulation

In regard to policy formulation, interview participants were asked about policy drivers, plans for policy enactment and risk management. The themes relating to the policy formulation process in Case 1 are presented below.

6.2.3.1.1. The main themes relating to policy drivers

According to the participants (see Appendix 6), the main drivers for the initiation of policy development included:

- Legislation
- Political drive
- Lobbying by key people
- Professional development and service needs

Legislation

Legislation was generally voiced as one of the key drivers which led to policy change.

'*…Really I think probably without the legislation it would never really have happened…So is there a good example of how, I don't know if it would come into your model, how that kind of ideation becomes practice through having a legislative process* (central initiative staff)'

Political drive

Some participants highlighted political drive as the force behind the policy.

'*…different subsequent government policy directives and changes in staffing levels and medical staff levels (*practitioner)'

Lobbying by key people

In addition, participants thought that key people lobbying at government

level were fundamental in influencing policy decision making.

'*…and also nurses themselves would have lobbied…, so nationally it was pushed by the Royal College of Nursing nurses themselves, also Miss Crown or whatever pushed* (manager)'

Professional development and service needs

On the other hand, most of participants stated that professional readiness and development, along with the needs of the service, were the basic factor behind policy change.

'it could have been lots of different reasons. Individuals that were keen to develop it within their area of practice, nurses were keen for their role to develop… I think people keen to develop their roles is one of the big things' (practitioner)

6.2.3.1.2. The main themes relating to planning for initiative enactment

The planning process to develop and move forward the policy initiative was explored. The main themes which emerged are seen below.

Strategic plan

In order to move the policy initiative forward towards enactment, the participants felt that a workable strategic plan was essential at national level and within the health boards. Furthermore, at national level, the development of a functional plan was perceived to help when considering the different contexts, the rational for resources allocation, and in predicting future benefits and establishing risk-management etc. Within the health boards, a detailed plan was seen to ensure that the policy initiative was implemented following the correct procedures. However, some participants felt that a strategic plan had not really been properly developed at the launch of the initiative.

'…so I think now we're in a position where we don't have people coming onto the course qualifying as prescribers and then not using their skills to the full. It's properly planned and a much more strategic process back in the boards' (central initiative staff)

Role establishment

Role establishment was viewed by the participants as another key theme related to planning for initiative enactment. While some stated that roles were well established, others claimed that the role boundaries were vague and confusing and needed to be clarified.

'…as well you know, everything was a wee bit more airy fairy and not too specific, so there were an awful lot of issues that we had around, what your role was, what your boundaries were and what you could prescribe. There was an awful lot of misunderstanding around that' (practitioner).

Infrastructure

Infrastructure was seen as important and took time to build.

'…it is one thing saying that legally you can do it, but to have the support in place and to have the governance and the policy, the education in place, not just in terms of getting a qualification but also to make sure that the infrastructure to go on and support was in place' (senior manager)

6.2.3.1.3. The main themes relating to risk management

Identifying risks is the first step towards risk management. In this case, some participants did not see any risks at all, others felt that a small number of risks existed. The main themes relating to risks identified in Case 1 are the following:

Incompetency

The participants expressed some concerns about the extended role. They felt that some staff were dealing with work beyond their expertise. Their skills and knowledge were not good enough to fit the specific role, given the limited training.

'The risks are, as they are with probably anything that a clinician does, that there are some clinicians that may not work within their competency and maybe prescribe things that they don't know about, don't know enough about, is not within their area of expertise, because it does say that you prescribe within your competency' (manager)

Risks in practice

Some felt that non-medical prescribers might feel free to use their power without following the rules, which could cause harm to patients.

'*…another issue, of course, was, that people felt if nurses could prescribe then it would be like carte blanche, they would be able to prescribe what they like and they would, and the prescribing would shoot up and all that kind of thing'* (central initiative staff)

'*…so the risks have been relatively small in terms of the majority of staff, who do not go out to cause harm, obey the rules and think wider but think about their confidence and competence, the biggest risk is that if somebody goes ahead and does something that is out with that'* (senior manager)

Waste

Some participants found there was a lot of waste during policy enactment. In particular, some staff had been trained as prescribers, but they did not use their skills.

'*… but when we did our research there were some nurses that we interviewed who hadn't prescribed and they felt that they couldn't prescribe now, it had been too long after the course, so there was quite a lot of waste'* (evaluator)

When the participants were asked how to manage the risks, they gave a range of views. The main themes include:

Governance

The participants believed that well-structured governance would ensure patient safety and effective practice.

'*…and so getting the policy through all the levels to make sure that the organisation was assured, that public safety wasn't going to be affected, was a hard arduous process, because it was lots of changes at once' (senior manager)*

Selecting right people

One participant specifically emphasised that selecting the right people for the training and the job should be an important organisational consideration.

'…but we had to actually look at very specifically about what groups of staff we were going to enable to do this in the first instance' (senior manager)

Multiple ways to meet standards

Some participants expressed the view that the use of different methods to meet professional standards might reduce risks in practice and enhance professional skills.

'…the fact that the education adheres to the nursing midwifery council standards, and indeed the health professions council have similar standards, and so any education courses meets these standards for the professional regulatory bodies and that's what the higher education institutions provide, so we know that the training and the education meets the standards' (senior manager)

'…and we provide a non-medical prescribing conference every year. (.) We have a website with up to date web-links on the (…) internet, on the medicines and policies website, so that nurses can click into the Scottish Government guidance very easily and very into the NPC guidance very easily, so that they don't, they just have to go to one site and all these web-links are there and it is very easy for them' (manager)

6.2.3.2. Themes relating to the policy translation process

When exploring the policy translation and enactment within organisations, the findings related primarily to the education programme and the commissioned evaluation involved in this initiative. The themes emerging from Case 1, relating to policy translation and enactment, are summarised in Appendix 6.

6.2.3.2.1. Themes relating to the training programme

The opinions of different stakeholders about the training programme were very positive indeed. There was a broad spectrum of impressions about the training programme, for example, they described it as '*tight and robust'* with '*consistent joint development'*. It was '*a generic model'* with '*blended learning'*, *'the same standards'* and '*nationally recognised'*. It was '*enjoyable and powerful'*.

'…with the fact that it is professionally regulated as a module. so there are a couple of other so for example health visiting, district nursing post registration courses are professionally approved mentorship and practice teaching modules are, but they don't have the tightness that non medical prescribing has (educator)

However, there were some issues and challenges that resonated with the interviewees. In particular, the issues included course design, the need to make it 'cohesive' but to strike a balance with the generic model.

'…the mental health nurses, for example, would be asked to look in people's ears and it's not anything they would be doing in their normal job. so that was a big challenge at the start, moving away from forcing people to go down a certain path in terms of the education. They needed to enable the prescribers. That was a challenge to start with, but the course itself, aside from the clinical skills aspect of it, the course itself covered pharmacology, looked at numeracy issues and prescribing and practice as well. You had a couple of observation skills to do' (practitioner)

Some interviewees thought studying on the training course was difficult, given the limited time, especially for students from different backgrounds.

'…it is a six month module, so it is very difficult to deliver intensive pharmacology around every medicine for a lot of different clinical areas isn't it?' (manager)

During the training programme, there was also acute awareness of the process of recruitment and selection for training.

'…and we have practice recognised here, so that when we are actually interviewing somebody to go on a course, we interview them to make sure that the things that I have mentioned already, that there is a need for it, that the individual has the appropriate experience and that there is funding. Then the higher education institution and service come together to interview, to just hear how we think, that the member of staff is going to apply it' (senior manager)

6.2.3.2.2. Themes relating to policy translation and enactment

The themes that emerged from the perceptions of different stakeholders, relating to policy enactment are presented below.

Alignment

Participants generally thought that a good alignment at vertical and horizontal level was essential when implementing the policy initiatives.

'I just think that you have got policy, you have got professional regulation, you have got practice and organisations, and you have got a practitioner who has their own aspirations and their career, and I suppose in the centre

you have got service and patients, haven't you' (educator)

'…so the Scottish Government had developed a leads group, a non-medical prescribing leads group and that group still meets every two months to discuss issues on a national basis and then regionally or at health board level. The director of nursing had to, you know, she had to find a lead for non-medical prescribing. She had to ensure that managers and lead nurses were aware of the programmes and had the capacity to look at workforce and look at who they should put in the programme and that then has to be disseminated down to staff on the ground' (manager)

Key project roles

The following words: *'leadership'; 'champions'; 'network establishment'; 'alignment for key contacts'; 'supporting and facilitating'* policy implementation, were frequently used to describe the key project role.

'…in terms of maybe my role as non-medical prescribing lead, it's trying to ensure that the processes are there that people understand their responsibilities, in order that I can fulfil what is being asked of NHS from the Scottish government' (manager)

'…I think you probably need some champions behind these things, you do need people who can see the potential and they don't give into the people who don't believe it can make a difference' (central initial staff)

However, one stakeholder was keen to emphasise that the way in which the key project role holders functioned was influenced by their experiences and personality.

'…the board nurse leads were critical but not all of them worked at the same level and you know it depends, some of them were brought in from junior roles and It depends on who is in that role… the personality and their experience because they had to deal with some of the doctors resistance and they had to, you know, they were the vanguard they were at the sharp end' (evaluator)

Contextual, cultural and individual influences

It was thought that *geographical differences, medical-led services and organisational management* would greatly impact on policy performance.

'…I suppose geographically different and I think the issue in some of the smaller boards would probably be quite different from some of the large boards' (central initiative staff).

'…getting doctors on our side, so you needed doctors support, we were recognising that they could stop it happening if they really wanted to stop it happening. Doctors could have done that, I have no doubt (evaluator)

'…I suppose again culture was that you were directed to go and do this course and then you did the course and then there wasn't really anything set up to support you' (practitioner)

Some stakeholders also thought that local individuals could potentially influence the policy implementation, to a large extent by their enthusiasm, personalities, leadership skills and professional development.

'…I think it depended a lot on the local nurse director (.) some were very enthusiastic and wanted to break new ground. So they would be encouraging lots of different nurses to come' (evaluator)

Communication strategies

In this case, the importance of having a communication strategy throughout the policy enactment process was widely highlighted by the stakeholders, for example, having regular meetings, establishing a good flow of communication from top down, using different methods of sending information, having a good communication network and personally visiting the establishment. However, some interviewees expressed the view that communication was still a problem within and across vertical and horizontal communication networks.

'…six years on we have an established a meeting four times a year and we have representation from every board in Scotland, including some of the smaller special boards like national services Scotland, NHS Education for Scotland and to a lesser degree Health Improvement Scotland (.) we have an education representative from high education institutes (.) we have somebody who is either in a strategic position from each of the health boards or who has a direct link to somebody in a strategic position' (senior manager)

Monitoring and feedback

The process of monitoring was mostly seen as a fundamental issue that required managing in different ways, such as by audit, peer review and active feedback. On the other hand, some interviewees said that the process of monitoring was not in place at beginning, and was not accessible for everybody.

'…I think initially the monitoring was fairly structured, in that the lead for non-medical prescribing within the Scottish Government would come to health boards and would go through…now, as it has become embedded, it is less formal. Now health boards are going to start peer reviewing. (.) I might review NHS processes and they might review mine, so there is going to be less rigorous monitoring, I suppose, by Scottish Government' (Manager)

Furthermore, while one manager specifically emphasised how feedback influenced the policy changes from bottom up, one practitioner stated that proactive feedback depended on different boards in the middle stage of the policy enactment.

'…and their responsibility is to look out how non-medical prescribing is monitored and governed within the board, but also to then influence changes in policy, how to feedback on legislation, or indeed what has to happen at a national level' (senior manager)

'…but at the time none of this was there, so the feedback would depend on how proactive you were locally, as to how far forward it went and I know certainly we did it very well but in other health board areas people weren't as proactive. I don't think from my knowledge of it was not so proactive, so feedback wasn't probably as good then, but certainly now the processes are set up, organised, and the feedback is much better and communication is much better' (practitioner)

Main issues relating to the process of policy enactment

During the policy enactment process, a number of issues were raised by participants. They stated that the problems concerned the readiness of NHS boards for policy change, the disconnection between local NHS boards and central government, and the need for system change. In particular, for example, the delays in receiving prescription pads were highlighted as a major problem, which was linked to a lack of support and action by managerial and administrative system.

'…we had nurses who waited 9 months before they could get a prescription pad, because they had to get it from an office in Edinburgh and someone from their health board had to see that they could, that they were entitled to get a prescription pad and then they had to decide (.) and there were a lot of things like that that made it difficult (.)' (evaluator)

Some participants also expressed concerns about the diversity of policy implementation and getting governance in place, the need for more

effective and structured management and lack of direction when enacting the policy initiative.

'…the concept was good and it's been fantastic, the actual development of it, but in the middle you could probably have seen it could almost gone two ways people have because actually I have some colleagues said, I am not doing the course just now, because the rest everything else as the setup for me to do it not properly. So there were some people that stood back from it, because it was not properly organised, so that was probably the big thing then in its first development' (practitioner)

6.2.3.2.3. Themes relating to commissioned evaluation

Most of the participants felt that the evaluation report had a largely useful impact on policy development. For example, some stakeholders saw the value of a commissioned evaluation, which could provide evidence for policy to practice change, could lead the action for justifying and supporting the policy initiative.

'…but I think that the report showed that nurses were safe prescribers and that we were providing a necessary service to patients and a safe service to patients' (manager)

However, the limitations of a commissioned evaluation were particularly emphasised by the stakeholders.

'…The timing of the research and indeed the progression came at a point where it did little more than confirm what was happening and that wasn't because necessarily it was about the timing of it. There wasn't the full potential to explore it from a research perspective, such as you are doing just now, because it was quite young and immature in it's progression, so the whole initiative was still in the early stages within Scotland, the implementation was still very early days. We had a lot of barriers that we talked about. It was still very primary care focused' (senior manager)

6.2.3.3. Themes relating to policy impact

All the participants believed the initiative had great benefits in relation to both delivering and receiving services. These benefits included the professional satisfaction of being personally valued, professional autonomy and development, improvement of the quality of care, encouraging a good relationship with patients and allowing service redesign.

'…Basically it is allowing services to be redesigned in different ways and for

nurses to use their expertise for the whole patient journey' (educator)

'…yes huge impact, in terms of delivering the service, the ability to complete your episode of care, without having to go to get someone else to sign a prescription or the other big problem that there used to be, if you went to something with a patient assessment. They sometimes didn't agree with what you wanted to prescribe, so, because they were prescribing, you would have to go along with what they wanted to prescribe, so it got rid of all that' (practitioner)

'the main positive is that the intention to enable patients to get quicker access to drugs, to have a better interface and to improve that access, where we wouldn't normally attend a GP, so again I mentioned midwives and community nurses, so that whole access, that was a drive from the initial Crown Report, has improved and we have seen the benefits' (senior manager)

The initiative also had benefits in relation to patient satisfaction at having better access to a range of health care professionals and staying at home for continuity of care.

'the patient is usually very happy with the consultation and happy with the explanation that the nurse has given them around the medicine that they are prescribing for them' (manager)

6.2.3.4. The themes relating to lessons learned from Case 1

The key themes were synthesised from all of the main factors and lessons emerging from the three stages of the policy to practice initiative (the process of policy formulation, implementation and impact). They are presented in Table 21:

Table 21: Key themes emerging from Case 1

Key themes emerged from Case 1	Case 1 (sources: number of participants)
Alignment	6
Evidence for sustainability	6
Communication and awareness	6
Gaps and challenges	6
leadership and governance	6
Motivation	6
Network	6
Strategy	6
support from different levels	6
collaboration and partnership	4
learning experience	4
Legislation	4

Resources	4
role definition	4
flexibility and adaptation	3
longevity (long term vision and impact)	3
managing changes	3
Power	3
Consistency	2
Engagement	2
evidence-based	2
Innovation	2
local autonomy and government decision	2
Priorities	2
team work	2
bottom to up	1
incremental change	1
Ownership	1

However, many of these themes have already been exemplified through the extracts from interviews included above. In concluding reporting of Case 1, several of the key themes that yield particular summative and potentially transferable learning are now presented.

Sustainability

Every participant was convinced of the sustainability of this initiative.

'…Oh yes it will develop in new ways (.) it certainly won't go away (.) and okay the professional standards may change slightly there may be change of focus but I can't see non-medical prescribing ever going away (.) it is the role of the advancing nurse…so I think to be fair this is a good example of an initiative that has evolved over time rather than some of the other things where you would question for example the review of nursing and community in 2006 you know you would question the evidence base behind that even some of the modernising nursing in the community stuff that is going on now' (educator)

'…I would say that since 2004 nurse prescribing has continually sent people on the courses. The courses are fairly well subscribed so there must be a need there and we must obviously be able to sustain it' (manager)

'…sustainable in terms of is going to keep going because they keep putting people through courses at and some nurses will leave health service but others will develop up so I think it will be sustainable' (practitioner)

'…the way that prescribing has been done it has been very good as an example there are lots of examples that are akin to the process that we have gone through in that it is positive but other initiatives haven't always benefited from that national drive funding and that collegiate work' (senior manager)

Leadership and governance

Strong leadership and governance at different levels were generally viewed as the key to leading the policy initiative effectively.

*"...I think one of the ways this has been effective is this leadership thing in the boards, it's a really key thing, if you have identifiable line leaders who are really clear about what their responsibility is, they understand what the strategy is" (*Central initiative staff)

*"I think that the positive is about leadership at a national level, leadership at a regulation level and leadership at a health board level. Now I am not saying that it all happened smoothly, but when it fell into place, I think that what you have seen is a marriage of leadership and innovation, people who were wanting innovative services" (*evaluator)

'I think to have a lead non-medical prescribing group is a key factor and a positive and I think for health boards to have a lead for non-medical prescribing is a key factor and a positive' (practitioner)

Support

All participants thought that the successful transfer of policy to practice relies, to a greater or lesser extent, on getting support from different levels, such as support from government and professional bodies, support from health boards, leaders, managers and colleagues.

'you would question, where did they get that from, you know, it is plucked out of thin air, whereas for prescribing there has always been that bit about the service redesign and the goals that has been supported by professional bodies policy etc' (educator)

'I think the fact that it has had a government steer as support, there is legislation behind it and there has been funding associated with it' (senior manager)

Network

Every participant believed that a tight network at national and local level could ensure the smooth enactment of the policy initiative.

'…Nationally there has been quite a high profile. There has been a good combination of support from government encouraging the boards to work together linking with higher education, so these are the positives of the network' (senior manager)

'I know that's right, which is why it was good that we had that support network as well, that, you know, we could help direct each other'

(practitioner)

Partnership and collaboration

The importance of partnership and collaboration in translating policy to practice was well noted by participants.

'you question why I certainly wouldn't change the collaboration between our NHS partners. I think all the universities working together in Scotland particularly are a really good example of maintaining standards and consistency across Scotland and that the sharing of practice etc the development process' (educator)

'…I think that if you have got educators (.) nurses who are going to be prescribers or whatever the change is, plus other key stakeholders at a local and national level working together, then I think that that makes a huge difference and certainly the nurse prescribing leads network across Scotland network across Scotland, you know, their academic leads, their work together makes a huge difference as well' (evaluator)

Engagement and teamwork

Engagement of individuals and effective team-work were critical in taking the policy initiative forward, and participants had different ideas on this.

'…so they appreciate when they work in their teams with nurses midwifes and AHP'S, that it's a great advantage to everybody concerned if those practitioners can prescribe' (manager 1)

'…but if I was to be involved in the future in policy development like that, I would want to make sure that all the I's were dotted and the T's crossed and everything was in place that should be in place or you were not in a position to be able to know what should be in place, to help people that are working in those roles or doing those roles, involve them in the development of it rather than trying to direct to gain the knowledge' (practitioner)

Powers

One participant gave particular insight on the dynamics of power.

'…now someone can have the power to stop it happening, but actually they don't have the power to make it happen and in this scenario it is like this, doctors could stop it happening but it isn't necessarily them that can make it happen (.) it would have to be charismatic lead and I know from the (…) research that champions were identified, that if you were seen to be a champion and you had champion qualities, you knew that was someone who could take a few hits but get their way, though those were important people and sometimes they had power that they didn't know they had, but

it is power by proxy as well, it is like I have power in this organisation but the only power I have is my bosses' power and I get it (.) I have it by proxy, so I have authority and in central government can have (.) central government lead was a key actor and had perceivably a lot power but didn't have the power to change what was happening over there in that hospital five miles away (.)the power to change that hospital five miles away sits with someone on the ground and it's about knowing who (.) going back to what I was saying there about who has the power to stop it and who has the power to make it happen, and we suddenly encountered both in the scenario that we went through' (evaluator)

Legislation

The participants specifically emphasised the fact that legislation led the formulation of the policy initiative, saw it through and sustained it.

'I think the key factor was, well, I always with the key factor is that the policy got through government, because it is law to have to change the medicines act, so that was key' (manager)

Issues and Challenges

Every participant expressed some concerns about issues and challenges in policy to practice change. These issues related to inconsistent enactment of the policy initiative, a mismatch of expectations at national, regional and local level. However, these were mostly seen as having been overcome as the initiative developed.

"...it soon became clear things were happening piecemeal across the country and in some areas there was a prescribing lead and a prescribing group that fed into the area and a therapeutic committee etc. and in some areas there wasn't that" (Central initiative staff)

"...so they were already saying, before the report was published, there is a gap here, there is a mismatch between what you are asking them to do and what they are able to do, there needs to be much more of a major mobilisation at the board level, at the local level" (Evaluator)

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

6.2.4. Case 1 summary

Case 1 gives a picture of the processes involved in developing an extended role through a policy to practice initiative, based on the views given by six participants who were involved in the initiative and the commissioned

report. This initiative was led mainly by legislation and was disseminated successfully throughout Scotland. The extended role evolved throughout the development of the initiative to meet patients' needs for quicker access to health and to encourage professional development. The main lessons learned from this initiative came from the in-depth study. The following sections will present the findings from the other three case studies in a similar manner.

6.3. Case 2 (new role)

6.3.1. Main data sources

The main sources of data used in Case 2 study were gathered from the commissioned report and five face to face in-depth case study interviews. They are presented below:

Table 22: Main data sources in Case 2

Main data sources in Case 2
The commissioned report
Five interviews: two central initiative staff, one manager, one educator, one practitioner

6.3.2. The features of Case 2

Case 2 is a joint initiative between the Scottish Government Health Directorates, NHS Education for Scotland (NES), Higher Education Institutions (HEIs) and NHS Boards. It concerns the development of a new role for the workforce and has been rolled out across Scotland. The features of Case 2 are illustrated below.

Table 23: Features of Case 2

Features	**Case 2 (new role)**
Context	**Outer context:** **.** The minister for health visited clinical areas and was told about the lack of support for learning and practice. **.** Policy advocating an innovative way to strengthen the educational role. **Inner context:** **.** Each NHS health board was encouraged to establish an effective network with support from national level.
Process	**.** Tripartite joint secured budget to set up the new role and implementation of change funded by Scottish government, health boards and universities. . A steering group was established. . A core job description from NES for the new posts. **.** Recruitment of 100 full time equivalent posts for relatively senior practice-based staff to fill the new role. **.**Joint induction programmes to develop the skills and share experiences at national, regional and local level. **.** The new role has full responsibility for supporting mentors and for the learning environment in practice. **.** A leading practitioner in each health board and three regional coordinators are to link the local board with national government. **.** During the implementing process, there was strong support from different levels and good leadership. But initially the new role boundary was vague, people couldn't fully understand the new role, its implementation varied locally, and it was difficult to evaluate.

	. Education and practice worked collaboratively.
Outcomes	. Successful tripartite process between NES, health board and university. . Increased number of employees for the new role. . The leading network had a structured communication strategy and a good alignment for governance. . NHS partners and other bodies seemed positive about the programmes. . The new role was embedded in practice with secured funding and support but would be uncertain without these. . Enhanced work-based learning and strengthened the learning environment. . High level of job satisfaction

6.3.3. Interview findings

6.3.3.1. Themes relating to policy formulation

At the stage of policy formulation in Case 2, the dominant themes involved policy drivers and the management of the change process to develop the new role. Under the main themes, sub-themes emerged. The main themes and sub-themes relating to the policy formulation process in Case 2 are presented in following sections.

6.3.3.1.1. The main themes relating to policy drivers

The main themes relating to the drivers for policy formulation include:

- Lobbies for professional needs
- Political drive
- Secured funding

Lobbies for professional needs

Most participants thought that emphasising the needs of the profession to the policy maker would drive the policy.

'…Probably at the very beginning, and I'm going back to 2003, and just prior to that, the minister for health at that time had been visiting these different clinical areas, and people were telling him that there wasn't enough support for learning and practice that they missed having a clinical teacher. And they felt that there was a lot expected of mentors, of the nurses in the front line to support students without specific support' (central initiative staff 1)

Political drive

Some participants viewed political push as a trigger which transferred the policy into practice.

'…I suppose I was very clear in my own mind that it had actually come from policy and it had been recognised in policy and I think it was 'Facing the Future' was the original document, about really strengthening education roles' (central initiative staff 2).

Secured funding

Secured funding was viewed as a key factor in driving the policy forward.

'…I know there was a bit of discussion about how that would be funded and the initial idea was it was funded for three years and it was funded by NES, by health boards and by universities' (manager).

6.3.3.1.2. The main themes relating to planning for initiative enactment: developing a new role.

The participants identified the factors which helped to develop the new role. In particular, they thought that a tripartite arrangement, consisting of, a champion with the right background, support from different levels and the development of a core job description was essential for developing the new role.

'…So the decision was taken that we would have 100 full time equivalent posts. The salary was going to be paid mainly by ourselves, but there would be a contribution from the NHS board and the university together, so there was a sense of co-ownership of the post, but the majority of the funding coming essentially from us' (central initiative staff 1)

'…the thought was to develop a role, a facilitative role to support education in clinical practice and the boards were consulted about that at an early stage. and at that time it was very much, and still is, seen as a partnership between the boards, the universities and the Scottish Government or NES, which more or less are the same, cause the funding comes from Scottish Government obviously' (educator)

Some participants also found that having a functional action plan was vital in establishing the new role.

'…How I would develop a new role would really depend on what that new role was, what was I trying to do, how, you know, how much authority would the new role have to have. So am I developing a new role that has a bit of authority to act, where I can say 'here's the boundaries, let's talk about how these might be delivered'. Which, I would probably, if I look at the PEF work and I think 'would I do it the same?'. I would probably still, because it's my natural like a little bit more detail around the outcomes, around the objectives at the beginning but I would be less tempted to write

it in tablets of stone, which I might have done in the past and say 'it must do these things and deliver these for things and this is how you've got to do it' and that would be my inclination, but I wouldn't do it like that, but it would probably have a bit more structure than we had at the beginning'(manager)

One central initiative staff member highlighted that it was important to consider long term sustainability when developing the new role.

'…So the functions that were required were more these kind of functions rather than actually one to one direct teaching in clinical areas, because that could still be covered in other ways. So thinking about it then, if we were thinking about using that funding, think about the policy arena. What would give us the best long term sustainable support for nurses, was probably what was key to the thinking round about the initiative' (central initiative staff 1)

On the other hand, some participants recognised there would be challenges when developing the new role. For example, one central initiative staff member stated that priorities in different organisations might be challenging for the new role.

'…I think one of the areas, in some ways when you've got one organisation you work for, you're very clear on what the priorities are, there's such value in three organisations working together but there's probably always some shared priorities but there's probably also some competing priorities and there's probably, you know sometimes thinking 'is that organisation getting more of the PEFs that what we are?'. I don't know how you can prevent that' (central initiative staff 2)

Others felt there were barriers which could hinder setting up the new role. They said that some staff could not understand the new role due to lack of guidance that the role boundaries were not clarified and were open to different interpretations.

'…Every NHS board wanted them to do something different… every board, everybody had different expectations of them. And even the practice education facilitators themselves had different expectations' (central initiative staff 1).

'…We have quite a clear focus on what practice education facilitators should be doing and therefore they don't get just given a whole load of work and said 'right just get on with that' to the exclusion of what they really should be doing. I think that does sometimes, that is a problem, certainly in some

boards I know where you're looking round, you've got to roll out an initiative and you're looking around for who can do it and 'oh, there's PEFs, we'll give it to them to do' (educator)

6.3.3.2. Themes relating to the policy translation process

6.3.3.2.1. Themes relating to the training programme

During the policy implementation process, a development programme for training was launched. This programme provided an opportunity to shape the new role significantly in the opinion of the different stakeholders. In particular, the integrated tripartite induction (national, regional and local induction) was seen to be useful.

'...So what we did throughout that year is on a number of occasions we had, so when there was about 10 in post, we had an induction day, and then we repeated that, as people came into post. And then once we had them all in post we had a national day, so we brought them all together…so supported regional induction, so that would mean, for example, the cluster of practice education facilitators were working in the west of Scotland, we brought them together…So the induction was important, and the development was important' (central initiative staff 1).

When the participants were asked to characterise the training programme, they described it as a work based and co-ordinated learning programme. By means of the face to face induction and the use of online development resources, the new roles were able to strengthen their skills in terms of leadership, decision making and facilitating.

'…but really for me it was on the job, seeing what other people were doing. I shadowed a lot of people, I had an induction week and I spent time with various people and was given work to do, you know, training programmes to deliver and develop so it was really very much, for me, when I was here, it was developed as I went on. And over the years it's been development, development, development' (practitioner)

'…it was about facilitation, it was about coordinating learning, it was about influencing. It was about some of the leadership around the practice learning. And it was about looking at impact, so we focused in on a number of different areas for the development' (central initiative staff 1).

6.3.3.2.2. Themes relating to policy translation and enactment

The themes that emerged from the views of different stakeholders, relating to policy enactment are presented below.

Alignment

When implementing the policy initiative, a large number of people and organisations needed to come into alignment to support the policy implementation process.

'…Well, I think the key groups would be, we needed to have, Scottish Government needed to be signed up to this, NES as a national education organisation, the boards and it would be the Scottish Executive Nurse Directors of course, our senior midwives and our universities, our heads and deans of school but the practice education leads, so then you would have to drill down. There would be the people that need to agree to it, to make it happen, which would be the strategic level and then there would be the operational level under that, which would be the leads for practice education within all our organisations' (central initiative staff 1).

Likewise, a senior manager thought that it was important to allocate the new posts on geographical terms and on terms of professional speciality, in order to cover different areas and all the specialities within the area.

'…Even the way in which people were appointed, some were appointed full-time, some appointed part-time, some appointed on geographical terms, some appointed on speciality, so they would have mental health PEFs, they would have adult PEFs, they would have midwifery PEFs whereas here we have PEFs that are based in that locality, in this locality and the next, because we've got a span of 90 miles one way and 40 miles the other way and then 35, 40 miles that way. We're quite wide stretched, so we did ours geographically, so that people cover different areas but also cover all specialities within that area' (Manager)

Key project role

During the policy implementation process, there were some leading project roles. The key project roles were largely viewed as a supportive network, which could push, lead, support and facilitate the initiative enactment, and make it progressed more smoothly.

'…we worked on an action plan which they produced based on the national PEF priorities, which I'm sure you'd be aware of, every year it develops' (manager)

'… I have to work with them on a day to day basis, I have to listen to them and I have to translate that back to Scottish Government and to the university as well. So, it's a bit like being a bit of a broker' (educator).

Importantly, one manager looked on all the new roles as key project roles in carrying out the policy initiative. This was demonstrated by a practitioner, who described exactly what she did in the new role.

'…I've had this conversation with the PEFs before, they are essentially managing a project. The project is about mentorship and supporting mentors and Flying Start, these are all project roles in my view. Within the team the roles are exactly the same, there is nobody who has any different role within the team' (manager)

'…Yes. To start with, it was around mentoring the students and giving them support and ensuring that their learning opportunities and learning environments were set up' (practitioner).

Contextual, cultural and individual influences

While some participants thought that agenda for change and service redesign would, to a large extent, influence the policy implementation process, others believed that governmental drive would be the most influential when implementing the policy initiative.

'…Well, I suppose, I suppose with anything, the most influential in terms of making people do something, is a letter that comes from Scottish Government that says 'we require you to do something'. You can't get more influential than that. So even though it would be nice to say everybody did this because they thought it would be the right thing to do, that's not why people did it in the first instance. People did it because they were told 'you don't have a choice' (manager)

Furthermore, some participants emphasised that champions, the personality, attitude and motivation of individuals would directly impact on the policy enactment.

'…I suppose that we've got stronger characters, but I think for me it's everybody has their opinion and when we're together as a support forum it's, we have a lot of discussion and everybody, some people can be more influential than others. But I think we all agree or disagree or come to a stalemate, where we maybe take it to the next meeting or it maybe goes to another forum to be discussed further, so it's kind of, there's always influences' (practitioner).

'…they do a fantastic job, they have their mentor database which is up to date, they make sure they know who all the mentors are, they email the mentors, give them updates…So, influential would probably be the PEFs themselves and their motivation' (manager)

Team work

The participants thought that there was strong team-work nationally and locally, which had a great effect on the policy implementation process.

'…and then PEFs locally worked very hard and they also linked with their colleagues in other parts of the region, so the region has grouped together as a group of PEFs who work with each other and try and make things, so they've all linked to each other and they share a lot, they're actually very good at communicating amongst themselves as groups' (manager).

Communication strategy

A structured communication strategy during the policy enactment process was frequently note by the participants, for example, the setting up of regular meetings as a support forum at national, regional and local level; the establishment of a communication network by email and telephone. This helped people share their experiences, learn from each other and find solutions to deal with problems.

'…Well, communication strategies, we have the practice education support forum and that feeds up and down. It does to, certain things get fed back to committee and meetings through the university and certain things get fed back to NHS Education Scotland as well, so there's a good communication across and also there's a good communication within the practice education team across NHS' (practitioner)

'…They're now part of their communication strategy, we have six weekly Senior Charge Nurse meetings, so Senior Charge Nurses from across the region all come together every six weeks. PEFs have a standing agenda item on there' (manager)

An educator pointed out that openness, in terms of listening to everybody, was vital as a communication strategy. She also highlighted that inflexibility could hinder a good flow of communication.

'…Inflexibility would be the greatest danger to that whole project, I think, from any stakeholder, so if somebody suddenly comes along and says 'well actually, we're going to do it like that and that's how I say it's going to be delivered' then that would probably be a death knell' (educator).

Monitoring and feedback

This initiative mainly used a reporting process and feedback from students, mentors and other staff to monitor the initiative. In addition to this, the monitoring process also incorporated feedback from regional co-ordinators and leading project staff on the boards.

'…There's got to be some sort of a process, a reporting process around all of that in place and at a senior level in the board, we have to make sure we can get that information to feedback to NES' (educator).

One central initiative staff member felt that they had gained a 'multi-state perspective' on things, by drawing together all the evidence from various sources, such as the commissioned evaluation report, an annual review and NMC approval visits etc.

'…we've had a review, we're calling it the PEF review, and what we've tried to do is pull together all types of evidence, so we've used some of the evidence from the national evaluation, we've used information from your annual report, from our NMC approval visits, I think some of the feedback we get from events and what we've done is pulled it together in one document' (central initiative staff 2).

However, some participants criticised the reporting process, saying that it was not able to collect the right information effectively.

