

Scottish Approach to Change: Reading List

Evidence Summary

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Foundations of implementation science and complex change

Skivington et al., MRC/NIHR (2021) new framework for developing and evaluating complex interventions

[Link: A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance | The BMJ](#)

Summary

The BMJ article introduces the updated MRC-NIHR framework for developing and evaluating complex interventions, shifting the focus from “does it work?” to a broader, decision-relevant agenda (acceptability, implementability, scalability and value). It proposes four complementary research perspectives—efficacy, effectiveness, theory-based, and systems—to be combined as appropriate to real-world needs. The framework is iterative rather than linear, organised into four phases (development/identification, feasibility, evaluation, implementation) and underpinned by six core elements to revisit throughout: context, programme theory, stakeholder involvement, key uncertainties, refinement, and economic considerations. By emphasising the interaction between interventions and their contexts, and by prioritising evidence that is useful to decision makers, it aims to improve transferability, scalability and impact in practice.

Key arguments and findings

- Pluralist perspectives: Useful evaluation goes beyond effectiveness to include theory-based and systems perspectives that account for context and system change.
- Decision-useful trade-offs: Researchers should sometimes accept more uncertainty to answer broader questions that matter for policy and practice (not just precise, narrow estimates).
- Iterative lifecycle: Work should cycle through development, feasibility, evaluation, and implementation, repeating or stepping back as needed.
- Six core elements throughout: Attend continuously to context, programme theory, stakeholders, uncertainties, refinement, and economic considerations at every phase.
- Context-mechanism-outcome fit: Effects depend on local context; mechanisms and conditions for change must be understood to enable adoption, scale-up and spread.

Where it supports the Scottish Approach to Change

- People-led change / Stakeholder involvement - The BMJ framework requires diverse stakeholder engagement throughout; Scottish Approach to Change treats “people-led” as a core enabler and embeds co-design across steps.
- Process rigour and project management / Iterative phases - BMJ’s phased, repeatable cycle with explicit attention to uncertainties and refinement aligns with Scottish Approach to Change’s eight Steps of Change (identify → understand → develop/design → prototype/test → review → implement → embed → spread) and its emphasis on measurement, governance and project management.
- Clear vision and programme theory - BMJ’s call to articulate and continually refine programme theory mirrors Scottish Approach to Change’s “clear vision and purpose” and use of logic models and criteria for success.
- Leadership, culture and decision-useful evidence - BMJ prioritises questions that matter to decision makers and implementation; Scottish Approach to Change stresses leadership, culture and executive stewardship to unblock barriers and turn learning into action.
- Learning systems and context - BMJ’s systems perspective and attention to context-mechanism interactions support Scottish Approach to Change’s Learning System enabler (continuous reflection, rapid feedback loops, triangulation of qualitative/quantitative data).
- Economic considerations and commissioning - The framework’s explicit economic lens complements Scottish Approach to Change guidance on ethical commissioning, options appraisal and affordability.

Guidance on how to develop complex interventions to improve health and healthcare (O’Cathain et al., 2019)

Link: [Guidance on how to develop complex interventions to improve health and healthcare](#)

Summary

This BMJ Open communication offers consensus-based guidance for developing complex health and care interventions. It argues that development should be dynamic and iterative, with continuous stakeholder involvement (from consultation to co-production), systematic evidence review, use of theory (including explicit programme theory/logic models), primary data collection, attention to context, and early planning for real-world implementation and evaluation. It recommends iterative prototyping to assess acceptability, feasibility and potential harms, and a transparent description to aid transferability. The guidance was produced via literature reviews, qualitative interviews, twin e-Delphi panels of developers and wider stakeholders, and a

consensus workshop, culminating in a practical framework of key actions rather than a single prescriptive method.

Where it aligns with the Scottish Approach to Change

- People-led change and co-production - The paper's call to involve stakeholders throughout - often via co-production to secure buy-in - mirrors Scottish Approach to Change's People-led enabler, which prioritises designing and delivering change *with* people, families, carers and communities.
- Iterative testing and learning - Its emphasis on iterative cycles and early testing aligns with Scottish Approach to Change's Prototype and test step, and the Learning system enabler that promotes rapid feedback loops, reflective practice and data-informed adaptation.
- Programme theory, evidence and context - Advocating explicit programme theory/logic models, evidence review, and contextual analysis supports Scottish Approach to Change's Process rigour (measurement, monitoring, evaluation) and Understand step to avoid solving the wrong problem.
- Design for real-world implementation - The guidance to plan for feasibility, adoption and scale-up maps to Scottish Approach to Change's Review for implementation, Define and implement, Embed and sustain, and Review for spread steps.
- Leadership, governance and project management - The focus on resourcing, decision-making and involving the right expertise complements Scottish Approach to Change's Leadership and culture enabler and its emphasis on governance and project management for momentum and oversight.

Wilson and Kislov (2022) - *Implementation Science* - Elements of Improving Quality and Safety in Healthcare (Cambridge Elements)

Link: [Implementation Science](#)

Summary

Wilson and Kislov's *Implementation Science* introduces the field as the study of methods that promote the systematic uptake of evidence-based interventions into routine healthcare practice and policy. It foregrounds three strands: (1) understanding determinants of implementation (barriers/enablers, context, behaviours), (2) designing and evaluating strategies to address those determinants, and (3) examining the implementation process itself, including mechanisms, adaptation, fidelity, and sustainability. It also treats the implementation (removing/retiring low-value practices) as a growing priority. Historically, the Element traces roots from the diffusion of innovation and audit and feedback to today's partnered research infrastructures (e.g., QUERI/CLAHRC/ARCs). The authors call for more theory-informed, mechanism-based explanations

and rigorous evaluation suited to complex systems-and stress the challenge of “getting implementation science into practice,” not just evidence into practice.

Key arguments and findings (from the Cambridge Element)

- What implementation science is: a science of methods to promote systematic uptake of evidence-based interventions, with endpoints such as acceptability, adoption, feasibility, fidelity, cost, penetration and sustainability.
- Threefold focus: (i) identify/contextualise determinants, (ii) design/evaluate strategies matched to those determinants, and (iii) explicate how implementation unfolds-mechanisms, adaptation, context effects, and sustainment.
- De-implementation matters: growing attention to removing or reducing low-value or non-cost-effective practices; determinants and processes can differ from implementation, needing tailored strategies and timeframes.
- Historical roots and social science lineage: diffusion of innovations, audit and feedback, guideline implementation; spread and adoption shaped by professional networks and system incentives.
- Infrastructure and partnering: impact improves when research and service delivery are integrated (e.g., QUERI; UK CLAHRCs → ARCs), with comparative evaluation of implementation strategies.
- Methodological stance: advocate theory-informed design, mechanism-based explanation, and evaluation approaches that fit complex adaptive systems.

Where it supports (and strengthens) the Scottish Approach to Change

- Process rigour and measurement → Determinants + strategy fit. The Element’s core cycle-determinants → matched strategies → evaluation aligns with Scottish Approach to Change’s Process rigour emphasis on governance, proportionate project management, measurement/monitoring/evaluation, triangulation, and using both quantitative and qualitative data to guide decisions.
- People-led change and behaviour: Implementation science centres on changing professional, patient and organisational behaviours; Scottish Approach to Change operationalises this via a People-led enabler (co-design, meaningful engagement, trauma-informed practice, reducing inequalities). Both positions stakeholder involvement as essential for feasibility, acceptability and sustainment.
- Learning systems and sustainability: The Element calls for attention to mechanisms, context and sustainability; Scottish Approach to Change makes this concrete through a Learning system enabler (iterative testing, reflective practice, feedback loops, rapid sense-making) and explicit sustainment steps after implementation.
- Theory-informed, mechanism-based practice ↔ Scottish Approach to Change’s structured method and QMS. The Element’s argument for theory and mechanism-based explanations

mirrors the Scottish Approach to Change's structured eight Steps of change (Identify → ... → Review for spread) within a Quality Management System that links planning, improving, maintaining and assuring quality.

- De-implementation ↔ Scottish Approach to Change's decision gates ("adopt/adapt/abandon"). The Element's focus on the-implementation is echoed in the Scottish Approach to Change's Review for implementation step, which explicitly considers whether to adopt, adapt, or abandon a change, and in guidance on making difficult choices and being explicit about what not to do.
- Leadership, culture and multidisciplinary partnering: Implementation success depends on organisational readiness, leadership and partnership; Scottish Approach to Change codifies this via Leadership and culture, plus explicit roles (system stewards, learning partners) and multidisciplinary change teams.
- Spread and scale: The Element's lineage in diffusion and spread maps to Scottish Approach to Change's final Review for spread step (deciding whether to spread the model, the change, or the approach, and on what conditions).

John Kay (2020) - *A Primer on Radical Uncertainty - An Introduction to Radical Uncertainty.*

Link: [Sir-John-Kay- -A-primer-on-radical-uncertainty](#)

Summary

Sir John Kay's *A Primer on Radical Uncertainty* argues that much of real-world decision-making happens under conditions where probabilities are unknowable, so optimisation and "numbers-driven certainty" are the wrong north star. Instead, leaders should craft robust reference narratives, make judgment calls, and adapt as evidence evolves. He cautions against "bogus quantification" and over-reliance on statistical significance or point forecasts, urging organisations to satisfice, design for resilience (modularity, redundancy), and learn through collective intelligence and communicative rationality. Practically, this means managing risks to the narrative, iterating, and privileging contextual insight over spurious precision-especially in complex systems like finance, health or policy.

Key arguments and findings

- Radical uncertainty ≠ risk: many policy and organisational choices lack knowable probability distributions; optimisation is often impossible.
- People think in narratives, not probabilities; scenario-style narratives support judgment better than false precision.
- Beware "bogus quantification": models, VaR, p-values, and RCT fetishism can mislead if treated as prediction machines rather than framing tools.

- Satisficing and evolution: effective decision-makers search for “good enough” options and adapt as conditions change.
- Resilience beats optimisation: complex systems need modularity and redundancy so local failures don’t cascade.
- Collective intelligence matters: communicative rationality and distributed expertise outperform isolated calculation.

Where it supports the Scottish Approach to Change

- Comfort with uncertainty: Kay’s core claim-lead amid unknowability-aligns with Scottish Approach to Change ’s explicit guidance to be comfortable with uncertainty and use flexible, iterative approaches.
- Iterative testing over false precision: His critique of optimisation and point forecasts supports Scottish Approach to Change ’s Prototype and Test step and use of PDSA cycles to learn quickly and adjust.
- Learning systems: Emphasis on collective intelligence maps to Scottish Approach to Change ’s Learning System enabler-using data, stories and reflective practice to turn knowledge into action.
- People-led change: Kay’s narrative/judgement framing reinforces Scottish Approach to Change ’s people-led principle-co-design with lived experience to keep context at the centre.
- Process rigour without “bogus quantification”: Scottish Approach to Change ’s measurement, monitoring and evaluation stresses triangulation, context, and curiosity-precisely Kay’s antidote to spurious precision.
- Leadership and culture: His call for resilience and communicative rationality aligns with Scottish Approach to Change ’s leadership behaviours-psychological safety, empowerment, and governance that enable learning.

Martin Eccles and Brian S Mittman (2006) - *Welcome to Implementation Science*

Link: [Welcome to Implementation Science | Implementation Science | Springer Nature Link](#)

Summary

This editorial launches *Implementation Science* and defines implementation research as the study of methods that promote systematic uptake of evidence into routine practice to improve the quality and effectiveness of care. It argues that uneven adoption of evidence across settings necessitates a dedicated venue that welcomes diverse theories, methods and designs. The journal’s scope spans clinical, community and policy contexts and explicitly values process evaluations, context description, protocols, and rigorously developed tools and materials often

missing from traditional end-stage outcome reports. As an electronic, open-access journal, it aims to accelerate learning cycles, broaden access, and strengthen dialogue between researchers and users (policy/practice). Overall, it sets the field's agenda: focus on behaviour and organisational change, context, methodological pluralism, and rapid dissemination to close the evidence-to-practice gap.

Key arguments and contributions

- Defines the field: Implementation research studies methods to promote systematic uptake of evidence in routine care to improve quality and effectiveness.
- Problem framing: Evidence is unevenly adopted across settings, leading to inappropriate care; closing this gap is a core health-system priority.
- Methodological pluralism: No single discipline or design is preferred; the journal invites protocols, theoretical work, process evaluations, methodological papers and tools.
- Centrality of context and behaviour: Understanding organisational and professional behaviour-and reporting contextual/developmental work-is essential for replication and spread.
- Open access and speed: Electronic, open-access publication accelerates dissemination and bridges researcher-user communication.

Where it supports the Scottish Approach to Change

- Systematic uptake ↔ *Process rigour* and the *Steps of change*: Emphasis on structured methods to move evidence into practice aligns with Scottish Approach to Change 's eight-step change cycle and its enabler of *process rigour* (governance, measurement, project management).
- Context and behaviour ↔ *Leadership and culture*: The focus on organisational/professional behaviour and context supports Scottish Approach to Change 's call for enabling leadership, culture, and delegated authority to make change stick.
- Process and developmental reporting ↔ *Learning system*: Prioritising process evaluations, reflective learning, and "what works where and why" mirrors Scottish Approach to Change 's learning systems with feedback loops, sense-making, and rapid iteration (e.g., PDSA).
- Multiple methods and tools ↔ Scottish Approach to Change toolset: Welcoming diverse designs and rigorously developed tools resonates with Scottish Approach to Change 's practical tool library (driver diagrams, options appraisal, measurement plans) to support disciplined change.
- Clinical, community, policy scope ↔ *Whole-system framing* and QMS: The journal's multi-level remit complements Scottish Approach to Change 's whole-organisation Quality Management System and systems thinking across services and sectors.

- Spread and replication \leftrightarrow *Review for spread* and *Embed and sustain*: Calling for contextual detail to enable replication directly supports Scottish Approach to Change 's review-for-spread step and its emphasis on sustaining and scaling practices that work.
- Researcher-user dialogue \leftrightarrow *People-led*: Strengthening communication with policy/practice users aligns with Scottish Approach to Change 's people-led ethos-co-design with those who use, deliver and enable services

Harvey G, Kitson A. (2016) - *PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice*

[Link: PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice - PMC](#)

Summary

Harvey and Kitson revisit the PARIHS framework and propose *i-PARIHS*, positioning facilitation as the active ingredient that aligns three core constructs-innovation, recipients and context-to achieve successful implementation. They redefine success as meeting agreed project goals, embedding the innovation in practice, and engaging stakeholders, addressing critiques of the original model's ambiguity and limited attention to individuals and the outer context. The paper operationalises *i-PARIHS* (including diagnostic/assessment guidance) and illustrates it with case studies that use audit/feedback and PDSA cycles, showing how evidence is adapted ("tinkered") to local priorities. Overall, *i-PARIHS* offers a more coherent, system-aware framework that keeps intuitive appeal while strengthening practical application through explicit facilitation roles and processes.

Key arguments and findings

- From PARIHS to *i-PARIHS*: Shifts from $SI = f(\text{Evidence}, \text{Context}, \text{Facilitation})$ to $SI = \text{Facilitation}(\text{Innovation} + \text{Recipients} + \text{Context})$, clarifying success and adding the recipient construct (individuals/teams) and outer context.
- Facilitation as active ingredient: Defines facilitation roles/processes that assess, align and integrate the other constructs; offers guidance to operationalise practice.
- Adaptation of evidence: Emphasises tailoring innovations to local priorities ("tinkering"), supported by collaborative learning, audit/feedback and iterative PDSA testing.
- Case evidence: Examples (e.g., CKD in primary care; continence and nutrition improvements) illustrate variable outcomes and the importance of context, leadership, and facilitation capacity.

Where it supports the Scottish Approach to Change

- People-led change: i-PARIHS elevates *recipients*-patients, staff, teams-as central actors, aligning with Scottish Approach to Change 's "people-led" enabler and emphasis on meaningful engagement, co-design and inclusion.
- Process rigour and iterative testing: i-PARIHS promotes structured facilitation, diagnostics, audit/feedback and PDSA cycles-mirroring Scottish Approach to Change 's process rigour, prototyping/testing, and data-driven decision-making.
- Leadership and culture in context: The framework's inner/outer context construct (including leadership, organisational culture and policy environment) supports Scottish Approach to Change 's call for enabling leadership, psychological safety and cross-system collaboration.
- Clear vision and purpose: i-PARIHS defines success as agreed goals and embedded practice, reinforcing Scottish Approach to Change 's insistence on explicit vision, purpose, and strategy to steer choices and trade-offs.
- Learning systems: i-PARIHS' use of iterative testing, feedback loops and reflective practice aligns with Scottish Approach to Change 's learning system enabler (networks, measurement, knowledge mobilisation).
- Quality management and systems view: By incorporating outer context and system-level factors, i-PARIHS complements Scottish Approach to Change 's Quality Management System lens and whole-organisation approach to sustaining improvement.

Jeffrey Braithwaite (2018) - *Changing how we think about healthcare improvement*

Link: [Changing how we think about healthcare improvement](#)

Summary

Jeffrey Braithwaite argues that after decades of effort, health-system performance remains stubbornly flat: only 50-60% of care aligns with high-level evidence, around one-third is waste, and ~10% of patients experience adverse events. He attributes this to healthcare's nature as a complex adaptive system-non-linear, locally determined, and resistant to top-down mandates. The article critiques restructuring, targets, and blanket policies, proposing a shift to learning systems that use feedback loops, small-scale experimentation, and multimethod evidence to nudge change. It offers principles and complexity-oriented enablers that prioritise frontline realities, natural networks, and patient-centred reform. Effective change, he contends, emerges from local contexts, begins small, and spreads through relationships rather than directive control.

Key arguments and findings

- Core metrics are "frozen": ~50-60% guideline-concordant care, ~30% waste, and ~10% adverse events persist over decades.

- Healthcare is a complex adaptive system; nonlinearity and emergence mean the same inputs yield different outputs, frustrating linear, top-down change.
- Structural “hardware” changes (e.g., reorganisations) show little benefit; “software” (culture, implementation) matters, though average effects are modest (~16%).
- Change is accepted when people are involved in decisions and rejected when imposed; focus should shift to coalface reality and natural networks.
- Build learning systems: start small, use strong feedback loops, convert data into shared intelligence, and keep the patient at the centre.

Where it supports the Scottish Approach to Change

- **People-led change.** BMJ: change gains traction when those affected are involved; imposition repels it. Scottish Approach to Change makes “people-led” a core enabler, embedding co-design and meaningful engagement.
- Leadership and culture. BMJ highlights the strong link between organisational culture and outcomes and the limits of top-down control; the Scottish Approach to Change emphasises leadership behaviours that create safe, trust-based, improvement-friendly cultures.
- Process rigour through measurement and learning. BMJ calls for feedback loops, multimethod evidence, and local intelligence; Scottish Approach to Change’s Process rigour details governance, measurement/monitoring/evaluation, and rigorous project management.
- Learning systems. The article urges turning healthcare into a learning system; Scottish Approach to Change names Learning system as a foundational enabler with networks, reflective practice, and knowledge mobilisation.
- Iterative testing and scaling. BMJ advocates small-scale initiatives that build up via feedback; Scottish Approach to Change’s Prototype and test (incl. PDSA) and Review for spread steps formalise that pathway.
- Pragmatic governance. BMJ warns against policy-heavy, target-driven mandates; Scottish Approach to Change’s governance guidance stresses proportionate oversight that creates action, not inertia.

Mathieson A, Grande G, Luker K. (2019) - *Strategies, facilitators and barriers to implementation of evidence-based practice in community nursing: a systematic mixed-studies review and qualitative synthesis.*

[Link: Strategies, facilitators and barriers to implementation of evidence-based practice in community nursing: a systematic mixed-studies review and qualitative synthesis | Primary Health Care Research and Development | Cambridge Core](#)

Summary

This mixed-studies systematic review (22 studies, 2010-2017) synthesises how evidence-based practice (EBP) is implemented in community nursing. Using Critical Interpretive Synthesis, it finds limited use of implementation theory (only six studies) and inconsistent terminology across the field. Key strategies that aid adoption include upfront training with ongoing support, clear role allocation (implementation teams, “local champions”), and visible managerial leadership. Perceived practicality-ease of use, time-saving and cost-effectiveness-facilitates uptake, while their absence (plus workload and infrastructure changes) impedes it. Implementation is inherently contextual, requiring both organisational and individual adoption; crucially, EBP gains traction when community nurses judge it useful and likely to improve outcomes for patients and carers.

Key arguments and findings

- Scope and method: 22 empirical studies on community/home (district) nursing were synthesised; few used theory to plan or evaluate implementation (n=6).
- Implementation is contextual and complex: success depends on both organisational conditions and individual practitioner adoption.
- Enablers/strategies: advance training plus continued support; role allocation (implementation teams, key nurses) and local champions; and visible managerial leadership.
- Facilitators: innovations that are easy to use, save time, and are cost-effective are more readily adopted.
- Barriers: inadequate training/support, workload and staffing pressures, and organisational infrastructure change; the inverse of facilitators.
- Adopter judgment matters: nurses adopt EBP when they see clinical utility and potential patient/carer benefit.

Where this supports the Scottish Approach to Change

- Leadership and culture → managerial support/champions: The review’s emphasis on managerial leadership and local champions mirrors SAC’s enabler that leaders create the conditions for change and empower others.
- Process rigour → structured roles, governance, and training: Findings on defined roles (implementation teams), proportionate project management, and sustained support align with SAC’s process-rigour enabler (governance, project management, measurement, evaluation).
- People-led → adopter buy-in and perceived value: The necessity that nurses deem an innovation beneficial to patients directly supports SAC’s people-led principle (co-design, meaningful engagement, trauma- and equity-aware practice).

- Learning system → use of theory and continuous evaluation: The review's critique of limited theory uses underscores SAC's call for learning systems that use evidence, reflective practice, and data (qualitative and quantitative) to adapt and improve.
- Clear vision and purpose → relevance and practicability: Facilitators such as ease of use, time-saving, and cost-effectiveness reinforce SAC's emphasis on a clear, practical vision that is affordable, implementable and anchored in users' needs.

Context, Readiness, Barriers and Facilitators

Summary

Long et al. (2022) - *Conceptualising contexts, mechanisms and outcomes for implementing large-scale, multisite hospital improvement initiatives: a realist synthesis.*

[Link: Conceptualising contexts, mechanisms and outcomes for implementing large-scale, multisite hospital improvement initiatives: a realist synthesis - PMC](#)

Summary

This realist synthesis explains why large-scale, multisite hospital improvement initiatives yield variable results across settings. Drawing on 51 conceptual papers and 31 reviews, the authors characterise such programmes as typically top-down, evidence-based and supported by both internal and external resources. They catalogue 28 implementation strategies (mapped to the ERIC taxonomy) and propose 23 context-mechanism-outcome (CMO) statements-grounded chiefly in Organisational Readiness Theory and Diffusion of Innovation-to explain how planning and assessment activities (e.g., local needs assessment, leadership engagement, audit-and-feedback, use of champions, and implementation teams) activate mechanisms that drive adoption and fidelity. The core argument is that outcomes depend less on the clinical intervention itself and more on *tailoring implementation to context with explicit theory-informed logic*.

Key arguments and findings

- Success hinges on implementation, not just the intervention: large-scale programmes are top-down, evidence-based, and require internal/external support; results depend on the accompanying implementation strategy.

- 28 strategies mapped to ERIC; planning/assessment dominate: common tactics include local needs assessment, leadership engagement, audit and feedback, recruiting champions, and forming implementation teams.
- Theory is underused; CMO logic adds explanatory power: the paper advances Organisational Readiness and Diffusion-of-Innovation lenses to generate 23 CMO hypotheses for “what works, for whom, in what contexts.”
- Contextual tailoring is essential: aligning strategies to local conditions builds buy-in, improves fidelity, and supports sustainability.

Where this supports the Scottish Approach to Change

- Process rigour and governance. The emphasis on structured planning, readiness assessment, and audit/feedback mirrors Scottish Approach to Change’s *Process rigour* enabler-governance that drives change, robust measurement/monitoring, and disciplined project management.
- Leadership and culture. Calls to actively engage leaders and build organisational readiness align with Scottish Approach to Change’s expectations of visible, enabling leadership, distributive roles, and psychologically safe cultures that permit experimentation.
- Clear vision and purpose. Top-down, evidence-based initiatives with explicit aims resonate with Scottish Approach to Change’s requirement to anchor change in a clear vision, strategy, and purposeful prioritisation.
- People-led, multi-disciplinary delivery. The paper’s focus on implementation teams, champions, and stakeholder engagement supports Scottish Approach to Change’s *People-led* enabler and guidance to assemble multi-disciplinary change teams that co-design and deliver improvements.
- Learning systems and theory-informed adaptation. Developing and testing CMO hypotheses to understand mechanisms echoes Scottish Approach to Change’s *Learning system*-using qualitative/quantitative data, reflective practice, and rapid feedback loops to turn knowledge into action.
- Alignment with Scottish Approach to Change’s steps of change. The paper strengthens Scottish Approach to Change’s early steps-*Identify, Understand, Develop and design*-and the *Review for implementation* decision point by foregrounding readiness, needs assessment, and formal review before scale-up.

Coles et al. (2020) - *The influence of contextual factors on healthcare quality improvement initiatives: A realist review*

[Link: The influence of contextual factors on healthcare quality improvement initiatives: a realist review - PubMed](#)

Summary

This realist review synthesised 35 studies to explain how and why context shapes quality improvement (QI) in healthcare. The authors developed an explanatory model showing how contextual factors at macro, meso, and micro levels interact across the improvement cycle—planning, implementation, sustainability, and transferability. They argue that considering context explicitly improves the design and delivery of QI initiatives and is essential for spread and sustainability across diverse settings. The review also calls for applying the proposed model prospectively to enhance improvement-planning processes. Overall, the paper reframes QI as context-sensitive work that requires alignment between system levels and stages of change to translate intentions into reliable, sustained outcomes.

Key arguments and findings

- Context is decisive: QI outcomes depend on interactions among contextual factors across macro/meso/micro levels, not just on the intervention itself.
- A staged lens matters: Context influences every phase—planning, implementation, sustainability, transferability—so design and evaluation must address each stage.
- Explanatory model proposed: The review offers a model linking context to stages of the improvement journey to guide context-sensitive intervention design.
- Implications for spread: Attending to context enhances the spread and sustainability of successful changes across settings.
- Next step: Apply and test the model prospectively to strengthen improvement planning.

How this supports the Scottish Approach to Change

- Whole-system alignment: The review’s macro/meso/micro framing aligns with Scottish Approach to Change’s system view—enablers + steps operating across organisational layers and a Quality Management System (QMS) underpinning planning, improving, maintaining and assuring quality.
- Stage-based change cycle: The paper’s emphasis on context across planning → implementation → sustainability → transferability mirrors Scottish Approach to Change’s eight Steps of Change (Identify, Understand, Develop and Design, Prototype and Test, Review for Implementation, Define and Implement, Embed and Sustain, Review for Spread).
- Leadership and culture as contextual levers: While the review aggregates “contextual factors,” Scottish Approach to Change operationalises these through the Leadership and culture enabler, specifying behaviours (e.g., trust, empowerment, psychological safety) that make improvement stick in context.
- People-led, stakeholder input: The review’s realist approach integrates stakeholder input; Scottish Approach to Change formalises this as People-led design and meaningful

engagement (trauma-informed, inclusive, rights-based) so context is understood with, not for, communities and staff.

- Spread and sustainability: The review highlights the challenge of spread/sustainability; Scottish Approach to Change builds this in with Embed and Sustain and Review for Spread steps, plus supporting learning systems to generalise and share learning.
- Process rigour: The paper argues for context-sensitive design; Scottish Approach to Change translates this into Process rigour (governance, project management, measurement/monitoring/evaluation) to ensure context-appropriate, reliable delivery.

Fu et al. (2023) - *Barriers and Facilitators to Implementing Interventions for Reducing Avoidable Hospital Readmission: Systematic Review of Qualitative Studies*

[Link: Barriers and Facilitators to Implementing Interventions for Reducing Avoidable Hospital Readmission: Systematic Review of Qualitative Studies - PubMed](#)

Summary

This qualitative systematic review synthesises barriers and facilitators to implementing peri-discharge interventions that reduce avoidable hospital readmissions. Thirteen studies were mapped to CFIR constructs and clustered around intervention design quality/complexity, network and communication, responsiveness to patient needs with adequate resources, and external incentives. Common barriers included limited resources, poor intra-team communication, misfit with existing workflows, complicated processes, low-usability of tools, and limited understanding of intervention content/effectiveness. Facilitators included regular information-sharing meetings, cultures valuing quality and accountability, financial penalties for high readmission rates, external support via QI programmes/community resources, and senior leadership backing. The authors conclude that context-tailored implementation strategies-co-developed with stakeholders-are essential to improve uptake and impact.

Key arguments and findings

- Implementation challenges are predictable and mappable: Barriers/facilitators cluster in CFIR domains (design quality/complexity, networks/communication, patient needs + resources, external incentives).
- Typical barriers: resource constraints, weak communication, workflow incompatibility, complex rollout, low practicality of tools, and limited staff understanding.
- Typical facilitators: routine cross-team meetings and information flow, quality-oriented organisational culture, external levers (e.g., penalties), external QI/community support, and visible senior leadership.

- Actionable implication: success depends on tailoring strategies to the local context through consensus-based formative processes with providers and service users.

Where it supports the Scottish Approach to Change

- Leadership and culture: The review’s emphasis on senior leadership and a culture of quality aligns with Scottish Approach to Change’s enabler to “create the conditions for change to thrive,” including executive teams removing barriers and sharing ownership.
- Process rigour and project management: Barriers around complexity, workflow fit, and tool usability reinforce Scottish Approach to Change’s call for systematic governance, measurement/monitoring, and proportionate project management across the change cycle.
- People-led and responsiveness to need: The CFIR theme of being responsive to patient needs mirrors Scottish Approach to Change’s people-led enabler (co-design, trauma-informed engagement, reducing inequalities) and emphasis on involving lived/living experience throughout.
- Learning systems and communication: The facilitator of regular information-sharing maps to Scottish Approach to Change’s learning systems (spaces to gather, sense-make, and mobilise knowledge) and governance that values reflective practice.
- External incentives and system levers: The role of penalties/external programmes is consistent with Scottish Approach to Change’s focus on commissioning, quality assurance, and aligning with national priorities to create enabling conditions for sustained change.

Haring et al. (2022) - *What can healthcare systems learn from looking at tensions in innovation processes? A systematic literature review*

[Link: *What can healthcare systems learn from looking at tensions in innovation processes? A systematic literature review - PMC*](#)

Summary

This 2022 systematic review reframes “barriers” to healthcare innovation as tensions—dynamic conflicts between stakeholders, values, and contexts that shape adoption. Reviewing 29 studies, the authors identified 42 tensions in nine categories; organising tensions dominated, and tensions peaked during implementation, most often as dilemmas. They arose from misaligned working cultures, competing priorities, and regulatory/organisational constraints, particularly in government-funded systems. Crucially, most tensions are addressable: surfacing them early, balancing agility with governance, and building reflexive capabilities can enable rather than impede innovation. The paper calls for policy and managerial strategies that systematically classify and manage tensions across the innovation lifecycle to improve uptake and spread.

Key arguments and findings

- Conceptual shift: study argues “tensions” offer a process-sensitive lens that better explains innovation dynamics than static “barriers.”
- Evidence base: 29 studies yielded 42 tensions across nine categories; organising tensions were most prevalent.
- Where they occur: tensions concentrated in implementation and commonly took the form of dilemmas.
- So what: most tensions can be managed; proactive strategies should improve implementation outcomes.
- Context: included studies were mainly from government-funded health systems.

Where the article supports the Scottish Approach to Change

- Surface and manage tensions early ↔ Scottish Approach to Change “Steps of change” and “Process rigour.”
The review shows tensions concentrate during implementation, requiring explicit governance, measurement, and staged decision points. Scottish Approach to Change builds this in via Define and implement, Embed and sustain, and Review for spread, supported by governance, evaluation, and project management.
- Align competing priorities ↔ Scottish Approach to Change “Clear vision and purpose.”
Because tensions reflect conflicting aims/values, Scottish Approach to Change’s emphasis on a shared vision, strategy, and trade-offs provides the anchor for consistent decision-making and reduces drift during delivery.
- Culture and relationships matter ↔ Scottish Approach to Change “Leadership and culture.”
The paper links tensions to working cultures and convictions; Scottish Approach to Change calls for compassionate, visible leadership, psychological safety, and distributed leadership to navigate conflict and sustain momentum.
- Stakeholder conflict as design input ↔ Scottish Approach to Change “People-led.”
Because tensions spring from divergent stakeholder perspectives, Scottish Approach to Change’s co-design and meaningful engagement with people who need, use, provide, and enable services directly addresses value conflicts and improves acceptability.
- Iterative learning to turn dilemmas into progress ↔ Scottish Approach to Change “Learning system.”
The review recommends reflexivity and adaptation; Scottish Approach to Change institutionalises learning networks, rapid feedback loops, and PDSA-style iteration to detect tensions and course-correct.

- Structure without rigidity ↔ Scottish Approach to Change “Process rigour” and QMS. The article’s call to balance agility with governance aligns with Scottish Approach to Change ’s quality management system and process rigour-using proportionate governance, measurement, and project management to enable (not stifle) change.

Parmar J, Sacrey LA, Anderson S, Charles L, Dobbs B, McGhan G, Shapkin K, Tian P, Triscott J. (2022) - Facilitators, barriers and considerations for the implementation of healthcare innovation: A qualitative rapid systematic review.

[Link: Facilitators, barriers and considerations for the implementation of healthcare innovation: A qualitative rapid systematic review - PubMed](#)

Summary

Parmar et al. conducted a qualitative rapid systematic review (28 studies) on implementing healthcare innovations. They catalogue common barriers, facilitators, and recommendations, and synthesise these into five practical considerations for successful uptake, spread, and scale: research and information sharing, intentional implementation planning, organisational underpinnings, creating the clinical context, and facilitative training. The review argues that implementation is highly context-dependent and that many barriers have parallel facilitators; therefore, tailored strategy bundles are needed rather than single “silver bullets.” The authors position their synthesis as an actionable guide to design implementation plans that fit local settings and support consistent person-centred care.

Key arguments and findings from the article

- Implementation success depends on five cross-cutting considerations: research/information sharing; intentional implementation planning; organisational underpinnings; creating the clinical context; and facilitative training.
- Barriers and facilitators mirror each other, so implementers should select complementary strategies tailored to the local context to enable spread and scale.

Where it supports the *Scottish Approach to Change*

- Intentional implementation planning → Process rigour and Steps of Change
SAC emphasises a rigorous, structured change process (governance, measurement/monitoring/evaluation, project management) and an eight-step cycle from Identify through Review for spread-directly echoing the review’s call for intentional implementation planning.
- Organisational underpinnings → Leadership and culture enabler
The review’s focus on organisational foundations aligns with SAC’s view that leadership,

culture, and psychological safety are essential conditions for transformation and sustained results.

- Research and information sharing → Learning system enabler
SAC advocates learning systems that use data, reflective practice, and rapid feedback loops to convert knowledge into action-supporting the review's emphasis on research use and active information exchange.
- Creating the clinical context → Clear vision and purpose + People-led design
Tailoring to context in the review complements SAC's requirement to anchor change in a clear vision and purpose, co-designed with people who use and deliver services, and grounded in local needs and inequalities.
- Facilitative training → Education, capability-building, and project support
SAC highlights capability building (QI, service design, leadership programmes) and structured project support as enablers to deliver and sustain change-matching the review's call for facilitative training.
- From pilots to spread and scale
The article's spread/scale orientation is mirrored by SAC's "Review for spread" step and its guidance on when and how to scale models versus approaches.

Rogers L, De Brún A, McAuliffe E. (2020) - *Defining and assessing context in healthcare implementation studies: a systematic review.*

[Link: *Defining and assessing context in healthcare implementation studies: a systematic review* - PMC](#)

Summary

This systematic review examines how "context" is defined and measured in healthcare implementation research, synthesising 64 empirical studies published over the previous decade. It finds substantial inconsistency in definitions, with studies alternately listing contextual factors, using framework sub-elements (e.g., PARIHS/CFIR), or offering richer but varied descriptions. The review highlights that context is dynamic and multi-level (individual, team, organisational, system), yet most analyses occur at the individual level, risking an incomplete understanding. Measurement approaches are heterogeneous; the Alberta Context Tool is the most used quantitative instrument, while qualitative studies rely on diverse frameworks. The authors argue for an operational definition and a more rigorous, multi-level assessment to improve comparability and strengthen implementation success.

Key arguments and findings

- Inconsistent definitions impede progress: Context is variably treated as lists of factors, framework sub-elements, or rich narratives, limiting comparability across studies.

- Context is dynamic and multi-level: Determinants span culture, leadership, resources, relationships, and setting, operating at individual, team, organisational, and system levels.
- Measurement is fragmented: The Alberta Context Tool is the most common quantitative measure (n=4), while qualitative and mixed-methods studies employ heterogeneous frameworks and tools.
- Unit of analysis skews to individuals: Most studies analyse context at the individual level (n=29), underrepresenting organisational/system layers critical to successful implementation.
- Call to action: The review proposes developing an operational definition and adopting a more rigorous, multi-level assessment to better link context with implementation outcomes.

Where it supports the Scottish Approach to Change

- Leadership and culture as core contextual determinants: The review’s emphasis on leadership, culture and organisational support aligns with Scottish Approach to Change’s “Leadership and culture” enabler for creating safe, empowering environments for change.
- People-led change: Recognition that social relations and lived experience shape implementation mirrors Scottish Approach to Change’s “People-led” enabler and guidance on meaningful engagement, trauma-informed practice, and reducing inequalities.
- Process rigour and measurement: The paper’s call for rigorous, multi-level assessment supports Scottish Approach to Change’s “Process rigour” enabler, including measurement, monitoring, evaluation, and triangulation of quantitative/qualitative data to guide decisions.
- Learning systems: The need to iteratively sense-make and adapt to contextual variation echoes Scottish Approach to Change’s “Learning system” enabler-using feedback loops, reflective practice and rapid learning to shape the change itself.
- Clear vision and purpose: By showing that context determines whether mechanisms lead to success or failure, the review underlines Scottish Approach to Change’s insistence on anchoring change in a clear vision/purpose to align decisions and governance.
- Eight Steps of Change: The review’s findings reinforce Scottish Approach to Change’s structured cycle (Identify → Review for spread), particularly the need to understand local context before design, prototype/test with users, and evaluate for implementation/sustainability.

Debra de Silva, Health Foundation (2015) - *What’s getting in the way? Barriers to improvement in the NHS*

Link: [WhatsGettingInTheWayBarriersToImprovementInTheNHS.pdf](#)

Summary

The Health Foundation's evidence scan synthesises 73 NHS studies (plus >100 international) to explain why improvement efforts stall. Barriers cluster at four levels: the initiative (e.g., poor fit/usability and thin evidence), individuals (skills gaps, competing priorities, resistance), organisations (leadership, culture, weak management/measurement, time and funding constraints), and the wider system (instability, fragmentation, incentives). Many impediments persist across design, delivery and dissemination-especially limited data use, lack of time/resources, and "projectness" that undermines sustainability. Compared internationally, the NHS exhibits greater structural churn, fewer incentives, and less improvement experience among staff. The scan recommends addressing capability, culture and system conditions alongside technical change design and measurement.

Key arguments and findings

- Barriers span initiative, individual, organisational, and system levels; they occur across design, delivery and spread phases.
- Usability/fit and weak evidence of interventions frequently impede adoption.
- Skills and confidence gaps in QI, project/change management, and analysis constrain progress.
- Leadership, culture, silo-working, and insufficient use of data are repeated organisational blockers.
- System issues-policy churn, fragmented partnerships, and misaligned incentives-limit durability and scale.
- A tendency toward "projectness" risks short-lived pilots without sustained embedding or spread.

Where it supports the Scottish Approach to Change

- Leadership and culture \leftrightarrow Enabler alignment
HF identifies leadership, culture and organisational stability as central barriers; Scottish Approach to Change places *Leadership and culture* as a core enabler with explicit roles, behaviours and executive responsibilities.
- Measurement, governance and project management \leftrightarrow Process rigour
HF notes insufficient data use, weak management and lack of time/funding across all stages; Scottish Approach to Change's *Process rigour* details governance, measurement/monitoring/evaluation, and robust project management throughout the change cycle.
- Skills and capability gaps \leftrightarrow Learning system and education
HF highlights deficits in QI/change skills; Scottish Approach to Change proposes *Learning*

systems, multidisciplinary teams, and formal training pathways (e.g., QI learner routes, leadership programmes) to build capability.

- Silo-working/tribalism and weak engagement \leftrightarrow People-led change
HF reports resistance and poor cross-boundary collaboration; Scottish Approach to Change mandates *People-led* design, inclusive engagement, and trauma-informed, inequality-focused practice.
- Poor fit/usability and thin evidence \leftrightarrow Co-design, prototyping and PDSA
HF finds misfit and complexity inhibit uptake; Scottish Approach to Change counters via *Develop and design* (options appraisal, co-design) and *Prototype and test* (iterative PDSA) to ensure contextual fit before scale.
- “Projectness” and lack of sustainability \leftrightarrow Implementation, embed and spread
HF warns pilots fade without structures for adoption; Scottish Approach to Change embeds decision gates (*Review for implementation*), *Define and implement*, *Embed and sustain*, and *Review for spread* to avoid pilotitis and achieve durability.

