

**Evidence Informed Policy and Practice:
A review of approaches used in health
improvement in Scotland**

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Executive Summary

The review of Evidence Informed Policy and Practice (EIPP) initiatives in health improvement in Scotland was commissioned by NHS Health Scotland and has been undertaken by Janie Percy-Smith and Viv Speller, independent consultants, together with Sandra Nutley of St Andrews University.

The overall purpose of the review was to inform and guide the future integration and development of EIPP within Health Scotland's new structure and corporate strategy, taking into account the wider evidence base on knowledge transfer and organisational learning.

Review objectives

The objectives for the review were as follows:

- To document the objectives, approaches, methods, outputs, networks and clientele for each EIPP programme being reviewed.
- To explore how and why work was prioritised within each EIPP programme.
- To assess the value of the activities and outputs of the EIPP programmes from a number of different perspectives.
- To assess the quality of the methods and approaches used to review, synthesise and present evidence for their networks and/or policy and practice clientele.
- To assess the effectiveness of the activities and outputs of the EIPP programmes in influencing policy and changing practice.
- To consider the implications for the future development of EIPP work in Health Scotland and the integration of this work and professional roles within the new structure and strategy.

Approach and methods

We have used a mixed method approach to meet these objectives. This has allowed us to obtain *extensive* information across EIPP initiatives together with more *intensive* information on the impact of those initiatives on relevant groups of practitioners. In addition we have explored issues at three levels:

Programme: Health Scotland's (and its predecessor agencies) objectives for the EIPP programme; input and support provided; success criteria; perceptions of outcomes.

Individual initiative: for the five initiatives under review - Coordinators' interpretation of their role and purpose; activities and interventions and the rationale for these; outputs; and perceptions of outcomes and 'what works'.

Practitioner: for the five initiatives under review - ‘reach’ in terms of networks and clientele; impact on behaviour, attitudes and practice.

We have collected data from five sources:

(1) *Literature review:* This was undertaken to provide a framework for analysing the EIPP initiatives and to inform our recommendations. The literature review summarises the existing evidence on getting evidence into policy and practice, including evidence on individual and organisational learning.

(2) *Documentary analysis:* This increased the team’s understanding of the purpose, objectives and rationale for the EIPP initiatives and to document the activities and methods used; understand the rationale for the approaches selected; and review the methods and approaches used for synthesising and presenting evidence.

(3) *Seminars:* Early on in the review a seminar was organised, attended by key stakeholders, in order to discuss the five initiatives in terms of: the context for the five EIPP programmes; the overall approach taken by each and the rationale for this approach; approaches to systematic reviews of research and collation of evidence, developing and disseminating evidence-based guidance, developing capacity to deliver evidence-based practice, learning from effective practice. In addition a seminar was organised to discuss a preliminary draft of this report and to consider the implications of the recommendations. Finally a small workshop was organised to test out the EIPP “decision map” which was developed in order to provide a framework within which EIPP activities might be taken forward within Health Scotland in the future.

(4) *Stakeholder interviews:* A total of 22 in-depth, face-to-face interviews were undertaken with key stakeholders drawn from Health Scotland and the Scottish Executive and in the case of the Tobacco Control programme of work. ASH Scotland and the Scottish Tobacco Control Alliance. The main purpose was to obtain data on perceptions of what has worked well and less well in terms of the activities and interventions.

(5) *Survey:* Participants in the Learning Networks were surveyed on their involvement with the networks and the impact of that engagement on their knowledge, attitudes and practice. This was supplemented with feedback from other sources including the evaluation of the Mental Health Improvement Evidence into Practice workshops and the independent study of the implementation of the 2000 smoking cessation guidelines.

Context

The context for this review is a growing interest in evidence informed policy and practice together with an increasing number of initiatives designed to promote,

encourage and support evidence use. Reflecting this wider context, public health and health education work has taken on board the issue of evidence use and this is, in turn, reflected in Health Scotland's mission and strategic objectives. Responsibility for EIPP work within Health Scotland is currently located within the Public Health Sciences Directorate with the Learning Networks situated within the Evidence for Action division. The Policy Evaluation and Appraisal division also has a role to play through the generation of evidence about "what works" from evaluations.

The Health Scotland EIPP initiatives are linked to the health improvement priorities of the Scottish Executive and, in the case of the three Learning Networks, to three out of the four National Demonstration Projects. All five initiatives under review have been funded by the Scottish Executive and are being delivered through Health Scotland and, in the case of the Tobacco Control programme of work, in conjunction with partners.

The five EIPP initiatives are intended to provide support for national programmes of work identified as priorities for health improvement. However differences in the contexts for each of the programmes have led to the EIPP initiatives developing in different ways. In conducting this review we have examined the assumptions underpinning the way in which they work together with their relationship to the broader models of EIPP identified in the literature, including those relating to evidence-practice relations, individual and organisational learning and evidence-policy relations.

Key findings and issues arising from the review

Location of EIPP work within Health Scotland

Evidence informed policy and practice is central to Health Scotland's mission and strategic objectives. Indeed it could be argued that the use of evidence to inform policy and practice is a fundamental principle that runs, or ought to run, throughout the organisation. In reality, however, EIPP work is concentrated in "pockets" - neither mainstreamed throughout the organisation nor concentrated wholly in one division. As a result the Programme/Network coordinators, while they have been relatively autonomous, have also been relatively isolated and not terribly well integrated into the wider structures and priority theme areas within which Health Scotland is organising its work. In addition while there has been some informal sharing of expertise between Coordinators, there have been few opportunities to formally develop a shared approach nor to benefit from some economies of scale.

Rationale for EIPP programmes

Although all of the five EIPP programmes have developed in significantly different ways, they all to a greater or lesser extent reflect a key underlying

assumption, namely that sharing evidence and information will have an impact on practice. However within that assumption there are significant differences in thinking about:

- What kinds of evidence and information should be collated and shared.
- How information and evidence should be presented and disseminated.
- The kinds of impacts that are sought.
- The target audiences - individual practitioners, organisations, partnerships, professional groups.

In addition, in each case there is a second order assumption that individuals will take learning back into their own organisations.

While it is entirely appropriate that the five programmes should have developed in ways that reflect their specific contexts and clientele, there are also opportunities for the development of a common approach and greater sharing of good practice.

If the five initiatives are reviewed in the light of the models of research use identified in the literature review, then it is clear that, in general, the underpinning model is that of the “research-based practitioner” involving a focus on individual practitioners accessing and applying research evidence. However the development of the Smoking Cessation Guidelines also reflects some aspects of the “embedded research model” involving the translation of research into standards, tools and procedures.

In terms of the approach informing using evidence to influence policy, there is less evidence of an underpinning model informing the way in which this work has developed. Inevitably there has been a high level of opportunism - striking while the iron is hot - especially in relation to Tobacco Control and Sexual Health with some positive outcomes in relation to policy impact. Furthermore there is evidence across the five programmes of attempts to be proactive in relation to policy and a desire for more ongoing and active engagement with policy makers on the evidence base.

Objectives, approaches, methods, outputs, clientele for programmes

The overarching objective set for the three Learning Networks was to disseminate the learning from the three National Demonstration Projects to which they relate. This has proved problematic because of issues around the timing of the external evaluation and delays in setting up internal monitoring and evaluation. In addition the ways in which the three Networks have evolved have differed in relation to the emphasis given to various aspects of the work. The HDA Evidence into Practice cycle espoused by all five initiatives includes four activities:

- Production of evidence briefings
- Analysis of practice implications

- Provision of practical advice and support
- Collection of evidence from practice

It is clear that the five programmes have engaged in all of these activities, at least to some extent. However the emphasis has been different in each case. For example the Heart Health Learning Network has concentrated very much on the production of evidence whereas the Mental Health Improvement Evidence and Practice Programme has focused much more on provision of practical advice and support.

In part the different approaches adopted by the five programmes are reflective of the perceived state of play in relation to each of the topic areas. However they also reflect the different strengths of the coordinators and the resources available to them. Based on the activities of the networks, the HDA cycle might be expanded into the following “task list”:

- Production of evidence briefings/syntheses
- Production/commissioning of new research
- Evidence into policy - dissemination and active engagement
- Evidence into practice:
 - dissemination
 - active engagement
 - support for practice change
- Capacity building in relation to research, research use and evaluation
- Practice into evidence - collection, appraisal and collation of practice-based evidence/case studies.

All of these tasks are important but together constitute too diverse a set of activities requiring too wide a skills base for any one individual to carry out effectively. Not surprisingly the coordinators have tended to focus on those activities where they feel they have the greatest expertise and/or where they can have the greatest impact.

It is important to acknowledge the impressive work programme and the large number of outputs generated by the five programmes over a relatively short space of time. Furthermore the evidence from this review suggests that these outputs have been well-received in terms of clarity of presentation, relevance and utility.

The “reach” of the programmes in terms of professional groups is extensive and includes groups beyond the health sector. However only limited work has, hitherto, been undertaken to specifically target organisations or professional groups. As a result the five programmes are dependent on individuals identifying themselves for inclusion in the EIPP work or for the Coordinators identifying generic groups of individuals.

An important aspect of the EIPP programmes has been their ability to involve others directly in the work through expert groups (eg Breastfeeding expert group), reference groups (Mental Health Improvement) and advisory groups (eg Learning Disability Resource guide group). This has benefits not only for the activities and outputs generated by the programme but also for the individuals involved in these groups.

Value of activities and outputs

The stakeholder interviews indicated wide ranging support for the EIPP programmes and their activities. However in most cases interviewees (other than the Coordinators) were only able to comment on specific activities or outputs that they were particularly familiar with so it was not possible to obtain a more differentiated view of the value of specific activities and outputs.

The survey of members of the three Learning Networks provided some additional insights. Overall across all three Learning Networks the specific outputs about which we asked were rated highly in terms of clarity of presentation (in the case of published outputs) and being well run and facilitated (in the case of events), relevance and utility. Network members have especially found useful the sharing of information and good practice.

The published outputs have been produced to a high standard and, at least in some cases, differentiated outputs have been produced aimed at different audiences (eg Smoking Cessation Guidelines).

However the survey indicated that the Networks *qua* Networks do not really work; a significant number of survey respondents said they did not feel very involved in the Network and some indicated that they did not know they were members. In reality some operate only as mechanisms for distributing materials. This raises issues around the role of the Networks especially given the amount of work involved in supporting and maintaining them.

Quality of evidence-based outputs

In producing evidence syntheses and briefings the Coordinators, together with their expert/reference groups, have had to go through a process of deciding how rigorous an approach to adopt towards what counts as evidence. This is a vexed issue and there has had to be a process of negotiation and accommodation in most cases. As a result the outputs of each of the programmes are different in relation to the kinds of evidence they include. This is a particularly difficult issue with regards collecting evidence from practice and practice-based case studies. These are very popular with practitioners but there does need to be a level of confidence that the examples that are being promulgated as “good practice” really do meet certain standards.

A further issue has been the length of time it takes to collate robust evidence. In some cases this can mean that practice moves ahead of the evidence.

In most cases in terms of outputs there has been a conscious effort to go beyond the production of evidence and, in line with good practice, to ensure:

- Ownership and involvement in the production of materials
- Accessibility of the materials produced
- Effective dissemination
- Engagement with target audiences
- Effectiveness in terms of influencing policy and changing practice.

The work of all five EIPP programmes is an ongoing process. However on the basis of the evidence to date it is clear that the main impact on practice has been on increasing knowledge and understanding and increasing awareness of research and evidence on the part of individuals.

A significant minority of survey respondents said that their practice had changed as a result of their involvement in the Learning Networks and examples were given of both quite specific and more general impacts. Where practice change had occurred the main facilitators were felt to be:

- relevance of evidence/guidance to practice
- credibility of evidence/guidance
- availability of good practice examples.

Sources of support for EIPP were found to be colleagues in one's own organisation and colleagues in other organisations and professional groups. However it is interesting to note the relatively high proportion of Heart Health survey respondents who cited the Learning network as a source of support. There was some evidence to suggest that two out of the three Learning Networks have also improved links between practice colleagues, increased collaboration between practitioners and researcher, and facilitated learning from practice.

In terms of policy the impact has been more variable. While significant policy impacts can be identified in relation to Sexual Health and Tobacco Control, it should be noted that in both these cases these were issues that were already high on the policy agenda. Perhaps the most important lesson is the importance of developing effective personal relations with key policy people so that the EIPP programme coordinators become a first port of call for policy makers around these health improvement topics. Nevertheless the importance of producing succinct but credible evidence briefings is paramount.

There has been perhaps more of an impact on policy locally especially where the programmes have actively engaged with health boards or where individual

practitioners have been in a position to make changes in local strategy or practice as a result of their engagement with the EIPP programmes.

Extent to which initiatives reflect messages from the literature

As we have seen the five initiatives all demonstrate a fit with at least some aspects of the EIPP models albeit with an emphasis on individual rather than organisational learning. Similarly, while all of the initiatives cite the HDA EIP model and there is evidence that all four stages are being pursued at least to a limited extent, there is, nonetheless a significant gap between theory and practice. Much of this implementation gap can be accounted for in terms of constraints that operate, albeit differently, in relation to the five programmes. These can be summed up as follows:

1. Resourcing - budget constraints have meant that Programme Coordinators have had to make choices as to what aspects of the work they focus on
2. Recruitment/staffing - especially an issue in relation to the Early Years Learning network, but also an issue in relation to the skills, backgrounds and expertise of those appointed to posts which has to a significant extent determined the focus of the programmes.
3. Politics - has brought some issues to the fore resulting in a need to focus on certain areas of work at the expense of others.
4. Timing - notably the timing of the evaluations of the National Demonstration Projects which has resulted in the Learning Networks developing and disseminating other information.

Recommendations

The findings from the review have led the Review Team to make the following recommendations.

Location, structure, roles

- Review the rationale for EIPP programmes and their links to Health Scotland priority theme areas and the Executive's health improvement priorities.
- Consider the location of EIPP within the Health Scotland structure in particular whether it might be more effectively embedded by mainstreaming it across the organisation rather than being in separate "pockets".
- Consider the role of learning within the EIPP programmes and the link to learning within Health Scotland.
- Develop an approach to using evidence to influence policy and identify who, within Health Scotland, is best placed to undertake this work.

Audiences, outputs, modes of engagement

- Review the "reach" of the programmes in terms of the target groups and consider whether a different approach involving organisations and/or professional groups might be helpful.

- Review whether or not the “research-based practitioner model” underpinning much of the EIPP work is the most appropriate.
- Consider the role of the Learning Networks qua networks and either redesignate them as contacts databases essentially as a mechanism for distribution (possibly as part of a central NHS Health Scotland data base) or reemphasise their role in shared learning as part of an enhanced programme of activities intended to support practice change.

Quality issues

- Explore opportunities for greater commonality of approach across the five programmes drawing on good practice from each.
- Develop a protocol for what counts as evidence for different purposes for use across the organisation and, in particular, a protocol for the collection of case study evidence from practice drawing on the practice already developed within the five EIPP programmes.

1. Introduction

1.1 Aims, objectives and scope of the review

This review of Evidence Informed Policy and Practice (EIPP) initiatives in health improvement in Scotland was commissioned by NHS Health Scotland and has been undertaken by Janie Percy-Smith and Viv Speller, independent consultants, together with Sandra Nutley of St Andrews University.

The overall purpose of the review is to inform and guide the future integration and development of EIPP roles within Health Scotland's new structure and corporate strategy, taking into account the wider evidence base on knowledge transfer and organisational learning. The review has been undertaken in two phases. The objectives relating to each phase are as follows:

Phase 1:

1. To document the objectives, approaches, methods, outputs, networks and clientele for each EIPP programme being reviewed.
2. To explore how and why work was prioritised within each EIPP programme.
3. To assess the value of the activities and outputs of the EIPP programmes from the perspectives of their networks and clientele in related policy and practice arenas (what aspects of the work were most useful?)
4. To assess the quality of the methods and approaches used to review, synthesise and present evidence for their networks and/or policy and practice clientele (are the evidence outputs fit for purpose?)
5. To assess the effectiveness of the activities and outputs of the EIPP programmes in influencing policy and changing practice in terms of a) a set of evidence-derived standards for EIPP work and b) the experiences and reflections of the Coordinators (what aspects of the work were most effective?)

Phase 2:

6. Given the results of the review (objectives 1-5) and existing evidence about knowledge transfer and organisational learning, what are the implications for the future development of EIPP work in Health Scotland and the integration of this work and professional roles within the new structure and strategy? Where should EIPP be positioned? What skills are required? Is there a single model or does it necessarily vary with the topic area and strength of the existing evidence base?

1.2 Methodology

1.2.1 Approach

In order to meet the objectives identified above, a mixed method approach was adopted that allowed the research team to obtain *extensive* information across the EIPP initiatives under review together with more *intensive* information on the impact of those initiatives on the relevant groups of practitioners. In addition this approach facilitated exploration of the issues at three levels:

- *Programme level*: Health Scotland's (and its predecessor agencies) objectives for the EIPP programme; input and support provided; success criteria; perceptions of outcomes of the programme.
- *Individual initiative level*: for the five initiatives under reviews - Coordinators' interpretation of their role and purpose; activities and interventions and the rationale for these; outputs from each initiative; and their own perceptions of outcomes and 'what works'.
- *Practitioner level*: for the five initiatives under review - 'reach' in terms of networks and clientele; impact on behaviour, attitudes and practice.

1.2.2 Sources of data

This report is informed by data from six sources as follows.

Literature review

The literature review had a two-fold purpose as follows:

- To provide a framework for analysing the EIPP initiatives under review, including informing the design of interview schedules and survey questionnaire
- To inform our recommendations about the future development of EIPP work in Health Scotland.

The literature review summarises the existing evidence on getting evidence into policy and practice, including evidence on individual and organisational learning. A summary of the literature review can be found at Annex A.

Documentary analysis

At programme level the purpose of the documentary analysis was to increase the review team's understanding of the purpose, objectives and rationale for the EIPP programme. At the level of each of the five initiatives the purpose was to assist in the documentation of the activities and methods used; understand the rationale for the approaches selected; and review the methods and approaches used for synthesising and presenting the evidence.

Preliminary seminar

Early on in the review a seminar was organised attended by key stakeholders in the EIPP programme. The purpose of this seminar was for the coordinators of the EIPP initiatives under review to give a presentation of their work, including:

the context for the programme; the overall approach taken by the programme and the rationale for this approach; approaches to systematic reviews of research and collation of evidence, developing and disseminating evidence-based guidance, developing capacity to deliver evidence-based practice, learning from effective practice. In addition the review team presented an overview of the models of organisational learning and EIPP that would inform the review.

Stakeholder interviews

A total of 22 in-depth, face-to-face interviews were undertaken with key stakeholders drawn from Health Scotland, the Scottish Executive and, in the case of the Tobacco Control programme of work, ASH Scotland and the Scottish Tobacco Control Alliance. The purpose of the interviews was to increase the Review Panel's knowledge of the EIPP programme and the individual initiatives following the documentary analysis and seminar and also to obtain data on perceptions of what has worked well and less well in terms of the activities and interventions within the programme. Individuals to be interviewed were identified in consultation with Health Scotland and a full list can be found at Annex B.

