A REALIST SYNTHESIS OF EVIDENCE RELATING TO PRACTICE DEVELOPMENT: FINAL REPORT TO NHS EDUCATION FOR SCOTLAND AND NHS QUALITY IMPROVEMENT SCOTLAND

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# TABLE OF CONTENTS

| Acknowledgements                           | 1 |
| Executive Summary                          | 4 |
| - Background                               | |
| - Methodology                              | |
| - Purpose                                 | |
| - Methods                                 | |
| - Findings from Literature Analysis        | |
| - Key Messages from Synthesis of all Data Sets | |
| - Recommendations for the Development of a PD Model | |
| - References                               | |
| **1. Introduction**                        | 13 |
| **2. Methodology**                         | 13 |
| **3. Findings from Literature Analysis**   | 39 |
| **4. Discussion of Findings/Data Synthesis** | 93 |
| **5. Conclusions**                         | 123 |
| **6. Recommendations for the Development of a PD Model** | 124 |
| **7. References**                          | 127 |

## APPENDICES

- Appendix 1: Steering Group Meeting 139
- Appendix 2: Project Team's Constructions 140
- Appendix 3: Programme Theories 141
- Appendix 4: Empirical papers where practice development is the explicit approach being used 142
- Appendix 5: Analytical or review papers 145
- Appendix 6: Empirical research about practice development and its approaches as concepts 147
- Appendix 7: Empirical research where practice development approaches are implicit in the approaches being used 148
- Appendix 8: Empirical papers seen but not containing evidence about practice development processes and outcomes 150
- Appendix 9: Duplicates 152
- Appendix 10: Data Extraction Form 154
- Appendix 11: Grey Literature 159
- Appendix 12: Email re invitation to participate in telephone interviews 163
- Appendix 13: Project information 164
- Appendix 14: Telephone interview schedule 166
- Appendix 15a: Theory Area 1 168
- Appendix 15b: Example of Themed Data from Theory Area 1 177
### TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The process of realist synthesis-adapted from Pawson et al (2004)</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>The ‘Dimensions of study of the ‘Who’ of Practice Development</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>The ‘Dimensions of study ‘By Whom’ of Practice Development</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>The ‘Dimensions of study of the ‘what/why’ of Practice Development</td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>The ‘Dimensions of study of the ‘How’ of Practice Development</td>
<td>26</td>
</tr>
<tr>
<td>6</td>
<td>Concepts in definitions of practice development</td>
<td>31</td>
</tr>
<tr>
<td>7</td>
<td>Databases searched</td>
<td>32</td>
</tr>
<tr>
<td>8</td>
<td>Classification of papers found</td>
<td>33</td>
</tr>
<tr>
<td>9</td>
<td>International Networks</td>
<td>34</td>
</tr>
<tr>
<td>10</td>
<td>Practice Development Roles of Population</td>
<td>35</td>
</tr>
<tr>
<td>11</td>
<td>Sample of participants selected for interview</td>
<td>36</td>
</tr>
<tr>
<td>12</td>
<td>Data Analysis Themes and Sub-themes</td>
<td>38</td>
</tr>
</tbody>
</table>

### FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Model for conceptualising practice development programme theories</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>Characteristics of context</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>Characteristics of culture</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Characteristics of leadership</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>Explanatory model for practice development</td>
<td>27</td>
</tr>
<tr>
<td>6</td>
<td>email to network members</td>
<td>34</td>
</tr>
<tr>
<td>7</td>
<td>Data extraction, analysis and synthesis</td>
<td>38</td>
</tr>
<tr>
<td>8</td>
<td>The PD Diamond</td>
<td>66</td>
</tr>
</tbody>
</table>
Background
Practice development (PD) is a term that has been used to describe particular approaches to supporting change in health care (predominantly nursing) for over 20 years. A number of studies have been published that have sought to clarify what is meant by the term and establish the relationships between its component parts (Garbett & McCormack, 2002; Manley & McCormack, 2003; McCormack et al., 1999; Unsworth, 2000). However, there remains a need to provide a full and critical in-depth review of the wide range of published and unpublished literature in this area. Those working within practice development draw on a range of theoretical and practical influences from a range of disciplines (management, education, organisational development and so on). There is also therefore a need to understand the relationships between perspectives, approaches and methods used under the heading of practice development and those employed in other forms of development activity within health services both nationally and internationally.

The commissioning brief for this study therefore provided a welcome and timely opportunity to carry out a much needed piece of work. The commissioned research from NHS Education for Scotland (NES) and NHS Quality Improvement Scotland (NHS QIS) invited tenders for a literature review examining the evidence around practice development. The commissioned research provided an opportunity to provide strategic direction underpinned by an evidence base to inform the ongoing integration of practice development strategies into healthcare systems and processes.