Leadership, Culture and Organisational Capability

Summary

Burgess and Downham (2025) - *Evaluating the Impact of NHS IMPACT*

Link: [REPORT Evaluating the Impact of NHS IMPACT](#)

Summary

This rapid, independent evaluation (41 interviews across ~40 NHS organisations) examines how NHS IMPACT-launched April 2023 as a five-pillar, unified improvement framework-has shaped the *conditions* for improvement in provider organisations. The report finds five interrelated effects: legitimacy (board-level traction), shared language (agnostic, cross-method coherence), connecting people (networks and learning spaces), translation (contextualising socio-technical change), and diverse interpretations (constructive debate). It also flags challenges: uneven local contexts, risks of over-standardising language, ambiguity around “management systems,” and concerns about the self-assessment tool’s evidence base and non-mandatory use. Overall, NHS IMPACT is judged a valuable lever that catalyses more systematic, organisation-wide improvement, while requiring continued refinement and long-term stewardship.

Key arguments and findings

- What NHS IMPACT is: a five-component framework-shared purpose/vision; people and culture; leadership behaviours; capability and capacity; embedding in management systems.
- Positive effects: elevates improvement’s legitimacy at the board level; builds shared language across methods/orgs; connects people via IDN/ILN, masterclasses and “lunch and learns”; supports translation to local contexts; stimulates dialogue through diverse interpretations.
- Evidence and method: 41 semi-structured interviews (≈1,000 transcript pages) plus survey; two years post-launch.
- Critical reflections: context inequities; tension between prescriptive guidance and autonomy (“tell or sell”); potential drawbacks of standardising language; confusion over management systems; self-assessment tool concerns and shift away from mandatory completion.

Where it supports the Scottish Approach to Change

- Clear vision and purpose / leadership and culture. NHS IMPACT’s *legitimacy* effect helps secure executive sponsorship and align strategy-mirroring Scottish Approach to Change enablers that stress clear vision, purposeful strategy, and leadership behaviours to “create the conditions for change.”
- People-led design. The report emphasises *translation* and socio-technical contextualisation, encouraging co-design and local adaptation-consistent with Scottish Approach to Change’s *people-led* principle and focus on engagement, equity and trauma-informed practice.
- Process rigour and governance. Use of self-assessment, networks, and management-system embedding aligns with Scottish Approach to Change’s call for systematic measurement, governance, project management and evaluation throughout the change cycle.
- Learning systems. NHS IMPACT’s connecting-people theme (IDN/ILN, masterclasses) resonates with Scottish Approach to Change’s *learning system*-structured spaces for reflection, rapid feedback, and spreading “bright spots.”
- Steps of change-sustain and spread. The report’s “longevity” challenge reinforces Scottish Approach to Change’s emphasis on *embed and sustain* and *review for spread* to avoid pilot-drop-off and ensure scale-up with fidelity.

NHS IMPACT - the five components (NHS England, 2023-24 aggregation)

Link: [NHS England » Building a shared purpose and vision](#)

Summary

NHS England’s “Building a shared purpose and vision” sets out how organisations co-create a

compelling, values-anchored vision that is owned by leaders, staff and communities, and used as the organising principle for improvement. It stresses inclusive co-design with people who use services and those with lived experience; executive sponsorship without top-down authorship; and continually “living” the vision through behaviours, priorities and governance. It advises aligning all improvement activity to the shared purpose, starting from current pressures, understanding frontline realities, and using engagement methods (e.g., crowdsourcing, events). It also recommends checking CQC “well-led” insights, viewing work through the service-user lens, and celebrating good practice to build momentum.

Key arguments and findings

- Create the vision transparently and inclusively, with leadership sponsorship but co-design across staff, communities and people with lived experience.
- Make the vision “lived” every day through core values, decision-making and governance; challenge work that does not align.
- Start from current NHS pressures, frame work in a purpose-driven (not compliance-driven) way, and deeply understand frontline contexts.
- Use practical engagement methods (crowdsourcing, events), consider CQC “well-led” findings, and reinforce progress by sharing good practice.

Where it supports the Scottish Approach to Change

- Shared vision and purpose: Both emphasise a clear, co-created vision that anchors decisions and trade-offs.
- People-led change: NHS England’s call to involve communities and lived experience mirrors Scottish Approach to Change ’s “people-led” enabler and co-design ethos.
- Leadership and culture: Executive sponsorship and “living the values” align with Scottish Approach to Change ’s focus on compassionate, enabling leadership and culture.
- Process rigour and governance: Aligning all improvement to purpose and using well-led insights supports Scottish Approach to Change ’s process rigour, governance and decision discipline.
- Learning orientation: Celebrating and sharing good practice to build momentum complements Scottish Approach to Change ’s learning systems and reflective practice.

Health Foundation (2025) - *Leading NHS groups: findings from interviews with group leaders in England*

Link: [Leading NHS groups - The Health Foundation](#)

Summary

Leading NHS groups (Health Foundation, 22 Aug 2025) examine the rapid emergence of NHS

provider groups in England and how leadership design shapes their success. Drawing on interviews with group leaders, it finds wide variation in legal form and purpose, but a common two-tier model: a group-level team for strategy and site-based teams for operations. Around a quarter of trusts have joined or plan to join groups, many post-pandemic, positioning groups as pivotal to delivering the 10-Year Health Plan and potential Integrated Health Organisations. The analysis argues that groups can concentrate leadership bandwidth, standardise improvement, and share capabilities across sites-but need clearer national policy, regulatory alignment, talent and data infrastructure, and unambiguous accountability to maximise benefits.

Key arguments and findings

- Groups are proliferating and heterogeneous, but usually adopt a strategic (group) + operational (site) leadership split that leaders view as fundamentally beneficial.
- Material system impact: roughly one in four trusts are already in-or plan to join-groups, with growth accelerating since the pandemic.
- Success depends on national enablers: the analysis calls for actions by policymakers, regulators and others to support groups and maximise their chances of success (eg, fit-for-purpose oversight and support).
- Link to major reforms: groups are well placed to help deliver the 10-Year Health Plan's ambitions; some may evolve into Integrated Health Organisations.

Where this supports the Scottish Approach to Change

- Leadership and culture: The emphasis on clear, distributed leadership across group and site levels aligns with Scottish Approach to Change 's call for leaders who set vision, empower others, collaborate and build psychological safety for change.
- Process rigour and governance: Group models that standardise improvement and clarify accountability echo Scottish Approach to Change 's enabler on *process rigour*-governance that creates momentum, uses data well, and prioritises outcomes over bureaucracy.
- Learning systems: Groups' potential to share methods and spread what works across sites supports Scottish Approach to Change 's *learning system* component-using iterative testing, reflection and knowledge mobilisation to accelerate improvement.
- People-led change: Site-based operational leadership keeps decision-making close to patients, staff and communities, complementing Scottish Approach to Change 's *people-led* enabler and its focus on engagement, equity and lived experience informing design.

Burgess, N., Currie, G., Crump, B., Dawson, A. (2022) - *Leading change across a healthcare system: How to build improvement capability and foster a culture of continuous improvement, Report of the Evaluation of the NHS-VMI*

Link: [Leading change across a healthcare system](#)

Summary

This Warwick Business School evaluation distils lessons from the five-year NHS and Virginia Mason Institute partnership on building organisation-wide improvement capability. It argues that Lean should be adopted as a whole-system management approach-anchored in visible executive commitment, disciplined routines (e.g., daily management, standard work), and broad staff training (“Lean for Leaders”)-rather than as isolated projects. It highlights the importance of aligning strategy, priorities and metrics (“the golden thread”), cultivating peer-to-peer learning networks, and sustaining governance that enables experimentation and spread. Quantitative and qualitative evidence-including interviews, observations, social-network analysis, and interrupted time-series-suggests these elements fortified resilience, notably during COVID-19.

Key arguments and findings

- Lean as a socio-technical management system (not a bolt-on toolkit) is essential to embed continuous improvement “from board to ward.”
- Executive sponsorship and role-model behaviours are non-negotiable for organisation-wide traction.
- Capability building at scale (e.g., Lean for Leaders), supported by standard routines and visual management, enables consistency and spread.
- Aligning aims, priorities and measures-the “golden thread”-prevents fragmentation and focuses effort on strategic outcomes.
- Peer learning and social connectedness among staff are powerful predictors of improvement maturity.
- Robust evidence use (mixed-methods, ITS) supports accountability and learning without stifling local adaptation.
- Crisis resilience: trusts leveraged Lean routines to redesign pathways rapidly during COVID-19.

Where the report supports the Scottish Approach to Change

- Clear vision and purpose ↔ “Golden thread” alignment - The call to align organisational strategy, objectives and metrics mirrors Scottish Approach to Change’s emphasis on a shared vision that guides choices and trade-offs.
- Process rigour ↔ Lean management routines - Daily management, standard work, governance cadence and systematic measurement echo Scottish Approach to Change’s process-rigour enabler (governance, monitoring/evaluation, project management, commissioning).
- Leadership and culture ↔ Visible, distributed leadership - The report’s stress on sustained executive commitment and behaviours that enable experimentation aligns with Scottish Approach to Change’s leadership culture-trust, psychological safety, and empowerment.

- People-led change ↔ Frontline engagement and co-design - Building capability across clinicians, managers and support staff, and engaging those closest to the work, supports Scottish Approach to Change 's people-led design and involvement of lived experience.
- Learning system ↔ Peer learning networks and reflection - Findings on social connectedness, learning networks and reflective practice directly reinforce Scottish Approach to Change 's learning-system components (data-informed sense-making, feedback loops, communities of practice).
- Scottish Approach to Change "Steps of change" ↔ Lean test-and-learn pathway - The report's pattern-diagnose, design, prototype/test (RPIWs/PDSA), implement, embed, review for spread-maps closely to Scottish Approach to Change 's eight steps from *Identify* through *Review for spread*.
- Equity and reliability ↔ Measurement and governance - The focus on standardised processes, transparent metrics and governance to avoid variation supports Scottish Approach to Change 's push to design for reliability and reduce inequalities through evidence-led decision-making.

Castiglione SA, Lavoie-Tremblay M. (2021) - *An Integrative Review of Organizational Factors Influencing Successful Large-Scale Changes in Healthcare.*

[Link: An Integrative Review of Organizational Factors Influencing Successful Large-Scale Changes in Healthcare - PubMed](#)

Summary

Castiglione and Lavoie-Tremblay conduct an integrative review of organisational factors that enable or hinder large-scale change (LSC) in healthcare. Searching four databases (2009-2018) and thematically analysing findings, they identify seven recurrent determinants of successful LSC: infrastructure support, organisational culture, leadership, change-management approach, clear roles and responsibilities, networks, and measurement and feedback. The authors argue that readiness for change is pivotal and that successful LSC reflects characteristics of learning organisations. They conclude by pointing to a reflective tool for nurse leaders to assess and strengthen these factors.

Key arguments and findings

- LSC requires organisational readiness-beyond individual projects-to sustain improvement.
- Seven factors consistently facilitate or impede LSC: infrastructure, culture, leadership, structured change approach, roles/responsibilities, networks, measurement/feedback.
- High-performing organisations act as learning organisations, integrating continuous feedback and reflection.

Where it supports the Scottish Approach to Change (Scottish Approach to Change)

- Leadership and culture → Scottish Approach to Change names “Leadership and culture” as a core enabler (trust, empowerment, psychological safety, distributive leadership). This directly mirrors the review’s emphasis on leadership and culture as central determinants of LSC.
- Infrastructure support → Scottish Approach to Change’s Process rigour (governance, project management, commissioning) and Quality Management System (QMS) provide the organisational scaffolding the review calls for.
- Change-management approach → Scottish Approach to Change operationalises this through the Eight Steps of Change (from Identify to Review for spread), giving the structured pathway advocated in the review.
- Roles and responsibilities → Scottish Approach to Change specifies RACI-based team building, governance roles, system stewards and learning partners-concretising the review’s call for clarity of accountability.
- Networks → Scottish Approach to Change’s Learning system, communities of practice and multi-disciplinary change teams echo the review’s finding that internal and external networks enable LSC.
- Measurement and feedback → Scottish Approach to Change foregrounds measurement, monitoring and evaluation, data curiosity and feedback loops within learning systems-precisely aligned with the review’s feedback imperative.
- Organisational culture as people-centred → Scottish Approach to Change’s People-led enabler (meaningful engagement, trauma-informed practice, inequalities and human rights focus) provides a practical expression of the culture shift the review associates with successful LSC.

Van den Hoed MW, Backhaus R, de Vries E, Hamers JPH, Daniëls R. (2022) - *Factors contributing to innovation readiness in health care organizations: a scoping review.*

[Link: Factors contributing to innovation readiness in health care organizations: a scoping review - PMC](#)

Summary

This 2022 scoping review synthesises 44 empirical studies (from 6,208 screened) to clarify “innovation readiness” in healthcare organisations and identify what drives it. The authors organise the evidence into four overarching factors-strategic course for innovation, climate for innovation, leadership for innovation, and commitment to innovation-with ten sub-factors beneath them. Most included studies were published since 2011 (n=36), almost half in hospital settings (n=19), and many examined the implementation stage, highlighting a lack of theory and a need for end-to-end, structured approaches to embed innovation. The review calls for clearer

definitions, a usable framework, and a better understanding of how these factors interact across all stages of the innovation cycle to help managers structurally embed innovation.

Key arguments and findings

- Four-factor synthesis of innovation readiness: strategic course, climate, leadership, and commitment-offering a practical organising frame where theory is currently sparse.
- Evidence base skewed to implementation: 21/44 studies focus there, signalling under-attention to upstream design and downstream spread/sustain phases.
- Field is emergent: calls for clearer concept definition and a formal framework for innovation readiness in healthcare.
- Structural embedding matters: managers need whole-cycle approaches; “climate for innovation” was most studied; individual commitment least, indicating cultural levers are better described than personal ones.

Where it supports (and strengthens) Scottish Approach to Change

- Clear vision and purpose ↔ Strategic course for innovation - The paper’s “strategic course” factor echoes Scottish Approach to Change’s emphasis on setting and using a shared vision, purpose and strategy to steer decisions and trade-offs.
- Leadership and culture ↔ Leadership for innovation and climate for innovation Findings on leadership and an enabling climate align with Scottish Approach to Change’s focus on leaders creating psychologically safe, collaborative cultures that empower teams and remove barriers to change.
- People-led ↔ Commitment to innovation and inclusive climate. The review highlights individual and collective commitment as part of readiness; Scottish Approach to Change operationalises this through people-led design and meaningful involvement of those who deliver and use services.
- Process rigour and QMS ↔ Need to “structurally embed” innovation across the whole cycle. Authors call for whole-cycle, structured approaches, not just implementation focus-mirroring Scottish Approach to Change’s eight Steps of Change (from Identify through Review for spread) and its Quality Management System backbone.
- Learning system ↔ Cross-stage understanding and feedback loops. The paper’s plea to understand factor interplay “in all stages” supports Scottish Approach to Change’s Learning system enabler (evaluation, reflective practice, rapid feedback, and spread of generalisable learning).

Russell Mannion (2022) - *Making Culture Change Happen: Elements of Improving Quality and Safety in Healthcare*

Link: [Making Culture Change Happen](#)

Summary

The Element argues that “culture change” is routinely invoked to improve healthcare quality, yet the evidence for engineering culture shifts is mixed and often thin. Mannion clarifies what organisational culture is, traces why it rose up the health-policy agenda, and reviews frameworks and tools used to assess culture and its links to performance. He cautions against simplistic, top-down campaigns; effective change must be sensitive to context, subcultures, and the layered nature of organisations like the NHS. The piece synthesises what is known about levers (e.g., leadership behaviours, measurement, and learning) and concludes with a pragmatic research and practice agenda that emphasises realistic expectations, rigorous evaluation, and multi-stranded, locally adapted approaches.

Key arguments and findings

- “Culture change” is not a silver bullet; the empirical base linking culture interventions to outcomes remains limited, so expectations should be modest and evidence-seeking.
- Organisational culture is layered and stratified (with subcultures), making uniform, top-down mandates unlikely to succeed.
- Measurement matters: use credible tools to assess culture and its relationship to quality/safety before, during, and after interventions.
- Leadership, context, and adaptive, multi-method approaches (not single methods) are the most promising levers.

Where it supports the Scottish Approach to Change

- People-led change. Mannion’s warning against top-down culture engineering echoes Scottish Approach to Change’s emphasis on co-design and involving people with lived experience to make change legitimate and stick.
- Leadership and culture as enablers. The Element spotlights leadership behaviours as primary levers; Scottish Approach to Change names “Leadership and culture” as one of five core enablers and details the capabilities needed to create psychologically safe, improvement-friendly environments.
- Process rigour and measurement. The call to measure culture and its link to performance aligns with Scottish Approach to Change’s “Process rigour” enabler and its guidance on governance, monitoring, evaluation, and data literacy for decision-making.

- Learning systems. Mannion’s case for iterative, evidence-seeking change complements Scottish Approach to Change ’s “Learning system” enabler-using rapid feedback loops, reflective practice, and knowledge mobilisation to adapt in context.
- Structured, iterative change. While the Element is conceptual, its insistence on context-sensitive, multi-stranded approaches dovetails with Scottish Approach to Change ’s eight Steps of change (identify → prototype/test → implement → sustain/spread), operationalising culture work through disciplined cycles.

Amy Gandon and Anna Garrod (2025) - *The Human Handbrake How Whitehall Culture Holds Back Public Service Reform.*

Link: [The-Human-Handbrake Breifing 2025 Sept.pdf](#)

Summary

The Human Handbrake argues that promising, people-centred public service reforms repeatedly stall in Whitehall not for lack of ideas, but because of cultural dynamics that privilege caution, central control and short-term “visible wins.” Drawing on interviews and organisational psychology, Demos identifies five reinforcing barriers-risk/fear, heroics over stewardship, tribes/silos, a bias for tidiness/uniformity, and tempo/short-termism-and points to “seeds” of solutions such as safe-to-fail spaces, incentives for collaboration, trust across boundaries, adaptive/local designs, and better ways to evidence long-term outcomes. The paper launches Demos’s *Powering Public Service Reform* programme to tackle culture, accountability, funding, digital enablement, and narrative as system-level levers.

Key arguments and findings

- Five cultural barriers in Whitehall: risk-averse behaviours; reward for individual “policy heroes”; siloed tribalism; preference for uniform, “tidy” solutions; and pressure for fast, countable results.
- Execution, not ideas, is the chokepoint-reforms are delayed, diluted or dismantled by system norms despite broad consensus for preventative, joined-up, people-centred services.
- Seeds of change include psychologically safe experimentation, cross-boundary collaboration, outcome-focused evidence and narratives, and space for local adaptation rather than top-down uniformity.
- Programme agenda: Demos will convene work on culture, accountability, funding, digital enablement, and communications to unlock reform.

Where this supports the Scottish Approach to Change

- Leadership and culture: Demos' call for safe-to-fail experimentation and distributed leadership mirrors Scottish Approach to Change 's emphasis on compassionate, empowering leaders who create psychological safety and remove barriers to change.
- People-led change: The critique of central "tidiness" and push for locally specific, relational reform aligns with Scottish Approach to Change 's people-led co-design and focus on inclusive engagement to meet real needs.
- Process rigour with flexibility: "Test, learn, iterate" solutions in the paper echo Scottish Approach to Change 's structured Steps of Change (prototype/test → review → implement → embed), PDSA cycles, and proportionate governance that enables action.
- Learning systems: Demos' recommendation to reward collaboration and learning over performance theatre reinforces Scottish Approach to Change 's learning systems-rapid feedback loops, reflective practice, and knowledge mobilisation as core governance.
- Measurement and narrative: The need to evidence long-term, preventative outcomes supports Scottish Approach to Change 's guidance on triangulating qualitative/quantitative data, using balancing measures, and presenting data clearly to sustain change.

Tatiana Fraser, *The Systems Sanctuary (2023) - The Art of Scaling Deep Research in Summary*

Link: [The+Art+of+Scaling+Deep+September+2023.pdf](#)

Summary

The Art of Scaling Deep reframes "scale" in social innovation beyond scaling up (policy) and out (replication) to emphasise inner work, relationships, cultural narratives, and context as the foundations of durable systems change. Drawing on interviews and peer learning with 25 systems leaders, the report defines scaling deep as "deep personal and broad cultural transformational work," highlights practices such as healing-informed leadership, narrative change, working with power, and long-view, iterative learning, and argues these create the conditions that make later scaling up/out effective. It also surfaces barriers-funding models, business-centric metrics, and the demand for linear, quantifiable outcomes-that undervalue this slower, context-rooted work, and call for new learning infrastructures and evaluative approaches that can recognise relational impact.

Key arguments and findings

- Definition and purpose. Scaling deep is the personal and cultural transformation required for durable systems change; it complements (not replaces) scaling up/out.
- Core practices. Inner work and healing; relationship- and context-centred work; narrative change; awareness of and work with power; and iterative, long-view learning.

- Impacts. These practices shift incentives, leadership norms, organisational habits, and collaboration patterns-preparing the conditions for systemic change.
- Barriers. Dominant funding logics, business-style metrics, and expectations of linear, easily measured outcomes suppress investment in relational and cultural work.
- Implications. Funders and practitioners should build learning infrastructures and evaluation approaches that value relationships, culture, and emergence.

Where it supports the Scottish Approach to Change

- People-led change. Scaling deep’s emphasis on relationships, lived experience, and healing aligns with Scottish Approach to Change’s *People-led* enabler and guidance on trauma-informed engagement and reducing inequalities.
- Leadership and culture. The call for healing-centred, reflective, trust-building leadership mirrors Scottish Approach to Change’s *Leadership and culture* enabler (psychological safety, collaboration, empowerment).
- Learning systems and iterative practice. Scaling deep’s long-view, iterative learning supports Scottish Approach to Change’s *Learning system* enabler and the use of rapid feedback loops and reflective practice.
- Process rigour with meaning. While critiquing narrow metrics, the report advocates appropriate evaluation for relational work-compatible with Scottish Approach to Change’s *Process rigour* (measurement, triangulation, proportionate governance).
- Narrative and vision. Reframing success and shifting narratives in scaling deep reinforce Scottish Approach to Change’s *Clear vision and purpose*-anchoring decisions and aligning change to shared purpose.
- From conditions to spread. Scaling deep prepares the human and cultural conditions that make Scottish Approach to Change’s *Steps of change* (prototype/test → implement → embed → review for spread) more likely to sustain and scale effectively.

NHS England (2025) - Draft Management and Leadership Framework

Link: [Draft Management and Leadership Framework](#)

Summary

NHS England’s draft *Management and Leadership Framework* sets out a national code of practice and staged standards/competencies (from “Fundamental” to “Executive”) to professionalise management across the NHS. The code is anchored in six principles-Accountability, Collaboration, Compassion, Curiosity, Inclusion and Integrity-and the standards span three domains: *Self-Effectiveness*, *Managing People and Resources*, and *Delivering Across Health and Care*. The framework aims to close long-noted gaps from the Messenger (2022) and Kark (2019) reviews by creating consistent expectations, aligning development and appraisal, and strengthening

performance, financial stewardship, improvement and innovation. Roll-out is tied to the 10-Year Health Plan, with socialisation from Autumn 2025 and digital self-assessment tools expected in early 2026.

Key arguments and findings

- A national, values-based code of practice for all NHS managers/leaders emphasises accountability, inclusion, compassion, collaboration, curiosity and integrity.
- Staged competency model (Fundamental → Executive) with nine standards across three domains defines what “good” looks like at each level and provides clear progression pathways.
- Consistency and accountability: the standards create a single benchmark for performance, financial balance, governance and improvement, assessed through aligned appraisals and supported by quality-assured learning.
- Implementation roadmap: finalisation and launch in 2025 with self-assessment/360 tools in 2026, integrated with NHS leadership development offers and the 10-Year Health Plan.
- Purpose and policy fit: designed to respond to Messenger/Kark and to elevate management as a recognised professional discipline across the NHS.

Where it supports the Scottish Approach to Change

- People-led change: The code’s *Inclusion, Compassion* and *Collaboration* principles (speak-up culture, co-production, belonging) reinforce Scottish Approach to Change’s people-led enabler and its emphasis on trauma-informed, rights-based engagement to reduce inequalities.
- Process rigour: Standards on performance management, governance, compliance, use of data/evidence and resource stewardship mirror Scottish Approach to Change’s process rigour, including measurement, evaluation, commissioning and proportionate project management.
- Leadership and culture: Explicit behaviours-visible, compassionate, psychologically safe leadership with integrity-align to Scottish Approach to Change’s leadership capabilities and culture for change.
- Learning system: The framework embeds curiosity, reflective practice and continuing professional development, echoing Scottish Approach to Change’s learning systems (rapid feedback loops, sense-making, knowledge mobilisation).
- Clear vision and purpose: Competencies that set/translate strategy and provide clear purpose and deliverables support Scottish Approach to Change’s “Clear vision and purpose” enabler.
- Change cycle fit: Competencies on leading improvement/innovation, supporting others through change and sustaining performance complement Scottish Approach to Change’s

eight steps (from *Identify/Understand* through *Prototype and Test, Define and Implement, and Embed and Sustain* to *Review for Spread*).

Bryan Jones, Tim Horton and Joe Home (2022) - *Strengthening NHS management and leadership: Priorities for reform*

Link: [Strengthening NHS management and leadership | The Health Foundation](#)

Summary

The Health Foundation’s briefing argues that good management is essential to high-quality, efficient NHS care, yet has been undervalued relative to “leadership.” It recommends reducing reporting burdens and “priority thickets,” creating clearer goals, and giving managers time and licence to move from firefighting to proactive improvement. It calls for consistent standards and capability pathways (avoiding “personality-led” management), better access to accredited development, and skills that fit today’s networked, data-driven, improvement-focused NHS—especially collaborative system leadership, performance measurement and QI. Stable, respectful, learning-oriented cultures are highlighted as critical, alongside parity for clinical and non-clinical managers. Overall, the paper urges a sustained, system-level effort to professionalise management and spread good practice.

Key arguments and findings

- Management matters for outcomes and productivity; effective management underpins high-performing, “well-led” providers.
- Reduce burdens and clarify purpose: cut upward reporting and focus on a small number of aligned quality goals so managers can add real value.
- Professionalise management: adopt consistent standards, role clarity and competency frameworks to avoid “personality-led” approaches.
- Invest in capability: expand access to accredited training and structured development for both clinical and non-clinical managers.
- Build the skills mix the NHS needs now: collaborative system leadership, data/measurement, quality improvement and technology implementation.
- Enable inclusive, learning cultures: stable leadership, respectful cultures and time for reflection are prerequisites for improvement.

Where it supports the Scottish Approach to Change

- Clear vision and purpose - HF’s call to replace “priority thickets” with a few overarching, aligned goals mirrors Scottish Approach to Change’s emphasis on a shared vision and strategy guiding decisions and trade-offs.

- Process rigour and proportionate governance - HF urges consistent standards, role clarity, and feasible workloads; Scottish Approach to Change 's *Process rigour* enabler specifies governance that creates momentum, systematic measurement/monitoring, and disciplined project management.
- People-led change and inclusive culture - HF highlights respectful, inclusive cultures where change is shaped by frontline teams; Scottish Approach to Change 's *People-led* enabler requires dignified engagement, co-design, and trauma-informed, inequality-reducing practice.
- Learning systems and reflective practice - HF stresses time/"air cover" for reflection and learning; Scottish Approach to Change sets out *Learning system* components-iterative testing, feedback loops, and psychological safety-to turn knowledge into action.
- Leadership and culture - HF advocates stable, collaborative leadership and parity of esteem for managers; Scottish Approach to Change details leadership behaviours (compassion, empowerment, systems thinking) and executive roles in creating conditions for change.
- Improvement methods and testing - HF prioritises QI capability and data-driven improvement; Scottish Approach to Change operationalises this via the eight *Steps of change* (e.g., *Prototype and test*, PDSA) and ongoing measurement for implementation, spread and sustainment.

Sharon Nash (2026) - *Creating the conditions where care can thrive: four actions for clinical leaders*

Link: [Creating The Conditions Where Care Can Thrive: Four Actions For Clinical Leaders | The King's Fund](#)

Summary

The King's Fund blog (Sharon Nash, 13 Feb 2026) argues that staff burnout stems from "high responsibility, low control," compounded by decade-old deficits in the basics of safe, humane work (places to rest, eat, and connect) and by moral injury when people can't deliver the care they were trained to give. It reframes wellbeing as organisational accountability (not individual resilience) and positions engagement as the antidote to burnout, with leadership pivotal to restoring agency and trust. Four practical actions follow: protect the basics; measure what matters (including professional fulfilment via light pulse surveys); make leadership a lived practice (psychological safety, debriefs, protected time); and build a radical, relational, cross-sector movement. The aim is to restore control, fairness and community so that care-and carers-can thrive.

Key arguments and findings

- Burnout is driven by high responsibility with low control; gaps in basic infrastructure and safety contribute to moral injury.

- Engagement (not “more activity”) is the opposite of burnout; leadership must listen, hold uncertainty and repair trust.
- Move beyond a metrics-only mindset: include professional fulfilment and co-produce changes with those affected.
- Wellbeing is a cross-sector challenge; learn from VCSE partners’ relational and restorative approaches.
- Four actions: protect basics, measure what matters, make leadership a lived practice, build a relational movement.

Where it supports the Scottish Approach to Change (Scottish Approach to Change)

- Protect the basics → Leadership and culture; human rights. Calls to create safe, restorative spaces align with Scottish Approach to Change’s enabler on *leadership and culture* (“create the conditions for change to thrive”) and *embedding human rights* (services must be available, accessible, acceptable, high-quality).
- Measure what matters → Process rigour and learning systems. The blog’s light-touch pulse surveys and focus on professional fulfilment mirror Scottish Approach to Change’s emphasis on *measurement, monitoring and evaluation* (use qualitative/quantitative data, triangulate, present clearly) and *learning systems* (reflection, rapid feedback loops).
- Leadership as lived practice → Leaders in change and psychological safety. Investing in leaders who listen and steward values supports Scottish Approach to Change’s *leaders in change* behaviours (presence, compassion, collaboration) and the learning system’s requirement for trust and psychological safety.
- Radical, relational movement → People-led, cross-sector work, commissioning. Cross-sector wellbeing coalitions echo Scottish Approach to Change’s *people-led* approach, multi-disciplinary teamwork, ethical commissioning, and the use of *system stewards/learning partners* and communities of practice to spread change.
- Restore agency/control → Change mindset and distributed leadership. The blog’s focus on agency aligns with Scottish Approach to Change’s *change mindset* (identify champions, start with willing workers) and distributive leadership to empower people closest to the work.

People-led Change, Co-production and Relational Practice

Summary

Middlemiss et al. (2024) - *Implementing midwifery continuity of carer (MCoC)* - Narrative analysis using CFIR

[Link: *Barriers and facilitators when implementing midwifery continuity of carer: a narrative analysis of the international literature* - PMC](#)

Summary

This narrative synthesis reviews international evidence on implementing midwifery continuity of carer (MCoC) and maps barriers and facilitators using the Consolidated Framework for Implementation Research (CFIR). The authors find the implementation literature to be patchy and often uncritical of the impetus for change, with inconsistent definitions of MCoC and limited attention to political and structural context. Practical issues-especially on-call arrangements, workforce deployment, and alignment with midwifery professional values-are frequently under-examined. The paper calls for more contextual, systematic evidence to inform implementation and cautions against transferring decontextualised findings across settings. Overall, successful implementation requires organisational support, clarity about the innovation, and rigorous evaluation tied to the local context.

Key arguments and findings

- Evidence base and definitions: Research on MCoC implementation is fragmented, with variable terminology and insufficiently critical use of effectiveness evidence when justifying rollout.
- Context matters: Political, structural and service-level contexts are often overlooked, undermining the transferability of findings across systems.
- Workforce design is pivotal: On-call models, case loading/team size, and role clarity are central determinants of feasibility and sustainability, yet are underspecified in much of the literature.
- Professional values and engagement: Alignment with midwifery ethos (relational, woman-centred care) is a key facilitator but requires realistic organisational support.
- Call for better implementation science: The authors advocate for contextualised evaluation and careful generalisation across settings.

Where this supports the Scottish Approach to Change

- Clear vision and purpose → scrutinise the ‘why’ for change. The paper’s critique that the *impetus for change is not critically examined* reinforces Scottish Approach to Change’s requirement to articulate a clear, shared purpose and strategy that guides decisions and trade-offs.
- Process rigour → robust governance, measurement, and evaluation. The call for *systematic, contextual evidence* aligns with Scottish Approach to Change’s emphasis on triangulating data, choosing meaningful comparators/timeframes, and embedding project management and governance to drive learning-led decisions.
- People-led → align with professional values and lived experience. The finding that alignment with midwifery values facilitates adoption fits Scottish Approach to Change’s people-led enabler and its guidance to co-design changes with those who deliver and use services.
- Leadership and culture → create organisational ‘space’ for change. Implementation depends on organisational support, role clarity, and psychological safety-core elements of Scottish Approach to Change’s leadership and culture enabler.
- Learning system → continuous, contextual improvement. The recommendation to avoid decontextualised transfer and to build local evidence mirrors Scottish Approach to Change’s learning system (iterative testing, reflection, and feedback loops to inform implementation and spread).
- Steps of change → practical pathway for MCoC roll-out. The article’s focus on workforce/on-call design and staged evaluation maps onto Scottish Approach to Change steps: *Develop and Design* (model options), *Prototype and Test* (PDSA), *Review for Implementation*, and *Embed and Sustain* before considering *Review for Spread*.

Kirst M et al (2017) - *What works in implementation of integrated care programs for older adults with complex needs? A realist review.*

[Link: *What works in implementation of integrated care programs for older adults with complex needs? A realist review - PMC*](#)

Summary

This realist review synthesised 65 evaluative studies of 28 integrated care (IC) programmes for older adults with complex needs to explain what drives successful implementation. Two recurring context-mechanism-outcome (CMO) patterns emerged: (1) trusting, multidisciplinary team relationships that enable effective coordination and continuity; and (2) provider commitment to and understanding of the model, which sustains fidelity and problem-solving in practice. Success was further enabled by strong leadership with clear goals and a supportive culture, joint governance structures, time to build implementation infrastructure, and flexibility to adapt to

local context. These conditions helped programmes achieve outcomes such as reduced acute utilisation and better patient/caregiver experience.

Key arguments and findings

- IC models for complex older adults typically include single-entry access, care coordination, multidisciplinary teams, self-management support, smooth transitions, and effective information management.
- Two core CMOs underpin success: trusting multidisciplinary relationships, and provider commitment/understanding of the model.
- Contextual enablers: visible leadership that sets clear goals and culture; joint governance; adequate time and infrastructure; implementation flexibility.
- These conditions are associated with reduced emergency visits/hospitalisations and improved patient and caregiver experience.

Where it supports the Scottish Approach to Change

- Leadership and culture - The review's emphasis on strong leadership, goal clarity and supportive organisational culture directly aligns with SAC's *Leadership and culture* enabler.
- Clear vision and purpose - Setting clear programme goals is repeatedly linked to successful implementation, echoing SAC's call for an explicit vision/purpose to guide choices and trade-offs.
- People-led - IC models incorporate self-management support and aim to improve patient/caregiver experience, reinforcing SAC's *People-led* principle.
- Process rigour - Joint governance, structured coordination and information management mirror SAC's *Process rigour* (governance, project management, measurement) to deliver reliable change.
- Learning system - The need for time to build infrastructure and flexibility in implementation resonates with SAC's Learning system-iterative testing, reflective practice and adaptation.

Scholl I, LaRussa A, Hahlweg P, Kobrin S, Elwyn G. (2018) - *Organizational- and system-level characteristics that influence implementation of shared decision-making and strategies to address them - a scoping review.*

[Link: Organizational- and system-level characteristics that influence implementation of shared decision-making and strategies to address them - a scoping review - PMC](#)

Summary

This scoping review synthesised 48 publications covering 32 implementation projects to examine why shared decision-making (SDM) remains difficult to embed in routine care. It finds that organisational factors, such as leadership commitment, culture, resources, priorities, team dynamics and workflows strongly condition SDM uptake. System-level levers such as policy, clinical guidelines, incentives, education and licensing also shape adoption yet are inconsistently aligned to SDM. The authors catalogue practical strategies (e.g., integrating decision aids in distribution systems, adapting workflows, aligning incentives) aimed at these determinants. Overall, the review concludes that SDM implementation is understudied at organisational/system levels and calls for context-sensitive, multi-level change strategies rather than relying solely on clinician-patient training or tools.

Key arguments and findings

- SDM adoption hinges on organisational leadership, culture, priorities, resources, teams and workflows.
- System enablers-policy, guidelines, incentives, education, licensing-must align with SDM for durable uptake.
- Published strategies target these determinants (e.g., embedding decision-aid distribution, workflow redesign, incentive alignment).
- There is a gap in evidence on organisational/system-level implementation of SDM; future work should use tailored, multi-level approaches.

Where it supports the Scottish Approach to Change

- Leadership and culture (Scottish Approach to Change enabler): The review highlights leadership commitment and organisational culture as pivotal, directly reinforcing Scottish Approach to Change 's emphasis on creating conditions where change can thrive.
- People-led change: SDM is inherently people-led, requiring meaningful involvement of people who use services; this aligns with Scottish Approach to Change 's call to co-design and engage lived/living experience.
- Process rigour (governance, project management, measurement): The authors point to workflow integration, resource planning and incentive alignment-mirroring Scottish Approach to Change 's process rigour, governance and project-management disciplines across the steps of change.

- Clear vision and purpose: The need to align organisational priorities and system incentives with SDM echoes Scottish Approach to Change 's focus on a shared vision/purpose that guides choices and trade-offs.
- Learning system: The review's call for continued evaluation and adaptation is consistent with Scottish Approach to Change 's learning systems-using qualitative and quantitative insights to refine and spread what works.
- Steps of change (design → test → implement → sustain → spread): Practical strategies (e.g., integrating decision aids, adjusting workflows) map onto Scottish Approach to Change 's structured cycle from Develop and Design to Prototype and Test, Define and Implement, and Embed and Sustain.

Andy Brooks, Luca Tiratelli, Beccy Baird, Kristina Bergman, King's Fund (2022) - *How to make change happen in general practice*

Link: [How to make change happen in general practice](#)

Summary

This King's Fund resource distils evidence on how change sticks in general practice into four principles: (1) change works best when it's bottom-up; (2) financial incentives/targets can shift activity but don't necessarily improve outcomes and may distort priorities; (3) the "soft stuff" (culture, relationships, trust, peer support) is critical; and (4) people need capacity and capability-time, skills, data, and supportive leadership-to deliver change. It translates these into practical implications for practices and ICSs: co-design metrics locally, use a "with not to" approach, avoid over-targeting, invest in leadership development, and provide flexible improvement support (e.g., analytics, OD, estates). Overall, it urges ICSs and practices to privilege culture, engagement and learning over purely contractual levers if they want sustainable improvement.

Key arguments and findings

- Bottom-up change outperforms top-down mandates; imposing change risks disengagement and failure.
- Targets and pay-for-performance shift behaviour but can create perverse effects and don't reliably improve quality or outcomes.
- Culture, relationships and peer networks matter as much as formal structures; invest in local leadership and psychological safety.
- Build capacity and capability (time, skills, analytics, HR/digital support) and "ready" stakeholders to enable change.

Where it supports the Scottish Approach to Change

- Bottom-up, people-powered change → Scottish Approach to Change “People-led” - King’s Fund’s call for locally owned, bottom-up improvement directly aligns with Scottish Approach to Change’s people-led enabler-co-designing with people who need, use, deliver and enable services to ensure compassionate, relevant and sustainable change.
- Beware blunt targets → Scottish Approach to Change “Process rigour” and “Clear vision and purpose”
The caution that incentives/targets can distort priorities echoes Scottish Approach to Change’s emphasis on rigorous, proportionate processes anchored in a clear vision, triangulated evidence, and meaningful measures-avoiding activity for its own sake.
- Culture and relationships → Scottish Approach to Change “Leadership and culture” - Prioritising psychological safety, trust and distributed leadership mirrors Scottish Approach to Change’s call for leaders who remove barriers, empower others, and foster compassionate, collaborative cultures across organisational boundaries.
- Build capability and learning → Scottish Approach to Change “Learning system” and “Process rigour”
Investing in skills, data, and supportive infrastructure supports Scottish Approach to Change’s learning systems (iterative testing, feedback loops, knowledge mobilisation) and process rigour (project management, governance, evaluation).
- Practical delivery pathway → Scottish Approach to Change “Eight steps of change”
The report’s practical advice to co-design metrics, test and adapt, and plan implementation complements Scottish Approach to Change’s end-to-end steps (identify → understand → develop/design → prototype/test → review → implement → embed/sustain → review for spread).