Survey

In order to obtain breadth of coverage a questionnaire was developed focusing on the engagement of practitioners with the three Learning Networks linked to the National Demonstration Projects on Heart Health, Early Years and Sexual Health and Wellbeing. The survey sought to obtain feedback from participants in the Learning Networks on their involvement with the networks and the impact of that engagement on their knowledge, attitudes and practice. A postal questionnaire was sent to all network members with the exception of those who had previously indicated to the coordinators that they did not want their contact details passed on for the purpose of the survey. Two email reminders were sent out and a total of 631 completed questionnaires were received representing an overall response rate of 21.8% with an even distribution across the three Learning Networks surveyed.

Following discussion it was felt not to be appropriate to undertake similar surveys in relation to the Mental Health Improvement Evidence and Practice and Tobacco Control programmes because in these cases no Networks had been set up. Feedback on the impact of these programmes has been drawn from other sources including the evaluation of the Mental Health Improvement Evidence into Practice workshops and the independent study of smoking cessation support in Scotland¹ which reviewed the implementation of the 2000 smoking cessation guidelines and informed the current Tobacco Control programme of work.

Feedback seminar and workshop

Following the production of a preliminary report the findings and draft recommendations were fed back to, and discussed by, a large group of

¹ This study was commissioned by Health Scotland and conducted by Market Research UK.

stakeholders who also considered the draft recommendations. Finally a small task-based workshop considered the draft EIPP “decision map” and tested it out in relation to three discrete areas of Health Scotland work (see Annexes C and D).

1.3 Review criteria

This review has been informed by our understanding of “what works” in relation to EIPP drawn from the literature This was distilled into a set of key questions that have underpinned the design of the interview schedule and survey questionnaire. These questions are summarised in Table 1.1.

Table 1.1: Key questions informing the Review

Meta-level issues					
How do the EiPP initiatives fit into broader Health Scotland strategies and objectives?	Why is the focus on these particular programme areas? What is the rationale?	Who are the stakeholders? How are they involved?	How are the EiPP programmes resourced?		
Issues relating to EIPP initiatives					
Aims and objectives	What is the programme set up to do?	What are the specific aims and objectives?	What are the priorities?	How were these developed?	Have they changed over time? In what ways? how?
Rationale/underpinning assumptions	What is the underpinning rationale for the programme? Is this explicit?	What models of evidence use underpin the programme? <ul style="list-style-type: none"> - organisational excellence model - research-based practitioner model - embedded research model 	How does the programme encourage evidence-informed policy? <ul style="list-style-type: none"> - classic knowledge-driven model - problem-solving, policy-driven model - interactive model - enlightenment model - political model - tactical model 		

Scope	How far does the programme cover the main stages and activities of the HDA evidence-into-practice cycle? - production of evidence briefings - analysis of practice implications - provision of practical advice and support - collect evidence from practice	What approaches/activities are being used?	Who are the targets audiences/participants in the programme?	What is its scope in terms of budget? numbers? etc	
Organisation and management	How is the programme organised and managed?	Who are the main stakeholders? Are they all equally engaged? Do they all share the same understanding of the programme?	Has the programme developed/changed over time? if so why, and in what ways?		
Delivery	What has been	How effective is the programme?	To what extent and how effectively does it		

	<p>produced in terms of evidence syntheses? How have they been produced? by whom? Are the evidence outputs 'fit for purpose'?</p>		<p>demonstrate the features associated with successful strategies for promoting evidence use?</p> <ul style="list-style-type: none"> - Translation of research: - Encouraging ownership - Enthusiasts/ champions - Contextual analysis/understanding of barriers to/enablers of change - Ensuring credibility - Providing leadership - Giving adequate support - Developing integration 		
Learning processes	<p>How far does the programme focus on learning as opposed to just sharing information?</p>	<p>How is the programme structured to facilitate learning? What sort of learning processes and methods are employed?</p>	<p>What level of learning is the focus of activities: individual, group, organisational and/or inter-organisational? Does the programme engage with groups and organisations or</p>	<p>What types of organisational learning are facilitated: single-loop, double loop or deuterio (meta) learning?</p>	<p>Is the focus just on improving individual capabilities or are the other disciplines addressed?</p>

			just with individuals?		
Impact					
What processes have worked well/less well?	What would count as a successful outcome from the perspectives of different stakeholders?	What has been the impact of the programme on: - Broader understanding/attitudes - Policy - Organisational practice - Individual practice	What aspects of the work of the programme have been most useful from the perspectives of different stakeholders?		

2. The context for NHS Health Scotland's EIPP initiatives

2.1 The broader context of evidence informed policy and practice

Over the last decade there has been widespread interest in the UK and elsewhere in ensuring that the best available evidence underpins policy decisions and the ways in which public services are delivered, in the expectation that this will lead to better social outcomes². In the UK this is reflected in a range of policy programmes which aim to use and contribute to the existing evidence base on what works in tackling social problems (such as Sure Start and New Deal for Communities).

A range of agencies have also been funded to promote, enable and support evidence informed policy and practice, such as the National Institute for Clinical Excellence (NICE), the Social Care Institute for Excellence (SCIE) and the Health Development Agency (HDA)³. The work of these agencies has emphasised the importance of developing robust methods for systematically reviewing the evidence relevant to a particular policy or practice question. However one of the greatest challenges facing evidence-informed policy and practice is not necessarily bringing evidence together and making it available, but actually getting it used⁴. Recognition of this challenge has led more recently to increased emphasis on supporting evidence use through developing collaborative working, learning networks and communities of practice.

A key policy concern is reducing health inequalities between social groups, regenerating disadvantaged neighbourhoods and ending cycles of social exclusion. Public health and health promotion bodies have an important role to play in addressing these issues, and in taking up this challenge they are expected to use evidence to inform their policies and actions. To this end, the HDA began its work in 2000 to maintain an up-to-date map of the evidence base for public health and health improvement, and disseminate advice to practitioners.

2.2 NHS Health Scotland context

Health Scotland is Scotland's national health improvement organisation. Created in April 2003, it combines the Health Education Board for Scotland with its focus on health promotion research and evaluation for programme implementation and practice development, and the Public Health Institute for Scotland which focused on gathering and disseminating population health information and evidence and the development of a multi-disciplinary public health workforce. Its purpose is to "work with others to take action to protect

² Cabinet Office (1999) *Modernising Government*. CM 4310. London: Stationery Office

³ From April 2005 the HDA has been combined with NICE to form the National Institute for Health and Clinical Excellence.

⁴ Davies, HTO, Nutley, SM and Smith, PC (2000) *What Works? Evidence-Based Policy and Practice*. Bristol: The Policy Press

and improve the health and well-being of everyone living in Scotland and to reduce health inequalities⁵.” Its objectives are to:

- advance understanding of Scotland’s health and how it can be improved
- provide timely, evidence-based/specialist inputs to health improvement policy and planning processes
- increase competence and capacity in the delivery of health improvement programmes
- improve the quality of strategies to disseminate evidence, learning and good practice.

Health Scotland’s main role, as set out in the 2005-08 Corporate Plan, is to collaborate with partners to increase capacity to improve health and reduce inequalities across Scotland.

The three learning networks which are reviewed in this report, sit within the Directorate of Public Health Science within Health Scotland and report to the Head of Evidence for Action. The main purpose of the Evidence for Action (EfA)⁶ division is to advise those involved in health improvement policy and practice on what works to improve health, based on reviews of evidence from interventions research, policy and programme evaluation and implementation knowledge. The key roles are:

- To review and synthesise published research evidence on the effectiveness of interventions in key policy-related areas and disseminate these in forms that are accessible to policy-makers and practitioners
- To provide evidence-based advice and briefings to inform the development of health improvement policies and national programmes in Scotland
- To facilitate the utilisation of evidence in health improvement practice.

The work programmes of both the EfA and Policy Evaluation and Appraisal (PEA) teams are closely aligned with the Scottish Executive’s Health Improvement priorities.

The Policy Evaluation and Appraisal (PEA) Division also has a role to play in relation to EIPP work. It is responsible for coordinating the evaluation of health improvement policy – conducting policy reviews, evaluations of national initiatives and new legislation, collating and reporting on existing evaluations, commissioning new evaluations, building evaluation capacity, and “Building on the work of the National Learning Networks to disseminate across policy and practice evidence of effective practice and lessons learned from evaluation”.

There is also a learning function built into the other large Directorate in Health Scotland (Programmes Design and Delivery) which has a Learning and Workforce Development team, Learning and Development Advisors and two “Alliance Networks”.

The five EIPP programmes under review are as follows:

⁵ NHS Health Scotland Corporate Plan, 2005-08, Summary

⁶ NHS Health Scotland, Directorate of Public Health Science (2005) *The roles of EfA and PEA Teams*.

- Sexual Health and Wellbeing Learning Network
- Heart Health Learning Network
- Early Years Learning Network
- Mental Health Improvement Evidence and Practice Programme
- Tobacco Control Programme of work.

While all of these initiatives are being delivered through NHS Health Scotland, they are funded by, and linked to the Scottish Executive. The three Learning Networks are linked to the National Demonstration Projects - Healthy Respect, Have a Heart Paisley and Starting Well - funded by the Scottish Executive. The Mental Health Evidence and Practice Programme is one of the supporting mechanisms for the Executive's National Programme for Improving Mental Health and Well-Being. The Tobacco Control programme is a long-standing programme of work that has been delivered through a collaboration including Health Scotland (formerly HEBS), ASH Scotland, the Scottish Tobacco Control Alliance (STCA) and the Partnership on Action for Tobacco Control and Health (PATH)⁷. It should also be noted that these five areas are referred to as "programmes" but they have not all been formally constituted as such. Furthermore they do not encompass all of the EIPP activities undertaken within Health Scotland. Rather they are exemplars of approaches to EIPP activity chosen to provide a basis for comparison.

2.3 Rationale for EIPP initiatives

The three learning networks were intended to operate in three ways:

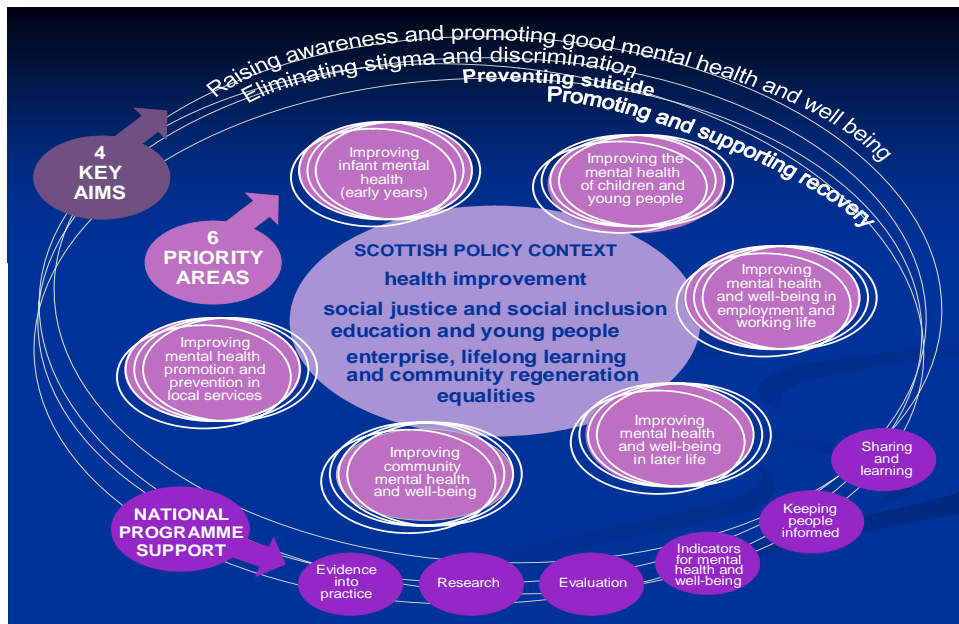
- To disseminate the learning from the National Demonstration Projects and, in particular, to act "as a conduit between the academic research teams commissioned to conduct independent evaluations of the demonstration projects, the project itself and national and local policy-makers and practitioners"⁸.
- To distil and disseminate the published evidence base on effective practice and collate together with evidence from practice.
- To support capacity-building and facilitate an interchange between policy and practice.

The Mental Health Evidence and Practice programme is intended to be one of the support functions for the National Programme to improve Mental Health and Well-Being as shown in Figure 2.1 below.

Figure 2.1: The National Programme to Improve Mental Health and Well-Being

⁷ PATH and the STCA are part of ASH Scotland

⁸ Wimbush, E et al (2005) "Evidence, policy and practice - developing collaborative approaches in Scotland", *Evidence and Policy*, vol. 1, no. 3, 391-407



Source: National Programme to improve Mental Health and Well-Being, Action Plan

The programme of tobacco control work has been a central part of Health Scotland and its predecessors' work for some years in collaboration with partners. The original smoking cessation guidelines were initiated in 1999 following discussions between HEBS and ASH Scotland. More recently key aspects of the ongoing programme of work have been the development of guidance to support the introduction of specialist smoking cessation services in Scotland, and the development of smoke-free legislation. It is these two elements that form the focus of enquiry in this review.

Thus in all five programmes there is an explicit commitment to EIPP work as a means of supporting health improvement work that has been identified as a national priority. However, what EIPP means in general or in the context of the specific programmes has tended not to have been clearly articulated. As a result the EIPP work associated with each of the five programmes has developed in somewhat different ways.

2.4 Underlying assumptions

In analysing the operation of the EIPP initiatives, it is important to surface the assumptions that underpin the way in which they work and how these relate to the broader models of EIPP summarised in the literature review (Annex A).

2.4.1 About evidence-practice relations

The three models of research use identified in a review for SCIE⁹ (see Annex A) have wider relevance and have been used in this study as a framework for analysis of the five EIPP initiatives under review. These three models are:

- Research-based practitioner model, where research use is the responsibility of individual practitioners;

⁹ Walter, I et al (2004) *Improving Research Use in Social Care*, London: SCIE

- Embedded research model, where research use is achieved by embedding research in the systems and processes of service delivery;
- Organisational excellence model, where the key to successful research use lies in the development of appropriate structures, processes and cultures within local service delivery organisations.

The SCIE review did not conclude that any one of these models is more effective than others for improving research use. Rather the conclusion was that the different models were suited to different situations such as the type of research evidence and sort of staff group involved in applying that research evidence. Hence there is a need to match research use models to different circumstances.

As part of the review we sought to establish the “best fit” between the five programmes and the three models of research use by asking the following key questions:

- Do the programmes engage with organisations (organisational excellence model)?
- Is the primary focus individual learning (research-based practitioner model)?
- How far do the programmes seek to translate research evidence into guidance and practice tools (embedded research model)?

Where the focus is on individual learning, we sought to establish any key assumptions about the facilitation of that learning which seemed to underpin the actions of the programme. In particular, we were interested in the extent to which they:

- Recognise and respond to different styles of adult learning
- Pay attention to the incentives and motives for learning
- Take in to account the role played by social and collaborative learning.

Where programmes engaged with organisations, we sought to establish any underlying assumptions about the process of organisational learning. In particular, based on the literature review, we were interested in the extent to which they focused on developing:

- Single loop learning, which emphasises compliance with guidelines and standards
- Double loop learning, which promotes combining external evidence with learning from the local context
- Meta-learning, which seeks to develop a reflective understanding of how the organisation learns.

2.4.2 About evidence-policy relations

The key issue to be examined here was the extent to which programmes assumed that they needed to play a passive or active role in relation to policy. A passive role is likely to be based on the assumption that the programme’s responsibility ends with making the evidence available for policy makers to use as they wish. In contrast, an active role is likely to be based on the assumption that personal contact and ongoing and sustained interaction with policy makers is essential if evidence is to impact on policy.

2.5 Key issues

The context for this review is a growing interest in evidence informed policy and practice together with an increasing number of initiatives designed to promote, encourage and support evidence use. Reflecting this wider context, public health and health education work has taken on board the issue of evidence use and this is, in turn, reflected in Health Scotland's mission and strategic objectives. Responsibility for EIPP work within Health Scotland is currently located within the Public Health Sciences Directorate with the Learning Networks situated within the Evidence for Action division with its emphasis on appraising and synthesising existing published evidence. However the Policy Evaluation and Appraisal division also has a role to play in relation to evidence informed policy and practice through the generation of evidence about "what works" from evaluations of current practice and interventions underway in the Scottish context.

The Health Scotland EIPP initiatives are linked to the health improvement priorities of the Scottish Executive and, in the case of the three Learning Networks, to three out of the four National Demonstration Projects. All five initiatives under review have been funded by the Scottish Executive and are being delivered through Health Scotland.

Each of the five EIPP initiatives is intended to provide support for national programmes of work identified as priority areas for health improvement. However differences in the contexts for each of these programmes have led to the EIPP initiatives developing in somewhat different ways. In conducting this review we have sought to examine the assumptions underpinning the way in which they work together with the relationship to the broader models of EIPP identified in the literature, including those relating to evidence-practice relations, individual and organisational learning and evidence-policy relations.

3. Scope of EIPP initiatives

*Towards a Healthier Scotland*¹⁰ pledged over £15m for the creation of four national demonstration projects which began in 2000 and were subject to both internal and external, independent, evaluation. The intention was that the demonstration projects should be “test sites for national action, applying and extending the evidence base so that we learn more”¹¹. They were intended to combine the best existing evidence with innovative practice. *Our National Health* (2000) announced the creation of the National Learning Networks which began in 2002 with a remit to disseminate learning from the Demonstration Projects. They were initially based and managed within PHIS but funded directly by the Scottish Executive. The original aim of all the Networks, as set out by the Scottish Executive in 2002 was as follows:

“develop and share the evidence base for action in order to develop stakeholders’ ability to translate these policy priorities into practice and inform future developments across Scotland. Specifically, their functions were to sift, collate, analyse and share existing evidence base, practice and experiences; to cultivate links with other relevant learning networks; and to identify implications for future practice and come forward with relevant strategies/plans.”

By contrast the Mental Health Improvement Evidence and Practice Programme came about as a result of funding from the National Programme for Health Scotland to set up a programme to support evidence into practice. Health Scotland then adapted this to be the Mental Health Improvement Evidence and Practice programme which included practice into evidence. The Tobacco Control programme of work was different again, bringing together a number of ongoing initiatives in Health Scotland and with other partners.

In this section we provide an overview of the five initiatives under review focusing on the contexts in which they were established, their aims and objectives, organisation and management arrangements, outputs and activities and how these have been delivered, and learning processes and methods employed.

¹⁰ Scottish Office (1999) *Towards a Healthier Scotland*

¹¹ (2000) *Our National Health*

3.1 Sexual Health and Wellbeing Learning Network

3.1.1 Context

Healthy Respect is the national demonstration project focusing on the sexual health of young people. The Scotland-wide Sexual Health and Wellbeing (SHW) Learning Network was set up in 2002 with the primary purpose of disseminating the learning from the Healthy Respect demonstration project.

3.1.2 Aims and objectives

The SHW Learning Network aims to:

- Provide a mechanism for sharing information and expertise on a multi-disciplinary, multi-agency basis
- Act as a bridge between policy, practice and research through:
 - Identifying gaps in the knowledge base
 - Building up the evidence base on “effective” interventions
 - Promoting promising practice
- Influence the development of strategic policy initiatives.

The overarching purpose of the Network that encompasses all of these objectives is to disseminate the learning from Healthy Respect. However this has, to a degree, been hampered by the fact that the evaluation of Healthy Respect did not report until March 2005.

This approach, and the Network’s work programme more generally, was shaped by a number of factors including feedback from the Healthy Respect launch event in February 2002 and the ongoing work of the Demonstration Project; the development by the Scottish Executive of a Sexual Health and Relationships strategy provided an opportunity to influence the policy agenda through the production of evidence papers; a stakeholders event in October 2004 which was used to identify key issues; and finally ongoing liaison with key stakeholders and the wider Network.