'…No, we haven't got that right I don't think. You know, if you were asking at the moment, and I think this came through the most recent leads meeting from all the boards leads exist, is that you're asking for the same information in several different ways and that's no good. You know, we haven't got time to faff about, I haven't got time, one of my reports last took it took me ten hours, that is not acceptable so, you know, we have to find some way of them asking us the right questions, how we get that information that enables us to quite quickly compile that report that they require. So, monitoring, it happens, it happens, we haven't got it right though' (educator)

Main issues relating to the process of policy enactment

There are several issues which emerge from the interview findings concerning the implementation of the initiative. For example:

Inconsistency

Some participants found that the policy initiative was enacted inconsistently within different health boards, in that there were different grading payments for the new role. Others thought that geographical differences led to inconsistent policy implementation.

'…and that did surface because of Agenda for Change, particularly. Because they were employed by the Boards, even though we were paying the funding to the Boards, it was the Boards responsibility around Agenda for Change. Different Boards ended up with different gradings, so that was a bit of a problem' (central initiative staff 1).

'…We'll always have differences, so in this area we're rural, we've got a big geographic area with a small population, so its spread around a lot of different areas, whereas in a city you'll have a very dense population in a very small geographic area, so there will always be differences' (manager)

Lack of understanding of the new role and need for more clarity about its boundaries and its' scope

During the policy implementation process, most stakeholders felt there was a particular problem in that people could not understand the new role with its vague role description. There was 'role creep' and lack of clear role definition and boundaries, which confused people.

'…But also because some of the Boards had extended the role which moved beyond just the Practice Education Facilitators, so some of them had a regional responsibility for some things, there was always a bit of role scope coming in' (central initiative staff 1).

'…I'm in a room when somebody said 'can we just get the PEFs to do that' which gives me the opportunity to say 'hang on a wee minute, that's not necessarily the role of the PEF' and to be able to easily explain why it's not the role of the PEF. So for instance, in one organisation the PEFs were doing flu vaccination, okay, now I'm quite clear that's not the role of PEF. Flu vaccinations do not come into a PEFs job description…Emergencies are one thing, but not allowing routine work to get in the way of the job, that's what we have to do' (manager)

6.3.3.2.3. Themes relating to the commissioned evaluation

Some participants felt that the commissioned report was crucial in providing evidence for the development of the new role. They thought it was a good report.

'…I think the evaluation report highlighted some of the strengths of the role' (central initiative staff 1)

'…Yeah, I think it's a good report. I think, particularly, any evaluation report is very welcome and yes it's very useful. Yes, definitely' (educator)

However, some participants criticised the fact that the commissioned evaluation research was limited by time and methodology. For example, the response rate was very low. They further pointed out that the report focused only on how the policy initiative was implemented and what the impact was.

'…I think there were challenges, as there always is, in response levels particularly, you know, around certain responses. I think it's like any evaluation, you're never quite sure, you know, you could just, because people volunteer to participate in research, sometimes you get the people who are enthusiastic and motivated, so maybe you don't always hear about the people that have concerns' (central initiative staff 2).

Noticeably, when the participants were asked about the report, some had never read it.

'…For the original? I did a number of years ago, I haven't read it recently, I have to admit hand on heart' (practitioner).

6.3.3.3. Themes relating to the impact of the policy

The participants thought the policy initiative was valuable in that it put education strategy on the agenda for health boards, which helped them set up a structured learning environment. They viewed the new role development as a lynch pin between practice and education.

'…we have placement areas that are much more geared up for education and learning than they might have been in the past and it isn't just by chance that they're good learning environments' (manager)

Some participants thought the initiative was a 'fantastic resource'.

'…they can pick up the phone to a PEF now if they've got anything at all, whether it's a cause for concern, whether it's a question about reasonable adjustment they have a direct line, they pick up the phone and I think that's when the PEFs do find that they get people will come to them with issues, with questions, so there's a fantastic resource' (central initiative

staff 2).

However, a practitioner who was employed by the local health board, said that the policy might not be the same in practice for other employees of the NES, because they had 'different focuses and viewpoints'. She further pointed out that some areas were not covered by the new role, which resulted in inequality.

6.3.3.4. Themes relating to lessons learned from Case 2

The key lessons learned from Case 2 are illustrated in Table 24. As explained in Case 1, only several key themes are exemplified below.

Table 24: Key themes emerging from Case 2

Key themes emerged from Case 2	Case 2 (Sources: number of participants)
Communication	5
Sustainability	5
Strategy	5
Alignment	4
collaboration and partnership	4
Gaps and challenges	4
learning experience	4
managing changes	4
Motivation	4
Resources	4
Engagement	3
flexibility and adaptation	3
leadership and governance	3
longevity (long term vision and impact)	3
support from different levels	3
compulsory issues	2
contextual and cultural factors	2
Innovation	2
Power	2
pragmatic initiatives and multiple policies	2
Priorities	2
role definition	2
team work	2
bottom to up	1
Consistency	1
incremental change	1
Ownership	1
service users	1

Sustainability

The participants described how the new role had become a permanent post within the boards and had become part of the infrastructure. It has evolved over years across Scotland.

'…So we had quite a bit of work to do with Government saying 'well we think this is going to work in the longer term' and securing funding beyond that. That was quite a sea change, because it meant the post then became a permanent post within the Boards and that was a significant difference in terms of how they were perceived within the Board. So they were no longer a 3 year project, they became part of the infrastructure. And as I say, we now fund them and we see that as part of our resource that they go out a permanent way' (central initiative staff 1)

'…Also, there's the responsiveness of the role, you know, as it started out seven or eight years ago, a role can't be made absolutely the same, you know, it's got to evolve in relation to what's required from the service and I think that's one of the big things and we have to work on it' (educator)

Strategy

Some stakeholders felt that developing a functional strategic plan and giving clear guidance nationally was the key to reducing the vagueness surrounding the new role. For example, one manager said:

'…What we didn't have, and we didn't have it for quite a long time, was even a standard job description for all the PEFs in Scotland, we had an outline job description that you could just add a bit to yourself. So there were quite a lot of things that were vague at the beginning, partly because the idea was a concept rather than anything else and I'm not sure that anybody realised how it would work or how it could work' (manager).

Collaboration and partnership

Every stakeholder agreed that collaboration and partnership were essential for policy to practice change. They specifically highlighted the tripartite funding secured by the government, boards and universities, which was extremely successful.

"...and a good thing about it was that it started out as a partnership initiative and that has always been, you know, I would say that has always been a shining light of the project and if we were to talk about other initiatives since then, and why they make or break, then if you don't have that, that we had from the beginning, then you won't get the same results that we've got, so I think partnership is important" (Manager)

Communication

Most participants recognised that an effective communication system was vitally important to make the policy initiative run smoothly. In particular, getting people to clearly understand the new role was fundamental, in order to deal with the problems from policy to practice change.

"...you can't operationalise something in a vacuum and it is working and knowing that those influences like finance, like resource, change, they're all going to bring pressures to bear, so we've got to be mindful of those, you know, in terms of how we communicate, when we communicate, who with, but I think communication is the influencing thing really. Overall, along with at a lot of things that impinge on whether it's effective or not" (Manager)

Challenges

The participants experienced some difficulties and challenges. For example, at the beginning it was difficult to get people to understand the new role and to define the new role. It was also challenging trying to motivate the mentors and students.

'…for a key factor is us trying to motivate staff and enthuse them to be undertaking some education, which can be difficult at a time when they're busy and not very motivated…Well I'm very motivated, but yeah, it's trying too, if they're very busy they'll be like 'education, I'm not doing that, cause I don't have time'. It's low on their priority, where it's high on my priority' (practitioner)

'…It was very difficult at the beginning, because we were going 'what are we supposed to do, what does that actually mean in practice, what will it mean on a day to day basis?'. That was difficult, it was very challenging, but seven or eight years down the line I think we probably have got a good initiative, partly because it was vague enough' (manager)

6.3.4. Case 2 Summary

Case 2 was a national policy initiative established and supported by three joint organisations to develop a new role, in order to support the learning environment in practice and to ensure that student experience was of the highest quality, primarily through the support of mentors. This policy was driven mainly by secured tripartite funding and lobbies for professional needs. It has worked very well due to the enthusiasm of the new role staff under the support networks. This new role has evolved since 2004 to

become a permanent post in health boards throughout Scotland. However, the new role development had a few problems because of the initial vagueness of the role description and inconsistency in implementation of the policy. The main lessons learned from Case 2 were addressed. The next section will present the findings in Case 3.

6.4. Case 3 (general education framework)

6.4.1. Main data sources

The main sources of data used in Case 3 study were collected from a commissioned report and six face to face in-depth case study interviews. They are summarised in the box below:

Table 25: Main data source in Case 3

Main data sources in Case 3
The commissioned report
Six interviews: three central initiative staff members (see Section 3.6.2.2), one manager, one educator, one evaluator

6.4.2. The features of Case 3

Case 3 was a pilot initiative launched by NHS Education for Scotland (NES) and the Scottish Government in April 2002. It involved three strands to target specific groups of AHPs at different stages of career development. This study focused only on an on-line development programme for learning for everyday practice through a range of learning activities with additional support from work based mentors, in order to support newly qualified practitioners of all Allied Health Professionals (AHPs) in Scotland. The features of Case 3 are described below:

Table 26: Features of Case 3

Features	**Case 3 (General education framework)**
Context	**Outer context:** . Policy advocating an innovative way to reduce the high attrition rate. **.** Government commissioned NES to set up a national model to support newly qualified practitioners. **.** NES promoting a policy concerning careers and retention of staff **Inner context:** **.** Government had feedback from practice saying they required additional support to be fit for purpose.
Process	**.** Ring fenced budget to support the specific initiative and implementation of change funded by Scottish government. **.** Government funding was limited in duration. **.** Consistent materials for web-based learning were developed. **.** Designated time allocated by line managers. **.** Practitioners took full responsibility for self-directed learning through e-learning integrated into KSF. **.** IT engaged. **.** During the implementation process, there was support from different levels, but

	it was hurried, in order to implement the policy within the limited time. There was a lack of national guidelines resulting in inconsistent allocation of resources. There was no clear local policy set up. It was difficult to evaluate.
Outcomes	**.** The initiative was highly dependent on government funding **.** Good for staff retention **.** Consistent learning materials promoted consistent care. **.** Secure funding helped the completion rate. **.** High impact with self- reporting process. **.** Growth in confidence in their ability to do the job and good prospects for career development. **.** The initiative stopped because of lack of funding.

6.4.3. Interview findings

The subsequent subsections will show the findings in detail.

6.4.3.1. Themes relating to policy formulation

At the stage of policy formulation in Case 3, the main themes and subthemes involved policy drives and planning for policy enactment. They are presented in the following sections.

6.4.3.1.1. The main themes relating to policy drivers

According to the six participants' views, the main themes relating to policy drivers included:

- Political support
- Professional lobbying about the need to support learning and practice
- Potential issues relating to workforce retention

Political support

The participants believed that political support was the main big driver for the policy development.

'they all seem to be underpinned by NHS policy and, in particular, by the sort of remit of NES which, at that time was very much focused on developing career pathways for Allied Health Professionals in particular, and also ensuring that they had appropriate staff in place' (evaluator)

Professional lobbying about the need to support learning in practice

Some participants felt a consensus among the professions that there was a need to support learning in practice was the thing which attracted the policy makers' attention.

'it came around in terms of the government trying to support newly qualified practitioners, so feedback had been from practice that those that were coming out required additional support to be fit for practice at the point of entry into the system'(central initiative staff 3).

Issues relating to the retention of newly recruited employees

Some participants thought that identified issues regarding recruitment and retention of the workforce were a driving force behind the policy.

'the policy was brought in because at that point in time, so would be around 2002, there was very high attrition rates with newly qualified nurses midwifes or AHP's in that first year of practice, with a lot of them leaving, so there had been a lot of money invested in their education. And then through one thing or another through lack of support, lots of different reasons, we had a very high attrition rate' (central initiative staff 2).

6.4.3.1.2. Themes relating to planning for initiative enactment

Regarding the plan for policy enactment, some participants thought that marketing and establishing objectives for the initiative were the first steps required to take the policy forward. Others felt that dealing with resistance at a strategic level would help people better understand the policy initiative before taking it into practice.

'yes, but it took a lot of negotiation and a lot of collaborative working. We also had some resistance from higher education establishments, as they thought we were rewriting their programme and they couldn't understand why we were asking them to go over the same things that they had gone over in their university courses' (central initiative staff 3).

6.4.3.2. Themes relating to policy translation process

During the policy translation process, an on-line training programme was established. The themes relating to the training programme are presented below.

6.4.3.2.1. Themes relating to training programme

Every participant thought the training programme was a very good on-line, work based resource for self-directed learning based.

'…The initiative had 10 core modules in it, things like communication,

research, evaluation policy, developing your clinical skills, developing your leadership skills, putting theory into practice. Those kind of modules. It's self-directed' (central initiative staff 2)

'there was some very good elements of it, for example clinical supervision, there was a very good section on clinical supervision and there was a very good section on critical appraisal and evidence-based practice and I used both of them, those units from flying start, as teaching aids, if you like to develop practice within the Allied health professional teams' (educator)

One manager stated that the training material benefited not only newly qualified practitioners, but also helped senior staff to find solutions to problems.

'but also I find it's actually a really good resource, I found for example senior members of staff that were having difficulties within their teams when they're working elsewhere and actually I advise them to go to flying start and get some of the information about resolving conflict or being more assertive, so it's actually a really good resource that I think other people can use' (manager).

However some stakeholders felt there were challenges for on-line learning, such as access to an IT system and time availability.

'the challenge was if it was web-based a big thing, then the challenge is about access to that, having IT systems that people can access, having time to be able to do that, but if we had done it in a paper document it would be sitting.' (central initiative staff 3)

6.4.3.2.2. Themes relating to the policy enactment

The main themes that emerged from the views of various stakeholders regarding the policy enactment are presented below.

Alignment

When putting the policy into real practice, a national steering group was formed to direct the programme. However, it very much depended on individuals to work through this initiative.

'the main groups would have just been as I said, the practice education facilitator, myself and whoever their supervisor was, because it was initially left up to the individual to work their way through it' (manager)

Key project role

During the policy implementation process, participants generally thought the functional roles of the key personnel, who were to take the policy initiative forward, were structured by leadership at national level and by local health boards. One manager highlighted that the practitioners themselves as playing a key role in the policy translation process.

'from a manager's perspective, ensuring that staff were aware of flying start and actually having time to access flying start within work time is part of their CPD, but also for them to understand that was an expectation that they would also do it themselves and it was not just time out of work, because it is a huge commitment completing flying start, so from that perspective I used it for that' (manager)

Context, cultural and individual influences

Some participants felt that geographic differences were of significant influence, when translating the policy into practice. For example, the initiative was not enacted in some remote and rural areas because there were no suitable staff.

'in a larger health board you would have many many new graduates starting work and they qualified in the summer see you ever cohort of new graduates starting would support each other through flying start… in the Allied health professionals we didn't have one single person to put through it, because it's a very small cohort staff. We had no vacancies and we had no money to recruit new staff, so I didn't use it as it was meant to be used, because we had no new graduate staff' (educator)

The professional culture and ethos of the profession was also viewed by the participants as being significantly influential when implementing the policy initiative.

'I suppose the only culture that was really influential was the fact that some people still had that difference between student culture and practitioner culture. That is a huge transition from student to practitioner and I think there was a lot of resentment at having to do it, because previous staff did not have to do it, because it was a new initiative, so there was a bit of that they thought they were guinea pigs at that point and had been given extra work to do to complete flying start' (manager)

Accordingly, some individuals were identified because of the responsibilities of their role, as having the potential to impact on the policy implementation.

'I suppose the practice education facilitator is the most influential person, because they were following it through' (manager).

Communication strategy

When implementing the policy initiative, a structured process of conversation was established through NES and health board leads. This provided great opportunities for critical stakeholders including practitioners to meet regularly and to share their practice and ideas.

'The communication is through the board leads, that's the main communication. The board leads meet, they meet regularly, they share practice, they share ideas, they share what's working. When board leads meet, the Flying Start team within NES attend that meeting but the Flying Start team within NES are trying to withdraw, in terms of the chair of that group are now the board leads, it's not chaired by NES. We facilitate the meeting in terms of venue, preparing an agenda but we're trying to get the board leads themselves to chair and to drive' (central initiative staff 2

However, one manager felt that the communication from top down seemed ineffective.

'we were not really part to that. We knew that there was that initiative to do it, but it was only local information we would get from the practice education facilitator to put it into place. I wouldn't say there was anything from a national perspective that was coming down to our level at all' (manager).

Monitoring and feedback

The participants thought that the monitoring system for the policy initiative was not well developed. It focused only on monitoring the completion rates within individual health boards. The feedback mainly depended on the evaluation reports.

'it's monitored within individual boards, so they try and monitor completion rates, it's not consistent' (central initiative staff 2)

Main issues relating to the process of policy enactment

During the policy translation process, several issues were of concern to the six participants. They emphasised the following:

Timing

One manager stated that it was difficult to have enough time to complete the training programme.

'the biggest problem if you like is the time factor that it takes, because even from a professional body they're saying that CPD should be approximately a half a day a month. Now I don't think for one second that you can complete flying start, the whole of it, in one year in one half day a month. I just don't think it would be possible' (manager).

Difficult to disseminate the initiative

Some participants pointed out that disseminating the policy initiative was affected by geographical restrictions and health board priorities. It was also thought that the policy initiative was not well received by new AHPs.

'I have a lot of people felt that the flying start was rolled out to the AHP's as just a sort of afterthought, without taking into consideration their prior learning and at the level at which they worked, and I don't think it was well received by many new graduate AHP's' (educator)

6.4.3.2.3. Themes relating to the commissioned evaluation

Most participants believed that the commissioned evaluation report was valuable, that the report showed the progress of the initiative and provided a basis of evidence for future development of the policy initiative. However, some participants doubted whether the evidence obtained from the small sample was valid and the evidence was not made full use of.

'think what it did was providing us with the actual evidence of what we knew. We know in my role with very much linked into the successes of flying Star and other areas and very aware of the areas that maybe aren't, haven't got as good completion rates' (central initiative staff 3)

On the other hand, there were some practical problems when evaluating the programme. For example, one evaluator said:

'when you undertake an evaluation right at the end of the implementation of the initiative it's quite difficult because, obviously ideally you want to be at the start and then at the end, you know, you want to do that pre test, post test, obviously that's not always possible, it's not always practical or, I mean, we obviously undertook our evaluation and we put forward our recommendations which were that, you know, this was something that was positive, that was potentially making a difference, now from us having made our recommendations I'm not sure what happens next, but I understand it's, that Flying Start's no longer used with this particular group' (evaluator).

6.4.3.3 Themes relating to the impact of policy

All of the participants thought that the policy initiative had a positive impact in helping new graduates enhance the knowledge and skills required to enable career development and progression. The main themes included:

Professional development

The participants felt the initiative strongly supported newly qualified practitioners in developing their professional career and in building up their confidence and capabilities in real practice.

'And I think it's also, there were actually some individuals as well, from my recall, who were able to progress much faster through a career framework' (evaluator)

'I think it helps to deliver confident and capable practitioners I think there's been the impact. We have done an evaluation of the programme and we've done an evaluation of the key things that make it successfully help completion' (central initiative staff 3).

A standard and structured learning environment

The participants believed that the policy initiative provided a standardised and structured learning environment for newly qualified practitioners. This promoted the delivery of consistent care for patients, patient safety and quality of service.

'but what it should be is actually making practice safer and a higher quality and standardising it across the team as well, so people are working to the same standard of proficiency, then it should ensure public safety for our

service users' (manager).

6.4.3.4. Themes relating to lessons learned from this initiative

The main lessons learned from Case 3 are presented in Table 27 and several key themes will be highlighted below.

Table 27 : Key themes emerging from Case 3

Key themes emerged from case 3	Case 3 (Sources: number of participants
Sustainability	6
Accountability	5
Alignment	5
Bottom to up	3
Collaboration and partnership	3
Communication	3
Consistency	2
Constructive network	2
Contextual and cultural factors	2
Engagement	2
Evolving network	1
Generating feedback by events	1
Good structure (vertical and horizontal integration)	1
Incremental change	1
Infrastructure	1
Integrated with other initiatives	1
Leadership and governance	1

Sustainability

The policy initiative was partly seen as unsustainable, due to the funding being stopped. However, the participants said that newly qualified practitioners would be still expected to complete the same training without funding.

'That scheme was, doesn't exist anymore… The Flying Start still exists and people are still expected to do Flying Start, but there's no money any more for the AHPs, personal money for the AHPs to, you know, to get through doing it. They're just expected to do it. I think that was quite an issue, that when the money stopped there was a message that went out, that people seemed to think that HPs no longer have to do it anymore, but they were expected still to do it, even if there wasn't any money anymore.' (central initiative staff 1).

Strategy

Some participants were of the opinion that a structured strategic plan would make the policy initiative more effective and efficient.

*"...I mean in terms of the strategic level, I think the value and importance placed on the initiative was in terms of developing the workforce, cause that was really, and still I think still is, seen as very important in Scotland, and I think they've developed those policies and those practices around that quite well" (*Evaluator).

Engagement

Some participants felt that getting people truly engaged with the policy initiative was critical, if practice was to change.

*"I think the sort of engagement part is that the people who have been through the programme couldn't see the relevance at the beginning, but at the end absolutely see how they have grown" (*Central initiative staff 3).

*"...And I know it's going to be difficult in some teams but actually, people will always find excuses not to do things if they don't see the value of it. So for me, that is the key issue, it's about individuals at each level buying into, being truly engaged with the process and the initiative, otherwise it will just come and go" (*Evaluator).

Challenges

The participants talked about some problems and challenges arising from Case 3. In particular, one pointed out that controversial funding was the key factor in the discontinuation of the initiative.

'Scottish Government had some additional money available which was there just for the HPs, it was never there for the nurses or midwives, so that was quite controversial' (central initiative staff 1)

6.4.4. Case 3 summary

Case 3 gives an example of a policy initiative concerning the development of a general education framework, to help the newly qualified practitioner build up their confidence in practice and to deliver consistent and standard care to the patient. The policy was driven mainly by professional lobbying in respect of the need to support learning in practice, and the potential issues of staff recruitment and retention. Scottish government funded the

initiative in the short term for specific practitioners to complete the training programme. The initiative was spread all over Scotland apart from some very remote and rural areas where no newly qualified staff was available. The specific financial support meant that there was a high completion rate for the training among the newly qualified practitioners. However, once the funding ceased, the policy initiative was unsustainable. The main lessons learned from Case 3 were also addressed. The following section will present the findings for Case 4.

6.5. Case 4 (enhanced role)

6.5.1. Main data sources

In the Case 4 study, the main data sources included a commissioned report and seven face to face in-depth case study interviews, details of which are in the box below:

Table 28: Main data sources in Case 4

Main data sources in Case 4
The commissioned report
Seven interviews: one central initiative staff member, one manager, one educator, one evaluator, one practitioner and two service user representatives

6.5.2. The features of Case 4

Case 4 was a national policy initiative which aimed at enhancing practitioners' knowledge, skills and behaviour to achieve best practice, through a specific training programme across mental health services in Scotland. The features of this initiative were drawn from the commissioned report and interview findings (see the Table 29).

Table 29: Features of Case 4

Features	**Case 4 (enhanced role)**
Context	**Outer context:** **.** Government had feedback from the national review of mental health nursing in Scotland. . New legislation for mental health nursing; Dissatisfaction with service users in UK. **.** Policy advocates innovative way to change in practice **.** Compulsory policy action plan**.** **Inner context** **.** Professional review **.** International professional influence **.** Service needs
Process	**.** The Scottish government provided adequate funding to support training and implement change. **.** Educational training resources were developed. **.** Commissioned voluntary sector organisations to delivery a training for trainers programme. **.** NHS board nurse directors to ensure the programme of training was in place. **.** The training programme involved two phases. First stage, NHS Boards nominated 68 participants to be trained as trainers in a five day training programme and a four day follow-up training programme that prepared them to deliver the training. The second stage was to enable the trainers to use educational materials as

	trainers, training them to be capable of delivering training and also of training others as trainers. The training took the form of an initial three day training as both trainees and trainers, then a two day follow up session that prepared them to recruit and train their own colleagues. . Three regional facilitator posts for two years were funded by government. Their roles involved supporting first wave trainers as they disseminated the training and also linking directly with NHS Boards. . The training time was designated and the training involved service users. . First stage training was compulsory policy with a high completion rate. . Staff shortages made the training programme difficult, and the second part of the training was not well attended because it was not compulsory.
Outcomes	. The initiative was influenced greatly by compulsory policy. . High completion rate and attendance in first training programme, but the second part of training was not. . Provided new knowledge and skills which led to more reflective practice and the involvement of more service users . Influenced the culture within practice . Promoted confidence . More service users' voices heard . The training materials were integrated into the pre-registration programme

6.5.3. Interview findings

6.5.3.1. Themes relating to policy formulation

In Case 4 at the policy formulation stage, the main themes emerging from the seven in-depth interviews involved policy drivers and a strategic plan for enactment. The next subsections will explain in detail.

6.5.3.1.1. Themes relating to policy drivers

The leading themes regarding policy drivers are presented below:

- Political advocacy and Professional review
- Human rights–based legislation
- National and of international influences
- Dissatisfaction of service users and service needs

Political advocacy and Professional review

Some participants thought that political support and a professional review were the main driving forces behind the context of the policy.

'the initiatives came out of the Review of Mental Health Nursing in Scotland…so that the Scottish Government wanted to take the review forward in the context of a changing and emerging policy and legislative context in Scotland' (central initiative staff)

'In 2009 the review of mental health nursing in Scotland, one of the key

drivers for the review was based on the idea that the mental health services needed to enhance and develop what we do in terms of mental health nursing so that people who use the services, the service users, the families, the carers, can have continuous improvement in their experiences as users of the services and also to have better care outcomes, you know, for them. So that was one of the key drivers that led, you know, to the review' (evaluator).

Human rights–based legislation

The participants regarded the new legislation for mental health based on human rights as another trigger for the policy development.

'There was a strong force for change in Scotland in mental health practice because of human rights based legislation, a move towards recovery, and service redesign. So it took place in that context of supporting change' (central initiative staff)

National and of international influences

One educator stated that national and international influences had an effect on the initiative development.

'So the kind of drivers really, nationally were coming from the kind of Sainsbury Centre down south, but mainly the stuff that was happening in Australia and New Zealand around recovery focused practice and involving people more meaningfully in their care' (educator)

Dissatisfaction of service users and service needs

Most participants believed that there was a need for change in the service to fill the gaps and that the service users' movement influenced the policy makers.

'I think that there had been an increase in more custodial care which is probably down to a number of reasons, but probably reductions in staffing. It's easier just to watch patients and keep them safe than actually engage with them… And I suppose lots of hospitals were getting smaller so we were just getting the really unwell people, less easy to work with, I suppose. And I think that there was general outcry about what it is that we, you know as mental health nurses we need to stand up and set out our stall and say what it is we do, what it is that makes us different, what do we do that an occupational therapist can't do, that a physiotherapist can't do, you know, we had to really identify what our, what our role was' (manager)

'why did it emerge, because the review of mental health nursing suggested a particular direction for mental health nursing, and as part of that we

recognised that we needed to have new skills and abilities, within the workforce, so the decision was to make training available to fill that gap' (patient representative).

'So I think a lot of it kind of came from that. I think there was also the service user movement was beginning to create, or beginning to develop an influence at the Scottish Government level to say 'We're really not happy with what we're receiving'. So I think that was probably one of the main drivers, people receiving services being uncomfortable and people were delivering services saying 'well how can we actually formalise care?'' (educator)

6.5.3.1.2. The national strategic plan for enactment

Concerning the plan for enacting the policy at the strategic level, the main themes included:

- Strategic leadership
- Resource preparation

One central initiative staff member explained that having visionary strategic leadership was essential in taking the policy initiative forward. The leaders took charge of the development of learning material to prepare for change and put infrastructures in place to support the policy change.

'At high strategic level, at boards, there was a values base that supported what we were trying to achieve, and enough strategic direction to make things happen by mobilising things within boards, and setting out a vision, and providing the leadership that was needed' (central initiative staff)

'We firstly developed learning materials, the Ten Essential Shared Capabilities (ESCs) at NES. A year after that we developed the Realising Recovery learning materials. So we developed the educational resources… We then commissioned a training for trainers programme, firstly to roll out the Ten Essential Shared Capabilities (ESCs), and thereafter Realising Recovery' (central initiative staff).

6.5.3.2. Themes relating to the policy translation process

During the policy translation process, the participants were asked about the training programme. The main findings emerging from the seven in-depth interviews are explained below.

6.5.3.2.1. Themes relating to the training programme

The views of the seven participants regarding the training programme were generally positive. The training was considered to be fairly 'enjoyable', a 'reflective process' and presented in a 'creative and productive way'. More specifically, this training programme involved service users, so that the trainers had 'lived experience'.

'So the primary evidence base that we used to create these kind of materials were Scottish Recovery Networks Narrative Research Project so the, a lot of the examples, the case studies, had been drawn directly from people's real life experience of recovery, so that's quite a different, that's unusual for a training resource in that's it's not just an expert opinion. It was very much about the lived experience of recovery, so I think that was quite a significant outcome as well. It was part of a shift in Scottish mental health towards recovery focus' (service user representative)

'And I think as well, just allowing staff as well to look into their attitude and change their thinking really. When I did the course, it was like a two day course but then I think they kind of disseminated it down to a one day course initially it was done. But it has, as I say, it's a lot more patient involvement' (practitioner).

'Up until then I'd been involved in delivering training, but it was always very, very focused on expert rather than lived experience. So that was good and that was something we replicated in health board. We had people who'd used services come and help us deliver the training to staff and that was really powerful I think' (educator).

However, some participants commented on the difference between the compulsory and the voluntary training. While the compulsory training had a high completion rate, the voluntary training was affected a lot by people's interests and the leadership commitment.

'One of the advantages that recovery has had, is through some of the initiatives not being compulsory, so people have come it much more from the heart. So you get the people who are committed and you get the enthusiasts but you don't necessarily get the people who are not committed and who are not interested. So, it's not clear cut whether that, it would have led to more people being trained for sure but whether they would have taken any of it on board, the outcome may have been no different. So it's complicated. there are big pluses and minuses to compulsory. You need carrots and sticks…Well there's arguments over that I don't, I think there's pluses and minuses for both. If it's compulsory then people potentially can put up more resistance and it feels like it's another top down ruling from the government' (service user representative).

Some problems regarding the training programme were also recognised by the participants. For example, some participants felt that the training course contained nothing new and that there was a lack of time for the training due to staff shortages.

'There were real challenges around some people believing 'well we do this already, this is nothing new' and we didn't sell it as anything new '(educator).

'There is obviously, as you know, all the managerial courses that we've got to do, but then at the moment as well with staff shortages and things like that, it's sometimes quite hard to get away to do training' (practitioner).

'but it was, you know, it was a lot of training for board areas to agree to. Cause it's so much time off the wards… so I think people need to have that protected time to come together and discuss 'well how values based has our practice been, what can we do to make our practice more values based?' So I think that would probably be a challenge' (manager)

6.5.3.2.2. Themes relating to policy translation and enactment

At the policy translation stage, the core subjects regarding organisational structure, the key project role, context and cultural influence, communication strategy, and a monitoring system were explored. The main themes are presented in more detail below.

Alignment

Most participants considered the network alignment, particularly the integration between vertical and horizontal alignment, was key to carrying out the policy initiative successfully. In particular, two voluntary organisations were commissioned to deliver the training for trainers programme, which was a very special alignment in implementing the policy initiative.

'Nursing, NHS bodies, nursing leaders, so directions of nursing for example there was also strategic oversight from a, there was a group in the Scottish Government who supported, who had strategic oversight of the work as well. But locally it would have been nurse leaders and people around them and then there was the spreading out to involve practitioners, front line practitioners' (service user representative)

'…and underneath the steering group we had groups for a variety of the

actions. So this was Action Group 1. Action Group 1 was around values based training, so we then had another group that sat, and it was mostly the trainers to be honest. They came together to decide how they, they would deliver it. But then you have to take back, so we created a plan but then that needs to go back to the steering group, to then go back to the operational group that sits from, you know, the service managers and I think it went to the Clinical Management Board as well in order to get their agreement' (manager)

Key project role

The participants had different ideas about the key project roles. Most of them thought that the provision of key project roles had played a significant part in leading the policy initiative forward, supporting the policy dissemination and implementation.

'the Programme Director at NES was taking that forward, the role of the National Implementation Group at the Scottish Government. For the recovery work, obviously the network director. We also had a person in post here specifically working across the two organisations on the recovery work. When we were supporting dissemination, we had three regional coordinators who supported the role. So there was a numbers of key project roles, both at the inception of the work, and also as we were trying to embed and sustained that. And there were roles within boards' (central initiative staff)

At the same time, some participants thought that key project roles within the health boards took different approaches. It largely depended on the people who were in that role showing their commitment to the initiative.

'It's entirely dependent on which area so I couldn't say, some places there may have been key roles and other places it just became part of someone's job. I don't think there were any jobs created out of this. I don't think there were specific, I mean there may have been people who were involved in organisational development or training, so it depends. I mean, it's 14 health boards and they all took different approaches' (service user representative)

Resources

Most participants thought that adequate resources were fundamental to ensuring the effective implementation of the policy initiative. For example, the participants explained the importance of giving time to staff for training and for delivering the training.

'There may be other issues pending that they need to use resources on to, you know, address. And implementing a policy initiative in any organisation requires a lot of, well requires resources, the resources have to be of quality, there is also the human resource, so human beings with the right expertise and skills to undertake the task at hand, they need resource in terms of time, resource in terms of expertise and knowledge, resource in finance to do that and then the man power' (evaluator)

'The negative factors, finance doesn't help. It, we have, you know, we have areas that are staffed to a safe level but not necessarily a therapeutic level, so that's a negative factor I would say that influences this and how you put it into practice' (manager)

Contextual, cultural and individual influences

During the policy enactment, some participants believed that governmental drive in conjunction with other policy agendas, would influence to a significant extent the process of the policy initiative enactment.

'Absolutely, yeah. I mean if they weren't there I'm pretty sure just because of the nature of things that the kind of, Minister of Health will have moved on to other things, I think the idea of Scottish Government tie in the mental health agenda and the social inclusion agenda helps it stays on as well as to do with health and wellbeing preventative care rather than dealing with problems as they arise, encouraging people to take ownership and responsibility for their health, mental health's a big, big part of that. So I think from that point of view it will stay on the agenda because there's no other way to go with it' (educator)

'And remember that this was part of the implementation of a much wider action plan. Where things were progressing well with the whole action plan, because everything was interconnected, they were progressing well with this. Where they weren't progressing well, it would be the same in both cases' (central initiative staff).

In addition, most participants felt that the culture of the organisation, in terms of the climate and the values within the organisation, was vitally important in shaping the policy translation process.

'There were real challenges around aspects of culture, so there's one thing saying 'we're going to work in a recovery focused way' and there's quite another when you're working in a recovery focused way and then within an acute inpatient service there's a critical incident so someone commits suicide or whatever, recovery focused staff can actually go out the window, because the organisation has to protect itself' (educator)

'Okay, I think from the culture, well thinking about the culture of the

organisation and how it's managed, I think was one of the first initiatives that really raised the bar for nursing. So I think that was why it was difficult because the culture was never to support that, you know, from a management point of view. The culture was never really to support a big initiative towards nursing. It was, there hadn't been anything like it before' (manager).

Moreover, some participants particularly highlighted the importance of the interests and efforts of individuals, and that policy initiative champions were the most influential when implementing changes around the initiative.

'The extent to which it was picked up was largely dependent on local interests in recovery and local leadership and local commitment to the whole strategy of change which is what the nursing review was, it was really a call for change in mental health nursing. So if it was an area where there wasn't really much interest in that, much, if there wasn't much leadership or much support for values based recovery focused practices then it didn't happen. So it was very important, to pin the leadership in that area was important' (service user representative).