Care Quality Commission (2021) - *Enabling innovation and adoption in health and social care: Developing a shared view*

Link: [Enabling innovation and adoption in health and social care](#)

Summary

The CQC’s *Enabling innovation and adoption in health and social care: Developing a shared view* sets out six evidence-based principles to help providers innovate responsibly and spread what works. It emphasises co-production with people, building innovation-friendly cultures, developing staff capability, adopting and sharing proven ideas, focusing on outcomes and equity, and managing change flexibly. The report argues the system often overvalues invention and underinvests in adoption, and that context-sensitive implementation and evaluation are essential. Developed with national partners (AAC, NICE, NHSX and others), it signals regulators’ commitment to apply these principles and build capacity for adoption.

Key arguments and findings from the CQC report

- Six provider principles: co-design with users; cultivate an innovation culture; support and train staff; adopt proven ideas and share learning; focus on outcomes/inequalities; manage change flexibly.
- Adoption matters as much as invention: England underuses proven innovations; success requires adapting to local context rather than expecting “out-of-the-box” transfer.
- People and equity first: involve service users early; consider groups at risk of exclusion to avoid widening inequalities.
- Leadership and culture enable innovation: permission to test/learn, psychological safety, and proportionate governance are critical.
- Measurement and learning: specify realistic goals; measure impact to guide decisions and communicate benefits; share learning across networks.
- System commitment: national bodies (e.g., AAC, CQC) will apply the principles to build adoption capacity.

Where the CQC principles support-and are supported by-the Scottish Approach to Change

- Co-design with people ↔ People-led enabler: CQC’s call to *develop and deploy innovations with the people who will use them* aligns with Scottish Approach to Change’s people-led approach, meaningfully engaging people (including trauma-informed practice), reducing inequalities, and embedding human rights.
- Innovation culture ↔ Leadership and culture enabler: Both emphasise leaders creating psychologically safe spaces, enabling experimentation, and modelling values-led behaviour to make change possible.
- Support your people ↔ Capability, roles and education: CQC’s focus on training, champions and super-users mirrors Scottish Approach to Change’s emphasis on multidisciplinary change teams, leadership capabilities, and structured education pathways (QI, service design, strategic planning).
- Adopt and share learning ↔ Learning system and Review for spread: CQC’s advocacy for adopting best ideas and sharing learning is operationalised in Scottish Approach to Change through learning systems, communities of practice, and explicit *review for spread* steps.
- Focus on outcomes/impact ↔ Process rigour, measurement and equity: Both require clear aims, robust measurement/triangulation, ongoing evaluation, and equality impact assessment to ensure benefits and avoid unintended harm.
- Flexible change management ↔ Iterative steps and PDSA: CQC’s flexibility principle aligns with Scottish Approach to Change’s iterative *prototype and test* using PDSA cycles, revisiting steps as needed, and structured implementation/embedding for sustainability.

Chris Fox, Hannah Hesselgreaves, Sarah Cooke, Nick Davies, Alex Fox, Stuart Hoddinott, Matthew Horne, Bob Klaber, Ashwin Kumar, Andrew Laird, Toby Lowe, Matthew Kálmán Mezey, Dawn Plimmer, Mark Smith, Stephen Taylor (2025) - *Policy Priorities to Support Relational Public Services*

Link: [Relational Public Services Policy](#)

Summary

This policy briefing argues that UK public services face a systemic crisis (rising “failure demand”, workforce burnout, poor outcomes) that cannot be solved by narrow productivity drives or tech-first reforms alone. Instead, it proposes scaling *relational public services*-ways of organising work that prioritise trust, continuity, flexibility and collaborative learning between citizens, practitioners and institutions (e.g., Human Learning Systems / Liberated Method). It contends the government’s current focus on AI and efficiency risks repeating New Public Management failures. To mainstream relational practice, it recommends three priorities: (1) shift funding to preventative, devolved models; (2) align regulators around learning (not compliance); and (3) reform the workforce to enable relational practice at scale.

Key arguments and findings

- Diagnosis: Decades of underinvestment and complex need have generated unsustainable *failure demand*, low trust and poor outcomes across health, social care, justice and education.
- Limits of tech-led reform: AI/efficiency programmes can help, but won’t change how services are managed or designed; a tech-first, target-driven approach risks repeating NPM-era fragmentation.
- What “relational” means: Redesign frontline work and leadership so relationships, discretion, continuity and local learning drive decisions-demonstrated in HLS and related initiatives with reduced failure demand, better outcomes and staff morale.
- Policy agenda (3 priorities):
 1. Funding: embed preventative, devolved, long-term funding;
 2. Regulation: coordinate inspectorates around learning/innovation;
 3. Workforce: develop roles, skills and conditions for relational practice.

Where it supports the Scottish Approach to Change

- People-led change: The briefing’s core premise-design with and around people-directly echoes Scottish Approach to Change’s *People-led* enabler and emphasis on co-design and engagement to make change compassionate, relevant and sustainable.

- Learning systems: Calling for regulators and systems that prioritise *learning over compliance* aligns with Scottish Approach to Change 's *Learning system* enabler and its use of iterative testing (e.g., PDSA), reflective practice and rapid feedback loops.
- Leadership and culture: The need to rebuild trust and enable discretion mirrors Scottish Approach to Change 's *Leadership and culture* enabler-leaders create psychologically safe spaces, remove barriers and enable bottom-up improvement.
- Process rigour (without target gaming): The paper's critique of NPM-style target regimes and its advocacy of structured, locally-adapted learning matches Scottish Approach to Change 's *Process rigour* (governance that creates momentum, meaningful measurement, triangulation of data).
- Clear vision and prevention focus: Its call for preventative, place-based funding and integrated services that support Scottish Approach to Change 's *Clear vision and purpose* and QMS framing (planning for quality, aligning to long-term outcomes and inequalities reduction).

Institute for Public Policy Research (2012) - *The Relational State: How Recognising the Importance of Human Relationships Could Revolutionise the Role of the State.*

Link: [relational-state Nov2012 9888.pdf](#)

Summary

IPPR's *The Relational State* argues that the UK should move beyond New Public Management's reliance on targets and markets and instead organise government to act *with* people, not merely *for* them—placing human relationships at the heart of public services. It proposes decentralisation, frontline discretion, and co-production, with public servants equipped in relational skills and technology used to *support* (not replace) relationships. The volume—anchored by Geoff Mulgan and Marc Stears—sets out practical tools (e.g., redesigning accountability, supporting citizen-to-citizen help) and sector implications in health, education and social care. Overall, it calls for experimentation, learning systems and locally tailored solutions to complex problems where continuity, trust and collaboration matter most.

Key arguments and findings from the IPPR collection

- Critique of NPM: 'Targets and markets' improved some baselines but demoralised staff, constrained innovation, and failed to rebuild trust in government.
- Governing *with* people: Shift from delivery to partnership-co-production, community capacity, and democratic participation in service design and oversight.
- Frontline relationships matter: Complex needs (e.g., chronic conditions, long-term support) require continuity and trusted relationships more than transactional interventions.

- Decentralisation and experimentation: Move decisions closer to place and enable iterative learning; use technology to connect people and professionals while streamlining non-relational tasks.
- Workforce and skills: Revalue professional judgement; train for relational capabilities alongside technical competence.
- Reframed accountability: Balance outcomes with the *quality of relationships* and democratic/relational accountability, not metrics alone.

Where this supports the Scottish Approach to Change

- People-led change/co-design: IPPR’s emphasis on co-production and citizen partnership aligns with Scottish Approach to Change’s *People-led* enabler and guidance to “meaningfully engage people in the design of changes.”
- Leadership and culture that empower the frontline: The call to trust frontline professionals and create safe spaces for innovation mirrors Scottish Approach to Change’s *Leadership and culture* enabler (e.g., empowering, compassionate, psychologically safe leadership).
- Learning systems and iterative improvement: IPPR’s push for experimentation and decentralised learning complements Scottish Approach to Change’s *Learning system* enabler and use of PDSA cycles and reflective practice to adapt in real time.
- Process rigour used proportionately: IPPR critiques command-and-control; Scottish Approach to Change operationalises proportionate *process rigour* via the eight *Steps of change* (Identify → Review for spread), governance, and measurement that enable, rather than stifle, relational practice.
- Place-based, locally driven solutions: Decentralisation in IPPR matches Scottish Approach to Change’s commissioning guidance to develop locally tailored responses and build markets that fit local need.
- Equity and human rights by design: The relational focus on dignity and inclusion is consistent with Scottish Approach to Change’s explicit commitments to reducing inequalities and embedding human rights in change.

Mark Smith, Hannah Hesselgreaves, Ron Charlton and Rob Wilson (2025) - *New development: The ‘liberated method’-a transcendent public service innovation in polycrisis*

Link: [*New development: The ‘liberated method’-a transcendent public service innovation in polycrisis*](#)

Summary

This Public Money and Management piece introduces the ‘liberated method’ (LM)-a relational, “bespoke-by-default” approach to public service innovation designed for polycrisis contexts.

Rather than fitting people into pre-existing pathways, LM starts from *what matters* in citizens' lives, couples high support with high challenge, uses small caseloads and discretionary budgets, and embeds continuous evaluation and learning. The authors argue LM transcends transactional, technocratic logics by privileging relationships, iterative testing, and development of intrinsic agency. Early evidence (e.g., case histories mapping life outcomes and historic service use/costs) suggests LM can improve outcomes, reduce demand on services, and generate public value, while providing managers with data to steer reform.

Key arguments and findings

- Problem framing: Complex needs are poorly served by siloed, specialist, referral-driven systems; outcomes are *emergent* and require approaches grounded in people's lived contexts.
- Design principles: LM is *bespoke by default*, privileging relationships over standardised protocols; practitioners operate under three rules and five principles, maintain low caseloads, and can say "just yes" to mobilise support rapidly.
- Practice model: High support-high challenge activates personal agency; casework is wrapped in a learning programme (journals, supervision, case reviews), enabling *planned emergence*.
- Value and impact: Mixed qualitative stories and quantitative time-series on service consumption (e.g., a "burning platform" trajectory) indicate improved life outcomes and potential falls in demand/costs.

Where the article supports the Scottish Approach to Change

1) People-led enabler

- LM begins with *what matters* to the person and co-designs support around lived experience-directly mirroring Scottish Approach to Change 's people-led emphasis on engaging people, families and carers to co-design change that is compassionate, relevant and sustainable.

2) Clear vision and purpose

- LM's insistence on agreeing a shared purpose in each case (not "what works" but *what matters*) reflects Scottish Approach to Change 's call for a clear vision/purpose that anchors decisions and tough trade-offs throughout change.

3) Process rigour (without bureaucracy)

- Although LM rejects rigid pathways, it brings rigour through embedded evaluative practice (measurement of outcomes, triangulating narratives with utilisation/cost data). Scottish Approach to Change explicitly frames process rigour as systematic and proportionate-*not valuing process over people*-and stresses curiosity with data, trend detection and triangulation. LM exemplifies this stance.

4) Leadership and culture

- LM depends on permissioning, discretion and trust-based cultures (akin to street-level empowerment) so practitioners can say “yes”, remove barriers and iterate. Scottish Approach to Change highlights leadership that empowers, collaborates, builds psychological safety and enables bottom-up change.

5) Learning system

- LM institutionalises ongoing reflective practice (journals, supervision, case reviews) and rapid feedback to adapt rules/principles-an example of planned emergence. Scottish Approach to Change’s learning system enabler calls for measurement-informed reflection, spaces to sense-make, and mechanisms to put knowledge into action.

Alignment with Scottish Approach to Change “Steps of change”

- Develop and design → Prototype and test: LM iterates ideas in practice with continuous PDSA-style cycles and sense-making.
- Review for implementation → Define and implement: LM uses evaluative evidence (life outcomes, service-use trajectories) to decide adoption/adaptation and to define scalable practices.
- Embed and sustain → Review for spread: LM’s principles and data model support sustaining approaches and assessing spread to new contexts-consistent with Scottish Approach to Change’s sustain/spread steps and emphasis on context-fit.

Matthew Horne, Halima Khan and Paul Corrigan (2013) - *People Powered Health: Health For People, By People and With People*

Link: [People-Powered-Health-2013.pdf](#)

Summary

The report argues for a system shift from care *for* people to care *by and with* people, combining clinical expertise with patient assets, peer support and community resources. It proposes three changes: (1) redefined consultations that embed shared decisions and self-management; (2) “more than medicine” services such as social prescribing, peer support and timebanking; and (3) co-designed pathways spanning health, social care and the voluntary sector. Evidence cited includes potential 7% cost savings (≈£4.4bn/year in England) through reduced AandE attendances and admissions. Delivery requires changes in commissioning, measurement, incentives, leadership, workforce culture and technology, and the development of system leadership to spread proven models.

Key arguments and findings

- Paradigm shift: Move from transactional care to co-produced care that treats patients and communities as partners and assets.
- Three practical pillars: Redefine consultations; commission “more than medicine” offers (e.g., social prescribing, peer support, timebanks); co-design integrated pathways.
- Compelling value case: Robust evidence indicates ~7% savings nationally by reducing avoidable utilisation; broader evaluations suggest higher potential.
- System enablers: Success hinges on reforming commissioning, what gets measured, financial incentives, clinical/system leadership, culture and tech.

Where it supports the Scottish Approach to Change

- People-led change: PPH’s co-design, peer support and community assets echo Scottish Approach to Change’s *People-led* enabler (meaningful engagement, equity, trauma-informed practice).
- Clear vision and purpose: PPH sets a clear vision-partnership of equals and better long-term outcomes-which aligns with Scottish Approach to Change’s emphasis on vision/purpose guiding choices.
- Process rigour and measurement: PPH calls to change what gets measured and redesign incentives; Scottish Approach to Change operationalises this through structured measurement/monitoring/evaluation and project management discipline.
- Leadership and culture: PPH highlights clinical/system leadership and workforce culture change; Scottish Approach to Change details the leadership behaviours, roles and culture needed for safe experimentation and learning.
- Learning and spread: PPH focuses on scaling proven innovations by tackling barriers; Scottish Approach to Change provides a Learning System and explicit review for spread step to mobilise and generalise learning.
- Commissioning for outcomes: PPH’s call to reform commissioning to fund “more than medicine” aligns with Scottish Approach to Change’s *Process rigour* and tools (e.g., ethical commissioning, options appraisal) to embed community-based solutions.
- Structured change pathway: While PPH is principle-led, its recommendations map onto Scottish Approach to Change’s Steps of Change (develop/design; prototype/test; define/implement; review for spread), providing a delivery scaffold for PPH models.

Adam Lent and Jessica Studdert (2021) - *The Community Paradigm: Why public services need radical change and how it can be achieved*

Link: [The-Community-Paradigm New-Local-2.pdf](#)

Summary

The Community Paradigm argues for a structural shift in UK public services from hierarchical (“state”) and transactional (“market”) models to a community-powered model in which people share power, resources and responsibility with public institutions. To meet rising, complex demand and enable prevention, New Local proposes unconditional devolution, participatory/deliberative decision-making, community commissioning, and collaborative, asset-based practice. The 2021 preface highlights COVID-19 lessons: places that enabled mutual aid and local public health responses outperformed top-down or outsourced solutions (e.g., national test-and-trace), underscoring that national ambitions depend on diverse, locally-embedded action. Real change, they argue, requires organisational culture change, shifting both macro and micro decisions toward communities and transferring money, assets, and governance roles to them.

Key arguments and findings

- Public services face unsustainable rising demand; legacy paradigms trap services in short-term, acute responses rather than prevention. A community paradigm is needed to mobilise local assets and agency.
- Five routes to embed community power: culture change; macro decision-making (citizens’ assemblies, deliberation); micro decision-making (relational/strengths-based practice); transfer of money/assets; and community governance.
- Policy proposals: unconditional devolution; participatory and deliberative democracy; collaborative delivery; and community commissioning that shares or hands commissioning power to communities.
- COVID-19 evidence: locally enabled mutual aid and council-community collaboration outperformed centralised or marketised responses (e.g., outsourced test and trace), while vaccination relied on community engagement.
- Core principle: “with power comes responsibility”-prevention requires enabling communities to exercise power alongside public services.

Where it supports the Scottish Approach to Change

- People-led design: New Local’s micro-decision focus (co-production, asset-based practice) aligns with Scottish Approach to Change’s *People-led* enabler-placing people, families and carers as partners in designing and delivering change.
- Leadership and culture: Both stress shifting organisational mindsets from paternalistic/transactional to collaborative, trusting cultures that empower frontline teams and communities.

- Clear vision and prevention: The paradigm’s prevention-first rationale complements Scottish Approach to Change ’s emphasis on clear vision and purpose to steer difficult choices and anchor implementation.
- Process rigour with learning: New Local calls for structured collaboration and community governance; Scottish Approach to Change operationalises this via eight steps of change (identify → spread), project management, and measurement, monitoring and evaluation with PDSA testing.
- Community commissioning: New Local’s recommendation to share or transfer commissioning power mirrors Scottish Approach to Change guidance on ethical commissioning and tailoring to local context and need.
- Learning systems: The report’s call for devolved, iterative practice aligns with Scottish Approach to Change ’s Learning System enabler-continuous reflection, data + stories, and feedback loops to adapt change.
- Equity and access through local insight: COVID lessons on community engagement for vaccine uptake back Scottish Approach to Change ’s focus on reducing inequalities and embedding human rights by designing for different population groups and contexts.

Rob Wilson, Max French, Hannah Hesselgreaves, Toby Lowe and Mark Smith (2024) - *New development: Relational public services-reform and research agenda*

Link: [*New development: Relational public services-reform and research agenda*](#)

Summary

Wilson et al. propose a relational public services reform and research agenda to overcome the lingering, “zombified” legacy of New Public Management’s transactionalism. They synthesise practice narratives (e.g., Human Learning Systems, Relational State, Radical Help) and argue for investing in relational infrastructure, scaling change appropriately, balancing specialism and generalism, and pursuing improvement via engaged, learning-oriented research. Crucially, they call for rethinking measurement and evaluation beyond technocratic “trust in numbers,” and for academia to co-produce change with practitioners rather than merely observing it. The paper contends that UK reform has lacked a coherent strategy since 2011, leaving change agents to drive bottom-up, relationship-centred approaches better suited to complex social challenges.

Key arguments and findings

- NPM’s transactional mindset persists, mutating and constraining reform; a relational paradigm centred on trust, deliberation and co-creation is needed.
- Practice narratives converge on relationality (e.g., Community Paradigm, Enabling State, Human Learning Systems), prioritising strengths-based, preventative, place-based work.

- Agenda for action: invest in relational infrastructure; scale change appropriately; balance generalist-specialist roles; use engaged research to drive learning and improvement.
- Measurement must evolve beyond narrow performance regimes-moving from “trust in numbers” to learning systems that support judgement, adaptation and equity.
- Academia’s role should be active and prospective-co-producing reform with practitioners rather than passively classifying it.

Where it supports the Scottish Approach to Change

- People-led change: The paper’s call for co-creation and citizen-state partnership strongly aligns with Scottish Approach to Change ’s “People-led” enabler and guidance on meaningful engagement and trauma-informed practice.
- Learning systems over compliance: Its emphasis on engaged research and continuous learning mirrors Scottish Approach to Change ’s Learning system enabler and use of iterative testing (e.g., PDSA) to inform action.
- Re-shaping measurement: The critique of technocratic metrics supports Scottish Approach to Change ’s Measurement, monitoring and evaluation approach-triangulating qualitative and quantitative data for sense-making, not just assurance.
- Leadership and culture: The relational turn requires leaders who build trust, enable distributed leadership and steward learning-core to Scottish Approach to Change ’s Leadership and culture enabler.
- Appropriate scaling and spread: The article’s call to “scale appropriately” aligns with Scottish Approach to Change ’s staged Steps of change, especially Review for spread and context-sensitive adoption.
- Multi-disciplinary capability: Balancing specialism and generalism reinforces Scottish Approach to Change ’s guidance on who you need around you and assembling multi-disciplinary change teams.
- Infrastructure and commissioning: Investing in relational infrastructure complements Scottish Approach to Change ’s focus on process rigour, governance, and ethical commissioning to enable people-centred, system-wide change.
- Prevention and inequalities: The paper’s practitioner narratives prioritise strengths-based, preventative approaches-consistent with Scottish Approach to Change ’s explicit emphasis on reducing inequalities and embedding human rights.

Mark Smith, Hannah Hesselgreaves, Ron Charlton and Rob Wilson (2025) - *New development: The 'liberated method'-a transcendent public service innovation in polycrisis*

[Link: *New development: The 'liberated method'-a transcendent public service innovation in polycrisis*](#)

Summary

This Public Money and Management article introduces the Liberated Method (LM)-a relational, “bespoke-by-default” approach to public service innovation designed for the complexity of polycrisis. Instead of fitting people into existing pathways, LM starts from *what matters* to the person, uses small caseloads, discretionary budgets, and three rules/five principles to enable high-support/high-challenge practice. It reframes orthodoxies (e.g., from specialist referrals to generalists who hold relationships; from default “no” to “just yes”) and embeds evaluative routines (case reviews, supervision, journaling) to drive *planned emergence*. Illustrative data include a client with 3,000+ service interactions and >£2m historic consumption, with LM redirecting trajectories by activating intrinsic agency and reducing demand. The authors argue LM demonstrates public value by coupling life-outcome change with measurable financial impacts.

Key arguments and findings

- Relational over transactional: Services should organise around relationships and context, not standardised pathways, to address complexity.
- Bespoke-by-default design: Generalists *hold the relationship*, pull in specialist input as needed, and default to permissioning (“just yes”).
- Three rules/five principles and small caseloads enable safe discretion, rapid response, and consistent practice without rigid protocols.
- Embedded learning (case reviews, supervision, practitioner journals) creates *planned emergence*-iterative adaptation informed by evidence.
- Public value evidenced: Coupling narratives with longitudinal data on life outcomes and public finances demonstrates reduced service consumption (e.g., a client with >3,000 interactions and ~£2m historic costs).
- Culture shift required: LM flourishes where leaders legitimise discretion, move from risk-aversion to trust, and prioritise efficacy over efficiency.

Where it supports the Scottish Approach to Change

- People-led: LM begins with *what matters* to people and co-creates support around lived context-directly resonant with Scottish Approach to Change’s people-led enabler (dignity, inclusion, co-design).

- Learning system: LM's embedded evaluation (case reviews, reflective practice, rapid feedback) mirrors Scottish Approach to Change 's learning-system core (measurement, sense-making, psychological safety).
- Process rigour (measurement, monitoring, evaluation): Using life-outcome and cost data to guide decisions aligns with Scottish Approach to Change 's emphasis on triangulation, trend detection, and choosing meaningful measures.
- Leadership and culture: LM's shift from default "no" to "just yes," and empowerment of frontline discretion, supports Scottish Approach to Change 's call for compassionate, enabling leadership and cultures that reduce fear and enable innovation.
- Clear vision and purpose: LM's rule to *agree on purpose* and orient interventions to *what matters* echoes Scottish Approach to Change 's insistence on a shared vision that anchors choices and tough trade-offs.
- Steps of change-iterative testing: LM's *planned emergence* and iterative adaptation are consistent with Scottish Approach to Change 's Prototype and Test, Review for Implementation, Define and Implement, and Embed and Sustain steps.
- Reducing inequalities: By focusing on people with complex, high-need, cross-system use, LM's intent aligns with Scottish Approach to Change 's priority to design for those most at risk and to monitor unintended consequences.

Public Health England (2020) - *Community-centred public health: Taking a whole system approach, Briefing of research findings*

Link: [Community-centred public health: Taking a whole-system approach](#)

Summary

Public Health England's *Community-centred public health: taking a whole system approach* argues for a system-wide shift that puts communities at the heart of public health to reduce persistent health inequalities. It synthesises evidence into 11 practical elements grouped under involving, strengthening, scaling and sustaining, and stresses values of equity, asset-based practice and co-production. The briefing sets out how local authorities, the NHS and VCSE partners can embed community-centred ways of working into strategies, commissioning and everyday practice, with advice on "where to start" and links to supporting resources and practice examples. It builds on prior whole-systems work (e.g., obesity) and is intended as a concise guide for leaders seeking place-based, cross-sector change.

Key arguments and findings

- A radical shift is required: Reducing widening health inequalities needs public health systems that are explicitly community-centred and place-based.

- Four organising headings, 11 elements: Practical components are grouped as involving (e.g., co-production), strengthening (community capacity, VCSE partnerships), scaling (embedding in strategy/commissioning) and sustaining (governance, learning, evaluation).
- Distributed leadership and cross-sector partnership are essential-LA, NHS and VCSE actors must align around shared purpose, resources and measurement.
- Start pragmatic, learn and spread: Provide “where to start” steps, curate resources, and create feedback loops so learning informs mainstream adoption.

Where it supports the Scottish Approach to Change

- People-led change: WSA’s emphasis on co-production and mobilising community assets mirrors Scottish Approach to Change’s *People-led* enabler, which places people, families and carers at the centre of design and delivery.
- Leadership and culture: WSA’s call for distributed leadership across local systems aligns with Scottish Approach to Change’s focus on leadership behaviours that empower, create psychological safety and remove barriers.
- Process rigour: WSA advocates governance, data, and evaluation to embed community-centred practice; Scottish Approach to Change codifies this through the *Process rigour* enabler and measurement guidance.
- Learning systems: WSA’s “sustaining” element highlights continuous learning and networks; Scottish Approach to Change formalises this in its *Learning system* enabler (reflective practice, rapid feedback loops).
- Clear vision and purpose: WSA urges alignment of strategies and commissioning to a shared purpose; Scottish Approach to Change’s *Clear vision and purpose* enabler operationalises this with practical guidance.
- Inequalities focus: Both frameworks make reducing inequities a core aim-WSA frames community-centred action as key to tackling inequalities; Scottish Approach to Change embeds equality, trauma-informed and human-rights principles throughout.
- From pilots to spread: WSA encourages moving from local initiatives to system practice; Scottish Approach to Change provides *Steps of change* (e.g., Review for implementation, Review for spread) to manage that journey.

Deborah Fenney, Loreen Chikwira and Kiran Chauhan (2023) - *Transforming power relationships in partnership working*

Link: [Transforming Power Relationships In Partnership Working | The King's Fund](#)

Summary

This King's Fund long read distils learning from the Healthy Communities Together programme about how to rebalance power in statutory-VCSE partnerships. It frames power as a *relational* property (moving from "power over" to "power with/to") and examines four arenas where imbalances show up and can be changed: partners' role expectations, funding and commissioning, working with communities, and language. Practical moves include building trust through regular reflective practice, resourcing VCSE participation, experimenting with locality commissioning models, and broadening what "counts" as evidence. The authors emphasise that progress is *iterative and contextual*: actions have intended and unintended consequences, so partnerships should test, reflect and adapt together. The piece ends with questions leaders can use to surface assumptions, redesign governance and strengthen shared agency.

Key arguments and findings

- Power is relational, not zero-sum-partnerships should cultivate "power with" by redesigning relationships, rituals and decision rights, rather than trying to "share out" a fixed pie.
- Four leverage points: expectations of roles, funding/commissioning arrangements, ways of working with communities, and the language partners use shape who has a voice and influence.
- Resourcing matters: who holds the budget and who is paid to attend/lead shapes participation; shifting resources (e.g., locality commissioning) can redistribute agency but brings new accountabilities.
- Evidence norms can entrench or rebalance power: partnerships should broaden acceptable data/evidence, recognising VCSE capacity and qualitative insight.
- Relationships and reflection are core methods: routine check-ins, shared reflection journals, and psychologically safe spaces enable honest challenge and learning.
- Expect complexity: interventions have trade-offs; adopt iterative, learning-oriented governance and keep revisiting assumptions.

Where this supports the Scottish Approach to Change

- People-led change/co-design: The long read's focus on working *with* communities and addressing structural inequity echoes Scottish Approach to Change's "People-led" enabler (trauma-informed engagement, inequalities focus, PANEL principles).

- Leadership and culture: Emphasis on trust-building rituals, psychological safety and compassionate challenge aligns with Scottish Approach to Change 's call for leaders who create safe spaces, empower others and model learning behaviours.
- Process rigour and governance: Reframing roles, clarifying decision rights, and scrutinising fund-holding mirror Scottish Approach to Change 's *process rigour* (governance that creates momentum, transparent decision-making, project management discipline).
- Commissioning for change: Locality commissioning and resourcing VCSE participation reinforce Scottish Approach to Change guidance on *ethical commissioning*, market-shaping, and investing in skills/relationships to reduce inequalities.
- Learning systems and reflective practice: The long read's iterative, reflective approach maps to Scottish Approach to Change 's "Learning system" enabler (rapid feedback loops, sense-making networks, capturing lessons).
- Measurement and evidence: Broadening what "counts" as evidence supports Scottish Approach to Change 's triangulation of qualitative and quantitative data, attention to outliers/trends, and proportionate evaluation.
- Clear vision and language: Attention to how language frames purpose and inclusion complements Scottish Approach to Change 's *clear vision and purpose* enabler and its practical guidance on communicating aims and boundaries.

Online Resource - *Liberating Structures: Including and Unleashing Everyone*

Link: [Liberating Structures - Introduction](#)

Summary

Liberating Structures (LS) offers a repertoire of 33 simple "microstructures" that replace or complement conventional meeting formats to *include and unleash everyone* in shaping decisions and action. LS argues that standard formats (presentations, managed/open discussions, status reports, brainstorming) suppress engagement and innovation; tiny design shifts-clear invitations, distributed participation, and rapid cycles-unlock collective intelligence, ownership, and faster follow-through. Examples include 1-2-4-All (scales inclusive idea generation), 25/10 Crowd Sourcing (rapidly surfaces bold, high-potential actions), Ecocycle Planning (portfolio review across birth-maturity-creative destruction-renewal), and Purpose-to-Practice (co-design of purpose, principles, participants, structure, practices). LS promotes *inclusive leadership* and routine involvement of diverse stakeholders, grounding its approach in repeatable "minimum specs" that make facilitation transparent and adaptable across contexts.

Key arguments and findings from liberatingstructures.com

- Conventional meeting structures stifle engagement and innovation; small design shifts can transform outcomes. LS adds 33 options to the “big five” formats, putting facilitation power in everyone’s hands via standardised design elements (“min specs”).
- Inclusive participation drives better ideas, ownership, and quicker implementation. LS places equal contribution at the core (e.g., *1-2-4-All*) to generate more-and better-ideas rapidly, with participants owning next steps.
- Repeatable microstructures enable rigour with flexibility. Each LS specifies the invitation, space, participation, group configuration, and timing, making it easy to learn, adapt, and string together for complex work.
- LS supports strategy, implementation, and continuous learning. Tools such as *Ecocycle Planning* (portfolio balance), *25/10 Crowd Sourcing* (top ideas fast), and *Purpose-to-Practice* (co-design initiatives) help move from discovery to execution and spread.
- Culture change comes from inclusive leadership and routine use. LS positions leaders as facilitators who distribute control, revealing hidden leaders and building innovative, collaborative cultures.

Where Liberating Structures supports the Scottish Approach to Change

Scottish Approach to Change enablers (people-led; leadership and culture; process rigour; clear vision and purpose; learning system) and eight steps of change (identify → understand → develop and design → prototype and test → review for implementation → define and implement → embed and sustain → review for spread) provide a whole-system pathway for quality and change. Below, LS methods that directly operationalise Scottish Approach to Change :

1) People-led

- Mechanism: Many LS are designed to *include and unleash everyone*, giving equal voice and creating psychologically safe, participatory design spaces (e.g., *1-2-4-All*, Troika Consulting, What I Need From You).
- Scottish Approach to Change link: Aligns with Scottish Approach to Change ’s “people-led” enabler and meaningful involvement of those who need, deliver and enable services.

2) Leadership and culture

- Mechanism: LS frames *inclusive leadership* that shares control, surfaces hidden leaders, and builds trust through day-to-day practices-reducing resistance and increasing innovation.

- Scottish Approach to Change link: Supports Scottish Approach to Change 's call for leaders to create safe, collaborative conditions where experimentation and learning thrive.

3) Process rigour

- Mechanism: Every LS has five "minimum specifications" (invitation, space, participation, configuration, sequence/time), providing repeatable rigour while remaining adaptive; strings of LS create end-to-end delivery flow.
- Scottish Approach to Change link: Reinforces Scottish Approach to Change 's emphasis on systematic governance, measurement, and project management without over-bureaucratising.

4) Clear vision and purpose

- Mechanism: Nine Whys clarifies fundamental purpose; Purpose-to-Practice co-designs purpose, principles, participants, structure, and practices at the outset.
- Scottish Approach to Change link: Matches Scottish Approach to Change guidance to anchor change in shared vision and strategy before making hard choices.

5) Learning system

- Mechanism: Ecocycle Planning builds portfolio thinking (birth-maturity-creative destruction-renewal); Social Network Webbing maps relationships to spread learning; LS strings enable rapid feedback and iteration (e.g., 25/10 for sensing bold ideas quickly).
- Scottish Approach to Change link: Supports Scottish Approach to Change 's learning systems that value reflective practice, rapid feedback loops, and spread of generalisable learning

Process Rigour, Governance and Evaluation

Summary

Al Bulushi et al. (2023) - *Implementation frameworks for polypharmacy management* - Scoping review

[Link: *Implementation frameworks for polypharmacy management within healthcare organisations: a scoping review* - PMC](#)

Summary

This scoping review synthesises organisational-level approaches to implementing polypharmacy

management. Screening 797 records yielded eight studies: two descriptive initiatives and six qualitative studies exploring implementation determinants. Reported barriers included weak organisational culture (lack of urgency/clear national plans), limited resources, and communication failures (notably patient information and care transitions). Facilitators included government funding, strong regulatory environments prioritising patient safety, national focus on older adults' care quality, coordinated national efforts, and the use of local evidence. The authors conclude that organisational-level implementation frameworks remain underdeveloped and call for structured, theory-informed approaches tailored to local context and culture, with robust evaluation strategies.

Key arguments and findings

- Evidence gap at organisational level: Despite abundant patient-level guidance on polypharmacy, there is limited research on organisational-level implementation frameworks; more theory-informed, context-sensitive work is needed.
- Scope and methods: From 797 records, 8 studies met criteria (2 descriptive; 6 qualitative) examining barriers/enablers and drawing on change frameworks (e.g., Kitson et al., Moullin's Generic Implementation Framework; some studies referenced Kotter/NPT/TDF/BCT).
- Barriers: Poor organisational culture and urgency; absence of national plans; resource constraints; communication issues-especially around patient information and transitions of care.
- Facilitators: Government funding; regulatory pressure for safety; national emphasis on older adults' care quality; coordinated national efforts; use of local/contextual evidence.
- Centrality of context: Meso-level factors-leadership, culture, data/information systems, knowledge and training-shape implementation success; frameworks must be adapted to local culture and systems.

Where the paper supports the Scottish Approach to Change

- Leadership and culture as prerequisites for change - The review highlights culture and leadership (incl. creating a "sense of urgency" and strategic vision) as decisive; Scottish Approach to Change names Leadership and culture as a core enabler of sustainable change.
- Clear vision and purpose - Calls for national plans and a strategic clarity map to Scottish Approach to Change 's Clear vision and purpose, including making tough choices and aligning decisions to strategy.
- Process rigour and governance - The paper's call for structured, theory-informed implementation frameworks with monitoring/evaluation aligns with Scottish Approach to Change 's Process rigour, governance for momentum, and robust Measurement, monitoring and evaluation.

- People-led design and communications - Communication failures (patient information, transitions) are noted barriers; Scottish Approach to Change 's People-led enabler stresses meaningful engagement, inclusive design, and trauma-informed practice to make change relevant and equitable.
- Learning systems and iterative testing - The review's emphasis on local evidence and evaluation mirrors Scottish Approach to Change 's Learning system plus Prototype and test (e.g., PDSA), and learning-driven governance.
- Staged implementation - Use of change frameworks (e.g., Kotter; implementation stages) reinforces Scottish Approach to Change 's Eight steps of change from Identify/Understand through Embed and Sustain and Review for Spread.
- System-level supports - Facilitators such as government funding and regulatory emphasis on patient safety are consistent with Scottish Approach to Change 's whole-system/QMS perspective that aligns organisational mechanisms to sustain quality.

Dai et al. (2024) - *Implementation Strategies for Quality Improvement in Palliative Care: A Scoping Review*

[Link: Implementation Strategies for Quality Improvement in Palliative Care: A Scoping Review - PubMed](#)

Summary

This scoping review identifies strategies that help embed person-centred outcome measures (PCOMs) into routine, hospital-based palliative care quality improvement (QI). Searching four databases (1990-2024) using the JBI framework, the authors mapped 115 unique strategies from 11 studies to the 73 ERIC discrete implementation strategies, covering 52% of ERIC. The most frequent categories were *train and educate stakeholders* and *support clinicians*, followed by *develop stakeholder interrelationships* and *use evaluation and iterative strategies*. Three cross-cutting themes emerged: what to do, how to do it, and who to do it with. Only four studies explicitly used implementation theories, models or frameworks (TMFs). The authors argue that strategies should be barrier-/facilitator-informed, theory-guided, and transparently reported to enable replication and measurement in practice.

Key arguments and findings

- Routine PCOM use can lift quality at individual and organisational levels, but adoption is hindered by time, resources, training gaps, negative attitudes and limited managerial support.
- 115 strategies mapped to ERIC; most used were education/training and clinician support, then relationship-building and iterative evaluation.
- Only 4 of the included studies were TMF-driven-highlighting a theory-practice gap that undermines replicability and scale.

- Recommendations: co-design strategies around identified barriers/facilitators, ground them in rigorous TMFs, and report components consistently.

Where this supports the Scottish Approach to Change

- People-led change: PCOMs operationalise person-centred care; the review’s emphasis on outcomes that matter to patients aligns with Scottish Approach to Change’s *People-led* enabler, and embedding lived experience in design and delivery.
- Process rigour: Calls for theory-guided, transparently reported strategies mirror Scottish Approach to Change’s insistence on systematic methods, governance, measurement/monitoring, and project management throughout the change cycle.
- Learning system and iterative improvement: Frequent use of “evaluation and iterative strategies” maps directly to Scottish Approach to Change’s *Prototype and Test* (PDSA), *Embed and Sustain*, and the *Learning system* enabler that values rapid feedback loops and reflective practice.
- Leadership and culture/capability building: Dominance of *training and educating stakeholders* and *supporting clinicians* supports Scottish Approach to Change’s focus on cultivating distributed leadership, capability, and psychologically safe cultures for experimentation.
- Clear vision and structured steps: The review’s themes-*what, how, who*-align with Scottish Approach to Change’s eight *Steps of change* (identify → review for spread) and the need for a clear line of sight from purpose to implementation.

Edwards, Coward and Carey (2022) - *Barriers and facilitators to implementation of non-medical independent prescribing in primary care in the UK: a qualitative systematic review*

Link: [Barriers and facilitators to implementation of non-medical independent prescribing in primary care in the UK: a qualitative systematic review - PubMed](#)

Summary

This qualitative meta-synthesis (23 UK studies) examines how non-medical independent prescribing (nurses, pharmacists, AHPs) is implemented in primary care. Using Diffusion of Innovations and CFIR as lenses, the authors identify barriers and facilitators across four stages-Preparation, Training, Transition, and Sustainment-and describe three deployment models (enhancement, substitution, and role-specific). Cross-cutting enablers include clear role design and governance, organisational/clinical leadership, access to records and decision support, mentorship and CPD, and interprofessional relationships; recurring barriers include medical resistance, unclear accountability, patchy training capacity, delayed start-up, and underuse of prescribers once qualified. The review argues for a coordinated, targeted implementation approach so IP can

reliably alleviate workforce shortfalls and improve medicines optimisation and access in primary care.

Key arguments and findings

- Implementation barriers/facilitators cluster in four stages: Preparation → Training → Transition → Sustainment.
- Effective IP relies on leadership buy-in, governance/role clarity, and supportive infrastructure (IT, protocols, data).
- Mentorship, supervision and CPD are critical for competence and ongoing use.
- Interprofessional relationships and patient awareness affect acceptance and uptake.
- A coordinated, targeted rollout across stages increases the likelihood of sustainable adoption.

Where this supports the Scottish Approach to Change

- Process rigour and governance. The review's call for clear governance, protocols and data support mirrors Scottish Approach to Change's emphasis on *process rigour* (governance, measurement, project management) to drive reliable change.
- Leadership and culture. Leadership endorsement to overcome professional resistance and enable role clarity aligns with Scottish Approach to Change's *leadership and culture* enabler for psychologically safe, improvement-oriented teams.
- People-led focus. Evidence of high service-user satisfaction with non-medical prescribing and the need to build acceptance supports Scottish Approach to Change's *people-led* principle of co-created, person-centred change.
- Learning system. The importance of mentorship, CPD and iterative capability-building reflects Scottish Approach to Change's *learning system*-capturing insights, reflective practice, and feedback loops to inform decisions.
- Clear vision and purpose. Designing IP roles (enhancement/substitution/role-specific) and defining accountability is consistent with Scottish Approach to Change's call for a *clear vision and purpose* that translates strategy into operational choices.
- **Steps of change-stage mapping.**
 - *Preparation* ↔ Identify / Understand (readiness, case for change).
 - *Training* ↔ Develop and design (capability, model design).
 - *Transition* ↔ Prototype and test / Define and implement (safe start-up, governance).