3.1.3 Organisation and management

The work of the SHW Learning Network is funded by the Scottish Executive. It is staffed by a coordinator working on her own from 2002 until 2004 when a project officer was appointed to assist with the work. They were initially located and managed within PHIS (Glasgow) and when Health Scotland was created they became part of the EfA division (Glasgow) although they are relatively autonomous within the organisation.

The work of the Network is funded by the Scottish Executive. Unlike some of the other EIPP programmes the SHW Learning Network has not established a Reference, Steering or Advisory Group to oversee its work. Instead the

coordinator has consulted with key stakeholders as and when this has been necessary. In addition the Coordinator has been very successful in drawing down specific additional advice and support for the work of the Network from the Executive, within Health Scotland and the wider Network as it has been required. For example a reference group was established to help with the collation of evidence for the briefing papers produced to support the development of the Sexual Health Strategy.

3.1.4 Delivery

The SHW Learning Network work programme is balanced between activities that are designed to promote the use of evidence in practice and those that are designed to encourage the production of evidence from practice.

The three priorities for the Evidence into Practice strand of the SHW Learning Network's work are:

- Influencing the wider cultural factors: social marketing and media communications
- Enhancing lifelong learning: developing links between education and other services; sex and relationships education
- Promoting better service use: reducing barriers to maximising sexual health particularly for black and minority ethnic groups and those with learning disabilities; effective interventions to minimise sexually transmitted infections (STIs).

The outputs relating to this strand of the work are as follows:

- A series of evidence papers to support the draft Sexual Health and Relationships strategy
- A number of focused events to encourage shared learning around:
 - education and health services links
 - developing local sexual health strategies
 - social marketing
- A series of Evidence Briefing papers including on abstinence programmes and condoms (see 3.1 for details of process used)
- Quarterly WISH (Wellbeing in Sexual Health) Newsletter and E-Bulletin to share information and highlight new research
- The development of a database of over 2000 members.
- Commissioned focus group work with young people with learning disabilities and from BME communities
- Development of enhanced SHARE materials including production of Sex and Relations Education resource list for young people with learning disabilities
- Shared learning events with NHS Boards and partners on Healthy Respect specifics.

Box 3.1: Process for producing Sexual Health Strategy Briefing Papers

- Identification of both academic and practice evidence drawn from a review of:
 - Published materials (on web and provided by Network members)
 - Consultation with key stakeholders (through Strategy engagement process, Network consultation days)
- Synthesis of key issues/gaps
- Subgroup (of Network members) to review draft materials
- Submission to main Reference Group

The practice into evidence strand of the SHW Learning Network's work has been implemented through:

- On the ground knowledge sharing through:
 - SRE seminars to showcase promising practice
 - Thematic seminars around particular issues
 - The newsletter and e-bulletin
 - Healthy Respect learning events
- Linking promising practice case studies/feedback from young people with systematic evidence
- Practical resources eg the Resource Review for learning Disabilities (see Box 3.2 for the process)

Box 3.2: Review of Learning Disability Resources - process

- Arose out of identified need from practitioners delivering SHARE programme and the Healthy Respect work
- Led by the SHW Learning network but also involved Healthy Respect and the FPA
- Trawl of existing database, networks, web
- Development of selection criteria
- Review by subgroup (final review commissioned)
- Continuous consultation with stakeholders
- Pilot, review and refine
- Publication, dissemination and feedback

The focus has been on individual learning through the dissemination of information, workshops and learning events, with the expectation that individuals take that learning back into their own organisations. Some specific targeting of professional groups on particular issues has been undertaken, for example PSHE teachers in Catholic schools

Organisational learning is achieved though individuals involved with network events becoming champions for change in their organisations. The development of the sexual health strategy has also provided a context for organisational change, and the focus on well-being has facilitated the involvement of a wider group of organisations and individuals.

One of the key characteristics of the SHW Learning Network has been the explicit commitment to widening the range of sectors and professionals exposed to the evidence base on sexual health together with the development of a shared agenda across organisational, sectoral and professional boundaries.

3.1.6 Fit with evidence informed practice and policy models

In relation to the stages of the HDA EIP cycle, there has been a more recent move to looking at different parts of the evidence, with the earlier emphases being on analysing practice implications and supporting change in practice. There is also a database of evidence from practice. This is a stronger focus on practice than is seen in the other networks with a clear emphasis on making evidence more accessible to policy and practice through face-to-face

methods rather than the production of tools. Effective leadership is seen to have been provided by the Network coordinator herself.

The focus of the network has been on developing individual learning, ie the research-based practitioner model of evidence into practice. In terms of evidence into policy characteristics, initially they were at a stage of assembling evidence that policy makers could seek out, but are now aiming to ensure a more active, ongoing engagement with policy-makers. This reflects the fact that sexual health was not on the policy agenda at the outset; so, in the first instance, steps had to be taken to draw the evidence together and have it available while, at the same time, influencing attitudes so that policy-makers accepted their need for it. This seems to have been done effectively and is an indication of the way in which these models may reflect different stages and different contexts in terms of the availability of evidence, and the readiness to use it in the policy arena.

3.2 Heart Health Learning Network

3.2.1 Context

Have a Heart Paisley (HaHP) is the National Demonstration Project on heart disease established in October 2000 with a £6m grant from the Scottish Executive. The long-term aim of HaHP was to reduce the total burden and levels of inequality of coronary heart disease in the town of Paisley through an integrated programme of secondary and primary prevention. The Heart Health Learning Network was set up to disseminate the lessons learned from the seventeen diverse projects within HaHP to the rest of Scotland.

3.2.2 Aims and objectives

The aim of the Heart Health Learning Network was to “blend the lessons emerging from HaHP with other sources of evidence to inform future policy and practice in Scotland”. It drew on the HDA EIP cycle with the stated intentions of applying the first three steps of analysing evidence, provision of practical advice and guidance, and supporting changes in practice. Attempts were made to apply the EIP model at both national and local levels. Theoretically it aimed to appraise evidence on all aspects of heart disease prevention that the Demonstration Project was engaged in; however, in practice, given the range of projects, it was not possible to do this. Instead a distinction was made between nationally led process of appraising evidence and producing guidance on population primary prevention of Cardio-vascular Disease, and a locally led process of reviewing the learning from the Demonstration Project for its local relevance. The Network supported this latter task through the systematic collation of learning from the HaHP projects on its website.

3.2.3 Organisation and management

The Learning Network had a Co-ordinator and, for a short while, an additional project officer. However this post remained vacant from 2004-2005. A multi-agency, multi-disciplinary national Executive Group was formed to give

strategic leadership to the Network. Flowing from this, a series of national Expert Groups (containing academic policy-makers and practitioners) were formed to implement recommendations from the Executive Groups. This involved reviewing the evidence on heart health risk factors (physical activity, diet and nutrition, smoking) and producing relevant guidance which was disseminated nationally to local policy-makers and practitioners.

The target audiences for the Heart Health Network are broad because Have a Heart Paisley has tackled so many issues; they range from cardiologists to community development workers. However in practice the EIPP work has focused on primary prevention rather than general health improvement with an emphasis on clinicians. The expert groups brought together academics, policy makers and practitioners and the exchange between academics and those using the research was seen to have been very helpful.

3.2.4 Delivery

The main output of the Learning Network has been the guide to Cardiovascular Disease (CVD) Prevention (see box 3.3 for approach taken to collation of evidence). A broader approach to evidence was used in collating all the outputs from Have a Heart Paisley (approximately 140 reports, journal papers, abstracts, presentations, posters etc). In addition the Heart Health website includes effective practice examples as well as traditional evidence.

Evidence is circulated to the Learning Network through:

- The database of 1200 contacts
- National and local events - Learning days
- A variety of media including reports, DVD/video, newsletters, posters, presentations
- Website - has a separate Have a Heart Paisley section as well as sections on general CHD evidence, policy and practice.

Box 3.3: Approach to collation of evidence - Cardiovascular Disease Prevention Guide

- Designed to support cardiac MCNs develop local primary prevention strategy
- Focussed on three priorities: physical activity, diet and nutrition and tobacco
- Formed “Expert Group” for each consisting of academics, policy makers and practitioners
- Initially took a very broad view of “evidence” (peer reviewed journal papers, reports, relevant policy, examples of current practice etc)
- Expert groups identified sources of evidence
- Coordinator reviewed, collated, summarised and fed back
- Guide was produced and included recommendations in relation to three priority areas based on the evidence.

Analysis of barriers to implementation was undertaken to an extent through the national conference on the draft CVD guide recommendations in March 2004. This included engaging practitioners in workshop debate to identify levers and barriers to implementation.

Capacity building has been less of a focus for the Heart Health Network. However capacity building work has occurred through the dissemination of information, evidence and current practice; national and local events; the CHD competency framework which is aimed at health care staff; and the CVD guide which identifies barriers and levers for change.

In terms of obtaining evidence from practice, again this has occurred through the process of putting together the CVD guide which includes 200 examples of good practice case studies; events; a commissioned review of cardiac Managed Clinical Networks' primary prevention strategies; and dissemination of information from Have a Heart Paisley.

3.2.5 Learning processes and methods employed

The Heart Health Network clearly and exclusively focused on individual learning. This was because it is the individuals who sign up for the network, receive information and join in as members rather than as organisational representatives. Although those individuals who are engaged in the working groups, or have attended events may have had more opportunities for shared learning, the main function of the Network has been to efficiently and systematically distribute information; it has not attempted to support learning or information exchange amongst members.

3.2.6 Fit with evidence informed policy and practice models

The Heart Health Network started with the production of evidence, primarily due to the role of the host organisation, PHIS, and achieved provision of practical guidance. Although it was felt that the CVD guide addresses some practical implementation issues, the Network did not directly support changes in practice. The Network also has a large collection of examples of practice on its website, and the learning from the Have a Heart Paisley project, but these aren't systematically fed into the evidence base.

The Network was seen to be strong on translating research and developing guidance. Users were involved in translating this and discussing its implications but this was only with those engaged in the process on the expert groups not the wider network. Opinions differ about the extent to which implementation issues were analysed during the process of production. Some practical support for change through open days is ongoing but this is fairly limited. The CVD guide is however, seen to be highly influential and the group has a unique and now recognised role for leadership in population primary prevention aspects of CVD.

In terms of evidence into practice models, the Network's main purpose has been to translate evidence into guidance. For evidence into policy there was a

sense that the emphasis had been on the more passive models of pooling evidence so policy-makers could seek it out, and enabling further engagement of policy-makers with the evidence. There was however some discomfort expressed that the Network was not being more proactive in this area, however this is in a context of a topic area where both the issue, and knowledge about much of the evidence, were already high on the policy agenda and, in 2005, became the focus of a major new national health improvement initiative, Prevention 2010..

3.3 Early Years Learning Network

3.3.1 Context

As with the other Learning Networks, the Early Years Network was established to further evidence-based practice in the area of child health (pre-birth to five years), through:

- assessing the existing evidence base, spanning both 'hard' evidence and professional expertise
- developing stakeholders' ability to translate this evidence into practice
- informing future policy and research.

Insights gleaned from the demonstration project, Starting Well, through internal and external evaluations were seen as key to this process. In addition the approach was informed by national policy documents: *For Scotland's Children; Health for all Children (Hall 4); It's everyone's job to make sure I'm alright*, and the Scottish Executive's *Integrated strategy for the early years*.

3.3.2 Aims and objectives

The Early Years Learning Network had two aims:

- To ensure Scotland-wide dissemination of lesson learned from Starting Well
- To institute an evidence into practice process by assembling the evidence base on early years issues and facilitating its implementation in Scotland.

However there were, from the outset, tensions between these two aims, arising from debates as to the extent to which Starting Well was itself evidence-based and whether or not EIPP work was a priority for Starting Well. In addition the breadth of focus of Starting Well meant that in practice it was not possible to undertake an EIPP process for all aspects of its work. An example of this tension was that breast-feeding was selected as the initial topic for the Learning Network for, in part, pragmatic reasons - as a systematic review had just been published by the Health Development Agency which meant that the work could start from the production of evidence based guidance. However there was not such a good fit between this work and Starting Well as the latter had not set out to improve breastfeeding rates.

3.3.3 Organisation and management

The Early Years Network has struggled as a result of difficulties in recruiting to the post of Coordinator. A coordinator was appointed initially part time and then full time but resigned her post in October 2004. Since then Health Scotland has not been able to recruit to the post. As a result additional funds were transferred to Starting Well to facilitate dissemination of project learning through the work of the Demonstration Project's Development Officer.

The work on breastfeeding was steered by a multi-disciplinary expert group, supported by the Learning Network Coordinator.

3.3.4 Delivery

The lessons that were to be disseminated from Starting Well by the Learning Network were not just those from the external evaluation which, in any case, would not be available until the end of the project, but also the experiential learning from Starting Well.

The Network created a database of 1500 individuals as a means of dissemination. In addition they developed new interactive means of taking this learning to people through the Roadshows described below.

Key activities of the Early Years Learning Network included:

- *Roadshows*: These were run at local Health Board level and were planned in a bottom-up way with local representatives to ensure that they combined lessons learned from Starting well with locally relevant issues, and were seen to be supported by senior management. They included exchange and discussion with practitioners/policymakers on issues to do with Early Years beyond, and including SW lessons. They were seen to be effective mechanisms for sharing learning, and providing a catalyst for change. Although aimed at both practitioners and local service managers, there may have been more of an emphasis on strategic delivery issues. In addition, while the target group was multi-sectoral, there was some difficulty in engaging with education primarily because the 0-5 focus was mostly pre-school.
- *Portfolio*: This was produced as a means of disseminating lessons from Starting Well. The aim was to 'chunk up report in a digestible way'.
- *Video*: This was a valuable dissemination tool but was considered to be a very positive view of the project rather than what did and didn't work.
- *Breastfeeding EIP group*: This was established to identify gaps in evidence an guide further review.
- *Production of further reviews of evidence* on selected aspects of breastfeeding that the available systematic reviews did not cover, on psychosocial aspects of breastfeeding and on organisational issues in neonatal units.

In terms of the HDA evidence into practice cycle the focus has been predominantly on the production of evidence briefings - notably the material on breast-feeding and the portfolio from the Starting Well evaluation - and analysis of practice implications and provision of practical advice/guidance

through the Starting Well Roadshows. It could be argued that some support for practice change was also instigated through the Roadshows.

3.3.5 Learning processes and methods employed:

One respondent was very clear that the learning focus was on individuals and groups of individuals; the other noted that groups were approached as co-workers, and that commissioners of child health services were also influenced. While commissioners of service were targeted, any organisational learning that resulted was seen to be as a result of the influence on individuals. Although inter-organisational learning was not addressed directly, there was clearly the intention to operate on partnerships and inter-organisationally through the Roadshow programme.

3.3.6 Fit with evidence informed policy and practice models

In relation to the EIP cycle it is clear that the breastfeeding work focussed on the stage of production of evidence briefings, but there was some indication that the roadshows disseminating the learning from Starting Well allowed for reflection on practice and to some extent supported change in practice. The collection of evidence from practice resulted from the internal evaluations of Starting Well only.

Generally both Starting Well and the breastfeeding review showed aspects of research translation, involvement of users in these processes, and facilitation of discussion about the implications of research. The breastfeeding work had intended to continue to develop guidance and analyse barriers to change, but this work was not completed. To some extent, for Starting Well, the production of guidance was achieved through the publication of the portfolio.

In terms of evidence into practice models it was felt that the main aims were to develop learning, and translate research into guidance and practical tools. For evidence into policy the main model in use was to enable ongoing engagement of policy-makers with evidence, but to some extent this was undertaken more passively through the provision of evidence that policy-makers could seek out.

3.4 Mental Health Improvement Evidence and Practice Programme

3.4.1 Context

The Mental Health Improvement Evidence and Practice programme was set up as a support activity for the Scottish Executive's Mental National Programme for improving Mental Health and Well-Being to be delivered by NHS Health Scotland with a remit to collect and disseminate the evidence base for mental health improvement and to support local practice. The development of the work programme has been informed by national and international debates and developments around what counts as evidence; integrating evidence and experience; getting evidence into practice - moving

from “passive” dissemination; the difficulties practitioners experience in contributing to the evidence base.

3.4.2 Aims and objectives

The overall aim of the programme is to establish a framework for developing and disseminating the best available information and evidence relevant to mental health improvement to inform future policy, practice and research in Scotland. The objectives are:

- To bring together evidence of effectiveness, combined with practical implementation knowledge
- Identify gaps in the evidence base and make recommendations for new research
- Convert evidence and practice knowledge into advice and guidance
- Increase and support capacity to translate both evidence *into* practice and evidence *from* practice.

3.4.3 Organisation and management

Like the Learning Networks, this work programme has been directly funded by the Scottish Executive and located within HEBS (Research and Evaluation), and latterly Health Scotland's EfA division. The funding available to the programme from the Scottish Executive has been £60,000 in 2003/04 increasing to £200,000 per annum for a further two years. The Mental Health Improvement Evidence and Practice Programme has had between a quarter and a half of a full time post. The work is overseen by a Reference Group made up of individuals from a range of different sectors with expertise in relation to both mental health improvement and evidence into practice initiatives.

3.4.4 Delivery

The overall approach is one that includes both getting evidence into practice and incorporating practice in evidence. The main activities and outputs to date have been as follows:

- *Evidence into practice workshops* - delivered locally in all 15 Health Board areas. An evaluation has been undertaken of these workshops¹²
- *Appraisal of Scottish Executive policy* - key policy documents were analysed in terms of the impact of mental health improvement evidence on policy; to assess how well the evidence base is being used. Summary was disseminated within the Scottish Executive and further work is planned.
- *Development and dissemination of evaluation guide series* - these have recently been disseminated. The intention was to encourage good practice in evaluation practice
- *Identification and dissemination of case studies* - of practice in mental health improvement in Scotland. These are evidence-based and evaluated and are also referenced in the Evaluation guides.

¹² Halliday, E, Friedli, L and McCollam, A (2004) *Evidence into practice Workshops: impact evaluation*, Scottish Centre for Mental Health

- *“Evidence into Practice” training for trainers* - the intention here is to build on the Evidence into Practice workshops by building capacity thus allowing the training to be cascaded.. This has been commissioned and will run in each Health Board area.
- *Introduction to Mental Health Improvement evaluation* – half day dissemination events for the evaluation guides
- *Mental health Improvement evaluation training* – delivered locally in Health Board areas. An evaluation of the training is being undertaken.
- *Review of measurement scales for practice evaluation.*

In addition plans are underway to undertake the following additional pieces of work:

- Additional support for evaluation eg an evaluation advisory/mentoring service and support for network development
- Identifying and working with audiences for mental health improvement who might be influential in terms of policy development and/or commissioning eg councillors. This is being developed with COSLA .
- Synthesising what works in primary health care - beyond systematic reviews - to be commissioned
- Reviewing risk and protective factors - to be commissioned.

The programme has, therefore, focussed to date less on synthesising evidence and more on building the capacity of individuals to use evidence and to undertake effective evaluation work.

3.4.5 Learning processes and methods employed:

The focus has been on building knowledge and capacity of individuals to be more aware of the evidence and in providing tools and techniques to use within their organisations.

The organisational emphasis has been through empowering individuals to advocate for change at local level but it was felt that more emphasis should now be on organisational learning through other networks specifically on the importance of mental health improvement to the work of health and local authorities. The evaluation of the Evidence into Practice workshops found that a majority of respondents had fed back learning from the workshops to colleagues.