Communication strategies

To translate the policy into practice more smoothly, all the participants thought that a well designed communication strategy was essential, so that everybody was engaged with the initiative change from top down to the shop floor. A variety of communication approaches could be used such as regular meetings and an annual conference etc.

'There is no point in the strategic leader coming to the organisation just saying 'this is what we're going to do, this is how we're going to do it' and pass it on to the middle management and leave them to get on with it, because that has been part of the practice, you know, in some organisations in the NHS. What they need to do is to have a key strategy which is well designed, well communicated so to each member of the organisation, so they need to make it is everybody's' business. Not a business for top level, middle level, it is everybody. And when it is everybody and, for example, the training in values base is done not just by front line staff or middle management but also their strategic thinkers, so there's a common understanding of what the values based is all about in mental health practice, then the possibilities of such an organisation being able to implement the action plans within the policy document is more likely than if only the front line is prepared for it and the middle layer management strategically they have not done the training' (evaluator)

Monitoring and feedback

In Case 4, the monitoring system consisted of feedback from service users and participants, the six monthly reports from health boards to SGHD and Action 1. The initiative was scrutinized by regional coordinators and other stakeholders. However, some participants believed that service users and practitioners were the best monitors of the policy implementation.

'and every six months we had to feedback to them about how, about the impact into practice, so we did that and then of course we would share that around all of the, all of the areas so that all of the nurses could see the differences that this was making' (manager)

'So in fact, at this point, one can argue that one of the monitors of policy implementation is the service users themselves, the practitioners themselves, if they are allowed to whistle blow, and then the organisations like the Care Commission that see people report to the Care Commission, the mental welfare organisation and the Ombudsman' (evaluator)

Main issues relating to the process of policy enactment

During the policy translation process, several dominant issues were of concern to the participants.

Diversity of implementation

All the participants stated that the policy was delivered very patchily within the boards due to various influencing factors. For example, the vanguard boards had a good network of leadership and a good balance of service user involvement, along with support from enthusiastic individuals to implement the policy successfully. Some boards lacked these things and were not fully engaged with the policy enactment.

'that we had Vanguard boards, that then went on to really demonstrate significant roll-out across the workforce. And you had other boards where there was little support for trainers, very little evidence of any impact whatsoever …As I've just described, some boards strategically picked people who were in a position to influence change. Some boards didn't. Some boards had very clear plans for implementation. Some boards didn't. Some boards had clear high level organisational buy-in to drive things. Some boards didn't. In some boards you ended up with extremely cohesive, supported groups of trainers, and in other boards there were one or two people with absolutely no support whatsoever' (central initiative staff)

'As I mentioned earlier it was variable, some areas did more than others,

some areas trained many people, other areas trained virtually no people at all. That was the key factor' (service user representative)

Superficial implementation

Some participants thought that the policy was enacted in a rather superficial way. They said:

'Less sure strategically whether that is still the case. I think it was, I'm less sure that's still the case, it's kind of been moved forward. Part of that might be because there's a belief centrally that 'well we're kind of doing this stuff, it's becoming embedded', anecdotally I don't think that's absolutely the case. My worry is that very often we badge things as recovery or values focused, when in fact we're still doing the same stuff, or pretty much the same stuff, just using different language' (educator)

'So I think the balance is out of kilter, I think it requires, I know they've refreshed the Rights, Recovery, Relationships documentation, and stuff like that, I don't know if there's the same explicit expectation for NHS boards to make sure this stuff is embedded in their culture. There's a wee worry that I have, that people talk the talk but don't walk the walk' (educator)

Lack of support from local management

Some participants pointed out that it was very difficult to put the policy into real practice without the support of local management.

'How difficult? Well, I guess, when people aren't supportive of something that you feel is right, I felt, I felt it was, I felt it was unfair on nursing. I felt that we were being supported from the Government and from NHS executive board but yet locally they seemed to be reluctant to give the time. So that's what I mean about it was difficult. It was just difficult negotiating' (manager)

6.5.3.2.3. Themes relating to the commissioned evaluation

When the participants were asked about the commissioned evaluation, they generally thought that the report provided clear evidence regarding what, how and why the policy worked. The report provided a role model for translating the policy into practice, and informed learning for future initiatives. However, the evaluation was limited because of the low response rate.

'I am not sure that it made a huge amount of change, apart from informing learning for future initiatives… It obviously went into the public domain. I

think to a large extent it found what we already knew, and I could have completely predicted the findings. I think that for the boards that were identified as the vanguard boards, it was motivating and affirming for them, because some of them knew they were vanguard boards' (central initiative staff)

6.5.3.3. Themes relating to policy impact

The policy initiative had a significant impact on improving the quality of services by providing specific training and encouraging more reflective practice, according to the participants.

'You know, I think it was about patients getting, staff realising that perhaps patients weren't getting the best care that they could have got, and because staff were afforded an opportunity to reflect on their practice I think that that was a big impact for them, and ultimately the way in which they went and delivered their practice would have been, should have been improved, or at least it should have been more reflective. That was what the, that was what the point of it was' (manager)

'I mean, I suppose the whole promoting recovery was a brand new concept for people, for some people, and you know, we had lots of discussions around how can you promote recovery around people who've got Alzheimer's. So it was trying to instil in people what recovery actually meant. And, yeah, there were a lot staff I think that really felt that people with chronic mental health problems were destined for a life of just dealing with those symptoms, and when you start introducing the recovery concept, then I think it did make people sit back and think about it' (manager).

Importantly, the policy initiative was embedded in the undergraduate mental health nursing curriculum, which changed pre-registration education in nursing.

'I think also one of the key differences is that this is something that's actually become embedded in the undergraduate mental health nursing curriculum' (educator)

Some participants thought the initiative had influenced the culture within practice. The participants also emphasised that it had a big impact on the value and satisfaction felt by service users, because it provided an opportunity to have their voices heard.

'but I think it was just like, I think to help staff to change their attitude and

I think getting more involved and getting the patients more involved. I think it was in order to get the patients and that more involved, rather than the just the nurse writing things, and things like that, and the doctor writing things, like involving the patients, so there's improvement there and I think everything, like all the initiatives that come out over the years, it's all been to improve things for the patients' (practitioner).

'It's enabled them to exercise their right to choose, so they, their autonomy as an individual, is very much brought to the fore as part of the Rights, Relationships and Recovery, you know, policy. That's the outcomes' (evaluator).

6.5.3.4. Themes relating to lessons learned from Case 4

The main lessons learned from Case 4 are presented in Table 30 and several key themes will be highlighted below.

Table 30: Key themes emerging from Case 4

Key themes emerged from case 4	Case 4 (Sources: number of participants)
Gaps and challenges	7
Sustainability	7
support from different level	7
leadership and governance	6
Resources	6
local autonomy and government decision	5
Priorities	5
service users	5
Alignment	4
collaboration and partnership	4
Communication	4
compulsory issues	4
incremental change	4
longevity (long term vision and impact)	4
engagement	3
innovation	3
integrated with other programmes	3
motivation	3
pragmatic initiatives and multiple policies	3
reflection	3
strategy	3
bottom to up	2
managing changes	2
network	2
power	2
consistency	1
contextual and cultural factors	1
evidence-based	1
learning experience	1
legislation and governance	1

Sustainability

The participants considered the initiative had a degree of sustainability. It was sometimes thought that the initiative was either integrated with other initiatives or embedded into practice. It was also explained that the training material had been integrated into the pre-registration education programme, which meant it continued to have an influence. However, it was questionable whether the university training had the same impact as the initiative training.

'There is a degree of sustainability because people were trained as facilitators, the materials are publically available, anyone can use them, they're all free to use and they've been, they've been used by various people and various countries as well' (service user representative)

'Probably not, if I'm being truthful because we've, we did a tranche of training. Each of the health board areas went off and did their thing. I'm pretty sure if they went back and did a straw poll of the health boards asking how much training continues to happen, or is it embedded within your supervision or clinical support structures, I think very few places would be able to say 'yeah, definitely, it's being maintained'. So that's not to diminish the impact of the initial training, but I think we've got a challenge to try and maintain the developments' (educator).

'I think it is sustained through the preregistration programmes, so now all of the mental health nurses, the future generation, should be exiting their programmes having undertaken that sort of the learning, but if they aren't experiencing that sort of practice, then it's often very difficult for individual practitioners to sustain that, if the culture is not conducive to that' (central initiative staff).

Priorities

Some participants thought organisational priorities at different levels were a key factor which would affect the policy to practice development.

*"I think the key issue for me is maintaining the focus. I think it's happening at a national level, I think there's a lot of interest nationally in it, I think in health board areas that the focus has moved on, so I think one of the things is around how you maintain focus" (*Educator)

It tends to be the latest great idea, which has been cooked up in St Andrew's House and then put out there and it feels like yet another thing coming along, another must do (service user representative).

Service user involvement

Each of the participants noted the significance of service user involvement within the policy initiative. In Case 4, listening to the opinions of service users was the exceptional aspect of this policy to practice change.

*'Scotland didn't have, in the same way as America had, the kind of consumer movement where there was a kind of ground swell to actually influence change. This change came from the centre and there were some support groups kind of influencing that to some extent. But I think there was some tensions in relation to this becoming something that was organisationally driven rather than something that came from a service user initiative, if that makes sense?' (*Educator)

*'...And I think what we're seeing is we, you can't enforce recovery top down. There has to be a commitment and a bottom up and we also have to open out to the voices of services users and carers and let them in, because they will inform us as much as services' (*Manager)

'I think the main difference. I think for the nursing staff was that all the paperwork that you do is actually done with the patient. You do like, obviously if the patient is well enough, cause sometimes if they're really psychotic initially then it's not fair on the patient. But now it's all done with the patient, and the patient signs a copy of their like, well when we do like a joint assessment the patient will sign it, the nurse will sign it' (Practitioner)

*'I think it was important to, definitely a success factor in it was the way that the knowledge that was included in those training materials that were subsequently picked up by people and practiced and used, came directly from people talking about their own recovery. I mean, that was really important, it was very different at the time, but that was vital and I would say that was reminded to be vital for anyone who was thinking about doing the same thing' (*Service user representative).

Professional leadership in boards

Some stakeholders stressed that local leadership had played a vital role in moving forward the policy initiative.

'The extent to which it was picked up was largely dependent on local interests in recovery and local leadership and local commitment to the whole strategy of change, which is what the nursing review was, it was really a call for change in mental health nursing' (service user representative)

Issues and challenges

A number of problems within the policy initiative were recognised by the

participants. For example, some participants pointed out that ineffective communication meant people were unable to get all the details. Others were concerned about meaningless change to practice.

'A lot of people's argument was 'well we do this already, you're not doing anything that not already there' despite the fact that we would show research that would say well clients are unhappy with the service they're currently receiving, and the majority of complaints that NHS gets across the board aren't to do with clinical procedures but to do with personal issues, how people have been treated, how information's been imparted. So there were challenges around that, there were a group of staff who were perhaps resistant to seeing this as something that they required' (educator)

Some stakeholders felt that they were struggling with the policy change under the pressure of workloads and the diversity of organisational structures.

'I think that people left the training with great intentions of changing and doing things differently, but I think that the pressures of working in these areas because they're, you know, nursing establishments have been reduced, they work 12 hour shifts, the people that are admitted are really unwell, I think that, it's a struggle, you can go through the training and you think 'yes, I'm going to do that, I'm going to do that' but when you come back it actually is a bit more difficult' (manager).

'It's the way that organisations work. The structures are very different in some NHS boards. At that time, the leadership structures for mental health nursing were extremely different across Scotland. Some boards had clear strategic professional leadership structures, which were absolutely absent in others. Boards also had different infrastructures, or lack of, for practice development and education' (central initiative staff).

6.5.4. Case 4 summary

Case 4 provides an example of seeking to enhance practitioners' knowledge, skills and behaviours to meet patient needs through a policy to practice development. Two voluntary organisations were commissioned by the government to train the trainers and they disseminated the training programme throughout mental health services in Scotland. This policy initiative was enacted variably within the health boards as a result of key influential factors. However, this policy initiative influenced cultural change within practice and service users' value and satisfaction. More specifically,

the training material was integrated into the pre-registration education programme as evidence of sustainability of the policy initiative. The main lessons and issues emerging from Case 4 are also highlighted.

6.6. Chapter 6 summary

This chapter has presented the findings of each case study, based mainly on the various opinions expressed in the in-depth interviews and also on some information from the commissioned reports. The main themes emerging from the findings have provided a holistic understanding of each policy initiative development based on Macduff's MAPPED model (2007a), regarding the policy context, process and outcomes. Thus, this chapter has given an account of each individual policy initiative and has pointed out the main lessons learned from each case study. The next chapter will present findings regarding similarities and differences in the initiatives, using cross case study.

Chapter 7. Findings from cross case analysis and synthesis

7.1 Overview of this chapter

Having explored the findings of each case using contrast and comparison, it is now time to deal with the aggregated findings across case analysis and synthesis. This chapter:

- Overviews the four cases giving a general picture of similarities and differences
- Presents and exemplifies the most common themes from interviews
- Applies two theoretical models to facilitate systematic analysis and synthesis of data enabling comparison within and between cases.
- Synthesises a summative typology of the policy initiatives
- Presents the findings / reactions regarding the MAPPED model (Macduff 2007a)

7.2. A summary of the four policy initiatives

The summary of the four cases is drawn from the findings of documentary data (15 reports) and interview data. These are presented in Table 31 along with policy aims, context, process, outcomes, dissemination and sustainability.

Table 31: Summary of the four policy initiatives

Policy initiative	Case 1 (extended role)	Case 2 (new role)	Case 3 (General education framework)	Case 4 (enhanced role)
Aims	To develop an extended role for the Scottish nursing workforce in order to meet patients' needs for quicker access to health care and to encourage professional development.	To develop a new role for the Scottish nursing and midwifery workforce in order to support the learning environment in practice through the coordination and the delivery of practice–based education for students and staff.	To help the newly qualified AHP practitioner build up their confidence in practice and to deliver consistent and standard care to the patient.	To enhance mental health nursing practitioners' skills, knowledge and behaviours to meet patient needs in Scotland.
Context	**Outer context:** **.** European working directives led to a change in GP contracts. **.** Law passed **Inner context:** **.** Development of an out-of-hours service increased nurse-led services. **.** Each NHS health board was encouraged to establish an effective network with support from national level.	**Outer context:** **.** The minister for health visited a clinical area and was told about the lack of support for learning and practice. **.** Policy advocating an innovative way to strengthen the educational role. **Inner context:** . Lobbies for professional needs	**Outer context:** . Policy advocating an innovative way to reduce the high attrition rate. **.** Government commissioned NES to set up a national model to support newly qualified practitioners. **.** NES promoting a policy concerning careers and retention of staff **Inner context:** **.** professional lobbying about the need to support learning and practice	**Outer context:** **.** Government had feedback from the national review of mental health nursing in Scotland . New legislation for mental health nursing **.** Policy advocates innovative way to change in practice **.** Compulsory policy action plan**.** **Inner context** **.** Professional review **.** International professional influence **.** Service needs
Process	**.** The Scottish government provided adequate funding to support training and implement change. **.** A steering group was established for the initiative at the strategic level, which involved policy maker, education, research and practice. **.** A training programme including Special skills training consisting of 26 days of study, a programme of 72 hours supervised learning in practice, along with a competency-based assessment was designed and implemented. **.** A range of staff who met the criteria for the training were recruited. **.** Qualified prescribers took full responsibility for patient care. **.** A leading practitioner in each board was appointed to link the local board with national	**.** Tripartite joint secured budget to set up the new role and implementation of change funded by Scottish government, health boards and universities. . A steering group was established. . A core job description from NES for the new posts. **.** Recruitment of 100 full time equivalent posts for relatively senior practice-based staff to fill the new role. **.**Joint induction programmes to develop the skills and share experiences at national, regional and local level**.** **.** The new role has full responsibility for supporting mentors and for the learning environment in practice. **.** A leading practitioner in each health board and three regional coordinators are to link the local board with national government.	**.** Ring fenced budget to support the specific initiative and implementation of change funded by Scottish government. **.** Government funding was limited in duration. **.** Consistent learning materials for web-based learning were developed. **.** Designated time allocated by line managers. **.** Practitioners took full responsibility for self-directed learning through e-learning integrated into KSF. **.** IT engaged. **.** During the implementation process, there was support from different levels, but it was hurried, in order to implement the policy within the limited time. There was a lack of national guidelines resulting in inconsistent allocation of resources. There was no clear	**.** The Scottish government provided adequate funding to support training and implement change. **.** Educational training resources were developed. **.** Commissioned voluntary sector organisations to delivery a training for trainers programme. **.** NHS board nurse directors ensured the programme of training was in place. **.** The training programme involved two phases. First stage, NHS Boards nominated 68 participants to be trained as trainers in a five day training programme and a four day follow-up training programme that prepared them to deliver the training. The second stage was to enable the trainers to use educational materials as trainers, training them to be capable of delivering training and also of training others as trainers. The training took the form of an initial

	government. . A Fair and structured monitoring process was available such as a peer review system. . During the implementation process, practitioners had support from different levels and good leadership. However, it was difficult to find a designated medical practitioner and to keep the database alive as people moved. In particular, there were delays in getting prescribing pads due to administrative issues. . Education and practice worked collaboratively	. During the implementing process, there was strong support from different levels and good leadership. But initially the new role boundary was vague, people couldn't fully understand the new role, its implementation varied locally, and it was difficult to evaluate. . Education and practice worked collaboratively.	local policy set up. It was difficult to evaluate.	three day training as both trainees and trainers, then a two day follow up session that prepared them to recruit and train their own colleagues. . Three regional facilitator posts for two years were funded by government. Their roles involved supporting first wave trainers as they disseminated the training and also linking directly with NHS Boards. . The training time was designated and the training involved service users. . First stage training was compulsory policy with a high completion rate. . Staff shortages made the training programme difficult, and the second part of the training was not well attended because it was not compulsory.
Outcomes	.The initiative improved the range and the quality of services for patient care, in particular by providing quicker and safer access for patients. . It is a good example of an initiative that has evolved over time. . The extended role caused minimal/no disruption and had dedicated funding and support. . Very high level of professional and organisational commitment.	. Successful tripartite process between NES, health board and university. . Increased number of employees for the new role. . The leading network had a structured communication strategy and a good alignment for governance. . NHS partners and other bodies seemed positive about the programmes. . The new role was embedded in practice with secured funding and support but would be uncertain without these. . Enhanced work-based learning and strengthened the learning environment. . High level of job satisfaction	. The initiative was highly dependent on government funding . Good for staff retention . Consistent learning materials enhanced consistent care. . Secure funding helped the completion rate. . High impact with self- reporting process. . Growth in confidence in their ability to do the job and good prospects for career development. . The initiative stopped because of lack of funding.	. The initiative was influenced greatly by compulsory policy. . High completion rate and attendance in first training programme, but the second part of training was not well attended . Provided new knowledge and skills which led to more reflective practice and the involvement of more service users . influenced culture within practice . promoted confidence . More service users' voices heard . The training materials were integrated into the pre-registration programme
Dissemination and Sustainability	. Disseminated successfully throughout Scotland . Sustainability guaranteed by legislation.	. Worked very well across Scotland, and very few areas were not covered by the new role . Sustained by a permanent post in each health board	. Disseminated all over Scotland apart from some very remote and rural areas. . Once the funding ceased, the policy initiative was unsustainable	. Inconsistently disseminated across Scotland . The training programme was integrated into the pre-registration education curriculum in mental health nursing. But most of the training for trainers in health boards was stopped.

Table 31 shows the main points relating to specific and generic aspects of the policy initiatives, which enables consideration of their similarities and differences. It is clearly seen that each of the four policy initiatives had their own aims and their particular processes of development and sustainability, both of which were affected by different contextual factors.

At the stage of policy formulation, Table 31 shows that the main factors were similar regarding policy context across the four cases. For example, political support and professional lobbying about service needs seemed to be dominant drivers in all the cases. However, there were some different contextual factors, which drove the policy initiatives. In Case 1, legislation appeared to have a strong influence in driving forward the policy initiative, while a national review of mental health nursing was one of the main driving forces behind the information for the policy in Case 4.

Although the four policy initiatives were implemented from top down, the process of translating policy into practice, was different across the four cases. Case 1 was funded by the government with an organisational management structure. A leading practitioner was appointed to each health board to link the local health board with the national steering group. This policy initiative developed a monitoring system including audit, peer review. Case 2 had tripartite joint funding through NES, health board and university. There was also a leading initiative manager working with three appointed regional coordinators to link the local health board with the national steering group. The initiative was monitored only by a reporting process and feedback. Case 3 was funded by the government in the short term. The local practice education facilitators (PEFs) and line managers in each health board led the dissemination of the policy initiative, which meant no specific project manager was available to lead in this case. The monitoring system was not well developed, focusing only on the completion rate and feedback. Case 4 was funded by the government and two voluntary organisations were commissioned for the training programme. Three regional facilitator posts for two years were funded by government to support first wave trainers as they disseminated the training and to link directly with NHS Boards. This initiative was also

supported by local line mangers in health boards. In Case 4, there was no formal monitoring system developed. However, the initiative evaluated the training completion rates, and had feedback from six monthly reports on Action 1. The policy translating process in terms of funding, management structure and the monitoring system, is mapped in the following box (Table 32).

Table 32: The policy translating process in terms of funding, management structure and the monitoring system

Policy initiatives	**Case 1**	**Case 2**	**Case 3**	**Case 4**
Funded by	Government	Jointly funded by government, health board and university	Government in the short term	Government
Management structure	. National Steering group . A Leading practitioner in each health board	. National Steering group . Three regional coordinators . A Leading initiative manager in each health board	. National Steering group . Local PEFs and line managers in health boards	. National Steering group . Two commissioned voluntary organisations . Three regional facilitators
Monitoring system	Audit, peer review and active feedback	Reporting process and feedback; annual review and NMC approval visits	Only monitored the completion rates and feedback	Completion rates, feedback , six monthly reports, Action 1

Accordingly, while each case had a different impact on service providers and service users, all four cases had a significant impact on professional development and quality of service. Also, the four policy initiatives were generally disseminated throughout Scotland. However, some cases were slightly different. For example, the post for the new role in Case 2 was not covered in some areas. In Case 3 the policy was not implemented in very remote and rural health boards, due to no suitable staff being available.

It is clear that each of the four policy initiatives had a certain degree of sustainability. Table 31 shows that Case 1 sustainability was high manifestly sustained by secured funding and legislation. Case 2 was manifestly sustained by the permanent post in each health board. On the other hand, Case 4 was less manifestly sustained, but the training material

was integrated into the pre-registration programme. The Case 3 was manifestly unsustainable, once the funding ceased.

As such, an overview of the four cases sets out the specific features of each policy initiative in terms of policy context, process and outcome. However, more generic lessons can be learned from the case studies, which will be presented in the following section.

7.3. The most common themes from 24 interviews

This section includes key themes relating to lessons learned from the four cases and the relationship between the four policy initiatives and with the others. They are presented more in detail below.

7.3.1 Key themes relating to lessons learned from the four cases

As explained in Chapter 4, this study applied the matrix coding in NVivo to systematically synthesise and interpret the diverse views from different stakeholders across the four cases. Through this approach, generic themes relating to key lessons and issues emerged from the four cases. These are presented in Table 33.

Table 33: Common themes relating to lessons learned from the four cases ranked by frequency using NVivo matrix coding queries

Common themes	Case1 (sources)	Case2 (sources)	Case3 (sources)	Case4 (sources)
Internal alignment	6	5	5	5
Communication	6	5	4	4
Gaps and challenges	6	4	5	7
leadership and governance	6	3	3	6
Motivation	6	4	2	4
Network	6	1	3	2
Strategic guidance	6	5	4	4
Support from different levels	6	3	4	7
Collaboration and partnership	4	5	3	4
Learning experience	4	4	3	1
Resources	4	4	4	6
Longevity (long term vision and impact)	3	3	2	4
Managing changes	3	4	2	2
Consistency	2	1	2	1
Engagement	2	3	3	3
Innovation	2	3	1	3
Local autonomy and government decision	2	1	1	5

Priorities	2	2	2	5
Team work	2	2	1	1
Bottom to up	1	1	2	2
Incremental change	1	1	1	4

A large number of common themes relating to lessons learned from the four policy initiatives can be clearly seen in Table 33. However, Table 33 also shows the number of sources in each case, which is important in order to get a sense of the general feeling across the case studies. In each case, most participants felt that 'internal alignment', 'communication', 'leadership and governance', 'Gaps and challenges', 'support from different levels', 'collaboration and partnership', 'resources' and 'strategic guidance' were crucial for policy to practice development. These themes will be presented and further explained below along with quotations from the different participants.

Internal Alignment

Good establishment of internal alignment at vertical and horizontal level seemed very prevalent in each case. It was regarded as fundamental for policy to practice initiatives. For example, people viewed that maintaining vertical alignment function at national, regional and local network is essential to achieve a degree of consistency, transferability and sustainability of policy to practice.

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

'...I just think that you have got policy, you have got professional regulation, you have got practice and organisations, and you have got a practitioner who has their own aspirations and their career, and I suppose in the centre you have got service and patients haven't you'.(Educator Case 1)

Some participants also highlighted the importance of temporal alignment for the development of policy initiatives. They looked on it as different things happened in 'right time'. An evaluator in Case 1 said:

'I think it developed because of all the different things that were happening. The changes with the doctors, the nurses were wanting to do more, the need for nurses to do more the political. Well all of those things coming together at the right time. So it was the right time for it to happen' (Evaluator in Case 1)

Communication

Almost every participant across the four cases viewed that effective communication was vitally important throughout the process of the policy initiatives. In particular, some participants highlighted what constituted effective /ineffective communication, for example:

'I have to say, I think it, communication is quite important, well it's vital and that's around having everybody at a senior level, and that's not just nurses and midwives, obviously because we're taking about nurses and midwives in terms of preparing nurses and midwifes, senior nurses and midwifes have got to understand about all of this, so I think communication is key, effective communication around people understanding what it's about, quality learning environments, how that fits with the workforce as a whole, the preparation of the workforce and having the right people in post at the right level. Well, right person, right place, right time in terms of, so, senior nurses have to understand that and where the whole practice placements fits with that' (manager Case 2)

'And another issue is called ineffective communication, where people don't understand why they are being asked to change. Sometimes change within organisations with, you know like, the NHS even here, you know, you don't get full explanation which is a skill in communication. To enable people to understand why they are being asked to change from the way they do things and it so true getting people to understand not just the way, but understand what it is they are being asked to do then that change will come' (evaluator Case 4)

Some pointed out how to communicate effectively.

'I think the success is always, it's always been clear to ourselves in practice education what the success is, but I think we always have to probably articulate that in a language and a message that our chief executives in organisations would understand, somebody who's not from an education background. You know, what is the message that we need to give to them about the benefits this role brings and what would happen if we didn't have this type of role?' (central initiative staff case 2)

Leadership and governance

'Leadership and governance' was frequently mentioned in each case. The participants thought that having robust governance and good leaders at different levels was critical to steer the policy into practice. In particular, the participants realized that leadership was about providing support, legitimizing professional actions across the wider organisation, access to resources and providing expertise to enable policy change. The quotations below from different participants in different cases aptly illustrate the importance of leadership.

'The key lessons learned are, I think, you've got to have robust governance, where you've got a funding model you've got to have robust governance' (central initiative staff member Case 2)

'The leadership is important because good leaders who understand how to take things forwards and understand the benefit of things can influence their co-workers and they can become the mechanism for communication and I think that's really important. People don't like change. People can be afraid of change and a very gross generalisation. Good leaders can help support those individuals because people feel unsure, they want, they need somebody to support them and help them' (evaluator Case 3)

'Leadership, I think of leadership as being the primary influential factor in putting this into practice, most definitely…I'm just repeating what I said, but I suppose one of the most important aspects is around leadership and leadership at all levels, so from executive to general management to nurses management to ward management' (manager Case 4)

Notably, some interviewees highlighted the influences of different leadership styles. For example:

'The next issue will be the leadership style and thinking of the, at the strategic levels, but also at middle line management and front line management of what's important to them and it also comes down to the individual level of people in those positions, of what is importance in this work about' (evaluator Case 4)

Gaps and challenges

Most participants from the four cases recognised that gaps and challenges always emerged from policy to practice changes. In particular, the issues of funding, allocating time, less guidance, different responses to policy and

the challenges at managerial level were viewed as predominant. They felt that dealing with the challenges and filling the gaps made the policy initiative work.

'I don't know how we would fill that gap. I mean, at the last leads meeting I was at, some challenging questions were being asked, well 'what if the funding was taken away, what if Scottish Government took away their bit of the funding?'. Well, we would have to find a way of making that work in the board. We would have to rationalise, regroup our position, look at what funding we've got and perhaps reduce our number of PEFs but we wouldn't get rid of PEFs. You know, we would probably have to look at how we fund what we've got and if we couldn't fund them all we would have to fund less' (manager Case 2)

'One of the big challenges in that was that at a managerial level, I think they thought if they just badged the thing with recovery that would make it happen' (educator Case 4)

'There were issues with infrastructures that boards had. As I've just described some boards strategically picked people who were in a position to influence change. Some boards didn't. Some boards had very clear plans for implementation. Some boards didn't. Some boards had clear high level organisational buy-in to drive things. Some boards didn't. In some boards you ended up with extremely cohesive supported groups of trainers, and in other boards there were one or two people with absolutely no support whatsoever' (central initiative staff member Case 4)

'When we had the nurse prescribers formulary there was less guidance from Scottish Government level as to what Health board's should do' (manager Case 1)

'Of course, the difficulty that we found was, in some places people were given a specially allocated time to go through do the training to get the mentoring and so on, other people didn't and they had to do it weekends and evenings whenever they could fit it in (time). So there wasn't necessarily parity between people's experiences' (evaluator Case 3)

Support from different levels

Across the four cases the notion of support was a strong theme in interviews, mentioned by different participants. One member of central initiative staff in Case 1 thought that political support providing financial fit for local need was 'an added element of success' from policy to practice change. However, probably of more significance, was that support from the ground floor in day to day practice was really significant to enable the practice change to happen. One evaluator in Case 1 felt:

"...central government lead was a key actor and had perceivably a lot power but didn't have the power to change what was happening over there in that hospital five miles away. The power to change that hospital five miles away sits with someone on the ground and it's about knowing who. Going back to what I was saying there about who has the power to stop it and who has the power to make it happen and we suddenly encountered both in the scenario that we went through".

Critically, the evaluator in Case 3 pointed out that while providing support at all levels was vitally important in changing practice, it was not always tangible in the process of policy development. She said:

"...You also have to have buy in from the next levels down. So they have to believe in it, if you like. There has to be buy in, so you have to have support at all levels and you have to mentors who are well trained, who know what they're, actually what their role is and you have to have time for people to undertake that role, you have to have time for newly qualified practitioners as well and you have to have clear, not just guidelines, but clear requirements around some of these things so that people get equity of experience, and I think that wasn't always the case".

Collaboration and partnership

The participants from different levels in the four cases had one voice that working collaboratively with colleagues, departments and organisations played a part in the success of from policy to practice development.

'I think that is probably one of the few areas of practice where I think education and practice has really worked collaboratively and in a progressive way to develop service and education' (educator Case 1)

'A key ingredient for me in terms of this translation, is partnerships between the NHS, voluntary sector organisations representing the voices of people, in this case I am talking about dementia, who are often better able than statutory organisations to challenge and to influence at a political level' (central initiative staff member Case 4)

Some participants gave their perspectives of how to work as a partnership successfully.

'I spoke before about partnership, very much from the universities and the board point of view, we would work as a partnership around that so, implementing it into practice is a joint thing and obviously the university, you know, if we're, if you were starting with a new PEF or a new initiative then it is how we fit that within a bigger picture and at the time when we started we had a collaborative education strategy' (manager Case 2)

'It wasn't something we tried to impose. We had to listen to what the boards needed. So that's how it's, it's been a partnership' (central initiative staff Case 3)

Resources

Most participants across the cases felt that sufficient resources in terms of infrastructure, the right people, secured funding and adequate time were a basic pre-requisite to ensure the policy change.

'But it was getting the right people with the right DMP's the right supervisors you know and when things didn't work out, it tended to be because you had a student who was a bit apprehensive or negative or who had a medical supervisor who wasn't prepared to give the time to the job' (evaluator Case 1)

'I think what was a crucial driver was the funding to support the role, it would never have happened if we hadn't that funding to support the role. The funding model was absolutely right, because if it had just been solely national funding I don't think the boards, the universities would have the same sense of ownership and responsibility for the roles, so it's actually brought the three organisations together, I think, that funding model was crucial' (central initiative staff member Case 2)

'We were, at that point we were well supported by our NHS body, we were given time and resources to deliver training, we were able to secure venues, that type of stuff, without any great problem' (educator Case 4)

Strategic guidance

Strategic guidance was regarded as a point for navigation for health board managers and practitioners.

'I mean within the initiative the key thing that had to be completed was a non-medical prescribing policy and framework which is for guidance to staff and also to managers and also a strategy the health board has had to develop (.) well myself along with the working group develop a strategy to support managers to think about non-medical prescribing when they are developing services, so that is the key things' (manager Case 1)

'But if I were to do it again, I would be much more clear nationally about what exactly are we asking these people to deliver and is there a standard way of delivering that across the country, because there isn't a standard way of delivering it even now' (senior manager Case 2)

Some felt that a clear strategy was concerned with the long-term success

from policy to practice development as a whole.

'I think because we thought it was the right thing to do. To be honest, I don't think there was much translation required. The Government were quite prescriptive. This is the action plan, this is the values based work, this is the recovery focused based work and this is what we'd like you to do, you know, it was quite clear, it was quite clear what we had to do' (manager Case 4)

Motivation and incentives

The participants across the four cases highlighted the importance of motivating the staff engaged with the policy initiative at different levels, as having an impact on policy to practice change.

'And always thinking through how will that individual fits in the PEF team, because the PEF team are very motivated and they're also very able to work on their own initiative, they come together as a team and they work really well in, in thinking about their job and what they're trying to achieve and how they're going to do it and they lay it out in practical steps and they do it and they don't need me holding their hand or chasing them or anything else, they do the work, they're motivated enough to do that. That is really key' (senior manager Case 2)

At the same time, participants felt a number of considerable incentives to motivate people were critical, such as giving clear message, professional development, personal value and beliefs and so on.

'And having a sort of clear message, so that the PEFs aren't confused or aren't mixed up or are thinking 'well, do I do this for NES, do I do this for the university or is it I'm actually meant to be doing this for the board?'. So I think for the PEFs themselves it's sometimes letting go of something they've been very comfortable working on and saying it's okay to do that because actually the things we're now going to be looking at are really exciting, are really topical and you've got such a key role in making them happen' (central initiative staff Case 2)

'Some boards, it's individuals responsibly to get it complete, but where they will find the problems if they haven't completed and they go for a promoted post they're going to be asked why have you not completed it. So it's to their advantage in some boards to get promotion and to get other CPDs to complete this first. In all boards to get promotion they would have expected you to have completed Flying Start '(central initiative staff Case 3)

Across the four case studies, some participants also felt that 'effective team work', 'engaging people during the policy translation process', and 'dealing with priorities in health boards' were an important part of policy to practice development.

Team work

Some participants saw the value of good team work.