Sustainment ↔ Embed and sustain / Review for spread (monitoring, scaling).

Rizvi F, Wilding HE, Rankin NM, Le Gautier R, Gurren L, Sundararajan V, Bellingham K, Chua J, Crawford GB, Nowak AK, Le B, Mitchell G, McLachlan SA, Sousa TV, Hudson R, IJerman M, Collins A, Philip J. (2023) - *An evidence-base for the implementation of hospital-based palliative care programs in routine cancer practice: A systematic review.*

[Link: An evidence-base for the implementation of hospital-based palliative care programs in routine cancer practice: A systematic review - PubMed](#)

Summary

This systematic review examines how hospital-based palliative care is implemented within routine oncology, focusing on which implementation frameworks are used, and the practical enablers and barriers to integration. Across 16 studies (post-2010), only seven explicitly applied frameworks (e.g., RE-AIM; MRC framework; SELFIE; DMAI). Reported enablers included supportive culture, clear cross-service introductions, adequate funding/workforce, advocates, co-design with end users, staff training, and strong multidisciplinary communication. Barriers included weak communication with patients/clinicians, stigma associated with “palliative,” limited training/role clarity, time pressures, staff turnover, fidelity challenges across sites, and insufficient policy and resources. The authors conclude that using implementation-science frameworks can systematically underpin the development, evaluation, and sustainability of integrated palliative oncology services.

Key arguments and findings

- Integration of early palliative care remains limited despite strong evidence of benefit; implementation science can close the “know-do” gap.
- Only 7/16 studies used explicit frameworks (RE-AIM, MRC, SELFIE, DMAI), indicating underuse of structured approaches.
- Enablers: supportive culture; clear programme introduction; adequate funding and staffing; champions/advocates; co-design; staff education; purposeful MDT communication.
- Barriers: poor stakeholder communication; stigma around “palliative”; limited training/awareness of guidelines; unclear roles; time and turnover pressures; intervention fidelity issues; policy/resource gaps.
- Recommendation: apply implementation frameworks to design, evaluate, and sustain integrated palliative care in oncology.

Where this supports the Scottish Approach to Change (Scottish Approach to Change)

- Process rigour: The review’s call to use implementation frameworks maps directly to Scottish Approach to Change ’s emphasis on rigorous, systematic processes (governance, data/measurement, project management) to achieve reliable change.

- Leadership and culture: Identifying *supportive culture* and *advocates* as enablers aligns with Scottish Approach to Change 's focus on leadership behaviours that create safe, enabling conditions for change.
- People-led: Co-design with end users echoes Scottish Approach to Change 's people-led enabler-designing and delivering change *with* those who use and deliver services.
- Learning system: Training needs, fidelity monitoring, and iterative evaluation mirror Scottish Approach to Change 's learning-system component-using qualitative/quantitative data, reflective practice, and feedback loops to adapt and improve.
- Clear vision and purpose + Steps of change: The review's stress on clear programme introduction/role clarity supports Scottish Approach to Change 's call for a shared purpose and staged delivery.

HM Treasury (2020) - Magenta Book: Central Government guidance on evaluation

Link: [HMT Magenta Book.pdf](#)

Summary

The Magenta Book is HM Treasury's core guide to designing, commissioning, and using evaluations across the UK public sector. It emphasises embedding proportionate evaluation from the earliest policy design stages, aligned to the Green Book and the ROAMEF cycle, to drive learning and accountability. It defines and connects process, impact, and value-for-money evaluation, encourages theory-of-change development, piloting, agile feedback loops, and rigorous data collection (quantitative and qualitative). The guide covers scoping, methods (from theory-based to experimental and quasi-experimental), data access/linkage, ethics, governance, and transparent dissemination. Annexes and supplements expand on analytical methods and evaluating complexity, supporting robust, context-aware designs that inform decision-making and "what works."

Key arguments and guidance highlights

- Evaluation is integral to policy: build it in early, proportionately, and use it throughout design, implementation, and review to manage risk and improve outcomes.
- Three evaluation lenses-process (delivery/implementation), impact (attribution/counterfactual), and value-for-money-should be combined for a full picture.
- Theory of Change and piloting: articulate causal logic and assumptions up-front; use pilots/agile cycles to test and adapt.
- Mixed methods and rigor: draw on qualitative and quantitative data; select from a wide toolkit (RCTs, QEDs, realist methods, CBA/CEA, synthesis).

- Data access and linking, ethics, transparency: plan for data quality/linkage, govern evaluations well, and share findings openly to support learning.
- Culture of continual improvement: routine, high-quality evaluation underpins better targeting, reduced delivery risk, and system learning.
- Handling complexity: adapt evaluation designs to context, boundaries, and change in complex systems.

Where it supports the Scottish Approach to Change

- Process rigour → Measurement, monitoring and evaluation
Scottish Approach to Change 's call for rigorous measurement, triangulation, and thoughtful presentation of data is directly reinforced by the Magenta Book's end-to-end guidance on combining process, impact, and VfM evaluation with robust methods.
- Clear vision and purpose → Theory of Change
Scottish Approach to Change stresses a clear vision/purpose to anchor decisions; the Magenta Book operationalises this through early Theory of Change and SMART objectives within ROAMEF, ensuring evaluation and intervention are co-designed.
- Learning system → Continuous learning and dissemination
Scottish Approach to Change 's "learning system" is mirrored by the Magenta Book's emphasis on openness/transparency and using findings to iterate policies and inform others-establishing a culture of ongoing learning.
- People-led → Mixed methods and qualitative quality
Scottish Approach to Change 's people-led design (co-design, lived experience) aligns with Magenta Book guidance to use qualitative alongside quantitative data and the government's supplementary guidance on quality in qualitative evaluation.
- Steps of change → Evaluation across the change cycle
Scottish Approach to Change 's eight steps (identify → understand → develop/design → prototype/test → review → implement → embed → spread) are supported by the Magenta Book's integration of evaluation before, during, and after implementation (pilots, agile feedback, final evaluation).
- Governance and commissioning → Managing evaluations well
Scottish Approach to Change 's governance/commissioning enablers are strengthened by Magenta Book chapters on managing evaluations, ethics, and roles-ensuring clarity, accountability, and proportional oversight.
- Reducing inequalities → Disaggregated insight
Scottish Approach to Change prioritises equity and human rights; the Magenta Book encourages examining differential effects ("for whom, how and why") and unintended consequences-providing an evidence spine for inequality-focused design and monitoring.

Royal Academy of Engineering (2017) - *Engineering better care a systems approach to health and care design and continuous improvement*

Link: [Engineering better care a systems approach to health and care design and continuous improvement](#)

Summary

The report argues that health and care are a complex “system of systems” and proposes a systems approach that integrates four complementary perspectives-people, systems, design, and risk-to guide service design and continuous improvement. It sets out an ordered series of critical questions and a practical framework for thinking and action, emphasising iteration before implementation, design as an exploratory process, and proactive risk management. The approach is intended for transformation teams at any scale (from pathways to cross-sector change) and to augment existing methods (e.g., IHI Model for Improvement) rather than replace them. Case examples illustrate benefits such as better integration, safer care, and improved experience when solutions are co-designed around people and interfaces across organisations.

Key arguments and findings

- Healthcare needs a consistent systems approach: improvements should consider all elements and interfaces across a “system of systems,” not isolated fixes.
- Four-perspective framework (people, systems, design, risk) provides a shared language and structure for design and improvement.
- Ordered questions + framework for action operationalise the approach, helping teams move from complex needs to validated solutions.
- Rigour matters: iterate before implementation; treat risk management proactively; use inclusive/co-design so services fit the widest user groups.
- Complements existing QI toolsets (e.g., PDSA, driver diagrams) by adding systems thinking, interface design, and systems safety assessment.
- Demonstrated value through case examples (e.g., integrated frailty response, medication safety), showing safety, experience and efficiency gains when systems are designed end-to-end.

Where it supports the Scottish Approach to Change

- People-led change - EBC centres design and improvement on people’s needs and capabilities, and advocates co-design to ensure accessibility and usability; Scottish Approach to Change makes “People-led” one of its five core enablers and embeds meaningful engagement and trauma-informed practice.
- Process rigour - EBC calls for iteration before implementation, structured critical questions, and proactive risk management; Scottish Approach to Change’s Process rigour enabler

operationalises this via governance, project management, commissioning, and measurement/monitoring/evaluation guidance.

- Clear vision and purpose - EBC's ordered questions and framework help teams clarify aims, scope and system boundaries; Scottish Approach to Change begins with a Clear vision and purpose and provides practical advice on strategy, tough choices, and triangulating evidence to set direction.
- Leadership and culture - EBC targets transformation teams and healthcare leaders, promoting disciplined, cross-boundary collaboration; Scottish Approach to Change elevates Leadership and culture (trust, psychological safety, distributed leadership) as preconditions for change.
- Learning system - EBC embeds continuous learning through iterative testing and evaluation; Scottish Approach to Change formalises a Learning system with infrastructure, roles (system stewards, learning partners), and feedback loops to convert insight into action.
- Structured delivery pathway - EBC's framework for action aligns with Scottish Approach to Change's eight Steps of change (Identify → Review for spread), providing compatible scaffolding from discovery to spread/sustain.

Government Analysis Function (2023) - *The Theory of Change Process - Guidance for Outcome Delivery Plans*

Link: [*The Theory of Change Process - Guidance for Outcome Delivery Plans - Government Analysis Function*](#)

Summary

The UK Government Analysis Function's Theory of Change (ToC) toolkit is a practical guide for planning, monitoring and evaluating policies, programmes and services across the public sector. It argues that a high-quality ToC aligns stakeholders around a shared impact, clarifies causal pathways and assumptions, and embeds proportionate monitoring and evaluation from the outset. It is most effective at the design stage but can be applied across the lifecycle to review direction and communicate the intervention's logic. The toolkit sets out an 11-step process-from stakeholder identification and evidence synthesis, through impacts, outcomes, outputs and inputs, to assumptions, risks, causal links, diagram/narrative and a monitoring-and evaluation plan-with workshop tips and real examples. The emphasis is on evidence-informed decision-making, consensus-building and transparent logic models that support better delivery and accountability.

Key arguments and findings from the Toolkit

- Purpose and value: ToC strengthens decision-making by aligning stakeholders on goals, clarifying evidence, assumptions and risks, and providing a monitoring and evaluation plan.
- When to use: Best at the design stage, but applicable before, during and after implementation to steer decisions and communicate logic.

- Process: An 11-step approach-stakeholders → evidence/context → impacts → outcomes → outputs/activities → inputs → assumptions → risks → causal links (+ timelines) → diagram/narrative → monitoring and evaluation action plan.
- How to develop: Proportionate, workshop-based, and collaborative, drawing on analysts and existing evidence to iteratively refine causal links.

Where it supports the Scottish Approach to Change

- People-led engagement: ToC begins with mapping and engaging a wide range of stakeholders to build consensus, directly reinforcing Scottish Approach to Change 's *people-led* enabler and co-design ethos.
- Clear vision and purpose: ToC requires explicit long-term impacts and SMART outcomes aligned to organisational goals; Scottish Approach to Change likewise centres a clear vision/purpose that anchors decisions and strategy.
- Process rigour and measurement: The toolkit's evidence synthesis, articulated assumptions/risks, causal links and MandE plan echo Scottish Approach to Change 's emphasis on governance, data curiosity, triangulation, and project management (e.g., RAIDs, stage control).
- Learning system: ToC makes learning explicit via monitoring and evaluation action plans; Scottish Approach to Change formalises this as a *learning system* with reflective practice and feedback loops to adapt change.
- Lifecycle alignment: ToC is usable across the delivery lifecycle; Scottish Approach to Change operationalises this through its eight *Steps of Change* (Identify → Review for spread), supporting iterative testing and sustained implementation.
- Proportionate approach: The toolkit's call for proportionate, context-sensitive application aligns with Scottish Approach to Change 's focus on proportionate processes that create action rather than bureaucracy

National Audit Office (2025) - *Lessons learned: Governance and decision-making on mega-projects Cross government*

[Link: Lessons learned: Governance and decision-making on mega-projects](#)

Summary

The NAO distils lessons on how to govern the UK's largest, riskiest "mega-projects." It argues that their scale, novelty, cross-government interdependencies and multi-decade horizons mean the *standard* single-department governance model often breaks down. The NAO recommends formally categorising "mega-projects," clarifying authority and accountability across the system (including HM Treasury/NISTA), strengthening gateway/business-case approvals, funding by maturity stages, and being prepared to halt projects if early evidence shows affordability,

feasibility or benefits are too uncertain. The report stresses decisions should emphasise outcomes and value (not just cost), and that capable people, constructive challenge and adaptive governance are essential from inception through delivery.

Key arguments and findings

- Define “mega-projects” as a distinct class and adopt governance tailored to their high cost, risk and strategic importance.
- Clarify authority and accountability across funders, sponsors and delivery bodies; consider central (HM Treasury/NISTA) roles on boards in early stages.
- Strengthen gateways and business cases to assure affordability, feasibility, benefits and value before proceeding; stage-gate funding by maturity.
- Be willing to stop or reset when early work shows risk/costs are prohibitive or benefits too uncertain.
- Focus decisions on outcomes and benefits (not just cost) and ensure suitably experienced people and an adaptive culture throughout delivery.

Where this supports the Scottish Approach to Change (Scottish Approach to Change)

- Clear vision and purpose: NAO’s call for a clear, strategic rationale and outcomes focus mirrors Scottish Approach to Change ’s emphasis that a shared vision anchors decisions and trade-offs.
- Process rigour: Stronger gateways, staged funding and robust business cases align with Scottish Approach to Change ’s governance, measurement/monitoring, and proportionate project management to “create action not inaction.”
- Leadership and culture: NAO’s need for experienced people, constructive challenge, and adaptive governance echoes Scottish Approach to Change ’s call for enabling leadership, psychological safety, and cross-organisational collaboration.
- Learning systems: The NAO’s emphasis on revisiting decisions and stopping/reshaping projects when evidence changes supports Scottish Approach to Change ’s iterative testing, reflective practice and learning networks.
- Steps of change: NAO’s maturity-based progression and “stop/go” discipline reinforce Scottish Approach to Change ’s staged cycle (identify → understand → design → prototype/test → review for implementation → implement → embed/sustain → review for spread).

Eckersley, P., Lakoma, K., Murphy, P., Caygill, T., and Pell, C. (2025) - *Accountability as a function of power relationships in public governance networks.*

Link: [Accountability as a function of power relationships in public governance networks](#)

Summary

Eckersley, Lakoma, Caygill, Pell and Murphy argue that accountability in public governance is shaped by how resources-and therefore power-are distributed across networks. Drawing on resource-dependence theory, they map three governance paradigms to distinct accountability logics: Traditional Public Administration (TPA) concentrates vertical, principal-agent control; New Public Management (NPM) fragments provision and yields multidirectional, inspection- and contract-based accountability; and New Public Governance (NPG) relies on shared resources, “power *with*,” and more horizontal, learning-oriented accountability grounded in co-production. They integrate concepts of *power over/to/with* retrospective and prospective accountability and set out testable hypotheses to guide empirical work. The contribution is a conceptual framework showing that shifts in resource configurations drive changes in how accountability is operationalised, with implications for the design of governance and performance systems.

Key arguments and findings

- Power-accountability linkage: Power and accountability are “inextricably connected”; who holds critical resources shapes how actors are held to account.
- Paradigm mapping:
 - TPA: Concentrated resources → hierarchical, vertical principal-agent accountability.
 - NPM: Diffused/outsourced resources → multidirectional, complex accountability (audits, inspectorates, contracts).
 - NPG: Shared resources in networks → horizontal accountability emphasizing learning and deliberation.
- Types of power: Distinguishes *power over*, *power to*, and *power with*, linking each to different accountability arrangements across paradigms.
- From sanction to learning: As systems move toward NPG, accountability becomes less sanction-centric and more oriented to collective learning and co-creation of public value.
- Hypotheses for practice/research: Provides a framework and propositions to guide empirical studies on how resource configurations structure accountability in real networks.

Where it supports the Scottish Approach to Change

- Learning as a core accountability mode: The article’s view that NPG favours horizontal, *learning-oriented* accountability aligns with Scottish Approach to Change ’s Learning System enabler (continuous reflection, rapid feedback loops, generalisable learning).

- People-led, co-produced change: NPG’s emphasis on co-design and co-production mirrors Scottish Approach to Change ’s People-led enabler and the expectation to involve lived and living experience throughout change.
- Networked leadership and culture: The shift from hierarchical control to shared “power *with*” supports Scottish Approach to Change ’s call for leadership that builds psychologically safe, cross-boundary collaborations and distributed stewardship.
- Process rigour amidst complexity: The paper’s account of NPM’s fragmented, multidirectional accountability underlines Scottish Approach to Change ’s focus on Process rigour-governance that creates momentum, purposeful measurement/monitoring, and proportionate project management to navigate complex systems.
- Measurement for learning, not just control: Discussion of inspections/metrics in NPM versus learning in NPG reinforces Scottish Approach to Change ’s guidance on triangulating qualitative and quantitative data to inform iterative testing (e.g., PDSA) and decision-making.

Lowe T, Wilson R. (2015) - *Playing the game of Outcomes-Based Performance Management. Is gamesmanship inevitable? Evidence from theory and practice.*

[Link: *Playing the game of Outcomes-Based Performance Management. Is gamesmanship inevitable? Evidence from theory and practice.*](#)

Summary

This article critiques Outcomes-Based Performance Management (OBPM) in public services, arguing that the simplification needed to specify and attribute “outcomes” turns delivery into a game whose rules incentivise gaming behaviours rather than genuine improvement. Reviewing theory and practice, the authors show how high-stakes outcome targets distort attention, create perverse incentives, and encourage organisations to optimise metrics rather than value for people. They reconcile mixed evidence on OBPM’s effectiveness by explaining that apparent successes reflect contexts where measures align with practice, while failures emerge when complexity is simplified away. The paper concludes that prevailing measurement orthodoxy needs rethinking toward approaches that prioritise learning in complex systems over attribution and control.

Key arguments and findings

- OBPM requires simplifying complex reality to make outcomes measurable and attributable. This simplification is a theory-inconsistent with complex social systems.
- The rules created by outcome targets promote gamesmanship, distorting behaviour by shifting effort to what is measured rather than what matters.

- Conflicting evidence about OBPM can be unified by understanding its underlying theory: when measures fit the context, OBPM may look effective; when they don't, it generates perverse effects.
- The authors call for a rethink of measurement orthodoxy toward learning-oriented governance in complex services.

Where it supports the Scottish Approach to Change

- From attribution to learning. The paper's call to replace control-oriented outcome attribution with learning aligns with Scottish Approach to Change's "Learning system" enabler-continuous reflection, mixed-method evidence, and rapid feedback loops to inform action.
- Nuanced measurement over target-fixation. The critique of simplistic targets supports Scottish Approach to Change's guidance to use measurement, monitoring and evaluation that triangulate qualitative and quantitative data, watch for outliers, choose meaningful time horizons, and avoid misleading presentations.
- Systems thinking. By noting that OBPM oversimplifies complex systems, the paper underlines Scottish Approach to Change's "Understand" step and tools (e.g., systems mapping) that consider wider system impacts before acting.
- People-led change. The argument that metrics can crowd out what matters to people complements Scottish Approach to Change's people-led enabler-co-design with people who use and deliver services to ensure relevance and equity.
- Leadership and culture. If targets induce gaming, leadership must create psychological safety and curiosity-driven governance-exactly the leadership and culture Scottish Approach to Change prescribes to enable reflective practice and improvement.

Becci Newton, Nigel Meager, Christine Bertram, Anne Corden, Anitha George, Mumtaz Lalani, Hilary Metcalf, Heather Rolfe, Roy Sainsbury and Katharine Weston (2012) - *Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery*

[Link: *Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery*](#)

Summary

This first-phase qualitative evaluation of the UK Work Programme (2011-12) examines how providers, subcontractors and Jobcentre Plus implemented a 'black-box' employment service under payment-by-results. It finds broadly similar delivery models built around assessment, action planning, adviser-led support and (variably delivered) in-work support. Early delivery was hampered by weak referrals/handovers and inconsistent communications between Jobcentre Plus

and providers. Personalisation often meant good adviser relationships but limited access to specialist support, partly due to cost pressures and high caseloads-raising risks of “creaming and parking” despite differential payments. Sanctions processes were inconsistently applied and undermined by procedural issues. Sustainability depended less on post-placement contact and more on the quality of the job match and preparation.

Key arguments and findings

- Delivery model: Providers followed similar stages-handover, assessment, out-of-work support, in-work support-typically via end-to-end advisers; use of specialist “spot” provision was rarer than planned.
- Referral/communication gaps: Weak information transfer and limited “warm handovers” reduced early engagement quality; JCP-provider communication varied widely.
- Personalisation limits: Action plans were common, but substantive tailoring and referrals to specialist help were constrained by cost and caseloads.
- Risk of “creaming and parking”: Differential payments did not fully prevent prioritising more job-ready participants.
- Sanctions: Predominantly triggered by missed initial appointments; processes were error-prone and often ineffective in practice.
- Sustained outcomes: Quality of job match and preparation were more decisive for employment sustainability than light-touch in-work support alone.

Where the report supports the Scottish Approach to Change

- Process rigour and governance: The evaluation’s call for better referrals, handovers and information flows aligns with Scottish Approach to Change’s emphasis on *process rigour*, governance that “creates change not inactivity,” and curiosity with data to guide decisions.
- People-led design: Participants sought clearer information and more involvement in action planning-consistent with Scottish Approach to Change’s *people-led* principle to co-design with lived experience and make engagement empowering.
- Measurement, monitoring and evaluation: Difficulties evidencing sanctions and outcomes echo Scottish Approach to Change’s insistence on robust measurement plans, triangulation of data and continuous learning loops.
- Leadership and culture: Variable JCP-provider relationships and adviser autonomy underscore Scottish Approach to Change’s focus on leadership that builds trust, removes barriers and fosters psychologically safe learning environments.
- Commissioning discipline: Risks of “creaming and parking” demonstrate why Scottish Approach to Change promotes ethical, context-sensitive commissioning that mitigates perverse incentives and targets need, not just throughput.

- Embed and sustain: Findings that sustainability depends on *job-fit* and preparation resonate with Scottish Approach to Change 's steps to *define and implement, embed and sustain* change with clear standards, capability building and feedback.

Department of Health and Social Care (2025) - Review of patient safety across the health and care landscape

Link: [Review of patient safety across the health and care landscape](#)

Summary

The DHSC-commissioned review (Dash, 7 July 2025) maps England's patient-safety landscape across six national bodies and the wider quality system. It finds a crowded, duplicative architecture that generates thousands of recommendations-often without cost-benefit analysis-yet delivers only modest safety gains. The review calls for a coherent national quality strategy, a revamped National Quality Board, streamlined investigations and complaints pathways, clearer accountability for improvement at the provider level (including executive responsibility for user experience), and much better use of data to drive learning. Overall, it urges a shift from external, fragmented oversight to provider-led delivery, standardisation and continuous improvement embedded in governance and management.

Key arguments and findings

- The landscape is overcrowded ($\approx 40+$ organisations), producing many overlapping reviews and recommendations with limited strategic impact. Streamlining and consolidation are required.
- England lacks a comprehensive *quality strategy*; the National Quality Board should be revitalised to set priorities and coordinate asks of providers.
- Too many recommendations lack cost/benefit analysis; accountability must sit with providers' boards and management, with stronger standardisation of core processes.
- Complaints and "voice of the user" functions are fragmented; trusts should designate senior executive leadership for user experience and simplify routes for feedback.
- Data and learning are underleveraged; the system should exploit NHS data to generate actionable insights and drive improvement.

Where the review supports (aligns with) the Scottish Approach to Change

- Clear vision and purpose / national strategy: The call for a coherent quality strategy mirrors Scottish Approach to Change 's emphasis on a shared vision and purpose driving choices and trade-offs.

- Process rigour and quality management: Recommendations to standardise core processes and embed provider-level governance echo Scottish Approach to Change 's process rigour, project management, and Quality Management System (QMS) approach.
- People-led change: The push to put executive responsibility on "user experience" and rationalise patient-voice channels aligns with Scottish Approach to Change 's people-led design and meaningful engagement principles.
- Learning systems and data: The review's critique of underused data and call for learning from incidents supports Scottish Approach to Change 's learning system, triangulation of qualitative/quantitative insights, and rapid feedback loops.
- Prioritisation and cost-benefit discipline: Concern about recommendations without costings reinforces Scottish Approach to Change guidance on options appraisal, measurement plans, and proportionate governance.
- Provider-led accountability: Shifting improvement responsibility to commissioning/providers is consistent with Scottish Approach to Change 's eight-step change cycle centred on local ownership and sustained embedding.
- Complaints simplification and equity: Streamlining complaints and improving responsiveness dovetail with Scottish Approach to Change 's focus on reducing inequalities and embedding rights-based, accessible services.

NHS Scotland (2022) - *The Blueprint for Good Governance in NHS Scotland*

Link: [*The Blueprint for Good Governance in NHS Scotland - Second Edition*](#)

Summary

The *Blueprint for Good Governance in NHS Scotland (Second Edition)* sets out a flexible, proportionate model for board governance that is "active" (data-driven, improvement-oriented assurance) and "collaborative" (partnership-based), with clear functions, enabling conditions, and delivery, evaluation and improvement approaches. It reframes "good governance" for healthcare, emphasising continuous review, responsiveness to context, and explicit governance of change. Supplementary guidance covers strategic planning and commissioning, risk management, assurance information, audit, and performance management. The document positions NHS Boards as anchor institutions that must demonstrate transparent, equitable stewardship while improving population health and tackling inequalities. Overall, it provides a whole-system governance architecture designed to stabilise services post-pandemic while enabling redesign and reform.

Key arguments and findings

- Defines *good governance* for healthcare, adding explicit expectations for *active* (intelligence-led) and *collaborative* (system-wide) governance.

- Presents a Blueprint model covering governance *functions, enablers*, and a delivery-evaluation-improvement cycle, intended to be adapted by each Board's context.
- Stresses continuous improvement and formal *governance of change* as core board business, not a parallel activity.
- Provides operating guidance on strategic planning and commissioning, risk management, assurance information systems, audit, and performance management.
- Requires transparent stewardship that improves *population health* and addresses *health inequalities* alongside safe, high-quality services.

Where the Blueprint supports the Scottish Approach to Change

- Active and collaborative governance ↔ People-led, leadership, learning culture
The Blueprint's call for data-driven, partnership governance aligns with Scottish Approach to Change enablers: *people-led change, leadership and culture*, and a *learning system* that enables reflective practice and spread.
- Governance of change ↔ Scottish Approach to Change's eight steps of change - Treating change governance as core board work mirrors Scottish Approach to Change's end-to-end cycle (Identify → Review for spread) and the expectation to iterate, test and adapt (e.g., PDSA).
- Assurance information and performance framework ↔ Measurement, monitoring, evaluation - The Blueprint's emphasis on assurance information and performance management supports Scottish Approach to Change guidance on triangulating qualitative/quantitative data, detecting trends/outliers, and presenting data clearly to inform decisions.
- Strategic planning and commissioning system ↔ Process rigour and ethical commissioning - The Blueprint's supplementary guidance on strategic planning/commissioning reinforces Scottish Approach to Change's *process rigour* (project management, governance) and its commissioning guidance that prioritises locally-tailored, evidence-based, ethical approaches.
- Risk management and audit ↔ Governance in change and project control
Board-level risk and audit arrangements echo Scottish Approach to Change's advice on proportionate governance that creates momentum, clarifies accountability, and manages risks/issues through stage controls and closure.
- Population health and inequalities ↔ People-led, reducing inequalities, human-rights - The Blueprint's requirement to improve population health and reduce inequalities aligns with Scottish Approach to Change's focus on co-design, EQIAs, trauma-informed practice, and embedding human rights (PANEL).

Fraser Battye (2025) - '*Rules of thumb*' for decision makers approaching analytical work

Link: [Rules of Thumb - Final Report 1.pdf](#)

Summary

This Strategy Unit report (for the Health Foundation) distils interview insights from 11 senior analysts into a non-technical checklist that helps NHS decision-makers rapidly gauge the quality of quantitative analysis and know when to seek specialist review. It groups quick “rules of thumb” into four domains-Source, Transparency, Expression, and Findings-covering provenance and incentives, methods and data quality, clarity of assumptions and openness of code/data, appropriate time windows and uncertainty, and plausibility/context of results. The intent is not to replace expert analytics, but to prime leaders to spot red flags, encourage open analytics, and strengthen analyst-decision-maker relationships so that choices are defensible and harm from poor analysis is avoided.

Key arguments and findings

- Four-domain test for quick triage: *Source, Transparency, Expression, Findings*-a one-page set of “rules” for non-analysts.
- Markers of quality include clear authorship/purpose, explicit methods and data quality assessment, stated and stress-tested assumptions, sharing underlying models/code (open analytics), careful presentation, use of suitable time periods, explicit uncertainty, and context-aware, plausible conclusions.
- Purpose is to prime judgment and improve relationships, not replace expert advice; it helps leaders spot obviously weak analyses and know when deeper technical assurance is needed.

Where it supports the Scottish Approach to Change

- Process rigour: The report’s emphasis on assessing methods, data quality, appropriate timeframes, treatment of outliers/trends, triangulation, and clear presentation mirrors Scottish Approach to Change’s guidance on *measurement, monitoring and evaluation* (e.g., choosing the right time period, triangulating data, avoiding misleading visuals).
- Learning system and transparency: Calls for sharing underlying analysis and being explicit about assumptions align with Scottish Approach to Change’s learning systems (open reflection, rapid feedback, knowledge mobilisation).
- Leadership and culture: The need for trusted analytical advice, governance that invites curiosity, and humility about limitations supports Scottish Approach to Change’s leadership behaviours (creating psychologically safe spaces, valuing evidence and reflective practice).

- Clear vision and purpose (indirect): By surfacing assumptions and evidential limits, the rules help leaders make defensible, purpose-aligned choices-echoing Scottish Approach to Change 's focus on clarity of vision, strategy, and trade-offs.
- People-led and reducing inequalities (indirect): Attention to concepts/definitions (e.g., avoiding over-broad groupings) and contextual plausibility complements Scottish Approach to Change 's people-led ethos and its guidance to design with specific populations and equity in mind.

Ko, Clifford Y MS, Giusti, Alessandra, Martin, Graham, Dixon-Woods, Mary. (2026) - Development and Testing of a Framework to Support the Planning of Small-Scale Improvement Projects in Surgery: A Multistage Process Including a Modified Delphi Exercise

Link: [Journal of the American College of Surgeons](#)

Summary

This JACS article reports the creation and testing of the Early Planning of Small-Scale Surgical Improvement (EPoSSI) framework-a nine-step, clinician-friendly guide (with a companion guidance table) to strengthen the *front-end* planning of local surgical QI projects. Developed through a five-phase process (evidence synthesis, sorting to themes, a 4-round modified Delphi with clinicians and improvement experts, prototype build, and user testing), EPoSSI was evaluated using a surgical vignette. Planning quality improved markedly when participants used the full framework: plans met 100% of predefined criteria versus 24% without it, with benefits seen for both attending/consultant and resident surgeons working alone or in teams.

Key arguments and findings

- Problem focus: Many small-scale surgical QI projects fail at the *planning* stage; a better, earlier structure is needed.
- Method: Framework co-designed via a multi-stage process, including a 4-round modified Delphi engaging clinicians and improvement experts.
- Product: A nine-step diagram + guidance table spanning team assembly, problem detailing, aim setting, intervention selection, implementation and monitoring plans, and end-of-project decision planning, plus steps to proceed/transition to launch.
- Effectiveness: In controlled testing with a clinical vignette, the full EPoSSI package increased planning comprehensiveness from 24% to 100% of criteria.
- Who benefits: Gains were observed for both attending/consultant and resident surgeons, and for individuals or teams.

Where it supports the Scottish Approach to Change

- People-led, leadership and culture: EPOSSI's first steps-*assemble an improvement team* and co-design early-mirror Scottish Approach to Change 's enablers that emphasise people-led change and leadership behaviours that create safe, collaborative spaces.
- Clear vision and purpose: EPOSSI requires explicit aims and problem detailing up front; Scottish Approach to Change likewise anchors change in a shared vision/purpose that guides decisions.
- Process rigour and governance: EPOSSI's structured planning for implementation, monitoring, and end-of-project decisions aligns with Scottish Approach to Change 's call for process rigour, proportionate governance, and project management throughout the change cycle.
- Measurement, monitoring and evaluation: Building measurement into EPOSSI's plan supports Scottish Approach to Change 's emphasis on using data (qualitative and quantitative), triangulation, and thoughtful comparisons to steer learning.
- Learning systems and iterative testing: Although EPOSSI focuses on *early planning*, it prepares for iterative testing and feedback-fully consistent with Scottish Approach to Change 's learning-system enabler and prototype and test / PDSA approach.
- Steps of change fit: EPOSSI strengthens Scottish Approach to Change 's early steps (Identify → Understand → Develop and design) and creates a clean bridge to Define and implement by requiring transition-to-launch decisions.

Health Foundation Q Community (2024) - *Quality Management Systems: resources to help you get started*

Link: [Quality Management Systems: resources to help you get... | Q Community](#)

Summary

This guide curates practical frameworks, tools and examples to help organisations design and embed whole-organisation Quality Management Systems (QMS). It frames QMS as a coordinated approach to planning, improving, controlling and assuring quality-drawing on the Juran Trilogy (with quality assurance added) and emphasising alignment to strategy, culture and board-to-frontline working. It stresses there is no single definition; instead, components should be dynamically linked, context-sensitive and supported by leadership and cultural change over time. The page also signposts enabling national policies (e.g., NHS IMPACT in England; Wales' Duty of Quality) and frameworks/standards (e.g., ISO 7101), plus case examples (e.g., ELFT, Jönköping) to illustrate how organisations operationalise daily quality control (standardisation, visual management, tiered huddles) alongside improvement and assurance.

Key arguments and findings

- A whole-organisation QMS integrates planning, improvement, control and assurance; components must be tightly linked and context-specific.
- Leadership, culture and strategy alignment are critical; implementation is multi-year and organisation-wide.
- Practical quality control at the frontline (standardisation, visual boards, tiered huddles, rapid escalation) sustains gains; assurance (audit, accreditation, compliance) checks the system meets intent.
- Momentum is bolstered by national levers (e.g., NHS IMPACT; Wales' Duty of Quality) and emerging standards (ISO 7101).

Where the QMS guide supports the Scottish Approach to Change

- Whole-system quality management. Q defines QMS as organisation-wide and strategy-aligned; Scottish Approach to Change 's QMS framework similarly spans planning, improving, maintaining and assuring quality as interconnected components.
- Clear vision and purpose. The guide underscores alignment to strategy and culture; Scottish Approach to Change lists Clear vision and purpose as a core enabler of successful, sustained change.
- Process rigour. Q highlights standardisation, visual management, huddles and escalation as day-to-day quality control; Scottish Approach to Change 's Process rigour enabler and its measurement/monitoring guidance mirror these controls.
- Leadership and culture. Q emphasises leadership behaviours and multi-year cultural change to embed QMS; Scottish Approach to Change identifies Leadership and culture (incl. governance and executive roles) as essential to change.
- People-led design. Q's quality planning starts with understanding patient/service-user needs and places control with those closest to the work; Scottish Approach to Change 's People-led enabler and co-design guidance align directly.
- Learning through iterative testing. Q promotes improvement methods (e.g., PDSA) within a connected management system; Scottish Approach to Change embeds learning systems and iterative prototype and test steps across its eight-step change cycle.
- Governance and assurance. Q positions assurance (audit/accreditation/compliance) as necessary alongside improvement; Scottish Approach to Change 's QMS and enablers integrate governance, assurance and evaluation to steward change.

Learning Systems, Continuous Improvement and Feedback Loops

Summary

Health Foundation (2024) - *How Improvement can help NHS productivity*

Link: [How improvement can help NHS productivity - The Health Foundation](#)

Summary

The Health Foundation and Q argue that boosting NHS productivity will only succeed if it's framed as a route to *better quality care*, not as "doing more with less." They propose five actions: build a shared, quality-centred productivity narrative; raise awareness of the interconnected conditions and methods that enable sustained improvement; create meaningful opportunities for system-wide collaboration and learning; focus improvement capacity on high-impact issues such as patient flow, failure demand and technology; and sustain improvement over time. The analysis stresses engagement with staff and patients, practical use of improvement science, and aligning frontline motivations with organisational goals-concerns echoed across the UK, including Scotland.

Key arguments and findings

- Reframe productivity as quality. Productivity gains should be positioned as maintaining or improving care quality to win support from staff and the public.
- Five action framework: (1) build a new narrative; (2) understand and mobilise enabling conditions and methods; (3) enable wide-scale collaboration and learning; (4) target flow, failure demand and tech where improvement methods have most promise; (5) ensure sustained focus over time.
- Whole-system engagement matters. Effective change connects frontline teams, organisations and national bodies, balancing patient experience with efficiency.
- Focus areas: Improving patient flow, reducing failure demand (avoidable work), and implementing technology are highlighted as near-term opportunities.
- UK-wide relevance. Similar productivity concerns are noted across the UK, including Scotland.

Where the analysis supports the Scottish Approach to Change

- Quality-centred narrative ↔ Clear vision and purpose. HF/Q's call for a shared, quality-first productivity story aligns with Scottish Approach to Change 's emphasis on a clear, co-owned vision that anchors decisions and trade-offs.
- Interconnected enablers ↔ Scottish Approach to Change 's five enablers. The need to mobilise infrastructural, cultural and capability factors mirrors Scottish Approach to Change 's enablers: *clear vision and purpose, process rigour, leadership and culture, people-led, and a learning system*.
- Collaboration and learning ↔ People-led and Learning system. HF/Q's stress on broad coalitions and reflective teams supports Scottish Approach to Change 's people-led design, psychological safety, and formal learning systems.
- Targeted improvement work ↔ Process rigour and testing. Prioritising flow, tackling failure demand, and deploying technology align with Scottish Approach to Change 's process rigour, measurement/monitoring, and iterative PDSA testing within the *Prototype and test* step.
- Sustaining and spreading change ↔ Scottish Approach to Change steps. The call to sustain improvement over time maps to Scottish Approach to Change 's *Embed and sustain* and *Review for spread* steps, with governance and project management to protect gains.

Atkins et al. (2023) - Effectiveness of QI collaboratives in UK surgical settings - Systematic review

[Link: Effectiveness of quality improvement collaboratives in UK surgical settings and barriers and facilitators influencing their implementation: a systematic review and evidence synthesis - PubMed](#)

Summary

This systematic review synthesised 15 reports covering 10 quality improvement collaboratives (QICs) in UK surgical services. Eight studies reported that their QICs achieved primary aims (covering patient outcomes and/or process indicators), while a stepped-wedge RCT found no improvement in patient outcomes, highlighting mixed effectiveness. Using the Consolidated Framework for Implementation Research (CFIR), the authors catalogued facilitators and barriers across intervention, inner/outer setting, individuals, and process domains; few barriers were intrinsic to the collaborative model itself. Overall, conclusions were cautious because many evaluations used weaker designs and reporting quality was variable. The authors recommend embedding robust evaluation designs in future collaboratives to strengthen causal inference about impact on surgical quality and outcomes.

Key arguments and findings

- Effectiveness is mixed: 8/10 QICs (15 reports) claimed success against primary aims, but the sole stepped-wedge RCT showed no improvement in patient outcomes.

- Context matters: Facilitators and barriers spanned CFIR domains (intervention, inner/outer setting, individuals, process), with few barriers inherent to the QIC intervention.
- Evidence quality limits certainty: Many evaluations had weak designs and variable reporting, warranting cautious interpretation.
- Call for rigour: Future QICs should build in stronger study designs and clearer reporting to credibly demonstrate impact.

Where this supports the Scottish Approach to Change

- Process rigour and evaluation: The paper’s call to embed strong study designs and measurement aligns with Scottish Approach to Change’s emphasis on “measurement, monitoring and evaluation” and rigorous project/programme management across the change cycle.
- Learning systems: QICs operationalise structured, multi-site learning-mirroring Scottish Approach to Change’s “Learning system” enabler that values rapid feedback loops, reflective practice, and spreading “bright spots.”
- Leadership and culture: CFIR-mapped determinants (inner setting, individuals, process) underscore Scottish Approach to Change’s need for enabling leadership, psychological safety, and cultures that support experimentation and improvement.
- Clear vision and purpose: Reported QIC success often hinges on clear aims and shared understanding-consistent with Scottish Approach to Change’s guidance to anchor change in a clear vision, strategy and explicit success criteria.
- People-led change: The review’s focus on multi-stakeholder engagement (teams, settings, processes) aligns with Scottish Approach to Change’s commitment to co-design and involving people who use and deliver services throughout the steps of change.