3.4.6 Fit with evidence informed policy and practice models

The mental health programme has focussed on all stages of the evidence into practice cycle although there has been less emphasis on the production of evidence briefings. The focus has been mostly on the provision of practical guidance and supporting changes in practice through the training programme. This has drawn on an evidence review and made people more aware of the evidence base. Collection of evidence from practice has been initiated through the collection of case studies but it is not clear how well this has been used.

The programme focussed on translating research for use by practitioners and developing guidance. It is unclear how extensive involvement of users has been in translating the evidence and more needs to be done to provide a forum to facilitate discussion about the evidence amongst a wider group of people involved in mental health research. The provision of practical support for change is seen to be a strength of this programme and an exemplar. As a model of evidence into practice it is clearly focussed on developing individual learning.

The programme does not have a clear identity in terms of the way it attempts to influence policy. This is because the primary focus of the programme is on influencing practice rather than policy. Furthermore the evidence base has only recently been collated and is not well known, although it has had some impact in driving policy. Efforts are continuing to engage with policy-makers on this agenda as opportunities arise.

3.5 Tobacco Control Programme of Work

The Tobacco Control programme is not a Learning Network set up in relationship to a National Demonstration Project or National Programme; rather it is a programme of EIPP work that has been ongoing for a number of years within HEBS (Research and Evaluation) working with partner organisations, which has now been brought together in NHS Health Scotland. The programme has involved a number of initiatives that synthesise and translate evidence on tobacco control into policy and practice. There have been three broad areas of work:

- Smoking cessation guidelines for Scotland (involving Health Scotland and ASH Scotland)
- Reducing smoking and tobacco related harm and the Scottish Tobacco Control Action Plan (originally involving HEBS, PHIS and ASH Scotland; latterly involving Health Scotland and ASH Scotland)
- Development of smoke-free legislation to which Health Scotland has contributed.

3.5.1 Context

The publication of the tobacco White Paper *Smoking Kills* in December 1998 was a key driver for the development of the *Smoking Cessation Guidelines for Scotland*. In 1999 the HEBS and ASH Scotland commissioned a writer to review the English Smoking Cessation Guidelines and adapt the recommendations to the Scottish context. These guidelines were published in December 2000. An evaluation of the implementation of the 2000 guidelines was commissioned in 2003 to determine their reach and the extent to which the recommendations had been implemented¹³. In 2003 the Health Education Board for Scotland and ASH Scotland commissioned an update of the Guidelines for Scotland to take account of the developments in the evidence base and the experiences of the smoking cessation services during the first three years of their operation. The views and contributions of the Smoking

¹³ McKissock, K (2005) *Study of smoking cessation support in Scotland*.

Cessation Coordinators were sought at an early stage together with case studies of good practice. A national consultation with stakeholder agencies was also included in the process.

The updated guidelines, together with a desktop guide, were published in September 2004 and distributed to NHS Health Boards and a wide range of health professionals. In addition a series of implementation seminars were organised in conjunction with the Scottish Tobacco Control Alliance (part of ASH Scotland) to increase awareness and implementation of the recommendations.

In 2001 PHIS, HEBS and ASH Scotland began work on a needs assessment for tobacco control in Scotland. The final document, *Reducing Smoking and Tobacco Related Harm*, brought together epidemiological evidence, evidence about effectiveness of interventions, a review of current action and recommendations for further action. This document, jointly published in January 2004 by Health Scotland and ASH Scotland formed the basis for *A Breath of Fresh Air: Tobacco Control Action Plan for Scotland*, which was published by the Scottish Executive, also in January 2004.

One of the actions outlined in *A Breath of Fresh Air* was a broad consultation on smoking in public places; this included a series of research studies including an estimate of passive smoking-related deaths in Scotland¹⁴ and a review of the evidence and the modelling of the impact of a smoking ban in Scotland¹⁵ which contributed to the decision by politicians to implement a complete smoking ban. A substantial programme of research has been commissioned by Health Scotland on behalf of the Executive to evaluate the impact of the smoke-free legislation.

3.5.2 Aims and objectives

Work on EIPP in relation to Tobacco Control has not taken place through the development of a Learning Network but through a partnership approach to the development of evidence-based policy and practice guidelines with dissemination through the Scottish Tobacco Control Alliance (STCA) which is part of ASH Scotland.

The STCA was set up in 2000 with funding from the Scottish Executive and based in ASH Scotland; it acts as an alliance with a wide membership, which has a participative role in the direction and operation of the alliance. Its main objectives and activities are:

- Information exchange and networking including the production of a newsletter
- Organising conferences, seminars, briefings

¹⁴ Hole, D (2005) *Passive Smoking and Associated Causes of Death in Scotland*. NHS Health Scotland

¹⁵ Ludbrook, A, Bird, S and van Teijlingen, E (2005) *International Review of the Health and Economic Impacts of the Regulation of Smoking in Public Places*. NHS Health Scotland

- Multi-sectoral input to national planning bodies and policy making fora including policy development, informing and influencing national responses to tobacco, and representation

The goal of the first set of smoking cessation guidelines (2000) was to inform the development of specialist cessation services. The second set (2004) aimed to update the evidence base to reflect the changes in evidence about effective service provision, and to incorporate the experiences of the cessation co-ordinators in establishment and initial implementation of the services.

3.5.3 Organisation and management

The work in relation to Tobacco Control does not constitute a formal programme as such although it shares many features with the other initiatives that are constituted as programmes. It can best be understood as a programme of work. The total budget for Health Scotland's tobacco control programme of work is £1.73m.

The different bodies involved in tobacco control work have various roles and remits, and different levels of connection and impact in different sectors. While ASH Scotland and HEBS collaborated on much of the earlier work on reviewing tobacco control evidence and production of guidance for example, ASH Scotland has a clearer lobbying role on policy. ASH Scotland's establishment of STCA created a practitioner network whose membership is open to individuals and organisations working with a specific tobacco control remit and those with a wider remit including tobacco control or groups vulnerable to tobacco. Rather than a learning network run from Health Scotland, the STCA fulfils much of the networking role from within the voluntary sector, disseminating information, and providing consultation opportunities with the field. The Partnership for Action on Tobacco and Health (PATH) is a joint initiative established by ASH Scotland and the Executive to be the main training provider. PATH also has a role in relation to data collection and the development of training standards.

3.5.4 Delivery

The approach in relation to Tobacco Control has been the synthesis of evidence to support the development of policy the implementation of which is then supported through partnership working and the development of guidelines including case studies of effective practice. The intention was to make recommendations about effective smoking cessation practice based on systematic review and critical appraisal of the evidence with a view to maximising the delivery of optimal care, and help educate and train health professionals and ensure they play an effective role.

The updated 2004 Smoking Cessation Guidelines (published by Health Scotland and ASH Scotland) were designed as an integrated package of materials including: the full guidelines, a short, accessible guide for practitioners, a magazine format aimed at smokers and a step by step guide for those trying to stop smoking (see Box 3.4 for summary of process).

Box 3.4: Process for developing smoking cessation guidelines

- Commission guidelines and desk-top guide (Jan 2003)
- Convene editorial team
- Authors review/update evidence
- Review recommendations with editorial team
- Seminar with smoking cessation co-ordinators to review recommendations (May, 2003)
- Revision based on seminar feedback
- National consultation and revision (Oct 2003)
- Final revision and development of practical desk-top guide (Jan 2004)
- Publication, launch and dissemination (Sept 2004)

In terms of the HDA EIP model, the Tobacco Control alliance has focused on the production of evidence briefings and analysis of the practice implications and provision of practical advice and guidance and rather less on supporting changes in practice and collection of evidence from practice. However there is recognition of the need to focus more on training which is planned, and also the ability to draw on effective practice examples following the introduction of reporting of performance management data on numbers of quitters.

3.5.5 Learning processes and methods employed

The Tobacco Control Alliance focussed learning on individuals, both as practitioners and as commissioners of services, whereas PATH is the vehicle for individual learning. The Smoking Cessation guidelines have provided a framework for learning and there was capacity building for those involved in their production, and through the series of consultation seminars; however it was not felt that learning was the main objective for the network. While the smoking cessation guidance included cost-effectiveness data and guidance on the structure of services which was aimed at organisational learning and change, it was recognised that this was mostly effected through an individual learning approach. For tobacco control, the STCA provides an opportunity for inter-organisational learning but this has not been emphasised.

3.5.6 Fit with evidence informed policy and practice models

In relation to the stages of the HDA EIP cycle, the production of the smoking cessation guidelines clearly started with the production of evidence. There was also an indication through seminars and the work of partner bodies such as PATH, of engagement in the interpretation of the evidence with practitioners, however it was felt that more needed to be done with regard to supporting the changes in practice and in collecting evidence from practice in the future. In terms of EIPP models the tobacco control work all clearly fitted with models around translation of evidence, involvement of users, facilitation of discussion about research implications and developing tools. However there was agreement that they didn't go far enough to look at barriers to implementation. There is a current audit of practice and consideration of ways of supporting practice change is under discussion. In terms of leadership there

was some sense that the authoritativeness of the guidelines gave a clear lead, but this was seen to be the role of Health Scotland rather than of the 'network'.

In terms of the fit with the Evidence into Practice models, the closest fit is, perhaps with the embedded research model because of the emphasis on translating research evidence into guidance and practice tools. However there was also seen to be a role for individual learning. In influencing policy the tobacco control work had clearly had a significant influence and respondents were clear that this should be a proactive process, pushing the policy agenda and enabling ongoing engagement of policy-makers rather than passively collecting evidence that policy-makers seek out.

3.6 Summary of key issues

The three Learning Networks were set up with an explicit brief to disseminate learning from the National Demonstration Projects to which they relate. However the timescale for the external evaluations together with difficulties around the setting up of internal monitoring and evaluation capacity within the Demonstration Projects¹⁶ meant that there was a time lag in the generation of evidence that could be disseminated through the Learning Networks. Furthermore the evidence base underpinning the Demonstration Projects was either incomplete or contested. As one interviewee put it:

“Learning Networks do not have the scope or capacity to share lessons that aren't there.”

Partly as a result of this and because of their very different organisational, policy and practice contexts, the five EIPP programmes developed in significantly different ways and the approach and activities of each has been different. If we compare the five programmes with the models of research use outlined in section 2.4 (and detailed in Annex A) it is clear that the Learning Networks conform most closely to the research-based practitioner model with their focus on individual practitioners accessing and applying evidence. However there is also some evidence of the embedded research model particularly in relation to the Heart Health Learning Network and, more particularly, the Tobacco Control programme of work.

There has been more of a focus on individual as opposed to organisational learning across all five programmes with attempts made to cater for different learning styles through the provision of a wide range of different modes of engagement with practitioners, publications and other outputs and types of event. To the extent that there has been a focus on organisational learning this has tended to incorporate some aspects of single-loop learning, which emphasises compliance with guidelines and standards, and double-loop learning, which promotes the combining of external evidence with learning from the local context. The Starting Well roadshows are, perhaps, an example of the latter.

¹⁶ Evaluation Task Group (2005) *National Health Demonstration Projects. Evaluation Task Group Review. October - December 2003*

In relation to evidence into policy, there has been some variation across the five programmes. However it is important to recognise that in all five cases the health issues to which they relate had already been identified as policy priorities, hence the existence of national programmes, and developing the evidence base was seen to be an integral part of the process. Nevertheless it is clear that in certain areas, notably, sexual health and tobacco, the work undertaken under the auspices of the EIPP initiatives has informed policy development and, indeed, the coordinators of all of the programmes have been active in this regard.

4. Effectiveness and impact

In this section we examine the effectiveness of the activities organised and run by the EIPP programme coordinators from the perspectives of Network members and interviewees. In addition the Evidence into Practice workshops run by the Mental Health Improvement Programme have been subject to evaluation¹⁷ and, where relevant, we also refer to this data. In terms of impact the key question is: have the EIPP activities resulted in any changes in awareness, general knowledge and understanding, individual or organisational practice, or policy.

4.1 Success criteria - perspectives on what count as successful outcomes

What Network members regard as success will depend on what they think the Networks have been set up to do. Table 4.1 shows that there is a relatively high level of consensus within and across all three Networks (but especially among Heart Health Network members) that the main purposes of the Networks are to:

- Draw together research and practice-based knowledge
- Provide guidance on good practice to practice organisations
- Provide information on research findings to practice organisations.

These responses are closely aligned with the purposes of the Networks as articulated by the Coordinators and Health Scotland stakeholders. Illustrative quotes are as follows:

“To build and share evidence and knowledge about heart health”

“Generate evidence ... Identify evidence on what works and get practitioners across the sectors to appreciate what mental health and wellbeing was about and then to say that there are some things that work and support them to take action.”

“Spreading good practice around Scotland.”

“To act as a conduit to disseminate learning from the national Demonstration Projects.”

However it is interesting to note that although most respondents to the survey thought that the Networks have been established to provide guidance to practice organisations rather than individual practitioners, the actual emphasis of the work of the Networks seems to have been the latter and this is reflected in comments from stakeholders.

¹⁷ Halliday, E, Friedli, L and McCollam, A (2004) *Evidence into practice Workshops: impact evaluation*, Scottish Centre for Mental Health

Table 4.1: What was the Network set up to do? - col percentage (number)

	Early Years	Sexual Health	Heart Health	Total
Draw together research & practice-based knowledge	65.5(97)	67.8(225)	80.8(122)	70.4(444)
Provide guidance on good practice to practice organisations	62.2(92)	68.7(228)	70.2(106)	67.5(426)
Provide info on research findings to practice organisations	64.2(95)	66.6(221)	71.5(108)	67.2(424)
Influence national policy	52.7(78)	59.9(199)	61.6(93)	58.6(370)
Provide guidance on good practice to individual practitioners	50.7(75)	56.9(189)	64.2(97)	57.2(361)
Provide info on research findings to individual practitioners	50.7(75)	56.0(186)	64.2(97)	56.7(358)
Influence local policy	43.2(64)	52.4(174)	54.3(82)	50.7(320)
Support practice organisations in making changes based on evidence	42.6(63)	48.8(162)	58.9(89)	49.8(314)
Support individual practitioners in making changes based on evidence	29.7(44)	36.7(122)	48.3(73)	37.9(239)
Use practitioners' knowledge to influence research	26.4(39)	40.1(133)	36.4(55)	36.0(227)
Develop practitioners' skills in relation to research & evaluation	27.0(40)	30.4(101)	31.8(48)	30.0(189)
Other	3.4(5)	4.2(14)	4.0(6)	4.0(25)
Don't know	13.5(20)	10.8(36)	4.6(7)	10.0(63)
Total (numbers)	148	332	151	631

Base = All respondents

4.2 Processes - which have worked well?

4.2.1 Networks

All three learning networks have invested heavily in creating and maintaining databases of contacts. The Scottish Tobacco Control Alliance operates in a similar manner. This is not the case for mental health where no such network has been established. Table 4.2 shows that, in the case of the three learning networks the most common form of involvement is to receive regular email updates. Over two thirds of respondents said that this was the case - 89% in the case of Heart Health Network members. Attendance at a workshop or

training event was mentioned by 44% of all Network members - slightly higher among Sexual Health Network members. 43% referred to use of the relevant Network website - 55% in the case of Heart Health. In general members of the Early Years Network were much less likely to say they participated in any of these ways reflecting the relatively low level of activity as a result of the failure to recruit to the Coordinator's post.

Table 4.2: How involved by Network - Percentage of column total (number).

	Early Years	Sexual Health	Heart Health	Total
Receive regular email updates	49.3(73)	69.0(229)	89.4(135)	69.3(437)
Attended workshop/ training event	31.1(46)	52.4(174)	40.4(61)	44.5(281)
Make use of the website	35.1(52)	41.0(136)	55.0(83)	42.9(271)
Receive regular paper updates	25.7(38)	48.2(160)	15.9(24)	35.2(222)
Involved in information sharing	22.3(33)	35.2(117)	27.8(42)	30.4(192)
Received guide/ toolkit/ evidence review	10.8(16)	21.7(72)	42.4(64)	24.1(152)
Contributed evidence/ information about practice	11.5(17)	17.2(57)	16.6(25)	15.7(99)
Contributed to production of guides/ toolkits/ evidence review	6.1(9)	9.6(32)	12.6(19)	9.5(60)
Involved in shaping the Network's programme	0.7(1)	3.6(12)	8.6(13)	4.1(26)
Other*	11.5(17)	8.1(27)	5.3(8)	8.2(52)

Base = All respondents

* "Other" includes a significant number of respondents who said that they had had no involvement or that they didn't realise that they were in the Network.

However of more significance is the fact that a significant proportion of Network members do not feel involved in the Networks in which they are

nominally members (see table 4.3). The majority of participants feel not very or not at all involved in the networks¹⁸. It is also worth noting that a significant number of questionnaires sent out to those on the Networks' mailing lists were returned uncompleted by people who said that they did not know that they were part of this Network. In other cases questionnaires were returned, partially completed but with the same kinds of comments as illustrated by the following:

- “Involvement is minimal and limited to awareness of website.”
- “I was not aware I was in it.”
- “Not sure what it is.”
- “Didn't realise I was a “member”.”

This suggests that, for some people at least, the networks are not really operating as networks as such, rather as distribution and contact lists.

Table 4.3: How involved do they feel by Network - Percentage of column total (number).

	Early Years	Sexual Health	Heart Health	Total
Not very involved	42.2(62)	37.0(121)	40.0(60)	38.9(243)
Neither involved nor not involved	4.3(21)	23.2(76)	35(23.3)	21.2(132)
Not at all involved	34.0(50)	18.0(59)	12.0(18)	20.4(127)
Quite involved	6.8(10)	18.0(59)	2.0(33)	16.3(102)
Very involved	0.7(1)	2.1(7)	1.3(2)	10(1.6)
Don't know	2.0(3)	1.5(5)	1.3(2)	1.6(10)

Base = All respondents

4.2.2 Published outputs

All of the five EIPP programmes have produced published outputs including: evidence briefings, evidence syntheses, guidance documents, newsletters and case studies, which are mostly available in both electronic and print formats. Survey respondents were asked whether they had seen the key outputs of each of the three Learning Networks (table 4.4) and if so whether they found them relevant (table 4.6) and useful (table 4.7).

Overall the proportion of Network members who said they had seen the outputs listed was variable with some outputs eg the Cardiovascular Disease Guide, scoring very highly (85% of Network members said they had seen it), with others scoring surprisingly low eg Early Years Learning Network case studies (only 7.5% of Network members said they had seen them).

¹⁸ See also, Cogan, H (2005) *Can managed learning networks facilitate learning and positively influence practice in individuals and their organisations?* MSC Management of Training and Development, University of Edinburgh, p. 53

Table 4.4: Percentage of respondents who have seen Network outputs
(a) Early Years Sexual Health (b) Heart Health (c)

Output	% (No) of respondents who have seen ...	Output	% (No) of respondents who have seen ...	Output	% (No) of respondents who have seen ...
Starting Well Portfolio	41.8 (61)	Cardiovascular disease: a guide	85.4 (129)	Healthy Respect Briefing Paper	55.8(183)
EY Network video	13.6 (20)	Cholesterol screening: a review	13.3(20)	WISH Newsletter	69.7(228)
Starting Well Evaluation Report	26.0 (38)	Funding: a beginner's guide	12.7 (19)	Learning Disability Resource Review	28.2 (93)
EY Learning Network Case Studies	7.5 (11)	Have a Heart Paisley reports & learning templates	70.7 (106)	Sexual Health Strategy Briefing Papers	45.5 (150)
EY Learning Network website	50.0 (74)			E-Bulletin	50.5 (166)
				SHW Learning network website	46.4 (153)

Base = all respondents by learning network

Of those respondents who had seen the published outputs of the Learning Networks, the vast majority in each case thought that the outputs were very or quite clearly presented (table 4.5.). A majority also thought that the outputs were very or quite relevant to them (table 4.6) and very or quite useful (table 4.7).