'And then PEFs locally worked very hard and they also linked with their colleagues in other parts of the region, so the region have grouped together as a group of PEFs who work with each other and try and make things, so they've all linked to each other and they share a lot, they're actually very good at communicating amongst themselves as groups' (senior manager Case 2)

Engagement

A large number of stakeholders across the four cases felt that full engagement of staff 'gave a sense of ownership' and could shape the policy initiatives. To some extent, how to get people engaged with the policy initiative was viewed as fundamental.

'So again it would be, lessons learned would be, how do we do that, how do we continue to do that so we are engaging people in shaping an initiative. And I think by doing that it gives a sense of ownership of it' (central initiative staff member Case 2)

'The most important thing if you're doing any initiative is to involve your staff '(practitioner Case 4)

'…So for me that is the key issue, it's about individuals at each level buying into being truly engaged with the process and the initiative otherwise it will just come and go' (evaluator Case 3)

'The strategy Clearly identified that would be required and everybody signed up to that and us directors all signed up to that so that's what we now have' (central initiative staff member Case 1).

Relative priorities

Across the four cases, priorities were influenced by different reasons, but how people value the policy was seen as a key.

'Absolutely, yeah. I mean if they weren't there I'm pretty sure just because of the nature of things that they kind of, Minister of Health will have moved on to other things' (educator Case 4)

'It's how the, how the individual boards prioritise, it's how they value. If they value Flying Start they'll make time for it, if they value flying start, they'll give their mentors support, they'll give their staff support, they'll acknowledge it when staff have completed' (central initiative staff member Case 3)

7.3.2. The relationship between the four initiatives and other initiatives: external alignment with other policy initiatives

Following the internal alignment presented above, external alignment was another key theme that emerged from the four cases. In this thesis external alignment concerns the external relationship between each policy initiative. Across the four cases, most participants viewed that the policy initiatives were not isolated but were more or less linked to other initiatives.

'That's a good question and in a short period of time a very difficult one to answer, because I think, practice education can't be seen in isolation from other things, for instance, you know, practice development, practice education, there's a temptation to see them as very separate things, they're not. Now that is my opinion, but I think that's increasingly become clear in the last probably four year, three years, that, you know, we can't just appoint a practice education facilitator in isolation. They've got to have good networks, they've got to sit in the support system with colleagues, other practice education facilitators, other people involved in education roles, whether it be practice development. They've got to be a good support system in place so that in itself, the initiatives got to be linked into other on- going initiatives' (manager Case 2)

A senior manager in Case 1 noticed that the initiative was 'very much tied into' the other initiatives.

'In terms of (.) I mentioned that mutuality is a bit of a driver, because it is part of caring for Scotland, which was our national policy document at the time and it still very much ties into the equality strategy' (senior manager Case 1)

Sometimes the existing policy initiatives could be influenced at the same time by introducing a new one. The participants highlighted:

'Prescribing has come about at a time of, I think, great uncertainty in community nursing particularly, but also it came about at a time when Agenda for Change was introduced, which was the process by which nurses are graded and their salary is linked, so you had this Agenda for Change, so when in the early days when people were asked if they would go on to a nurse prescribing programme, they would be saying oh do I get a higher grading if I do that and that wasn't always the case' (evaluator Case 1)

'…Well, I think, it was around the increased focus on getting it right with student placements, around the quality of the learning environment which, you know, there had been, there's a document behind you on the wall 'Quality Standards for Practice Placements', you know, that was developed round about the same sort of time and it was around there being clarity, around what quality looks like in terms of practice placements and everybody was signed up to that. To support staff in practice to support students and that was what the driver was, the main driver' (educator Case 2)

In addition, some participants thought the policy initiatives were instrumental in driving forward other initiatives such as 'Leading Better Care' 'Advanced Practice', 'Senior Charge Nurse Review' etc.

'Well I suppose it's been instrumental in driving forward Advanced Practice, advanced level practice in nursing, nurse led initiatives and midwifery led initiatives' (central initiative staff member Case 1)

'There's a couple of things that would come to mind, Leading Better Care, Senior Charge Nursing, large kind of initiative and its part of their role. They have that kind of an overall responsibility for that clinical learning environment which is kind of their area of practice. It's absolutely crucial that they're supported in that role, because they have so many priorities and commitments, so we see the PEF role as being crucial to supporting the Senior Charge Nurse round about building and strengthening the clinical learning environment' (central initiative staff member2 Case 2)

Furthermore, some participants thought that mutuality of the appropriate initiatives made practice more effective, with dynamic development.

'...the current political drive - Safe Effective Person Centred - you can very much say that yes it improves medicine safety, it is effective because you are getting the right drugs to the patient, it is person centred because I am bringing the drug to you I am seeing you face to face or I have seen you at home. It ticks all the boxes okay. Previously the national drivers were about improved health population health. Mutuality about individuals taking responsibility for their health long term conditions prescribing fits that all. So that is an example, so in terms of tissue viability, fitting it into public

*health wasn't quite as easy - mutuality yes, but still if somebody gets a sore it is not necessarily because they are neglecting themselves. So how much responsibility can you take? So that is to demonstrate that some things it is harder to get an initiative to fit a political imperative, and the ones that succeed and indeed have the longevity are the ones either fit political imperative but then can morph and be dynamic (*Central initiative staff Case 1)

7.4. Findings across the four case studies through the lens of the two theoretical frameworks

Chapter 4 explained how and why this study chose two relevant theoretical frameworks to present the four case study findings. The following sections will show the summary mapping that arises from the application of Ross et al 2011 and May's models to the four case studies.

7.4.1. Summary mapping of findings arising from the application of Ross et al (2011)

The findings from the four policy initiatives based on the Ross et al (2011) theoretical framework are presented in Appendix 7. They are now compared and contrasted below.

7.4.1.1. Governance and key contextual factors

According to the Ross et al framework, governance and contextual factors were considered as political and organisational contexts, through whose funding the policy initiative was developed, implemented and supported.

Policy context and funding

The four case studies suggested that the political driver and the funding were fundamental to the development of a policy initiative. Each of the four policy initiatives were generated by policy directives with different aims. For example, The Mental Health (Care and Treatment Scotland) Act 2003 in Case 4, NHS Developing confident, capable health practitioners (NHS Education for Scotland 2008) in Case 3.

Different funding models supported the four policy initiatives, ranging from central government funding in Case 1 and 4, to a tripartite joint secured

budget strongly supported by Scottish government, health boards and university in Case 2. Whereas, Case 3 was short-term funding by government.

Organisational context and support

At national level, a steering group led the policy initiative in the four cases. In addition, all except Case 3, distinctive management arrangements were required either at health board or regional level or both. There was a project leader in each health board in Case 1 and 2, while there were three coordinators in Case 2 and 4. The practitioners had varying degrees of access to the project leaders or regional coordinators, while in cases 1, 2 and 4, they reported directly to their clinical manager.

The support from health boards for the enactment of policy initiatives varied in the four cases. The different organisational structures in each health board might either support or hinder the policy initiative translation. For example, in Case 1, support from nursing managers, project leaders, practitioners, designated medical staff and colleagues was noted. Whereas, in Case 4, support from senior managers, line managers, practitioners and commissioned voluntary organisations was highlighted. On the other hand, each board had autonomy to develop their own strategies and operational policies. Line managers found it very difficult to allocate training time for practitioners, due to staff shortages.

7.4.1.2. Incentives and motivating factors

According to Ross et al (2011), the term incentive is not only defined as financial, but focuses more on the processes, relationships and people issues within organisations. Therefore, these incentives were more concerned with contextual, professional and personal factors.

Contextual features related to incentive

Across the studies effective and explicit organisational commitment, in terms of providing support, appeared important to successfully develop, implement and sustain the policy initiatives. This was achieved in most cases (Case 1, 2, 4) through different key stakeholders, such as senior

managers from nursing, midwifery and other disciplines, who promoted the benefits of the policy initiative and of role development, showing how they would provide positive patient care. As well as this, support from staff on the shop floor was critical. In particular, the study in Case 4 found that the frontline staff were key to attendance at the training programme. However, In Case 3, some rural and remote organisations were unable to enact the policy, because they did not have suitable staff. This also greatly affected the sustainability of the initiative.

In the four cases, the lack of available resources was a disincentive. For instance, the delayed prescribing pad was a big barrier at the early stage of enacting the policy initiative in Case 1, while inadequate time allocation was a dominant issue in Case 3 and 4.

Professional and personal factors

Incentives were identified across the case studies that reflected on professional and personal features, including a perception that the initiatives provided an opportunity for the development of professional knowledge and skills, leadership and professional autonomy. Opportunities for career progression and personal remuneration were seen as motivating factors.

The case studies also identified individual enthusiasm, value and beliefs, and personal characteristics as being crucial in influencing the implementation of the policy. In particular, the individual leaders' personalities were emphasised by some participants.

As such, applying the analytical framework of Ross's model is helpful in highlighting how policy contextual factors influence the formulation of policy initiatives and the translation process. Moreover, it is helpful in highlighting the extent to which incentives such as organisational, professional and personal support motivate people to engage with policy to practice change. However, this framework is still limited in investigating the process of policy implementation.

7.4.2. Findings from the application of the Normalisation Process Model (NPM) framework to the case studies

As discussed before, NPM is a theoretical model which focuses attention on factors that affect the implementation and integration of complex interventions in healthcare. According to the definitions of constructs and dimensions of the NPM framework, the findings regarding the policy implementation across the four cases are presented respectively in Table 34.

In order to take analysis further, these dimensions were synthesised subjectively, using a simple score that reflects the normalization potential in the four policy initiatives. The degree of normalization potential is characterised as either 'high', 'moderate' and 'low' (see Table 35). If the criteria meet the two dimensions, then the normalisation potential is graded as high. This can be seen with the construct of interactional workability in Case 1. If the criteria meet only one dimension, the normalisation potential is graded as moderate. This can be seen with the construct of skill-set workability in Case 4. If the criteria meet none of the dimensions, the normalisation potential is graded as low. This can be seen with the construct of contextual integration in Case 3.

Table 34 : The findings from the application of NPM's different dimensions

Constructs of NPM	Dimensions of NPM	Case 1	Case 2	Case 3	Case 4
Interactional Workability (IW)	Congruence	The law was passed through legislation; the role of practitioners was well accepted by patients and doctors. The role boundary was clear by law	The role of Practitioner was well recognised by health boards as a permanent post. The boundaries were a bit vague and confused at the beginning.	The newly qualified practitioners' verbal and non-verbal conduct was governed by formal and informal rules. The focus of professional-patient interaction was encouraged.	There was good involvement of service users with professionals. They shared the view that more human rights based legislation should be applied in mental health. All mental health nurses would have their training through the commissioned training for trainers.
	Disposal	The initiative greatly improved patient access to services and access to professional development	The initiative strongly supported the learning environment in practice.	The initiative had a positive impact on newly qualified practitioners who obtained confidence to delivery standard care to patients. The online training programme was also valuable material for staff CPD.	The initiative provided new knowledge and skills which led to more reflective practice and the involvement of more service users. It influenced the culture within practice.
Relational Integration (RI)	Accountability	All the practitioners were qualified after passing the specific training programme. They were solely responsible for the patient's safety and treatment.	The practitioners were selected by their qualification and experience. They had a joint induction with the development programme and were responsible for facilitating mentors to support students, and they also supported the learning environment in practice.	The transition of practitioners from being newly qualified staff to expert professionals went smoothly after the online training programme. They were able to take full responsibility for the care of patients.	The practitioners' accountability in service provision was improved to different degrees through the dispersal of almost 2000 mental health workers receiving some sort of the training. This enabled them to enhance their knowledge and skills in practice and led to more reflective practice.
	Confidence	The practitioners used their skills and knowledge to the full with the patients and this was authorised by government. They had more opportunities to communicate with patients and had a good relationship with them.	The new role was growing and authorised by local health boards to be a single post. The practitioners felt valued in using their skills and knowledge to help the mentors make decisions, solve problem etc. trusting relationships between the PEF, mentors and students	The newly qualified practitioners were able to deal with problems in their routine job. Their credibility and confidence in service provision were highly valued after the training.	The practitioners felt much more confident in using their skill, when dealing with problems, making decisions and communicating with patients. Their credibility was improved.

			were maintained		
Skill-set Workability (SW)	Allocation	The post of practitioner was spread throughout Scotland. The practitioners were led and monitored by a constructed management in health boards	The post of practitioner was disseminated across Scotland, but some areas were not covered by the new role. The new role was led and monitored by a constructed management at local and regional level.	The policy initiative was disseminated across Scotland, but was not enacted in some remote and rural areas due to a lack of suitable staff. The surveillance of the newly qualified practitioners was dependent solely on the local PEF and the line manager, who had to check the process of online training completion.	The policy initiative was disseminated all over Scotland. The initiative was monitored by three regional coordinators and local managers.
	Performance	The practitioners were allowed to prescribe and had autonomy to use their skill sets. It was no different from doctors' prescribing.	Practitioners were very positive and enthusiastic in their work in the new role. They led the initiative very successfully. The new post has become part of the infrastructure within boards.	The newly qualified practitioners were strongly supported financially and encouraged. And the completion rate was high.	The initiative was enacted variably within the health boards. Some vanguard boards were identified. The implementation was superficial in some boards.
Contextual Integration (CI)	Execution	A constructed management in each health board was established; prescribing pads were available for nursing prescribers. The initiative was audited and there was a peer review	Established a constructed management at local and regional level. The new role was funded as a single post. The evaluation for the initiative was dependent on the feedback, annual review	No specific management was set up, the Local PEFs and line managers in health boards were leading the initiative. The initiative was implemented based on the government funding for a short term only, which led to the programme stopping. The evaluation for the initiative was dependent on monitoring the completion rate.	The management structure involved two commissioned voluntary training organisations and three regional coordinators. The training material was integrated into the pre-registration programme. The evaluation for the initiative was dependent only on the completion rate and feedback.
	Realization	At the strategic level, there was negotiation about the risk management system and action plan. They valued the work that was done within them.	At the strategic level, they had an action plan but no risk management.	At the strategic level, they had an action plan but no risk management.	At the strategic level, they had an action plan but no risk management.

Table 35: Normalisation potential of the four initiatives applying NPM

Cases	Normalisation Process Model (NPM) framework			
	Interactional workability(IW)	**Relational integration (RI)**	**Skill-set workability (SSW)**	**Contextual integration (CI)**
Case 1 (extended role)	**High**: professionals had more opportunities to communicate with patients effectively. They were able to be concerned about the wider issues of patient care. The professionals could appropriately meet patients' needs and the process was made much smoother and safer for the patients. Both professionals and patients shared a belief in the legitimacy of nursing prescribing. The number of nursing prescribers is increasing, which led to patients having better access to the health service through the goals and meaning.	**High**: relationship of trust between patients and professionals administering intervention highly maintained. Trusting relations between physicians and others were maintained. Confidence and accountability in service provision were definitely implicated. Through legislation, nursing prescribing is authorised in conjunction with specialised training, resulting in the nurses' own professional accountability and them working as an independent prescriber, able to prescribe all the medicine from the BNF.	**High:** intervention was well suited to provision by nursing prescribers and this expanded their skills. It led to the professionals using high level clinical knowledge to provide a wider array of activities, thereby releasing time from doctors and enhancing the range and the quality of the service. The monitoring of the processes of intervention was fairly structured. Definition and boundaries of the extended role now well formed. Distribution and surveillance well structured. Nurse prescribers have autonomy to manage their skill-sets.	**High:** Service added complexity and workload to primary and secondary care. The government is still funding the training course. There is a leading person at national, regional and local level. The most important point is that nursing prescribing has been legislated. This extended role was evaluated and risk was well managed and mitigated.
	Moderate: the PEF and mentors and students are highly	**High:** trusting relationships between the PEF and mentors	**High:** intervention was well suited to supporting the	**Moderate:** Service added complexity and workload

Case 2 (New role)	interactive. They are able to communicate effectively. The PEF strongly support mentors in decision making, dealing with difficulties etc. Legitimacy established with local goals and meaning. However, the description of the new role was a bit vague and confused at the beginning.	and students maintained. Confidence and accountability in service provision were improved. The new role of expertise growing, and authorised by local boards to work as a single post. This new role mostly utilised by health boards.	clinical learning environment by the introduction of the new role. It led to a permanent post in each health board to perform a set of activities. This new post has become part of the infrastructure within boards. Definition and boundaries of this new role are now well established.	in supporting the clinical learning environment. There is still funding for this post and the post is embedded into practice. Three way resourcing is good but fragile due to uncertain funding. There is a leading person at national, regional level.
Case 3 (General education framework)	**High**: Focus of professional-patient interaction was encouraged. Newly qualified professionals were able to be concerned about wider issues of patient care. During the interaction, the professionals' verbal and non-verbal conduct was governed by formal and informal rules. Goals, legitimacy and outcomes partially developed.	**High**: trusting relationships between patients and professionals administering intervention remain high. The credibility of professionals' accountability and confidence in service provision was highly promoted. This led to the newly qualified staff being able to deal with problems in their routine job and being able to transition from newly qualified to practitioners.	**Moderate:** intervention was appropriate to professionals administering intervention and improved their skills. The professionals were able to have a degree of autonomy in using their particular skill-sets. Good quality work can be done within them. There was very little surveillance of this scheme.	**Low:** Government allocated specific funding for a short period, which led to the programme simply stopping. A national leader was responsible for the resource allocation.

Case 4 (Expanded role)	**High**: Focus of professional-patient interaction was highly related with service users involvement. Both professionals and patients shared beliefs in more human rights based legislation being introduced, and shared expectations about the goals of care that all metal health nurses would have through the commissioned training for trainers programme. Professionals shared their experience in practice.	**Moderate:** trusting relations between patients and nurses administering intervention maintained. Trusting relations between some physicians and others were established. Confidence and accountability in service provision were improved to different degrees through the dispersal of almost 2000 mental health workers who had received some sort of training as a result of the initiative. But expertise was not very evident.	**Moderate:** disseminating the training across all NHS health boards in Scotland. However, intervention was seen by some staff as nothing new but it led to more reflective practice. The distribution and surveillance was partial but now included in pre-registration education.	**Moderate:** Compulsory policy and voluntary process for the training programme. Commissioned training courses have stopped. However, this programme is influencing pre-registration education. There was a national leader working with regional and local managers.

Looking at Table 35, it becomes clear that Case 1 was highly embedded into practice, compared to Case 3, which was not normalised. Case 2, to a large degree, was normalised as the initiative progressed, while Case 4 seemed to be uncertain. At the process of policy implementation, Case 2 had main problems with role definition and boundaries, which were indicated in the construct of Interactional Workability (IW). In Case 3, the big issue was found in Contextual Integration (CI), in that the initiative was unsustainable once the funding ceased. There were several challenges in Case 4 during the enactment of the policy initiative. For example, the initiative was enacted inconsistently within the health boards, and the implementation was superficial in some health boards, which led to the sustainability of the initiative being uncertain. These points relate to the three constructs of Relational Integration (RI), Skill-set Workability (SW) and Contextual Integration (CI).

As such, applying May's model is valuable for identifying the specific problems and gaps when implementing policy initiatives. It also helps assess the normalisation of policy interventions. Nevertheless, it focuses very much on the process of policy implementation.

Therefore, the different lenses of the two models have been applied in this thesis to synthesise understanding of policy to practice change. In effect, while each model has its limitations, their lenses are needed to help understand the full scope of policy to practice. Apart from this, these models also help build towards a typology in relation to policy initiatives. For the purposes of this thesis, it is now important to analyse and synthesise in more depth a typology of the four policy initiatives.

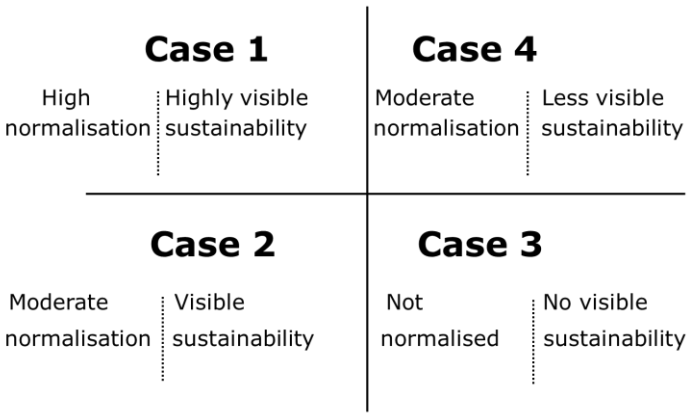
7.5. A summative typology of the initiative process and outcome

Through the processes of comparison and contrast above, it becomes possible to synthesise a summative typology of key process (normalisation) and outcome (sustainability). Figure 22 depicts this.

As a result, the findings regarding the visibility of policy sustainability, along with the degree of normalisation potential interventions presented

in Table 35 can be used to construct a summative typology of policy initiatives for the four cases (see Figure 22).

Figure 22: A summative typology of the initiative process and outcome



In Figure 22, a policy initiative was categorised as high, moderate, low or not normalised based on the evidence about normalisation from the preceding analyses. In addition, a policy initiative was also classified highly visible, visible, less visible and not visible based on the evidence about sustainability from the preceding analyses. Reflecting on the four cases, the construction of a typology for policy to practice development featured relatively distinct types. Case 1 was strongly normalised during the process of policy implementation with highly visible sustainability, as opposed to Case 3. Case 2 was moderately normalised with visible sustainability, while Case 4 showed moderate normalisation with less visible sustainability.

This typology might suggest some association between the concepts of normalisation and sustainability. However, the exact nature of this is unclear. It is interesting to note that perhaps the ideal initiative would be one that becomes so highly embedded that it becomes taken for granted practice (which may in turn make its sustainability less noticeable). In this regard, Patton (2002) highlights that typologies are built on ideal types rather than a complete and discrete set of categories. As Macduff (2007b) states in his review of typology in nursing, there is

the potential risk is that ideal types become reified as empirical data is fitted around them.

7.6. Findings for developing and refining the MAPPED model

When doing the in-depth face to face interviews, the participants were also asked to talk about the MAPPED model. Most of the interviewees shared their opinions and suggestions regarding the MAPPED model, only four participants decided not to comment on it.

7.6.1. The characteristics of the MAPPED model

Most of the participants thought that the MAPPED model was useful and helpful in understanding the nature of policy to practice change from top down. It indicated weak links and blocks within the process of policy development and implementation. It was also viewed as a policy tool for monitoring the progression of the policy initiative change. Some interviewees noted that the MAPPED model created a macro model for policy change at national level and a micro model at regional and local health board level.

'… so to know a bit more about why policy doesn't get into practice or how policy does get into practice, I think can help make sure that all the effort that does go into practice… and it is a bit akin to process mapping in a sense, where you are looking at where the weak links are and you could look at the nurse prescribing and come across a weak link in terms of preparation of the service and training the service and readiness for prescribers… and there are things as I described with that example where a tool like this could be helpful to just explore why it is not happening, to then use that to make it happen' (evaluator)

'I think the model is helpful, and understanding what happened between the policy being developed and actually being in operation' (central initiative staff)

'In my current experience working with senior charge nurses to help them thinking about, you know, taking forward and using tools in their practice, I think for some of them this would be quite useful because, you know, because having done some work with quite recently, with a group, in terms of how they look at change and manage change, it's very much like this isn't it' (manager)

However, the limitations of the MAPPED model were emphasised by the

participants. Those limitations and suggestions are presented in the following section.

7.6.2. Limitations and suggestions regarding the MAPPED model

The participants felt that the MAPPED model was difficult to understand, in particular, the language used in the model was very academic. Some participants were not sure how to use this model and they felt that model was hard to follow.

'I did find the terminology quite complex though and I had to keep reading through it. I just wondered why it needed to be so complex, that's all I would say. I can certainly see parallels with what happened with prescribing. I wasn't quite sure about this bit here, this individual agency/ collective agency what does that mean… The language is a bit difficult to understand but also the structure, the visualisation of it helps' (central initiative staff member)

On the other hand, most of the participants felt that feedback loops or spirals would be helpful to improve policy initiatives in future. One participant viewed the feedback provided evidence for policy development.

'While there is a top down yes, but this is what is informing that (.) so it is to have a more circular or it may be a case of you get to a point that you need to go back and so it could be that return loop as well as an overarching circle, you know, that way you could have your double headed arrows' (senior manager)

'It's a cycle of development, yeah, that's absolutely right… It does make sense of the spiral' (evaluator)

At the same time, some interviewees suggested that the MAPPED model needed to have some elements added in certain parts. For example, three central initiative staff members suggested adding 'strategic level' to part 4 of the MAPPED model. Others proposed that elements relating to 'barriers and supports'; 'leadership and partnership' should be added to part 3 of the model.

7.7. Summary

This chapter has provided a summary of the similarities and differences across the four cases regarding policy to practice change. This study has also compared the findings from the two different theoretical frameworks which were applied to analyse and synthesise understandings from the four cases.

Although the development, implementation and sustainability of the four policy initiatives varied, cross-case analysis indicated that some common and specific themes emerged from the findings across the four cases, the most dominant of which seemed to be the themes of 'policy internal alignment' and 'gaps and challenges'. In addition, this chapter highlighted policy external alignment at macro- level, regarding the external relationship between the four policy initiatives and others. This provided a broader vision as to how policy initiatives interact and link with each other, and how the initiatives developed continuously. This theme will be explained further in the next chapter.

Application of the two theoretical frameworks highlighted different features of the four policy initiatives relating to contexts, processes and outcomes. This enabled a summative typology of normalisation and sustainability to be constructed. Further consideration of modelling and explanation was evident in presenting the findings of the MAPPED model in terms of strengths and limitations.

The cross case analyses and syntheses undertaken in this chapter informed my thinking about the need to construct a new overall model for considering policy to practice initiatives. This will be presented in the next chapter within the context of discussion of the study findings.

Chapter 8. Discussion of the findings

8.1. Overview of this chapter

Following presentation of the key findings of the study in chapters five, six and seven, it is useful now to briefly review the study aims and research questions as a means of focusing on discussion of the study.

The research sets out to explore and explain the nature of policy to practice development in NMAHPs in Scotland through studying relevant reports and in-depth case studies. It was based on literature that identified the gaps in knowledge regarding policy to practice development and suggested the need for further systematic in-depth study for national policy initiatives. This study addressed the gaps through the central research questions:

a. Why and how did these particular initiatives emerge?
b. How did each project progress and impact?
c. What has been learned about each particular initiative (e.g. why did each develop as it did)
d. What has been learned across these initiatives?
e. What are the key transferable lessons from initiatives of this study?

This chapter will conduct a detailed discussion of the findings presented in chapters five, six and seven, along with reflection on relevant national and international literature regarding policy to practice development. The discussion includes three main sections. The first will focus on the key findings to answer research questions a-d reflecting on relevant literature, in order to ascertain the extent to which the findings fit with what is already known relating to policy and practice change. Based on the findings and literature, the next section will then posit a new explanatory model to help analyse individual policy initiative development at micro-level. The last section will discuss policy external alignment in connection with external relationship between policy initiatives and their continuous development at macro-level.

8.2. Understanding policy to practice initiatives

The process of policy to practice development is not viewed as step-wise and linear, rather a dynamic, iterative, interactive and complex endeavour (Sabatier 2007; Nutley et al 2007; Ross et al 2011). The complexities of policy to practice development are also well recognised (Rose 1979; Evans and Penney 2012), in particular, the diversity of policy terms used make it more difficult to understand (Wilson 2008). The central research questions a-d, however, can lead to a better understanding of policy to practice initiatives: Why and how did particular initiatives emerge? How did each project progress and impact? What has been learned from the findings?

8.2.1. Why and how did particular initiatives emerge?

Clearly, my study focused less on analysis of policy content, and much more attention was paid to the process of development of policy initiatives, in particular, the contextual factors which influenced their development, in order to answer the first research question.

As discussed in the literature review, the application of Kingdon's model (1995) and Ross et al model (2011) may give possible explanations as to why and how the four policy initiatives were formed and moved onto central agendas. The development of the four policy initiatives is compared and contrasted through the lens of the theoretical frameworks applied to the four case studies presented in Appendices 7 and 8, in order to gain further insight into the policy formulation process.

In Kingdon's model (see Appendix 8) the dimensions of problems, policies, politics and policy entrepreneurs paint a complete picture of the fundamental policy agenda, raising questions as to how and why the issues and particular solutions reach the top of the four policy initiative agendas. This gives useful insight for the case studies and literature review. However, the issues and problems are only likely to reach the government decision agenda when they are linked to the other three dimensions (Harrison, Moran and Wood 2002; Brunner 2008; Greathouse et al 2005).

While the dimensions of policy problems, politics and policies vary across the four policy initiatives, the policy entrepreneurs seem dominated more by leading professions who lobby. This agrees significantly with the previous study by Macduff (2007a). He found that these entrepreneurs were more an antecedent force rather than opportunistic respondents, in that they proactively brought the problem, policy and political streams together. Likewise, it is also suggested by Pettigrew et al (1992) that the process of policy formulation is very much to do with the actions of individuals, the reactions of individuals and the interactions between them. In other words, it is important to recognise that the key actors bring the problems and issues onto the policy agendas.

The application of Ross et al model (2011) yielded valuable information about policy contexts which move forward or constrain the formulation of the policy initiative. However, it needs to be borne in mind that the impact of context cannot be seen as separate from the wider issues of policy agendas (Pettigrew et al 1992). Evidence in the research demonstrated that contextual factors including inner and outer context had significant impact on the process of policy formulation (see Section 7.4.1). Although in the four cases policy context varied in the extent to which it drove the central agendas (Table 31), political advocacy, funding and professional lobbies seemed dominant factors in every case. These findings concur with other studies such as Ross et al (2011); Hunter (2010); Macduff (2007a); Hupe and Hill (2007) and so on.

Therefore, in order to address the first research question, this thesis provides an in-depth analysis of the development of the four policy initiatives, which are driven by different contextual factors. As the participants said:

'There is probably multi factors really but (.) there is the demographics of the population, you know an increase in people with long term conditions, older persons etc (.) the aging workforce and actually the fact that how can the NHS be sustainable with the amount of staff they have got etc (.) there was also another big impact was the European working directives' (educator).

'I think it was partly because of the profession arguing for it. I think it was partly because the nurses who were operating at government level were equally supportive. And you know I can't remember names, but there were some key people around, there were other senior you know the chief nurses for the country, who embraced this idea. And without their support then you would not get political support because all these changes had to come about as acts of parliament... You know it had to be legislated for, so without political support then you would have got to where we are' (evaluator).

The next section will discuss how the policy initiatives progressed and what impact they had.

8.2.2. How did each project progress and what impact did it have?

The answer to this research question is well mapped by Table 31 in Chapter 7 which summarizes the primary understandings of implementing policy initiatives constructed through empirical study. At the early stage of policy implementation, various educational training programmes were developed and enacted in innovative ways in relation to each of the four policy initiatives. During this stage, some difficulties and specific issues regarding the training programmes emerged from the four case studies. For example the educationalists were particularly concerned that the course design should fit the policy purpose and meet the real needs of practitioners, which is challenging. However, there is growing evidence to address the importance of managing the balance between expectations for policy change and personal needs (Ross et al 2011).

Furthermore, the completion rate and the attendance were much more influenced by the nature of policies and were at the discretion of individual practitioners. The most dominant issue was about the allocation of training time for the staff, who were often working in extremely busy clinical areas. These findings are much related to other studies such as Hunter (2010). My study suggests that good preparation for the development of a training programme is necessary, and how to promote good attendance levels is still a challenge for the policy implementation actors.

This study also systematically explores the factors which influence the implementation of policy initiatives. In particular, local contextual, cultural and individual influences were carefully analysed in each case. The findings indicated that national policies were interpreted differently at regional and local levels because of geographical diversity, organisational structures and cultures, which shaped the policy initiatives. Unsurprisingly the policy initiatives were implemented with different degrees of consistency across the four cases. The factors influencing policy translation process have been identified by previous studies (Ross et al 2011; Watt et al 2005; Green et al 2011).

In addition, this study identifies key project performers with different roles within the case studies. For example, in four cases national steering groups played a strategic leadership and a coordination role, and so were able to make decisions on how to utilize resources or how to disseminate policy during the policy translation process. Some key actors on health boards in each case were identified as champions to lead and scrutinise the implementation of the policy initiatives. The frontline individuals' values, beliefs, passions and behaviours were also often powerful enough to sway the progression of policy initiatives and change in practice.

These findings are very useful in helping to explain the multi-implementation theories on whether decision-making is top-down or bottom-up, or a synthesis of the two (Sabatier 1999). It is claimed that national policy is made from the top down, not from the bottom up, reflecting the values, interests and preferences of the governing elite (Dye 2001; Ha et al 2010). However, it is argued that the implementation of policy is influenced by frontline staff who can change policies significantly (Lipsky 1971; Hjern and Porter 1981; O'Brien and Li 1999; May and Winter 2009; Haycock-Stuart and Kean 2013). In particular, Haycock-Stuart and Kean (2013) suggest that developing a bottom up approach to the formulation and implementation of policy is more likely to positively engage with frontline staff that leading to a more successful policy to practice change. This view was also noted by a

range of different stakeholders in my case studies. For example, one educator said:

'I think that the people that were involved around the, the trainers, we had the first wave and the second wave, so there was about a dozen people in total and I think because they really felt it was the right thing to do and they were all credible practitioners, I think they were very influential. Cause they'd taken time out to become trainers, I think that their peers really valued that. So they would probably be the main influencing characters, I would say, the trainers themselves' (educator).

Subsequently, a combination of the study and literature review, a synthesised implementation theory of both top down and bottom up appears more logical and reasonable to explain policy to practice change. They are not absolute opposites, rather, they more or less interplay and interact (Sabatier 1999).

In addition to this, there were also a number of issues in the development of new role and an extended role, which arose during the policy translation process. In particularly, the role definition and boundaries need to be fully clarified (Ross et al 2011). As some participants described:

'…I think the only issue was that people didn't understand what the PEF job was going to be. They'd never had something like that before, it was totally new, they weren't quite sure what it was doing and that wasn't just everybody else, that was the PEFs themselves and me going 'okay' and it was the same for the university staff, they weren't clear either. So nationally and locally, people were a wee bit sceptical. They were going 'I'm really not sure what they're meant to be doing, they're just a bunch of folk', you know. So it did take a bit of time to get down to, and I say a bit of time, I mean a couple of years nationally and locally to work out what are the things? PEFs were doing things but it wasn't always clear what they were doing and why. It took people a long time to understand what they were doing, I think, that's what was the problem' (manager)

'But at the time that was one of the variations that there was, so my medical prescriber my medical practitioner who was my mentor did not have the understanding of this. so the professional issues of me undertaking the module was a concern to me because the direction I may have got from the medical practitioner might not have been accurate for me as a professional, it would have been accurate for them to direct another medical professional how to prescribe but not for me' (practitioner).

As such, systematic in-depth empirical study into education and practice has been critically important as a core for understanding the enactment of policy initiatives. There is also extensive evidence that confirms the importance of the policy implementation process, which is strongly associated with the policy outcomes (Durlak and DuPre 2008). Accordingly, analysis of the process of translating policy initiatives is well recognised by scholars, policy makers and practitioners because the process of translation is essential when assessing the internal and external validity of interventions (Walt et al 2008; Durlak and DuPre 2008). The internal and external validity of policy interventions has been evaluated by the application of May's NPM model (2006) in Chapter 7 (see Table 35 in Section 7.4.2). This is useful in building up knowledge of the processes by which complex policy interventions become or do not become routinely embedded in practice (May et al 2011).