Endalamaw et al. (2024) - A scoping review of continuous quality improvement in healthcare system: conceptualization, models and tools, barriers and facilitators, and impact

[Link: A scoping review of continuous quality improvement in healthcare system: conceptualization, models and tools, barriers and facilitators, and impact - PubMed](#)

Summary

This scoping review synthesises 87 studies to clarify what continuous quality improvement (CQI) is, which models and tools are used, what enables or impedes implementation, and what impacts CQI delivers in healthcare. It finds 14 CQI models and 19 tools in use, with the Plan-Do-Study/Check-Act (PDSA/PDCA) cycle most common. Reported benefits span system “structure” (e.g., leadership, workforce, technology), care “processes” (coordination, access, safety, efficiency) and clinical outcomes (morbidity and mortality). Barriers cluster as cultural (e.g.,

fear/blame), technical, structural, and strategic (e.g., weak planning). Effective CQI is cyclic, team-based, data-driven, and iterative, requiring clear objectives, short learning cycles, and stakeholder engagement. The authors argue that leaders must cultivate CQI mindsets and proactively remove barriers to realise sustained quality gains.

Key arguments and findings

- CQI is defined as an iterative, team-based, data-driven cycle-identify gaps, test changes, evaluate, and adapt-rather than a one-off project.
- PDSA/PDCA dominates among 14 models and 19 tools catalogued; Lean, Six Sigma (DMAIC), and Breakthrough Series are also widely used.
- Impacts occur across structure, process and outcomes (Donabedian): better leadership/workforce/technology use; improved coordination, access, safety, efficiency; and reductions in morbidity/mortality.
- Common barriers include culture (resistance, blame), technical limitations, organisational structures/processes, and weak strategy/planning.
- Facilitators include multidisciplinary teams, short learning cycles, feedback loops, stakeholder involvement, and leadership commitment.

Where this supports the Scottish Approach to Change

- Process rigour: The review's emphasis on structured, iterative methods (especially PDSA) aligns with Scottish Approach to Change's "Prototype and test" step and its call for rigorous measurement, monitoring, and evaluation.
- Learning system: CQI's cyclic learning, rapid feedback, and "celebrate success and failure" ethos mirrors Scottish Approach to Change's Learning System enabler-continuous reflection, qualitative/quantitative data, and rapid feedback loops.
- Leadership and culture: The paper's identification of cultural barriers (fear/blame) and the need for leaders to enable CQI supports Scottish Approach to Change's call for psychologically safe, compassionate leadership that empowers innovation.
- People-led change: CQI's stress on multidisciplinary teams and stakeholder engagement reinforces Scottish Approach to Change's "People-led" enabler and guidance to co-design with people who use, deliver and enable services.
- Clear vision and purpose: The review notes the importance of clear objectives/mission for CQI teams, echoing Scottish Approach to Change's requirement to anchor decisions in a shared vision and strategy.
- Steps of change → spread: CQI collaboratives (e.g., Breakthrough Series) and standardisation link to Scottish Approach to Change's "Review for spread" step and guidance on when/how to scale ideas.

- Equity and access: Reported gains in accessibility and continuity of care align with Scottish Approach to Change 's focus on reducing inequalities and embedding rights-based, person-centred services.

Golburean et al. (2024) - *A systematic review and proposed framework for sustainable learning healthcare systems*

[Link: A systematic review and proposed framework for sustainable learning healthcare systems - PubMed](#)

Summary

This systematic review synthesises recent evidence on Learning Health Systems (LHS) and proposes a framework for making them sustainable at scale. Adoption remains fragmented-often confined to a single department or only parts of the LHS cycle-despite growing interest. The authors catalogue 33 implementation strategies (e.g., auditing and feedback, local consensus-building, and modifying record systems) and extract three integrated findings: (1) robust digital infrastructure optimises service delivery; (2) LHS participation can improve patient care and outcomes; and (3) LHS can influence provider behaviour and the wider health system. Notably, patient engagement, aligned governance, and a rapid-learning culture were the least reported. The paper calls for broader, system-level implementations with stronger evaluation of patient, provider, population, and cost outcomes.

Key arguments and findings

- Adoption gap: LHS are rarely implemented end-to-end; efforts tend to be departmental or partial cycle.
- Implementation playbook (33 strategies): includes changing record systems, local consensus discussions, and audit and feedback.
- Three integrated findings: (i) digital infrastructure optimises service delivery; (ii) positive impact on patient care/outcomes; (iii) influence on providers and the health system.
- Underdeveloped enablers: patient engagement, aligned governance, and rapid-learning culture were the least reported.
- Call to action: scale beyond single services and evaluate effects on outcomes and costs with stronger, theory-informed designs.

Where this supports the *Scottish Approach to Change*

- Learning System as a core enabler - The paper's emphasis on continuous learning loops and timely feedback aligns with Scottish Approach to Change 's Learning System enabler- "continual, rapid learning from iterative testing," protected time for reflection, rapid feedback loops, and knowledge-to-action processes.

- Process rigour: measurement, monitoring, evaluation - Findings that LHS require strong digital infrastructure and routine data flows echo Scottish Approach to Change 's insistence on measurement, monitoring and evaluation, triangulating qualitative and quantitative data, spotting trends/outliers, and using data to guide change.
- Governance and leadership and culture - The review highlights aligned governance and a culture of rapid learning as under-reported yet essential-precisely the Scottish Approach to Change enablers calling for curious leadership, psychologically safe learning spaces, and effective governance that accelerates change rather than stalls it.
- People-led change (patient engagement) - The reported gap in patient engagement reinforces Scottish Approach to Change 's emphasis on people-led design, meaningful involvement, trauma-informed practice, and embedding human rights from the outset-areas Scottish Approach to Change treats as non-negotiable enablers for sustainable improvement.
- Steps of Change ↔ LHS cycle (operationalisation) - The paper's call to implement LHS at scale matches Scottish Approach to Change 's eight steps of change (identify → understand → develop/design → prototype/test → review → implement → embed/sustain → review for spread) and its use of PDSA cycles for iterative testing and learning.
- Quality Management Systems (QMS) and system-wide alignment - LHS' system-level data and feedback infrastructure support Scottish Approach to Change 's QMS-coordinating planning, improving, maintaining and assuring quality, with enablers (vision, process rigour, people-led, leadership and culture) integrated across the organisation.

Golburean et al. (2024) - A systematic review and proposed framework for sustainable learning healthcare systems

[Link: The effectiveness of quality improvement collaboratives in improving stroke care and the facilitators and barriers to their implementation: a systematic review - PubMed](#)

Summary

This systematic review synthesises 12 quality improvement collaboratives (QICs) in stroke care and finds that QIC participation consistently improves clinical processes (e.g., adherence to evidence-based practices). At the same time, patient-level outcomes show limited or uncertain improvement-likely reflecting the short duration and implementation variability of collaboratives. Key facilitators include inter- and intra-organisational networking, robust feedback mechanisms, engaged leadership, and access to exemplars; major barriers include organisational restructuring, weak prioritisation/support, and time and resource constraints. Notably, patient/carer

involvement and explicit attention to health inequalities were rare within the reviewed QICs. The authors recommend designing collaboratives with stronger leadership, feedback loops, and sustainability planning, and call for research on the persistence of gains post-collaborative.

Key arguments and findings

- QICs reliably improve clinical processes, but evidence for patient outcomes is limited and uncertain, partly due to short-term programmes.
- Facilitators: cross-organisational networking, feedback/data use, leadership engagement, and sharing best practice examples.
- Barriers: organisational change during the QIC, lack of prioritisation/support, and insufficient time/resources for teams.
- Gaps: minimal patient/carer involvement and limited consideration of health inequalities across collaboratives.
- Implication: plan for sustainability beyond the collaborative period and strengthen implementation infrastructure.

Where this supports the Scottish Approach to Change (SAC)

- Leadership and culture: The review's emphasis on leadership engagement as a facilitator aligns with SAC's enabler that leaders create conditions for change, remove barriers, and model collaboration.
- Process rigour and feedback: QICs benefit from feedback mechanisms and structured methods-mirroring SAC's focus on rigorous governance, measurement/monitoring, and project management through the steps of change (e.g., Prototype and test, Review for implementation).
- Learning systems: The need for networking and sharing exemplars echoes SAC's Learning system enabler, which promotes iterative testing, rapid feedback loops, and "knowledge into action."
- Embed and sustain: Uncertain durability of QIC effects supports SAC's explicit steps to Embed and sustain and review for spread to move beyond pilot phases and secure long-term adoption.
- People-led and inequalities: The review's finding that patient/carer involvement and inequalities were rarely addressed reinforces SAC's call for people-led change and proactive inequalities focus throughout planning and design

David Atkins, Amy M. Kilbourne, and David Shulkin (2017) - *Moving From Discovery to System-Wide Change: The Role of Research in a Learning Health Care System: Experience from Three Decades of Health Systems Research in the Veterans Health Administration.*

[Link: *Moving From Discovery to System-Wide Change: The Role of Research in a Learning Health Care System: Experience from Three Decades of Health Systems Research in the Veterans Health Administration | Annual Reviews](#)**

Summary

Atkins, Kilbourne and Shulkin distil three decades of Veterans Health Administration (VHA) experience building a learning health care system (LHS). As an integrated system with >\$1B/year in research, the VHA aligned science with clinical priorities, leveraged national EHR data, and used implementation science (e.g., QUERI) to move evidence into routine care. They describe three pathways by which research changes practice: (1) guideline-driven diffusion of definitive trial results; (2) co-creation when evidence is incomplete (researchers and operations iterate together); and (3) policy-driven “natural experiments” that generate evidence at scale. Case examples (e.g., integrated primary care-mental health, telehealth for PTSD) show measurable quality gains and the importance of top-down and bottom-up spread.

Key arguments and findings

- Large integrated systems can operationalise an LHS by embedding research, aligning it to operational priorities, and exploiting enterprise data (EHRs) to evaluate and scale change.
- Three research-to-practice pathways-guideline diffusion, co-produced innovation, and policy-enabled natural experiments-explain how evidence shapes care at the system level.
- The VHA’s QUERI programme illustrates structured implementation science that accelerates uptake of best practices across a national network.
- Mental health examples (PC-MHI, telehealth, facilitated psychotherapy) demonstrate reduced access barriers and better quality than many private-sector comparators, highlighting the value of iterative testing and spread.
- Effective spread requires both top-down sponsorship and bottom-up engagement, plus metrics beyond “big data” to include patient- and provider-centred “deep data.”

Where it supports the Scottish Approach to Change

- Learning system ↔ Scottish Approach to Change Learning System (enabler): The article’s LHS core (continuous measurement, reflective practice, rapid feedback, “bright spots,” spread) mirrors Scottish Approach to Change’s learning system emphasis on infrastructure, psychological safety, and knowledge-to-action loops.
- Process rigour and governance: QUERI, use of enterprise EHR data, formal review points, and staged spread align with Scottish Approach to Change’s call for

measurement/monitoring, project management, clear governance, and proportionate, structured processes across the eight steps of change.

- People-led design and “deep data”: The VHA’s stress on combining big data with patient/provider-centred qualitative insight supports Scottish Approach to Change ’s people-led engagement, triangulation of data, and trauma-informed, inclusive practice.
- From testing to spread: VHA examples (e.g., telehealth for PTSD; PC-MHI) show iterative prototype-test → review → implement → embed → spread, directly reflecting Scottish Approach to Change ’s eight-step cycle and its formal “review for implementation/spread” decision points.
- Leadership and culture: The article highlights the necessity of executive sponsorship, shared priorities, and distributed leadership to enable scale-consistent with Scottish Approach to Change ’s leadership and culture enabler (creating safe spaces, removing barriers, empowering teams).

Kislov R, Wilson PM, Knowles S, Boaden R. (2018) - *Learning from the emergence of NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs): a systematic review of evaluations*

[Link: Learning from the emergence of NIHR Collaborations for Leadership in Applied Health Research and Care \(CLAHRCs\): a systematic review of evaluations - PMC](#)

Summary

This 2018 Implementation Science review synthesises 26 evaluations (reported in 37 papers) of England’s NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs). It finds evaluations concentrated on how these research-practice partnerships were formed and organised (vision, values, structures), the role of boundaries, and the deployment of knowledge brokers/hybrid roles to mobilise knowledge, alongside patient/public involvement and capacity building. However, robust evidence of impact on health-care provision or outcomes was limited, with little clarity on which knowledge-mobilisation approaches work, where, how, and why. The authors call for evaluations that interrogate mechanisms and context and position CLAHRCs within “learning health system” thinking.

Key arguments and findings

- CLAHRCs were locally shaped university-NHS partnerships (with matched funding) designed to accelerate applied research into routine practice.
- Most evaluations examined partnership formation (vision, values, structures) and boundary work-especially knowledge brokers and hybrid roles-as central to knowledge mobilisation.

- Patient and public involvement and capacity building featured prominently across evaluations.
- There was a notable lack of evidence on early, measurable impacts on services or outcomes; the paper urges more rigorous, mechanism-focused evaluation to determine what works, where, and why.
- CLAHRCs are positioned conceptually within learning health systems that blend knowledge production and implementation.

Where it supports the Scottish Approach to Change

- People-led change. The emphasis on patient/public involvement and co-production in CLAHRCs mirrors Scottish Approach to Change 's "People-led" enabler (designing and delivering change with people who use services).
- Learning system. CLAHRCs are framed within *learning health systems*, aligning directly with Scottish Approach to Change 's "Learning system" enabler that values continual reflective practice, data-informed iteration, and knowledge mobilisation.
- Leadership and culture; clear vision and purpose. Evaluations focusing on partnership vision/values and cross-boundary leadership echo Scottish Approach to Change 's call for clear purpose and enabling leadership and culture.
- Process rigour (measurement, monitoring, evaluation). The paper's finding of limited impact evidence strengthens Scottish Approach to Change 's emphasis on rigorous measurement, governance, and staged testing (e.g., prototype/test, review for implementation) to demonstrate outcomes.
- Steps of change. CLAHRCs' locally tailored development and capacity building resonate with Scottish Approach to Change 's end-to-end cycle (identify → understand → develop/design → prototype/test → implement → embed/sustain → review for spread).

Tom Hardie, Tim Horton, Nell Thornton-Lee, Joe Home, Penny Pereira. (2022) - *Developing learning health systems in the UK: Priorities for action*

[Link: Developing learning health systems in the UK: Priorities for action](#)

Summary

Developing learning health systems in the UK (Health Foundation, 2022) argues that a learning health system (LHS) is a systematic, iterative, *data-driven* approach that enables teams and providers to learn from routine care and improve as "business as usual." The report finds a persistent gap between the *promise* and *practice* of LHSs, driven by inconsistent definitions, variable digital maturity, insufficient analytical capacity, and uneven improvement capability. It proposes four focus areas-learning from data, harnessing technology, nurturing learning communities, and implementing improvements-and sets out eight priority actions for

policymakers and organisational leaders (e.g., clear vision, interoperability, protected time for frontline teams). Sixteen UK case studies illustrate practical pathways from local microsystems to national initiatives. Overall, LHSs are positioned as an engine for recovery, productivity, and sustainable service transformation.

Key arguments and findings

- What an LHS is: a provider or network that learns from routine care and improves continuously as part of day-to-day operations-*not* a bolt-on programme.
- Gap to close: large disparity between interest in LHSs and real-world delivery due to unclear vision/definitions and limited evidence on “how to start.”
- Four domains for progress: (1) learning from data, (2) technology, (3) learning communities/human infrastructure, (4) implementing improvements.
- Eight priority policy/leadership actions: build a clear narrative and evidence base; improve digital maturity; grow analytical workforce and open tools; achieve interoperability; strengthen implementation and improvement capability; cultivate learning culture; protect frontline time; develop organisational improvement capability.
- Practically grounded: 16 UK case studies show LHS approaches spanning full systems and component areas (e.g., Flow Coaching Academy, PINCER, SAIL, PReCePT2).
- Why it matters now: LHSs provide a scalable “implementation mechanism” to adapt and embed innovations, aiding recovery and long-term redesign.

Where it supports the Scottish Approach to Change

- Learning system (Scottish Approach to Change enabler) ↔ Learning communities and human infrastructure in LHSs: both emphasise networks, psychological safety, reflective practice, and turning knowledge into action.
- Process rigour (Scottish Approach to Change enabler) ↔ Implementing improvements and data use in LHSs: shared focus on measurement, triangulating qualitative/quantitative data, iterative testing (e.g., PDSA), governance, and evaluation.
- Leadership and culture (Scottish Approach to Change enabler) ↔ Board-level responsibility and learning culture in LHSs: both call for visible, compassionate leadership, protected time, and embedding improvement in strategy.
- People-led (Scottish Approach to Change enabler) ↔ Stakeholder communities in LHSs: both prioritise co-design with people who use services, inclusion, and ethical engagement to reduce inequalities.
- Clear vision and purpose (Scottish Approach to Change enabler) ↔ Clear narrative/vision for LHSs: both frameworks insist on an explicit, shared purpose to align decisions, investment, and spread.

- Scottish Approach to Change steps: Prototype and Test → Review → Define and Implement → Embed and Sustain → Spread ↔ LHS as “implementation mechanism” that iterates, embeds, and scales what works.
- Quality Management System in Scottish Approach to Change ↔ System interoperability, analytical capability, and digital maturity in LHSs: both stress whole-organisation systems that connect planning, improving, maintaining, and assuring quality.

Centre for Public Impact (2021) - *Human Learning Systems: Public Service for the Real World*

Link: [Human Learning Systems: Public Service for the Real World](#)

Summary

The report argues that New Public Management (NPM)-characterised by “markets, managers and metrics”-creates a dehumanising, fragmented and wasteful public service, incentivising gaming rather than learning. It proposes Human Learning Systems (HLS) as a practical alternative grounded in three principles: being human (relationships and bespoke support), enabling continuous learning (rigorous, shared inquiry), and supporting healthy systems (collaboration across actors and scales). HLS is enacted through learning cycles, experimentation, and governance that optimises for learning over control, with case studies from local to national levels. The report highlights systems leadership and “humble government” that devolve power, build trust, and adapt to context, closing the strategy-implementation gap.

Key arguments and findings

- Diagnosis of the problem: NPM’s target/contract regime produces defensive cultures, data gaming, and higher costs with more complaints, divorcing services from real lives.
- Core HLS principles: Put people and relationships first; make learning the management strategy; work on the system (multiple scales, connected cycles).
- Method in practice: Use learning cycles to understand context, co-design experiments, measure meaningfully, and govern for learning rather than control.
- Leadership shift: From command-and-control to systems leadership and humble government that empowers practitioners and residents to learn and decide together.
- Evidence base: Synthesis of dozens of case studies demonstrates HLS is workable across organisations, places, and countries, improving outcomes by adapting to complexity.

Where HLS supports the Scottish Approach to Change (Scottish Approach to Change)

- People-led change - HLS centres relationships, bespoke support and co-design; Scottish Approach to Change names People-led as a core enabler and embeds trauma-informed, inclusive engagement to design for real needs.

- Learning as the engine of change - HLS replaces performance control with learning cycles and governance for learning; Scottish Approach to Change makes Learning system one of five enablers and details how learning networks, reflection, data and feedback loops drive improvement.
- Rigour in process and measurement - HLS emphasises rigorous inquiry, experimentation and meaningful measurement; Scottish Approach to Change 's Process rigour enabler, PDSA testing, and guidance on measurement/monitoring operationalise that discipline.
- Clear purpose and strategic alignment - HLS begins with clarifying shared purpose within the system; Scottish Approach to Change 's Clear vision and purpose enabler, with strategy-to-action guidance, mirrors this starting point.
- Leadership and culture - HLS calls for systems leadership/humble government-devolving power, enabling trust and adaptation; Scottish Approach to Change 's Leadership and culture enabler specifies the leadership capabilities and behaviours that create safe, learning-oriented environments.
- End-to-end change cycle - HLS' design-test-learn approach aligns with Scottish Approach to Change 's eight Steps of change (Identify → Review for spread), including prototyping, formal review for implementation, and spread decisions.
- Equity and context - HLS insists outcomes are created in complex systems and must be tailored to context; Scottish Approach to Change explicitly hard-wires reducing inequalities and human rights into planning and evaluation-complementary emphases on person-centred, context-sensitive change.

Halima Khan (2023) - *Social RandD: the next phase of public service reform?*

Link: [Social-RD the-next-phase-of-public-service-reform.pdf](#)

Summary

This Bennett School policy brief argues that public service reform needs a “social RandD” approach that couples innovation methods with explicit social goals. It critiques past New Public Management reforms and proposes reform as innovation through people, enabled by relationships, knowledge and technology. The paper advances five alternative assumptions for policymaking (treat reform as social change; design as a system; view people as having potential; embrace plural knowledge; respect context) and translates them into three priorities: involve citizens and frontline staff; learn continuously via feedback and experimentation; and develop people’s capabilities (dignity, hope, purpose, agency). It outlines a future agenda including embedding an RandD system, investing in social infrastructure and knowledge, and applying social RandD locally where learning loops are strongest.

Key arguments and findings

- Performance has deteriorated; money alone won’t fix broken models-so reform must change how services are designed, delivered and learned from.

- Two core critiques: social policy often ignores social needs (belonging, validation, agency), and current reform lacks RandD (methods, infrastructure, investment).
- Social RandD concept: innovate through people; relationships are central enablers alongside knowledge and technology.
- Five refreshed assumptions for policy (social change, systems lens, human potential, plural knowledge, contextual fit).
- Three priorities for practice: (1) deliberation/participation with citizens and staff, (2) learning loops and experimentation, (3) human development capabilities.
- Future agenda: embed an RandD system; invest in social infrastructure/knowledge; strengthen localism/devolution; deepen public-sector productivity via learning and workforce motivation.

Where it supports the Scottish Approach to Change

- People-led change and co-design. Social RandD prioritises deliberation with citizens and frontline staff; Scottish Approach to Change’s *People-led* enabler emphasises meaningful engagement, trauma-informed practice, and co-design to make services personal, coordinated, and enabling.
- Learning systems and continuous feedback. The brief calls for learning throughout policymaking via evidence, feedback loops and experimentation; Scottish Approach to Change embeds *Learning systems*, iterative testing and reflective practice across governance.
- Iterative testing and RandD discipline. Social RandD argues for systematic development and spread of better approaches; Scottish Approach to Change operationalises this through *Prototype and Test* (e.g., PDSA), *Review for implementation*, and *Review for spread*.
- Process rigour and measurement. The paper’s RandD framing aligns with Scottish Approach to Change’s *Process rigour* (governance, measurement/monitoring/evaluation, project management, commissioning) to move beyond ad-hoc pilots.
- Context-sensitive, locally driven solutions. Social RandD stresses context and localism/devolution; Scottish Approach to Change highlights “developing locally driven solutions,” ethical commissioning, and tailoring to local need and conditions.
- Human development and leadership/culture. The brief centres dignity, hope, purpose and agency; Scottish Approach to Change’s *Leadership and culture* enabler builds psychologically safe, empowering environments and leadership capabilities to realise those outcomes.
- Systematic spread and sustainability. Social RandD asks what can scale and how; Scottish Approach to Change makes spread and sustainment explicit steps (*Embed and sustain* → *Review for spread*), supported by Quality Management Systems.

Hesselgreaves, H., Hobbs, C., French, M., Wilson, R., and Lowe, T. (2025) - *Applying critical systems thinking through phronetic pluralism: Learning from human learning systems and the adaptive learning pathway*

[Link: Applying critical systems thinking through phronetic pluralism: Learning from human learning systems and the adaptive learning pathway](#)

Summary

The paper argues that today's complex public service challenges demand *systemic leadership* and *adaptive learning*, and shows how Critical Systems Thinking (CST) can be translated into practice through "phronetic pluralism." Using Human Learning Systems (HLS) and the Adaptive Learning Pathway (ALP) as exemplars, the authors demonstrate pragmatic, multi-method ways to move beyond New Public Management's target-driven orthodoxy toward learning-led, relational practice. They advocate creative holism-selecting and combining methods across paradigms-and emphasize meso-level sense-making, continuous reflection, and engaged scholarship at the science-policy interface (e.g., UK Cabinet Office work). The core claim is that plural, learning-centred approaches make systems thinking usable for managers and policymakers, improving real-world outcomes while keeping attention on power and context.

Key arguments and findings

- Practice gap and remedy: Systems thinking often stalls as either fatalism or idealism; *phronetic pluralism* provides a pragmatic bridge from CST to practice.
- Exemplars in use: HLS and ALP operationalise CST by embedding continual learning, relational knowledge and adaptive management in public service reform and systemic leadership.
- Creative holism: Managers should draw from multiple methods (e.g., boundary critique, SSM, system dynamics), guided by context, across creativity → choice → implementation → reflection phases.
- Governance relevance: There is growing policy pull (e.g., UK Cabinet Office) to "weave systems thinking" into policy design, legitimising pluralistic, learning-led approaches.

Where it supports the Scottish Approach to Change

- Learning System enabler → HLS/ALP: The paper's call for continuous, rapid learning, sense-making, and feedback loops directly aligns with Scottish Approach to Change's Learning System enabler (culture, evaluation, networks, reflective practice).
- Leadership and culture → systemic leadership: Emphasis on systemic leadership, psychological safety and reflective practice mirrors Scottish Approach to Change's Leadership and culture guidance (empowerment, collaboration, presence and compassion).

- People-led design → relational practice: The article’s focus on relational knowledge and participatory, practice-based learning underpins Scottish Approach to Change ’s People-led enabler (meaningful engagement, co-design, inclusion and ethics).
- Process rigour → creative holism: Jackson’s four-phase creative holism provides structured, yet flexible rigour that complements Scottish Approach to Change ’s expectations for governance, measurement, project management and commissioning.
- Iterative change cycle → Scottish Approach to Change steps: The paper’s advocacy of iterative learning and adaptation supports Scottish Approach to Change ’s eight steps of change-especially *Develop and design* → *Prototype and test* → *Review for implementation* → *Define and implement* → *Embed and sustain* → *Review for spread*.

Hannah Hesselgreaves, Max French, Melissa Hawkins, Toby Lowe, Amy Wheatman, Mike Martin and Rob Wilson (2021) - *New development: The emerging role of a ‘learning partner’ relationship in supporting public service reform*

[Link: *New development: The emerging role of a ‘learning partner’ relationship in supporting public service reform*](#)

Summary

This article argues that public service reform in complex systems is best supported by *learning partnerships*-nested, relational arrangements between public managers, consultants and academics that make continuous, reflective learning the engine of change. It positions these partnerships within action learning-action research traditions and complexity-informed public management, moving beyond New Public Management to practices like convening cross-stakeholder conversations, curating shared evidence, and iterating through experimentation. The paper outlines roles (practitioner, consultant, academic), typical activities (“convene, converse, curate”), and the governance needed (e.g., supervision for learning partners) while acknowledging tensions and dualisms inherent in such collaborations. Ultimately, it contends that building soft learning infrastructure across organisations improves sense-making and enables sustainable, system-level improvement.

Key arguments and findings

- Learning partnerships as a model: A structured, relational mechanism (practitioner-consultant-academic) that embeds continuous learning in reform efforts.
- From NPM to complexity-informed practice: Shift from target/command logics to experimentation, reflection and sense-making across systems.
- Core activities: “Convene, converse, curate” to enable multi-level learning (first-, second-, third-person) and knowledge mobilisation.

- Methodological roots: Builds on action learning/action research, double-/triple-loop learning, and communities of practice.
- Implementation realities: Highlights dilemmas (e.g., competing agendas, power dynamics) and calls for governance/supervision to sustain the partnership model.

Where it supports the Scottish Approach to Change

- Learning systems: The paper's call for "soft learning infrastructure" and iterative learning mirrors Scottish Approach to Change's *Learning system* enabler-using data, reflection and rapid feedback loops to turn knowledge into action.
- People-led and collaborative culture: Emphasis on convening diverse actors and nurturing relationships aligns with Scottish Approach to Change's *People-led* enabler and its focus on co-design, inclusion and trauma-informed engagement cultures.
- Leadership and culture for change: The article's recognition of tensions and the need for psychological safety/governance complements Scottish Approach to Change's call for leadership that creates safe spaces, empowers teams and models compassionate behaviours.
- Process rigour with flexibility: Using AL/AR methods, iterative testing, and sense-making supports Scottish Approach to Change's *Process rigour*-structured governance, measurement, and evaluation that still adapts to context.
- End-to-end change cycle: The partnership model's experimentation and reflection map onto Scottish Approach to Change's steps (Identify → Understand → Develop and design → *Prototype and test* → Review/Implement → *Embed and sustain* → *Review for spread*).

Toby Lowe, Max French, Melissa Hawkins, Hannah Hesselgreaves and Rob Wilson (2021) - *New development: Responding to complexity in public services-the humanlearning systems approach*

[Link: *New development: Responding to complexity in public services-the human learning systems approach*](#)

Summary

The article proposes Human Learning Systems (HLS) as an alternative to New Public Management for complex public services. Drawing on work with 300+ organisations, it argues that outcomes emerge from systems, not discrete interventions, and sets out three pillars: Human (relational, strengths-based practice encapsulated by *VEST*-Variety, Empathy, Strengths, Trust), Learning (iterative experimentation, using data for reflection rather than targets, and commissioning for learning capacity), and Systems (stewarding roles that build trust, shared purpose, and collaboration over competition). The authors frame four types of complexity-experiential, compositional, dynamic, and governance-and report that HLS provides a common language and

community infrastructure, with early exemplars showing promise while calling for complexity-aware evaluation and modest attribution claims.

Key arguments and findings

- NPM's limitations in complexity: Target- and market-driven orthodoxy struggles with "wicked" problems; HLS offers a different management logic.
- Three-pillar model (Human-Learning-Systems):
 - *Human*: centre relationships and strengths (VEST).
 - *Learning*: iterative experimentation, "funding for learning," and data for reflection, not gaming.
 - *Systems*: stewarding shared purpose across actors; aligning commissioning to enable collaboration.
- Four domains of complexity (experiential, compositional, dynamic, governance) require adaptive, relational practice.
- Emerging practice and evidence: A growing collaborative community and case examples (e.g., local prototyping, co-commissioning) indicate improvements; evaluation should be complexity-informed and cautious about attribution.

Where the article supports the Scottish Approach to Change

- Learning culture and learning systems: HLS makes *learning* the engine of improvement; Scottish Approach to Change 's *Learning system* enabler embeds reflective practice, learning networks, and rapid feedback loops.
- Process rigour through evidence and iteration: HLS advocates iterative testing and using data for reflection; Scottish Approach to Change stresses *Measurement, monitoring and evaluation*, PDSA cycles, and project management to add rigour.
- System stewardship and collaboration: HLS calls for supra-organisational *system stewarding* and commissioning for collaboration; Scottish Approach to Change details *system stewards, learning partners*, and ethical commissioning to unite sectors.
- Clear purpose and shared vision: HLS emphasises establishing shared purpose across actors; Scottish Approach to Change 's *Clear vision and purpose* enabler anchors choices, trade-offs, and alignment.
- Leadership and culture for safe experimentation: HLS promotes positive "error cultures" and trust in public servants; Scottish Approach to Change highlights leadership behaviours that create psychologically safe spaces for innovation.
- Compatibility with Scottish Approach to Change steps of change: HLS's iterative experimentation maps onto Scottish Approach to Change steps-*Identify/Understand* → *Develop and design* → *Prototype and test* → *Review for implementation* → *Define and implement* → *Embed and sustain* → *Review for spread*.

James Plunkett (2026) - *Can Test and learn Methods Save the NHS*

[Link: *Can Test and Learn methods save the NHS? | by James Plunkett | Feb, 2026 | Medium*](#)

Summary

James Plunkett argues that “test and learn” (iterative, feedback-driven) methods can and should be used in healthcare, but they must be adapted to the NHS’s specific realities: clinical risk, regulatory constraints, entrenched hierarchy, and evidence expectations. He calls for embedding clinical expertise inside multidisciplinary design teams (not as a late-stage gate), fusing service-design iteration with established research and evaluation practices, and creating operating environments that permit small, safe tests with rapid learning cycles. He also highlights the need for better data and interoperability to shorten feedback loops and for cultural shifts that reduce hierarchy, enable psychological safety, and normalise iteration beyond one-off “pilots.” The piece concludes with proposals for building capability and governance to scale what works-quickly but safely-across services.

Key arguments and findings

- Healthcare is different-so adapt “test and learn.” Iteration is viable in the NHS but must respect safety, ethics, regulation and evidence standards; therefore, methods need tailoring rather than simple transplant from other sectors.
- Embed clinicians in design teams from the start. Clinical expertise should sit *inside* multidisciplinary teams (not as an end-stage assurance step) so testing learns quickly without compromising safety.
- Fuse design iteration with research/evaluation. Pair agile prototyping with accepted research approaches so tests generate credible evidence while improving real-world delivery.
- Fix data and interoperability to power rapid feedback. Poor integration blocks improvement: enforcing standards and learning from existing NHS innovators is essential.
- Shift culture: reduce hierarchy; normalise continuous iteration (not finite “pilots”). Language and norms matter; teams need psychological safety and permission to keep iterating beyond a go/no-go milestone.

Where it supports the Scottish Approach to Change

- Iterative testing aligns with Scottish Approach to Change ’s Steps of Change. Plunkett’s “test and learn” maps directly to Prototype and Test with small-scale PDSA cycles, then Review for Implementation, Define and Implement, Embed and Sustain, and Review for Spread.
- Multidisciplinary, clinician-embedded teams ↔ Scottish Approach to Change ’s people mix. Scottish Approach to Change specifies involving clinicians, people with lived

experience, third sector, data, service design, QI and PMO skills across the cycle-precisely the team shape he advocates.

- Culture and leadership enablers. His call to tackle hierarchy and create psychological safety reflects Scottish Approach to Change 's Leadership and Culture enabler and learning-oriented governance (curiosity, reflective practice).
- Learning systems. The article's emphasis on shortening feedback loops and sharing what works is consistent with Scottish Approach to Change 's Learning System enabler (measurement, reflective practice, rapid feedback).
- Process rigour and evidence. Combining design iteration with evaluation mirrors Scottish Approach to Change 's Process Rigour (measurement, monitoring, evaluation; proportionate governance; project management).
- People-led change. Engaging staff and communities early and throughout testing aligns with Scottish Approach to Change 's People-Led enabler and the emphasis on co-design to build ownership and sustain adoption.

From pilots to spread. Moving beyond one-off pilots to sustained improvement and scaling mirrors Scottish Approach to Change 's explicit stages for Embed and Sustain and Review for Spread.

Lowther HJ, Harrison J, Hill JE, Gaskins NJ, Lazo KC, Clegg AJ, Connell LA, Garrett H, Gibson JME, Lightbody CE, Watkins CL.(2021) - *The effectiveness of quality improvement collaboratives in improving stroke care and the facilitators and barriers to their implementation: a systematic review.*

[Link: *The effectiveness of quality improvement collaboratives in improving stroke care and the facilitators and barriers to their implementation: a systematic review - PubMed*](#)

Summary

This systematic review synthesises 12 quality improvement collaboratives (QICs) in stroke care and finds that QIC participation consistently improves clinical processes (e.g., adherence to evidence-based practices). At the same time, patient-level outcomes show limited or uncertain improvement-likely reflecting the short duration and implementation variability of collaboratives. Key facilitators include inter- and intra-organisational networking, robust feedback mechanisms, engaged leadership, and access to exemplars; major barriers include organisational restructuring, weak prioritisation/support, and time and resource constraints. Notably, patient/carer involvement and explicit attention to health inequalities were rare within the reviewed QICs. The authors recommend designing collaboratives with stronger leadership, feedback loops, and sustainability planning, and call for research on the persistence of gains post-collaborative.

Key arguments and findings

- QICs reliably improve clinical processes, but evidence for patient outcomes is limited and uncertain, partly due to short-term programmes.
- Facilitators: cross-organisational networking, feedback/data use, leadership engagement, and sharing best practice examples.
- Barriers: organisational change during the QIC, lack of prioritisation/support, and insufficient time/resources for teams.
- Gaps: minimal patient/carer involvement and limited consideration of health inequalities across collaboratives.
- Implication: plan for sustainability beyond the collaborative period and strengthen implementation infrastructure.

Where this supports the Scottish Approach to Change (SAC)

- Leadership and culture: The review's emphasis on leadership engagement as a facilitator aligns with SAC's enabler that leaders create conditions for change, remove barriers, and model collaboration.
- Process rigour and feedback: QICs benefit from feedback mechanisms and structured methods-mirroring SAC's focus on rigorous governance, measurement/monitoring, and project management through the steps of change (e.g., Prototype and test, Review for implementation).
- Learning systems: The need for networking and sharing exemplars echoes SAC's Learning system enabler, which promotes iterative testing, rapid feedback loops, and "knowledge into action."
- Embed and sustain: Uncertain durability of QIC effects supports SAC's explicit steps to Embed and sustain and review for spread to move beyond pilot phases and secure long-term adoption.
- People-led and inequalities: The review's finding that patient/carer involvement and inequalities were rarely addressed reinforces SAC's call for people-led change and proactive inequalities focus throughout planning and design

Digital, Data and Technology-Enabled Transformation

Summary

James et al. (2021) - *Spread, Scale-up, and Sustainability of Video Consulting in Health Care*

Link: [Spread, Scale up, and Sustainability of Video Consulting in Health Care](#)

Summary

This systematic review synthesises evidence on spreading, scaling, and sustaining video consultations beyond pilots. Drawing on the NASSS framework, the authors analysed 13 papers covering 10 services across six regions, spanning video-to-home, hub-and-spoke, and national rollouts. They identify enablers-committed leadership and local champions, supportive reimbursement, usable technology, pre-existing relationships, and capacity to adapt over time-and recurring barriers, including weak long-term strategy, resistance to change, reimbursement/cost frictions, and limited digital confidence among staff. Crucially, the literature often treats scale-up as multiple technical deployments rather than a distinct, theory-informed organizational change process, leaving an evidence gap on how to embed and sustain video consulting at the system level. The authors call for more rigorous, theory-driven research to support mainstreaming of video consultations post-COVID-19.

Key arguments and findings

- Scope and typologies: 13 studies/10 services in six regions; models included *video-to-home*, *hub-and-spoke*, and national programs.
- Enablers: visible leadership and a telehealth champion; appropriate reimbursement; user-friendly tech; strong inter-staff relationships; and adaptation of technology/services over time.
- Barriers: lack of long-term strategic planning; resistance to change; cost/reimbursement challenges; and limited staff technical experience.
- Theory gap: spread/scale often framed as a sum of implementations, not a distinct, theory-informed change process; call for stronger evidence on sustainability.

Where it supports the Scottish Approach to Change

- Leadership and culture: The review's emphasis on embedded leadership and local champions mirrors Scottish Approach to Change's enabler that leaders create the conditions for experimentation, remove barriers, and model improvement behaviours.
- Clear vision and purpose: Failures linked to an absent long-term strategy reinforce Scottish Approach to Change's insistence on an explicit vision/purpose to anchor decisions and trade-offs.
- People-led change: Value of pre-existing staff relationships and stakeholder buy-in aligns with Scottish Approach to Change's people-led enabler-co-design with users, families, and frontline teams.
- Process rigour: Reimbursement, governance, and service design issues map to Scottish Approach to Change's process rigour (governance for momentum, measurement/monitoring, proportionate project management and commissioning).
- Learning system: The need for adaptation over time supports Scottish Approach to Change's learning systems-iterative testing (e.g., PDSA), critical reflection, and rapid feedback loops to embed and spread what works.
- Steps of change: The article's spread/sustainability focus aligns with Scottish Approach to Change's end-to-end cycle (prototype and test → review for implementation → define and implement → embed and sustain → review for spread).

Ross J, Stevenson F, Lau R, Murray E. (2016) - *Factors that influence the implementation of e-health: a systematic review of systematic reviews*

[Link: Factors that influence the implementation of e-health: a systematic review of systematic reviews \(an update\) - PMC](#)

Summary

Ross et al. synthesise 44 systematic reviews (2009-2014) on why e-health implementations succeed or fail. Using the CFIR framework, they find that success depends on aligned, multilevel factors: the technology's fit with workflows; enabling policy/financing; organisational readiness, leadership and culture; workforce capability and engagement; and a disciplined implementation process with monitoring and iterative adaptation. The review converts disparate lessons (from EMRs to decision support and telehealth, across primary, secondary and home care) into practical recommendations and highlights persistent risks-fragmented evidence, insufficient attention to context, weak change management, and underinvestment in evaluation. It offers an empirically grounded checklist for leaders and implementers and further tests CFIR's utility in digital health.

Key arguments and findings

- Implementation is multilevel and context-dependent: determinants cluster across intervention characteristics, outer setting (policy/incentives), inner setting (structure, culture, readiness), individual clinicians, and process (planning, engagement, training, evaluation).
- Fit and workflow integration matter more than features: technologies must solve real problems, align with tasks, and minimise unintended burdens; otherwise, adoption stalls.
- Leadership, governance and resourcing are pivotal: visible sponsorship, clear roles, and adequate time/budget for change management and training correlate with uptake.
- Structured, iterative methods help: staged roll-out, ongoing measurement, and feedback loops enable adaptation and scale; lack of evaluation undermines spread.
- CFIR is a useful organising lens, and the authors translate evidence into practical recommendations while identifying gaps for future research.

