**THE GAP BETWEEN POLICY AND ACTION AT THE CLINICIAN/PATIENT INTERFACE**

**Background**

Every country has health policies. These policies probably have input from many clinical experts and are usually conducted at high levels in the overseeing Health Departments. The discussions around these “policies” can be lengthy but usually pay a lot of attention to detail. Usually everyone’s opinions are dutifully acknowledged and where there are differences, compromise occurs. Sometimes, in order to keep everyone happy, the statements and guidelines become so non-controversial and general as to be almost meaningless.

At the end of these discussions and meetings, policy documents are produced. These are often lengthy with many pie charts; bar graphs and graphics. The documents are usually visually attractive and widely distributed.

Then we come to the next step; the reason why policy documents are produced – presumably to affect measurable change. However, there is little research around the effectiveness of the implementation phase and even less research around evaluating the process of awareness as a result of the policy and patient outcomes as a result of the formulation and implementation of the policy.

A Rapid Response System (RRS) was introduced in the State of New South Wales in Australia, a health jurisdiction of over 7 million people. A standardised vital sign observation chart was introduced into over 250 hospitals (Hughes C, Pain C, Braithwaite J, Hillman K. ‘Between the flags’: implementing a rapid response system at scale. BMJ Qual Saf 2014;23(9):714-777). The process was developed and informed by clinicians with appropriate experience in RRSs. The Chief Executives of every hospital in the State was made responsible for the implementation of the charts. Moreover, a response to abnormal criteria was also demanded. The responding staff had to have appropriate experience, knowledge and skills. The introduction of the standardised system was mandated in every hospital. By simply stating, "this is what must happen and here is how it was to be done," a policy document and its baggage was avoided.

The system was effectively implemented in all 250 hospitals. Unfortunately the recommendation by the clinicians on the overarching committee to integrate outcome indicators for each hospital never eventuated. As a result, while the process of at-scale implementation has occurred, the outcome has never been formally evaluated.

**A SWEDISH STUDY ON THE UPTAKE OF GUIDELINES FOR END OF LIFE *(Lind S, Wallin L, Brytting T, Fürst CJ, Sandberg J. Implementation of national palliative care guidelines in Swedish acute care hospitals: a qualitative content analysis of stakeholders’ perceptions. Health Policy 2017;121:1194-1204)***

During 2012 national clinical guidelines for palliative care were published in Sweden. Guidelines for palliative care were also issued by the National Board of Health and Welfare in Sweden.

The study involved interviewing local politicians, chief medical officers, actively practising health professionals in acute hospitals.

***Almost no-one had any knowledge of the policy documents.***

The article concluded by recommending that a lot more research should be directed at evaluating the effectiveness of implementation strategies. They also recommended that new ways to link policy and implementation were to be developed and patient outcomes were to be evaluated in order to judge whether the strategy was effective.