The summative typology (see Figure 22) was constructed through the application of the three models following analysis and synthesis of a range of data (see chapter 7), which demonstrates the different policy process, impacts and outcomes across the four cases. The typology of policy initiatives allows people to make their own judgement as to the potential transferability of particular policy features (Macduff 2007b). It can also be used both as stimulus for developing more effective policy initiatives and for stimulating further research into long-term sustainable policy initiatives (Mitchell and Shortell 2000). Thus the four in-depth case studies were compared and contrasted, so that a cumulative picture of how the policy initiative progressed and impacted could be built.

More importantly, this study aimed to understand why these initiatives progressed as they did, particularly in relation to policy and practice change. The next section will give insight into what has been learned from the four policy initiatives.

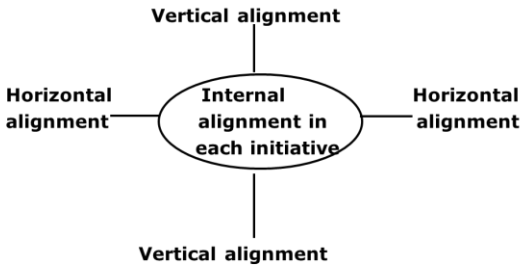
8.2.3. Undertaking policy to practice initiatives: what has been learned within and across initiatives?

Chapter 7 provides an answer to this question by presenting the main themes and subthemes relating to lessons learned from the policy initiatives, and the perspectives and experiences of the different stakeholders who were involved the initiatives. These findings also incorporate the significant factors which influenced and shaped the development. These key lessons and factors are discussed below.

Policy internal alignment

The case study analysis revealed the importance of policy internal alignment at vertical and horizontal levels, which was viewed as a skeleton to support each policy and practice change (see Figure 23).

Figure 23: Policy internal alignment



Currently, it is recognised that successful policy initiatives tend to involve a suitable 'policy alignment' in a world of competing and complex national policy and practice development (Bodas Freitas and Von Tunzelmann 2008). Within each initiative, internal alignment is concerned about a policy initiative's governance structures (control and coordination) (Mitchell and Shortell 2000), in relation to vertical and horizontal alignment. Policy vertical alignment refers to the extent to which a particular governmental sector has sought to implement the policy objectives as central in the portfolio and the hierarchies of management powers within organisations. For example, a Scottish

national steering group led the implementation of the policy initiatives, along with the hierarchal management, such as chief nurse, line manager and ward manager within health boards. Policy horizontal alignment is the extent to which a comprehensive cross-sectorial structure for the policy initiatives is developed within and across organisations (Lafferty and Hovden 2003), such as HEI and health boards; different departments within or across each health boards. Mitchell and Shortell (2000) also use 'high' and 'low' metrics as a possible categorisation for policy alignment. This helps in the construction of a typology of policy alignment. This is presented in the Table 36 below.

Table 36: Typology of policy internal alignment relating to vertical and horizontal alignment

Policy internal alignment	**Degree of alignment**			
Vertical	High	High	Low	low
Horizontal	High	low	High	low
Likely outcome in terms of influence on practice	High	Mixed, patchy	Mixed, patchy	low

Evidence shows that where the two policy alignments (vertical and horizontal) are high, the result is 'high policy alignment—high influence of policy over practice change'. Where the two are low, there is a 'low policy alignment—low influence of policy over practice change'. Even when one of the two is low, there is to some extent low influence of policy over practice (Mitchell and Shortell 2000). Therefore, both of the policy alignments interact to influence policy to practice change. This typology of policy alignment can be applied to the case studies in my enquiry (see Table 37).

Table 37: Typology of policy internal alignment applied in the four cases

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

To a significant extent, the Scottish government steering group led and controlled the four national programmes from a top down governance structure (vertical), while collaboration between universities and health boards, coordination between different disciplines within organisations, and support from peers and colleagues (horizontal) influenced the implementation of policy to practice change. Clearly, Case 1 had a high vertical alignment but horizontal alignment progressed during the implementation from medium to high. While there was a lack of administrative and medical support at an early stage, there was positive support from pharmacies. Case 2 had high vertical and horizontal alignments resulting in a very positive influence on policy to practice change. For example, there was a strong management structure (steering group, three regional coordinators, PEF leaders in each health board) and a strong PEF network system. In Case 3, vertical policy alignment was slightly low compared to other three Cases (see Section 7.2). At the horizontal level in Case 3, people complained about the specific funding for completing the training in a certain group, which had negative impact on the initiative. Although in Case 4 vertical alignment remained high, some line managers struggled with time allocation to staff for the training, and very few other professions attended the training, such as the medical group. In this regard, the research findings

showed that policy internal alignment had a significant impact on the implementation and sustainability of each policy initiative at micro-level.

Sustainability and normalisation

Importantly, this study has provided insight into the factors which impact on making a policy initiative sustainable and normalised in practice.

The cross case study provided a range of evidence from different perspectives concerning the sustainability of the policy initiatives. The findings also showed the different levels of sustainability in the four cases. However, the question is how to ensure a policy initiative is sustainable. The literature illustrates many factors that can affect the sustainability of policy initiatives, such as financial security, clear strategic planning, education, effective leadership, and support from different levels (Israel et al 2006; Parrish et al 2009; Scott 2007; Shediac-Rizkallah and Bone 1998). These themes were consistently emerging from my case study. The particular findings across the cases highlighted that policy alignment (discussed above) had a significant influence on sustaining the policy initiatives, in that a high level of policy alignment had a positive impact on sustainability. This would attract policy makers and other key actors, since less attention needed to be given to sustaining the policy initiative over the long term.

The analytic findings through the lens of the NPM model (May 2006) revealed the different degree of normalised practice in the four cases (see Table 35). In particular, this study critically analysed and synthesised why the policy initiatives were or were not embedded into daily practice. It focused on identifying the factors that promote or inhibit routine embedding from policy to practice. More interestingly, the degree of normalisation in implementing the policy initiatives seemed positively associated with the level of policy sustainability, suggesting an interactive relationship (see Figure 22). From this, it is important to recognise that the organisational implementation of a policy initiative along with normalised collective action, including exogenous and

endogenous factors, can support embedded practice in policy initiatives (May and Finch 2009). Nevertheless, this study is limited, in that it does not deal with how collective action can be normalised, and future study would be worthwhile.

However, the challenge is how and when to sustain policy initiatives in NMAHPs practice (Achterberg 2013). In other words, when should an initiative end: when it has served its policy purpose or when it has been thoroughly embedded in existing practice? For example, if central government stops actively engineering internal alignments, is an initiative sufficiently embedded/normalised within individual health boards that it will sustain itself? Case 1 and 2 show high sustainability associated with internal alignment. Focusing on internal alignment, Case 3 and 4 tended to show the opposite. Such approaches for sustained policy initiatives require more study (Achterberg 2013).

Leadership

As noted in Section 7.1.2., one of the most important lessons learned from the case studies was the importance of leadership, which is a theme frequently highlighted in the literature (Antrobus and Kitson 1999; Greenhalgh et al 2004; Cummings and McLennan 2005; Fixsen et al 2005; Stith et al 2006; Durlak and DuPre 2008; Callaghan et al 2009; Babcock et al 2010; Green et al 2011; Hunter 2010; Ross et al 2011; McNellis, Genevro and Meyers 2013). They suggest that leadership has a great influence on policy to practice change by shaping the system, altering the climate, balancing resources and leading the policy initiatives. Although leadership comes in many forms, scholars have identified that an organizational leader or leadership team from top down with a clear vision for policy to practice change, providing appropriate incentives, motivation and support, is essential. For example, Antrobus and Kitson (1999) have found that effective nursing leadership is a vehicle through which both health policy and nursing practice can be influenced and shaped.

Reflecting on this study, dispersed leadership still happened at a number of levels and in a range of ways. For example, individual nursing prescribers and PEFs in Case 1 and 2 were motivated personally and professionally to develop their own leadership skills in influencing practice change. However, the notion of leadership was seen as important at all levels from policy over to practice. One senior manger pointed out:

'Leadership, I think of leadership as being the primary influential factor in putting this into practice, most definitely…I'm just repeating what I said, but I suppose one of the most important aspects is around leadership and leadership at all levels so from executive to general management to nurses management to ward management' (manager Case 4)

The literature has also identified the profile of the effective nursing leader, along with the processes through which leaders interpret and translate the policy to practice change (Antrobus and Kitson 1999). The evidence from my study also supports this point, since it shows that the personalities, attitudes and values of the leaders greatly affected the interpretation of policy to practice development.

In addition, one of the significant findings from my study was that mid-level leaders played an important role in bridging the gap between policy and practice change, this is also reflected in other studies (Birken et al 2013; Carr et al 2009; Spillane et al 2002; Burch and Spillane 2004). As a participant highlighted:

'The next issue will be the leadership style and thinking of the, at the strategic levels, but also at middle line management and front line management of what's important to them and it also comes down to the individual level of people in those positions of what is importance in this work about' (evaluator Case 4)

Communication

Effective communication is well recognised as being a significant factor in successful policy to practice change (Greenhalgh et al 2004; Babcock et al 2010; Durlak and DuPre 2008; Williams et al 2004; Hunter 2010).

My analysis revealed that communication throughout the policy implementation varied considerably in each case. In particular, communicating an understanding of the policy was interpreted and translated differently in different health boards, which had a big impact on the practice change. The findings show that Case 2 and Case 4 were more affected by this than the other two. More importantly, Cases 1 and 2 established communication strategies using a diversity of communication approaches, such as by having regular meetings, conferences, emails, bulletins, telephone conversations, personal visits and so on. The structured communication strategies in Case 2 provided a good flow of communication among practitioners enabling them to share their experiences, issues and to deal with problems and solutions. One educator said*:*

'So, yes, it's a challenge, you've got to have constant conversations about it. It's no good thinking we'll meet once a year and never speak again. As the year goes on then, we've got to be communicating back and forth around some of the issues there are and thinking about how we solve them and what the solutions are to the issues that come up'.

At the same time, the findings identified that open communication in terms of listening to everybody was vitally important throughout the policy enactment process.

On the other hand, ineffective communication in the four cases was highlighted by various stakeholders. For example, some middle managers complained about lack of information about the policy nationally, which meant they did not feel part of the policy initiative. Communication across departments in Case 1 was impeded by administrative management with the result that the prescribing pad was delayed. This suggested the need for change in the organisational structure to facilitate effective communication. Such communication issues and the quality of communication have been identified as key elements in influencing a policy initiative's development (Tourish and Mulholland 1997; Scott, Mathews and Gilson 2012).

Nevertheless, a large number of participants thought that effective communication was highly necessary in order to give people a good understanding and awareness of the policy, and to engage people fully within and across vertical and horizontal communication networks, when implementing policy to practice changes.

Support from different levels

'Support' in those policy initiatives is the most pervasive finding of the study, and deserves extended discussion.

Support for policy to practice development in this thesis covers a range of actions taken at national and local government level, by the organisational management and administrative bodies on health boards, by professional bodies and by practitioners at the frontline. All areas of support have an important impact on policy to practice change, because they interact with each other (May and Winter 2009; McLaughlin 1987). In particular, the front line implementers are thought to be the key to practice change, since they are directly responsible for practice. Studies found that those responsible for implementation at various levels of the policy initiative did not always do as they were told, nor did they always act to maximize policy objectives. Instead at times they seemed to act quite individually, and to be frustratingly unpredictable, if not even totally resistant (McLaughlin 1987). Clearly, without support from frontline implementers, policy initiatives would simply pile up on shelves, rather than affect real practice. On the other hand, support from the top is just as important, because these people are leading the change by providing financial, managerial and monitoring back up. Correspondingly, May and Winter (2009) emphasize in particular the important influence of politicians, managers, and the dispositions of street-level bureaucrats in shaping actions from policy to practice change. Albeit, they have identified that the influence of politicians and managers is relatively limited in comparison to the influence of frontline practitioners' attitudes and behaviour regarding the policy and practice change.

Looking at my case studies, support from different levels varied, and to have visible support at all the levels within each policy initiative is still challenging. Evidence showed that there were some positive examples: the release of new resources for infrastructure, such as secured funding for the initiatives, protected time and a venue for the training programme, and establishment of a new managerial construction from top down. At the other extreme, evidence indicated that organisational priorities and structures had an impact on the policy initiatives and negative attitudes sometimes resisted policy enactment. For example, in Case 1 there was resistance from medical staff at an early stage, which meant a slow response to policy agenda. This was a critical problem, causing difficulty in finding designated medical practitioners to support the training.

However, there was strong support from top down, such as support from government and professional bodies, support from health boards, leaders, managers and colleagues. More importantly, both Cases 1 and 2 had solid support from practitioners, since they were highly motivated by promotion opportunities. Case 4 revealed that some line mangers seemed reluctant to allocate training time for their staff. However, support from service users greatly influenced policy to practice development. Case 3 was strongly supported by government funding, resulting in a high completion rate for the training programme. Unfortunately, the initiative ceased because of short term funding. Case 2 generally had strong support from various levels. One practitioner said:

'We have a lot of support. I am very lucky to work in the theatre ambulatory care team and we have the practice educator... So as a team we support each other. There's also the practice education support forum which meets quarterly and that's where all the practice education staff from NHS come together and we can support each other and discuss areas of good practice and maybe help each other out with training sessions…So the support is fantastic'.

Compulsory and voluntary policy

One of the significant findings across the cases is the issue of compulsory or voluntary educational training. In the case studies,

although the evidence showed that the compulsory training completion rate was higher than the voluntary one, it was argued by participants that the voluntary programme was more highly valued, shown by people's interest, enthusiasm and commitment to the policy. They put their heart into the training and this had the potential to increase their inner energy and the effort they put into the policy initiatives. However, they thought that possibly both compulsory and voluntary policies had 'pluses and minuses'. People need 'carrots and sticks' from policy through to practice change. One service user representative argued:

'*I think there's pluses and minuses for both. If it's compulsory then people potentially can put up more resistance and it feels like it's another top down ruling from the government. One of the advantages that recovery has had is through some of the initiatives not being compulsory, so people have come to it much more from the heart'.*

'That it's very difficult to get, to get it right around the extent to which a policy or initiative should ever be compulsory and that there's no simple answer to that one, I'm not just rushing to say everyone should do everything because I think it's, I think it's very complicated. That, probably this is a slightly different point, probably there's more to do in terms of supporting people as champions of new learning and new ways of working'. Having, you know, building up an infrastructure and a coalition and working with a group of champions in working outwards, might be more effective. I think that's everything'.

Literature also shows findings consistent with this cross case study. For example, Frehywot et al (2010) have identified three types of compulsory programmes in 70 countries. They find that incentive linked compulsory service programmes have better outcomes than non-incentive based ones and compulsory programmes are more effective. However, many health professionals object to compulsory service programmes because they are not always sustainable (Cavender and Albán 1998; Liaw et al 2005; Henderson and Tulloch 2008). Studies suggest that compulsory programmes should be accompanied by a supportive system and incentives, which may be more costly than none-incentive based compulsory programmes, but can maximise the effectiveness (Ferrinho and Van Lerberghe 2000; Liaw et al 2005; Omole, Marincowitz and Ogunbanjo 2005; Lehmann, Dieleman and Martineau 2008).

Motivation and incentives

The discussion above addressed the importance of support from people on the shop floor for the policy and practice change, the question is how to get the support from the policy implementers. In other words, how to motivate and encourage people to be fully engaged with the policy initiatives.

Motivation and incentives do not simply have a narrow financial definition, but also taking a broader view, they refer to a complex array of psychological and social mechanisms of support (Davies et al 2005; Marshall and Harrison 2005; Ross et al 2011). Some evidence shows that psychological and social rewards are of greater importance than financial rewards (Spooner, Chapple and Roland 2001; Chaix-Couturier et al 2000), which indicates that personal financial gain does not always drive professional behaviours (Marshall and Harrison 2005). The more convincing explanation of motivation and incentives involves understanding the relationship between external incentives such as material rewards and the internal motivation of health professionals, such as their personal values, beliefs and behaviours, personal interests and professional development. From the social/psychological perspective, the contribution of financial motivation can be maximised only if the impact of the financial incentives on the internal drivers of the health professionals is properly understood (Marshall and Harrison 2005; Holleman et al 2014). This is highlighted by Ross and her colleagues (2011), who have taken into account incentives of a contextual, professional and personal nature, which reflect a mixture of financial, psychological and social influences on policy to practice change. This thesis too, provides evidence of the importance of financial rewards and internal incentives. For example, the practitioners both in Case 1 and 2 were highly motivated by internal rewards, such as professional development, personal value and satisfaction, as well as being supported by secure funding. This had a very positive impact on policy to practice change. Some participants echoed:

'I think it was very much if you had local people who were keen to see

how things would develop or had services that at that particular time were in a state where they were developing and they saw prescribing as something that would make a big difference so they were ready for it' (evaluator)

'So being quite proactive about developing things and about CPD as well because it was not just about doing the course and starting to prescribe.it was about all the professional support and development you need it so where do we get that from what we went haven't got it for ourselves will stop' (practitioner)

'Yes, so the PEFs have done that themselves. I'm the manager for the PEFs but it's very light touch because the people we have in those jobs are very motivated, they're motivated to support the mentors, they do a fantastic job…They were a very excited bunch of people who came in and could see a chance to do something that nobody else had done' (senior manager)

In Case 3, the training programme took into account professional promotion in the boards, which motivated the newly qualified practitioners a lot to complete the training by themselves. As one member of central initiative staff stated:

'No, some boards, it's individuals' responsibly to get it complete, but where they will find the problems if they haven't completed and they go for a promoted post they're going to be asked why have you not completed it. So it's to their advantage in some boards to get promotion and to get other CPDs to complete this first. In all boards to get promotion they would have expected you to have completed Flying Start'

Thus, how to motivate frontline staff to be actively engaged with the policy initiative becomes an important theme emerging from the case studies. Even though the size of the motivation or incentive does not have a linear relationship with its impact (Marshall and Harrison 2005), well motivated policy implementers may generate distinctive outcomes from policy to practice (Ross et al 2011).

Competing priorities

Competing priorities within the policy initiatives varied considerably. Some stakeholders were quick to respond to the specific initiative and recognised it was critical to make it a priority at that time. Some

thought that the initiative was either out of touch with working practice or nothing new to the practice. Others thought that the initiative was important, but were unable to make it priority. The participants stated:

'*So there're initiatives that have been developed externally and then of course they need to be rolled out across the organisation. So sometimes those can take a bit of priority because they say 'this is a wonderful new idea' and it is, but it's kind of an add on, you're like 'okay, I've got all these other things to do and right, that's great' so it's trying to fit everything in and for them it's a priority cause it's new and they want it integrated. And for us we're like 'oh, that's fab' but not necessarily a priority in our minds to start with'* (practitioner).

"I think the main issues in terms of the translation process, once again it's about organisation priorities, what is a priority to an organisation? So, for example, here the priority will be ensuring students, you know, go through the programme successfully, but how do you do that? You want to ensure that at the end point of the student completing the programme they have acquired what the professional body has laid down, that this is a must, this is a should, in addition to what the university academic regulations say must and should have. So what, how that, you know, is achieved is ensuring that (Evaluator)

This finding concurs with the study by Macduff (2007a,b) who critically analysed contrasting priorities with the typology of Scottish family health nursing practice. Furthermore, lack of time for educational training, as identified by the case studies, is undoubtedly the overriding factor which people feel prevent them from being able to engage with the initiatives. Case 3 and 4 were more predominant on this point. This has been highlighted as a barrier in a large amount of literature and empirical studies, for example, in the findings from fifteen identified evaluation reports and Hunter (2010). Hunter (2010) emphasised that extra time must be given to the staff to engage with policy initiative change. Thus lack of time and competing priorities can combine to affect the policy and practice development.

Organisational culture

Studies have identified that organizational culture, stakeholder values and beliefs and the concepts of "what is in it for me?" were essential factors in influencing policy and practice change (Greenhalgh et al 2004; Fixsen et al 2005; Stith et al 2006; Durlak and DuPre 2008). They particularly identified a positive work climate, in terms of practitioners'

morale, trust and collegiality, the organisational norm and readiness (e.g. openness to change and innovativeness) and a shared vision within the organisation as a positive aid to change and vice versa.

Reflecting on my study, organisational culture in terms of organisational infrastructure and engagement, to large extent, impacted the policy initiative developments in each case. As one member of central initiative staff said:

'*As I've just described, some boards strategically picked people who were in a position to influence change. Some boards didn't. Some boards had very clear plans for implementation. Some boards didn't. Some boards had clear high level organisational buy-in to drive things'*.

In addition, the views of staff about the initiative, i.e. 'what is in it for me' seemed to influence the practice change. For instance, some participants described:

'I think we have some senior practice educator facilitators who've been around since the very beginning. I think they're quite influential…they know what's it's about, they're supportive of it. I think it's important that whoever's in the role that I'm in needs to have a very clear grasp of what it's all about and what their role is in that… If you don't have clarity around what those roles are there for and how they work together then you're lost a little bit'(manager).

'It's a good experience, I enjoy it, no two days are the same. I didn't ever see myself as an educationalist but I'm very glad I'm here. It's, as I say, interesting. Every day providing support in education and learning opportunities for people, not just student nurses, it gives you some joy because you're actually maybe progressing somebody, their development or even just having the light bulb moment when you explain it in a certain way and they go 'I get that now'. So it's just, it's just different and a good exciting, dynamic role' (practitioner)

Resourcing initiatives

Resourcing policy initiatives was a theme frequently highlighted by different participants in all the cases. In this study, participants specifically emphasised the need for resources such as funding, timing, administration, IT material, venues and staffing etc. In particular, selecting the right people, such as identifying the key stakeholders, effective leadership, champions in health boards, was seen as a valuable

resource to take the policy initiative forward. For instance, the participants stated:

'But getting the right people around the table agreeing on the title, the role, the function, the job description, the objectives was all very important to it' (central initiative staff)

'I think it is being able to identify the key stakeholders right at the beginning and to work with the key stakeholders' (evaluator).

Across the four cases, a large number of participants thought that sufficient resources, to some extent, meant that the policy initiative progressed more smoothly. By contrast, limited or lack of resources was seen as a barrier to the progress of the policy initiative.

Looking at other studies on barriers to policy and practice change, for example, Watt et al (2005); Sword, Watt and Krueger (2004); Cochrane et al (2007); Callaghan et al (2009); Baker et al (2010), have shown that lack of resources is a significant factor. They emphasised the need for sufficient resources to ensure the successful implementation of policy and practice change. These studies were also clear about how inadequate resources inhibited the policy enactment. While Sword, Watt and Krueger (2004) identified that timing could be particularly important for the policy initiative, Durlak and DuPre (2008) found that effective human resource management was one of the key factors which significantly influenced policy implementation. In particular, the ability to 'back fill' posts to free up staff was an on-going and significant difficulty (Wilkinson 2011). For example, in Case 4 the problem was the difficulty of providing replacement staff while others were off the ward undertaking the training programme.

Additionally, limited financial provision has been classified as one of the barriers to practice change by the Cochrane Effective Practice and Organisation of Care Group (Baker et al 2010). This was echoed by different stakeholders in this thesis. The most significant resource issue in all the cases regarding the four policy initiatives was the funding, which had great impact on policy dissemination and sustainability.

However, it is hard to establish which element within the resources is the most important when considering policy to practice change, because financial support, staffing, timing and infrastructure are interconnected in a policy initiative, and they can influence each other. Lack of any one of them can affect the policy to practice change (Baker et al 2010). There is a need to consider in some detail, the issues discussed above indicating that any one element of resources can be a barrier to policy to practice change.

As such, the discussion above has presented a picture of how and why each policy initiative developed and impacted. The important lessons emerging across the four case studies have also been analytically discussed and related to the relevant literature. Moreover, these lessons provided important material to facilitate the synthesis of an original and integrative explanatory model.

8.3. The development of a new model

Following the consideration of several models relating to policy analysis discussed previously and the application of two models, along with the findings from the case studies about the MAPPED model, I have developed a new explanatory model for analysing each policy to practice development. This draws on knowledge gained from the literature review (See Chapter 2), the discourse and the core themes of the 24 interviews and 15 reports. The central ideas came from the Walt et al, and Macduff models, integrated with the Kingdon, Pettigrew and, May models. The new model is presented in Figure 24, along with notes of explanation.

Figure 24: A new model for analysing policy to practice initiative adapted from Macduff (2007); Walt et al (1994); Kingdon (1995); May et al (2011); Pettigrew (1988)

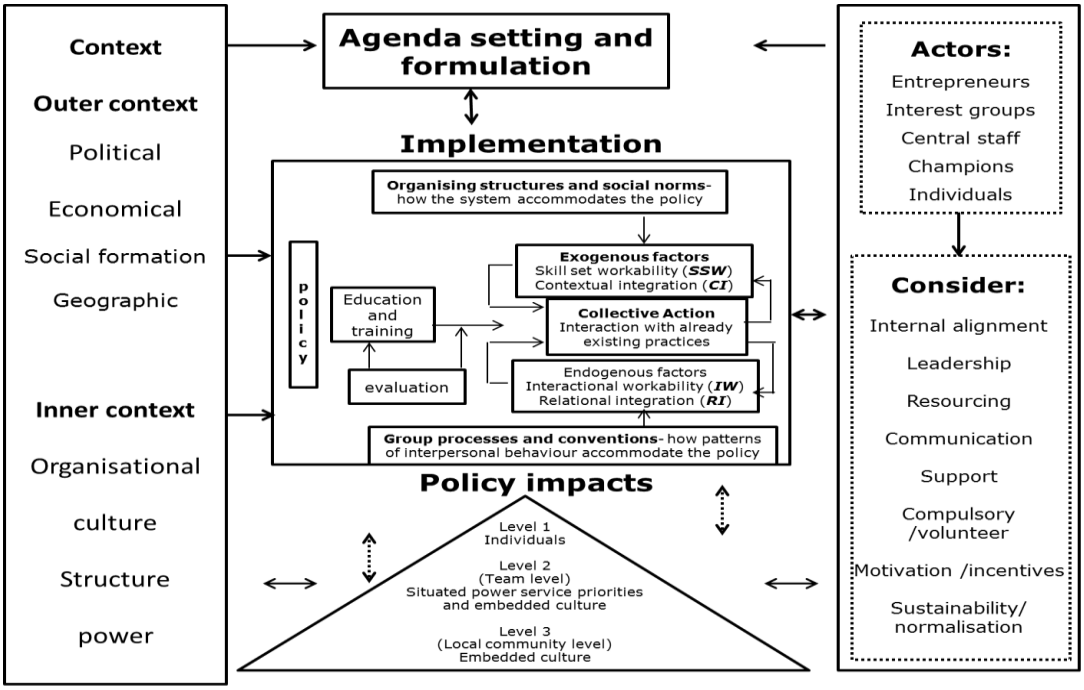


Figure 24 presents a new integrated model for analysing each policy to practice development. This links the policy triangle model (context, content, outcomes and actors) provided by Walt et al, the explanation of policy to practice development from top-down provided by Macduff's MAPPED model, the explanation of context factors, which may impact on policy and practice development provided by the Pettigrew model, the explanation of policy implementation processes provided by May's NPM mode, and the explanation of policy agenda setting provided by Kindon's multiple windows framework.

This integrated model can provide useful insight. It can help explain and understand the structures, processes and impact from each policy to practice development. It can also be a tool to help explore weaknesses in and barriers to the processes of policy to practice initiatives. This can link to the cross case findings of gaps and issues when translating policy into practice. In particular, it shows four detailed features of each policy

implementation process, which can be used to examine whether the policy has been embedded into practice, and to identify the problems and issues emerged from policy intervention including exogenous and endogenous factors.

More importantly, this model examines policy to practice development not only from top to down, but also incorporates the influence of bottom to up through key actors such as local champions and front-line staff. Apart from this, it is very clear that the new integrative model addresses the key actors throughout the process of the policy to practice development. At the same time, some important factors influencing on policy translation process need to be considered, which are associated with the key lessons learned from the case studies regarding leadership, communication, support, motivations and sustainability and so on. This is vital to make policy development spiral and make the policy implementation process run more smoothly and become sustainable.

The new model highlights the power of policy contextual factors, both inner (e.g. organisational structure, culture and power) and outer (e.g. political, economical, social factors), which may influence policy initiative development. The findings on internal alignment at vertical and horizontal levels are incorporated in the structure and format of the model. In turn, the policy outcomes may lead to changes in both inner and outer contexts, such as individual changes, organisational changes, social culture or political change. In addition, the new model also incorporates the research process into policy development, starting with education and the training programme.

As such, the new model provides a potentially valuable framework to analyse prospectively (or retrospectively) how a particular initiative might be best rolled out and the consideration of the important factors that will influence similar types of development within and beyond NMAHPs.

Overall the above discussion has tended to focus on individual initiative in isolation at the micro-level. However, as one of the key themes 'competing priorities' showed, staff are usually dealing with serial demands and a number of concurrent policy initiatives. In moving towards the final parts of the discussion, it is important to step back and adopt a more macro-perspective on how policy initiatives variously evolve, co-exist, align and decline or prosper. In the next section I will discuss the dynamic development of various concurrent policy initiatives on health boards and the relationship between them by means of macro-level consideration.

8.4. The relationship between policy initiatives (policy external alignment) and their continuous development

8.4.1 Policy external alignment

Another significant finding of this study demonstrated that there were some important thoughts from different participants regarding policy external alignment at macro-level in connection with external relationship between policy initiatives

While dynamic, integrative and interactive relationships were identified across the case analyses, literature and empirical studies also recognise the challenges of how policy initiatives work with each other when they are all in place, and the importance of seeing one policy as 'part of a big jigsaw' (Sölvell, Lindqvist and Ketels 2003; Ketels 2003). As one of the participants said:

'I certainly think they are but I think they coincided with a number of other things like, we said the quality standards for practice placements, you know, the work that we've done since then around retention to the undergraduate programme. There's a whole lot of work around that and practice education is a part of that so, I think it's important to see it as part of a big jigsaw where if you take one piece out it's going to be missed but really, so it's important to have all the pieces in place and to think about how they work with each other and how you demonstrate that they work with each other' (line manager).

Sölvell, Lindqvist and Ketels (2003) termed the 'big jigsaw' as a cluster of initiatives. The definition of cluster initiatives is used diversely, with a critical debate about the dimension and value added by the cluster concept, since it is context-related, and driven by purpose (OECD 2010; Schmiedeberg 2010). However, in this thesis the term "cluster initiatives" is used to describe a group of policy initiatives with different forms and objectives supported and implemented within a region at a specific period of time.

Sölvell et al (2003) first attempted to analyse the process and structure of cluster initiatives based on a broader sample of more than 250 of them, which provides interesting initial insights into cluster initiatives. Sölvell et al (2003) have identified that dynamic policy initiatives offer a new way of conducting policies to promote organisational competition and to enhance institutions for collaboration through advanced training and scientific infrastructure. They highlight that dealing with these initiatives heralds a new era in the development of policy initiatives, in terms of how they should be carried out effectively. In particular, structures and processes used to progress certain initiatives could be adopted or adapted to translate other policies or a cluster of policies, into practice effectively.

'Model we use in terms of lead contacts is replicated in other programs at work I think probably what happens needs now is lessons learnt that there are lots of different education programs and we can't have steering groups and lead contacts every single one because of the fiscal climate it was a luxury we probably had when this program project was developed so we need to have an overarching steering group for contacts within that because it tends to be the same people who come to all the different meetings so I think that's properly a lesson learned and I learned we have a good model in terms of steering group lead contacts vocational contacts and have to say the infrastructure perhaps education structure is integral to any kind of policy and health education (central initiative staff Case 3)'.

To a significant extent, some initiatives have strong thematic and temporal linkages with each other. For example, the linkages between 'Leading Better Care' and 'Value-Based Care'; 'Nurse Prescribing' initiative and 'Advanced Nursing Practice' happened in Scotland.

However others do not effectively link to each other. For instance, some new policy initiatives may be 'locked in' or clash with existed initiatives which make the new initiatives more difficult (OECD 2010). Notwithstanding, the cluster initiatives share some common patterns of organisational structure such as organisational infrastructure, leadership and staff, and some general process of translating policy into practice, as a consequence of aspirations to improve patient care directly or indirectly.

Reflecting on the 15 policy initiatives, most of them were not thematically linked to each other, but they might share a similar organisational structure, some general process of translating policy into practice and some of the potential lessons to be learned. However, the question is how did these cluster initiatives co-exist and develop?

The clear message is that the implementation of these initiatives at the time depends on the strength of interaction between the various organisations involved, which allows knowledge to flow more easily and enables the participants to organize collective actions with a significant impact on how the available assets of the policy initiatives are deployed (Ketels 2003). However, the weakness of inappropriate policy external alignment can be an extra barrier to policy and practice change (OECD 2010). For example, the evidence in this case study showed that cluster policy initiatives sometimes confused staff. They viewed them simply as recycled ideas. One senior manager in Case 4 experienced:

'It was interesting people saying 'oh this is just the same stuff as we got years ago, the same stuff, different day' but it was my first real experience of this type of thing so it was interesting just to hear people, you know 'oh that's everything just goes round in a circle', that was quite an interesting lesson to hear. Instead of thinking what we were doing was something bright and shiny and innovative. It wasn't really, it was maybe just a little bit more structured than it had been before, yeah?'

On the other hand, the biggest challenge for local organisations is how to use the impetus of those initiatives and to integrate them into

organisational strategies. In other words, what is more important is how organisations and individuals adopt the new way to prioritise and organise policies. As one senior manager stated:

'Health boards don't necessarily, won't necessarily do what the government suggests they should do. Because they don't have to do it. You know, my naïve mind thought that if the government said this had to done it should be done, but it didn't contribute to the HEAT targets. It didn't contribute to the delivering for mental health because that was quite specific around, you know, targeted pieces of work, so actually health boards had to be very focused and focused on what the outcomes would be for them before you get the buy in. You had to really sell it and say how it would impact on the practice and make the links towards delivering for mental health because without that they couldn't see it.'

Reflecting on my case studies, while the government seemed to be important in terms of funding the initiatives and ensuring some level of organizational support, local organisations and individuals played a critical role in prioritising and integrating the policy initiatives into real practice. Otherwise, the policy initiatives would either simply pile up on the shelves or be added to the paper work. One practitioner stated:

'So it took a wee while, but obviously it's quite embedded now but obviously if anything else comes out, a new initiative, we might add it on to the paperwork, but it'll be easy enough done' (practitioner).

As such, having comprehensive strategies of developing an appropriate and flexible policy external alignment is necessary, in order to help cluster policies adapt to the particular regional and local context, and to also help address and mitigate the risks associated with cluster policy initiatives (OECD 2010).

Nevertheless, too little attention has been paid to studying the appropriateness of cluster health policy initiatives in NMAHP. They are rare and often not very robust (Andersson et al 2004). Hence, it serves for further study.

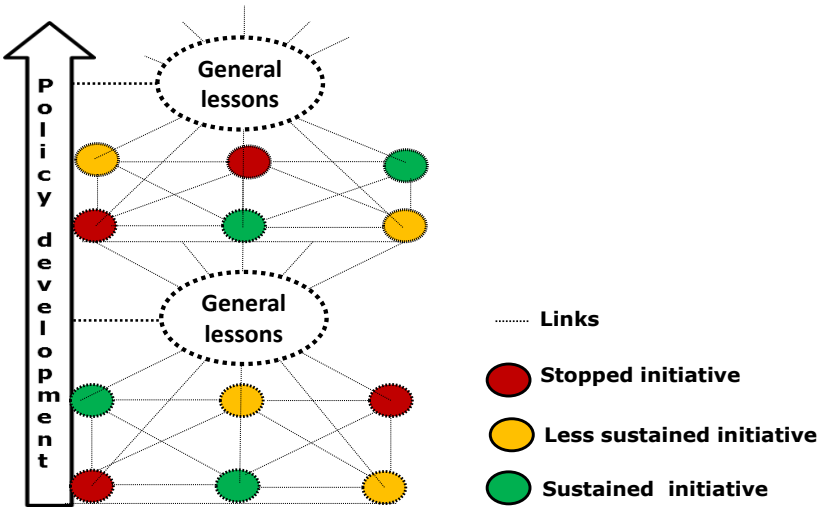
8.4.2. The continuous development of policy initiatives

The research findings indicate that policy initiatives develop over time, and are not a phenomenon that just appears or disappears overnight.