How the paper supports the Scottish Approach to Change

- People-led change: The review stresses active engagement of clinicians and end-users throughout planning, testing and adoption-mirroring Scottish Approach to Change 's commitment to co-design with people who need, use and deliver services.
- Leadership and culture as enablers: Findings on the importance of executive sponsorship, psychological safety and clear roles directly align with Scottish Approach to Change 's enabler on leadership and culture.
- Process rigour: Emphasis on governance, staged implementation, and continuous monitoring/evaluation maps to Scottish Approach to Change 's process-rigour enabler and its eight Steps of Change (identify → understand → develop/design → prototype/test → review/implement → define/implement → embed/sustain → review/spread).
- Learning system: The call for feedback loops and iterative adaptation supports Scottish Approach to Change 's learning-system enabler (measurement, reflection, and knowledge mobilisation).
- Clear vision and purpose: The paper's recommendation to anchor implementations in explicit goals and problem statements echoes Scottish Approach to Change 's guidance to articulate vision/purpose and use them to steer decisions.

Greenhalgh T. (2018) - *How to improve success of technology projects in health and social care.*

Link: [How to improve success of technology projects in health and social care | Public Health Research and Practice | ConnectSci](#)

Summary

Greenhalgh introduces the Non-adoption, Abandonment, Scale-up, Spread and Sustainability (NASSS) framework to explain why many digital health projects underperform: multiple, interacting complexities sit across seven domains-condition, technology, value proposition, intended adopters, organisation(s), wider system, and adaptation over time. The paper recommends first diagnosing where the complexity lies, then simplifying what can be simplified, and finally managing residual complexity adaptively. Ten practical rules are offered (e.g., distributed leadership, co-developing an evolving vision, nurturing relationships, co-designing routines with users, capturing data for iterative sense-making, controlling scope, and addressing regulatory barriers). A NASSS-CAT assessment tool helps teams decide what to start, scale, adapt or stop-improving the odds of scale-up, spread and long-term sustainability.

Key arguments and findings

- Technology projects fail primarily due to *complexity across seven domains*, not because of isolated “technology” issues.
- Improve success by *understanding, reducing*, and then *adaptively responding* to unavoidable complexity.
- *Ten rules* for complex programmes: strengthen (often distributed) leadership, co-develop an evolving vision, nurture relationships, co-design with users, capture and use data for ongoing deliberation, control scope, address regulatory barriers, etc.
- Use *NASSS-CAT* to assess complexity and inform investment, implementation and stop/go decisions.

Where it supports the Scottish Approach to Change

- Clear vision and purpose: NASSS urges *co-developing an overall, evolving vision*-mirroring Scottish Approach to Change 's emphasis that vision and strategy anchor decisions and trade-offs.
- People-led change: NASSS prioritises *co-design with intended users* and addressing frontline concerns; Scottish Approach to Change similarly mandates *meaningful engagement, trauma-informed practice*, and designing with lived/living experience.
- Process rigour: NASSS's structured diagnosis (NASSS-CAT), scope control, and data-driven iteration align with Scottish Approach to Change 's *measurement, monitoring and evaluation* and *project management* disciplines.

- Leadership and culture: NASSS calls for *distributed leadership* and nurturing cross-organisational relationships-consistent with Scottish Approach to Change 's leadership capabilities (empowerment, collaboration, psychological safety).
- Learning system: NASSS emphasises *capturing progress data and adaptive learning over time*; Scottish Approach to Change formalises this via *Learning Systems* and iterative testing (e.g., PDSA) to inform change.
- Spread and sustainability: NASSS places scale-up/spread/sustainability at the core problem; Scottish Approach to Change operationalises this through *Embed and Sustain* and *Review for Spread* steps.

Large-scale, Cross-sector and System Transformation

Summary

Best et al (2012) - Large-System Transformation in Health Care: A Realist Review

Link: [Large-System Transformation in Health Care: A Realist Review - PMC](#)

Summary

This realist review examines how large-system transformations (LST) in health care succeed or stall by analysing mechanisms that work (or fail) in specific contexts through a complex adaptive systems lens. It distils five “simple rules”: blend designated with distributed leadership; build feedback loops; attend to history; engage physicians; and include patients and families. Rather than prescribing universal solutions, the authors emphasise context-mechanism-outcome explanations, iterative planning, and learning-oriented evaluation to guide “what tends to work, for whom, and in what circumstances.” They argue the government’s role is to create conditions for change (e.g., enabling policy, convening, resourcing) while avoiding over-specification and control, and to support continuous monitoring and adaptation.

Key arguments and findings

- Uses a realist review approach to explain LST via context-mechanism-outcome configurations, framed by complex adaptive systems.
- Defines LST as coordinated, system-wide change across multiple organisations to improve quality, efficiency, and population outcomes.
- Identifies five simple rules: (1) blend designated and distributed leadership; (2) establish feedback loops; (3) attend to history; (4) engage physicians; (5) include patients and families.

- Stresses iterative planning, monitoring, and adaptation over fixed targets; success depends on nurturing learning environments.
- Clarifies government’s role: enable, convene, resource, and evaluate-without attempting rigid control of complex change.

Where it supports the Scottish Approach to Change

- Blended leadership → Scottish Approach to Change “Leadership and culture” and distributive leadership. Best et al. call for combining designated and distributed leadership; Scottish Approach to Change operationalises this via leadership behaviours, executive team roles, and *distributive leadership* through system stewards.
- Feedback loops → Scottish Approach to Change “Learning system” and PDSA. The review’s emphasis on feedback and ongoing adaptation aligns with Scottish Approach to Change’s learning systems, rapid feedback loops, and iterative PDSA testing.
- Attend to history/context → Scottish Approach to Change “Clear vision and purpose” grounded in evidence and local insight. Best et al. argue for understanding historical and contextual factors; Scottish Approach to Change requires triangulating data, policy, and lived experience to inform vision and strategy.
- Engage physicians → Scottish Approach to Change’s multi-disciplinary, clinician-involving change teams. The review highlights physician engagement as critical; Scottish Approach to Change repeatedly emphasises involving clinicians and other professionals at all stages of change.
- Include patients and families → Scottish Approach to Change “People-led.” Best et al. prioritise patient/family involvement; Scottish Approach to Change embeds meaningful engagement, trauma-informed practice, human rights, and inequality-focused design.
- Iterative, learning-oriented evaluation → Scottish Approach to Change “Process rigour” (measurement, monitoring and evaluation). Both frameworks reject one-off pilots in favour of continuous measurement and staged decisions (adopt/adapt/abandon).
- Government as enabler → Scottish Approach to Change governance and commissioning. The review’s view of government creating conditions for change reinforces Scottish Approach to Change’s guidance on governance, commissioning, and executive leadership, enabling change.

THIS Institute, Ipsos and The Health Foundation (2025) - A framework to guide early planning (“the front end”) of large-scale change programmes in health and healthcare

Link: [THIS-Institute -National-Programme-Framework](#)

Summary

THIS Institute's *framework to guide early planning ("the front end") of large-scale change programmes in health and healthcare* provides a practical, question-led tool for teams designing national or system-wide programmes. It structures early planning around three domains- programme purpose and content; contexts, stakeholders and implementation strategy; and programme management, governance, costing/scheduling, and learning-operationalised through 14 core questions and "what good looks like" prompts. Developed with the Health Foundation and Ipsos via literature review, interviews with programme leaders, stakeholder consultation and testing with policy teams, it aims to reduce early-stage failure by clarifying the case for change, fit of a large-scale approach, theory of change, risk, equity, and monitoring/learning plans.

Key arguments and findings

- The 'front end' is decisive: many large programmes falter due to weak early design; structured questions can pre-empt common pitfalls.
- Start with a robust case for change and test whether a large-scale national programme is the *right* vehicle versus bottom-up alternatives.
- Define goals, scope and benefits (including equity impacts) and prioritise trade-offs transparently.
- Develop and iteratively test a theory of change, including what is standardised vs locally adaptable.
- Plan for politics and context: stakeholder engagement, governance and accountability must reflect real implementation environments.
- Institutionalise learning: set out evaluation, data, and feedback loops for continuous improvement from the outset.
- Provenance: the framework was co-produced with the Health Foundation and Ipsos, informed by evidence review, interviews and live testing.

Where THIS Institute's framework supports the Scottish Approach to Change

- Clear vision and purpose: both emphasise defining the case for change, a compelling vision, and measurable aims as anchors for all decisions.
- People-led design: both require meaningful stakeholder engagement (patients, staff, partners) early and throughout to ensure acceptability and implementability.
- Process rigour: governance, project management, risk, measurement and evaluation are core in both approaches, with explicit tools and checkpoints.
- Learning system: both embed continuous learning via data, reflective practice, and feedback loops to adapt during implementation.

- Equity focus: THIS asks teams to assess equity/inequality effects when setting goals and selecting solutions; Scottish Approach to Change foregrounds reducing inequalities and human-rights-based design.
- Iterative change cycle: THIS advocates prototyping/piloting and decision gates; Scottish Approach to Change 's steps (identify → understand → develop/design → prototype/test → review/implement → define/implement → embed/sustain → review/spread) mirror this cadence.
- Leadership and culture: both stress distributed leadership, psychological safety, and the role of executive teams in removing barriers and sustaining momentum.

Mackie S, Darvill A. (2016) - *Factors enabling implementation of integrated health and social care: a systematic review*

[Link: Factors enabling implementation of integrated health and social care: a systematic review - PubMed](#)

Summary

This rapid review synthesises UK evidence on organisational factors that help or hinder the scale and spread of innovations in children's social care. From 10 studies (3 reviews, 7 primary), the authors group determinants into adopter, organisational, and wider-system domains. Consistent enablers include senior leadership buy-in, sustained funding, specific training and support, strong inter-professional and professional-carer relationships, multidisciplinary communication and joint working, and compatible data systems to support collaboration. Common barriers include short-term or absent funding, implementation overload (multiple priorities), and structural change. The authors emphasise that while findings offer clear pointers for policy and practice, overall confidence is limited by study quality (many service evaluations and non-systematic reviews).

Key arguments and findings

- Leadership matters: Senior management/leadership buy-in consistently enables scale and spread.
- Resourcing is pivotal: Short- and long-term funding is repeatedly cited as an enabler; lack of sustained funding is a major barrier.
- Capability and support: Targeted training and support for professional staff facilitate adoption and implementation.
- Relational infrastructure: Trusting inter-professional and professional-carer relationships, plus multidisciplinary communication and joint working, underpin success.

- Information infrastructure: Compatible data systems enable collaboration and coordinated delivery.
- Implementation load and churn: Multiple priorities and changing structures commonly derail or delay spread.
- Evidence caveat: Confidence in the evidence is limited by the predominance of service evaluations/non-systematic designs.

Note: This is a preprint and not peer-reviewed.

Where the review supports the Scottish Approach to Change (SAC)

- Leadership and culture - The review's emphasis on senior leadership buy-in aligns with SAC's enabler that leaders set vision, remove barriers, and create psychologically safe spaces for change.
- Process rigour (governance, data, project management, commissioning) - Calls for compatible data systems and structured decision-making echo SAC guidance on measurement, monitoring and evaluation, governance that "creates momentum", and the "power of good project management." Barriers around short-term funding reinforces SAC's focus on commissioning and resourcing as prerequisites for reliable change.
- People-led change - The review's finding that professional-carer relationships enable spread supports SAC's people-led enabler: co-design with people who need, access and use services to make change relevant and sustainable.
- Learning system and capability building- The need for specific training and support in the review complements SAC's learning system-cultures, networks and feedback loops that build capability and mobilise knowledge across the system.
- Clear vision and purpose- The review highlights implementation overload and shifting structures as barriers; SAC addresses this by anchoring change in a clear vision and purpose that guides choices, sequencing and trade-offs.
- Steps of change (Identify → Spread) - The review's emphasis on structured scale-up aligns with SAC's eight steps of change and its formal review for implementation and review for spread checkpoints to decide whether to adopt, adapt, or abandon.

Helen Gilbert Edward Peck (2014) - *Service transformation: Lessons from mental health - Kings Fund*

Link: [Service transformation: Lessons from mental health](#)

Summary

Service transformation: Lessons from mental health distils how England's mental health services moved from institutional care to community-based models and extracts "10 lessons" for wider NHS reform. Success depended on a compelling narrative that engaged stakeholders; redesigning (not just relocating) services around local needs; vertical integration across inpatient, community, social care and the voluntary sector; and robust evaluation. The authors stress investing in new capacity ("double-running") before closing beds, recognising that community models don't automatically save money and that large-scale change is non-linear and multi-year. Workforce development, team-based care coordination, stable leadership and mechanisms for shared learning were critical enablers; nationally set priorities helped, but local flexibility and rigorous testing mattered most.

Key arguments and findings

- Build an honest, powerful narrative and engage stakeholders early.
- Redesign care; don't just shift care settings.
- Integrate vertically across hospital, community, social care, and voluntary providers.
- Let local need drive model choice; evaluate against clear objectives.
- Invest in new capacity before closures; expect double-running costs; savings are not automatic.
- Anticipate unexpected effects and new demand in complex system change.
- Develop the workforce for new roles; enable team-based coordination.
- Provide high-quality, stable leadership and create mechanisms for shared learning.
- Accept that transformation is non-linear and will take years, plan accordingly.

Where it supports the Scottish Approach to Change

- Narrative, vision, engagement → Scottish Approach to Change "Clear vision and purpose" + "People-led".
King's Fund emphasises a compelling narrative with broad stakeholder engagement; Scottish Approach to Change requires a clear, lived vision and co-design with people who use services.
- Redesign and local tailoring → Scottish Approach to Change Steps: *Understand* → *Develop and design* → *Prototype and test* → *Review for implementation*. The report warns against replicating old services and calls for locally responsive design and evaluation; Scottish

Approach to Change operationalises this through iterative testing (incl. PDSA) and formal review points.

- Vertical integration and cross-sector working → Scottish Approach to Change “Process rigour”, commissioning, and QMS. Integration across inpatient, community, social care and the third sector aligns with Scottish Approach to Change’s emphasis on rigorous governance, ethical commissioning and whole-organisation quality management.
- Double-running and system-wide planning → Scottish Approach to Change “Define and implement”, project management, and governance. Investment before closure mirrors Scottish Approach to Change’s call for resourcing, phased implementation, documented operating models and oversight to sustain change.
- Evaluation and measurement → Scottish Approach to Change “Measurement, monitoring and evaluation” and the Learning System. King’s Fund calls for clear objectives and proper evaluation; Scottish Approach to Change embeds measurement plans, triangulation of data, and learning networks to turn evidence into action.
- Workforce, roles, team-based care → Scottish Approach to Change “Leadership and culture” + education and capability-building. The report’s focus on new roles and coordination teams is echoed by Scottish Approach to Change’s leadership behaviours, capability programmes and multidisciplinary change teams.
- Non-linear, multi-year change and uncertainty → Scottish Approach to Change “Creating a change mindset”, “Embed and sustain”, “Review for spread”. Both frameworks stress that transformation is iterative, requires persistence, and needs structures to embed, sustain and (where appropriate) spread learning.

Michael Lawrie, Jo Scott, Taisie Lewis, Nathan Brandsen, Rebecca Writer-Davies (2025) - *Improving the effectiveness of complex national service change programmes in health care*

Link: [ipsos report template](#)

Summary

Ipsos (with THIS Institute and the Health Foundation) synthesises 17 interviews with senior programme leaders to draft a practical framework for designing complex national programmes in health care. It argues that programmes operate in politicised environments, face pressure to “fix” system problems quickly, and must navigate distributed power across many actors. The draft guidance emphasises (1) rigorous problem definition and scoping, (2) tailored stakeholder strategies combining hard levers (funding, regulation) with soft levers (guidance, learning), and (3) adaptive, credible leadership able to reconcile political expectations with operational realities. Next, the framework will be tested and refined with a broader stakeholder group before wider application.

Key arguments and findings

- Politicised context: National programmes must align to shifting political priorities and different definitions of success while maintaining operational feasibility.
- Problem first, then solution: Teams too often rush to implementation; robust, multi-perspective problem exploration and clear scope are “mission-critical.”
- Distributed power and stakeholders: Success depends on mapping power, tailoring messages, and sustained engagement across Treasury, national bodies, providers, professions, patients and unions.
- Layered influence model: Combine incentives and controls (funding, staff resources, regulation, performance) with adaptable specifications, support, evaluation and learning to shift behaviour.
- Leadership profile: Programme leaders must be politically astute, decisive yet open, connective and resilient (“surf every wave”).
- Method: Findings derived from think-aloud interviews with 17 senior leaders (Dec 2024-Feb 2025), analysed thematically to inform a testable draft framework.

Where the report supports the Scottish Approach to Change

- Clear vision and purpose → Politicised context + scoped problems
Ipsos’ call to articulate a unifying vision and set clear scope and priorities mirrors Scottish Approach to Change ’s emphasis on vision as the anchor for choices and trade-offs.
- Process rigour → Problem exploration, staged design, and assurance
The report’s warning against “rushing to stand up a programme” and its advocacy of structured levers, evaluation and learning substantiate Scottish Approach to Change ’s process rigour (governance, measurement, options appraisal, PDSA, formal review points).
- Leadership and culture → Adaptive, credible, enabling leaders
Ipsos’ leadership profile (politically astute, connector/challenger, decisive yet open) aligns with Scottish Approach to Change ’s leadership characteristics and executive roles that create psychological safety, remove barriers and steward learning.
- People-led → Stakeholder mapping and tailored engagement
The focus on distributed power and tailored strategies across frontline staff, professional groups and communities reinforces Scottish Approach to Change ’s people-led approach and meaningful involvement from the outset.
- Learning system → Use evaluation and support as influence
Ipsos positions evaluation and learning as core influence mechanisms; Scottish Approach to Change ’s learning system enabler similarly embeds reflective practice, rapid feedback loops and knowledge mobilisation in governance.
- Scottish Approach to Change steps of change ↔ Ipsos design guidance Ipsos’ sequence-deep problem identification, option development, layered influence, and iterative learning-

maps directly to Scottish Approach to Change 's Identify → Understand → Develop and Design → Prototype and Test → Review for implementation → Define and Implement → Embed and Sustain → Review for spread.

NHS England (2018) - *Leading Large Scale Change: A guide to leading large scale change through complex health and social care environments A practical guide*

Link: [Leading Large Scale Change: A Practical Guide](#)

Summary

Leading Large Scale Change: A Practical Guide (NHS England, Apr 2018) sets out how to mobilise systems toward a fundamentally new future state by coupling a shared purpose and narrative with distributed leadership, mass stakeholder engagement, and mutually reinforcing changes in structures, processes and behaviours. It foregrounds social-movement thinking (“change platforms”), ambidextrous leadership, and practical tools (e.g., 30/60/90-day cycles, PDSA, logic models, stakeholder/commitment analyses) to create the conditions for scale and spread. Measurement, governance and finance are treated as enablers, not end-states; the aim is sustained shifts in mindsets and outcomes. The guide emphasises participation, co-production and diversity, and argues that transformation in health and care must privilege networks over hierarchy, evidence-informed learning cycles, and continual reframing to keep energy for change high.

Key arguments and findings

- What “large-scale change” (LSC) is: a system-wide, deeply disruptive shift achieved through key themes, distributed leadership, mass engagement, and coordinated changes across structures, processes and behavioural patterns.
- Conditions for LSC: build a compelling shared purpose and narrative; mobilise through social-movement principles; favour “change platforms” over programmes; lead with networks (new power) rather than hierarchy (old power).
- Leadership stance: adopt ambidextrous styles (both explore and exploit), create climates where everyone can contribute, and manage energy for change.
- Practical toolkit: use planning questions, driver diagrams, logic models, PDSA, 30/60/90-day cycles, stakeholder and “continuum of commitment” analyses, and robust measurement strategies to guide learning and adaptation.
- Spread and sustainability: prioritise participation, co-production and diversity; align governance and finance to enable scale and enduring adoption.

Where it supports the Scottish Approach to Change

- People-led change. The guide's emphasis on participation, co-production and diversity directly reinforces Scottish Approach to Change 's People-led enabler and guidance on meaningfully engaging people and reducing inequalities.
- Clear vision and purpose. NHS England's call for a unifying shared purpose and compelling narrative aligns with Scottish Approach to Change 's requirement for an explicit vision and purpose to anchor decisions and trade-offs.
- Process rigour. The guide's use of logic models, driver diagrams, PDSA, 30/60/90-day cycles, measurement for learning, and attention to governance/finance mirrors Scottish Approach to Change 's Process rigour enabler (measurement, project management, commissioning).
- Leadership and culture. Distributed/ambidextrous leadership, storytelling, and creating climates where everyone contributes echo Scottish Approach to Change 's Leadership and culture (capabilities, roles across the system, psychologically safe learning).
- Learning systems. The guide operationalises learning through iterative tests (PDSA), short planning cycles, and measurement for adaptation-fully consistent with Scottish Approach to Change 's Learning system enabler and emphasis on reflective practice and knowledge mobilisation.
- Steps of change-operational alignment. While framed differently, NHS England's toolkit (identify the case, engage stakeholders, design options, test, decide, implement, spread) maps closely to Scottish Approach to Change 's eight steps (Identify → Understand → Develop and design → Prototype and test → Review for implementation → Define and implement → Embed and sustain → Review for spread).

Health Foundation (2012) - Cross sector working to support large-scale change

Link: [CrossSectorWorkingToSupportLargeScaleChange.pdf](#)

Summary

This Health Foundation evidence scan (2012) synthesises 139 empirical studies on how organisations work across sectors to deliver large-scale change. It catalogues common approaches-such as organisational mergers, cross-organisational collaboratives, co-location, joint appointments, shared IT, and single assessment processes-and distils what helps or hinders progress. The strongest enablers are clear leadership and vision, supportive culture and attitudes, well-defined roles with joint training, and robust infrastructure and processes (including information-sharing and aligned incentives). It also cautions that the literature offers limited comparative evidence on the "best" model, making context, system boundary definition, and genuine stakeholder engagement-rather than top-down directives-critical to success and spread.

Key arguments and findings

- Whole-system ambition needs cross-sector working to achieve transformational improvement; success depends on how the “system” is defined and governed.
- Common models: mergers; networks/collaboratives; co-location; joint roles; shared IT and single assessment pathways.
- Core facilitators: leadership and vision; culture and attitudes; staff roles/training; infrastructure and processes (time/resources, information systems, aligned incentives).
- Barriers and risks: role confusion, jurisdictional disputes, lack of buy-in, and purely top-down change approaches.
- Evidence gaps: few comparative studies on which model works best across contexts.

Where it supports the Scottish Approach to Change

- Clear vision and purpose - The scan’s emphasis on shared vision and goals directly mirrors Scottish Approach to Change ’s first enabler (“clear vision and purpose”) as the anchor for decisions and trade-offs.
- Leadership and culture - Findings that strong, credible leadership and a collaborative culture are critical align with Scottish Approach to Change ’s “leadership and culture” enabler (e.g., empowering, compassionate, system-wide leadership).
- People-led change and stakeholder engagement - The scan warns against top-down change and stresses stakeholder engagement; Scottish Approach to Change operationalises this through “people-led” design, trauma-informed engagement, and inequality reduction.
- Process rigour (governance, measurement, project management) - Calls for clear roles, joint processes, and aligned incentives align with Scottish Approach to Change ’s “process rigour,” including governance, measurement/monitoring/evaluation, and disciplined project management.
- Learning systems and information-sharing - The scan highlights networks/collaboratives and systems to share information; Scottish Approach to Change formalises this as a “learning system” with rapid feedback loops and knowledge mobilisation.
- Cross-sector teaming and multi-disciplinary capability - Use of joint appointments and teams drawn from different organisations reinforces Scottish Approach to Change ’s call for multi-disciplinary change teams and distributed leadership.
- From testing to spread - The scan’s focus on factors that enable spread supports Scottish Approach to Change ’s end-to-end steps (prototype/test → review for implementation → embed/sustain → review for spread).

King's Fund (2025) - How to support partnership working: Learning from the Healthy Communities Together programme

Link: [how to support partnership working hct 2025.pdf](#)

Summary

How to support partnership working distils learning from the three-year Healthy Communities Together programme run by The King's Fund and The National Lottery Community Fund. It argues there is no single template for cross-sector partnering; success depends on strategic alignment, adequate and flexible resourcing, explicit "test-and-learn" design, and realistic timeframes for transformational change. The report sets out practical guidance for planning and design, delivery, and oversight/governance, emphasising balanced support for both partnership development and outcomes delivery. It highlights the importance of capturing and sharing learning, addressing power dynamics (including the role of funders), and planning for sustainability and legacy beyond grant periods. Overall, it provides a pragmatic playbook-covering budgeting, evaluation, communications, and review points-for commissioners and support organisations aiming to build equal NHS-local authority-VCSE partnerships that improve community health and reduce inequalities.

Key arguments and findings

- No one-size-fits-all model: Partnership programmes must allow flexibility while being clear about aims, assumptions and constraints; transformational change takes time, and progress is non-linear.
- Design for "test and learn": Be explicit about what will be tested, build in active review points, and expect plans to evolve as realities surface.
- Balance relationship-building and delivery: Over-prioritising delivery risks replicating old ways of working; over-prioritising learning risks missing outcomes-programmes must consciously balance both.
- Resource for complexity: Budget for consistent staff capacity, learning capture, evaluation, and communications; partnership work typically needs more resources than anticipated.
- Tackle power dynamics: Funders and support partners should use influence carefully to avoid reinforcing existing power imbalances and to enable equal VCSE participation.
- Plan for sustainability and legacy: Build routes to embed, spread and influence beyond the programme's funding window.
- Purpose and scope clarity: Ensure strategic alignment with organisational strategies and governance to secure visibility and long-term support.

Where the report supports the Scottish Approach to Change

- Clear vision and purpose → Strategic alignment and explicit aims - Scottish Approach to Change stresses a shared vision and purpose to anchor decisions and trade-offs. The report advises aligning partnership programmes with organisational strategies, capturing assumptions and aims at the outset, and revisiting them at key review points-directly reinforcing Scottish Approach to Change 's emphasis on clarity of intent guiding change.
- Process rigour → Governance, evaluation, staged reviews - Scottish Approach to Change 's enabler of "process rigour" calls for systematic methods, proportionate governance and robust measurement. The report specifies budgeting for evaluation from the start, structuring oversight and governance, and using active review points during delivery-mirroring Scottish Approach to Change 's disciplined cycle and emphasis on evidence-informed decisions.
- People-led → Equal VCSE partnership and community focus - Scottish Approach to Change requires people-led change through meaningful involvement of people and partners. The report's core hypotheses and design centre on equal participation of VCSE organisations and work that benefits communities, with support to capture/share learning-consistent with Scottish Approach to Change 's people-led principle.
- Leadership and culture → Safe spaces, power awareness, and shared leadership Scottish Approach to Change highlights leadership that empowers, builds trust, and creates psychologically safe cultures for experimentation. The report frames partnership facilitation as a balancing act, cautions against reinforcing power imbalances, and recommends structured learning spaces-all hallmarks of the enabling culture Scottish Approach to Change describes.
- Learning system → Deliberate learning capture and peer learning - Scottish Approach to Change 's learning system enabler promotes continuous reflection, data-informed adaptation, and spread of "bright spots." The report makes "enabling and capturing learning" a core function, recommending regular learning activities, peer-to-peer support, and communications to influence wider systems.
- Scottish Approach to Change 's eight steps of change → Programme phases and review points - Scottish Approach to Change 's steps (Identify → Understand → Develop and design → Prototype and test → Review for implementation → Define and implement → Embed and sustain → Review for spread) provide a full change cycle. The report's staged approach-development then delivery, with explicit testing, iterative adaptation, and sustainability/legacy planning-maps closely to these steps, especially prototyping/testing, review points, embedding, and spread.

Durka Dougall, Matthew Lewis and Shilpa Ross (2018) - *Transformational change in health and care: Reports from the field*

Summary

This King's Fund report synthesises lessons from four recognised transformation exemplars- Bromley by Bow (community-led primary care), Birmingham and Solihull's RAID service (liaison psychiatry), Northumbria's Specialist Emergency Care Hospital, and Buurtzorg (nurse-led community care). It defines transformational change as creating an entirely new state of practice and performance, arguing it is emergent, people- and purpose-led, and propelled by collaborative, distributed leadership. Change journeys are "messy, fluid and multi-layered," requiring small tests, learning, sponsorship, and movement from pilots to business-as-usual, with progress guided by data, stories, and enabling cultures. The report calls for a system that gives time and support for learning, while navigating tensions between urgency and the time transformation needs.

Key arguments and findings

- What counts as transformational change? Defined as the emergence of "an entirely new state... with a profoundly different structure, culture or level of performance," distinct from incremental improvement.
- Purpose- and people-led transformation. Effective efforts centre on a core purpose of improving people's lives, with communities, staff and service users shaping models and plans.
- Distributed, collaborative leadership. Success relies on leadership across boundaries, sponsorship by commissioners/politicians, and cultures that enable teams to act.
- Learning over control. Transformation is "multi-layered, messy, fluid and emergent"; favour curiosity, small-scale testing, and iterative learning over command-and-control.
- From pilots to business-as-usual. Cases show pathways from initial tests to routine adoption (e.g., RAID moving "from pilot to business as usual"), underpinned by governance and data.
- Use of data, stories and simple tech. Progress is guided by outcomes, narratives, and clinically useful IT that makes work easier.
- Real tensions to navigate. 'Old power' vs 'new power', urgency vs engagement time, innovation vs safety, and working within constraints while nurturing new structures.

Where it supports the Scottish Approach to Change

The King's Fund findings align closely with Scottish Approach to Change 's five enablers and eight-step framework.

- Enablers: alignment and reinforcement

- Clear vision and purpose - KF's emphasis on a *core purpose* mirrors Scottish Approach to Change's call to anchor change in a shared vision that guides decisions and trade-offs.
- People-led - Community- and staff-driven transformation (e.g., Bromley by Bow; Buurtzorg) reflects Scottish Approach to Change's requirement to engage people with lived experience as partners in design and delivery.
- Leadership and culture - Distributed, cross-boundary leadership and psychologically safe, supportive cultures in KF echo Scottish Approach to Change's leadership behaviours and culture for improvement.
- Process rigour - KF's movement from *tests/pilots to BAU* and the role of governance, sponsorship and measurement map to Scottish Approach to Change's process rigour (governance, project management, evaluation).
- Learning system - KF's call to "strengthen how we learn together," privileging iterative testing and feedback loops, aligns with Scottish Approach to Change's formal learning systems to turn knowledge into action.

Steps of change: case-study parallels

- Identify and Understand - KF sites start by seeing *local need* and context (e.g., community deprivation; ED mental health gaps), aligning with Scottish Approach to Change's diagnostic stages.
- Develop and Design - Co-design with users and partners in the cases reflects Scottish Approach to Change's collaborative option development.
- Prototype and Test - KF highlights small-scale trials and learning cycles; Scottish Approach to Change explicitly promotes PDSA-style testing.
- Review for implementation; Define and Implement - The KF narrative of formalising and scaling successful pilots mirrors Scottish Approach to Change's decision and implementation steps.
- Embed, Sustain and Review for spread - KF shows sustained adoption and spread (e.g., Buurtzorg's growth; RAID scaling), fully consistent with Scottish Approach to Change's emphasis on sustainability and spread.

Bottom line: The King's Fund's real-world evidence strongly endorses Scottish Approach to Change's integrated model-people-centred purpose, distributed leadership, disciplined testing and measurement, and intentional learning and spread-as the practical conditions for transformational change in health and care.

Deborah Fenney (2025) - *Keeping the faith in cross-sector partnership working: how to maintain motivation and drive*

Link: [Keeping The Faith in Cross-Sector Partnership Working | The King's Fund](#)

Summary

This King's Fund long read distils learning from five Healthy Communities Together partnerships on how to sustain motivation and momentum in cross-sector collaborations. It argues that partnering is hard, slow work-buffed by turnover, funding pressures and system reform-but progress endures when individuals' values align with a shared purpose, peers provide mutual support, and partnerships intentionally design governance rhythms, inclusive membership, and spaces for reflection. Continuity is reframed as *evolution*-knowing what to hold and what to let go-while maintaining legitimacy and demonstrating impact to local systems. The piece offers six practical ways to "keep the faith," spanning personal efficacy, peer networks, purpose, representation, convening/governance, and adaptive practices that fit changing contexts.

Key arguments and findings

- Context is punishing; partnering is non-linear. Covid-19 aftermath, cost-of-living, restructures and funding cuts sap energy and continuity-so motivation must be actively cultivated.
- Align values and purpose. Personal purpose that matches a partnership's aims protects against burnout and sustains commitment.
- Invest in peer connection. Peer support, cross-sector learning spaces and sense-making reduce isolation and refresh motivation.
- Keep the shared purpose live. Revisit, reshape and reaffirm purpose ("coherence of intent") to counter drift back to business-as-usual.
- Maintain representative membership. Balance VCSE, NHS and local authority voices; proactively manage joiners/leavers and "warm" handovers.
- Design governance and convening rhythms. Dedicated convenors, proportionate governance, and adapted contracting (e.g., MoUs) maintain momentum and trust.
- Show impact. Articulate the distance travelled to sustain internal motivation and external legitimacy.

Where it supports the Scottish Approach to Change

- Clear vision and purpose. The emphasis on continually reaffirming shared purpose mirrors Scottish Approach to Change 's *Clear vision and purpose* enabler and strategy-to-action discipline.

- Leadership and culture that enable safe, relational work. Creating reflective spaces, psychological safety, and compassionate convening aligns with Scottish Approach to Change’s call for leaders who build trust, remove barriers, and model curiosity.
- People-led and multi-sector inclusion. Maintaining balanced VCSE-statutory membership and coordinating across sectors supports Scottish Approach to Change’s *people-led* enabler and cross-boundary collaboration ethos.
- Process rigour with proportionate governance. The article’s focus on governance rhythms, convenors, and adapted contracting resonates with Scottish Approach to Change guidance on project management, governance that creates action, and ethical commissioning.
- Learning systems and reflective practice. Using shared learning, sense-making and articulating “distance travelled” reinforces Scottish Approach to Change’s *Learning system* enabler and measurement/monitoring for improvement.
- Embedding and sustaining change. Reframing continuity as evolution and planning for legacy aligns with Scottish Approach to Change’s steps to *Embed and sustain* and *Review for spread*.

Deborah Fenney and Loreen Chikwira (2025) - *Partnering for change: six key insights for cross-sector partnerships*

Link: [Partnering For Change: Six Key Insights For Cross-sector Partnerships | The King's Fund](#)

Summary

The King’s Fund distils learning from the three-year Healthy Communities Together programme into six practical insights for cross-sector partnerships. It stresses the need to continually clarify purpose, define a distinctive partnership role, and invest in deep, psychologically safe relationships that can weather staff turnover and system shocks. It urges flexible, ‘test-and-learn’ ways of working-balancing governance with playfulness-while attending to power, influence, and system context so partnerships can align bottom-up community work with top-down support. Reflective questions throughout help partnerships and system leaders translate these insights into action.

Key arguments and findings from the King’s Fund long read

- Revisit and sharpen purpose to stay pragmatic and focused amid shifting constraints.
- Define a clear, distinctive role (boundaries, contribution, theory of change) to engage the wider system effectively.
- Invest in relationships and psychological safety; “relationships are the work” and enable influence beyond the partnership.
- Balance structure with flexibility-use governance (MOUs, contracts) but create space for emergence and playfulness.

- Work with power and influence deliberately, blending bottom-up community action with top-down sponsorship.
- Adopt iterative, learning-oriented practice, using reflective questions to adapt to context and sustain momentum.

Where this supports the Scottish Approach to Change

- Clear vision and purpose → King’s Fund’s call to “reassess and clarify purpose” directly echoes Scottish Approach to Change’s enabler to define and use clear vision and purpose to steer choices and trade-offs.
- Process rigour and governance → Emphasis on distinct roles, boundaries, and governance (MOUs/contracts) aligns with Scottish Approach to Change’s process rigour (structured decision-making, governance, measurement).
- Leadership and culture → The need to build psychological safety, model new behaviours, and secure senior sponsorship mirrors Scottish Approach to Change’s leadership and culture enabler.
- People-led approaches → Case examples that start from community narratives and shift power towards VCSE and residents reinforce Scottish Approach to Change’s people-led principle and ethical commissioning focus.
- Learning system → The King’s Fund’s reflective framework and “test-and-learn” approach support Scottish Approach to Change’s learning system (iterative testing, sense-making, sharing learning).
- Steps of change (prototype → embed → spread) → The article’s adaptive, iterative partnering maps onto Scottish Approach to Change’s eight steps of change, particularly prototype and test, embed and sustain, and review for spread.

King’s Fund (2025) - *How to support partnership working: Learning from the Healthy Communities Together programme*

Link: [how to support partnership working hct 2025.pdf](#)

Summary

This King’s Fund report distils three years of learning from the Healthy Communities Together programme on how to design, fund and run cross-sector partnerships between VCSE organisations, local authorities and the NHS. It argues there is no single template for partnering; success depends on strategic alignment, realistic resourcing, and an explicit “test-and-learn” ethos with tolerance for uncertainty. It stresses balancing support for *learning to partner* with delivery for communities, building in evaluation from the outset, managing power dynamics (including the role of funders), and investing in communication, influence and legacy planning. Above all,

transformational change takes time and proceeds in phases, so programmes need structured review points, flexible governance and sustained capacity to capture and use learning.

Key arguments and findings

- No one-size-fits-all: Partnership models must fit local strategy, governance and context.
- Test-and-learn: Flexibility and explicit learning aims are essential; progress is iterative and non-linear.
- Resource realistically: Partnership work needs more capacity than expected and must cover learning, delivery and coordination.
- Balance priorities: Support relational partnering *and* tangible community outcomes; avoid over-indexing on either.
- Embed evaluation and review: Plan measurement early; use phased review points to realign aims and methods.
- Attend to power and communications: Acknowledge funder influence and invest in transparent communications and dissemination.

Where it supports the Scottish Approach to Change

- Clear vision and purpose: Calls for strategic alignment and explicit aims mirror Scottish Approach to Change 's emphasis on shared vision as the anchor for decisions.
- Process rigour: Advocates early evaluation planning, governance and structured review points-consistent with Scottish Approach to Change 's governance, measurement/monitoring and project-management guidance.
- People-led change: Elevates VCSE-statutory equal partnership and community benefit, aligning with Scottish Approach to Change 's people-led enabler and inclusive engagement.
- Learning system: The "test-and-learn" model and investment in capturing/sharing learning directly reflect Scottish Approach to Change 's learning systems and iterative improvement approach (e.g., prototype/test).
- Embed and sustain: Emphasis on sustainability, legacy and phased spread aligns with Scottish Approach to Change 's "embed and sustain" and "review for spread" steps.

Spread, Scale and Sustainability

Summary

Albury et al, Innovation Unit and Health Foundation (2018) - *Against the odds: Successfully scaling innovation in the NHS*

Summary

Against the Odds examines how ten NHS innovations achieved spread and impact despite system constraints, shifting the focus from barriers to the enablers of scale. It argues that adoption is a social process shaped by context, relationships and local priorities-not just evidence and directives.

Successful scale required:

- building demand through professional and patient networks
- using qualitative stories alongside quantitative data
- balancing fidelity and adaptation
- and creating dedicated scaling vehicles rather than relying on lone champions

The authors urge system leaders to resource adopters with time, expert support and commissioning approaches that enable adaptation, while recognising and rewarding adoption work. The report concludes there is no single right pathway; scale emerges from the interplay among innovation, local contexts, and wider policy/financial conditions.

Key arguments and findings

- Adoption needs resourcing: time, space, expert support and recognition for *adopters*, not just innovators.
- Build demand via networks and narratives that align with existing priorities; relationships trump mass messaging early on.
- Use qualitative stories as well as quantitative evidence to win hearts and minds and make the case for change.
- Balance fidelity with local adaptation-codify core components while allowing contextual tailoring.
- Create scaling vehicles (organisations/teams) rather than relying on lone champions.
- Leverage system conditions: commissioning frameworks, policy and financial levers can kick-start momentum but aren't a magic bullet.

- External funding can catalyse spread-but sustainability depends on how it's used to build ongoing capability.
- There is no single playbook; success depends on the interaction between innovation, local context and system dynamics.

Where it supports the Scottish Approach to Change

- People-led change: IU/Health Foundation stresses engaging professional and patient networks and lived experience in building demand; Scottish Approach to Change positions co-design and meaningful engagement as a core *enabler*.
- Leadership and culture that enable experimentation: the report calls for leaders to create safe spaces, recognise adopters, and resource adaptation; Scottish Approach to Change highlights compassionate, empowering leadership and psychologically safe cultures as prerequisites for change.
- Process rigour with flexibility: balancing fidelity/adaptation and using qualitative *and* quantitative evidence mirrors Scottish Approach to Change 's emphasis on rigorous governance, measurement/monitoring and proportionate project management.
- Commissioning as an enabler: recommendations to use commissioning frameworks to enable sustainable spread align with Scottish Approach to Change 's guidance on ethical commissioning and tailoring to local context.
- Learning systems and spread: case-based insights and codifying "core" versus "adaptable" elements support Scottish Approach to Change 's learning systems, iterative testing (PDSA), and explicit steps for *review for spread*.
- Clear vision and purpose: IU/Health Foundation urge alignment with national/local priorities to create strategic opportunities; Scottish Approach to Change centres' vision/purpose as a foundational enabler guiding choices and trade-offs.