Methodology
The study was underpinned by a method of systematic review of a diverse range of evidence called realist synthesis (Pawson et al., 2004). This methodology has been developed as a method for studying complex interventions in response to the perceived limitations of traditional systematic review methodology which, it is argued, follows a highly specified and intentionally inflexible methodology, with the aim of assuring high reliability. A realist review, in contrast, follows a more heterogeneous and iterative process, which is less amenable to prescription but which needs to be equally rigorous. The audit trail of the review needs to show how decisions were made, evidence sought, sifted and assessed, and findings accumulated and synthesised.

Purpose
The purpose of this review was to identify approaches to practice development and critically examine the evidence base that supports them drawing on both empirical data and expert opinion. The expected outcomes were:

- Comparative analyses of approaches to practice development
- Indicators to guide choice of approaches that match particular circumstances
- Indicators that may lead to the development of a Scotland-wide model of practice development for health care organisations

Methods
The study was designed in two phases:

Phase 1 focused on reviewing the published practice development literature using the review methods of realist synthesis as outlined by Pawson and colleagues (2004). The phase was operationalised through 3 stages of work from explicitly agreeing the focus of the study, the identification of contributory theories to practice development that would shape the review questions (the review was structured around 13 areas of theory reflecting 4 broad theoretical perspectives of PD), the development of a set of bespoke review forms, searching for literature to answer these questions and finally conducting the systematic review of the literature. One hundred and sixty nine (169) papers were selected for review following various stages of refinement of the search strategy. Of these papers, 71 explicitly used practice development as a study methodology or studied the experience of involvement in practice development; 30 were scholarly reviews of practice development literature; 6 were concept analyses; 29 papers were
studies where practice development was implicit to the work and 33 empirical research studies that related to practice development but did not focus on PD processes or outcomes.

Phase 2 was informed by the outcomes of phase 1 and undertaken in two stages – stage 1 included the review of the grey practice development literature using the same review processes as phase 1 and stage 2 involved the conducting of telephone interviews with key informants internationally. A total of 41 items of grey literature were reviewed and in addition four books were reviewed that are widely referenced in the literature because they add to an understanding of PD methodology (Bellman 2003; Bryar and Griffiths 2003; McCormack, Manley & Garbett 2004; Page, Allopp and Casley 1998). A total of 47 interviews were undertaken with key informants representing strategic, organisational, unit and academic roles in the UK, Republic of Ireland, Sweden, The Netherlands, New Zealand, Australia, Canada and the USA. The interview schedule was derived from the initial themes derived from the literature review.

Data Extraction, Analysis and Synthesis
Data analysis and synthesis followed an eight step process. Data from the published literature were extracted and inputted onto data extraction sheets. The data from the individual data extraction sheets for the published literature were extracted and copied onto ‘theory synthesis forms’ for each of the four theory areas. These data were grouped according to the particular emphasis in the data and the researchers’ impressions of the specific meanings in the data. Each theory synthesis form was read and re-read in order to gain overall impressions of the data and rough notes were made. The data from each theory synthesis form was then themed. In some cases, the original papers were revisited in order to clarify meanings and finalise themes. A draft report was formulated and presented to the project steering group for discussion, clarification and challenge. Some ‘gaps’ in the literature were identified (for example the lack of accounts regarding the funding of PD projects) and these were highlighted as important considerations in the review of the grey literature and in telephone interviews.

The grey literature data was then fed into the ‘theory synthesis forms’ for each of the theory areas in order to form a complete data set. The data were re-read and the initial themes reconsidered based on the evidence from the grey literature. Few themes changed significantly but instead the grey literature either strengthened or weakened initial themes. For example, in the published PD literature, accreditation is only considered as a ‘driver’ of PD whilst the grey literature identified a more ‘enabling’ role for accreditation frameworks and a basis for establishing collaborative relationships between healthcare organisations and higher education institutions. The themes were constructed into a narrative and these narratives formed the structure of the “findings from literature analysis” section of this report.

The final stage of analysis consisted of an analysis of the telephone interviews. The interview data were themed under the questions on the interview schedule. Key quotes and comments were highlighted and these were fed into the discussion of the data in order to highlight particular issues, confirm themes from the literature, verify or contradict the strength of claims made in the literature analysis and identify novel issues and themes. This final stage resulted in the identification of 4 overarching themes and 9 sub themes that synthesised all the data. This synthesis forms the structure of the “discussion/data synthesis” section of the main report. Only key messages from these themes are provided in this executive summary.
Findings from Literature Analysis

Theory area 1 - Properties of the people and context in practice development

What impact does the extent of involvement of different stakeholders have on the outcomes of practice development?
Overall, the literature is diverse in its views about stakeholder involvement in PD. It is clear that the involvement of all key stakeholders is important but which stakeholders and what processes of involvement appear to be less clear. Many of the studies that espouse the importance of the involvement of stakeholders do not appear to be adopting a systematic approach to this part of the project design. The assumption that stakeholder involvement is a key success factor is evident but with little evidence of models of involvement being engaged with to inform approaches adopted. Studies that do report on stakeholder involvement do little to systematically demonstrate the relationship between involvement and outcomes achieved.