Table 4.5: Outputs - How clearly presented - % who said they were very or quite clearly presented

(a) Early Years

(b) Heart Health

(c) Sexual health

Output	Very/quite clearly presented	Output	Very/quite clearly presented	Output	Very/quite clearly presented
Starting Well Portfolio	92.0 (57)	Cardiovascular disease: a guide	89.8 (115)	Healthy Respect Briefing Paper	95.0 (172)
EY Network video	94.5 (17)	Cholesterol screening: a review	100.0 (20)	WISH Newsletter	90.5 (201)
Starting Well Evaluation Report	97.3 (36)	Funding: a beginner's guide	89.5 (14)	Learning Disability Resource Review	98.9 (92)
EY Learning Network Case Studies	100.0 (11)	Have a Heart Paisley reports & learning templates	91.5 (97)	Sexual Health Strategy Briefing Papers	94.7 (142)
EY Learning Network website	89.9 (62)			E-Bulletin	89.1 (147)
				SHW Learning network website	93.1 (135)

Base = all those respondents who had seen each output

Table 4.6: Relevance of outputs - % who said they were very or quite relevant

(a) Early Years

(b) Heart Health

(c)

Sexual health

Output	Very/quite relevant	Output	Very/quite relevant	Output	Very/quite relevant
Starting Well Portfolio	90.3 (56)	Cardiovascular disease: a guide	89.8 (115)	Healthy Respect Briefing Paper	89.1 (162)
EY Network video	83.3 (15)	Cholesterol screening: a review	90.5 (19)	WISH Newsletter	86.9 (193)
Starting Well Evaluation Report	94.8 (36)	Funding: a beginner's guide	89.5 (17)	Learning Disability Resource Review	87.2 (82)

EY Learning Network Case Studies	100.0 (11)	Have a Heart Paisley reports & learning templates	89.7 (96)	Sexual Health Strategy Briefing Papers	92.0 (138)
EY Learning Network website	88.4 (61)			E-Bulletin	85.5 (141)
				SHW Learning network website	91.8 (134)

Base = all those respondents who had seen each output

Table 4.7: Usefulness of outputs - % who said they were very or quite useful
(a) Early Years (b) Heart Health (c) Sexual health

Output	Very/quite useful	Output	Very/quite useful	Output	Very/quite useful
Starting Well Portfolio	79.0 (49)	Cardiovascular disease: a guide	89.8 (115)	Healthy Respect Briefing Paper	83.9 (152)
EY Network video	66.6 (12)	Cholesterol screening: a review	90.0 (18)	WISH Newsletter	82.9 (184)
Starting Well Evaluation Report	89.5 (34)	Funding: a beginner's guide	82.3 (14)	Learning Disability Resource Review	86.1 (80)
EY Learning Network Case Studies	81.9 (9)	Have a Heart Paisley reports & learning templates	87.8 (93)	Sexual Health Strategy Briefing Papers	88.7 (133)
EY Learning Network website	80.6 (54)			E-Bulletin	81.2 (134)
				SHW Learning network website	92.5 (135)

Base = all those respondents who had seen each output

4.2.3 Events

The five EIPP programmes have between them run a significant number of events. These have varied considerably in their format and purpose to include:

- Consultation eg through national and local conferences and seminars during the production of both the CVD guide and smoking cessation guidance
- Awareness raising eg Have a Heart Learning Days and Healthy Respect Shared learning events
- Networking eg through the organisation of local events attended by a range of local service providers with a common interest such as the Starting Well roadshows and SHW Linking Education and Services seminar
- Dissemination eg Sexual Health Strategy Briefing events
- Training eg Mental Health Evidence into Practice workshops and Mental Health Improvement Evaluation Training.

Members of the three Learning Networks were asked which events they had attended (see Table 4.8) and those who had attended were then asked to say whether they found these events relevant (table 4.9) and useful (table 4.10). In each case a large majority of those who had attended said they found the events very or quite relevant and very or quite useful. A majority in each case also said that they found the events well run and facilitated.

Table 4.8: Events - % who attended (number)

(a) Early Years

(b) Heart Health

(c)

Sexual health

Event	% of respondents	Event	% of respondents	Event	% of respondents
Roadshows	21.9 (32)	2004 Have a Heart Conference	29.3 (44)	Linking Education & services seminars	28.7 (94)
		Have a Heart Learning Days	17.3 (26)	Healthy Respect Shared Learning Events	24.3 (80)
				Strategy Briefing Events	18.3 (60)

Base = all respondents

Table 4.9: Events - % of those who participated who said they were very/quite relevant

Event	% of respondents who participated	Event	% of respondents who participated	Event	% of respondents who participated
Roadshows	83.4 (25)	2004 Have a Heart Conference	97.7 (44)	Linking Education & services seminars	96.8 (89)
		Have a Heart Learning Days	88.9(24)	Healthy Respect Shared Learning Events	94.9(74)
				Strategy Briefing Events	94.7 (54)

Base = all respondents

Table 4.10: Events - % of those who participated who said they were very/quite useful

Event	% of respondents who participated	Event	% of respondents who participated	Event	% of respondents who participated
Roadshows	73.3 (24)	2004 Have a Heart Conference	93.2 (41)	Linking Education & services seminars	90.2 (82)
		Have a Heart Learning Days	77.0 (20)	Healthy Respect Shared Learning Events	91.0 (71)
				Strategy Briefing Events	93.0 (53)

Base = all respondents

4.4 Impact

The survey asked respondents whether or not membership of the Learning Networks had had an impact on themselves in terms of increased awareness of research and evidence through to changes in practice. As Table 4.11 shows, across all three Networks the most common impact was increased awareness of research and evidence followed by an impact in terms of general knowledge and understanding.

Table 4.11: Types of impact on **self** by network - percentage of total respondents in each network who said that the network had had an impact on themselves %(no.)

	Early Years	Sexual health	Heart Health	All
Awareness of research & evidence	59.7(86)	74.6(241)	78.2(115)	72.0(442)
General knowledge & understanding	56.3(81)	75.9(245)	74.0(108)	70.8(434)
Individual practice	26.3(36)	44.0(140)	44.2(65)	40.0(241)
Organisational practice	27.3(38)	41.1(129)	35.6(52)	36.6(219)
Knowledge & skills in relation to research & evaluation	26.6(37)	39.3(123)	36.4(52)	35.6(212)
Attitudes	23.6(33)	40.9(130)	31.5(46)	34.6(209)

Base = All respondents . NB: High numbers of “don’t knows” in response to this question

When asked about the impact of the Networks on others a very high percentage of respondents said “don’t know”. However of those who gave a response, again awareness of research and evidence and increased knowledge and understanding were the most common responses (see table 4.12)

Table 4.12: Types of impact on **others** by network - percentage of total respondents in each network who said that the network had had an impact on others %(no.)

	Early Years	Sexual health	Heart Health	All
Awareness of research & evidence	27.7(39)	43.0(136)	45.5(66)	40.0(241)
General knowledge & understanding	28.6(40)	41.3(130)	44.5(65)	39.1(235)
Knowledge & skills in relation to research & evaluation	19.6(27)	26.3(82)	28.3(41)	25.2(150)
Attitudes	13.8(19)	25.6(80)	26.2(38)	23.0(137)
Individual practice	15.2(21)	26.1(82)	26.2(38)	23.6(141)
Organisational practice	17.3(24)	29.1(91)	24.1(35)	25.1(150)

Base = all respondents

NB: High numbers of “don’t knows” in response to this question.

4.4.1 Awareness of research and evidence

The interviews generally confirmed the view presented by the survey data that increased awareness of research and evidence had resulted from the activities of the five EIPP programmes. In relation to the mental health improvement evidence and practice programme, the evaluation of the Evidence into Practice workshops reported that “Attending the workshop and

recognising the body of evidence in existence increased people's ability to put forward a case for mental health improvement. ...The workshop also raised people's awareness of the existence of evidence and how evidence could be applied to funding bids, projects and arguments."¹⁹

4.4.2 General knowledge and understanding

Again the interviews confirmed that increased general knowledge and understanding had resulted from the activities of all EIPP programmes under review. Specifically:

- The **Tobacco Control** alliance was seen to have increased general understanding of issues to do with the complexities of quitting and costs; however this was felt to be one influence among many including the debate on the legislation.
- **Heart Health Learning Network** was felt to have had a positive impact on general understanding of primary prevention aspects of heart health, and also an increased understanding of different professionals groups' viewpoints and priorities, although this was largely limited to those that joined the expert groups.
- **Early Years Learning Network** was felt to have increased understanding about the nature of the Starting Well project and its effects, but for the breastfeeding work this was limited to those involved in the expert groups. There was some shift in attitudes apparent on very specific issues that were addressed within the Starting Well programme such as skills mix.
- **Mental Health:** The evaluation of the Evidence into Practice workshops found that "The most frequently cited learning point was that the workshops contributed to an increased awareness of all that is involved in ensuring good mental health"²⁰.
- **Sexual Health Learning Network** was felt to have increased understanding of the issues and resulted in a change in attitudes that has now put the topic of sexual health more firmly on the agenda at national and local level.

4.4.3 Knowledge and skills in relation to research and evaluation

The programme where this has been addressed most explicitly is mental health improvement where a series of evaluation guides have been produced and the issue has also been addressed in the Evidence into Practice workshops. The evaluation of the workshops found that while some people felt that the workshops had "helped them reconsider how to approach the process of evaluation" and "They had become more aware of the types of indicators required and available to measure mental health", translation of this learning into practice had created challenges.

¹⁹ Halliday, Friedli and McCollam, *ibid*, p.17-18

²⁰ Halliday, Friedli and McCollam, *ibid*, p.17

4.4.4 Attitudes

The interviews suggested that attitudes had changed significantly in relation to mental health and sexual health. In the case of mental health the change was around the salience of the issue, while for sexual health it was around a change in attitudes about what was appropriate in addressing sexual health issues. In addition it was felt that there had been some impact on the Heart Health expert group's attitudes towards the quality of health improvement evidence. In relation to tobacco, attitudes to do with recognition of the addiction were also felt to have been affected, particularly for a wider audience rather than the smoking cessation specialists.

4.4.5 Individual practice

Survey respondents from the three learning networks were asked whether they had changed any aspect of their practice as a result of their involvement in the network. As Table 4.13 shows, across all three networks 24% of respondents said they had changed some aspect of their practice, with the figure higher in relation to Sexual Health and Heart Health (29% in each case). Although this is a minority of network members, this is, nevertheless a not inconsiderable achievement given the kinds of barriers that individuals are likely to face in introducing practice changes. Box 4.1 gives some examples of the kinds of changes introduced.

Box 4.1: Examples of practice changes reported by survey respondents

Early Years

I am much more aware of the need for more evidence in practice.

Planning to set up a toy library in a tower block which provides access to health Visitor services and outreach services.

More multi-agency work.

Starting Well Demonstration project guide - use of skill mix in primary care teams.

Heart Health

More community involvement ie food coops in my areas working with members of community rather than just health professionals.

Encouraged the set up of local exercise classes for patients with heart disease.

Informed development of local work plan for healthy eating and physical activity.

Thinking about how we could adapt the self-improvement/management model from Braveheart into a local setting.

Have used the evidence provided by the Network to support development bids.

Sexual Health

Trying to expand and improve sexual health care services in our locality.

Felt more informed about gay/lesbian and transsexual issues and was able to discuss this informatively with patients.

Developing health education programmes for children with special needs.

In working with young people who are accommodated we have developed more client focussed services and improved uptake of sexual health and wellbeing information and the young people are more receptive.

We have made significant changes to our young people's services and have developed protocols and guidelines accordingly.

I have incorporated much of the information provided into various aspects of the health component of my PSE teaching as well as using some of the information in my development of the new sex education programme for the school.

Networking opportunities and presentation of work has enabled me to develop work jointly with partner organisations.

Those respondents who had been able to make some changes to their practice were asked what factors had facilitated this process. As Table 4.14 shows, the most commonly cited factors were that the evidence/guidance was relevant, that it was credible and good practice examples were available. In addition the timeliness of the evidence/guidance was also important.

Table 4.13: Changed any aspect of practice as a result of the network - percentage of total respondents in each network %(no.)

	Early Years	Sexual health	Heart Health	All
Yes	13.5(19)	28.8(92)	28.8(92)	23.8(145)
No	75.9(107)	56.3(180)	62.6(92)	62.3(379)
Don't know	10.6(15)	15.0(48)	14.3(21)	13.8(84)

Base = all respondents

Table 4.14: Factors that have been helpful in making changes to practice - percentage of respondents in each networks %(no)

	Early Years	Sexual health	Heart Health	All
Evidence/ guidance was relevant to practice	10.1(15)	20.5(68)	16.6(25)	17.1(108)
Credible evidence/ guidance provided	8.8(13)	17.2(57)	15.2(23)	14.7(93)
Good practice examples available	6.1(9)	17.8(59)	15.9(24)	14.6(92)
Evidence/ guidance was available at the time it was needed	3.4(5)	13.0(43)	10.6(16)	10.1(64)
Support provided by colleagues	3.4(5)	11.1(37)	8.6(13)	8.7(55)
Support provided by managers	2.0(3)	7.2(24)	4.0(6)	5.2(33)
Resources were available to implement changes	2.0(3)	6.6(22)	4.0(6)	4.9(31)
Other	0.7(1)	2.1(7)	3.3(5)	2.1(13)

Base = all those who said that they had introduced changes as a result of the Network.

Those respondents who said they had not made any changes to their practice as a result of their involvement in the Networks were then asked if they would like to make changes but were finding it difficult to do so. Across this group 15% said there were changes they would like to make (see Table 4.15). Again the figures were higher for Heart Health and Sexual Health. The main barriers to change faced by this group were felt to be lack of resources to implement changes, lack of support from managers and local or national policy contexts that were not supportive of change.

Table 4.15: Would like to make changes to practice as a result of the network but finding it difficult - percentage of total respondents in each network %(no.)

	Early Years	Sexual health	Heart Health	All
Yes	11.5(12)	17.1(32)	16.1(15)	15.4(59)
No	42.3(44)	51.3(96)	59.1(55)	50.8(195)
Don't know	46.2(48)	31.6(59)	24.7(23)	33.9(130)

Base = all respondents

Table 4.16: Barriers to making changes to practice - percentage of respondents in each networks %(no)

	Early Years	Sexual health	Heart Health	All
Lack of resources to implement changes	6.1(9)	7.2(24)	6.0(9)	6.7(42)
Lack of support from managers	4.1(6)	3.6(12)	3.3(5)	3.6(23)
National/local policy was not supportive of change	2.7(4)	3.3(11)	2.0(3)	2.9(18)
Lack of support from colleagues	2.0(3)	2.4(8)	2.6(4)	2.4(15)
Evidence/ guidance not relevant to practice	2.0(3)	0.6(2)	0.7(1)	1.0(6)
Evidence/ guidance not available at the time it was needed	2.7(4)	0.3(1)	0.7(1)	1.0(6)
Good practice examples not available	1.4(2)	-	-	0.3(2)
Other	1.4(2)	3.9(13)	3.3(5)	3.2(20)
No barriers to change	1.4(2)	0.3(1)	0.7(1)	0.6(4)
Total (numbers)	148	332	151	631

Base = all those who would like to make changes but facing difficulties = 631

In relation to mental health the evaluation of the Evidence into Practice workshops reported that 85% of respondents had made use of information from the workshop for one or more of the following purposes:

- to support their own work
- to make the case for mental health improvements
- for their own interest
- in developing new areas of work.

In addition the evaluation also found that half of respondents indicated that they had been able “to achieve, or make progress towards the personal actions that they had specified at the end of the workshop”. Examples of actions included:

- Using learning and understanding in everyday role and thinking more holistically about improving mental health
- Influencing policy development to include mental health and wellbeing and ensuring that mental health improvement is supported through multi-agency planning documents (for example, the local Joint Health Improvement Plan)
- Disseminating knowledge through training, conference and sharing information within organisation and partners
- Working with others in developing mental health improvement activities
- Taking forward a conference with other colleagues from workshop²¹

The evaluation of the mental health Evidence into Practice workshops also found that the main barriers to introducing change following participation in the workshops were:

- lack of resources

²¹ Halliday, Friedli and McCollam, *ibid*, pp. 14-15

- lack of organisational commitment to mental health improvement
- low priority for mental health improvement from colleagues
- lack of staff available
- organisational change
- lack of confidence.²²

The interviews confirmed the view that some changes to individual practice had been achieved although this was an area where there was still considerable work to be done. In addition the interviews indicated that stakeholders probably assume that the relationship between providing evidence and practice change is more linear than is actually the case. As we have seen the greatest impact was in relation to increased understanding of research evidence and general understanding and awareness. While these kinds of changes are not unimportant they are not the kinds of changes to practice that might be assumed to have taken place following exposure to research and evidence. As we have seen, the barriers to practice change can be considerable especially when individuals are, or feel that they are, unsupported within their own organisations in relation to introducing changes on the basis of evidence.

4.4.6 Organisational practice

In the interviews stakeholders generally indicated that organisations as such were not the primary focus for the EIPP work. However, as we have seen, much of the work of the EIPP programmes is predicated on the assumption that individuals, who are the main targets for the EIPP work, will then take their learning back into their organisations and make changes not only to their own individual practice but also to that of their organisations. In reality establishing the extent to which this happens in practice can be problematic: it can be difficult to clearly delineate what constitutes a change in individual practice and what constitutes a change in organisational practice (as can be seen in the examples of individual practice change presented in Box 4.1).

Nevertheless the interviews indicated the following areas in which organisational practice had occurred to some extent:

- **Tobacco Control:** The smoking cessation guidance had given health boards a framework for the establishment of new smoking cessation services and for their accountability. The organisational changes seen have therefore not been as a result of the guidelines alone but in that they have become the basis of a performance management tool which now needs to be used effectively.
- **Heart Health:** What limited influence there has been was only through the efforts of individuals involved in the network or applying the learning.
- **Early Years:** Some organisational impact occurred mostly as a result of the Starting Well dissemination and roadshows. The main aim here however was to impact on partnership rather than individual organisational learning.

²² Halliday, Friedli and McCollam, *ibid*, p. 18

- **Sexual Health:** Changes in organisational practice are likely to come about through the local implementation of the national strategy
- **Mental Health:** The evaluation of the Evidence into Practice workshops found that respondents had discovered through the workshops the importance of organisational support to achieve change. “This included the need to work with partners towards shared goals. The importance of raising awareness both within organisational structures and externally was identified as an aid to take forward local action. A key element in this was raising awareness at management level within organisations and engaging “hard to reach” professionals (for example NHS operational staff) in workshop training.”²³

As we have already seen (Table 4.12) relatively few respondents to the survey were able to say whether the activities of the Learning Networks had had an impact on others, although those that were able to said that this took the form of “awareness of research and evidence” and “general knowledge and understanding”. However when asked whether individuals received support for evidence informed practice within their own organisation from various sources respondents were most likely to indicate that this was forthcoming from colleagues in their own organisation or other organisations or from professional groups (Table 4.17). This suggests the potential importance of focusing on organisations or groups within organisations to promote evidence informed practice change.