They are continuous, dynamic and iterative and coherent with policy cycle (see Figure 1: ROAMEF model). However, it is argued that continuous success of cluster policy initiatives depends on their capability to change and to adapt (Andersson et al 2004; Schmiedeberg 2010).

The evolution of policy initiatives can also be seen in the case studies. For example, in Case 1, the policy initiative has evolved over ten years through legislation to upgrade it. In Case 2, the initiative has matured by establishing a permanent post in boards. The legacy of Case 4 initiative remains important via pre-registration education. Evidence from the case studies also suggests that these initiatives are going through different stages of a life cycle, where some of them are sustainable in policy long term, some may wither in the end but are important in laying the ground for later efforts, and some may not be well sustained (see Figure 22 and Figure 25).

Figure 25: A model of the dynamic, continuous and iterative development of initiatives from policy to practice



In Figure 25, the round dots with three colours represent the different types of policy initiatives discussed in section 7.3. The green represents sustained policy initiatives, the yellow is less sustained initiatives and the red is the initiatives which fail in the end. Some of these initiatives

may impact on practice change at the time and develop dynamically, so that they may significantly drive policy change through systematic reviews or studies or feedback via key actors through to policy makers. Therefore, the policy initiatives are not static but continuously develop (Figure 25). They can be further developed to a higher level with new models to lead practice change derived from general lessons across the successful and failed initiatives, along with the continuous and dynamic development of policies, in order to provide the best care to service users. Two examples of this are the development of nurse prescribing and advanced nursing practice in Scotland. We must bear in mind that the new models of policy initiatives at the higher level may incorporate sustained initiatives or less sustained initiatives. In doing this, the new developed initiatives at the higher level (Figure 25) play new roles in practice change. Accordingly, these initiatives will again become one of the three types of policy initiatives (sustained, less sustained and un-sustained initiatives) based on the progression of each policy initiative. As such, new policy solutions can be further devised and developed continuously and iteratively. Moreover, the 'general lessons' from previous initiatives can be crucial as potential facilitators or setbacks to influence policy makers, managers and practitioners for improving or hindering subsequent ones.

The dynamic and continuous development of policy initiatives was also recognised by some stakeholders in the case studies, such as:

'And I quite like the fact that it's now moved in to the sort of quality strategy and we're using those bits of work from that. You know, the patient experience and the, the work behind that, the person centeredness. I like that because I think it keeps it fresh. I don't think we can keep going on about the 3Rs and the values practice based and recovery. I don't, I think, I think it's just what people said 'it's the same thing, it's just different' but actually maybe that's how it has to be. It always has to be reenergised. I think that would be, from a managers point of view, to keep you interested I think it has to be the same thing but just done differently' (manager).

To date, however, much of this process of learning seems to be left to individuals and has not been systematically harnessed. To this extent

Figure 25 may be seen as rather idealised but is a potentially useful outcome of this first systematic attempt to examine NMAHPs initiatives in Scotland. Bardach (2008) highlights the importance of this collective learning from policy to practice developments but dynamic analysis of the policy initiatives is still in its infancy. Consequently, more attention needs to be paid to research findings regarding how policy initiatives work in place, and what their impact on policy to practice change is in the future.

8.5 Summary

This chapter has critically discussed the findings from cross case study, informed by literature review. In particular, this chapter analytically reviewed how and why the policy initiative developed and was implemented, drawing on the findings that emerged from the systematic in-depth case studies (including the 15 reports), in order to better understand the nature of policy through to practice change. The discussion was also informed by theories and models to provide deeper insight into conceptual thinking regarding policy and practice.

The discussion chapter provided in-depth review of lessons learned from this study. It incorporated the significant factors, which shaped the policy developments, borne out by the literature. Policy internal alignment was a prevalent theme, drawing on the different perspectives from diverse stakeholders. This offered an opportunity to construct a typology of policy internal alignment to help understand how the different types of internal alignment affect the policy over to practice change. To a significant extent, this showed that constructing effective and structured management relating to policy and practice development is crucial.

The development of a new model helps to understand more clearly how a particular policy initiative can be rolled out at micro-level. The origins and contributions of the new model have been discussed in detail. In addition, this chapter has discussed policy external alignment and the development of dynamic and continuous policy initiatives, which have

created another useful lens at macro-level. Accordingly, this critical review of the findings indicates that there is a need for more systematic studies regarding cluster policy initiatives.

The next chapter will provide conclusion to the study by presenting reflection on the study, and the implications to policy, education, practice and future research with relevant recommendations.

Chapter 9. Conclusion

9.1. Overview of this chapter

This chapter concludes the thesis by reflecting on the research methodology and methods, and considering the implications for future policy, education, practice and research, along with relevant recommendations. It ends with reflections on the last of the study's research questions.

9.2. Reflections on the study

While the key findings of the study were discussed in detail in the last chapter, the review of the study below focuses on the contribution of the research, and reflects on the conduct of the study along with its strengths and limitations.

9.2.1. Reflections on the research methodology

Reflecting on the study, chapter three gave a detailed analysis of the decisions made regarding the selection of methodology. The methodology was selected as one that reflected the need for qualitative studies of policy and practice development, in order to answer the research questions adequately (Ritchie and Spencer 2002). Accordingly, in-depth case studies were considered appropriate for health policy analysis in order to systematically investigate a phenomenon in its real-life context (Yin 2003; Berg and Lune 2012). These are to be distinguished from other types of research, such as evaluation research.

The use of case studies in previous health policy analysis (Ross et al 2011; Ha et al 2011; Ridde 2008; Green et al 2011; Williams et al 2004), and by experts in a review of published literature (Gilson and Raphaely 2008), along with the guidance offered by a substantial body of work (Yin 1994; Brady and Collier 2004; Alexander and Bennett 2005), underpins this as an appropriate choice. This enabled me to understand the way in which stakeholders were actually involved in real policy to practice change, and provided substantial insight into their various views regarding the policy initiatives investigated in this study. The use of

multiple sources of data provided the depth and breadth of understanding of policy and practice development, which was seen as one of the contributions to the research study (Robson, 2011; Berg and Lune 2012). Furthermore, the methodology enabled contrast and comparison across the cases by undertaking the four case studies, which is again a strength, since this met the methodological aims and objectives of this study (Wilkinson 2011). Yin (2003, P46) suggests that multiple case studies are frequently 'considered more compelling, and the overall study is therefore regarded as more robust'. However, to date, there is a paucity of systematic empirical study relating to nursing policy to practice development in Scotland. This study has contributed to filling this gap.

9.2.2. Reflections on the research method

Research design

The retrospective study was designed as multiple case studies to systematically analyse and synthesise the key lessons learned from those completed Scottish policy initiatives. Although some initiatives were carried out some years ago, which may affect the participants' ability to recall exactly what happened, this is not thought to have hindered the research, because a historical perspective can yield knowledge of value to the health care service more generally (Macduff 2007a). The nature of the study concerns what key lessons can be learned from policy to practice developments. Many participants were able to provide robust information about their perspectives and experiences with detailed recall, while others struggled with specific recalls. The documentary data, in particular the 15 evaluation reports were a valuable additional source of both subjective and objective data (Robson 2011). They provided background information on the policy initiative's context, process and impact. This contributed to a holistic picture of policy and practice development in each case.

This study also conducted a thorough and novel review of the identified 15 Scottish policy initiatives, generating new ideas for evaluating the evaluation reports themselves. This review helped develop case selection strategies. The strategies for case selection offered the rationales of how and why the cases were selected. These cases were selected not to cover variations in the geography or size of projects, but they were considered to provide a balance in the different attributes of policy initiatives from a theoretical perspective. The cases selected took account of a number of characteristics regarding policy initiatives, such as projects relating to different intended outcomes: a new role; an extended/expanded role; an enhanced role development and a general educational framework. In particular, each of the cases was concerned with its own specific context, organisational culture and individuals. However, the nature of the similarities and the patterns that emerged will be a part of the future development of Scottish policy initiatives.

Methods for data collection and analysis

A combination of purposive and snowball sampling enabled access to participants (Penrod et al 2003; Berg and Lune 2012). As a result, 24 face to face in-depth interviews were successfully achieved though this was time-consuming. Access to a range of different stakeholders with a diversity of policy initiative roles in each case also provided multiple perspectives (McDonnell, Jones and Read 2000; Berg and Lune 2012; Denzin 2012).

The application of multiple theoretical frameworks to analyse and synthesise the collected data meant the study was more structured and comprehensive, and therefore increased the depth of understanding regarding policy initiatives (Denzin 2012; Berg and Lune 2012). More importantly, these theories helped develop an integrated model to better explain policy to practice change, which was seen as one of the original contributions of the study. Finally, this study applied NVivo 9 to effectively manage data and to greatly help cross-case analysis. Thus, the use of multiple sources of data, case studies, using NVivo for data management and analysis, and theoretical frameworks enhanced the

rigour of the study (Miles and Huberman 1994; Burns and Grove 2001; Berg and Lune 2012; Denzin 2012; Saldaña 2013). In these factors lay the strengths of the study design, in that they provided breadth and depth to the data and also added a theoretical framework to the analysis (Denzin 2012; Berg and Lune 2012; Silverman 2010; Williamson 2005).

Therefore, this study has demonstrated the value of a first systematic in-depth research study of Scottish policy to practice developments in NMAHPs. The findings of this study are relevant for the field of NMAHPs policy to practice development in general. Most importantly, the comparison and contrast of the findings from the above studies has resulted in a comprehensive list of critical lessons for the development of future initiatives that might be considered by policy makers, educators, practitioners and others with the aim of improving patient care.

9.2.3. Reflection on the limitations of methodology and methods

Reflecting on the study, several limitations can be recognised. First and foremost, the limitations of case study methodology have been detailed in Chapter 3.2.2.2. In particular, the selection of four particular case studies meant a limitation of scope. The main reasons why only four cases were selected for systematic in-depth study were pragmatic. The study period was time-limited, there were financial constraints and there were difficulties in arranging access to different stakeholders across Scotland. Moreover, when research ethics procedures were taken into consideration, choices had to be made. However, the number of cases is not the most important thing in in-depth case study, as it is generalised to produce theoretical propositions rather than to provide information for specific populations or universes (Yin 2014).

The use of snowball sampling for participant recruitment is another limitation, since it inevitably tends to introduce colleagues and friends from the interviewee's own networks (Berg and Lune 2012). Moreover, the participants in this study came more from governmental, academic and managerial levels, rather than practitioner and service user levels (see Table 11).

Thirdly, I am still relatively inexperienced as far as interviewing and qualitative analysis are concerned, which meant that on occasions I missed opportunities to ask questions or to fully probe and interpret the participants' perceptions. For example, when some participants answered that leadership was the most influential factor, at first I did not always probe why that was. In addition, my own cultural background in terms of nationality and immersion in professional nursing to some extent influenced interpretation of the data, although this was mitigated by checking from my supervisory team.

Finally, it is important to acknowledge that on occasions there were different interpretations of, and reactions to, initiatives from the different disciplines involved (e.g. nursing and AHPs). However this was not a prominent theme and the research was not designed to explicitly focus on a comparison of this sort. It is proper to note though that my own professional background, and that of my Principal Supervisor, make it likely that interpretations may be predominantly nurse-centric at times.

9.3. Implications of the study and related recommendations

It is said that transferring any research knowledge needs the interactive engagement of relevant audiences to make it effective (Lavis et al 2003). However, Lomas (1990) argues that the impact of any study findings depends on its capability and capacity to change the beliefs, values, and policy assumptions of the relevant audiences. The next section will explore the overall implications of the research findings for health policy, education, practice and research.

9.3.1. Implications and recommendations for policy

At national policy level, policy translation is sometimes insufficient to introduce practice change effectively. The organizational, professional, and social contexts within which the policy is to be implemented must be thoroughly considered (Ross et al 2011). Evidence from this study shows that there is still a need for effective policy translation processes and greater monitoring of policy initiatives. This study has demonstrated that the factors regarding policy alignment, leadership and resourcing of an

initiative greatly affected the effectiveness of implementing policy to practice change.

To disseminate and sustain the policy initiative successfully, policy internal and external alignment at temporal, vertical and horizontal levels emerged as an important element across the cases. This study showed that high policy internal alignment at both vertical and horizontal level had a great influence from policy to practice development in each case. Any aspect of policy internal alignment can affect the effectiveness of national policy initiatives. While the role of political commitment to the governmental led initiatives is essential, the horizontal alignment across the managerial bodies who will handle the important issues is critical. Only when policy internal alignment is solid at hierarchical central control and there is cooperation with horizontal inter-managerial bodies, does the policy initiative seem to run smoothly. At the same time, having appropriative policy external alignment is critical to balance the competitions and priorities of cluster initiatives at the time and to support rather than hinder each other. Therefore, it is strongly recommended that:

1) ***The development of a strategy for policy internal alignment involving top down and cross-sectional cooperation, and appraising policy external alignment (cluster initiatives) needs to be considered more deliberately when progressing a policy initiative. My model offers a means for prospective, concurrent and retrospective considerations in this regard.***

There is a need for continuous effective leadership and support for the policy initiatives. This study showed that strong leadership at all levels seemed to be inevitably fundamental for policy to practice change. In particular, strategic leadership which provided clear guidance, managed different expectations and enabled people to clearly understand the initiative through effective communication, was perceived more successful in leading the policy enactment. Strategic leaders need to take the critical issues, potential difficulties and specific challenges of

policy formulation and implementation into account because of the scale of the project. The creation of a long term steering group with leadership involving core central initiative staff, clinicians, educators, and researchers is of great potential benefit in transferring policy into practice effectively. At the stage of policy formulation, lobbies from professional leaders seemed to be a critical factor in driving the policy initiatives. This indicates that it is necessary to consult with all key stakeholders throughout the process of policy formation, in order to make the policy more feasible and workable.

The issues of resourcing the policy initiative emerged as one of the generic themes across the four case studies. Thus, attention needs to be paid to certain resource issues in order to implement change effectively. For example, the successful joint funding in Case 2 seemed a good example of secure financial support for the implementation of the policy initiative and this also meant that the three funding bodies were fully involved and actively engaged with the initiative. However, the importance of financial resources for ensuring policy initiatives is likely to be addressed at national level in all cases, which highlights the dedication of the Scottish Government to improving health care through policy to practice change. Staff shortages, which had a negative impact on the ability of practitioners to engage with the policy initiative, had significantly hindered the policy to practice change in Case 4. For example, the lack of staff resulted in difficulty in allocating protected time for practitioners to take part in the initiative training programme. If bottom-up approaches are presumed to be critical as already discussed, then sufficient staffing to smooth the progress of initiative development will be fundamental as a means of engaging practitioners with policy to practice change (Wilkinson 2011). Across the cases, some participants emphasised the importance of selecting the right people to lead and implement the policy initiatives effectively. This implies that decisions taken during the process of recruitment and retention are vitally important. In particular, selecting appropriate leaders for different levels was not just about their leadership skills, but their profiles and their personalities were equally important. Thus, it is suggested that:

2) ***Fostering continuous effective leadership at all levels should be a top priority, and extra time should be allocated to key actors rather than adding to existing workloads.***

The lack of formal national and local monitoring of the effectiveness of policy initiatives was another issue that emerged in the case studies. While most of the policy initiatives had been evaluated by external commissioned research, which was able to produce some evidence of the progress of the policy initiatives, a politically commissioned evaluation study is limited and may not be as effective as formal monitoring systems such as an audit (Hunter 2010). It is therefore suggested that:

3) ***The establishment of reliable concurrent monitoring system for policy initiatives to gauge their enactment and effectiveness is very important.***

Unsurprisingly, this study showed that most of the 15 evaluation reports had predominately positive rather than negative views of the policy initiatives. Furthermore, most of the reports lacked any theoretical or conceptual models to guide the research design and analysis. The evaluation research was also limited by a relatively short time scale or by the demands of a quick policy shot (Jowell and Britain 2003). While a large number of stakeholders in all the cases agreed that the evaluation reports provided significant evidence for policy to practice change, these evaluation reports in themselves were episodic and fragmental, failing to build up cumulative knowledge to provide robust and convincing evidence for policy to practice developments. Moreover, evaluation researchers need more space and autonomy to express their criticism. Accordingly, there is a pressing need to develop a structured analytical framework for policy evaluation research, so that the reports are more constructive and comprehensive, and to further improve the rigour of evaluation research (Denzin 1989). However, the processes of policy development are not linear, the challenges of policy ambiguity and complexity need to be fully taken into account. Accordingly, it is recommended that:

4) The systematic study of these evaluations needs more attention and resourcing.

9.3.2. Implications and recommendations for practice

As has been seen in Chapters 6 and 7, at practice level, the depth and breadth of policy enactment varies across the four cases. Moreover the study has identified variations associated with the crucial areas of effective communication, collaboration, competing priorities, support networks, organisational factors, personal and professional attitudes and motivations, engagement with policy initiatives and the need for involving service users in local health boards. The evidence indicates that in some health boards, the policy initiatives could be rolled out even further and the practice could be more widely and deeply embedded if those critical areas played a more positive part and their development was encouraged instead of obstructed.

The findings from this study support the need for practitioners to have greater engagement in policy to practice development. The need is both for improved exogenous processes regarding how organisational structure and social norms accommodate the policy to practice change, and endogenous processes relating to how patterns of interpersonal behaviours adapt to practice change. The need for enhanced, good and open communication at both vertical and horizontal levels to enable staff to fully understand and be aware of the policy initiatives was demonstrated. The desire of practitioners to be supported by a more visible, effective and structured management network and the need for identified champions in boards as evidence of their support, interest and commitment was clear. It is evident in this study that building a supportive network and collaborative relationship between initiative post holders within and across organisations and departments to exchange and share information about the best practice and solutions is vital, but may at times be lacking in the operational management system.

The case studies demonstrated that middle level managers and line managers acted as a conduit for policy and practice in the top down

process. However, the demands of their local priorities could mean the policy initiative taking second place. Sometimes they also did not feel part of the policy initiative, as they were not fully informed about national policy. Consequently, this could be a negative factor influencing the effective implementation of the policy initiative. This concurs with the study by Durlak and DuPre (2008). Evidence suggests that there is a need to address the role of middle level and line management in progressing policy to practice change (Birken et al 2013; Wilkinson 2011; May and Winter 2009).

In the case studies, geographical diversity and the organisational system and culture had a significant impact on the policy translation process. In particular, organisational culture, including a positive work climate with shared vision such as staff buy-in and organisational norm regarding the policy initiatives such as openness to change, has been identified as an important factor in progressing policy to practice change (Durlak and DuPre 2008; Greenhalgh et al 2004; Fixsen et al 2005; Stith et al 2006; Mackenzie 2008). In addition, there is scope in each board to find a way of prioritising the efforts of the policy initiative by making it reflect national priorities. This means that attention needs to be paid to how an organisation integrates and incorporates the new policy initiative into its existing practice and routines. On this basis, it is recommended that:

1) ***The role of middle management needs to be more deliberately addressed in progressing policy to practice change, by ensuring these managers are enabled to have a greater understanding of and engagement with policy initiatives. Targeted training and more long-term educational initiatives would be useful in this regard.***
2) ***The influences of organisational factors and local cultures need to be actively taken into account.***

This thesis has shown the issues and problems that arise from the implementation of policy initiatives at local health board level, which impede the progress of policy to practice change. Some uncertainty remains about the extent to which the complex interventions of the

policy become routinely embedded in daily practice or, in contrast, are superficially implemented. In other words, how do the policy initiatives inform organisational culture and practitioners' beliefs, attitudes and behaviours with the consequence of improving patient care? This may not only be related to health care management and organisational factors, but may largely be linked to individuals' behaviour and their own priorities in daily practice. The point is, it often depends on how the front-line practitioners value the policy initiatives.

More importantly, the lack of shared information amongst staff regarding the policy initiatives from macro policy level, meso organisational level down to micro interpersonal level was voiced in each case. Some health boards at local level did not maximise opportunities for policy initiatives to act as a lever for practice change as had been anticipated in Cases 3 and 4. The research evidence in the study demonstrated that there was patchy geographical policy performance, a fragmentation of policy enactment and also a haphazard approach to mainstreaming implementation in some health boards. Furthermore, the difficulties are seen when there is a plethora of initiatives to be enacted in practice and some potentially clash (OECD 2010). Thus, it is recommended that:

3) ***The issues of external and more internal motivation and incentive for the front-line implementers need to be fully considered, so that they can be actively involved with the policy initiatives and enable real change to happen in practice. In particular, the wish of practitioners to be personally valued and to have the opportunity for professional development and on-going support needs to be kept in mind.***
4) ***Information sharing systems at macro, meso and micro levels should be developed to enable the implementation of policy initiatives more effectively.***

9.3.3. Implications and recommendations for education

An education programme was integrated as part of each of the four policy initiatives. These provided opportunities to develop and enhance

the practitioners' proficiency regarding their skills and knowledge in relation to the new policy, in order to prepare staff effectively for policy to practice change. To a large extent, education not only helps staff acquire mastery in specific skills and knowledge, but also focuses on enhancing their sense of empowerment and motivation, which may have more effect on their future performance in translating policy into practice (Durlak and DuPre 2008).

However, research indicates that education can take place only if necessary resources such as learning materials, financial support, time, staffing, and administration have been secured, along with other factors positively posited for the implementation (e.g. effective leadership and support) (Durlak and DuPre 2008; Dufrene et al 2005; Sterling-Turner, Watson and Moore 2002).

It is evident in the case studies that there still remain challenges for course design because the courses within a policy initiative are usually designed in a short space of time. They need not only to meet a required standard, but to suit the policy target, the practice needs and practitioners' preferences. There is a need to address the issues of attendance and the completion rate and to establish criteria and approaches for recruiting appropriate staff for education. Active forms of teaching methods including for example, modelling, role play, multiple-discipline learning and teaching, training for trainers and performance feedback were thought to be helpful and worthwhile. In particular, this study presents many positive views about core educational materials which were integrated into the education programme and into the relevant pre-registration curriculum. This was recognised and utilised by organisations beyond Scotland. Thanks to this, the policy initiatives provide information which could help decide on an innovative education system which would make education truly fit for practice and for patient needs.

The evidence in the case studies shows considerable variations in teaching time and depth, along with the risk of a significant dilution of

core content, the problem of deciding an appropriate learning period. In addition, the difficulties in allocating time for learning were seen as one of the biggest issues in this study. Notwithstanding, those educated staff often return to the workplace where colleagues may not appreciate the nature of the new learning or need for it. However there tends to be little infrastructure to support specific related change in practice. Moreover, as Praslova (2010) points out, evaluations rarely get beyond Stage 1 (reaction) of Kirkpatrick's training evaluation model.

On this basis, it is recommended that:

1) ***A comprehensive strategic plan for course design and the sourcing of the best examples for education needs to be more carefully thought out.***
2) ***The integration of a policy initiative training programme within relevant undergraduate and postgraduate curricula needs to be promoted to ensure long-term sustainability.***
3) ***The participation of service users in policy initiative training programmes can be beneficial and add value, and should be considered whenever possible.***
4) ***Contingencies for staff turnover need to be put in place by educating new staff, so that implementation work is not delayed.***

9.3.4. Implications and recommendations for NMAHPs research regarding policy to practice change within Scotland and beyond

In effect, a fair amount was already known about how policy was translated into practice and how those initiatives impacted on practice and patient care, but there was little attempt to ask why the policy initiatives developed and were translated in the way that they were. In particular, very little systematic in-depth empirical research has taken place regarding NMAHPs policy to practice development within and outwith Scotland (Macduff 2007a; Ross et al 2011). Thus, in the absence of empirical evidence about what lessons were learned from the myriad of Scottish NMAHPs policy initiatives, this study has first addressed that gap by means of a systematic in-depth approach, which empirically

explores Scottish policy via practice changes within NMAHPs, in order to further understand the nature of policy initiative development and to bring together the key lessons learned from the study. This thesis has strengthened some findings of other studies in relation to the factors that either facilitate or hamper policy through to practice change, such as the complexity and dynamics of the policy initiative, effective leadership, communication, organisational culture and collaborative partnership etc. More importantly, this research has highlighted the valuable findings from previous relevant studies which are either not being addressed, or not being recognised, such as policy internal alignment at vertical and horizontal levels, policy external alignment and related continuous development. On this basis, it is suggested that:

1) Further research needs to be undertaken as to how a cluster of health policy initiatives work, develop, and impact

This thesis has also addressed what has been achieved in Scottish NMAHPs since 2005. In the 15 commissioned reports, we see the extent to which most of their aims and objectives focused on the process and impact of the policy initiatives (see Table 15). An inherent tendency to mirror and reify the policy process was evident. This type of evaluation research can be heavily criticised because of the extent to which the evaluations are aimed at serving those who have political power. It is perhaps not surprising that many more positive findings rather than negative ones resulted from most of the 15 selected reports. There is a feeling that evaluation research is often designed more to comply with policy goals than as a scientific attempt to assess the effectiveness of a policy (Squires and Measor 2005; Taylor and Balloch 2005).Therefore, the question is how far do evaluation findings contribute to the framing and reframing of health policy and practice development. In other words, to what extent does their 'evidence' inform a basis for health policy thereby being genuinely utilised to change and develop health care services. It follows from this that it is vitally important to understand that evaluation research can only be one part of a broader learning process.

Furthermore, this study has productively developed a new explanatory model based on other theories and models to enhance the understanding of policy and practice development (Figure 24). This model can be also used as an analytical template for analysing each policy to practice initiative in terms of their potential for prospective policy planning, progress monitoring and retrospective learning. In this way, the new model can be useful for discovering the influences on, and implications of each policy initiative. Likewise, it could also be valuable in analysing other health and social care policy to practice changes. However, the suitability of this model needs to be further tested to expand its applicability.

It is therefore recommended that:

2)The developed new model in this thesis needs to be further tested and disseminated to researchers undertaking studies of policy to practice change

Clearly, arising from this study, there is scope for further study to be undertaken regarding policy to practice change. Firstly, there is a paucity of research on how to critically review policy evaluation research. Although this study has developed a framework to assess the 15 identified evaluation reports, the developing and testing of a suitable appraisal tool for evaluation research needs to be addressed. In this regard, this framework would be useful in the systematic study of evaluation reports from policy to practice, and in determining evidence-based policy developments. However, due to its limitations and the current absence of existing validated tools, it is recommended that:

3)An effective tool for appraising the quality of policy evaluation needs to be further developed and deliberately tested

Secondly, the involvement of service users is under researched but is important to policy to practice change. Two service user representatives provided valuable views in this study. However, any future research

design needs to take into consideration how to access service users, in order to elicit their experiences and understanding of policy to practice change. Thirdly, while more systematic data generation and empirical analysis is needed, a research knowledge exchange event needs to be properly designed, in order to discover the views of different key policy informants and to integrate the lessons learnt from previous studies. A study of this kind would also be helpful for testing and developing relevant theory. Fourthly, there would be scope for further study of education programmes relating to policy initiatives, looking at course content, teaching methods and their impact. Accordingly, two recommendations can be made:

4) A longitudinal study needs to be carefully designed to compare the impact of policy initiatives and a knowledge exchange event needs to be conducted to integrate the lessons learnt from previous studies

5) Further study needs to be undertaken with service users to elicit their perspectives on what can be learned overall from national initiatives.

Finally, this study, overall, adds to the theoretical and conceptual development of understanding the process of Scottish health policy to practice change. It has clearly shown the complexity of the policy process, in terms of policy formulation, implementation and impact through theoretical approaches using different types of data, which have provided crucial insight into embedded views of multiple actors. Consequently, this study contributes a more detailed understanding of the complex policy process. However, further study of this nature needs to bear in mind how best to study aspects of the policy process by the use of theoretical approaches, which reflect different facets of overall policy to practice change (Walt et al 2008). Such study could contribute to a more robust international evidence base for understanding and undertaking policy through to practice change, this would be very valuable. In this regard, the final recommendation can be made:

6)Further systematic research needs to be taken regarding NMAHPs policy to practice change within UK and beyond

9. 4. Conclusion

Following the reflections on this study and relevant recommendations, it is now time to complete this thesis by answering what has been learned about the development of NMAHPs policy to practice initiatives beyond Scotland, and what this signifies in the wider context. This ties in with the last research question which is the main topic of this chapter*: What are the key transferable lessons we can learn and how can they be taken forward?*

So what additional transferable learning has been generated?

The thesis first systematically analysed Scottish policy to practice developments in NMAHPS from 2005 to 2010, focusing on the views and experiences of various people who implemented the policies. This gives us a better understanding of the nature of policy to practice change. Secondly, general lessons and issues coming from those important national policy initiatives were identified, which are potentially very valuable for future health policy developments in Scotland.

Likewise, the common lessons seem likely to have a more generic application beyond the development of Scottish health policy and that they could be relevant in other areas, where local culture and contexts need to be carefully considered. As importantly, the approaches used in this study could become an exemplar for systematically analysing policy to practice change in NMAHPs and other practice based professions, and the developed new model (Figure 24) can be seen as potentially valuable for the analysis of health policy to practice developments from top-down and bottom-up. In addition, this study has also posited a diagram to show how policy initiatives develop continuously over time at macro-level, which can be appropriated/incorporated into new developments as they evolve. This could be valuable in future research investigating how a cluster of health policy initiatives work and develop in Scotland and beyond.

As such, this study has systematically explored, discussed and answered the six central research questions. In the process, this thesis has designed an original multiple case study to interrogate the views of different stakeholders regarding the development of Scottish policy to practice change in NMAHPs within six years. It has also applied several theoretical frameworks and developed an original explanatory model to help better understand the nature of health policy to practice change. In doing so, this study makes a useful academic contribution which can inform further development in related areas.

In summary, this study has first and foremost demonstrated the value of systematic in-depth research on Scottish policy to practice developments in NMAHPs not only for future policy-makers, educators, researchers and practitioners, but also for the general public, with the aim of improving patient care.

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Appendices

Appendix 1: MAPPED Model (Macduff 2007a)

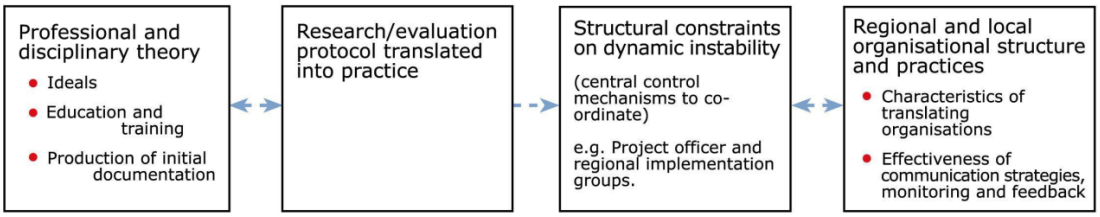
Part 1: Initial policy formulation and advancement

Agency		
Aspiration	Individual Agency	
Awareness and anticipation of opportunities		
Alignment around advocated agendas		
Authority		Collective Agency
Alliances for advancement		
Advantageous adaptation		

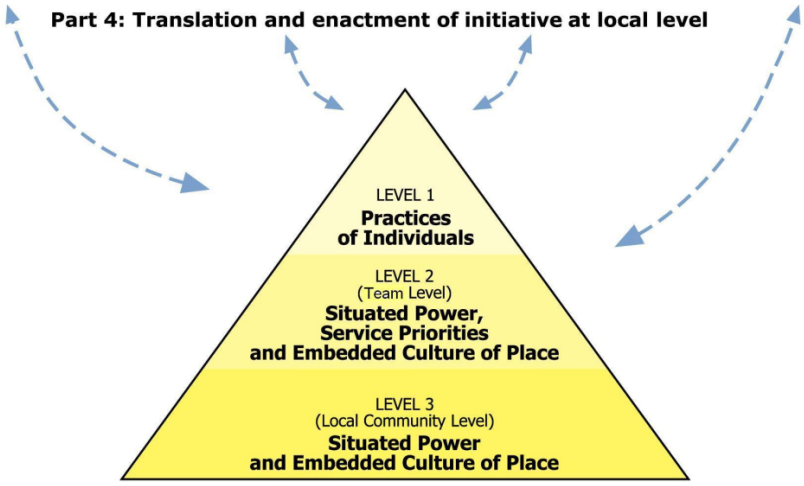
Part 2: Taking the policy initiative forward towards enactment

Level of analysis	Mode of technological development	Mode of knowledge production	Mode of containment	Mode of strategic expansion
Ideation	Idea of new technology.	Notion of research/ evaluation.	Judgements about value.	Key actors.
Mobilisation	Constructs of appropriate design and operation.	Constructs of research/ evaluation methodology.	Selective enrolment into communities of practice.	Emergent practitioner communities.

Part 3: Key elements influencing articulation between policy and practice



Part 4: Translation and enactment of initiative at local level



Appendix 2: A critical review of the 15 identified initiatives

Policy initiatives tend to be complex, diverse and dynamic interventions, resulting in evaluation reports involving a diverse range of methods and designs, including well established quantitative and qualitative data (Walt et al 2008). While quantitative methods may help to show to what extent complex initiatives work, qualitative studies can provide insight into why and how complex initiatives work. In addition, a commissioned evaluation can offer the opportunity for evaluators to ask 'how', but very limited opportunity to determine 'what' is to be evaluated and ask 'why' (Macduff 2007; Taylor and Balloch 2005). Moreover '*since so much of the evaluation is commissioned by policy makers, how far does the framing of policy issues depend on dominant political discourse*?' (Taylor and Balloch 2005, p.5). Taking this into consideration, it is important to find a way to critically review the quality of content and methodological rigour within the 15 evaluation reports. It is particularly important to critically appraise the quality of commissioned evaluation studies, since quality assurance is one of the distinctive strengths of evaluation research as a source of gaining knowledge for future policy and practice developments (Länsisalmi et al 2006).

Nonetheless it is a particular challenge for any appraisal to find a way of combining evidence of evaluation quality, using both qualitative and quantitative studies in order to capture the full complexity of a policy intervention, its impact and its transferability to other contexts (Nutley et al 2010). It is also very difficult to assess such evaluation studies because evaluation research is different in character from other studies (Taylor and Balloch 2005). How to systematically appraise the quality of such evaluation reports is still being debated (Gilson and Raphaely 2008). Furthermore, there is to date, no comprehensive appraisal tool for assessing how valuable the commissioned evaluation studies are. This thesis initially seeks to develop a framework for assessing the quality of evaluation studies.

1. Strategies for developing a framework for critical appraisal of the commissioned evaluation studies

Quality appraisal tools are mostly employed to gauge the value of initial research studies, in terms of the validity and reliability of the primary research (Taylor, Dempster and Donnelly 2007). However, traditional quality appraisal focuses only on the quality of methodological standards, which does not in itself provide a sufficiently good basis for assessing the value and contribution of evaluation research to policy and practice (Boaz and Ashby 2003). While methodological rigour is of significant importance when examining the value of an evaluation study, attention should also be paid to the ways in which the evaluation research will be useful and useable for policy and practice developments. In other words, the quality of the messages in the evaluation report, and the quality and transparency of the report should not be ignored (Taylor and Balloch 2005).