What impact does the scale of a study have on the outcomes of practice development?
Few studies consider the impact of the scale and size of the practice development work undertaken. There appears to be little consideration given in project planning as to how the issue of scale would be handled and the differing considerations needed to manage large and small practice developments. In addition, little emphasis is placed on the importance of ‘scale’ in the published literature and the grey literature appears to replicate standardised approaches to dissemination (conférences, presentations and publications).

How do contextual factors in the study setting have an impact on the outcomes of practice development?
The PD literature raises a number of contextual considerations including organisational structures, the expertise of practice developers and contextual barriers to effective change. The impact of context is evident in both the published and the grey literature and indeed the latter provides a richer source of information for ‘getting inside’ the context of practice settings and its impact on PD. Where practice developers align themselves in the organisation appears to be significant in terms of the ability of the setting to overcome contextual barriers. The published literature is particularly weak in teasing out the benefits or otherwise of decisions made about where to align PD work and practice developers.

How do cultural factors in the study setting have an impact on the outcomes of practice development?
In the PD literature the characteristics of an effective workplace culture that are reported in the ‘culture literature’ are evident to a greater or lesser extent. The importance of having clarity of values and beliefs, a shared vision for practice, high regard for individuals, commitment to learning in practice and effective organisational processes that enable the previous characteristics to be realised are emphasised. The more recent PD literature places significance on the development of a learning culture to support and sustain PD work.

How do styles of leadership in the study setting have an impact on the outcomes of practice development?
Whilst the majority of the PD literature does make some reference to leadership, it is very unclear from the literature at what level this leadership should be provided, i.e. clinical or strategic, internal or external etc. There does appear to be a consistent view that having inspirational and transformational leadership is an essential ingredient of successful PD work and the leader working to develop a shared vision with participants and stakeholders in PD activity is a key component of that leadership.
Theory area 2 – Properties of the people involved in developing practice

How does the location of a practice developer have an impact on the outcomes of practice development?
The literature largely divides into the two broad themes of insider and outsider roles. However, the accounts reported demonstrate that in practice this crude and simplistic role distinction is rarely realised in practice. Outsider roles appear to have little connection with the actual development of practice and instead adopt a largely facilitative and educational function of internal practice developers or those engaged in PD projects. Internal practice development roles are largely combined with or are a sub-role of other role functions, e.g. service or department manager, clinical educator. The authority that comes with these roles appears to contribute to the effectiveness of PD. However, such role combinations also bring challenges of integration and the facilitative function is in danger of being seen as an additional rather than an integrated role function.

How do the means by which the practice developer gains access to the practice environment have an impact on the outcomes of practice development?
Most reports of PD do raise issues of access particularly when there is an external facilitation relationship in place. The key issues that appear to emerge in this data though are firstly the importance of negotiation and secondly the need for role clarity. It would appear from the literature that the key issue is not that of the role adopted (be it an internal or external role) but more to do with the way that roles are negotiated and clarified, consistent with the overall purpose of the developments being undertaken.

How do the methodological positions taken by practice developers have an impact on the outcomes of practice development?
The methodologies adopted for practice development are diverse and wide ranging. There is little consensus about the most effective methodology and further, there is little evidence of learning being transferred from one study to another in terms of methodological effectiveness. A number of methodological approaches appear to be reported most often – ‘participatory models’; action research oriented models; and pedagogical models. These are not mutually exclusive approaches and indeed there are major overlaps between them. However, when there are methodological considerations reported in the literature, they can be seen to fall within these broad methodological perspectives.

Theory area 3 – Issues surrounding the initiation and carrying out of practice development

How do factors involved in the initiation of practice development have an impact on its outcomes?
Practice developments are initiated from three broad sources - educational and credentialing drivers; policy drivers; and practice drivers. These are not mutually exclusive categories as it is evident in the literature that whilst there are few accounts of developments arising from ‘practitioners’, many practice developments may in fact do so but they are shrouded in (for example) a policy agenda in order to legitimise them. Educational and credentialing drivers differ from professional development agendas as they start with the specific intention of impacting on practice.

What are the foci of practice development activity and how do they have an impact on its outcomes?
The evidence concerning the focus of practice development identifies six main categories of activity: promoting and facilitating change; evidence translation and communication; responding to external influences; education; research into practice; audit and quality. How these foci impact on outcomes from practice development work is largely dependent on the clarity of focus among project facilitators, managers and project participants. Having a common vision across these stakeholders is key in order to ensure that there is an agreed focus and targeted outcomes.
Theory area 4 – Approaches used to the use of knowledge, bringing about change and supporting learning in practice development

How do approaches taken to support learning within practice development have an impact on outcomes?
There is much consistency of learning approaches utilised in practice development reported in the literature. Largely these approaches can be labelled as ‘active learning’ or ‘reflective learning’ strategies, i.e. they focus on the active engagement of participants in the learning consistent with adult learning theories. The dominant approach reported is ‘action learning’ but there are very few studies of the effectiveness of action learning. There is little evidence in the literature of a direct relationship between the learning strategies utilised and the practice development outcomes achieved. The most commonly reported outcome is that of ‘increased confidence’ among participants.