Table 4.17: Support for evidence-based practice within own organisation: %(no)

	Early Years	Sexual health	Heart Health	All
Colleagues in own organisation	69.6(103)	61.7(205)	70.2(106)	65.6(414)
Colleagues in other organisations	54.1(80)	59.9(199)	56.3(85)	57.7(364)
Professional groups	58.1(86)	51.8(172)	58.3(88)	54.8(346)
Learning Network	29.7(44)	50.3(167)	59.6(90)	47.7(301)
Managers	49.3(73)	38.3(127)	42.4(64)	41.8(264)
Other	10.1(15)	8.7(29)	12.6(19)	10.0(63)
No support received	6.1(9)	4.5(15)	6.0(9)	5.2(33)
Total (numbers)	148	332	151	631

Base = all

4.4.7 Policy

In terms of the impact of the EIPP programmes on policy it is somewhat difficult to disentangle effects because, to a large extent the EIPP programmes were set up in these areas because they had already been identified as priority areas and, indeed, the importance of adopting an evidence informed approach had already been identified as an important

²³ Halliday, Friedli and McCollam, *ibid*, p. 18

component of the programmes. The question therefore is the extent to which specific evidence produced by the Programmes has had an impact on policy. Such an impact can clearly be identified in relation to sexual health where the evidence briefings on, for example, the effectiveness of abstinence programmes, have influenced the shape of the national strategy. Similarly, with tobacco control, the evidence connected the design and implementation of effective delivery of new services with the introduction of smoke-free legislation.

In addition, in relation to Heart Health, the CVD guide has had an influence on national and local policy through, for example, the more recent requirement for the managed clinical networks to have a primary prevention strategy. In addition aspects such as the physical activity recommendations are reflected in the national strategy. The Early Years Network and Starting Well was felt to have had little impact on policy at national level, due mainly to the greater influence of the 'Hall 4' recommendations that it was working within. However locally some policy change was felt to have been achieved. The Evidence into Practice workshop evaluation indicated that some respondents had used the learning from the workshops in developing or revising local mental health and well-being strategies or to influence the local Joint health Improvement Plan²⁴. It is also the case that evidence generated by the Learning Networks has contributed to and influenced the development of Phase 2 of the National Demonstration Projects.

While a majority of survey respondents said that they didn't know whether the Learning Networks had had an impact on either national or local strategy or policy (Tables 4.18 and 4.19), those who were able to respond identified, in particular, some changes to local strategy and policy (although, once again, it is difficult to clearly differentiate these from changes to organisational practice); see Box 4.2 for examples.

Table 4.18: Impact on national strategy/policy by network - percentage of total respondents in each network %(no.)

	Early Years	Sexual health	Heart Health	All
Yes	18.4(27)	34.5(114)	35.1(53)	30.9(194)
No	11.6(17)	6.7(22)	5.3(8)	7.5(47)
Don't know	70.1(103)	58.8(194)	59.6(190)	61.6(387)

Base = all respondents

Table 4.19: Impact on local strategy/policy by network - percentage of total respondents in each network %(no.)

	Early Years	Sexual health	Heart Health	All
Yes	23.3(34)	29.4(96)	37.4(55)	29.8(185)
No	17.1(25)	13.8(45)	8.2(12)	13.2(82)
Don't know	59.6(87)	56.9(186)	54.4(80)	56.9(353)

Base = all respondents

²⁴ Halliday, Friedli, McCollam (2004) *ibid*, p.13

Box 4.2: Examples of impact to local policy or strategy cited by survey respondents

Early Years:

More targeted practice

More joint working between agencies; better understanding of roles”

Heart Health

Through MCNs, development in each Board area of primary prevention strategies.

Have used evidence reviews ... to shape guidance for men’s health work.

We have incorporated into our local strategy aspects of best practice from the HHLN in the areas of primary prevention.

Prevention Guide is being used locally to assist us to produce a Tobacco Control strategy and a physical activity strategy and review our existing food and nutrition strategy.

Sexual Health

Shared learning on learning disability issues have prompted health boards/local authorities to write policy regarding sexual activity.

Made us think through links with education. Helped us consider range of training issue.

Development of guidance tool for staff.

We are supporting schools better and more strategically, involving parents and giving teachers more confidence and young people better information.

Thus the areas where there would appear to have been the most impact in relation to evidence into policy are Tobacco Control and Sexual Health and Wellbeing. In the former case the lead officer identified the following four features as being critical to the success of the work:

- A robust review of the evidence combined with a short guide and related materials resulting in both *credibility and utility* of the evidence produced.
- Consultation with services to provide a *reality check* on the recommendations, advice on *implementation* and *case studies* of good practice.
- A close fit with wider *policy developments* which released new funding through the Tobacco Control Action Programme and legislation on smoking in public places. As a result the guidelines were both *timely* and had *political support*.
- A strategy for the *active dissemination* of the guidelines to practitioners, senior managers and policy makers to ensure that their implementation was given *priority*.

This view is supported by the EIPP literature (see Annex A).

4.5 Similarities and differences in stakeholder perspectives on what has been most useful

Each of the five EIPP programmes under review has focussed on rather different aspects of the task of getting evidence into policy and practice. As a result it is difficult to generalise about whether different stakeholders regard particular aspects of the work as more or less useful. For tobacco control although the respondents were all from different sectors, there was considerable unanimity in their responses. It has to be remembered, however, that this work built on considerable previous experience of tobacco control work including political lobbying in ASH Scotland, and the production of the earlier set of guidelines by HEBS and ASH Scotland. In addition the work is actually the result of effective collaboration and task distribution between the Executive, Health Scotland, ASH Scotland, STCA and PATH, which are also part of ASH Scotland

In Heart Health there was a difference between the respondents in terms of the perception of impact that the network had had on practice, but this was largely due to more detailed insights from previous research with this emphasis. For the most part interviewees commented that they did not have the information to assess whether there had been impacts on practice. In Early Years there were distinct differences in responses dependent on whether the interviewee's focus was on the national demonstration project outputs or the breastfeeding evidence review. These were clearly not using the same models or processes and were not necessarily that compatible at the outset. It is difficult to say whether their goals and impacts would have become more closely aligned if the work had actively continued.

In relation to sexual health there was widespread agreement at all levels that the Learning Network, and more specifically the Coordinator, had had a significant impact on policy as a result of her input into the development of the national strategy. However stakeholders were perhaps less aware of the significant work that has been done at practice level in developing a common agenda and approach to sexual health education and promotion across different sectors and disciplines.

4.6 Key Issues

All three Learning Networks have invested heavily in the creation of databases of contacts which form the basis of the "networks". However the Networks as *networks* do not appear to be terribly effective; network members do not share a sense of belonging. They are, perhaps, better seen as mechanisms for distributing and disseminating published outputs. Those members who do feel a greater sense of involvement are those who have played a more active part, for example as members of an "expert group". Face to face engagement has a greater potential to create networks or "communities of practice".

The published outputs produced by the programmes are widely regarded as being clearly presented, relevant and useful and case studies appear to be especially valued by practitioners. However the penetration of published outputs into practice communities could perhaps be improved. There may be a need to create more succinct publications that are specifically tailored to the needs of particular target audiences.

The five EIPP programmes have, between them, run a significant number of events of different kinds and for different purposes. Overall a large majority of those who have attended these have found them to be both useful and relevant.

When asked about the impact of the activities of the Learning Networks on themselves and others a large number of survey respondents said they didn't know. Where responses were obtained these indicated that the most significant areas where there had been an impact were in relation to awareness of research and evidence and general knowledge and understanding. This was confirmed, in large part by the interviews.

Nevertheless some changes to individual practice had occurred although there was little evidence to suggest that there had been an impact on organisational practice.

Some significant changes to national policy had occurred in relation to sexual health and tobacco control as demonstrated by key elements in relation to strategy and implementation that reflect the evidence generated by the relevant EIPP programmes.

5. Discussion and recommendations

5.1 Discussion of findings

5.1.1 *Meta-level issues*

Evidence informed policy and practice is central to Health Scotland's mission and strategic objectives. Much of this work is located within the Evidence for Action division of the Public Health Sciences Directorate. However it is also a central concern of the Policy Evaluation and Appraisal division. Indeed it could be argued that the use of evidence to inform policy and practice is a fundamental principle that runs, or ought to run, throughout the organisation. In reality, however, EIPP work is concentrated in "pockets" within the organisation - neither mainstreamed throughout the organisation nor concentrated wholly in one division. One consequence is that the Programme/Network coordinators, while they have been relatively autonomous (as reflected in the different approaches they have adopted) have also been relatively isolated and not terribly well integrated within the wider structures of Health Scotland. In addition while there has been some informal sharing of expertise between Coordinators, there have been few opportunities to formally develop a shared approach nor to benefit from some economies of scale.

The EIPP areas of work do not clearly link to the "topic" areas around which Health Scotland is organising its work. While there is a clear rationale for the three Learning Networks - in terms of their relationship to the National Demonstration Projects - and a rationale for the Mental Health Improvement Evidence and Practice programme has been articulated in terms of its support for the National Programme to Improve Mental Health and Well-Being, it is not immediately clear why these areas of work should have EIPP programmes and others not, especially since the Health Scotland topic areas reflect the Scottish Executive's health improvement priorities.

5.1.2 *Rationale for EIPP programmes*

Although each of the five EIPP programmes have developed in significantly different ways, they all, to a greater or lesser extent, reflect a key underlying assumption, namely that sharing evidence and information will have an impact on practice. However within that assumption there are significant differences in thinking across programme about:

- What kinds of evidence and information should be collated and shared
- How information and evidence should be presented and disseminated
- The kinds of impact that are sought
- The target audiences - individual practitioners, organisations, partnerships, professional groups.

In addition, in each case there is a second order assumption that individuals will take learning back into their own organisations.

While it is entirely appropriate that the five programmes should have developed in ways that reflect their specific contexts and clientele, there are perhaps opportunities for an exploration of the extent to which there might be a greater commonality of approach and sharing of good practice.

Overall if the five initiatives are reviewed in the light of the models of research use described in section 2.4 then it is clear that, in general, the underpinning model is that of the “research-based practitioner”. However the development of the Smoking Cessation guidelines also reflects some aspects of the “organisational excellence model”.

In terms of the approach to research in use in relation to policy, there is less evidence of an underpinning model informing the way in which this work has developed. Inevitably there has been a high level of opportunism - striking while the iron is hot - especially in relation to Tobacco Control and Sexual Health with some positive outcomes in relation to policy impact. In addition the Improvement Evidence and Practice programme has sought to begin a process in relation to influencing policy, by commissioning an appraisal of Scottish Executive policy in order to review the extent to which the evidence base on mental health improvement has been reflected. There is an obvious discomfort across the five programmes with the more passive notions of collating evidence so that policy-makers can seek it out when needed. Although not yet achieved across all areas, there is a desire for more ongoing and active engagement with policy makers on the evidence base.

5.1.3 Objectives, approaches, methods, outputs, clientele for programmes

The overarching objective set for the three Learning Networks was to disseminate the learning from the three National Demonstration Projects. This has, in practice, proved problematic because of issues around the timing of the external evaluations and delays in setting up internal monitoring and evaluation. In addition the ways in which the three Networks have evolved have differed in relation to the emphasis given to various aspects of the work. The objectives for the Mental Health Improvement Evidence and Practice programme have been articulated in terms of one of a number of supports for the Mental Health Improvement programme whereas the work around Tobacco Control has developed much more as a programme of work around a series of key tasks. The HDA Evidence into Practice cycle includes four activities:

- Production of evidence briefings
- Analysis of practice implications
- Provision of practical advice and support
- Collection of evidence from practice.

It is clear that all of the five EIPP programmes have engaged in all of these activities, at least to some extent. However the emphasis has been different in each case. For example the Heart Health Learning Network has concentrated very much on the production of evidence whereas the Mental Health Improvement Evidence and Practice Programme has focused much more on provision of practical advice and support.

In part the different approaches adopted by the five programmes are reflective of the perceived state of play in relation to each of the topic areas. However they also reflect the different strengths of the coordinators and the resources available to them. Based on the activities of the networks, the HDA cycle might be expanded into the following “task list”:

- Production of evidence briefings/syntheses
- Production/commissioning of new research
- Evidence into policy - dissemination and active engagement
- Evidence into practice:
 - dissemination
 - active engagement
 - support for practice change
- Capacity building in relation to research, research use and evaluation
- Practice into evidence - collection, appraisal and collation of practice-based evidence/case studies.

All of these tasks are important but together they constitute too diverse a set of activities requiring too wide a skills base for any one individual to carry out effectively. Not surprisingly the coordinators have tended to focus on those activities where they feel they have the greatest expertise and/or where they can have the greatest impact. The range of activities encompassed within the Coordinator’s role may also be a factor in explaining the difficulties experienced in recruiting to the Early Years Learning Network Coordinator’s post.

It is important, nevertheless, to acknowledge the very impressive work programme and the large number of outputs generated by the five programmes over a relatively short space of time. These outputs have encompassed:

- A wide variety of published outputs
- A range of dissemination, training and capacity building events
- The development of contact and distribution lists.

Furthermore the evidence from this review suggests that these outputs have been well-received in terms of clarity of presentation, relevance and utility.

The “reach” of the programmes in terms of professional groups is extensive and there is evidence to suggest that there is engagement with groups beyond the health sector. For example the Sexual Health and Wellbeing Learning Network has successfully engaged individuals within the education sector and in relation to Mental Health, there are currently attempts to work with COSLA to increase the awareness of councillors. However with one or two exceptions (Early Years Roadshows and briefings of Health Boards on Mental Health Evaluation Guides) only limited work has been undertaken to specifically target organisations or professional groups. As a result the five programmes are very much dependent on individuals identifying themselves for inclusion in the EIPP work or for the Coordinators to identify generic groups of individuals. However there is some evidence from the survey that individuals do take learning back into their own organisations.

An important aspect of the EIPP programmes has been their ability to involve others directly in the work through expert groups (eg Breastfeeding expert group), reference groups (Mental Health Improvement) and advisory groups (eg Learning Disability Resource guide group). It is clear that this ability to draw on a wider group of stakeholders has benefits for the activities and outputs generated by the programme but also, significantly for the individuals involved in these groups. However they can be resource-intensive and there needs to be mechanisms in place both for resourcing people's time to participate in groups and for resolving disagreements eg around what counts as evidence.

5.1.4 Value of activities and outputs

The stakeholder interviews indicated wide ranging support for the EIPP programmes and their activities. However in most cases interviewees (other than the Coordinators) were only able to comment on specific activities or outputs that they were particularly familiar with so it was not possible to obtain a more differentiated view of the value of specific activities and outputs.

The survey of members of the three Learning Networks provided some additional insights. Overall across all three Learning Networks (but to a lesser extent for the Early Years Network) the specific outputs about which we asked were rated highly in terms of clarity of presentation (in the case of published outputs) and being well run and facilitated (in the case of events), relevance and utility. Network members have especially found useful the sharing of information and good practice.

The published outputs have been produced to a high standard and, at least in some cases, differentiated outputs have been produced aimed at different audiences (eg Smoking Cessation Guidelines).

However the survey indicated that the Networks *qua* Networks do not really work; a significant number of survey respondents said they did not feel very involved in the Network and some indicated that they did not know they were members. In reality some operate only as mechanisms for distributing materials. This raises issues around the role of the Networks especially given the amount of work involved in supporting and maintaining them.

5.1.5 Quality of evidence-based outputs

In the case of all of the significant evidence syntheses and briefings the Coordinators together with their expert/reference groups have had to go through a process of deciding how rigorous an approach to adopt towards what counts as evidence. This is a vexed issue and there has had to be a process of negotiation and accommodation in most cases. For example in the development of the updated Smoking Cessation Guidelines there was a need for negotiation between the editorial team and the authors about what counts as evidence. In general there has been a tendency to move towards a broader view of evidence than would generally be accepted within a traditional systematic review approach to include evidence from practice. As a result the

outputs of each of the programmes are different in relation to the kinds of evidence to include. This is particularly difficult in relation to collecting evidence from practice and practice-based case studies. These are very popular with practitioners but there does need to be a level of confidence that the examples that are being promulgated as “good practice” really do meet certain standards.

A further issue to emerge has been the length of time it takes to collate robust evidence. In some cases this can mean that practice moves ahead of the evidence. This was arguably the case in relation to the production of the new smoking cessation guidelines.

In most cases in terms of outputs there has been a conscious effort to go beyond the production of evidence and to ensure:

- Ownership and involvement in the production of materials (eg production of Smoking Cessation guidelines)
- Accessibility of the materials produced (eg the integrated package of Smoking Cessation materials aimed at different audiences; the Learning Disability Resource guide produced by the SHW Learning Network)
- Effective dissemination (eg the approach adopted in relation to the dissemination of the Mental Health Improvement evaluation guides)
- Engagement with target audiences (eg seminars for practitioners organised by Health Scotland in partnership with STCA and ASH SCOTLAND around the Smoking Cessation Guidelines and seminar for Senior Management of Health Boards; Sexual Health and Heart Health Learning Days).

5.1.6 Effectiveness in terms of influencing policy and changing practice

It is important to preface the discussion of effectiveness by the observation that the work of all five EIPP programmes is a process and a process that is still ongoing. So in many ways it may be premature to make judgements about the impact on policy and practice. However on the basis of the evidence to date it is clear that the main impact on practice so far has been on increasing knowledge and understanding and increasing awareness of research and evidence on the part of individuals.

A significant minority of survey respondents said that their practice had changed as a result of their involvement in the Learning Networks and examples were given of both quite specific and more general impacts. Furthermore it is interesting to note that where practice change had occurred the main facilitators were felt to be:

- relevance of evidence/guidance to practice
- credibility of evidence/guidance
- availability of good practice examples.

Also, significantly, in terms of the earlier discussion of the focus on individuals as opposed to organisations, sources of support for EIPP were found to be colleagues in one’s own organisation and colleagues in other organisations and professional groups. However it is interesting to note the relatively high proportion of Heart Health survey respondents who cited the Learning

Network as a source of support. There was some evidence to suggest that the Learning Networks (although not Early Years) have also improved links between practice colleagues, increased collaboration between practitioners and researchers, and facilitated learning from practice.

The underlying assumption of the EIPP programmes, that sharing learning will lead to practice change, needs to be questioned on the basis of this evidence. However if we return to the two models that have informed much of this review - the HDA evidence into practice cycle and the three models of research use - we can see that in the first case the emphasis is on supporting and building capacity for practice change. This aspect of the EIPP work has been variable across the five programmes or is only just beginning. In the case of the models of research use the emphasis is on ensuring that the “right” model or combinations of models is used so that EIPP efforts are targeted in the right place using the most appropriate modes of engagement. The different approaches across the five initiatives suggest that there have been some attempts to do this in practice.

In terms of policy the impact has been more variable. The Sexual Health Learning Network (or more accurately, the Coordinator) has had a significant impact on policy in terms of the development of the Sexual Health Strategy. Similarly the Tobacco Control programme of work conducted with partners has also had an impact on national policy in terms of smoking cessation and smoke-free public places. However it should be noted that in both these cases these were issues that were already high on the policy agenda. Perhaps the most important lesson is the importance of developing effective personal relations with key policy people so that the EIPP programme coordinators become a first port of call for policy makers around these health improvement topics. Nevertheless the importance of producing succinct but credible evidence briefings is paramount.