Horton, Illingworth and Warburton, Health Foundation (2018) - *The spread challenge*

Link: [The-spread-challenge](#)

Summary

This report reframes "spread" as a problem of successful uptake, not just adoption, showing why interventions that work in one site often underperform elsewhere. The authors argue that complex health-care changes are social, context-sensitive and dynamic, so they must be codified in ways that distinguish what's core from what can be adapted, then tested and revised with early adopters before wider rollout. Effective spread programmes should shift attention and resources from innovators to adopters, building their capability, motivation and opportunity, and creating peer networks to capture learning across contexts. Policymakers should normalise real-world testing, fund the upfront costs of adoption, and reward implementation-not only invention.

Key arguments and findings

- The “replicability problem”: impacts often drop (“voltage drop”) when interventions move contexts; spread must focus on effective replication, not mere diffusion.
- Complexity matters: interventions are socio-technical and context-dependent; spread efforts must account for behaviours, culture and systems, not just tools or pathways.
- Codify for adaptation: describe interventions so adopters know what is essential versus adaptable (principles, theory of change, required skills), reframing fidelity to allow smart local tailoring.
- Formalise a testing-revision phase: select diverse early sites, expect adaptation, and use feedback loops to refine the model before scale.
- Design spread around adopters: build readiness and capability (training, time, resources), provide implementation support (funding, enablement), and use peer networks to share learning.
- Policy implications: reward adoption, expand real-world testing, and compare performance across contexts as a standard stage of the innovation cycle.

Where it supports the Scottish Approach to Change

- People-led, co-design, and early involvement - The report’s shift to put adopters and local users “front and centre” supports Scottish Approach to Change ’s people-led enabler and emphasis on engaging lived experience across the Develop and design and Prototype and test steps.
- Learning systems and iterative testing - It's called to formalise testing-revision and create peer networks aligns with Scottish Approach to Change ’s Learning system enabler (measurement, reflective practice, knowledge mobilisation) and PDSA-driven Prototype and test and Review for implementation steps.
- Process rigour with room for adaptation - Codifying core vs. adaptable components mirrors Scottish Approach to Change ’s Process rigour (governance, measurement, evaluation) while encouraging contextual tailoring through options appraisal and iterative refinement.
- Leadership, culture, and capability-building - Emphasis on building adopter capability, motivation and opportunity reinforces Scottish Approach to Change ’s Leadership and culture enabler and guidance on multi-disciplinary change teams and executive sponsorship.
- From pilots to sustained spread - Normalising real-world testing before scale, then resourcing implementation, supports Scottish Approach to Change ’s Define and implement, Embed and sustain, and Review for spread steps, ensuring changes become business-as-usual before wider adoption.

Papoutsi, Greenhalgh and Marjanovic (2024) - *Approaches to Spread, Scale-Up, and Sustainability*

Link: [*Approaches to Spread, Scale-Up, and Sustainability*](#)

Summary

Papoutsi, Greenhalgh and Marjanovic examine why local healthcare improvements so rarely spread and persist. They clarify definitions—spread (transfer), scale-up (building infrastructure for widespread implementation), and sustainability (maintaining/adapting over time)—and argue these are overlapping, non-linear processes rather than sequential phases. The Element synthesises frameworks suited to complex systems: the Dynamic Sustainability Framework (continuous adaptation), the 3S infrastructure approach (structure, strategy, supports for scale), and NASSS (non-adoption, abandonment, and challenges to scale-up, spread, and sustainability). Case narratives (e.g., NHS Scotland’s video consulting) illustrate how early investment in infrastructure, iterative learning, and contextual adaptation enable durable adoption. The authors conclude that improvement should grow organically within context, balancing fidelity with adaptation, and supported by governance, data, and learning capacity.

Key arguments and findings

- Conceptual clarity matters: spread ≠ scale-up ≠ sustainability; each requires distinct strategies.
- Non-linear view: spread, scale-up, and sustainability should be pursued in parallel, not as a stepwise pipeline.
- Balance fidelity and adaptation: protect the “hard core” of an intervention while adapting the “soft periphery” to local context; focus on function over form.
- Infrastructure is pivotal: the 3S approach emphasises structure, strategy, and support as prerequisites for scale.
- Work with complexity: use frameworks like Dynamic Sustainability and NASSS to anticipate emergent behaviour across organisations and systems.
- Illustrative case: NHS Scotland video consulting shows how early infrastructure and sustainability planning accelerate spread.

Where it supports the Scottish Approach to Change

- Non-linear, iterative change: Cambridge argues spread/scale/sustain are concurrent; Scottish Approach to Change’s eight steps explicitly allow revisiting stages (e.g., prototype-review-implement) with PDSA cycles.
- Enablers and infrastructure: The 3S emphasis on structure/strategy/supports mirrors Scottish Approach to Change’s five enablers (clear vision and purpose, process rigour, leadership and culture, people-led, learning system).

- Fidelity vs adaptation: Cambridge’s “hard-core/soft-periphery” and “function over form” align with Scottish Approach to Change guidance to co-design locally, adapt to context, and embed changes into BAU.
- Learning systems: Both stress continuous measurement, reflective practice, and knowledge mobilisation to sustain gains.
- Governance and project management: Cambridge highlights governance and capability building for scaling; Scottish Approach to Change operationalises this via project management, measurement/monitoring, and proportionate governance.
- Case convergence - Near Me: Cambridge cites NHS Scotland’s video consulting as an example of early infrastructure and sustainability thinking; Scottish Approach to Change’s case study on Near Me documents the same trajectory from prototyping to embed and sustain and then spread.

Zurynski et al (2023) - *Built to last? Barriers and facilitators of healthcare programme sustainability*

[Link: Built to last? Barriers and facilitators of healthcare program sustainability: a systematic integrative review - PubMed](#)

Summary

This systematic integrative review synthesised 124 studies (2011-2022) to identify what helps or hinders the sustainability of implemented healthcare improvement programmes. Mapping findings to the Integrated Sustainability Framework, the most frequently cited determinants were inner setting and process factors, followed by intervention characteristics. Recurrent enablers/barriers included leadership and organisational support, training/supervision and capability, and staffing/turnover; in the outer setting, funding, stakeholder leadership, and socio-political context mattered. Only 23% of studies reported sustainability beyond five years, and definitions of “sustainability” were inconsistent. Programmes were discontinued for reasons such as insufficient resourcing, poor contextual fit, limited planning, and intervention complexity. The authors call for long-term evaluations and more consistent use of implementation frameworks.

Key arguments and findings

- Sustainability depends on multiple levels: inner setting, process, intervention design, and outer setting.
- The highest-leverage determinants reported were leadership/support (49%), training/supervision (44%), and staffing/turnover (40%).
- Funding and broader socio-political context are critical outer-setting factors; lack of resourcing is a common reason for discontinuation.

- Evidence on long-term sustainability is thin; few studies follow programmes beyond 5 years, and definitions of sustainability vary widely-limiting comparability.
- The field needs consistent frameworks and longitudinal evaluation to understand what endures and why.

Where the findings reinforce the Scottish Approach to Change

- Leadership and Culture - The review's emphasis on leadership/support as a core determinant aligns directly with Scottish Approach to Change 's enabler that leaders create the conditions for safe experimentation, collaboration and persistence.
- Process Rigour, Planning and Governance - Discontinuities linked to limited planning and intervention complexity reinforce Scottish Approach to Change 's call for process rigour, structured project management, and strong governance throughout the eight Steps of Change.
- Capability, Training and Supervision - The review identifies training/support/supervision as pivotal; Scottish Approach to Change embeds learning systems, skills development, and role clarity (e.g., system stewards, learning partners) to build and retain capability.
- Resourcing and Commissioning - Funding as a sustainability driver maps to Scottish Approach to Change 's guidance on ethical commissioning, aligning resources with local need and creating capacity for prevention and early intervention.
- Contextual Fit and Adaptation - The review notes poor fit and complexity undermine sustainability; Scottish Approach to Change mitigates this via prototype and test (PDSA), options appraisal, and review for implementation/spread to adapt solutions to context.
- Long-term Evaluation and Learning - The call for long-term programme evaluation dovetails with Scottish Approach to Change 's embed and sustain step and its learning system emphasis on continuous measurement, reflective practice, and feedback loops.
- Stakeholder Leadership and People-led Change - The importance of external stakeholder leadership in the review complements Scottish Approach to Change 's people-led enabler-co-design with people, families, carers, and partners to build ownership and durability.

Koorts H, Ma J, Swain CTV, Rutter H, Salmon J, Bolton KA. (2024) - *Systems approaches to scaling up: a systematic review and narrative synthesis of evidence for physical activity and other behavioural non-communicable disease risk factors*

[Link: *Systems approaches to scaling up: a systematic review and narrative synthesis of evidence for physical activity and other behavioural non-communicable disease risk factors* - PubMed](#)

Summary

This systematic review (21 studies; 2016-2021) examines how systems approaches are used to scale up interventions targeting four behavioural NCD risk factors (physical inactivity, tobacco,

alcohol, diet). Only 19% (n=4) of interventions explicitly embedded systems thinking across design, implementation and scale-up. The authors classify studies into high, moderate, and no systems use, synthesise common barriers and enablers, and conclude that employing systems approaches in scale-up remains in its infancy. They call for practical guidance on communicating and operationalising systems methods in research and practice to achieve population-level impact.

Key arguments and findings

- Underuse of systems thinking: Only 4/21 studies fully applied systems thinking across the scale-up pathway.
- Three levels of systems use: Five studies = high (explicitly targeted system relationships and change); seven = moderate; nine = no explicit systems framing despite multi-level delivery.
- Scaling is complex: Contextual variation, multi-agency delivery, and data/attribution challenges hinder robust evaluation at scale.
- Action needed: The field needs clear, practice-oriented guidance to operationalise systems approaches for implementation and scale-up.

Where it supports-and can be operationalised by-the Scottish Approach to Change

- Learning systems and feedback loops: The paper's call for guidance to *operationalise* systems approaches aligns with SAfC's Learning System enabler: build infrastructure for rapid feedback, reflective practice, and qualitative/quantitative insight to adapt during scale-up.
- Structured end-to-end method for scale-up: SAfC's Eight Steps of Change (from *Identify* → *Review for spread*) provides the practical pathway the review says is missing-particularly for testing, implementation, embedding, and spread at the system level.
- Process rigour for complex scale-ups: SAfC emphasises measurement, monitoring, evaluation, governance, and project/programme management to deal with attribution and context variability that the review highlights as scale-up challenges.
- People-led, multi-stakeholder collaboration: The review notes the multi-agency nature of scaled interventions; SAfC's People-led and Leadership and Culture enablers operationalise co-design, shared ownership, and cross-boundary leadership needed for system-level change.
- Clear vision/purpose to navigate complexity: SAfC's Clear Vision and Purpose enabler helps maintain alignment and decision discipline as interventions adapt across diverse contexts during scale-up.

Mala Mann, Kate Lifford, Susan O’Connell, Alison Weightman, Lydia Searchfield, Ruth Lewis, Alison Cooper, Adrian Edwards (2023) - *A rapid review of what organisational level factors support or inhibit the scale and spread of innovations in children’s social care*

[Link: A rapid review of what organisational level factors support or inhibit the scale and spread of innovations in children’s social care | medRxiv](#)

Summary

This rapid review synthesises UK evidence on organisational factors that help or hinder the scale and spread of innovations in children’s social care. From 10 studies (3 reviews, 7 primary), the authors group determinants into adopter, organisational, and wider-system domains. Consistent enablers include senior leadership buy-in, sustained funding, specific training and support, strong inter-professional and professional-carer relationships, multidisciplinary communication and joint working, and compatible data systems to support collaboration. Common barriers include short-term or absent funding, implementation overload (multiple priorities), and structural change. The authors emphasise that while findings offer clear pointers for policy and practice, overall confidence is limited by study quality (many service evaluations and non-systematic reviews).

Key arguments and findings

- Leadership matters: Senior management/leadership buy-in consistently enables scale and spread.
- Resourcing is pivotal: Short- and long-term funding is repeatedly cited as an enabler; lack of sustained funding is a major barrier.
- Capability and support: Targeted training and support for professional staff facilitate adoption and implementation.
- Relational infrastructure: Trusting inter-professional and professional-carer relationships, plus multidisciplinary communication and joint working, underpin success.
- Information infrastructure: Compatible data systems enable collaboration and coordinated delivery.
- Implementation load and churn: Multiple priorities and changing structures commonly derail or delay spread.
- Evidence caveat: Confidence in the evidence is limited by the predominance of service evaluations/non-systematic designs.

Note: This is a preprint and not peer-reviewed.

Where the review supports the Scottish Approach to Change (SAC)

- Leadership and culture - The review's emphasis on senior leadership buy-in aligns with SAC's enabler that leaders set vision, remove barriers, and create psychologically safe spaces for change.
- Process rigour (governance, data, project management, commissioning) - Calls for compatible data systems and structured decision-making echo SAC guidance on measurement, monitoring and evaluation, governance that "creates momentum", and the "power of good project management." Barriers around short-term funding reinforces SAC's focus on commissioning and resourcing as prerequisites for reliable change.
- People-led change - The review's finding that professional-carer relationships enable spread supports SAC's people-led enabler: co-design with people who need, access and use services to make change relevant and sustainable.
- Learning system and capability building- The need for specific training and support in the review complements SAC's learning system-cultures, networks and feedback loops that build capability and mobilise knowledge across the system.
- Clear vision and purpose- The review highlights implementation overload and shifting structures as barriers; SAC addresses this by anchoring change in a clear vision and purpose that guides choices, sequencing and trade-offs.
- Steps of change (Identify → Spread) - The review's emphasis on structured scale-up aligns with SAC's eight steps of change and its formal review for implementation and review for spread checkpoints to decide whether to adopt, adapt, or abandon.

Braithwaite J, Testa L, Lamprell G, et al (2017) - *Built to last? The sustainability of health system improvements, interventions and change strategies: a study protocol for a systematic review*

[Link: *Built to last? The sustainability of health system improvements, interventions and change strategies: a study protocol for a systematic review*](#)

Summary

This BMJ Open paper sets out a protocol for a systematic review on the *sustainability* of healthcare improvements, interventions and change strategies. Motivated by pressures such as ageing populations, chronic disease, wasteful spending and rising expectations, the authors argue that sustaining benefits over time is a core challenge for health systems. The review will identify and synthesise empirical studies (post-2011) that *measure* sustainability, catalogue definitions and theoretical frameworks, and appraise methods and tools. A pluralist search strategy (multiple

databases, expert contact, snowballing) and staged screening are described; the authors note conceptual ambiguity around “sustainability” as a key limitation to address. The intended outcome is practical guidance to help clinicians, policymakers, and managers design changes that last and inform a more sustainable health system.

Key arguments and (proto-)findings from the paper

- It is a protocol, not a results paper-there are *no empirical findings reported*; the contribution is a rigorous plan to synthesise how sustainability is defined, measured and theorised in healthcare improvement literature.
- Why this matters: health systems face mounting, system-level pressures (ageing, multimorbidity, technology costs, waste), so sustaining improvement is essential to long-term system performance.
- Field gap: definitions and measures of “sustainability” are inconsistent; a consolidated map of frameworks and tools is needed for practitioners.
- Methodological stance: adopts a pluralist, multi-source search and a staged review process to strengthen *process rigour* and utility for policy and practice.

Where it supports the Scottish Approach to Change (Scottish Approach to Change)

- Process rigour: The protocol’s structured, multi-database strategy and staged screening mirror Scottish Approach to Change ’s emphasis on systematic governance, measurement, and evaluation to guide change.
- Learning system: By synthesising evidence on what sustains improvement and disseminating outputs to decision-makers, the paper contributes to the kind of continuous, networked learning Scottish Approach to Change calls for.
- Clear vision and purpose: The protocol articulates a precise aim (identify how sustainability is defined/measured) and inclusion criteria-aligned with Scottish Approach to Change ’s call for a clear purpose to anchor decisions.
- People-led focus (indirect): The rationale recognises the shift toward patient-centred models and consumer expectations-consistent with Scottish Approach to Change ’s requirement to design change *with* people and for equitable access.
- Leadership and culture: The authors frame sustainability as a system property requiring coordinated action across stakeholders-echoing Scottish Approach to Change ’s emphasis on leadership behaviours and cultures that enable change.
- Steps of change-Identify and Understand: The work systematically *identifies* the sustainability problem and *understands* current evidence/methods-foundational to Scottish Approach to Change ’s first two steps before design and testing.

Lennox L, Linwood-Amor A, Maher L, Reed J. (2020) - *Making change last? Exploring the value of sustainability approaches in healthcare: a scoping review.* Health Res Policy Syst.

[Link: Making change last? Exploring the value of sustainability approaches in healthcare: a scoping review - PMC](#)

Summary

Lennox et al. (2020) present a scoping review of how sustainability frameworks, models and tools are actually used in healthcare practice. They identify 68 studies across primary, secondary, tertiary and community settings, finding that approaches are mainly used for analysis, evaluation, guidance, assessment and planning. Reported benefits include clearer conceptualisation of “sustainability” and better interpretation of sustainability data; challenges include construct ambiguity and difficulties applying tools in real-world contexts. Critically, only 14/68 studies reported sustainability outcomes, so the impact of using these approaches remains unclear. The authors call for greater rigour and reporting, and propose an updated list of sustainability outcome variables to guide future assessment.

Key arguments and findings

- Scope and uptake: 68 peer-reviewed applications of sustainability approaches, with usage increasing and spanning multiple care settings.
- Primary purposes: Approaches are used for analysis, evaluation, guidance, assessment and planning in improvement programmes.
- Benefits: They help clarify constructs (what “sustainability” means) and interpret sustainability data.
- Challenges: Conceptual ambiguities and application difficulties reduce consistency and comparability.
- Evidence gap: 14/68 studies reported sustainability outcomes; thus, the impact of these approaches is still uncertain.
- Implications: The field needs stronger methodological rigour and reporting, plus agreed outcome variables to study and support sustained change.

Where this supports the Scottish Approach to Change

- Process Rigour (Scottish Approach to Change enabler): The review’s call for structured methods, clear measures, and stronger reporting directly reinforces Scottish Approach to Change’s emphasis on rigorous governance, measurement/monitoring/evaluation, and proportionate project management in change.

- Learning System (Scottish Approach to Change enabler): Sustainability is framed as an ongoing process of adaptation as well as an outcome-aligned with Scottish Approach to Change 's learning systems that use data, reflection and feedback loops to evolve change.
- Embed and Sustain (Scottish Approach to Change step): The paper's core concern-making change last-supports Scottish Approach to Change 's dedicated "Embed and sustain" step and the need to protect the conditions that keep changes working overtime.
- Measurement, Monitoring and Evaluation (within Process Rigour): The identified outcome-reporting gap and proposed outcome variables echo Scottish Approach to Change 's guidance to plan measurement early, triangulate data and track impact, including balancing measures.
- Clear Vision and Purpose (Scottish Approach to Change enabler): The paper's point that teams must define what exactly is being sustained (intervention, practices, benefits) resonates with Scottish Approach to Change 's requirement to anchor change in a clear vision and purpose that guides decisions and trade-offs.

Moon SEJ, Hogden A, Eljiz K. (2022) - *Sustaining improvement of hospital-wide initiative for patient safety and quality: a systematic scoping review.*

[Link: Sustaining improvement of hospital-wide initiative for patient safety and quality: a systematic scoping review - PMC](#)

Summary

Moon, Hogden and Eljiz conduct a systematic scoping review of 17 hospital-wide patient safety/quality initiatives to understand what sustains improvement beyond initial implementation. They identify 62 factors clustered into three themes-People, Process, and Organisational Environment-and surface two cross-cutting mechanisms, Influence and Action. The most critical ingredients were well-coordinated delivery, customised local integration, and continued change effort over time (mean follow-up 4.3 years). Notably, only 53% of studies used a guiding framework, and none explicitly focused on sustainability, underscoring a gap between implementation and lasting adoption. The authors offer an actionable conceptual framework to help hospitals plan, execute and maintain change with sustainability in view.

Key arguments and findings

- Hospitals often fail to sustain hard-won improvements; sustainability requires attention after implementation.
- 62 factors fell into People (roles, leadership, engagement), Process (planning, execution, maintenance, measurement), and Organisational Environment (culture, governance, resources).

- Three elements most associated with sustained results: coordinated change delivery, local tailoring/integration, and ongoing effort.
- Only 53% used a guiding framework; none centred sustainability-revealing a framework gap that the authors address with a practical model.

Where this supports the Scottish Approach to Change

- People and Leadership → Scottish Approach to Change “People-led” + “Leadership and culture”
The review’s People theme and emphasis on roles, leadership, and engagement align with Scottish Approach to Change’s enablers to involve people who need, use and deliver services, and to create safe, empowering cultures for change.
- Process (planning, execution, maintenance) → Scottish Approach to Change “Process rigour” + Eight Steps of Change - The call for structured planning, testing, and ongoing maintenance maps directly to Scottish Approach to Change’s process rigour and the eight steps (Identify → Understand → Develop and design → Prototype and test → Review for implementation → Define and implement → Embed and sustain → Review for spread), including explicit use of PDSA testing.
- Organisational Environment → Scottish Approach to Change “Clear vision and purpose”, “Learning system”, and QMS Findings that sustained change needs a supportive culture, governance, and resources reinforce Scottish Approach to Change’s focus on a clear strategic anchor, learning systems with feedback loops, and a Quality Management System (plan-improve-maintain-assure) to embed reliability.
- Coordinated delivery and local integration → Scottish Approach to Change’s co-design and local tailoring
The review’s stress on well-coordinated delivery and customised local integration is mirrored in Scottish Approach to Change’s guidance on co-design with communities, proportionate governance, and adapting approaches to local context while maintaining fidelity.
- Continued effort and spread → Scottish Approach to Change “Embed and sustain” + “Review for spread”
The requirement for continued effort over the years aligns with Scottish Approach to Change’s explicit steps to embed/sustain changes as business-as-usual and then assess readiness for spread to other settings.
- Framework gap → Scottish Approach to Change’s actionable framework, because few studies used robust frameworks and none focused on sustainability, the review implicitly validates the need for an actionable, sustainability-oriented framework-precisely what Scottish Approach to Change provides through its enablers + steps + tools.

Zurynski Y, Herkes-Deane J, Holt J, McPherson E, Lamprell G, Dammery G, Meulenbroeks I, Halim N, Braithwaite J. (2022) - *How can the healthcare system deliver sustainable performance? A scoping review.*

[Link: How can the healthcare system deliver sustainable performance? A scoping review - PMC](#)

Summary

This scoping review (142 articles) explores how “sustainable performance of healthcare systems” (SPHS) is defined, measured, challenged, and improved. Only 27% of sources provided explicit definitions—mostly financial—but newer work broadens SPHS to include patient/workforce acceptability, system resilience/adaptability, and rapid uptake of evidence and innovations. Measurement remains largely financial, with a shift toward composite indicators spanning financial, social, and health outcomes. Persistent barriers include complex case-mix, fragmented/siloed systems, and evidence-to-practice and policy-to-practice gaps. Proposed solutions emphasise enabling workplace cultures, direct community/consumer involvement, adoption of evidence-based practices/technologies, and critically long-term monitoring and evaluation to adapt to changing needs. The authors call for context-relevant frameworks and robust, flexible measures to embed lasting change.

Key arguments and findings

- Definitions are inconsistent and too narrow: Only 27% defined SPHS; financial framing dominates, though broader lenses now include acceptability, resilience, and absorptive capacity for evidence/innovation.
- Measurement must evolve: Predominantly financial metrics are giving way to composite measures that integrate financial, social and health outcomes.
- Contextual barriers persist: Complexity, fragmentation, siloed professions, and translation gaps undermine sustainability.
- What helps: Supportive cultures, meaningful consumer/community involvement, and adoption of evidence-based practice and technologies.
- What’s required to sustain gains: Ongoing monitoring/evaluation and context-relevant frameworks to enable adaptation over time.

Where this supports the Scottish Approach to Change (Scottish Approach to Change)

- People-led change: The review’s emphasis on direct community/consumer involvement aligns with Scottish Approach to Change’s *People-led* enabler and co-design ethos.
- Leadership and culture: Calls for enabling workplace cultures mirror Scottish Approach to Change’s focus on leadership behaviours, psychological safety, and collaboration to make change “stick.”

- Process rigour and measurement: The move toward composite metrics and the need for long-term monitoring reinforce Scottish Approach to Change 's guidance on measurement, evaluation, and triangulating data within a rigorous change process.
- Learning systems: The review's stress on continuous evaluation and adaptability maps directly to Scottish Approach to Change 's *Learning system* enabler (feedback loops, reflective practice, and knowledge mobilisation).
- Context-relevant frameworks → Scottish Approach to Change 's structured steps: The call for context-specific frameworks and scalable spread supports Scottish Approach to Change 's eight *Steps of change* (prototype and test → review for implementation → embed and sustain → review for spread) and the Quality Management System scaffolding.

Côté-Boileau É, Denis JL, Callery B, Sabeau M. (2019) - *The unpredictable journeys of spreading, sustaining and scaling healthcare innovations: a scoping review.*

[Link: The unpredictable journeys of spreading, sustaining and scaling healthcare innovations: a scoping review - PMC](#)

Summary

This scoping review synthesises how innovations in healthcare *spread, sustain and scale* ("3S") and why the journey is often unpredictable. Screening 641 records (24 included), the authors distil practical guidance into five priorities: (1) clarify the why; (2) emphasise perceived value and feasibility; (3) focus on work-as-done (what people do); (4) broker dialogue between policy and delivery; and (5) ensure inclusivity and capacity-building. They highlight that structural change alone is insufficient: social dynamics, context and frontline engagement determine whether local improvements achieve wider adoption. Notably, fewer than 40% of healthcare improvement initiatives progress from adoption to sustained implementation that spreads beyond a single area, underlining the need for deliberate 3S strategies.

Key arguments and findings

- The 3S continuum is social and non-linear. Progress hinges on context, relationships and emergent learning rather than a fixed blueprint.
- Five actionable levers: focus on the *why*; demonstrate *value/feasibility*; centre on *work-as-done*; create *policy-delivery dialogue*; and invest in *inclusivity and capability*.
- Structural reorganisations are insufficient without frontline engagement, supportive policies, incentives and patient/citizen participation.
- Adoption-to-spread gap: <40% of initiatives sustain and spread beyond one area, so active spread strategies are required.

Where this supports the Scottish Approach to Change

- “Focus on the why” ↔ Clear vision and purpose (Scottish Approach to Change enabler). Both stress an explicit vision, tough choices, and strategy-to-action to anchor decisions and sustain momentum.
- “Work-as-done” and process discipline ↔ Process rigour + PDSA. The review’s emphasis on real practice conditions aligns with Scottish Approach to Change’s measurement, triangulation, and iterative *prototype and test* using PDSA cycles.
- Policy-delivery dialogue ↔ Learning systems and governance. The call to broker dialogue is mirrored in Scottish Approach to Change’s *learning system* (rapid feedback, reflective practice) and proportionate governance that enables action.
- Inclusivity and capacity-building ↔ People-led, leadership and culture, education. Both foreground co-design with people with lived experience, psychological safety, and capability-building across teams.
- Deliberate spread ↔ Scottish Approach to Change “Review for spread” step. The review’s 3S lens directly supports Scottish Approach to Change’s explicit stage to appraise what to spread, where, and how, before initiating a new project cycle.
- Context-sensitivity ↔ Scottish Approach to Change’s end-to-end cycle. Attention to context and emergent learning in the review echoes Scottish Approach to Change’s eight steps (from *Identify* to *Embed and sustain* and *Review for spread*) and its QMS foundation.

NHS Institute for Innovation and Improvement. (2007) - *Improvement Leaders’ Guide: Sustainability and its relationship with spread and adoption, General improvement skills*

[Link: *Improvement Leaders’ Guide: Sustainability and its relationship with spread and adoption, General improvement skills*](#)

Summary

This Improvement Leaders’ Guide sets out what “sustainability” means in service improvement- “holding the gains and evolving as required”-and why projects often fail to last (the “evaporation” effect) or remain isolated (“islands of improvement”). It presents practical factors that most influence durability and spreads-leadership, staff engagement, ownership, incentives, dedicated resources, and sound implementation-and links these to the adoption process, emphasising social networks and attraction over top-down push. The guide recommends using the Model for Improvement and PDSA cycles and signposts the NHS Sustainability Model as a diagnostic to predict and strengthen sustainability. It concludes that the determinants of sustainability and spread are largely the same; building them in from the outset increases the likelihood that improvements become “the way we do things here” and can scale.

Key arguments and findings

- Definition matters: sustainability is not stasis; it is “holding the gains and evolving as required,” with processes and mindsets becoming the norm.
- Two common failure modes: (1) improvement evaporation-gains decay after initial effort; (2) islands of improvement-local wins that never spread.
- Determinants are shared for sustainability and spread: senior sponsorship, credible leadership, staff engagement, ownership, incentives, effective relationships, dedicated resources, and thoughtful implementation pace.
- Adoption is social: spread follows adoption; attraction, peer networks and relationships outperform “push” communications.
- Use improvement discipline: apply the Model for Improvement and iterative PDSA testing so only proven changes are embedded.
- Assess and design for durability: the NHS Sustainability Model provides a structured diagnostic to identify strengths/risks and guide action.

Where the guide supports the Scottish Approach to Change

- NHS ILG theme → Scottish Approach to Change alignment (evidence) Leadership and senior sponsorship are pivotal to sustain and spread change. Scottish Approach to Change names Leadership and culture as a core enabler and defines roles from board to programme leads that remove barriers and maintain momentum.
- People engagement and ownership drive durability; early, broad involvement reduces resistance. Scottish Approach to Change’s People-led enabler embeds co-design with people who use, deliver and enable services to build relevance, legitimacy and support.
- Process discipline and project management (e.g., PDSA, governance, measurement) are required, not optional. Scottish Approach to Change’s Process rigour enabler plus the Eight Steps of Change (Identify → Review for spread) operationalise governance, data, PMO and iterative testing.
- Adoption via social networks: spread comes from creating attraction and peer-to-peer influence. Scottish Approach to Change’s Learning system enabler builds networks, learning partners and system stewards to mobilise knowledge and support spread.
- Clarity of purpose and incentives: a shared aim and visible benefits sustain change. Scottish Approach to Change foregrounds Clear vision and purpose to align choices, prioritise effort and guide decisions over time.
- Plan for spread from the start; factors for sustainability and spread are the same. Scottish Approach to Change ends with Review for spread, explicitly assessing what to scale, where and how, using evidence and context-fit.

Tim Horton, John Illingworth and Will Warburton (2018) - *The spread challenge: How to support the successful uptake of innovations and improvements in health care*

Link: [The-spread-challenge.pdf](#)

Summary

The spread challenge (Health Foundation, 2018) explains why proven service innovations often underperform when replicated and sets out how to design for *successful uptake*, not just initial adoption. It highlights the “replicability problem” in complex, socio-technical interventions; argues for better codification that specifies core components, adaptable elements, skills, behaviours and implementation methods; and calls for a formal testing-and-revision phase before large-scale rollout. It urges programmes to put adopters front and centre-building capability, resourcing implementation, fostering peer networks, and creating behavioural and contextual supports-alongside more real-world testing and comparative evaluation across settings. Overall, spread is presented as a distributed, iterative learning effort that must invest as much in the *receiving contexts* as in the originating innovation.

Key arguments and findings

- The replicability problem: effects often diminish (“voltage drop”) when interventions move to new contexts; success requires understanding and redesign for local conditions.
- Complexity matters: many health-care changes are social, context-sensitive and dynamic; spread efforts must address behaviours, culture and systems-not just technical steps.
- Codify for adaptation: describe interventions so adopters know the *non-negotiable core* versus what can be adapted; include theory of change, required skills and implementation guidance (not only “what” but “how”).
- Formal testing and revision phase: use early, diverse adopter sites to surface learning; revise the intervention and its guidance before scale.
- Design programmes around adopters: build motivation, opportunity and capability; provide time, resources, training, and peer learning networks; reward adoption.
- More real-world evidence: compare performance across contexts as a standard stage in the innovation cycle.

Where it supports the Scottish Approach to Change (Scottish Approach to Change)

- People-led change/engagement. The report emphasises adopters and frontline teams as co-creators of local solutions and learning, aligning with Scottish Approach to Change ’s people-led enabler and multi-stakeholder involvement across all steps.
- Process rigour. Calls for explicit codification, governance of spread, and staged testing mirror Scottish Approach to Change ’s eight Steps of change (Identify → Prototype and test

→ Review for implementation → Define and implement → Review for spread) and its measurement/PM discipline.

- Learning system. Advocates peer networks and mechanisms to capture and share adopter learning; Scottish Approach to Change positions Learning systems as core infrastructure for continuous reflection, feedback loops and knowledge mobilisation.
- Leadership and culture. Notes the need for culture change, relationship-building and capability-building for adopters; Scottish Approach to Change 's Leadership and culture enabler specifies psychologically safe, empowering environments and distributed leadership.
- Clear vision and purpose. Recommends building consensus on the problem and proposed solution to sustain commitment; Scottish Approach to Change begins with a shared vision and purpose guiding choices and trade-offs.
- Review for spread (what to spread?). The report advises deciding whether to spread the *model* or the *approach/principles* and clarifying what core vs. adaptable-precisely the questions in Scottish Approach to Change 's Review for Spread step.

NHS Confederation (2023) - *Scaling innovation within healthcare systems: Practical considerations*

Link: [Scaling-innovation-within-healthcare-systems-practical-considerations-FNL.pdf](#)

Summary

This practical guide distils lessons from NHS case studies to help organisations adopt and scale proven innovations. It argues that scaling succeeds when teams (a) Understand the local problem, capacity and priorities, (b) engage early and continuously with the full stakeholder ecosystem (clinicians, managers, patients, partners), and (c) Future-proof with fit-for-purpose incentives, implementation resources, and plans for sustainability beyond seed funding. Illustrative examples include community diagnostic centres (CDCs), CAR-T therapy, and FeNO testing in primary care, each showing how local needs assessment, cross-functional engagement, and resourcing models enabled uptake and impact (e.g., reduced DNAs, improved access, positive patient feedback). A short checklist translates these insights into actions for innovators and system decision-makers.

Key arguments and findings

- Three core pillars for scaling: *Understand* (local needs, capacity, ties to priorities), *Engage* (regular touchpoints across the ecosystem), *Future-proof* (funding, incentives, and a sustainability plan).
- Context matters: CDCs succeeded where siting reflected transport patterns and local constraints; national best practice sharing and autonomy for local leaders accelerated progress.

- Whole-system engagement: Early involvement of clinicians, managers, labs and patients (e.g., CAR-T) built robust business cases and operational readiness.
- Incentives and implementation support drive uptake: FeNO spread was enabled by AAC funding, QoF incentives, and ready-to-use implementation resources (business cases, data/evaluation guidance).
- Evidence of impact: Barnsley CDC reported 100% positive patient ratings, fewer DNAs in some services, and improved efficiency, strengthening the sustainability case.
- Actionable tool: A concise checklist assigns complementary actions to innovators and system decision-makers to make adoption repeatable.

Where the NHS Confederation guidance supports the Scottish Approach to Change

By Scottish Approach to Change enablers

- Clear vision and purpose - The 'Understand' pillar requires aligning innovations with national/local priorities and authentic local problems; Scottish Approach to Change emphasises vision/purpose as the anchor for choices and trade-offs.
- People-led - The 'Engage' pillar mandates early, ongoing involvement of all affected groups (including patients), mirroring Scottish Approach to Change 's people-led design and meaningful engagement principles.
- Process rigour - Future-proofing through incentives, governance, and implementation resources (business cases, measurement/evaluation advice) aligns with Scottish Approach to Change 's process rigour (governance, measurement, project management).
- Leadership and culture - Success factors include empowered local leadership, senior buy-in, and supportive national teams-core to Scottish Approach to Change 's leadership and culture enabler.
- Learning system - Central sharing of best practice among CDCs and regular stakeholder touchpoints reflect Scottish Approach to Change 's emphasis on learning networks and reflective practice.

By Scottish Approach to Change steps of change

- Identify and Understand - Needs assessment, capacity analysis and problem framing correspond directly to the opening Scottish Approach to Change steps.
- Develop and Design + Prototype and Test - The guidance's stakeholder co-design and staged roll-out in case studies (e.g., CAR-T readiness, FeNO pathway adaptation) reflect Scottish Approach to Change 's collaborative design and iterative testing ethos.
- Define and Implement / Embed and Sustain - 'Future-proof' explicitly addresses funding models, incentives, and tooling to embed changes as business-as-usual-core to Scottish Approach to Change 's implementation and sustainment steps.

- Review for spread - The guidance's purpose-scaling proven innovations-aligns with Scottish Approach to Change 's explicit review-for-spread step.

Policy Design, Commissioning, Public Value and Strategic Reform

Summary

Khalil et al. (2025) - Implementing value-based healthcare: a scoping review of key elements, outcomes, and challenges for sustainable healthcare systems

[Link: Implementing value-based healthcare: a scoping review of key elements, outcomes, and challenges for sustainable healthcare systems - PubMed](#)

Summary

This scoping review synthesises 145 studies on implementing value-based healthcare (VBHC) across settings and geographies. It finds that the U.S. dominates the VBHC evidence base ($\approx 65\%$), with Europe contributing substantially; study designs are largely cohort and cross-sectional. Funding/operating models most often reported include Value-Based Purchasing and Time-Driven Activity-Based Costing. Reported outcomes span patient-reported measures and cost savings, but measurement remains inconsistent. Key barriers include fee-for-service inertia, limited funding, and professional resistance; enablers include leadership, multidisciplinary collaboration and digital tools. The authors call for standardised outcome measurement, aligned financial incentives, and greater data transparency to scale VBHC reliably.

Key arguments and findings

- VBHC adoption is widespread but uneven, with most evidence originating from the U.S.; European contributions are growing.
- Common models: Value-Based Purchasing and TDABC are the most frequently cited approaches for funding/costing within VBHC programmes.
- Outcome measurement is fragmented, spanning PROMs to cost metrics; lack of standardisation hampers comparison and scale-up.
- Barriers: persistence of fee-for-service payment, insufficient funding, data challenges, and clinician resistance.
- Facilitators: strong leadership, multidisciplinary collaboration, and digital/telehealth tools supporting implementation and monitoring.

- System asks: align incentives, standardise outcomes, and improve transparency to sustain and spread VBHC.

Where it supports the Scottish Approach to Change

- Clear vision and purpose: The review’s call for explicit outcome frameworks and aligned incentives mirrors Scottish Approach to Change ’s emphasis on anchoring change in a clear vision and strategy to guide decisions.
- Process rigour: The need for standardised measures, robust data, and evaluation aligns with Scottish Approach to Change ’s process-rigour enabler (measurement, monitoring, evaluation; project management and governance).
- Leadership and culture: Identification of leadership and organisational support as key facilitators directly reflects Scottish Approach to Change ’s focus on leadership behaviours, psychological safety, and enabling cultures for change.
- People-led: Emphasis on PROMs and stakeholder engagement in VBHC implementation supports Scottish Approach to Change ’s principle of co-design and involving people with lived experience.
- Learning system and iterative change: The review’s recommendation to use digital tools and feedback loops to learn and adapt aligns with Scottish Approach to Change ’s learning systems and the eight iterative steps (prototype/test; review; embed; spread).

Charles Tallack, Anita Charlesworth, Elaine Kelly, Ruth McConkey, Stephen Rocks. (2020) - *REAL Centre The bigger picture: learning from two decades of changing NHS care in England.*

Link: [The Bigger Picture - Health Foundation](#)

Summary

The report reviews how NHS-funded activity in England changed from 2000/01 to 2017/18, finding total activity more than doubled (114%)-far beyond what demographics alone would predict (<1% per year). Growth concentrated in hospital-based planned care, while primary and community services lagged, despite policy rhetoric to shift care “upstream.” Activity accelerated in the 2000s alongside higher funding, then slowed post-2010 as funding tightened; life expectancy gains also stalled and even reversed in some deprived groups. The authors argue that choices-funding, workforce, incentives, technology-drive activity patterns and set out six lessons: define clear population-health goals, understand service contributions, project morbidity systematically, align workforce and delivery plans, focus on inequalities, and build coherent policy/multi-year investment to translate intent into reality.

Key arguments and findings

- NHS activity rose 114% (avg. 4.6%/yr); demographics explain <1%/yr-so policy, supply, demand and incentives dominate.
- Growth skewed to hospitals: planned care expanded rapidly; GP consultations grew only ~0.7%/yr, shifting spend toward acute services.
- Despite long-standing aims, there's "little sign" of a sustained shift to primary/community care.
- Funding and workforce choices correlate with activity: faster growth and quality gains in the 2000s; slower growth and stalled life expectancy post-2010.
- Inequalities matter for some groups (e.g., younger women in deprived areas), life expectancy declined.
- Six lessons stress clear population-health goals, morbidity projections, aligned workforce/service plans, and coherent long-term policy/investment.