How do approaches taken to bringing about change within practice development have an impact on outcomes?
The current literature does not allow for the direct measurement of practice development outcomes arising from specific change interventions. A variety of change strategies are reported in the literature – some of which can be described as ‘technical’ in nature, i.e. they focus on a specific aspect of practice that is narrowly defined. Technical changes that are reported as being successful appear to have been located with an overarching practice development framework. Facilitative approaches that focus on helping participants to ‘find their own way’ through the change process appear to be favoured. Facilitation strategies are poorly articulated and evaluated.

What forms of knowledge use and knowledge generation are used in practice development and what are the consequences for the outcomes?
A general finding of the PD literature is that it does not pay much attention to the forms of knowledge underpinning the development activity. Indeed a particular weakness of the literature is the ‘evidence’ underpinning many of the developments undertaken. There is little evidence of practice developers making explicit the evidence underpinning their work and this is particularly the case when it comes to the use of empirical evidence. The knowledge generation potential of practitioners/participants in practice developments is largely untapped.

Key Messages from Synthesis of all Data Sets
1. There is no evidence to suggest the superiority of multidisciplinary over unidisciplinary practice developments. However, consistent with other developments in contemporary healthcare delivery, the review suggests a general sense of multidisciplinary PD being ‘better’. However, the key issue is that the decision should reflect the overarching intent/desired outcomes of the development work itself.

2. The involvement of managers in PD is crucial to the successful implementation of PD processes and the sustainability of outcomes. However, the evidence would suggest mixed-support from managers for PD work. This can be attributed to a lack of understanding of PD in a healthcare world that is driven by short-termism and practice cultures that continue to be suspicious of managers. Practice development has an important role to play in the modernisation of health and social care services because of its focus on ‘practice’. Managers need to understand how PD can contribute to the modernisation and development of effective services.

3. There is universal acceptance of the need for service user involvement (or engagement) in PD work. However, there is currently little evidence of this happening in a proactive way currently and most involvement is representative of ‘consultation’ rather than involvement. There is a need for further research, development and training to be
undertaken with practice developers and service users in order to develop meaningful engaged relationships in PD.

4. The evidence continues to suggest that practice developers in ‘formal’ PD roles continue to experience isolation and role ambiguity. The expertise required by practice developers to undertake particular roles is largely unknown and unrecognised. There is a need to develop a greater understanding of the particular knowledge, skills and expertise needed to operate in differing PD roles. Clarity about ‘what is in and what is out’ of specific PD projects is needed in order to maximise available expertise and evaluate outcomes. However, there is also a need to discontinue the dominant focus on PD roles per se and instead develop transferable principles for the facilitation of PD within and across organisations.

5. Collaborative relationships with Higher Education Institutions (HEIs) can provide an important means of reducing isolation for practice developers, but also a way of extending the potential for systematic and rigorous processes to be adopted. However, the principles upon which such relationships are established are crucial to the success of such collaborations.

6. If PD processes and outcomes are to be sustained beyond the life of particular project timeframes, then there is a need to embed practice development activities in learning strategies. Therefore PD and learning are inextricably linked. There is no evidence in the PD literature of ‘traditional education’ processes having a direct impact on practice. Reflective learning strategies and in particular ‘action learning’ appear to have more to offer the sustainability of PD and there is a need for further evaluative research in this area.

7. There is consensus in the data that effective practice development requires the adoption of participatory methodological approaches. No one methodology is favoured and thus promoting one as a favoured methodology would not help to advance practice in this field. The diversity of approaches appears to enable new knowledge about effective processes to emerge.

8. There is growing consensus concerning the practice development methods that are effective in ensuring participatory engagement and in bringing about changes in the culture and context of practice. The complexity of PD militates against the correlation of any one method with PD outcomes. Methods accounted for in the literature that appear to be transferable fall into four groupings – (1) using and generating knowledge; (2) involvement of stakeholders; (3) developing participation and shared ownership; (4) effecting development of patient care. Further research is needed to advance the development and testing of these methods in order to inform outcome measurement.

9. There is no available costing model for PD. The majority of PD funding is focused on the resourcing of practice development roles. However, as we move more towards an integrated methodology of PD where the emphasis is on particular methods rather than roles per se, then costing models need to be developed. Based on the evidence arising from this review, it should be possible to devise a costing model to match the methodologies and methods identified.

10. Outcome measurement in PD is complex and does not lend itself to traditional methods of outcome evaluation. The evidence suggests that outcome measurement needs to be consistent with the espoused values of ‘participation and collaboration’ where data collection and analysis is an integral component of the development itself. A wide range of outcomes are evident from published practice developments and there is a need for the replication of these in
further studies. In addition, consideration needs to be given to the ‘stable’ methods of PD through scientific measures as separate activities from theory generating and knowledge development activities.

