Abstract Number B1
Oral

The use of evidence in local policy implementation: a case study of Scotland's Alcohol Strategy

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Background

The Scottish population experiences high rates of alcohol-related harms and associated health inequalities. In response, the Scottish Government has developed and implemented Scotland's Alcohol Strategy, a whole-population approach to changing Scotland's relationship with alcohol. Within the process of implementing this public health policy, little is currently known about how Local Authority implementers used different kinds of evidence. The academic literature also reveals broader gaps in knowledge around the use of evidence in sub-national health policy implementation, having focused largely on national-level policy and specific interventions.

Research Topic

This presentation will discuss the emerging findings from a research project investigating Local Authorities' use of different kinds of evidence in the process of implementing Scotland's Alcohol Strategy.

Research Design

This qualitative, embedded case study incorporates both documentary data and key stakeholder interviews at Local Authority level. The theoretical framework of this project is informed by complex systems thinking.

Results

This paper will present the findings from a thematic analysis of relevant policy documents, annual reports, meeting minutes and internal memos, which will be supplemented by an analysis of the emerging findings from 10 semi-structured interviews with Local Authority implementers in the selected case study area.

Academic Contribution

Focusing on alcohol policy, this project provides new insights into the way implementers in Local Authorities use evidence in their decision-making about policy implementation. It also builds on theoretical debates about the use of complex systems thinking to inform or frame the study of evidence use in public health policy implementation.

Abstract Number B2
Oral

Knowledge into Action: An organisational approach to mobilising knowledge to improve population health and reduce health inequalities in Scotland.

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NHS Health Scotland (HS) is a knowledge broker organisation. Our aim is to generate and mobilise knowledge and work with partners to design better policies and improve practice in order to improve population health and reduce health inequalities in Scotland. This paper describes the model of Knowledge into Action (KIA) developed by HS to inform how we will work more effectively to achieve this and offers examples from ongoing work.

Within HS we have adopted a broad concept of knowledge which includes experiential and contextual knowledge in addition to scientific knowledge. This offers the flexibility to incorporate the most appropriate forms of knowledge to address public health issues at a national or local level and is consistent with an evidence-informed approach to public health. The model incorporates the key activities of the KIA cycle: knowledge generation, management and application. Central to the model is early and active engagement with stakeholders and customers. This ensures that the knowledge we generate and mobilise is relevant to the needs of our target audience and that learning from this engagement informs future developments.

Recent work undertaken by HS in relation to Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) and Social Prescribing for Mental Health is described. These case studies illustrate how various aspects of the KIA model have informed our work and helped to influence policy and practice in these areas.

No One's Playing Ball: Investigating barriers to successful partnership in public health practice

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Background

Partnerships in public health form an important component of commissioning and implementing services, in England and internationally. In this research, we examine the views of stakeholders involved in a City-wide health improvement programme which ran from 2009 -2012. We examine the practicalities of partnership work in community settings, and we describe some of the challenges and barriers faced by staff implementing a large, multi-organisation health improvement programme.

Methods

Qualitative, semi-structured, face-to-face interviews. We conducted a thematic analysis and used the 'OSOP' technique to help identify themes. Purposive sampling was used to identify participants in three types of roles: board of directors, project managers and intervention managers.

Findings

Fifteen out of seventeen requested interviews were completed. We found that conflict and tension were often concurrent with desire and motivation for harmony in the partnership. Micro-partnerships with sustained tension often limited aspects of intervention implementation. Knowledge and 'evidence' was seen to be used for different strategic ends and held different meanings depending on the stakeholder perspective. Silos were discussed as problematic, yet our findings suggest that they may have been necessary for certain positive micro-partnership developments. This revealed a mismatch between rhetoric surrounding the source of conflicts and a realistic understanding of what components of the programme were functional and which were more hindrance than help. The exchanging of different types of knowledge, at key time points in the programme, was critical to how staff viewed the operational success of the projects within.

Conclusions

Silo-based working may continue to pose 'wicked problems' for public health community-based practice if the beliefs and assumptions about certain approaches to implementation and knowledge exchange are not confronted. Our research highlights concepts to consider for improving partnership and understanding realistic knowledge exchange in public health practice.

Evidence-based public health: An exploration of its supporting evidence and a manifesto for epistemological pluralism

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The call for evidence-based practice (EBP) to lead public health resonates throughout the contemporary impact agenda. Within clinical practice, and within medical research, the role of EBP has come largely to be accepted as valid. Evidence-based public health (EBPH) has always been, however, slightly more contentious. This presentation argues that EBPH often provides inadequate evidence of its own claim to value-neutrality through the way that its empiricism aligns it with the most Westernised, individualised and behavioural aspects of public health. Neither the EBPH introduction to public health of evidence, nor the EBPH definition of public health evidence as empirical, will provide public health with the value-neutrality which EBP claims to provide. In order to provide impact, EBPH needs to embrace pluralism; it needs to accept multiple value-bases and standpoints; it needs to appraise these alongside multiple sources and forms of evidence and it needs to focus on its historical aim of eliminating inequitable and unethical health inequalities. This presentation will consider a number of research studies which have begun to do so.

Challenging Evidence and Impact

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This paper explores the problems inherent in using evidence of impact as commissioning and performance management mechanisms for health and wellbeing policy and practice.

It unpicks the problems in the theory which underpins the use of impact measures as tools for public policy performance, and uses these to reinterpret the evidence about the effectiveness of methodologies to measure health and wellbeing from a commissioning and performance management perspective.

The paper explores two theoretical concerns: 1) Can impact be measured? And 2) Can impact be attributed?

It uses this theoretical understanding to cast new light on the evidence that has been generated concerning the implementation of outcomes-based commissioning and performance management. It explores the problems of the way in which such performance management regimes are required to simply the world, and the way that this simplification leads to the creation of performance management for health and wellbeing as a game – the performance of performance management.

The nature of this game is then further explored – what are the rules? What are the cultures required to play it well? What impact does playing this game have on those who undertake the work, and what impact does it have on those whose health and wellbeing is the subject of policy concern?