Where it supports the Scottish Approach to Change (Scottish Approach to Change)

- Clear goals ↔ Clear vision and purpose. Call for explicit population-health goals mirrors Scottish Approach to Change 's first enabler to anchor decisions and trade-offs.
- Use evidence and projections ↔ Process rigour. Emphasis on understanding service contributions and projecting morbidity aligns with Scottish Approach to Change 's measurement, monitoring, evaluation and triangulation of data.
- Translate intent into delivery ↔ Eight steps of change. Noting the gap between rhetoric and reality supports Scottish Approach to Change 's structured cycle (identify→review for spread) to move from pilots to embedded BAU.
- Workforce-service alignment ↔ Leadership and culture + governance. The report's warning on misaligned workforce and service plans reinforces Scottish Approach to Change 's leadership, governance and programme management guidance.
- Shift left on care ↔ People-led design and ethical commissioning. Failure to rebalance away from acute care underlines Scottish Approach to Change 's people-led co-design and locally tailored commissioning to redesign pathways closer to home.
- Inequalities focus ↔ Reducing inequalities and human-rights lens. Evidence of stalled/declining life expectancy in deprived groups supports Scottish Approach to Change 's explicit requirement to assess and reduce inequalities throughout change.
- Learn and spread what works ↔ Learning systems and review for spread. The push for coherent, long-term policy and the identification of "what works" aligns with Scottish Approach to Change 's learning systems, feedback loops and spread readiness.

Chris Ham (2025) - *What can we learn about implementation from previous NHS reforms?*

Link: [What can we learn about implementation from previous NHS reforms? | NHS Confederation](#)

Summary

Sir Chris Ham distils lessons from past NHS reforms to guide the delivery of today's 10-Year Health Plan. He contrasts two successes—the decades-long transformation of mental health from asylums to community care, and the 2000s reductions in acute waiting times—with less successful efforts to shift physical health care out of hospitals. The through-lines: fund double-running costs; invest in new capacity before closing old; let money follow patients; allow local innovation; maintain stable, high-quality leadership; and take a whole-system view. Equally, reform is iterative and “messy,” requiring discovery-led implementation and strategic patience. Failures typically stem from underpowered implementation, pilots that never scale, and the inability to move resources from hospitals into the community. Above all, trust and back staff and experienced managers as agents of change.

Key arguments and findings

- Implementation trumps intent: Reforms succeed when delivery mechanisms (funding, incentives, capacity) are designed as carefully as the goals.
- Resource realism: Successful shifts require double-running funds, investing before closing, and money following patients; assuming community care is cheaper is risky.
- Leadership and system view: Stable, capable leadership and a whole-system perspective are critical where many organisations are involved.
- Local innovation and adaptation: Change is iterative and context-specific; allow discovery-led implementation and local tailoring.
- Time horizons: Even “successful” reforms take years; central bodies need strategic patience.
- People power: Staff and managers are the NHS's most important asset and must be trusted and supported as the primary agents of change.

Where the article supports the Scottish Approach to Change

- Process rigour and governance: The call to fund double-running, align incentives, and manage transitions maps to Scottish Approach to Change 's emphasis on process rigour, robust governance, measurement, and project management across the change cycle.
- Learning mindset: Ham's “messy,” iterative discovery mirrors Scottish Approach to Change 's learning system—iterative testing (e.g., PDSA), reflective practice, and rapid feedback loops to adapt change.

- Leadership and culture: The need for stable leadership and a system view aligns with Scottish Approach to Change 's leadership and culture enabler (distributed leadership, psychological safety, collaboration).
- People-led change: Trusting staff and local leaders as agents of change is consistent with Scottish Approach to Change 's people-led principle-co-design with people who use, deliver and enable services.
- Clear vision with practical strategy: The article's focus on delivery mechanisms complements Scottish Approach to Change 's clear vision and purpose, plus strategy-to-execution steps across Identify → Implement → Sustain.

UK Government (2022) - *The Green Book: UK government guidance on appraisal*

Link: [The Green Book - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/107122/gb2022.pdf)

Summary

The Green Book is the UK government's core guidance for appraising policies, programmes and projects. The 2026 edition is shorter, clearer and reframes value for money (VfM) to emphasise *overall social value*-not just benefit-cost ratios. It anchors appraisal in the ROAMEF cycle (Rationale, Objectives, Appraisal, Monitoring, Evaluation, Feedback), strengthens place-based and distributional analysis, and embeds proportionality, risk/uncertainty, and theory of change within the Five Case Model for business cases. Crucially, ministers should receive rounded advice where BCRs are not used as crude pass/fail thresholds, supporting more balanced investment choices across regions.

Key arguments and takeaways

- Purpose and scope: Appraisal provides *objective, impartial* advice on options to achieve government objectives; mandatory across UK government and widely adopted by devolved administrations.
- VfM = social value: Decisions must weigh monetizable and non-monetisable effects, risk, distributional and place-based impacts-not just BCRs.
- ROAMEF and theory of change: Rationale, SMART objectives, and explicit theories of change are required foundations for appraisal quality.
- Five Case Model and proportionality: Business cases should follow the Five Case Model, scaled to project size/complexity.
- Distributional/place-based analysis: Dedicated guidance elevates analysis of who benefits and where, addressing underinvestment concerns.
- 2026 refresh: The document is substantially shorter and clearer; updates implement the 2025 review and signal a "fair hearing" for all parts of the UK.

Where the Green Book supports Scottish Approach to Change (alignment highlights)

- Clear vision and purpose → Rationale, objectives, strategic fit
Scottish Approach to Change 's call for a shared vision and explicit purpose maps to Green Book requirements for the *case for change*, *SMART objectives*, and *strategic fit* that guide all subsequent analysis.
- People-led design → Social value and stakeholder perspectives
Scottish Approach to Change centres' lived experience and co-design. Green Book's VfM definition requires consideration of non-monetisable outcomes (e.g., wellbeing, equity) and effects on households/communities alongside agencies-encouraging early, meaningful engagement.
- Process rigour → Options generation, longlist/shortlist, risk and uncertainty
Scottish Approach to Change 's process rigour is reflected in the Green Book's structured options framework, explicit risk/uncertainty treatment, and expectation of proportional but disciplined analysis from longlist to preferred option.
- Learning systems and measurement → Monitoring, evaluation, feedback
Scottish Approach to Change 's learning system aligns with ROAMEF's monitoring and evaluation stages and with the expectation that appraisals draw on prior evaluations and plan for future evaluation from the outset.
- Leadership and culture → Governance and balanced decision-making
Scottish Approach to Change 's emphasis on leadership that removes barriers and empowers teams is reinforced by the Green Book's move away from BCR pass/fail thinking toward rounded judgments, enabling senior leaders to back place-appropriate options.
- Equity and inequalities → Distributional and place-based analysis
Scottish Approach to Change 's focus on reducing inequalities is supported by explicit distributional analysis and place-based assessment in the Green Book, making impacts on different groups and geographies a core part of VfM.

Michael Howlett, Giliberto Capano and M. Ramesh (2018) - *Designing for robustness: surprise, agility and improvisation in policy design*

[Link: *Designing for robustness: surprise, agility and improvisation in policy design*](#)

Summary

Designing for robustness: surprise, agility and improvisation in policy design argues that in volatile, uncertain, complex and ambiguous (VUCA) contexts, public policies fail when they are optimised solely for efficiency and routinisation. Instead, policymakers should design for robustness-building agility, flexibility, redundancy and feedback into both policy content and processes. The authors clarify types of uncertainty (including "deep uncertainty"), link these to appropriate design responses, and recommend procedural tools-formal review cycles, continuous learning

mechanisms and adaptive governance-to enable timely course correction. Robustness, they contend, is not accidental: it can be intentionally planned through leadership, capacity-building and the incorporation of learning-by-doing and iterative adjustment into policy mixes.

Key arguments and findings

- Robustness as a core design criterion: Effective policies must maintain performance despite internal or external shocks; efficiency-only designs are brittle in turbulent environments.
- Agility + redundancy beat rigid optimisation: Robust policies intentionally include spare capacity and adaptable procedures (e.g., feedback loops, automatic/semi-automatic adjustment) to pivot as contexts change.
- Match design to types of uncertainty: The paper distinguishes parameter/fuzzy uncertainty from “deep uncertainty,” arguing that different uncertainties warrant different adaptive design responses.
- Iterative learning-by-doing: Formal review points and continuous learning processes (not just one-off evaluation) are necessary to surface surprises and drive timely adaptation.
- Leadership and capacity matter: Robustness requires competence, brokerage and entrepreneurship to mobilise resources and institutionalise adaptive routines.
- Policy mixes need procedural tools: Beyond substantive instruments, procedural tools (review cycles, monitoring, learning systems) make adaptation practicable.

Where this supports the Scottish Approach to Change - The article’s prescriptions closely reinforce Scottish Approach to Change ’s enablers and steps of change.

Alignment with Scottish Approach to Change enablers

- Learning system → intentional, continuous learning and feedback - Scottish Approach to Change calls for measurement systems, reflective practice, rapid feedback loops and safe spaces to “fail fast” and learn; the article likewise centres formal review and continuous learning as prerequisites for robustness.
- Process rigour → structured governance + adaptive mechanisms - Scottish Approach to Change emphasises governance that creates momentum, rigorous project management, measurement/monitoring and proportionate processes; the paper underlines procedural tools, feedback mechanisms and adaptive governance to navigate uncertainty.
- Leadership and culture → capability, brokerage, psychological safety - Scottish Approach to Change highlights leaders who empower, remove barriers and foster psychologically safe, improvement-oriented cultures; the article stresses leadership competence and entrepreneurship as conditions for adaptive, robust policy.
- Clear vision and purpose → anchor amidst adaptation - Scottish Approach to Change positions vision/purpose as the decision anchor through change; the article notes that

agility must be guided (not ad hoc), pairing adaptability with directional clarity to avoid over- or under-reaction.

- People-led → co-production for real-world robustness - Scottish Approach to Change 's people-led approach (lived experience, inclusive engagement, equity) supports better sensing, faster feedback and more credible adaptations-consistent with the paper's emphasis on learning-by-doing and continuous translation of learning.

Alignment with Scottish Approach to Change steps of change

- Prototype and test → iterative adaptation under uncertainty - Scottish Approach to Change 's PDSA-style testing mirrors the paper's call for experimentation, incremental learning and redesign in response to surprise.
- Review for implementation / embed and sustain → formal review points
Scottish Approach to Change builds in explicit decision gates and ongoing monitoring to decide adopt/adapt/abandon and to sustain gains-exactly the formal review cycles advocated for robustness.
- Review for spread → context-sensitive scaling - Scottish Approach to Change 's emphasis on assessing what to spread (model vs. approach) and in which contexts reflects the article's insistence on matching design responses to the type/degree of uncertainty.

Harry Quilter-Pinner and Halima Khan (2023) - *Great Government: Public Service Reform in the 2020s*

Link: [Great government](#)

Summary

IPPR's *Great Government* argues the next UK administration will inherit one of the toughest public-service contexts since WW2 and cannot rely on either "more money" or "reform alone"; it needs a smarter state delivering prevention, personalisation and productivity ("the three Ps"). It proposes a five-part playbook: set bold, legislated missions; make smart, long-term, prevention-focused investment; build workforce capability; drive learning and improvement (via What Works centres, data labs and supportive "failure regimes"); and devolve power with longer funding settlements and shared governance. The report rejects New Public Management as "running out of road", calling instead for high-trust, high-skill, high-autonomy public services and systematic spread of proven innovations.

Key arguments and findings

- Crisis baseline: Even matching past peak improvement rates, it could take ~10 years to restore NHS access, up to seven years for the schools' attainment gap, and a decade to clear court backlogs.

- From “bigger vs smaller” to “smarter” state built on the three Ps-prevention, personalisation, productivity-backed by both funding and reform.
- Five drivers of reform: 1) Missions embedded in law and Whitehall governance; 2) Mission-tested, long-term investment including a new *Prevention Investment Expenditure* category; 3) Workforce new deals, CPD guarantees, licences to practise, and pro-worker tech; 4) Learning and improvement infrastructure (What Works, data labs, improvement bodies, supportive failure regimes); 5) Devolution of powers, multi-year settlements, and stronger local voice.
- Beyond NPM: Shift from targets/competition to intrinsic motivation, professional capability, and continuous learning to spread what works.

Where IPPR supports the Scottish Approach to Change

- Clear vision and purpose ↔ Missions: Scottish Approach to Change ’s first enabler (“clear vision and purpose”) aligns with IPPR’s call to set a small number of legislated missions with shared outcome frameworks-anchoring choices and trade-offs.
- Process rigour and measurement ↔ Smart investment and improvement: Scottish Approach to Change ’s emphasis on governance, data, monitoring/evaluation and proportionate project management maps to IPPR’s *mission test*, prevention-oriented budgeting, What Works centres, and data labs.
- People-led change ↔ Personalisation and “good help”: Scottish Approach to Change ’s people-led enabler (co-design, inclusion, trauma-informed practice, human rights and inequality focus) is reinforced by IPPR’s push for personalised services, citizen assemblies, and frontline empowerment.
- Leadership and culture ↔ High-trust, high-skill model: Scottish Approach to Change ’s leadership and culture enabler (distributive leadership, psychological safety, capability-building) is echoed in IPPR’s shift to high-trust/high-skill/high-autonomy public services and workforce “new deals”.
- Learning system ↔ Drive learning and improvement: Scottish Approach to Change ’s learning systems (iterative testing, PDSA, reflection, spread) match IPPR’s proposal to make the public sector the “world’s largest learning organisation” with supportive improvement infrastructure.
- Steps of change ↔ Spread and implementation discipline: Scottish Approach to Change ’s eight-step cycle (identify → understand → design → test → implement → embed → review/spread) complements IPPR’s focus on systematic spread of effective models and supportive failure regimes.

Anthony McKeevr, Edward Jones, Georgia Fredriksson and Skeena Williamson (2025) - *Pioneers of Reform: Realising a new vision of ICB strategic commissioning*

Link: [*Pioneers of Reform*](#)

Summary

Pioneers of reform sets out a practical vision for Integrated Care Boards (ICBs) to move from transactional contracting to strategic commissioning that actively shapes population health and service transformation. It argues this is essential to steward ~£164bn effectively and deliver the government's "three shifts" (hospital → community, illness → prevention, analogue → digital). It proposes six commissioning shifts-reactive → proactive; downstream → upstream; competition → collaboration; transactional → transformational; cost → value; compliance → leadership-supported by a phased implementation (vision and infrastructure; planning and performance reform; new ways of working; embedded culture). The report emphasises pathway-based commissioning, shared accountability, new payment mechanisms, integrated analytics, and leadership capability, cautioning that ICB running-cost reductions risk slowing progress and urging a national framework plus peer-learning networks.

Key arguments and findings

- Strategic commissioning is pivotal to put the NHS on a sustainable service and financial footing and to deliver the "three shifts."
- Six shifts define the new approach:
 1. Reactive → proactive; 2) downstream → upstream; 3) competition → collaboration; 4) transactional → transformational (pathways/cohorts); 5) cost → value (outcomes/ROI); 6) compliance → leadership (empowered local leaders).
- Priority enablers include pathway-based models, shared risk/payment mechanisms, integrated neighbourhood teams, and multi-year planning aligned to outcomes.
- Implementation should be phased: vision and support infrastructure; reform of planning/performance; new ways of working (data, contracts, risk-share); and cultural embedding through learning networks.
- Capability requirements span diplomacy, data/analytics, change management and system leadership; a national strategic commissioning framework and peer learning are recommended.
- Cutting ICB running and programme costs by 50% could slow the transition; mitigation and clarity of roles are needed.

Where it supports the Scottish Approach to Change

- Reactive → proactive and downstream → upstream: The report's emphasis on anticipatory, community-based, prevention-focused commissioning aligns with Scottish

Approach to Change 's People-led enabler, Clear vision and purpose, and early Steps of change (Identify → Understand) grounded in triangulated data, needs analysis and inequalities/human-rights lenses.

- Competition → collaboration: Calls to replace organisational silos with genuine partnerships echo Scottish Approach to Change 's Leadership and culture (trust, distributive leadership) and multi-disciplinary change teams working across sectors and with communities.
- Transactional → transformational: Commissioning whole pathways for cohorts mirrors Scottish Approach to Change 's end-to-end Steps of change (Develop and design → Prototype and test → Define and implement → Embed and sustain), with structured project management and governance.
- Cost → value: Shifting to outcomes and ROI is directly supported by Scottish Approach to Change 's Process rigour-measurement, monitoring and evaluation; options appraisal; and use of balancing measures to avoid unintended harms.
- Compliance → leadership: The move to empowered, locally accountable leadership aligns with Scottish Approach to Change 's Leadership and culture (courage, compassion, system stewardship) and Learning system that enables continuous reflection, rapid feedback loops and spread.
- Phased implementation and capability-building: The report's staged roadmap and skills focus reinforce Scottish Approach to Change 's emphasis on Learning systems, Education and training, and structured project management to sustain change and review for spread.

Emma Tomkinson (2020) - *Outcome-based contracting for human services*

Link: [Outcome-based contracting for human services](#)

Summary

This evidence review examines government-funded outcome-based contracts in public human services and finds a thin, fragmented evidence base with few robust comparisons to grants or block funding. Where payments are tied to specific outcome metrics, providers reliably deliver against those measures-but unmeasured aspects of quality often stagnate or worsen, and perverse incentives (e.g., "cream-skimming" and "parking") can emerge. Contract design- especially the choice and weighting of metrics, the balance of service fees vs. outcome payments, and the degree of provider flexibility-drives behaviour and results. The paper situates these contracts within broader New Public Management reforms and concludes that governments must design metrics that truly reflect desired outcomes and continuously learn and adjust to mitigate unintended effects.

Key arguments and findings

- The evidence base comparing outcome-based contracting to other funding models is limited; robust causal claims are rare.
- Providers optimise to what is paid for: measured outcomes improve, while unmeasured (but important) elements may not.
- Payment structures can create adverse incentives (e.g., serving easier clients, underserving harder-to-help groups).
- Contract context and constraints (governance, rules, data, workforce) shape providers' ability to affect outcomes.
- Iterative refinement of metrics and payment weights is essential to align incentives with policy intent.

How this supports the Scottish Approach to Change

- Process rigour and measurement/design quality - Tomkinson shows that “you get what you pay for,” so outcome metrics must be selected, tested and re-balanced to avoid gaming and unintended consequences-directly echoing Scottish Approach to Change 's emphasis on rigorous measurement, monitoring/evaluation, and proportionate governance to guide decisions. The paper's call for triangulating evidence and revisiting payment models aligns with Scottish Approach to Change guidance to be *curious with data*, compare meaningfully, watch trends/outliers, and use evaluation to adapt.
- Clear vision and purpose - Because metrics steer behaviour, the review underlines the need to anchor contracts in a clearly articulated outcome vision (not proxy activities), supporting Scottish Approach to Change 's insistence that vision/purpose should drive choices and trade-offs.
- People-led approaches and equity - Findings on “cream-skimming/parking” reinforce Scottish Approach to Change 's focus on designing for inclusion and reducing inequalities; measures must protect harder-to-help groups so that changes benefit those with the greatest need.
- Leadership and culture - The review shows that contracting environments, rules, and leadership behaviours can constrain or enable outcomes, aligning with Scottish Approach to Change 's call for leaders to remove barriers, enable flexibility, and set cultures that value learning over compliance alone.
- Learning system and iterative change (Steps of Change) - Tomkinson's recommendation to iteratively refine metrics/payment weights mirrors Scottish Approach to Change 's *Prototype and Test* → *Review for implementation* → *Define and implement* → *Embed and sustain* → *Review for spread* cycle and PDSA-style learning loops.

Comptroller and Auditor General (2015) - *Outcome-based payment schemes: government's use of payment by results*

Link: [Outcome-based-payment-schemes-governments-use-of-payment-by-results](#)

Summary

The NAO reviews government use of outcome-based payment (Payment by Results, PbR) across major programmes (Work Programme, Troubled Families, offender rehabilitation pilots, and DFID aid), concluding that PbR is technically challenging, risky and costly for commissioners, and not suitable for all services. Commissioners should justify why PbR is preferable to alternatives, rigorously design payment mechanisms (including baseline/counterfactuals), understand provider risk capacity, and actively monitor performance to avoid perverse incentives (e.g., “parking” harder-to-help groups). The report calls for systematic evaluation and a central repository of expertise so departments stop “reinventing the wheel” and build an evidence base for when PbR works and delivers value for money. Government insight accompanying the report estimates PbR schemes account for at least £15 billion of public spending and reiterates the need for stronger cross-government oversight and learning.

Key arguments and findings

- PbR is not universally appropriate. Use it only when outcomes are measurable, attributable to providers' actions, and when the operating context fits; commissioners should explicitly justify PbR over alternatives.
- Design and transaction costs are high; risks often underestimated. Effective PbR requires specialist skills, time and piloting; rushing to implement without pilots has harmed value for money.
- Payment mechanisms must create the right incentives. Poorly set prices/metrics risk ‘cream-skimming’/‘parking’; understanding provider costs and risk appetite (including supply-chain capacity) is essential.
- Set baselines and counterfactuals. Establish stretching but attainable expectations above the non-intervention rate to avoid paying for outcomes that would have happened anyway.
- Active performance management is non-negotiable. Commissioners remain accountable and need robust, timely outcome data to detect under-performance and prevent undesired behaviours.
- Evaluate PbR itself, not just programmes. Plan evaluation from the outset and build a cross-government learning function as a repository of practice and evidence; NAO notes PbR totals at least £15 billion, heightening the case for oversight.

Where the NAO report supports the Scottish Approach to Change

- Process rigour and governance. NAO's demand for rigorous design, clear baselines/counterfactuals, and ongoing performance management aligns with Scottish Approach to Change 's enabler "Process rigour" (governance that creates momentum, robust measurement/monitoring/evaluation, proportionate project management).
- Learning systems and evaluation. NAO's call for a central repository and planned evaluation mirrors Scottish Approach to Change 's "Learning system" enabler-continuous reflective practice, data-driven sense-making, and rapid feedback loops embedded in governance.
- People-led and reducing inequalities. NAO warns of perverse incentives (e.g., neglecting harder-to-help groups) and stresses understanding service users; Scottish Approach to Change 's "People-led" enabler and explicit focus on inequalities/human rights provide the practical antidote (co-design, inclusive engagement, balancing measures).
- Clear vision and purpose. NAO asks commissioners to articulate why PbR is used and what it should achieve; Scottish Approach to Change centres on shared vision/purpose guiding choices and trade-offs.
- Prototype and test before scaling. NAO criticises rushed roll-outs without pilots; Scottish Approach to Change operationalises prototyping and PDSA cycles within the "Prototype and test" step to de-risk implementation.
- Commissioning capability. NAO emphasises understanding provider capacity and risk allocation in complex supply chains; Scottish Approach to Change 's commissioning guidance (ethical, context-specific, relationship-based) complements this by building the markets and partnerships you want to see.
- Quality Management System (QMS). NAO's insistence on structured oversight, data, and assurance aligns with Scottish Approach to Change 's QMS components (planning, improving, maintaining, assuring quality).

Nigel Edwards (2026) - Commissioning: lessons from the last 30 years and implications for the new role of ICBs

[Link: Commissioning: lessons from the last 30 years and implications for the new role of ICBs | Nuffield Trust](#)

Summary

Nigel Edwards reviews three decades of NHS commissioning and argues that repeated reorganisations, over-ambitious scopes, limited capacity, and information asymmetries have constrained impact. For ICB-led strategic commissioning to succeed, decisions should devolve to

the place and neighbourhood level, with providers leading pathway redesign and ICBs creating strategic frameworks, clear decision rights, and sensible standardisation. Edwards cautions against micromanaging through contracts or proliferating KPIs; instead, use capitation with gain-sharing where appropriate, align national performance management with population-health aims, co-produce plans with local stakeholders, and focus on data-driven understanding and evaluation. Above all, avoid overloading ICBs with objectives and build incentives and financial frameworks that let providers “do the heavy lifting” on redesign.

Key arguments and findings

- Commissioning has been the most reorganised layer since 1990, reflecting a mismatch between policymakers’ expectations and reality.
- Common failure modes: over-detailed micromanagement, too many KPIs, thin capacity, and information asymmetry that favours providers; frequent reorganisations erode institutional memory.
- Shifting care out of the hospital repeatedly failed due to stranded costs, misallocated financial risk, and weak links from contracts to clinical behaviour.
- ICBs should devolve design/delivery to place and neighbourhoods; providers should lead pathway redesign, with ICBs setting incentives and financial frameworks rather than doing redesign themselves.
- Payment reform: prefer capitation with gain-share, where the aim is less/better care; reserve activity-based payment for areas needing volume growth.
- Governance clarity is critical: specify what must be standardised vs. tailored locally; articulate decision rights; co-produce plans with stakeholders.
- Focus commissioning on four stages (context, strategy, allocation, evaluation) but don’t overload ICBs with tasks 2-3; strengthen data-driven evaluation.

Where this supports the Scottish Approach to Change

- People-led and co-production: Edwards’ call for plans to be “much more co-produced” with local stakeholders aligns with Scottish Approach to Change ’s people-led enabler and emphasis on meaningful engagement and trauma-informed, inclusive design.
- Devolution to place and provider-led redesign: The recommendation to push decisions to neighbourhoods and let providers do the “heavy lifting” mirrors Scottish Approach to Change ’s steps of change (co-design, prototype/test, embed) and multi-disciplinary teaming close to services.
- Process rigour over micromanagement: Rejecting detailed procurement/contract micromanagement in favour of clear frameworks, proportionate governance, and iterative learning is consistent with Scottish Approach to Change ’s *process rigour*, project management discipline, and PDSA-driven testing.

- Clear vision, decision rights and standardisation: Edwards’ stress on clarity about what’s standardised and who decides supports Scottish Approach to Change ’s *clear vision and purpose* and governance guidance to align decisions to strategy.
- Learning systems and evaluation: The article’s focus on dynamic, data-driven understanding and evaluation resonates with Scottish Approach to Change ’s *learning system* enabler and advice on triangulating data, monitoring, and reflective practice.
- Commissioning capability and ethical approach: The call to avoid overloading and to build realistic capability supports Scottish Approach to Change ’s “power of good commissioning”-invest in skills, tailor to local context, and challenge competition-driven approaches with ethical commissioning.
- Population health and inequalities: Edwards’ population-health framing aligns with Scottish Approach to Change ’s requirements to design for those most at risk, embed human rights, and assess inequalities from the outset.

Nigel Edwards (2026) - *Commissioning: lessons from the last 30 years and implications for the new role of ICBs*

Link: [Market-Shaping States](#)

Summary

Mazzucato and Kattel argue that today’s challenges require moving beyond a “market-failure-fixing” state to a *market-shaping* state that co-creates public value. They reconceptualise the public sector’s enduring agility-stability tension as a design problem and propose a three-layer framework: structural capacities (long-term direction and institutional endurance), organisational routines (coordinated practice), and dynamic capabilities (experimentation, learning, and reconfiguration under uncertainty). The paper critiques New Public Management’s focus on static efficiency and outsourcing, contending that such reforms erode in-house capability and impede transformation. It calls for mission-oriented strategies that integrate socio-technical transitions with high-quality public services, anchored in rights-based and inclusive outcomes.

Key arguments and findings

- The dominant “market failure” lens is inadequate for climate, care, digital and industrial transitions; states must *shape* and co-create markets to steer innovation and growth.
- The agility-stability paradox should be solved by *interconnected capacities*: structural (direction, endurance), routines (coordination), and dynamic (experimentation/learning). Public value emerges from their interaction.
- New Public Management’s emphasis on static efficiency, outsourcing and transactional metrics undermined institutional memory and transformational capacity.

- Public services and socio-technical systems must be treated holistically; mission-oriented policy should align public-private-civic collaboration toward equitable, sustainable outcomes grounded in human capabilities and rights.

Where this supports the Scottish Approach to Change (Scottish Approach to Change)

- Clear vision and purpose → Structural capacity: Scottish Approach to Change 's insistence on a system-wide vision and strategy mirrors the paper's call for structural capacities that set and sustain direction over time.
- Process rigour and eight "Steps of change" → Organisational routines: Scottish Approach to Change 's end-to-end change cycle (identify → review for spread), governance, and project management operationalise the routine layer that translates direction into coordinated practice.
- Learning system and iterative testing (PDSA) → Dynamic capabilities: Scottish Approach to Change 's learning systems, data-driven reflection, and small-scale prototyping build the experimentation/learning capabilities the paper deems essential for adaptation under uncertainty.
- People-led change and co-design → Market co-creation: Scottish Approach to Change 's people-led enabler and emphasis on lived experience align with the paper's public-value, co-creation stance and rights-based foundations.
- Leadership and culture → Institution building: Scottish Approach to Change 's focus on psychologically safe, empowering leadership complements the critique of NPM and the need to rebuild in-house capabilities and institutional endurance.
- Quality Management System (QMS) → Whole-system management: Scottish Approach to Change 's QMS framework (planning, improving, maintaining, assuring) operationalises the paper's call to integrate services and socio-technical transitions within a single, mission-oriented management approach.
- Equity and human rights → Normative foundation: Scottish Approach to Change 's explicit focus on inequalities, trauma-informed practice and PANEL principles reflects the paper's normative grounding in human capabilities and just outcomes.

De-implementation and Behaviour Change

Summary

Norton WE, Chambers DA (2020) - *Unpacking the complexities of de-implementing inappropriate health interventions.*

Link: [Unpacking the complexities of de-implementing inappropriate health interventions - PMC](#)

Summary

Norton and Chambers argue that de-implementation—stopping, reducing, restricting, or replacing inappropriate health interventions—is essential to minimise harm, cut waste, and improve population health. They frame de-implementation as a distinct challenge from implementing new evidence-based practices, shaped by multi-level factors spanning the intervention, patients, professionals, and organisations. The authors propose a helpful classification (ineffective, contradicted/ “medical reversals,” mixed, untested) to prioritise what to de-implementation, and they emphasise the need to tailor strategies to context, define appropriate outcomes, and anticipate unintended consequences (e.g., access gaps or workflow disruption). They call for more rigorous research on mechanisms, measurement, and strategy selection to guide safe, equitable de-implementation across settings.

Key arguments and findings

- De-implementation is different from implementation and requires distinct considerations across intervention, patient, provider, and organisational levels.
- Authors outline four types of action: *remove*, *replace*, *reduce*, and *restrict* the use of interventions.
- Propose a classification of targets—*ineffective*, *contradicted (medical reversal)*, *mixed*, and *untested*—to prioritise efforts and tailor strategies.
- Stress rigorous definition and measurement of outcomes and vigilance for unintended negative consequences during de-implementation.
- Call for context-sensitive strategies and more research on mechanisms and evaluation methods to guide practice.

Where this supports the Scottish Approach to Change (Scottish Approach to Change)

- People-led and multi-stakeholder engagement
The article’s multi-level lens (patients, professionals, organisations) reinforces Scottish

Approach to Change 's *people-led* enabler and early, meaningful involvement across the change cycle (Identify → Understand → Develop and design).

- Process rigour: measurement, governance, decision points
Emphasis on selecting the right outcomes and monitoring for unintended effects aligns with Scottish Approach to Change 's *process rigour* (measurement/monitoring/evaluation) and its formal Review for implementation decision gate before moving to scale.
- Iterative testing before adoption at scale
The need to tailor strategies and evaluate impact maps to Scottish Approach to Change 's Prototype and test step (e.g., using PDSA cycles) and structured progression through the steps of change.
- Leadership and culture for 'stopping' care safely
Organisational and cultural factors highlighted by the paper support Scottish Approach to Change 's *leadership and culture* enabler-creating psychologically safe conditions to unlearn practices, support decisions to de-implementation, and remove barriers.
- Learning systems and spread - The call for stronger evidence on *how* to de-implementation fits Scottish Approach to Change 's Learning system enabler and the Review for spread step-capturing insights, packaging learning, and determining what should (or should not) spread.
- Equity and unintended consequences - The paper's caution about negative side-effects chimes with Scottish Approach to Change 's focus on reducing inequalities, balancing measures, and embedding human rights and EQIA throughout change, ensuring de-implementation does not exacerbate disparities.

Andrea M. Patey, Catherine S. Hurt, Jeremy M. Grimshaw and Jill J. Francis (2018) - *Changing behaviour 'more or less'-do theories of behaviour inform strategies for implementation and de-implementation? A critical interpretive synthesis*

[Link: *Changing behaviour 'more or less'-do theories of behaviour inform strategies for implementation and de-implementation? A critical interpretive synthesis* | *Implementation Science* | Springer Nature Link](#)

Summary

Patey et al. critically synthesise theory use across 66 papers to ask whether behaviour change theories distinguish between implementation (doing more of evidence-based behaviours) and de-implementation (doing less of low-value behaviours). They find that the most commonly used theories do not differentiate approaches for increasing vs decreasing behaviour frequency. A frequently observed tactic for de-implementation is behaviour substitution (replacing an unwanted behaviour with a preferable one), yet the literature offers little theoretical guidance on selecting substitutes. The only theory to make an explicit distinction is Operant Learning Theory, though some of its techniques may be unacceptable in health systems. The authors call for clearer theoretical rationales and practical methods tailored to de-implementation, not just implementation.

Key arguments and findings

- Most behavioural theories used in health settings do not distinguish between increasing and decreasing behaviour frequency.
- Behaviour substitution is a common de-implementation strategy, but there is no robust theoretical basis or guidance for choosing the substitute behaviour.
- Operant Learning Theory explicitly separates strategies for implementation vs de-implementation; however, some techniques (e.g., punishment/extinction) may be ethically or practically unacceptable in healthcare.
- Implication: we need theory-informed, context-acceptable methods specifically for de-implementation rather than assuming symmetry with implementation.

Article: *Changing behaviour 'more or less'-do theories of behaviour inform strategies for implementation and de-implementation?*

Where this supports the Scottish Approach to Change

- Process rigour and “Understand → Develop and Design → Prototype and Test”
The paper’s call for distinct, theory-informed de-implementation strategies reinforces Scottish Approach to Change ’s emphasis on systematic diagnosis, option appraisal, and iterative testing (e.g., PDSA) to ensure the right mechanism is used for the right behaviour (increase vs decrease).
- People-led and Leadership and Culture - Concerns about the acceptability of certain operant techniques underline Scottish Approach to Change ’s requirement to co-design changes with people, build psychological safety, and ensure leadership enables ethically acceptable approaches tailored to local contexts.
- Learning System (continuous reflective practice and feedback loops)
The identified theoretical gaps (e.g., how to select substitute behaviours) align with Scottish Approach to Change ’s learning systems that capture insight, evaluate what works, and adapt strategies over time-especially crucial for de-implementation where evidence is thinner.
- Clear Vision and Purpose - Framing change explicitly as “increase these behaviours / decrease those behaviours” echoes Scottish Approach to Change ’s need for clear aims and decision criteria that guide choices, trade-offs, and sustainment.
- Review for Implementation, Embed and Sustain -The article’s warning against assuming symmetry between implementation and de-implementation supports Scottish Approach to Change ’s formal review points and sustainment planning to confirm mechanisms are effective and acceptable before scaling.

Education, Training and Teamwork as Improvement Interventions

Summary

Lauren E. Benishek, Albert W. Wu and Michael A. Rosen (2025) - *Education and Training as Improvement Interventions Elements of Improving Quality and Safety in Healthcare*

Link: [Education and Training as Improvement Interventions](#)

Summary

The Cambridge Core Element *Education and Training as Improvement Interventions* synthesises evidence from learning sciences and healthcare education to show how well-designed training can drive quality and safety. It argues that training must be treated as a multi-stage process-before, during and after the learning event-with outcomes shaped by learner characteristics and organisational context. The authors distil the literature into five pillars: ensure training is appropriate; create a positive learning environment; design and implement accessible, usable, effective training; support transfer into practice; and evaluate impact beyond satisfaction. They highlight pitfalls (e.g., over-reliance on learner reactions, unsupported “learning styles”) and promising approaches (simulation, just-in-time learning, integrated coaching), and emphasise linking education projects to organisational priorities and competency models. Three case examples illustrate the benefits and challenges of rigorous training design in real healthcare settings.

Key arguments and findings

- Training effectiveness is multidimensional, multilevel, and dynamic outcomes span knowledge, skills, attitudes, individual/team/organisational levels, and change over time; therefore, evaluation must go beyond satisfaction to observable behaviour and system performance.
- Context matters-leader/peer support, culture, and opportunities to apply learning substantially influence pre- and post-training motivation and transfer; systems-based design is recommended.
- Five pillars of effective training: (1) ensure training is appropriate (needs analysis, readiness); (2) create a positive learning environment; (3) design and implement accessible, usable, effective instruction; (4) support transfer and sustainment; (5) evaluate rigorously.

- What to avoid / common pitfalls: training alone cannot fix systemic issues; “learning styles” tailoring lacks empirical support; learner reaction scores correlate weakly with behaviour change.
- Promising approaches: simulation and experiential learning (balanced with scalability), just-in-time learning, embedded coaching, and alignment with competency models and organisational priorities.

Where it supports the Scottish Approach to Change

- Clear vision and purpose → training aligned to organisational priorities and competencies - The Element urges coupling education projects to service priorities and competency frameworks so training targets the *right* problems and skills-directly echoing Scottish Approach to Change ’s emphasis on a clear vision/purpose guiding decisions and options appraisal.
- Process rigour → evidence-based design, testing, and evaluation - Its five-pillar model (needs analysis; learning environment; evidence-based design; transfer support; rigorous evaluation) aligns with Scottish Approach to Change ’s call for systematic measurement, governance, quality-improvement methods (e.g., PDSA), and project management across the steps of change.
- Leadership and culture → conditions for transfer and sustained change - By showing that leader/peer support and safety culture shape motivation and transfer, the Element reinforces Scottish Approach to Change ’s focus on compassionate, enabling leadership and creating psychologically safe spaces where experimentation and learning can thrive.
- People-led → co-production and meaningful involvement - The Element promotes tighter linkage between curricula and practice, broader stakeholder participation (including patients) and real-world application-supporting Scottish Approach to Change ’s people-led enabler and meaningful engagement in design and delivery.
- Learning system → continuous feedback, coaching, and spread - Its stress on ongoing coaching, just-in-time learning, behavioural evaluation, and closing the loop mirrors Scottish Approach to Change ’s learning system enabler (continuous reflection, evaluation, knowledge mobilisation) and later steps (embed, sustain, review for spread).
- Alignment with Scottish Approach to Change steps of change. *Identify / Understand*: needs analysis and contextual assessment before training. *Develop and design / Prototype and test*: apply evidence-based instructional design; use simulation and iterative tests. *Review for implementation / Define and implement*: evaluate beyond reactions; plan for transfer and support. *Embed and sustain / Review for spread*: build coaching and learning infrastructure to maintain gains and enable spread.

Jan B. Schmutz, Laurenz L. Meier and Tanja Manser (2019) - *How effective is teamwork really? The relationship between teamwork and performance in healthcare teams: a systematic review and meta-analysis*

[Link: How effective is teamwork really? The relationship between teamwork and performance in healthcare teams: a systematic review and meta-analysis](#)

Summary

This systematic review and meta-analysis (31 studies; 1,390 teams) examines whether teamwork improves performance in acute healthcare. The pooled, sample-size-weighted correlation between teamwork processes (e.g., coordination, communication, non-technical skills) and performance outcomes (clinical and process) was $r = 0.28$ (approx. OR = 2.8), indicating a medium, beneficial effect of teamwork. Importantly, this positive relationship held regardless of moderators such as team composition, familiarity, task type, team size, patient realism (simulation vs real), or performance measure. The authors conclude that healthcare organisations should recognise, invest in, and systematically strengthen teamwork to benefit patient outcomes and reliability of care.

Key arguments and findings

- Teamwork matters: Teamwork is positively and moderately associated with performance in acute care ($r = 0.28$; OR ≈ 2.8).
- Robust across contexts: The effect did not significantly vary by team/task characteristics or performance measure (clinical vs process).
- Actionable implication: Organisations should maintain and improve teamwork (e.g., team training, non-technical skills) to enhance patient safety and quality.

Where this supports the Scottish Approach to Change

- People-led and multidisciplinary working: The paper's core finding-that coordinated team behaviours improve outcomes-aligns with Scottish Approach to Change 's emphasis on people-led change and bringing together those who *need, use, deliver and enable* services to co-design and deliver improvements.
- Leadership and culture: Scottish Approach to Change calls for leadership that creates psychological safety and empowers teams; the review's call to strengthen teamwork supports building such cultures to improve performance.
- Process rigour and improvement methods: Scottish Approach to Change promotes rigorous, data-driven change (e.g., PDSA testing, measurement/monitoring); the review justifies investing in these structured approaches to team functioning and non-technical skills.

- Learning systems: Scottish Approach to Change 's learning systems (sharing insights, iterative testing, rapid feedback loops) provide the infrastructure to develop and sustain teamwork capabilities, evidenced to improve outcomes.
- Embedding and spread: Scottish Approach to Change 's steps (embed/sustain; review for spread) are consistent with translating evidence about teamwork into routine practice and scaling what works across services.

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