Recommendations for the Development of a PD Model

1. Policy and Strategy

1.1 A seminar should be held with interested stakeholders to explore ways in which the findings and recommendations from this study could be developed into a PD model for Scotland.

1.2 Practice development needs to be recognised as a methodology that can contribute to the modernisation of health and social care services through its focus on improving workplace cultures. Key policy and strategy stakeholders need to be targeted in order to develop a strategic way forward for connecting practice development methods with service/systems developments, set within a modernisation and risk management agenda.

2. Methodology and Methods

2.1 No one methodological perspective can serve all PD functions. However, all PD work should have evidence of a participatory, inclusive and collaborative methodology being used.

2.2 Practice development evaluation frameworks need to embrace the methodological principles of participation, collaboration and inclusivity.

2.3 A programme of education and awareness raising needs to be implemented for service and practice managers in order to improve understanding of the methodologies and methods of PD.

2.4 Strategic level work needs to be undertaken to explore the nature of the relationships between higher education institutions and health care organisations in order to establish core collaborative principles for joint working.

2.5 Practice development programmes need clarity of focus and on this basis decisions made about their unidisciplinary or multidisciplinary focus.

2.6 Practice development projects should be able to demonstrate evidence of using all the following methods:
   - Agreed ethical processes
   - Stakeholder analysis and agreed ways of engaging stakeholders
   - Person-centredness
   - Values clarification
   - Developing a shared vision
   - Workplace culture analysis
   - Collaboration and participation
   - Developing shared ownership
   - Reflective learning
   - Methods to facilitate critical reflection (e.g. action learning)
   - High challenge and high support
   - Feedback
   - Knowledge use
   - Process and outcome evaluation
   - Facilitation of transitions
   - Giving space for ideas to flourish
   - Dissemination of learning
   - Rewarding success

2.7 Further research is needed to advance the development and testing of these PD methods in order to inform outcome measurement.

3. Roles and Relationships

3.1 Further development and training should be undertaken with practice developers and service users in order to develop meaningful engaged relationships in PD.

3.2 There is a need to balance the dominant focus on PD roles with the development of transferable principles based on the methods outlined here (recommendation 2.6) for the facilitation of PD within and across organisations. Organisations should review the variety of roles in place/needed that can operationalise PD methods and develop an
infrastructure to enable senior staff to coordinate this work.

4. **Learning Strategies**

4.1 If PD processes and outcomes are to be sustained beyond the life of particular project timeframes, then there is a need to embed practice development activities in learning strategies. Reflective learning strategies and in particular ‘action learning’ appear to have more to offer the sustainability of PD. However, there is a need to evaluate action learning as a ‘method’.

5. **Funding**

5.1 PD costing models should be based on the funding of PD methods alongside the funding of roles that can facilitate the transferability of these methods across different contexts.

5.2 A practice development costing model should be developed that focuses on the resourcing of particular PD methodologies and the PD methods outlined in recommendation 2.6.

6. **Evaluating Effectiveness**

6.1 A strategic level evaluation framework should be developed that is consistent with the theory of complex interventions and their evaluation. This would enable the evaluation of the impact of PD frameworks and generate new knowledge about the effectiveness of PD processes and outcomes derived.

**References**


1) INTRODUCTION

In February 2005 NHS Education for Scotland (NES) and NHS Quality Improvement Scotland (NHS QIS) invited tenders for a literature review examining the evidence around practice development. The study commissioners noted the increasing amount of literature in the area characterised by the emergence of a range of theoretical frameworks and conceptual analyses emerging in what had initially been a relatively ill-defined umbrella term for a range of change management and knowledge use strategies (Garbett & McCormack, 2002; Manley & McCormack, 2003; McCormack et al., 1999; Unsworth, 2000).

The project brief stipulated two phases. In the first, a literature review focusing on empirical work that had been carried out in the field of practice development, culminating in recommendations regarding the parameters of a second phase. The second phase would focus on the so-called ‘grey’ literature and on accessing expert opinion from key informants in order to arrive at a final report, providing a critical appraisal of evidence available for the effectiveness of the various models of practice development with attention being paid to issues of cost and sustainability.

The authors of this report were successful in being invited to carry out the study. The team is composed of researchers with a background in research in the field of practice development (as well as knowledge utilisation, practice research, user participation, leadership and quality) supported by an information expert.

The report sets out the two phases of work, including the methodology used in each phase, the findings from each and a presentation of the synthesised data in order to answer the review questions. Finally, key recommendations are identified in order to take this work forward and consider actions arising from the evidence reported.