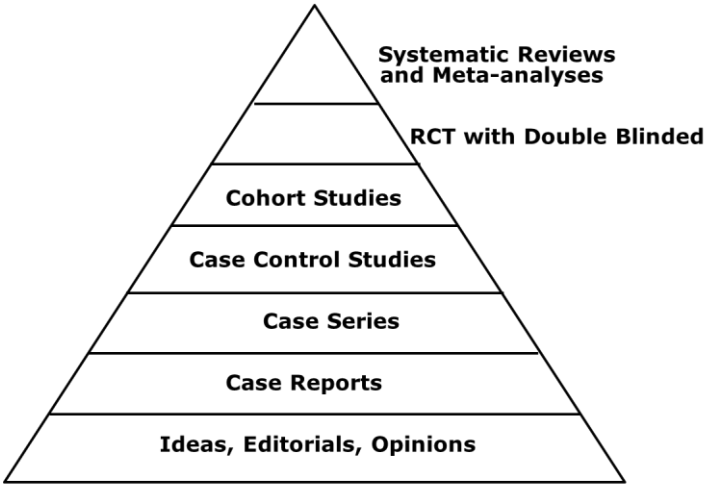
Accordingly, the strategies for developing a framework for critical appraisal of the quality of commissioned evaluation studies are based on existing appraisal tools such as JBI (Joanna Briggs Institute), CAS (Critical Appraisal Skills) and Campbell collaboration. These are well known tools for assessing the quality of research studies. However, they only focus on the methodological quality with little concern for meaningful utilisation of evaluation research. In this study the scope of quality appraisal is broadened to consider the appropriateness of methods, the clarity of aims of the evaluation study and the research stance, the content of evaluation reports and their relevance for policy and practice. Thus, these considerations informed the development of a new framework to assess the quality of evaluation studies, which would combine methodological rigour with the quality of reports (see Table 1). Table 1 presents the common criteria for critically appraising the quality of commissioned evaluation research, which consists of 10 dimensions along with the overall scores for each research study.

Table 1: Common criteria for critical appraisal of the quality of commissioned reports

Critical appraisal of the quality of commissioned evaluation studies			
Common criteria			
1) Is there a clear statement of the aims?	very clear	clear	not clear
2) Is the methodology of the evaluation research clear	very clear	clear	not clear
3) Is the research design appropriate to address the aims?	very appropriate	appropriate	not appropriate
4) Is the recruitment strategy appropriate for the aims?	very appropriate	appropriate	not appropriate
5) What is the extent of participation/ response:1.low 2.fair 3.high?	high	fair	low
6) Is the analysis of the data sufficiently rigorous?	very rigorous	rigorous	not rigorous
7) Is there a clear statement of findings and recommendations relating to the data?	very clear	clear	not clear
8) Is there an underpinning theoretical framework?		yes	no
9) Have ethical issues been taken into consideration?		yes	no
10) What is the main evaluation stance: Judgement; Explanation; Development; Empowerment?			

This appraisal framework does not use traditional Hierarchy of Evidence to appraise internal validity. Traditional Hierarchy of Evidence is widely used to rank research according to its validity, in order to help interpretation and evaluation of the research findings (NHMRC, 1995) (see Figure 1). For example, the systematic review and RCT are in the pride of place at the top of the hierarchy as the 'gold standard'.

Figure 1: Hierarchy of Evidence



However, in effect the Hierarchy of Evidence does not appear to provide sufficient credibility to the 'lower levels', in terms of differentiating and valuing appropriately the range of designs within this category (Taylor et al 2007). For example, case studies with surveys and interviews are usually designed for the purpose of evaluating policy to practice initiatives (Gilson and Raphaely 2008; Taylor et al 2007; Walt et al 2008), but they are classed as lower levels in the Hierarchy of Evidence. Furthermore, the word 'trial' is more suited to the laboratory, but is inappropriate for policy makers and practitioners in health care, particularly in NMAHPs (Gilson and Raphaely 2008). The term 'intervention or implementation study' seems to be a more suitable and acceptable description of a study that evaluates policy to practice developments in NMAHPs.

Therefore, the strategies for developing the framework to critically review the 15 evaluation reports have been drawn up using several approaches. First and

foremost, the common criteria suggested for the appraisal framework in this study have been chosen in order to assess the level of clarity in the statement of study aims, the research methodology and the findings related to the data, and to assess the level of appropriateness regarding the choice of design, the data collection tool(s), the survey response rate and the methods of analysis, since they are important areas when appraising rigour (Mays and Pope 2000; Giacomini and Cook 2000). These areas are graded from 1 to 3, assessing the quality of different aspects, three being the highest score. The characteristics '*Relevant'*, '*Understandable*' and '*Achievable*' have been used to develop the criteria for assessing the grade of clarity and appropriateness, according to the 15 selected study aims, objectives and designs. In doing so, appropriateness and clarity are graded as very clear/very appropriate, clear/appropriate and not clear/appropriate, depending on how well the selected study aims/objectives and designs satisfy the three characteristics ('*Relevant'*, '*Understandable*' and '*Achievable*').

In addition, the other three fields included in the common criteria: the application of the theoretical framework, the research stance, and the consideration of ethical issues are also dealt with individually.

As discussed in chapter two, a theoretical framework can be of benefit for policy and practice initiatives by deepening our understanding of causality, and by bringing coherence to a fragmented body of knowledge (Walt et al 2008). Consequently, when applying a theoretical framework to evaluation reports in this appraisal, one point is given if the answer is 'yes', and no point if the answer is 'no'. The element of ethical consideration is also included, because it is a long standing procedure used to support and promote good quality research study (Boaz and Ashby 2003).

In the same way, the evaluation stance is perceived as significantly important in this appraisal framework. This point is congruent with primary discussion about positionality and research stance. Different research stances are of possible interest, as much for what they hide as for what they reveal because the commissioned initiative evaluators ' work relates to wider issues of power' (Taylor and Balloch 2005, p3). According to Stern (2004), it is useful to

consider the extent to which on evaluation is for: '*judgement*' means summarily assessing what has been achieved and what has not; '*explanation*' is used in order to understand what works; evaluation used as '*development*' means that it helps improve implementation; evaluation as '*empowerment'* means it can strengthen institutions, communities and or networks. In other words, the purpose of empowerment evaluation is self-determination, democratisation, advocacy and liberation (Taylor and Balloch 2005, p6). Thus, the various facets of research stance can be categorised as *judgement; explanation; development* and *empowerment*, four components used to assess the 15 initiative evaluation reports without scoring, according to the evaluation aims, objectives, findings and discussions.

Finally, in addition to the common criteria in Table 1, I have included research related to policy process such as policy development, policy implementation and outcomes, and what the policy initiatives intend to develop, such as the creation of new roles in the workforce, the extension/expansion and enhancement of roles and a general education framework. These criteria have been also used to review the 15 evaluation reports but no scoring.

Combining the common criteria and other approaches discussed above, the next section presents the different features of the 15 evaluation reports in more detail, including the features of the methodologies and the method designs, the features of policy initiatives, the research stance and policy stages, and the overall quality of the 15 selected evaluation reports.

2. The features of the methodologies and the method designs in the 15 reports

Successfully undertaking evaluation research of a policy to practice initiative requires that studies are designed to seek an explanation for, or understanding of, the context, processes and outcomes of policy initiatives (Bochel and Duncan 2007). This very often leads to an evaluation design using a mixed method, which combines quantitative and qualitative research. This is a dominant characteristic of the selected 15 initiative reports (see Table 2). Table 2 shows the study methodologies and methods used in the 15 selected research evaluations.

Table 2: Overview of 15 study designs

Name of evaluation report	Study design (derived from reports)						
	case study	questionnaire	interview	focus group	RCT	audit	systematic review
Advanced Practice Succession Planning Development Pathway	1	1	1				
An education programme for staff working with acutely ill and injured children and young people	1	1	1				
The Impact of Educational Resources to Support Values-Based and Recovery-Focused Mental Health Practice	1	1	1	1			
Evaluation of the Extension of Independent Nurse Prescribing in Scotland	1	1	1	1			
Midwife Prescribing Project						1	
Mellow Babies		1			1		
The establishment of the Practice Education Facilitator role project	1	1		1			
Scotland Cleanliness Champions Programme		1	1				
A Pilot program for the role of Maternity care assistant in Scotland	1	1	1	1			
The succession planning development pathway for consultant nurse, midwives and AHP	1	1	1				
Allied Health professions support and development scheme		1	1				
Evaluation of flying start NHS		1	1	1			
NM in Scotland: being fit for practice		1	1				1
Clinical leaders for the future (ECCF)		1		1			
Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards	1	1	1				
In total	8	14	11	6	1	1	1
Percentage	53.3%	93.3%	73.3%	40.0%	6.7%	6.7%	6.7%

On the one hand, almost all of the 15 reports used questionnaire surveys (93%) for descriptive study, apart from one study which was designed as RCT. Unfortunately, the RCT design was not very successful and rigorous. On the other hand, the research design in the 15 selected reports focused particularly on qualitative study in order to examine the implementation processes and the outcomes of the initiatives. This consisted mainly of in-depth interviews, semi-structured interviews or telephone interviews (73%) and focus group discussions (40%). Triangulation is also markedly visible in the research methods and data sources. More than half the evaluation reports (53%) conducted multiple case studies in order to produce an in-depth study. There

was one study which involved a systematic review within a mix-methods design and one study was an audit.

While most of the 15 selected policy evaluation reports were designed to be mixed method combining quantitative and qualitative research studies, the quality of methodological rigour varied. Overall, it can clearly be seen that a large proportion of these reports have rigorous research design, involving multiple case studies in order to obtain rich and robust information for the findings. These provide strong evidence for policy makers and practitioners, even though the quality of some policy evaluations is affected by poor response rates. However, although several evaluations conducted case studies, such cross-case approaches need more explicit use of formal case study than is usually the case. In particular, the rationale of case selection must be clearly set up, each case must be sufficiently complete, alternative perspectives must be carefully considered and efforts must be made to identify and clarify in a logical way unusual experiences and findings (Yin 2009).

Furthermore, some studies, even those with a comprehensive and rigorous research design were not applied appropriately. For example, the report designed as a RCT study is the lowest total score (see Table 3), when the complex and uncertain situation in the intervention process was taken into consideration. To a large extent it is difficult to make a methodological judgement based on the developed criteria, because the amount of detail provided in reports is sometimes rather limited. Also, most of the criteria are to some extent subjective, so that when making a judgement, it is very difficult to avoid some individual interpretation. However the same can be said even for using well established critical appraisal tools, such as CASP or JBI (Katrak et al 2004). Furthermore, the development of this framework for critical appraisal of the quality of evaluation report was critically reviewed by my principle supervisor.

3. The quality of the 15 selected evaluation reports

Based on the criteria stated above, this study systematically evaluated the quality of the 15 selected evaluations (see Table 3). The maximum possible

score is 23. In this study, Table 3 presents the details of the critical appraisal of the quality of the 15 reports.

Table 3: Overview of the quality of 15 commissioned studies

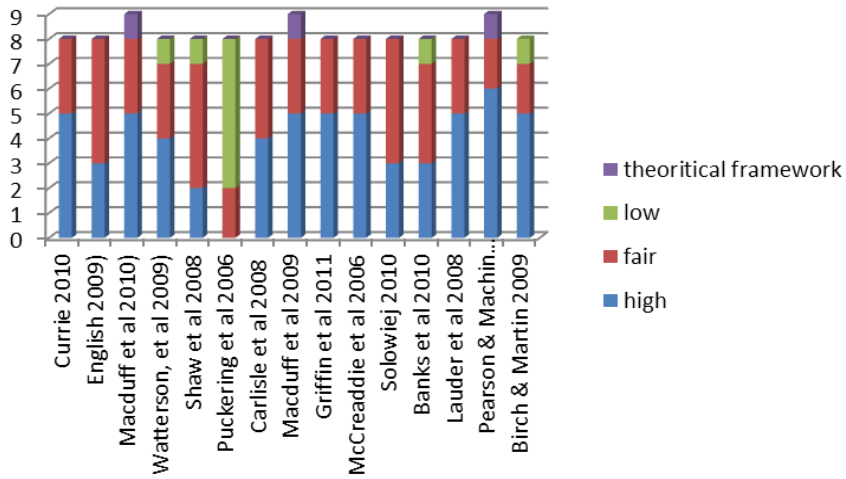
Critical appraisal of the quality of commissioned evaluation studies										
Authors of project	**Is there a clear statement of the aims?**	**Is there a clear evaluation research methodology**	**Is there an underpinning theoretical framework?**	**Is research design appropriate to address the aims**	**Is the recruitment strategy appropriate to the aims**	**Have ethical issues been taken into consideratio**	**The extent of participation, response: 1.low 2.fair 3.high**	**Is the data analysis sufficiently rigorous**	**Is there a clear statement of findings that relate to dat**	**Total Score**
By Currie 2010	3	3	0	2	3	1	2	2	3	19
By English 2009)	2	3	0	2	3	1	2	2	2	17
By Macduff et al 2010)	3	3	1	2	3	1	2	2	3	20
By Watterson, et al 2009)	3	3	0	2	3	1	1	2	2	17
By Shaw et al 2008	3	2	0	2	2	0	2	2	3	16
By Puckering et al 2006	3	3	0	2	1	NA	1	1	3	14
By Carlisle et al 2008	3	3	0	2	2	1	2	2	3	18
By Macduff et al 2009	3	3	1	2	3	1	1	2	3	19
By Griffin et al 2011	2	3	0	2	3	1	3	2	3	19
By McCreaddie et al 2006	3	3	0	2	2	1	3	2	3	19
By Kazia Solowiej 2010	3	2	0	2	2	1	2	2	3	17
By Pauline Banks et al 2010	3	3	0	2	3	1	1	2	3	18
By William Lauder et al 2008	3	3	0	2	3	1	1	2	3	18
By Pearson and Machin 2010	3	3	1	2	3	1	3	2	3	21
By Birch and Martin 2009	3	3	0	2	3	1	1	2	3	18

Overall, 14 reports show a good quality of research study with a total score above 16 out of 23 points. The highest score is 21 points, while the lowest one is 14 points. A fairly large proportion of reports have 18-19 points as a total score, but they appear to have been affected by a lower response rate. The higher scores of 20 and 21 were achieved by those who seemed to have successfully applied a theoretical framework.

At the same time, each of the reports has been critically synthesised by showing the number of different qualities within the criteria of the seven dimensions which have 3 points in total and two dimensions which have 2

points in total. The term 'high' and 'very clear/very appropriate' means that dimension gained a score of 3, 'fair' and 'clear/ appropriate' is 2 and 'low' and 'not clear/appropriate' is 1. Figure 2 presents the number of different qualities in each report and also indicates which report has successfully used a theoretical framework. Only 5 reports have one dimension with a low score, due to the very low response rates. This has been highlighted and discussed in the reports and was mainly caused by the questionnaire being sent out by a third party. One report appears to be of poor quality, standing out from the others because of inappropriate application of RCT design. Most of the reports were poorly framed, they did not consider any conceptual model or theoretical framework to guide the design and analysis. Only three reports have effectively incorporated theoretical frameworks into the research design. Two reports used the MAPPED model (Macduff 2007a), another one employed 'Realistic Evaluation Methodology' (Pawson and Tilley 1997).

Figure 2: The quality profile of each commissioned evaluation research



However, the dimensions of the criteria are limited to ten questions, and this could adversely affect the overall quality in policy analysis. Therefore, within the limitations discussed above, the features of policy initiative types, research stance and design for policy stage should be included, when systematically appraising the quality of policy evaluation reports.

4. The features of policy initiative types, Research stance and Policy stages in the 15 reports

While this thesis gives a complete picture of the 15 study designs, great attention has been paid to examining the other three elements of policy initiatives, based on a combination of the reports' stated aims / objectives/ questions and the nature of their findings and discussion sections. This includes examining the type of initiatives, the research stance and the evaluation designed for the policy stage. Table 4 summarises the number of grouped policy initiatives, the number of reports by policy stage and by research stance. In the 15 selected evaluation reports, seven policy initiatives tended to expand or enhance existing roles, four made the case for the development of new roles or for an educational framework respectively. A wide range of research stances is clearly seen from Table 4. However, the research stand point of judgement and explanation is noticeably dominant, being 67%. This is of particular significance, in that the evaluators do not only focus on what has been achieved, but also highlight what works in policy. Another three reports merely concentrate on how the policy works. In contrast, one report is simply a statement of judgement.

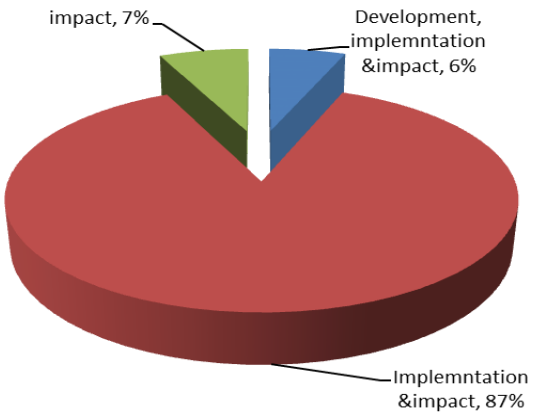
Table 4: Summary of the 15 studies categorised by type of initiative, research stance and policy stage

Type of initiative	No. of reports	No. of reports by research stance					No. of reports by policy stage		
		EXP & JUD & DEV	EXP & JUD	EXP & DEV	EXP	JUD	PDE & POP & PIM	POP & PIM	IM
Ext/expand/ enhanced role	7	1	2	1	2	1		6	1
New role	4		4					4	
Educational framework	4	2	1		1		1	3	
% in total	100	20	47	7	20	7	7	87	7

Notes: PDE=policy development; POP=policy implementation; PIM-policy impact
EXP=explanation; JUD=judgement; DEV=development

Similarly, Table 9 shows (87%), i.e. most evaluation design explores both the policy implementation process and its impact, with few considering only the policy development or simply the policy impact (see Figure 3).

Figure 3: The policy stages as a percentage of the 15 reports



As illustrated above, most studies (87%) were designed to explore policy implementation and impact. This is significant, as the policy implementation process shows how the policy initiative works and the factors that affect policy impact (Bochel and Duncan 2007). It is also clear that the research stance of the 15 evaluations varied, though most of them were undertaken from the standpoint of judgement and explanation. The objective of the different studies can affect considerably what evidence is sought, and how the information gained is broadened and deepened, drawing on the primary data. For example, some reports give insight into how the policy initiative works and why things happen as they do. These reports are well documented examples of policy in a policy context, showing its implementation and impact by means of a theoretical framework, which is used to direct and guide policy analysis, to deepen understanding, enable explanation and to allow for generalisation (Macduff et al 2010; Pearson and Machin 2010). However, some reports simply present their findings with little attempt even to classify the findings. They cite inadequate examples of policy, which provide limited detail, or embrace too many issues and experiences and have too little depth and breadth (e.g. report of *Mello Babies*).

Again, a much higher proportion of reports show diversity in understanding and implementing policy initiatives in local areas, because of the way in which different actors interpret policy content and goals. It is recognised by scholars that, because policy is often ambiguious, this can lead diverse actors to interpret the same act in a different way (Berman and Corporation 1978; Eaton Baier, March and Saetren 1986). As a result, the implemented policy initiative varies from place to place. This also affects effective policy initiative development, which does not merely depend on good technical design or using evidence to generate policy, but also needs to take account of the values and interests of the different local policy actors (Gilson and Raphaely 2008). Nonetheless, very few of the 15 reports examined this in depth.

At the same time, evaluators generally have to manage expectations from politicians. For example, to what extent were these commissioned evaluations influenced by politicians, who may have conflicting expectations from the evaluation (Bochel and Duncan 2007). Also, the tight evaluation timetable with the added political pressure for quick results has to be balanced with concern for robustness. Thus, the reality of the evaluation-policy relationship is likely to modify the nature of what the final report contains.

Finally, despite the fact that a great number of the 15 reports highlighted the perspectives of different key stakeholders, there is a lack of concern in some reports about how the policy impacts on service users. This should not be neglected, since it has been pointed out that the involvement of service users in the design and implementation of policy evaluation research is also a significant indicator of quality (Fisher 2002).

5. Summary

The sections above have discussed the strategies for the development of a comprehensive framework to enable a critical appraisal of the quality of commissioned policy evaluations. This framework includes the extra dimensions of appraising the quality of the policy report content along with methodological rigour, which is important for synthesising complex policy issues, interventions and outcomes. In particular, it places emphasis on the quality of the content of important policy to practice initiatives in a way that is

useful. However, we must ask ourselves in what way the research findings can provide the most robust evidence for policy makers and practitioners? This question remains unanswered, and is still a challenge for future policy researchers.

More importantly, due to the absence of any existing validated tool for such reports, the approach of my framework has sought to be based on logic, but it necessarily has limitations and is essentially an explanatory development. Therefore, an effective tool for appraising the quality of policy evaluation needs to be further developed and deliberately tested, in order to provide convincing evidence for creating policy and practice developments effectively and efficiently.

Appendix 3: Pilot study

Lessons learned from the pilot study on "Back to the Floor"

1. Introduction

Pilot studies play a vital role in health research in that they can yield information on both process and potential outcomes in preparation for the major study (Burns and Grove 2001). Well-designed and well-conducted pilot studies can be used to test the feasibility of the research protocol with a small sample and to pre-test the particular research instrument such as a questionnaire or interview schedule (Van Teijlingen and Hundley 2001; Leon et al 2011). However, pilot studies are generally under-discussed and under-utilised, in particular developing a pilot study in qualitative research (Van Teijlingen and Hundley 2001; Sampson 2004). Therefore, reports on these 'lessons learned' are invaluable to others embarking on research using similar methods and instruments. This paper reports the lessons learnt from an external pilot study on "Back to the Floor" conducted in preparing for the main PhD study of analysing Scottish policy to practice in NMAHPs.

2. Definition of a pilot study

The definitions of a pilot study are various but similar to a feasibility study intended to guide the planning of a large-scale investigation (Thabane et al 2010). Also, Lancaster and his colleagues (Lancaster et al 2004) classify pilot study as external and internal pilot study. They define an external pilot study as a stand-alone piece of work planned and carried out independently of the main study. On the other hand, they also describe an internal pilot study is incorporated into the main study design. Both of the internal and external pilot studies have advantages and disadvantages. This paper conducted an external pilot study and will be discussed below.

3. Background of the pilot study on "Back to the Floor"

A main part of the PhD research is an in-depth study of four national policy to practice developments within Scottish nursing, midwifery and allied health professions. This involves documentary analysis and interviews with a range of those who were involved in the initiatives. In order to test methods and processes, a small external pilot study of a local policy to practice

development ("Back to the Floor") was undertaken by seeking to interview three people who were involved in the initiative.

The "Back to the Floor" initiative started in NHS Grampian in 2007 with some coaching/counseling interventions, and it has been externally evaluated, making it similar to some of national initiatives that will form the core of the PhD research.

4. Objectives of pilot study

The pilot study aimed to test the research processes, particularly to test interviewing and analysis skills prior to the main study.

5. Ethical issues

The researcher and her supervisor are aware of three individuals who were involved in the "Back to the Floor" at different levels and in different capacities, but who had since changed their role or retired. A structured research protocol for the pilot study was conducted to apply for ethical approval from Robert Gordon University, School of Nursing and Midwifery Ethics review panel. After ethical approval, the information sheet, an invitation letter and a consent form were sent to the three participants. As these interviews may be "on the record", the participants were asked to choose either 'public record' or 'anonymous' in the consent form.

6. Methods

Before the interviews the researcher had undertaken an initial documentary analysis by applying Spencer's Framework in order to better understand the initiative and its development. After receiving the three consent forms from the participants, the researcher arranged the interview venues and time discussed with interviewees by emails or telephone. The three participants comprised a project officer, one person who participated in the "Back to the Floor" practice and an initiative evaluator. Subsequently an in-depth individual semi-structured interview was conducted with each person in order to reflect on the interview process. At the end of an interview, the participants were expected to give feedback by answering structured questions on the interview content and process itself. The interview schedule was developed by the researcher based on MAPPED model (Macduff 2007a), and it was reviewed by

her supervisor. The interviews were digitally recorded and transcribed verbatim.

The interview transcripts were analysed thematically by using qualitative content analysis (Ritchie and Spencer 2003). The initial thematic framework was constructed by a combination of extracting the key themes from the content and interview topics (Ritchie and Spencer 2003). The following steps were coding, charting, mapping, interpreting and summarising the material from the transcripts (see Table1). The summary of the emerging themes and sub-themes derived from the analysis will be presented in the findings section.

7. Findings:

The findings that emerged from "Back to the Floor" drew out the nature of initiative from policy to practice in terms of context, process and outcome and highlighted the lessons learnt from the pilot study.

7.1. The findings should help to better understand the nature of "Back to the Floor" through the pilot study which is summarily presented in Figure 1:

Table 1: Understanding the nature of initiative

Understanding the nature of Back to the Floor		
Context	Initiative formulation	After the director of nursing in NHS Grampian read in the Nursing Standard about the ideas of "Back to the Floor" developed in Guy's Hospital and St Thomas' NHS in London, the senior nursing managers thought it was a good idea that could make the nurse managers more visible and more credible to the support of the ward sisters and staff. A project officer was appointed to lead The "Back to the Floor" initiative.
	Location and coverage	NHS Grampian Acute Sector.
Process	Planning process	The project officer organised a series of senior nurse manager meetings to agree that all nurse managers with navy epaulettes uniform in the Acute Sector would work in a clinical area of their choice every Friday morning, and they would then have a meeting together that afternoon to share the experiences of the process and to deal with any difficulties. Before this could happen, basic training and updates on practice fields such as: moving and handling; resuscitation, coaching and counselling were initiated. The initial information about Back to the Floor was disseminated through the staff Team Brief, the hospital's "upfront" magazine and a number of briefing sessions were led by members of the project steering group. The briefing sessions offered the opportunity to ask questions and to raise any issues of concern regarding Back to the Floor. It was planned to report the progress to the director of nursing periodically

	Translation process	In total 18 nurse managers participated in the "Back to the Floor" and relevant clinical staff were also involved. Within the translation process, there was collective support from nursing hierarchy, and willingness of the executive group and operational managers. The barriers were mainly from nurse managers themselves because they lacked confidence to go back to the floor after their long period away from clinical practice and they felt time constrained. Some risks were also identified about the errors associated with staff anxious because they thought the nurse managers were there to spy on them. And another risk was pointed out that "Back to the Floor" seemed to have a Hawthorne effect which meant people were not necessarily truly engaged.
	Evaluation process and impacts	An external evaluation team was commissioned to monitor the project progress by using formative and summative designs to feedback the relevant information to the steering group as the weeks progressed and reported the findings at the end of the period. The evaluation applied combined methods to collect the data. The well structured evaluation seems to have influenced the local policy, but did not appear to have changed very much, except some management practice development. Key issue which emerged from the evaluation process was the dual role of the evaluator.
Outcome	The main impacts and outcomes of the "Back to the Floor" initiative are: • Developing personal and professional skills • Promoting a good relationship between staff and patients, between nurse manager and staff • Improving communication strategies • Enhancing staff morale • Building up consolidated team work	

7.2. The lessons learned from the pilot study are divided into two sections. The first section is that of lessons learnt from the "Back to the Floor" initiative, the other section relates to the lessons learnt about the research process.

7.2.1. Lessons learnt from the "Back to the Floor" initiative

The important key lessons from "Back to the Floor" are summarised as below.

- **Sustainability**

The "Back to the Floor" initiative ran successfully in the short term. However, it has now effectively ceased. The main reasons for this can be argued as below.

Investing to continue

Investing to continue means the need for continuous development creation which requires a great deal of preparation including systematic analysis of capacity for the initiative, objective risks assessments, and development of

feasible and flexible management systems (Nutley and Homel 2006). Such investment appears to have been absent from this initiative even though the project officer had made some planning and had a development team for the project. As one of the participants said:*"I'm still convinced that what influences an initiative like this is the sense of purpose and planning in the first place, and having it integrated into strategy. And this initiative was never like that, it wasn't carefully thought out, it was sort of opportunist." (Evaluator)*

Local organisational initiative

This "Back to the Floor" initiative was envisaged as a local project which directly related to the role and capacity of nursing agency in NHS Grampian. The biggest challenge to a local project is lack of support from national policy, especially lack of a resources budget placed into project development. There was also a shortage in the workforce after the recent organizational changes including voluntary redundancy. As a result, the nurse managers had an exceptional time constraint to continue Back to the Floor. Besides, nursing agency was very much limited to initiative developments as Davies (2004) notes, "nursing management does not have strong voice to fully integrate into general management structure" (Davies 2004). In doing so, this initiative was weak and unable to compete successfully with other initiatives.

- **Separate the research and evaluation from initiative**

The initiative simultaneously sought to evaluate the project in order to get timely feedback and also to monitor the project progress to reshape and update the evidence base. This project has been noticeably successful at performing this. Evidence applied evaluation results on various aspects of the program emerged from the view of interviews: "*research did certainly influence the local policy and bring some on management of practice development though it did not change very much" (Project officer)*. Clearly, a permeable wall was built up between the research activity and the mainstream program. However, some issues also emerged because some of these objectives do not easily fit with one another. For example, one of the pilot interviewees who led the initiative evaluation struggled with the dual role

of evaluator and initiative developer. From this point of view, it can be hard to criticise the benefits and problems from the role of research/evaluation.

7.2.2. Lessons learnt from the pilot study related to research process

Through the pilot study, main lessons learned associated with research process are as below:

- **Lessons learned on building self-confidence and identifying potential practice problems in the data collection process**

To a large extent, the successful interview depends on the personal and professional qualities of the interviewer (Spencer et al 2003), but practice helps you to be successful. Frankland and Bloor (1999:154) state that "pilot study can be carried out if the researcher lacks confidence or is a novice, particularly when using the interview technique". As a qualitative researcher with limited interviewing experience, it is very important to build up self-confidence to meet the requirements of a qualitative interviewer via pilot study. After pilot interview, I discovered that that I was not anxious anymore and was able to speak in a natural way. Furthermore, the pilot study helped me to identify potential practice problems in the interview process. For example, through the pilot study I now know how to arrange a venue which is suitable for interviews within a comfortable, private, and quiet environment. Sometimes the size of room can be crucial for concentration when having a face to face interview and for keeping a clear record, and how to prepare my interview package without missing anything. I also now know how to operate the recording equipment by checking batteries and functions. These things may seem trivial, but they are quite essential.

- **Lessons learned on interviewing skills**

When I faced an interviewee, I practiced suitable space, eye contact and appropriate body language to reflect my professional qualities to the interviewee. During the pilot interview I learnt how to listen, digest what was said and understand the interviewees, and then decide how to probe further. I learned how to interact with interviewees and how to make my interview

questions flexible and structured in a clear, logical way mixed with curiosity. For instance, an interviewee who spoke about the "Back to the Floor" said the initiative 'needed to be conducted in an organic way' during my pilot interview, and I was very interested in what 'organic way' might be. So I asked her what 'organic way' meant. I also learned how to organise my questions without repetitions or omissions. During the interview stage, I learned how to establish a rapport with my interviewee by demonstrating my interest, trust, respect and flexible response. Finally, I learned that I should probe for more opinions from interviewees before I ended my interview.

- **Lessons learned on testing the interview schedule and ethical issues**

To test and refine the interview schedule, and to try to assess and find the best ways for the main research process was one of the major parts of my pilot study. Therefore, I specifically built into my interview schedule a section asking participants to reflect upon the interview and consider the weaknesses and strengths of the interview, as well as to give feedback on how they had experienced the interview to check any difficulties during the interview. The feedback from one of participants pointed out the interview period was too tiring and some of the reflection questions confused the interviewee. From then onwards, we tried to have a break at different stages of the interview, and this ensured the interviewees understood that they were in different stages of policy to practice questioning. The number of questions was decreased and there was some re-ordering to improve the flow. Moreover it was decided that not all the questions in the schedule would be relevant to all interviewees and the choice of questions could be tailored somewhat to the participants' role in the initiative.

Apart from these, the pilot study has tested the ethical concerns of whether people are willing to be "on the record" interviews because my main project will involve some key people who are on the public record. My pilot study shows that all of three participants agreed to be individually named as participating which means the pilot study suggests this may be feasible though it does not guarantee success in the main project research (Van Teijlingen and Hundley 2001; Thabane et al 2010).

8. Conclusion

This paper has explained why and how the pilot study was conducted. This further demonstrates the importance of a pilot study in conducting a main research study. Especially for a less experienced qualitative researcher, there are invaluable benefits in putting a toe or two in the research waters before diving in. However, one should bear in mind that a pilot study should be carefully designed with clear aims and objectives and rigorous methodology, otherwise it will not produce dividends (Lancaster et al 2004; Van Teijlingen and Hundley 2001; Sampson 2004).

Appendix 4: Information sheet; invitation letter and consent forms

INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

An analysis of policy to practice developments in Nursing, Midwifery and Allied Health Professions within Scotland during the past 6 years

We invite you to participate in a research project. We believe it to be of potential importance. However, before you decide whether or not you wish to participate, we need to be sure that you understand firstly why we are doing it, and secondly what it would involve if you agreed. We are therefore providing you with the following information. Read it carefully and be sure to ask any questions you have, and, if you want, discuss it with outsiders. We will do our best to explain and to provide any further information you may ask for now or later. You do not have to make an immediate decision.

Background: In recent years the Scottish government has increasingly sought to effect practice change in the nursing, midwifery and allied health professions (NMHAPs) through centrally formulated initiatives involving: national educational programmes; national project management; directives and incentives to Health Boards; and concurrent evaluation research. However, to date there has been very limited attempts to identify the key lessons that emerge from this approach to initiating change. While each particular initiative is usually subject to some evaluation, the full potential for learning through intra and cross-case analysis has yet to be realised. In particular, identification and explanation of key factors that influence and sustain successful development require systematic study. This is important as critically and systematically learning from the past could help towards improving patient care. Thus we wish to learn from those with in-depth

experience and understanding of particular policy to practice initiatives in NMAHPs.

What is the purpose of this study? This study aims to better understand the nature of initiatives, and to identify and synthesise key issues and lessons from important national initiatives and to develop a useful explanatory model. In this way it should be possible to systematically provide evidence for policy-makers and practitioners in order to integrate and develop future national initiatives.

Why have I been chosen? As someone who is/or has been involved in one or more of these types of initiatives, your experiences are potentially very relevant to the research project. We hope that the opportunity to reflect on your experience and discuss them in relation to an explanatory model will prove both interesting and useful to you personally.

Do I have to take part? No, it is up to you to decide whether or not to take part. If you are interested in taking part, please return the interview consent form. You are free to withdraw at any time and without giving a reason.

What will happen to me if I take part? Participation will involve an interview seeking your experiences and perceptions of the initiatives. We are particularly interested in: (1) Learning about the context, process and outcome of an initiative as you experienced it. (2) Exploring the value of an explanatory model. (3) Identifying general issues and lessons. This would take around 60-80 minutes, and would take place at a mutually suitable time and location. Ideally this would be in-person and we will strive to make such a meeting feasible. If not, consideration would be given to video-link interview or telephone interview. You may also be invited to forward an email invitation to participate in the study to other relevant colleagues involved in a specific initiative.

Interviews will be digitally recorded, provided you give permission to do so. A copy of the digital recording of your individual interview will be made available to you should you wish. You will be free to terminate your involvement at any point in the research.