There has been perhaps more of an impact on policy locally especially where the programmes have actively engaged with health boards or where individual practitioners have been in a position to make changes in local strategy or practice as a result of their engagement with the EIPP programmes.

5.1.7 Extent to which initiatives reflect messages from the literature in relation to effective practice/fit with the EIPP models

As we have seen the five initiatives all demonstrate a fit with at least some of the EIPP models albeit with an emphasis on individual rather than organisational learning. Similarly, while all of the initiatives cite the HDA EIP model and there is evidence that all four stages are being pursued at least to a limited extent, there is, nonetheless a significant gap between theory and practice. Much of this implementation gap can be accounted for in terms of various constraints that operate, albeit differently, in relation to the five programmes. These can be summed up as follows:

- Resourcing – staffing and budget constraints have meant that Programme Coordinators have had to make choices as to what aspects of the work they focus on

- Recruitment/staffing - especially an issue in relation to the Early Years Learning network but also an issue in relation to the skills, backgrounds and expertise of those appointed to posts which has to a significant extent determined the focus of the programmes
- Politics - has brought some issues to the fore resulting in a need to focus on certain areas of work at the expense of others
- Timing - notably the timing of the evaluations of the National Demonstration Projects which has resulted in the Learning Networks developing and disseminating other information.

5.2 Recommendations

The findings of the review give rise to the following recommendations in relation to the future development of EIPP work in Health Scotland.

5.2.1 Location, structure, roles

- *Review the rationale for EIPP activities and their links to Health Scotland topic areas and the Executive’s health improvement priorities.* For evidence into practice and policy initiatives to be effective then they need to be central to an organisation’s work rather than peripheral. Therefore there is a strong case to be made for EIPP work to reflect and support mainstream priorities.
- *Consider the location of EIPP within the Health Scotland structure.* Following on from the previous point, it is worth considering whether EIPP work might be more effectively embedded by mainstreaming it across the organisation rather than being in separate “pockets”. It may be helpful to consider the work of the EIPP programmes in terms of a set of functions that relate to particular topic areas as shown in the matrix below (Figure 5.1). It could be argued that all of these topic areas and functions are already included as part of the Health Scotland topics. It may therefore be possible to more firmly embed EIPP within Health Scotland by effectively mainstreaming it by including it within the job descriptions of current posts.

Figure 5.1: Mainstreaming EIPP work across Health Scotland

Topic Area \ Function	Mental Health	Tobacco Control	Early Years	Sexual Health	Heart Health
Producing research/evidence	All divisions within Public Health Science Directorate				
Making research/evidence accessible	Communications				
Dissemination	Communications				
Support for evidence informed	Learning & Development Advisors within Topic teams				

practice - individual learning					
Support for evidence informed practice - organisational learning	Health Scotland Topic Leads				
Training/capacity building around research & evaluation	Coordinated by learning & Workforce Development				
Encouraging evidence informed policy	Health Scotland Topic Leads				

- *Consider the role of learning within the EIPP programmes and the link to the Learning and Workforce Development Division within Health Scotland.* All of the five programmes have, to a greater or lesser extent, been involved in training. Again this is an activity which already has a clear place within Health Scotland. While some of this training is specific to the particular EIPP programmes, much of it is more generic and relates to capacity building for research use and to undertake evaluation work. It may be that this aspect of the EIPP work could be more effectively undertaken by those whose main role is the provision of training.
- *Develop an approach to using evidence to influence policy and identify who, within Health Scotland, is best placed to undertake this work.* Influencing practice and influencing policy on the basis of research and evidence require quite different skills and mechanisms. It may be the case that those within Health Scotland who are engaged in ongoing work with policy makers are better placed to “insert” research and evidence than the EIPP coordinators.

5.2.2 Audiences, outputs, modes of engagement

- *Review the “reach” of the programmes in terms of the target groups and consider whether a different approach involving organisations and/or professional groups might be helpful.*
- *Review whether or not the “research-based practitioner model” underpinning much of the EIPP work is the most appropriate.* The proposition underpinning the three models of research use identified in section 2.4 is that the model of research use underpinning EIPP work should be based on an analysis of who are the audiences for evidence and research and how best we might engage with them. The research-based-practitioner model is effective with certain groups but is likely to be less effective for others. It may therefore be worth exploring the extent to which the other models might also be helpful in encouraging research use with different groups.
- *Consider the role of the Learning Networks qua networks and either redesignate them as contacts databases essentially as a mechanism for*

distribution (possibly as part of a central NHS Health Scotland data base) or reemphasise their role in shared learning as part of an enhanced programme of activities intended to support practice change.

5.2.3 Quality issues

- *Explore opportunities for greater commonality of approach across the five programmes drawing on good practice from each.* To some extent the five programmes have developed in relative isolation from each other (although it is recognised that there has been some sharing of experience across the Learning Networks). There is now, perhaps, an opportunity to pool these different experiences and share the learning from each by developing a common protocol for future work while recognising the continuing need for each to be responsive to the particularities of their particular clienteles and contexts. (See Annexes D and E for a preliminary “decision map” together with worked examples of how this might be applied in practice.)
- *Develop a protocol for what counts as evidence for different purposes for use across the organisation* and, in particular, a protocol for the collection of case study evidence from practice drawing on the practice already developed within the five EIPP programmes.

ANNEX A: SUMMARY OF LITERATURE REVIEW

The literature review aimed to summarise existing evidence on approaches to developing evidence-informed policy and practice, including the role of individual and organisational learning. It drew on existing review material and combined this with key papers relating to the public health field (see reference list).

Much of the early literature on evidence-informed policy and practice assumed that there were stocks of knowledge (mainly in the form of research and evaluation evidence) on the one hand and potential users of this knowledge on the other. Evidence use, it was argued, depended on finding effective ways of communicating and disseminating existing knowledge to potential users. However, over time there has been a growing disillusionment with simple dissemination models of how evidence-informed policy and practice can be achieved (Nutley et al 2003).

In promoting **evidence-informed practice** there are now many calls for thinking to move beyond dissemination in order to capture the complexities of getting evidence to influence what happens in practice (Desforges 2000; Halliday and Bero 2000). This involves not only efforts to accumulate evidence in the form of robust and accessible systematic reviews but also actions to support evidence use (Davies et al 2000).

Within the public health field, an influential summary of the challenges faced is the Health Development Agency's evidence-into-practice cycle (see Figure A1.1), which highlights how dissemination needs to be combined with measures to support practice change.

Figure A1.1: The Health Development Agency's Evidence into Practice cycle (Kelly et al 2004)



A subsequent review of activities in the health promotion field (Speller et al 2005) suggests the need for four parallel tracks of activity:

- Systematic reviews of research and the collation of evidence
- Developing and disseminating evidence-based guidance
- Developing the capacity to deliver effective evidence-based practice
- Learning from effective practice.

A cross-sector literature review on what works to promote evidence-based practice (Walter et al 2005) draws together evidence on the success of different strategies and mechanisms for promoting research use. This found that some remarkably consistent lessons emerge across different studies, in different contexts, and from different approaches to promoting evidence-based practice. They are:

- *Research must be translated.*
To be used, research needs to be adapted for or reconstructed within local policy and practice contexts. Simply providing the findings is not enough. Adaptation can take multiple forms, including tailoring research results to a target group; enabling debate about their implications; "tinkering" with research in practice; or developing research-based programmes or tools.
- *Ownership is key.*
Ownership - of the research itself, of research-based programmes or tools, or of projects to implement research - is vital to uptake. Exceptions can however occur where implementation is received or perceived as a coercive process.
- *The need for enthusiasts.*
Individuals enthusiasts or "product champions" can help carry the process of getting research used. They are crucial to sell new ideas and practices. Personal contact is most effective here.
- *Conduct a contextual analysis.*
Successful initiatives are those which analyse the context for research implementation and target specific barriers to and enablers of change.
- *Ensure credibility.*
Research take-up and use is enhanced where there is
 - credible evidence
 - endorsement from opinion leaders - both expert and peer
 - demonstrable high level commitment to the process.
- *Provide leadership.*
Strong and visible leadership, at both management and project levels, can help provide motivation, authority and organisational integration.
- *Give adequate support.*
Ongoing support for those implementing change increases the chance of success. Financial, technical, organisational and emotional support are all important. Dedicated project co-ordinators have been core to the success of many initiatives.
- *Develop integration.*
To assist and sustain research use, activities need to be integrated within existing organisational systems and practices. All key stakeholders need to be involved. Alignment with local and national policy demands also supports research use.

Although evidence about the effectiveness of combining multiple interventions to increase evidence use is mixed and incomplete, Grimshaw et al (2004) suggest it is plausible that multifaceted approaches built from an assessment of barriers to change and with a clear theoretical underpinning may be more effective than stand-alone strategies.

A review of ways of improving research use in social care examines how different strategies and interventions are combined within multifaceted approaches (Walter et al 2004). It developed three models which seemed to capture the very different ways in which people were thinking about research use and how it could be improved: the research-based practitioner model; the embedded research model; and the organisational excellence model (see Box A1.). Although developed within the context of social care, these models appear to have wider applicability across the health, education and social care sectors. The review considered whether any one of these models is more effective than the others in improving research use. The conclusion was that different models are suited to different situations, such as the type of research evidence and the sort of staff group involved in applying that evidence. Hence there is a need to match the strategies and activities aimed at improving research use (and the implicit models which underpin these) to different circumstances.

Box A1.1: Three models of research use in social care

Research-based practitioner model

- It is the role and responsibility of the individual practitioner to keep abreast of research and ensure that it is used to inform day-to-day practice.
- The use of research is a linear process of accessing, appraising and applying research.
- Practitioners have high levels of professional autonomy to change practice based on research.
- Profession education and training are important in enabling research use.

Embedded research model

- Research use is achieved by embedding research in the systems and processes of social care, such as standards, policies, procedures and tools.
- Responsibility for ensuring research use lies with policy makers and service delivery managers.
- The use of research is both a linear and instrumental process: research is translated directly into practice change.
- Funding, performance management and regulatory regimes are used to encourage the use of research-based guidance and tools.

Organisational excellence model

- The key to successful research use rests with social care delivery organisations: their leadership, management and organisation.
- Research use is supported by developing an organisational culture that is 'research-minded'.

- There is local adaptation of research findings and ongoing learning within organisations.
- Partnerships with local universities and intermediary organisations are used to facilitate both the creation and use of research knowledge.

Source: Walter et al 2004, pp 25-26

An important contrast between the research-based practitioner model and the other two models is that the former assumes that individual practitioners should be targeted as a means of achieving practice change, whereas the latter two models focus on organisational and system level interventions as the key to achieving change. Similarly, in relation to developing learning, the research-based practitioner model stresses the importance of individual learning, while the other two models place greater emphasis on the concept of organisational learning.

The literature on individual learning is vast and a systematic review of this was beyond the scope of this project. However, an existing review of this literature argues that at least three factors seem to be important in promoting individual learning (Cogan 2005):

- Understanding and responding to different adult learning styles
- Understanding the incentives/ motives for learning
- Paying attention to the role played by social and collaborative learning – social learning occurs by observing and imitating others; collaborative learning arises from being around and interacting with others.

Organisational learning is an emergent field of study and there is as yet no overall agreement about what it is, let alone how it can be facilitated. However in general it seems to refer to the way organisations build and organise knowledge and routines, and use the broad skill of their workforce to improve organisational performance (Dodgson 1993). Organisations that deliberately seek to develop organisational learning are often referred to as learning organisations. In the context of understanding the development of evidence-informed practice, studies which highlight the different learning routines found within organisations are helpful. Of particular importance is the distinction between three learning routines: single loop learning; double loop learning, and meta-learning (Arygris and Schon 1996). See Box A1.2 for an illustrative example of each of these routines. The message is that most organisations struggle to move beyond single loop learning. Indeed the adoption of an embedded research model (with its focus on translating evidence into standards, guidelines and protocols) may reinforce a culture of single loop learning. Hence those seeking to promote double loop and meta-learning are likely to favour an evidence-informed practice approach informed by the organisational excellence model.

Box A1.2: Learning routines: a healthcare example

Single loop (or adaptive) learning - A hospital examines its care of obstetric patients. Through clinical audit, it finds various gaps between actual practice and established standards (derived from evidence based guidelines). Meetings are held to discuss the guidelines, changes are made to working procedures, and reporting and feedback on practice are enhanced. These changes increase the proportion of patients receiving appropriate and timely care (that is, in compliance with the guidelines).

Double loop (or generative) learning - In examining its obstetric care, some patients are interviewed at length. From this it emerges that the issues that are bothering women have more to do with continuity of care, convenience of access, quality of information and the interpersonal aspects of the patient-professional interaction. In the light of this, obstetric care is dramatically reconfigured to a system of midwife led teams in order to prioritise these issues. The standards as laid down in the evidence based guidelines are not abandoned but are woven into a new pattern of interactions and values.

Meta-learning – The experience of refocusing obstetric services better to meet patient needs and expectations is not lost on the hospital. Through its structure and culture, the organisation encourages the transfer of these valuable lessons. The factors that assisted the reconfiguring (and those that impeded it) are analysed, described and communicated within the organisation. This is not done through formal written reports but through informal communications, temporary work placements, and the development of teams working across services. Thus, the obstetric service is able to share with other hospital services the lessons learned about learning to reconfigure.

Reproduced from Davies H.T.O. and Nutley, S. M., (2000)

There has been substantial interest in recent years in the potential for learning networks to facilitate the sharing of ideas, knowledge and innovations across organisational and professional boundaries, both in the private sector (Bessant et al 2003) and in the public sector (Currie 2006).

Learning networks may take many forms and serve a range of purposes (see Box A1.3). They may also be formal (officially organised) or informal and emergent. Many professional networks start through informal, self-organisation but then become more formalised over time.

Box A1.3 A typology of learning networks		
Type	Learning target	Examples
Profession	Increased professional knowledge and skill	Profession institutions
Sector based	Improved competence in some aspect of competitive performance	Trade associations Sector-based research organisations
Topic based	Improved awareness/	Best practice clubs

	knowledge of a particular field	
Region based	Improved knowledge around themes of regional interest	Clusters and local learning co-operatives
Supplier or value-stream based	Learning to achieve standards of best practice in say quality delivery	Particular firms supplying to a major customer or members of a shared value stream
Government-promoted networks	National or regional initiatives to provide upgrades in capacity	Regional development agencies
Task support networks	Similar to professional networks, aimed at sharing and developing knowledge about how to do a particular task.	Practitioner networks
Abstracted from Bessant et al 2003: 24		

The effectiveness of learning networks is often viewed in term of their success in enhancing the individual learning of participants, although most studies of learning networks have not really grappled with the issue of how to measure their benefits (Armfield et al 2002). From a private sector study, Bessant et al (2003) have identified eight core network processes, and the effectiveness of a learning network is said to vary according the way these processes are handled (see Box A1.4)

Box A1.4 Eight core network processes	
Processes	Underlying questions
Network creation	How the members of the network is defined and maintained
Decision making	How (where, when, who, etc) decisions get taken
Conflict resolution	How (and if) conflicts are resolved
Information processing	How information flows and is managed
Knowledge capture	How knowledge is articulated and captured to be available for the whole network
Motivation/ commitment	How members are motivated to join/ remain in the network
Risk/ benefit sharing	How the risks and benefits are shared
Integration	How relationships are built and maintained between individual representatives in the network
Reproduced from Bessant et al 2003: 36	

Within public services, there have been various initiatives aimed at sharing knowledge and innovations across professional and organisational

boundaries. These include collaboratives and managed clinical networks in healthcare and beacon award schemes in education and local government. Reviews of these initiatives identify a number of key problems limiting the extent of knowledge sharing: the contested nature of knowledge; differences in interests in and between organisations; and the stickiness of knowledge – professional knowledge is difficult to share because it is tacit and difficult to articulate to others. The educational and socialisation regimes of the different healthcare professions create epistemic cultures that are not shared between the professions. These often act as barriers to a common, shared understanding of knowledge (Dopson and Fitzgerald 2005).

Evaluations of the beacon award schemes have found that they tend to overemphasise knowledge exchange via websites, which in turn focuses attention on the exchange of explicit knowledge. This contrast with what the practitioners involved in these schemes valued most: the opportunities to gain tacit knowledge through site visits and close working and active dialogue with their counterparts (Hartley and Bennington 2006).

A key issue for both the healthcare collaboratives and the beacon award schemes is that they are contrived networks rather than emergent communities of practice. The concept of ‘communities of practice’ (Wenger 1998) has been influential in understanding how knowledge is generated, communicated and applied in practice contexts. A communities of practice can be defined as ‘a group of professional and other stakeholders in pursuit of a shared learning enterprise, commonly focused on a particular topic’ (Buysee et al 2003: 266). The central tenets of a community of practice are said to be that knowledge is situated in experience and experience is understood through critical reflection with others who share this experience (Buysee et al (2003). Studies of communities of practice suggest that there is a need to develop a clearer understanding of the processes of collective sense making, in order to understand how to encourage the more systematic use of relevant research knowledge in collective decision making. Research suggests that it is important to focus attention on naturally occurring communities of practice rather than contrived networks, but the identification of these is not likely to be straightforward (Bate and Robert 2002).

The literature on **evidence-informed policy making** has developed somewhat separately from that concerned with practice issues. Much of the policy-related literature is conceptual rather than empirical, although there are a growing number of relevant surveys of policy makers’ views and case studies of whether and how evidence has informed policy. These shed light on when research evidence is most likely to have an impact on policy and three factors seem to be key: the timeliness and credibility of research; the existence of good research-policy links; and a conducive political context (see Box A1.5).

<p>Box A1.5: Factors influencing the impact of research on policy Nature of research</p>
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Research needs to be:

- Timely
- Practically relevant with clear implications
- High quality
- Credible
- Presented in a 'user-friendly' way

Research-policy links

The importance of:

- Personal contacts
- Linking agents
- Ongoing and sustained interactions

The political context

Impact is more likely where research:

- Fits current ideology
- Aligns with current interests
- Does not contradict other sources of information

Source: Walter 2005

There are various models of the process by which research and evaluation evidence influences policy but most of these are variations on Weiss's (1979) six models of the possible ways in which research enters the policy process:

1. *Classic, knowledge-driven model*: a linear view that research findings may be communicated to impel action;
2. *Problem-solving, policy-driven model*: a second linear view that begins with policy makers and the problems they face, which leads them to search for useful evidence;
3. *Interactive model*: here the process is modelled as a set of (non-linear; less predictable) interactions between researchers and policy makers, with research impact happening through complex social processes of 'sustained interactivity';
4. *Enlightenment model*: this model eschews the notion that research impacts are simple and instrumental in effect; instead research is seen to impact through '*the gradual sedimentation of insight, theories, concepts and perspectives*';
5. *Political model*: here research findings are seen as but more ammunition in adversarial systems of decision making;
6. *Tactical model*: in this model, research becomes a resource to be drawn on whenever there is pressure for action on complex public issues, and may be used not just to bolster decision making but also to stall and deflect pressure for action.