2. METHODOLOGY

The study methodology is based on a recently developed framework derived from realistic evaluation (Pawson & Tilley 1997). Faced with the challenge of evaluating ‘messy’ data collected in unpredictable practice contexts, evaluation researchers in health care have increasingly begun to turn to realistic evaluation as a means of linking together mechanisms and their outcomes in relation to the contexts in which they occur (Redfern et al 2003; Greenhalgh et al 2004; Tolson
A systematic review of evidence is a process of secondary research that identifies studies relevant to a particular topic, appraises the quality of these studies according to predetermined criteria and synthesises their results using a scientific methodology. Systematic reviews emphasise explicit and reproducible methods. Conventional systematic reviews tend to impose a strict hierarchy of evidence focused on questions of effectiveness and address very narrowly focused questions that rarely reflect the complexity of the context in which interventions are operationalised. Therefore reviews may not exist or be possible for more complex service delivery or policy issues. As a consequence, the review findings may have limited clinical applicability. The stringent requirements for study selection and amount of data required for confident claims about generalisable findings mean that systematic reviews frequently conclude that firm recommendations are difficult to make on the basis of available evidence (Dopson et al., 2003).

The positivist underpinnings of systematic reviews suggest that generalisable findings can only be derived from evidence that has a strong relationship between cause and effect, i.e. that the same effect is produced with regularity. Regularity is therefore only likely to occur under specific circumstances i.e. in a closed system (Wilson & McCormack, 2006). Such closed systems fail to recognise the complexity of the natural world, a world in which the same mechanism can produce different outcomes dependent on the context.

It is argued that plural forms of evidence are generated through the complex interactions between processes (mechanisms). This complex interaction can result in poorly defined explanations regarding why events occur under certain circumstances and in what ways these events are experienced by participants (Pawson & Tilley 1997; Pawson 2002; Redfern et al 2003). The key question that researchers working within a realistic perspective ask is, how do certain causal mechanisms (e.g. a workshop) operating in particular circumstances (e.g. a particular practice development project) create certain changes (outcomes)? This empirical characteristic of realistic research means that researchers are primarily concerned with analysing the causal mechanisms within the environment, any interactions that occur between mechanisms and the power of mechanisms to generate outcomes (Outhwaite 1987). They observe that, when it comes to the delivery of complex programmes and services, the ‘same’ intervention never gets implemented in an identical manner. Even if it did, the recipe for success in one setting might not be transferable to a different context. Because causal mechanisms always occur in a particular social context, there is a need to understand the complex relationship between these mechanisms and the effect the context has on their effectiveness. Causal mechanisms always operate within constraining or enabling factors (the effects of the contexts) and realists thus argue that mechanisms cannot be understood properly outside of their context and de facto evaluated thoroughly if they are
isolated from their context. Thus realists attempt to understand complex social interactions/interventions. Complex social interventions according to Pawson et al (2004) and Sridharan et al (2006) are comprised of theories, involve the actions of people, consist of a chain of steps or processes that interact and are rarely linear, are embedded in social systems, are prone to modification and exist in open systems that change through learning. A realist goal is explanatory and thus realist evaluations ask ‘what works for whom in what circumstances, in what respects and how?’

Pawson and colleagues (Pawson & Boaz 2004, Pawson et al. 2004, Pawson 2006) have developed a model for synthesising plural forms of evidence that are generated through the complex interactions between processes (mechanisms). The model called ‘realist synthesis’ draws on the methodological logic of realistic evaluation and applies it to the synthesis of plural forms of evidence. The approach hinges on the identification and testing of ‘programme theories’: interventions that are designed to have a particular outcome. A realist synthesis follows similar stages to more familiar forms of systematic review (see table 1) with some particular features that distinguish it. Notably a realist synthesis derives its focus from a negotiation between the study commissioners and the researchers. Realist synthesis has been developed in response to the limitations of systematic reviews outlined earlier. A realist review carries exactly the same objective, the refinement of theories rather than an attempt to make claims about the absolute preferability of one alternative over another. What the consumer of such a review should expect is knowledge about choices to be made around a particular intervention together with ideas about why they work (or not).