Later in the project you will also be invited to contribute to a 'Research Knowledge Exchange event' where participants will share their experiences of such initiatives via focus groups and respond to emergent findings from the study.

Will my taking part in the study be kept confidential? Your participation in an individual interview will be kept confidential, and none of the interview material will be made personally attributable to you as a named individual within the reporting of the study. Moreover, generic role descriptions such as "educator", or "practitioner" will be used to promote anonymity. All contributions to the focus groups will be reported in aggregate format and no individual will be identified in related reporting. The information obtained in the study will be stored securely within the School of Nursing and Midwifery, RGU and retained for a period of ten years.

Who has reviewed this study?

This study has been reviewed and approved within the Robert Gordon University. NHS Education for Scotland (NES) has also reviewed the study and supports facilitation of access. The study is however, doctoral student research which is independent of NES and not endorsed by it as such.

What happens to the results?

All participants will receive a summary report of the findings if desired. In addition, I will disseminate findings through conferences and peer-reviewed articles in journals. Also, will be available e-thesis on OpenAIR, RGU: https://openair.rgu.ac.uk/

Thank you for taking the time to read this Information Sheet and for considering taking part in this study. For further information or enquiries please contact:

Ziying Shuai (Suzy) 01224 262952 1006081@rgu.ac.uk
Or
Dr.Colin Macduff (Academic supervisor) 01224 262935 c.macduff@rgu.ac.uk

LETTER OF INVITATION

An analysis of policy to practice developments in Nursing, Midwifery and Allied Health Professions within Scotland from 2005 to 2010

Dear Colleague
I am writing to ask if you would be willing to take part in a research project that is analysing selected policy to practice developments in order to identify key lessons. As we are aware that you have had involvement in _____, We would appreciate if you would consider the attached information sheet and return the consent form if you are willing to participate.
We believe participants will find the process of reporting on particular initiatives and wider related issues interesting and valuable.
We would be most grateful if you would consider taking part. Given the number of initiatives impacting on NMAHPs delivering service in Scotland, it is very important that we learn relevant transferable lessons about context, process and outcomes.
Many thanks!

Yours sincerely

Ziying Shuai (Suzy)
PhD Research Student
School of Nursing and Midwifery,
The Robert Gordon University,
Garthdee Road, Aberdeen.
AB10 7QG
Tel: 01224 262952: e-mail 1006081@rgu.ac.uk

Dr. Colin Macduff (Academic supervisor)
Reader
School of Nursing and Midwifery,
The Robert Gordon University,
Garthdee Road, Aberdeen.
AB10 7QG
Tel: 01224 262935: e-mail c.macduff@rgu.ac.uk

INTERVIEW CONSENT FORM

CONSENT FORM FOR INDIVIDUAL INTERVIEWS

An analysis of policy to practice developments in Nursing, Midwifery and Allied Health Professions within Scotland during the past 6 years

Researcher: Ziying Shuai

Please initial box

1. I agree that I have read and understand the information sheet dated ..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I agree to take part in the above study. ☐
4. I agree to the interview being audio recorded. ☐
5. I agree to the publication of direct quotations from my interview on the basis that they will not be attributable to me as a named individual. ☐

Name.....

Date..... Signature.....

Telephone contact.....E mail contact.....

Researcher (name).....

Date..... Signature.....

Version 2: 18/05/2012

Appendix 5: Interview schedule

Check understandings - Purpose and format of interview. Consent form returned. Confidentiality. Is interviewee happy with this?

Check circumstances - Current role and work setting. Which initiative being involved?

a) Why and how did the initiative emerge?

Thinking of the initial formulation of the idea:

When and how did you first become aware of the initiative (intension of independent nurse prescribing)?

What did you understand the initiative to be about?

What was the need for it and what purposes did it serve?

Who were the key people who made it emerge?

Who did it really matter to (e.g. in terms of individuals and groups?)

Was it driven from within nursing or out with the profession?

What was its relationship to other concurrent developments?

What were the key processes that advanced the idea at strategic level?

Do you know to what extent was there support and/or resistance?

What sort of involvement did you have personally at this point?

Looking back, in summation, why did it emerge as it did?

What factors emerge for you as most influential in this (shapers/helpers/barriers)?

Thinking of the planning for enactment of the project:

How did you plan for putting the idea into practice?

What sort of reaction did you expect people would have to the idea?

How would you characterise the risks and benefits of this project when you were planning for this initiative?

How did you plan to reduce the risks?

To what extent (and how) would the plan for this idea be managed?

Looking back, in summation, why was enactment planned in this way?

What factors emerge for you as most influential in this (shapers/helpers/barriers)?

How the planning process of this initiative compare with other initiatives?

b) How did the project progress?

Thinking of the education or training program

What was the need for an educational/training programme and what purposes did it serve?

What were the main issues that arose in developing the education/training programme?

What was the theoretical framework/underpinnings for the training programme?

What were the main issues arising in enactment of the education/training programme?

How was it evaluated (e.g. methods; stakeholders involved; findings?)

What were the main impacts and outcomes associated with the education/training programme?

Why did the training programme develop and impact in the way that it did?

For the training program, what factors emerge for you as most influential in this (shapers/helpers/barriers)?

How does this compare with other programmes of this type?

Thinking of the process of translating the initiative into practice:

What organisations and groups were most involved in translating the idea at regional and local levels?

Were there key project roles and, if so, how did these work?

What were the main issues that arose in these translation processes?

To what extent were particular contexts and cultures influential?

To what extent were particular individuals influential?

How would you characterise the balance between central control of the project and local translation or implementation?

Can you comment on the effectiveness of communication strategies, monitoring and feedback?

Looking back, why was the initiative translated into practice in the way that it was?

What factors emerge for you as most influential in this (shapers/helpers/barriers)?

How does this translation process compare with other initiatives of this type?

Thinking of the impacts and outcomes for individuals delivering and receiving services:

What were the main impacts and outcomes for those delivering services?

What were the main impacts and outcomes for those receiving services?

What were the main impacts and outcomes within relevant communities?

How would you characterise the successes and difficulties at local level?

Why did the initiative impact in the way that it did locally?

How does the impact of this initiative compare with other projects?

Thinking of formal evaluation processes and outcomes:

What was the need for an evaluation and what purposes did it serve?

What were the main issues that arose in developing the evaluation plan?

What was the underpinning methodology informing the evaluation?

What were the main issues arising in enactment of the evaluation plan?

In what way, if any, did the evaluation impact on policy, education and/or practice? (i.e. did it change anything?)

Why did the evaluation develop and impact in the way that it did?

What factors emerge for you as most influential in this (shapers/helpers/barriers)?

How does this evaluation research compare with others?

How would assess/gauge the quality of commissioned evaluation reports?

c) <u>What has been learned about this particular initiative?</u>

To what extent has the initiative proved sustainable?

Were the impacts and outcomes as you expected?

Has it changed anything?

Is it worth continuing this initiative?

What, if anything, would you do differently if you were involved in this sort of initiative again?

Why did the initiative develop and impact in the way that it did?

What factors emerge for you as most influential in this (shapers/helpers/barriers)?

What then are the key lessons that emerged for you from this initiative?

d) Understanding the initiative through the MAPPED model

Explain main elements and relationships with MAPPED model using visual depiction

To what extent does this help to explain and understand the development of this initiative from policy through to practice?

Which parts have most relevance for you?

Are there any aspects/elements that are not covered in the model that would be useful to develop?

Would feedback processes/loops be useful in relation to the different parts of the model?

If so, what and how?

Appendix 6: Key themes emerging from Case 1

Key themes relating policy formulation process in Case 1	Sources
1. Drivers and triggers	6
External drivers	6
Legislation	5
policy drive	4
changes of demographics, economics, workforce and service delivery	3
Internal drivers	6
professional needs and readiness	6
services needs	6
Lobbies	3
fit for purpose	3
Key people and their roles	4
Champions	4
2. Aims and targets	4
better access	4
expand competencies	3
Effectiveness	1
3. Supports and resistance	5
Resistance	5
individual profession's reaction	5
other professional resistance	4
organisational system	4
lack of motivation	3
Culture	2
lack of confidence	2
Poor management	2
role identity	2
Poor communication	1
Difficult keep database updated	1
routine tweaks	1
Limited resources	1
Uncertainty	1
Supports	5
staff attitudes	5
leading network	4
Enthusiasm	4
Governance	3
evidence-based	2
Acceptance	2
Collaboration	1
good communication	1
Awareness	1
expert group	1
4. Relationship with other initiatives	5
instrumental drivers	3
mutuality and responsibility	3
an example	2
Help	2
positive influence	2

advancing role development	1
Confused	1
5. Planning for enactment	4
strategic plan	3
knowledge preparation	2
building confidence and competence	2
Communication strategies	2
individual conversation	2
Infrastructure	2
role establishment	2
Standards	2
choosing right person	1
central discussion	1
link to management	1
Governance	1
resource allocation	1
6. Risk management	5
Identify risks	5
Incompetence	3
not obey rules	3
no standard	2
no valuing	2
Wasting	2
Anxiety	1
contradiction (intension)	1
gaps in knowledge and practice	1
Inconsistency	1
not updated	1
succession plan	1
Uncertainty	1
Strategies for reducing risks	5
Governance	2
meet standards	2
robust processes	2
awareness and understanding	1
Monitoring process	1
staff selection strategy	1
Support	1
training and education	1
7. Expectations	3
acceptance by professions	1
Curious	1
job satisfaction	1
not clear	1
not going	1
8. Key factors	2
tight network	5
Alignment	4
Legislation	3
collaboration and partnership	2
readiness and willingness (compliant)	2
role identity	2

well prepared	2
Communication	1
Confidence	1
Leadership	2
Motivation	2
organisational system	1
Standard	1
strategic plan	1

Key themes relating to policy implementation process in Case 1	**Sources**
1. Education or training programme	6
Characteristics	6
Consistency	5
generic module	3
joint development	3
tightness and robust	3
Accountability	2
blended learning	2
learning portfolio and network	2
national recognised	2
new direction (innovative way)	2
work based learning	2
a big driver	1
a certain flexibility	1
Enjoyable	1
formal education	1
Powerful	1
Key factors	4
Funding	4
Partnership	2
Standards	2
Enthusiasm	1
Mentorship	1
national policy	1
Main issues and challenges	6
course design	5
varied background	5
Balance	4
Inconsistency	4
Timing	4
Wasting	4
Complex	3
Entirety	3
lack of support	3
fit for practice	2
different style	2
difficult studying	2
service readiness	2
work based learning	2

Conflict	2
disconnections between learning and practice	2
Push	2
some confusion	2
legal aspect	1
Repetitive	1
theoretical framework	1
differences between learning and practice	1
professional issues	1
service user involvement	1
geographic problem	1
different geography	1
different portfolio	1
Funding	1
time allocation	1
lack of IT skills	1
Mentorship	1
need updated	1
organisational readiness for change	1
stressful assessment	1
Recruitment and selection	5
Restrictive	4
admission criteria	2
Governance	2
very limited	2
Multidisciplinary	1
right people	1
role boundary	1
2. Key project roles	6
Leadership	5
network establishment	5
support and facilitate	5
alignment for key contacts	3
increasing awareness	3
strategic plan	3
Coordination	2
Ensuring	2
leading or chair	2
selecting staff	2
developing education programme	1
Lobbying	1
provide local intelligence	1
Scrutiny	1
need research	1
peer review groups	1
push, help and support and facilitating	1
strategic plan and direction	1
3. Context, culture and individual influential	6
Attitudes	5
Support	4
local leadership	4
Champions	3

not sure	2
Reluctant	2
geographical difference	2
Confidence	1
Happy	1
local interest	1
Threatened	1
Trust	1
embedded practice	1
Funding	1
individual role	1
Legislation	1
organisational culture and ethos	1
public acceptance	1
Accustomised	1
Embrace	1
social norm and expectations	1
working settings change	1
4. Communication strategies	5
communication methods	5
sharing learning experience	3
Network	3
leading network	3
Meetings	2
top-down	2
update database	2
bottom to up	1
mixed approaches	1
same template	1
sharing good practice	1
using social media	1
peer network	1
5. Monitoring and feedback	6
Reviews	4
peer review	4
Audit	3
developing structured system	3
Governance	2
Approval	1
feedback activity	1
reflecting appraisal into practice	1
annual review	1
Scrutiny	1
timetabled plan	1
6. Balance	5
Interactive	4
consistency between government and local implementation	3
gaps of expectations	3
government facilitation and guidance	3
board embraced	2
detached linkage	2
sharing; discuss; a hub	2

Feedback	1
7. Difficulties and successes	6
Difficulties	6
understanding the roles	3
difficult to robust	2
lack of support	2
role identity	2
difficult to measure	1
Dilemma	1
Failing	1
hard to attribute	1
no evidence	1
Tensions	1
role boundary	1
Successes	4
professional development	3
benefits of health	2
improve access (improve patient journey)	2
frequent reviewing	1
giving advice	1
8. Key factors and main issues	6
Key factors	6
Network	5
Support	5
Alignment	4
leading network	4
Funding	3
collaboration and partnership	2
Engagement	2
Power	2
Legislation	2
team work	2
updating database	2
Flexibility	1
good structure (vertical and horizontal integration)	1
implementing standards	1
leadership and governance	1
Legislation	1
local autonomy and champions	1
local leadership	1
Motivation	1
local network	1
support network	1
policy imbedded	1
Recognition	1
Resources	1
right people	1
right time	1
Strategy	1
clear guidance	1
Government	1
Mentoring	1

professional support	1
open, trust, happy, fair	1
understanding the roles	1
role identity	1
Main issues	6
inconsistency (varied implementation)	5
limited in practice	3
multiple-disciplinary learning	3
get governance in place	2
less guidance	2
managing changes	2
not understand the role	2
role boundaries	2
partnership not overt	2
different opinions	1
difficulty in local management	1
in infancy	1
depend on individuals	1
depends on boards	1
Infrastructure	1
lack of strategy for the role (lack of direction)	1
lack of support	1
less engagement	1
Longevity	1
need to change in system	1
not organised properly	1
not really understand the action plan from managerial level	1
not standardised	1
role scope	1
Priorities	1
professional attitude	1
transforming service	1
Unsettled	1

Key themes relating to policy impact and outcomes in Case 1	**Sources**
delivering services	5
improve quality of services	5
Benefits	2
better relationship with patients	2
patient safety	2
service redesign	2
change culture within practice	1
changing practice	1
drug review	1
personal value	1
professional development	1
time management	1
receiving services	6
better access	6
patient satisfaction	3
staying at home	2

mind-set change	1
relevant community	5
enhance the range and quality of service	3
public awareness	3
knock on benefits for health	2
improve compliance	1
incremental change	1

Key themes relating to policy evaluation in Case 1	**Sources**
Methodology	2
case studies	1
comparison studies	1
mixed methods	1
Impacts	5
Limited	3
provide evidence	3
not convinced	2
Outdated	2
Firewall	1
justify and support	1
lead to action	1
Key factors	1
Funding	1
general positivity	1
team work	1
Main issues	3
a huge delay	1
Access	1
constant changes	1
lack of comparative study	1
timing too early	1
Quality	5
limited value	3
good report	2
more positive	2
not published properly	2
not detailed	1
badly writing	1
don't answer government need	1
Manipulated	1
quite confused	1
Tighter	1
Key themes relating to lessons learned from Case 1	**Sources**
Alignment	6
Evidence for sustainability	6
Communication	6
Gaps and challenges	6
leadership and governance	6
Motivation	6
Network	6

Strategy	6
support from different level	6
collaboration and partnership	4
learning experience	4
legislation and governance	4
Resources	4
role definition	4
flexibility and adaptation	3
longevity (long term vision and impact)	3
managing changes	3
Power	3
Consistency	2
Engagement	2
evidence-based	2
Innovation	2
local autonomy and government decision	2
Priorities	2
team work	2
bottom to up	1
incremental change	1
Ownership	1

Appendix 7: Application of a conceptual framework (governance, incentive and outcomes) for Case 1-4--Adapted from Ross et al 2011

Application of a conceptual framework (governance, incentive and outcomes) for Case 1 (extended role)			
Governance **Contextual features:**	**Implementation of policy to practice initiative**		**Impact**
	Supportive mechanism (incentives/motivators)	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Policy context	**.** European working directives change in GP contracts; development of out of hours service increased the nurse-led services **.** Law passed . Each NHS health board was encouraged to establish an effective network with support from national level. .Opportunities for leading practitioners to work at national level (e.g. national conference every two months)	. The development of other policy priorities may reduce opportunities for nurse-led initiatives. . Government funding was limited . lack of national guidelines at beginning	.sustainability is highly impacted by healthcare policy . Overwhelming support for non-medical prescribing to improve the range and the quality of services for patient care, particular in quicker and safer access to patients.
Resources and budget	.Adequate budget to support training and implementing change funded by Scottish government . Authority to mobilize adequate resources without delay. . Increasing the number of staff with trained skills to fulfil responsibility of the extended role .Sufficient resources, e.g. IT, online web sources . Standards from NES or DOH and from NMC . Adequate time allocated for training	. Delay in getting Prescribing pads due to administrative elements . Expectation that training would be achieved within a set time and reality of long periods of unpaid time required to fulfil this . Inadequate financial compensation . Difficulty in getting a designated medical practitioner . Difficult to keep database alive as people move . Time constraint for learning; no protected learning time arranged in some places . Resources wasted	. The extended role for services may cost more. . System needed to be changed to enable people to practice . Challenges for secondary care at outpatient clinic as it is out of the hospital budget . Initiative has come at a good time . Some problems could get a quicker solution if there was a better administrative process
Support and sustainability	. Political support; support from NES . Government structure supported access to the course . Opportunities and vehicles to address the initiative given to key stakeholders (e.g. politicians, chief nurse, doctors and practitioners); Highlighting the benefits	. Inadequate support from medical staff and managers . Lack of strategic leadership to carry the initiative in some areas . Lack of effective management system . Lack of support from front practitioners involved in the initiative . Lack of motivation for complex and challenging	. A good example of an initiative that has evolved over time . Sustainability of the role was un-disturbed with dedicated funding and support . Sustainability of the initiative was developed as the

	to organisation, professionals and patients . Support from nursing managers, practitioners, designated medical practitioners, colleagues and peer support . Education and practice worked collaboratively . Autonomy to develop each NHS own strategies and operational policies . Practitioners readiness and willingness . Fairly structured monitoring process . Good communication strategies . Consistency in course assessment, recruitment criteria . Good leadership at different levels . Effective network . engagement and enthusiasm . Peer review system	the nature of the extended role . Conflict with development and the initiative . Lack of clarity in the scope of the extended role . Lack of audit process and review system . No clear standards guidance . Partially inconsistent teaching course . No clear local policy set up . Difference in expectations centrally and locally . Conflict between individual opinions and organisations, and evidence base	programme spread out . A challenge relation to the NHS and their workforce
Patterns of working	. Prescribers took full responsibility for patient care . Prescribers spent their expert practice directly with patient	. Shortages of staff	. High impact report . Higher confidence in their ability to do their job . Evidence showed nursing prescribing provided a safe service to patients . NHS partners and other fields seem positive about the programmes . High level of job satisfaction and patient satisfaction . Very high level of professional and organisational commitment
Influencing governance mechanism, e.g. market, hierarchical, network	. A lead practitioner in each health board would link the local board with national government	. Lead person had multiple roles	. The lead person had a heavy workload
Personal features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors**	**Organisational, staff and patient outcomes**

Preparation for the role	. Special skills training consisting of 26 days study, 72hours of supervised learning in practice . Criteria for recruitment and admission to the programme . Competency-based assessment by means of portfolio	. Time was very limited for training . Time consuming for the procedure . Prescribers training tended to focus on a generic model rather than speciality . Inadequate supported preparation (e.g. resources and IT skills)	. An incremental course . A training model with tightness . Increased patient safety . Enhancement of professional knowledge and expertise
Career aspirations	. Opportunity to develop wider range of professional knowledge and skills . Opportunity for nurses using their expertise for whole patient journey . Opportunity to develop career progression . Opportunity to address the role involved in response to the needs of patients and the organisation . The training course fed into accreditation	. Increasing their workload while releasing doctors' time . More responsibilities to be taken . Inadequate work competency	. High job satisfaction and commitment . Growth of confidence for career competencies
Professional features: Professional implications of development	. Opportunity to build up clinical decision making and professional judgement . Opportunity to develop an autonomous role for NMAHPs . Opportunity to build up team work . Opportunity to develop nurse-led services	. Fear "overly medicalised" . Difficult to measure cost-effectiveness	. An increase in professional recognition and respect . Allowing services to be redesigned . Balance between NHS trust and national expectation

Application of a conceptual framework (governance, incentive and outcomes) for Case 2 (New role)			
Governance contextual features (Adapted from Ross et al 2011)	**Implementation of policy to practice initiative**		**Impact**
	Supportive mechanism (incentives/motivators)	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Contextual features: Policy context	**.** The minister for health visited clinical area and he was told the lack of support for learning and practice . Policy advocating innovative way to strengthen educational role . Each NHS health board was encouraged to establish an effective network with support	. The development of other policy priorities may reduce opportunities for this initiative. Government funding was limited . Lack of national guidelines . Lack of strategy for the new role at beginning	. Sustainability is highly impacted by health policy . Strong support - learning in practice to lynchpin education and practice.

	from national level. .Opportunities for leading practitioners to work at national level (e.g. a leads forum meeting twice a year)		
Resources and budget	.Tripartite joint secured budget to support the new role and implementation of change funded by Scottish government, health boards and universities . A national resource. . 100 full time equivalent posts with relatively senior practice-based staff to take responsibility in the new role . Sufficient resources, e.g. online web sources	. Inconsistent staffing for the new role allocation. E.g. some areas covered by PEF but some areas no PEF at all.	. The new role for services cost more. . Valuable for inputting education strategy in boards . Structured learning environment . Secured funding embedded the new role into practice . Ensuring workforce in the future . Personal value and more confident
Support and sustainability	. Political support; support from NES . Government structure support for access to the course . Opportunities and vehicles to address the initiative to key stakeholders (e.g. politicians, chief nurse and practitioners) . Highlighting the benefits to organisation, professionals . Clear strategic plan for new role . A core job description from NES . Some flexibility in vagueness . A single job description post . Good structure with vertical and horizontal integration . Support from nursing managers, practitioners, colleagues . Education and practice worked collaboratively . Autonomy for each NHS to develop their own strategies and operational policies . Practitioners readiness and willingness . Good communication	. Lack of strategic leadership to carry initiative in some areas . Varied implementation . Vagueness of role description . Lack of motivation for complex and challenging the nature of the new role . Conflict with development and the initiative . Lack of clarity in the new role . Lack of evidence-base as a new role . No clear guidance for standards . No clear local policy set up . Conflict between individual opinions and organisations . Difficulty in establishing role boundary . Difficult to manage different expectations . Lack of understanding of the new role . Hard to measure	. Sustainability of the new role was embedded in practice with secured funding and support . Sustainability of the initiative was developed and the programme spread out . Sustainability of the new role would be uncertain without funding and support . Meeting professional standards . Facilitating clinical academic careers and paths . Enhancing work-based learning . Improving quality learning in practice . Strengthening the learning environment

	strategies . Consistency in recruitment criteria and national induction . Good leadership at different levels . Effective network . engagement and enthusiasm		
Patterns of working	. Full responsibility for supporting mentors and learning environment in practice . No line management responsibilities with the expectation to be leaders rather than managers . Some autonomy to develop to meet local needs	. Shortages of staff . Not fully understanding the new role	. High impact with reporting process . High confidence in their ability to do their job . Evidence showed the value of the new role . NHS partners and other fields seem positive about the programmes . High level of job satisfaction . Very high level of professional and organisational commitment
Influencing governance mechanism, e.g. market, hierarchical, network	. Services usually operated according to organisational priorities . A leading practitioner in each health board and three regional coordinators would link the local board with national government	. Multiple policies impacting on new role . Agenda for change created numerous problems with new role in terms of banding and payment	. Different boards ended up with different gradings . Role confused or diluted . The new role was expanded depending on employment needs . The leading network developed a structured communication strategy and a good alignment for governance
Personal features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**

Preparation for the role	. Having joint induction programmes to develop the skills and share the experiences . Criteria for recruitment and admission to the programme . Academic qualification and experience assessment by means of portfolio . Clarity of role objectives and role boundaries . Getting people to understand the role . Online development programme sharing the resources between NES, universities and health boards	. Generic roles challenging specific skills . Organisational priorities affect the new role . Lack of time . Inadequately supported preparation (e.g. resources and management support)	. Helpfulness of nominated role . More confidence and personal value . Meets professional standards
Career aspirations	. Opportunity to develop wider range of professional knowledge and skills . Opportunity for career progression . Opportunity to address the role involved in response to the needs of clinical learning practice and the organisation	. Increased workload while taking on the new role . More responsibilities to be taken . Role dilution . Lack of support . Threatening to take over the other roles	. High job satisfaction and role commitment . Growth in confidence for career development . Increased numbers of employment for the new role
Professional features: Professional implications of development	. Opportunity to build up decision making and professional leadership skills . Opportunity to provide lynchpin between practice and education . Opportunity to build up team work . Opportunity to bring practice learning into curriculum development . Opportunity to build up a structured learning environment . Opportunity for the development of the nursing workforce	. Difficult to measure the impact	. An increase in professional recognition and respect . Allowed services to be redesigned . Balance between NHS trust and national expectation . Successful tripartite process among NES, health board and university

Application of a conceptual framework (governance, incentive and outcomes) for Case 3 (General education framework)			
Governance Contextual features (Adapted from Ross et al 2011)	**Implementation of policy to practice initiative**		**Impact**
	Supportive mechanism (incentives/motivators)	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**

Contextual features: Policy context	. Policy advocating innovative way to reduce the high attrition rate **.** Government had feedback from practice asking for additional support to be fit for practice **.** Government commissioned NES to build up national model to support newly qualified practitioners **.** NES promoting the policy about careers and retention of staff	. The development of other policy priorities may reduce opportunities for this initiative . Government funding was limited in duration . Lack of national guidelines . Lack of enough time to implement initiative	. Sustainability is highly impacted by government funding . Good for staff retention . Consistent support to enhance consistent care . Rushed when setting up and challenges to sustainability
Resources and budget	. Ring fenced budget to support the specific initiative and implementing change funded by Scottish government . Authority to mobilise adequate resources without delay . Adequate time allocation for implementing the initiative .Sufficient resources, e.g. online web sources, IT etc.	. Inconsistent designation of the training budget . Varied time allocation . Inadequate resource provision, e.g. no internet access or IT etc. . Lack of time implemented in a hurry . Inadequate staffing level with portfolio system	. The specific budget cost extra money. . Valuable for inputting education strategy in boards . Structured learning environment . Secured funding helped the completion rate . Ensuring workforce in the future . Personal value and more confident
Support and sustainability	. Political support; support from NES . Government structure supports access to the course . Opportunities and vehicles to address the initiative to key stakeholders (e.g. politicians, managers and practitioners) . Highlighting the benefits to organisation, professionals . Clear strategic plan and consistent learning materials for web-based learning . Autonomy for each NHS to develop its own strategies and operational policies . Consistent support from universities, senior managers, line managers, practitioners,	. Lack of strategic leadership to carry policy in some areas . Varied implementation . No clear local policy set up . Lack of motivation . Lack of time . Lack of support from local managers . Conflict between individual opinions and organisations . Less engagement . Hard to measure . Key people moved away . Challenging HEI pre-registration education	. Sustainability of the initiative was embedded in practice with secured funding and support . Sustainability of the initiative was levelled out with the programme . Meeting professional standards . Enhancing web-based learning . Improving quality learning in practice . Strengthening learning environment . Consistent support providing a

	colleagues . Education and practice worked collaboratively . Practitioners' readiness and willingness . Good communication strategies . IT support . Engagement and enthusiasm		standard approach . Workforce development . The initiative stopped due to lack of funding
Patterns of working	. Full responsibility for self-directed learning through e-learning . Designated time allocated by line managers	. Shortages of staff . Lack of time	. High impact with self-reporting process . High confidence in their ability to do their job . Evidence showed the value of training programme . NHS partners and other fields seem positive about the programmes . Professional competence updated . High level of job satisfaction . Very high level of professional and organisational commitment
Influencing governance mechanism, e.g. market, hierarchical, network	. Services usually operated by organisational priorities . IT engagement . Agenda for change . knowledge skills framework	. Multiple policies impacted on implementing initiative . Lack of IT skills and support	Government stopped the funding and the project became unsustainable. The leading network ensured structured communication strategies
Personal features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Preparation for the role	. Consensus conference . Getting people to understand the role . Online learning programme sharing the resources between NES, universities, health boards and practitioners	. Organisational priorities affect the programme's implementation . Lack of time . Inadequately supported preparation (e.g. resources. IT and management support)	. More confidence and personal value . Meet professional standards

Career aspirations	. Opportunity to develop wider range of professional knowledge and skills . Opportunity to develop career progression . Opportunity to address the role involved in response to the needs of clinical learning practice and the organisation	. Increase in workload while attending the training . More responsibilities to be taken . Lack of support	. High job satisfaction and role commitment . Growth of confidence for career development . Appears to have helped staff retention
Professional features: Professional implications of development	. Opportunity to build up confidence for professional knowledge and skills . Opportunity for a lynchpin between practice and education . Opportunity to build up a structured learning environment . Opportunity for healthcare workforce development	. Difficult to measure the impact	. An increase in professional recognition and respect . Workforce development . Balance between NHS trust and national expectation . Successful tripartite process among NES, health board and university

Application of a conceptual framework (governance, incentive and outcomes) for Case 4 (Enhanced role)			
Governance and contextual features (Adapted from Ross et al 2011)	**Implementation of policy to practice initiative**		**Impact**
	Supportive mechanisı (incentives/motivators)	**Constraining mechanism (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Contextual features: Policy context	**.** Government had feedback from the national review of mental health nursing in Scotland . New legislation for mental health nursing **.** Policy advocating innovative way to change in practice **.** Compulsory policy action plan	. The development of other policy priorities may reduce this initiative's opportunities . Voluntary process for second part of training course	. Sustainability is highly impacted by compulsory policy . Changing more medicalised care to personal interactions . High completion rate for those attending first training programme . Low attendance for the second training courses

Resources and budget	. Development of educational resources . Commissioned voluntary sector organisations to delivery a training for trainers programme . Authority to mobilise adequate resources without delay . Adequate time allocation for attending training course	. Restricted budget within NHS . Inadequate resources provided . Varied time allocation . Some lack of support from local management . Staff shortage	. Providing new knowledge and skills to make for more reflective practice and more service users involvement . Valuable for inputting education strategy in boards . Changing culture within practice . Personal value and more confident . More service users' opinions heard
Support and sustainability	. Political support; support from NES . Compulsory policy . Opportunities and vehicles to address the initiative to key stakeholders (e.g. politicians, chief nurse and practitioners) . Highlighting the benefits to the organisation and professionals . Clear strategic plan to support the dissemination of the educational resources . More organisational corporate accountability . Autonomy for each NHS to develop its own strategies and operational policies . Strong support from senior managers, line managers, practitioners, colleagues . Practitioners readiness and willingness . Good communication strategies . Engagement and enthusiasm	. Lack of strategic leadership to carry policy in some areas . Not in target for phase two training . Varied implementation . No clear local policy set up . Lack of motivation . Lack of time . Lack of support from local managers . Conflict between individual opinions and organisations . Less engagement . Hard to measure . Lack of role modelling . No understanding or awareness of the policy initiative . Different organisational structure	. Sustainability of the initiative was embedded in practice with support . Sustainability of the initiative was levelled out with the programme . Integrated into the pre-registration programme . Positive for risk taking . Meeting professional standards . More reflection on practice . Enhancing workforce development . Improving quality of service with more service users' involvement . Uncertain whether the initiative will be sustainable . Varied initiative implementation
Patterns of working	. Full responsibility for training others as trainers from commissioned organisations . There were line management responsibilities with the expectation to be leaders rather than project leaders. . Designated time for training	. Shortages of staff . Lack of time	. High confidence in their ability to do their job . Evidence showed the value of training programme . Professional updating . High level of patient satisfaction . Very high level of professional commitment

	. More patient involvement care . More reflection on practice		. Difficult to allocate the time for staff training
Influencing governance mechanism, e.g. market, hierarchical, network	. Services usually operated according to organisational priorities . Visionary strategic leadership	. Multiple policy development . Second part of training was not on target	. Multiple policies impacting on implementing initiative . The leading network developed structured communication strategies and a good alignment for governance . Plus and minus effects on compulsory policy and the voluntary process
Personal features:	**Supportive mechanism (incentives/motivators)**	**Constraining mechanisms (disincentives/inhibitors)**	**Organisational, staff and patient outcomes**
Preparation for the role	. Clear strategic plan and direction helped . Developing training for trainers programme . Getting people to understand the role . Designating staff time for the training . Delivering training with lived experience	. Organisational priorities affect the implementation of the programme . Lack of time . Inadequately supported preparation (e.g. resources. IT and management support) . Nurse practitioner training tended to focus on experts	. More confidence and personal value . Meets professional standards
Career aspirations	. Opportunity to develop wider range of professional knowledge and skills . Opportunity for nurses to work in a reflective way and develop a range of transferable skills . Opportunity to address the role involved in response to the needs of service redesign	. Lack of motivation . Nothing new to the nurses, felt the same . Lack of support . Few opportunities to develop career in nursing-led care but skills highly transferable	. High job satisfaction and role commitment . More service user involvement and high patient satisfaction
Professional features: Professional implications of development	. Opportunity to build up confidence for professional knowledge and skills . Opportunity to learn new professional knowledge and skills . Opportunity to build up a good relationship with service users . Opportunity for workforce development	. Resulted in current care being very medicalised . Low political power of nurses and nursing	. An increase in professional recognition and respect . workforce development . Balance between NHS trust and national expectation . Successful tripartite process using NES, health board and university

Appendix 8: Application of Kingdon's agenda setting model to the four policy initiatives

Dimension of model	Case 1	Case 2	Case 3	Case 4
Problems	European working directives change GP contracts, patients' waiting list, Cumberlege Report (DHSS, 1986). Crown report (1989)	Lack of support for learning and practice; Report by Aston and Molassiotis (2003); report from The Development of Quality Standards for Practice Placements Project (NHS Education for Scotland 2003)	High attrition rate, recruitment and retention issues; Report on themes 2004 - 2006 (NHS Education for Scotland, 2007).	National review of mental health nursing in Scotland (SEHD2006); Media about patients' complains
Policy	To increase prescribing powers of nurses via legislation	An innovative way to strengthen the educational role in practice providing support, educational input and development activities, and to ensure that nursing and midwifery students are given a positive and valuable learning experience during practice placements	eHealth Strategy 2008 – 2011 (NHS Scotland and The Scottish Government. 2008); To set up a national model to support newly qualified practitioners	Action 1: 'All mental health nurses will have undertaken value-based training by June 2008'
Politics	Caring for Scotland (Scottish Executive Department of Health 2001a), Delivering for Health (SEHD 2005), Delivering Care, Enabling Health (SE 2006a) and Visible, Accessible and Integrated Care (SE 2006b)	'Facing the Future' (Scottish Executive Department of Health 2001b)	Delivering Care, Enabling Health (SEHD 2006); Building a Health Service Fit for the Future (SE 2005)	Mental health (Care and treatment) Action 2003; Delivering for Mental Health (2006);
Policy entrepreneurs	Policy makers; Professions at government level, leading practitioners lobby for change	The minister for health, leading professions lobby	Policy makers; Leading professions lobby	Policy makers; Leading professions lobby