There is little empirical support for the knowledge-driven model and only limited evidence of the operation of the problem-solving model (although this is frequently cited as an aspiration in government documents aimed at

improving policy making²⁵). More often than not, research seems to enter the policy process through social interaction and the gradual sedimentation of ideas, combined with policy makers' active search for and adoption of research findings to support a predetermined opinion or course of action (the political model). It seems that research evidence is more likely to be used selectively (to support an argument) or conceptually (to enhance general understanding) than directly to inform a specific policy decision (Weiss 1980; 1998)

Overall the literature on approaches to developing evidence-informed policy and practice provides a range of models and frameworks for analysing and appraising initiatives aimed at promoting evidence use. While it suggests that there are some common features of effective approaches to promoting evidence-informed policy and practice (centred on research translation, personal contact, and ongoing support and interaction), it also emphasises that there is no one best model for enhancing evidence use. Successful initiatives are likely to be those which analyse the context for evidence use and tailor approaches and actions accordingly.

²⁵ See for example, Performance and Innovation Unit (2001) *Better Policy Delivery and Design: A Discussion Paper*. London: Cabinet Office

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ANNEX B: LIST OF INTERVIEWEES

EIPP Programme/Network “coordinators”	
Shirley Fraser	Sexual Health and Wellbeing Learning Network Coordinator
Jacki Gordon	Formerly Early Years Learning Network Coordinator
Sally Haw	Senior Public Health Advisor, NHS Health Scotland
Emma Hogg	Mental Health Improvement Programme Coordinator
Matthew Lowther	Heart Health Learning Network Coordinator
EIPP Programme “Sponsors”	
Sarah Davidson	Head of Tobacco Control Division, Scottish Executive
Gregor Henderson	National Programme Director, Mental Health and Well being, Scottish Executive
Cathy Magee	National Coordinator of Health Demonstration Projects, Scottish Executive
Maureen Moore	Chief Executive, ASH Scotland
Joyce Whyttock	Scottish Executive Health Dept. Tobacco
Health Scotland Stakeholders	
Mary Allison	Head of Healthy Living Topics
Helen Cogan	Learning and Development Advisor, NHS Health Scotland
Lindsay MacHardy	Director of Programme Design and Delivery, NHS Health Scotland
Wilma Reid	Head of Learning and Workforce Development, NHS Health Scotland
Graham Robertson	Chief Executive, NHS Health Scotland
Emma Witney	Head of Children and Young People
Other stakeholders	
Linda de Caestecker	Acting Director of Public Health, Glasgow Health Board
Dermot Gorman	Deputy Director of Public Health, Lothian NHS Board
Michael Killoran Ross	Project Manager, National Demonstration Project “Starting Well”, Greater Glasgow Health Board
Dona Milne	Healthy Respect Project Coordinator
David Pattison	Chief Medical Officer’s Dept, Scottish Executive
Brian Pringle	ASH Scotland, Scottish Tobacco Control Alliance (SCTA)

ANNEX C: EIPP DECISION MAP

The EIPP Decision Map is intended to facilitate the development of a common approach to the planning of EIPP activity across Health Scotland drawing on the findings of the Review of EIPP approaches and the broader literature on evidence into practice.

The elements of the Decision Map are organised around the key EIPP tasks identified in the review. These are:

- Production of evidence briefings/syntheses
- Production/commissioning new research
- Evidence into policy – dissemination and active engagement
- Evidence into practice – dissemination, active engagement and support for practice change
- Capacity building in relation to research, research use and evaluation
- Practice into evidence, collection, appraisal and collation of practice-based evidence/case studies

However the Decision Map reflects the recognition that, in reality, EIPP work does not always proceed in a linear manner from identification of evidence through the translation and dissemination of that evidence and transfer into policy and practice. Rather there are numerous potential starting points including, for example:

- Announcement of a new policy initiative
- Publication of an evaluation report with implications for policy or practice
- The identification of an area of practice which could be improved through an understanding of the relevant evidence
- Publication of a systematic review of evidence in relation to a priority area
- The identification of a need for training among practitioners in relation to evaluation
- The need to use evidence to support developments in relation to a health priority theme or issue.

The review demonstrated that the type of EIPP activity undertaken needs to respond to the status and development needs of any particular issue at a given time, in relation to its context in research, policy and practice. The start point for planning EIPP activity needs, therefore, to be determined in relation to these issues. Checklist A provides a list of issues to consider in deciding the most appropriate starting point.

Having determined where to start ie what tasks are required in the overall EIPP process for the issue under discussion, the subsequent checklists provide prompts and questions to be considered for each phase in the

process to be delivered effectively. The responses to the initial questions (A) should help identify which subsequent sections (B – E) to focus on. The questions and prompts in each of these have been drawn from the literature and the learning from the EIPP review. These checklists are intended as guides and it is not expected that they will be either followed slavishly or that all the issues in each section will be addressed.

At the end of each section the user is invited to either reconsider their EIPP priorities or objectives or to identify action points.

Checklists

- A. Initial questions
- B. Translation / dissemination of evidence into policy/practice
- C. Production of evidence
- D. Support for practice change
- E. Influence public opinion

A. Initial questions

1. Where on the decision map do you think you are starting from? What has prompted this EIPP activity? *(eg new organisational priority; evaluation report; need for practice change; availability of new evidence; identification of an evidence gap)*

2. What are Health Scotland's priorities in relation to this area of work?

3. What are you trying to achieve through the EIPP process?

4. What changes would you expect to see as a result?

5. Who are the other key players in relation to this area of work?

Having considered the above questions summarise the responses in the table below:

Starting point	HS Priorities	Objectives	Outcomes	Key players

B. Translation / dissemination of evidence into policy/practice

These questions assume the existence of some evidence of relevance to policy or practice. *(If this is not the case refer to Checklist C.)* They relate to relationships with national, regional and local policy and practice. By “practice” we mean any individual or organisation with a role in planning, managing, commissioning or delivering services.

Audiences

1. Who is/are the audiences for this evidence?
 - Internal - Health Scotland?
 - National policy organisations?
 - Local/regional policy organisations?
 - Practice organisations?
 - Individual practitioners?
 - Wider public?
 - Others?

2. What kinds of changes are you trying to achieve through the communication of this evidence?
 - Attitudes, knowledge, understanding
 - Policy/strategy
 - Practice

Nature of the evidence

3. Is the evidence synthesised and presented in ways that are appropriate to the different policy and practice audiences? *(If not you may need to refer to checklist C)*

4. Does the evidence have practical relevance and are the policy implications clear?

5. Is the evidence based on high quality research from a credible source?

Policy context

6. Are there ongoing links between Health Scotland and policy organisations/individuals in relation to this issue? Can these links be used as a means of inserting the evidence into policy discussions?

7. Does the evidence “fit” with current policy priorities and concerns?
8. What are the evidence needs of policy makers in relation to this issue? *(If they are not met by the evidence currently available you may need to refer to checklist C)*
9. Does the evidence confirm or contradict the information coming from other sources/political groups? If so are there implications for the way in which this evidence is communicated?

Practice context

10. What are the current evidence needs of practitioners in relation to this area of work?
11. Does the evidence have implications for:
 - Autonomous professionals who are able to modify their practice?
 - Organisations or systems requiring change to processes or procedures?
12. Given the nature of the evidence, the target audience and the changes sought, what would be the most appropriate mode of communication?
13. Does the preferred approach necessitate additional support for practitioners to introduce changes? *(Refer to checklist D)*

Having considered the above questions:

- Do you need to rethink your priorities in relation to this area of work? If so go back to section A.
- Summarise the actions to be taken in the table below:

Action to be taken	Lead officer/dept	Timescale	Links to ...

C. Production of Evidence

“Evidence” may be produced on the basis of all or some of the following:

- Reviews/syntheses of existing research - produced by Health Scotland and other organisations
- Programme/project/policy reviews and evaluation
- Commissioning of new research
- Collating evidence from practice.

Issues to consider in relation to the production of evidence are as follows:

1. What is the state of evidence in relation to this theme/priority/issue?
2. What are policy and practice needs in relation to evidence in this area (*refer to checklist B*)
3. Are there evidence gaps that are a priority to be filled? If so can this best be achieved through:
 - a. Reviewing/synthesising existing research
 - b. Commissioning/undertaking a programme/project/policy review or evaluation
 - c. Commissioning new research
 - d. Collating evidence from practice.

The following questions relate to a, b and c above.

4. What should be the scope of the synthesis, evaluation or new research? (*Relate to policy and practice needs and identified evidence gaps*)
5. Who are the potential audiences for the synthesis, evaluation or new research? (*Refer to checklist B*)
6. How should the synthesis, evaluation or new research be commissioned and managed to maximise ownership among target audiences?
7. How should the findings from the synthesis, evaluation or new research be communicated to the target audiences? (*Refer to checklist B*)

Collating evidence from practice

8. What kind of evidence are you seeking to obtain from practice? (*Relate to policy and practice needs and identified evidence gaps*)
9. Which groups of practitioners and practice organisations are likely to be involved?
10. Are there existing Health Scotland links with these individuals/ organisations or networks that can be tapped into? Who in Health Scotland is best placed to make the links?
11. Is there an existing protocol that can be used/adapted for the purposes of gathering the evidence from practice that is required?
12. Who are the potential audiences for evidence from practice? (*Refer to checklist B*)
13. How should the collation of evidence from practice be undertaken and managed to maximise ownership among target audiences?
14. What steps will you take to quality assure the evidence from practice and ensure that it is “fit for purpose”?
15. Are practitioners likely to have support needs in order to carry out this exercise effectively? If so how will these be met? (*Refer to checklist D*)
16. How should the findings from the synthesis, evaluation or new research be communicated to the target audiences? (*Refer to checklist B*)

Having considered the above questions:

- Do you need to rethink your priorities in relation to this area of work? If so go back to section A.
- Summarise the actions to be taken in the table below:

Action to be taken	Lead officer/dept	Timescale	Links to ...

D. Support for practice

The review of EIPP approaches (supported by other research evidence) showed that dissemination of evidence alone is rarely sufficient for practice change to take place. In addition individual practitioners and/or organisations may need support to understand the implications of the evidence for their practice and to make changes in systems, processes or practice. Practitioners and practice organisations may also need support to effectively evaluate their own practice and/or collate the learning from practice to feed into the evidence base.

1. Who are the practitioners/practice organisations whose practice you are seeking to change?
2. What kinds of support are required? How might this be best delivered?
3. Does Health Scotland have ongoing links with these groups that can be built on? If not who in Health Scotland would be best placed to take the lead in supporting practice change? (*Programme Design and Delivery? Learning and Development Advisors? Evidence for Action?*)
4. Could the programme of practice support identified benefit from the involvement of partner organisations? (*eg professional organisations*)
5. What do we know about the context for change in this area? Specifically, what are the likely barriers to, or enablers of, the changes required? What are the implications for the programme of support?
6. Are there issues relating to organisational cultures, systems or processes that need to be addressed by the support programme? How will this be achieved?
7. How will the impact of the support programme be reviewed and evaluated?

Having considered the above questions:

- Do you need to rethink your priorities in relation to this area of work? If so go back to section A.
- Summarise the actions to be taken in the table below:

Action to be taken	Lead officer/dept	Timescale	Links to ...

E. Influence public opinion

Although the EIPP review did not look specifically at the role of Health Scotland and partner agencies in using evidence to influence public opinion, this may, in some circumstances, be an important route through which evidence influences policy or practice. The questions below are suggested for consideration to ensure that this aspect is also considered alongside the other tasks.

1. What are Health Scotland's objectives in trying to influence public opinion?
(Raise awareness? Inform? Change behaviour? Create pressure for change?)
2. Is the evidence in relation to this issue topical or likely to be of interest to the general public?
3. Is it based on high quality research from a credible source?
4. Can the evidence be summarised clearly and succinctly for a wider public audience?
5. What is the best medium for conveying this information?
6. Does Health Scotland have links with the media in relation to this issue?
7. Is there someone in Health Scotland with a lead for dissemination to the general public on this issue?

8. Are there any community or voluntary groups with whom Health Scotland could form an alliance in relation to this issue?

Having considered the above questions:

- Do you need to rethink your priorities in relation to this area of work? If so go back to section A.
- Summarise the actions to be taken in the table below:

Action to be taken	Lead officer/dept	Timescale	Links to ...

ANNEX D: EIPP DECISION MAP WORKSHOP, 23RD MARCH, 2006

The aim of the workshop was to present and test a framework for EIPP planning, drawing on the work undertaken during the review, which would enable a common approach across Health Scotland to decision-making about EIPP activity.

A draft decision-map and checklists for action were presented to a small group of staff drawn from different sections of Health Scotland who are involved in different aspects of the process of EIPP. These were used as a guide to the discussions using three case study examples. The draft tool contained nine checklists:

- A. Initial questions
- B. Translation/dissemination of evidence into policy
- C. Commissioning new research
- D. Production of evidence syntheses
- E. Translation and dissemination of guidance for practice
- F. Provide support to change in practice
- G. Build evaluation capacity
- H. Collate learning from practice
- I. Influencing public opinion

The three case studies were briefly introduced by the relevant programme manager and then discussed using the questions and prompts in the checklists as an aide. The case studies included:

- Cross-programme learning from evaluations
- Alcohol strategy
- Local government health improvement programme

The discussions aimed to both assist with the decision-making process around these three issues as well as provide some pointers to the usefulness of the planning tool and ways in which it might be improved. Following the workshop the EIPP Decision Map was revised.

Cross-programme learning from evaluations

The Policy Evaluation & Appraisal team co-ordinates the evaluation of health improvement policy and has developed an evaluation strategy and work programme. One of the strands of the work programme that they wish to develop further is that of cross-programme policy learning from evaluations. Usually the dissemination of evaluation research is confined to reporting findings from single programmes. Rarely are evaluations from different programmes examined to identify common themes and learning from implementation. While it may not be possible to synthesise evaluation findings about impact and effectiveness there may be potentially important common themes that can be brought together across the findings from process evaluations about policy implementation and programme delivery. So a key question to consider is whether there is common or shared learning from the evaluations of major national health improvement initiatives, such as the National Demonstration Projects, Healthy Living Centres and pilots of Smoking Cessation Services for Young People. Using the EIPP framework the key lesson from this overview about the way in which projects are commissioned, planned and funded was examined.

The evidence needs to inform the way future projects are commissioned. One issue would be to stop commissioning projects on a short time scale, allowing for more research planning and development time. This requires influencing policy-makers, research funders and commissioners. On the basis of a preliminary discussion using the initial questions it was decided the checklists relating to 'translation/dissemination of evidence into policy'; 'translation and dissemination of guidance for practice' and 'support for practice change'; and 'building evaluation capacity' would all be appropriate to consider.

The following points arose in the discussions:

- The need to synthesise process lessons learnt from different research studies not just individual findings
- The interconnections between synthesis of evidence and its dissemination, and the need to synthesise findings at different levels
- While there are good connections between research and policy these need to be re-examined for their appropriateness for this type of evidence
- The audiences for this evidence include internal programme managers, the Scottish Executive, other identified funding bodies and others at local level. The findings regarding commissioning need to be disseminated to these wider audiences

- Questions regarding the political context need to be expressed positively in order to identify the added value of the evidence to policy makers
- It was felt that evaluation capacity should be an integral part of capacity-building and not kept as a separate checklist
- Developing the practice of commissioning should be the focus for this area of work. However currently reference to 'practice' in the tool was being interpreted as the practice of those delivering services at the 'sharp end'. The decision tool should be revised to be clear that practice referred to any individual or organisation with a role in planning, managing, commissioning or delivering services.
- The separation of checklists regarding dissemination of guidance to practice and support to changing practice was not felt to be helpful as these were interdependent.

Alcohol strategy

This is a relatively new thematic priority for Health Scotland where the evidence is not yet influencing health policy. Cirrhosis mortality has risen since 1997 prompting the recognition of the need to prioritise this area. However there is not yet a coherent overview of the evidence relating to alcohol prevention. The policy context is the Alcohol Action Plan, but the connections between the Executive and Health Scotland need clarity. Policy, legislation and strategy are not in line with current evidence. Identifying the evidence base and research gaps was a clear starting point for this programme, although what is known about the effectiveness of brief interventions is clear enough to also take action on influencing practice change.

From the initial description and discussion the priorities for action included:

- Taking stock of the evidence
- Building the capacity of professionals working on alcohol issues
- Providing guidance and support to implementation of brief interventions
- Revision of the alcohol action plan

These indicated attention to the checklists relating to: 'production of evidence syntheses'; 'translation and dissemination of guidance for practice'; 'provide support to change in practice' and also 'influencing public opinion'. The discussions based around the questions highlighted the following issues:

- While much was known about the evidence base in this area it had not been collated and disseminated clearly
- There is a need to complement international evidence with locally commissioned research to ensure the Scottish culture is adequately represented

- There is a need for a Health Scotland protocol for reviewing policy and evidence from research in order to ensure consistency and quality
- The questions within checklists relate to different stages in each process and it may not be possible to address them all initially.
- A protocol is needed for the translation and dissemination of evidence into guidance
- With regard to alcohol it was possible to work through questions relating to guidance production and practice change referring to the evidence on the effectiveness of brief interventions. This demonstrated that within a programme area different strands of activity may be ready for action on different aspects of EIPP.
- While considering the changes required these were clearer for individual changes rather than organisational changes. This highlighted the need on occasion to 'recycle' through the questions to refine the focus of certain strands of activity.
- Both the initial questions and the checklists provided a way into structuring discussion around a wide and complex programme to unpack issues and make decisions about future activities.

Local Government Health Improvement Programme

Health Scotland has recognised the significant and important contribution that councils play in health improvement, particularly on the determinants of health, and have created a Local Government Programme in order to develop connections and provide evidence based support. Health Scotland is working in partnership with COSLA to deliver this programme. Apart from the need to integrate national policy drivers across sectors, there is also a wider problem of the lack of understanding in many quarters of the importance of action on the determinants of health for health improvement.

Key questions with relevance to EIPP include the role of evidence in assisting the integration of policy at national and local levels, and whether this is a function of Health Scotland through dissemination of evidence. It was decided to focus on the issues around 'production of evidence syntheses' and 'translation and dissemination of evidence into policy'. The following observations were made:

- While attempts were made to address the specific items in these lists it became clear that the starting point for this programme was further back and more thought needed to be given to the initial questions in order to help frame the focus and objectives of the programme
- A central message of the programme is around social determinants of health, this might provide the overall focus for consideration of the EIPP approach

- The concept of evidence needed to be broadened for this area. This is due to the nature of the evidence available on determinants and the different perspectives on evidence of the local government audience
- An overview of evidence from other bodies/sources is necessary
- Also a clear understanding of the priorities of community plans in order to clarify the focus of the evidence review
- Learning from practice and local intelligence would also need to be collated at this point to make the evidence relevant to the audience
- The decision map was considered helpful in structuring discussion around a new area of work in order to consider a wide range of aspects. However at this stage it was not possible to follow the detail of the checklists.

General observations about process

The decision map was felt to be useful as it made the steps in planning EIPP approaches explicit, and provided a systematic and replicable process for addressing them. It might be improved by a sense of a time-frame for stages, and a clearer match with the organisational structure of Health Scotland to allow for individual responsibility for taking work forward. The questions about evidence seemed to emphasise evidence drawn from systematic reviews and it was thought this would be improved by inclusion of wider terms of reference for evidence. A number of the checklists asked about the existence of protocols, and it was felt that a formal protocol may not be desirable or feasible for all stages. However the sense of common systems, guidelines or models to follow that were used across Health Scotland was considered necessary.

Overall it was felt that this was a helpful resource to clearly identify the aims and objectives of programme areas, and to enable clear communication of the sense of direction of work. However, the checklists themselves should be presented less prescriptively, and more as triggers or prompts for discussion.

Following the workshop the decision map has been revised to take account of these points.