This approach is relevant to a systematic review of evidence pertaining to practice development as practice development can be seen to embrace the features of complex social interventions – it is comprised of theories, involves the actions of people, consist of a chain of steps or processes that interact and are rarely linear, is embedded in social (healthcare) systems, is prone to modification and it usually exists in open systems that change through learning.
<table>
<thead>
<tr>
<th>Phase 1</th>
<th>‘Traditional’ stages in systematic review</th>
<th>Stages in a realist synthesis study</th>
<th>Activities undertaken at each stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the scope of the review</td>
<td>1.1 Identify the question</td>
<td>For example:</td>
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<tr>
<td></td>
<td></td>
<td>• What is the nature and content of the intervention?</td>
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<td></td>
<td></td>
<td>• What are the circumstances or context for its use?</td>
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<td></td>
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<td>• What are the policy intentions or objectives?</td>
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<td></td>
<td></td>
<td>• What are the nature and form of its outcomes or impacts?</td>
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<td></td>
<td></td>
<td>• Undertake exploratory searches to inform discussion with review commissioners/decision makers</td>
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<tr>
<td>1.2 Clarify the purpose(s) of the review</td>
<td></td>
<td>For example:</td>
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<tr>
<td></td>
<td></td>
<td>• Theory integrity – does the intervention work as predicted?</td>
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<td></td>
<td></td>
<td>• Theory adjudication – which theories about the intervention seem to fit best?</td>
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<td></td>
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<td>• Comparison – how does the intervention work in different settings, for different groups?</td>
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<td></td>
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<td>• Reality testing – how does the policy intent of the intervention translate into practice?</td>
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<tr>
<td>1.3 Find and articulate the programme theories</td>
<td></td>
<td>• Search for relevant ‘programme theories’</td>
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<td></td>
<td></td>
<td>• Draw up 'long list’ of programme theories</td>
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<td></td>
<td></td>
<td>• Group, categorise or synthesise theories</td>
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<td></td>
<td></td>
<td>• Design an evaluative framework to be ‘populated’ with evidence</td>
<td></td>
</tr>
<tr>
<td>Search for and appraise the evidence</td>
<td>2.1 Search for the evidence</td>
<td>• Decide and define purposive sampling strategy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Define search sources, terms and methods to be used (including cited reference searching)</td>
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<tr>
<td></td>
<td>2.2 Appraise the evidence</td>
<td>• Test relevance – does the research address the theory under test?</td>
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<tr>
<td></td>
<td></td>
<td>• Test rigour – does the research support the conclusions drawn from it by the researchers or the reviewers?</td>
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</tr>
<tr>
<td>Extract and synthesise findings</td>
<td>3.1 Extract the results</td>
<td>• Develop data extraction forms or templates</td>
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<tr>
<td></td>
<td></td>
<td>• Extract data to populate the evaluative framework with evidence</td>
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<td></td>
<td>3.2 Synthesise findings</td>
<td>• Compare and contrast findings from different studies</td>
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<td></td>
<td></td>
<td>• Use findings from studies to address purpose(s) of review</td>
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<td></td>
<td>• Seek both confirmatory and contradictory findings</td>
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<td></td>
<td>• Refine programme theories in the light of evidence</td>
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<td></td>
<td>3.3 Consultation on and refinement of findings</td>
<td>• Identify expert cohort from literature (citation and volume of publications) and relevant networks</td>
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<td></td>
<td></td>
<td>• Telephone interviews</td>
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<td></td>
<td>* NB THIS STAGE HAS BEEN DESIGNED SPECIFICALLY FOR THIS STUDY</td>
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<tr>
<td>4. Draw conclusions and make recommendations</td>
<td></td>
<td>• Involve commissioners/decision makers in review of findings</td>
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<td></td>
<td></td>
<td>• Draft and test out recommendations and conclusions based on findings with key stakeholders</td>
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<td></td>
<td></td>
<td>• Disseminate review with findings, conclusions and recommendations</td>
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</tbody>
</table>

Table 1: the process of realist synthesis – adapted from Pawson et al (2004)
2.1 **FINDING AND ARTICULATING THE PROGRAMME THEORIES**

Pawson et al (2004) sets out the following steps for a review using this realist synthesis approach.

- **Concept Mining**: extraction of a theory from the existing literature.
- **Theory Formalisation**: codification of the theory into a set of explanatory propositions (or model).
- **Evidence Synthesis**: revision and development of that model to explain the complex pattern of success and failure found in the empirical evidence.

Phase 1 of the study addressed the first two of these steps (concept mining and theory formalisation). Phase 2 of the study continued the process of theory formalisation through the analysis of grey literature and interviews with ‘experts’ as well as engaging in ‘evidence synthesis’. Developing the focus of the study and the theories to be examined is an important aspect of a realist synthesis study (Pawson et al 2004) as it provides the structure for examining a diverse body of information.

For this study the structure was developed from:

- The steering group’s ideas and questions (appendix 1)
- The project team’s constructions (appendix 2)

The challenge of developing the framework for a realist synthesis is to find the level of abstraction that allows the reviewers to both stand back from the mass of detail and variation in the data set and also meet the purpose of the review as required by the commissioner. To this end the framework is structured around the following four ideas (see figure 1):

**Figure 1: Model for conceptualising practice development programme theories**
• **Who?** – looking at dimensions around the people who are the focus of practice development at the level of the individual, team, organisation (e.g. the people who get developed) and so on – so it’s ‘who’ in a specific sense (e.g. practitioners, users) as well as in a collective sense (e.g. teams). This idea includes the concepts of leadership, culture and context.

• **By who?** – looking at the dimensions involved in the people doing the developing, for example looking at their orientation to the people that they are working with (insider/outsider etc.)

• **What/why?** – looking at the impulse to engage in practice development work, working with ideas around inductive and deductive rationales and the role of policy initiatives

• **How?** – looking at the actual mechanisms involved, facilitation styles, theoretical orientations, knowledge utilisation, involvement of users.

These ideas need to be related to the outcomes that result (figure 1 above), where the analysis in each quadrant looks to understand relevant outcomes in relation to the programme theories being scrutinised, e.g. in the ‘How’ quadrant, action learning as part of an emancipatory strategy is meant to produce outcomes x and y and whether it did or not, and under what circumstances.

**Quadrant 1: Who?**

Practice development studies have been taking place at a number of levels. In the early 1990’s debates started about the relative merits of practice versus nursing development units (Page *et al* 1998). Subsequently an increasing prominence of the perspective of person centredness in practice development emerged (McCormack *et al*. 1999). The rationale for this perspective was predicated on the belief that if the focus of practice development is to be on improving the experience of the patient, it is most likely to occur when all those who have an effect on the patient are involved. Practice development studies in the literature reflect both unidisciplinary and multidisciplinary approaches. Similarly new studies are still being set up that focus primarily on nursing. It is therefore relevant to explore the relative merits of studies in terms of the number of stakeholders involved.

Similarly, the literature contains examples of studies on different scales from single clinical units to whole organisations. From a conceptual point of view it is argued that practice development requires both facilitation and a supportive managerial context (McCormack *et al* 1999,
McCormack et al. (2002) to reach its full potential. It therefore seems to be of use to examine evidence about the extent to which the scale of a study has an impact on the outcomes.

Reviewing a practice development definition from a concept analysis undertaken by Garbett & McCormack (2002), which emphasised that the notions of culture and context are a focus for practice development work, suggested that the PARIHS framework (Rycroft-Malone et al., 2002) could provide the basis for conceptualising the recipients of practice development work and their readiness to participate in practice development activity. The PARIHS framework includes an analysis of workplace culture, practice context and leadership. Analysis of these concepts has previously been published by the PARIHS project team (see McCormack et al. 2002). Figures 2-4 below set out the key characteristics of the concepts of context, culture and leadership.
Figure 2: Characteristics of context

- Lack of clarity around boundaries
- Lack of appropriateness and transparency
- Lack of power and authority
- Lack of resources
- Lack of information and feedback
- Not receptive to change

- Physical
- Social
- Cultural
- Structural

Boundaryless clearly defined

Figure 3: Characteristics of culture

- Unclear values and beliefs
- Low regard for individuals
- Task driven organization
- Lack of consistency

- Able to define culture(s) in terms of prevailing values/beliefs
- Values individual staff and clients
- Promotes learning organization
- Consistency of individuals role/experience to value:
  - Relationship with others
  - Teamwork
  - Power & authority
  - Rewards/recognition

Figure 4: Characteristics of leadership

- Traditional, command and control leadership
- Lack of role clarity
- Lack of teamwork
- Poor organizational structures
- Authoritative decision making processes
- Didactic approaches to teaching/learning/managing

- Transformational leadership
- Role clarity
- Effective teamwork
- Effective organizational structures
- Democratic inclusive decision making processes
- Enabling/empowering approach to teaching/learning/managing
In terms of ways of looking for features in empirical practice development studies, therefore we proposed that a review of the ‘who’ of practice development should focus on those themes and elements set out in table 2.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Elements</th>
</tr>
</thead>
</table>
| 1.1 Level of involvement | • Practitioners only, unidisciplinary  
| | • Practitioners only, multidisciplinary  
| | • Multiple levels of involvement (e.g. managers, external agencies, service users/patients) |
| 1.2 Scale of activity | • Small scale (e.g. single clinical unit)  
| | • Medium scale (e.g. service)  
| | • Large scale (e.g. organisational) |
| 1.3 Context in which practice development takes place | • Weak  
| | • Strong |
| 1.4 Culture in which practice development takes place | • Weak  
| | • Strong |
| 1.5 Leadership in environment in which practice development takes place | • Weak  
| | • Strong |

Table 2: The ‘Dimensions of study of the ‘Who’ of Practice Development

The ideas set out in the above model have the advantage of being theoretically robust developed as they have been through the systematic examination of large numbers of practice based studies.

In summary, the logic of realist synthesis focusing on developing explanations about what works, for whom in which circumstances this first quadrant is concerned with abstractions about ‘for whom’ and ‘in what circumstances’.
Quadrant 2: By Whom?

Practice developer (or facilitator) roles are conceptualised in the literature in a number of ways e.g. insiders, outsiders and those whose role incorporates practice development. These distinctions and the relationships between different practice development roles and practice areas are shown in the literature to have an effect on the conduct of practice development work. In addition, practice developer roles can have a defined clinically specific or in contrast, Trust-wide remits. There is also an issue of how the practice developer ‘got there’ in the first place – how did they come to be involved in a particular practice development programme? Were they invited? Imposed? Or, did they negotiate their way in? From our discussions we postulated that practice developers’ main routes for involvement in a practice development programme were either by invitation, through negotiation or were imposed.

The intention here is to develop theoretical propositions about the impact of the position of the practice developer in relation to the people with whom they will be working. Another potential dimension can be theorised from Manley and McCormack (2003) and their conceptualisation of technical and emancipatory approaches to practice development. The assumption underpinning the idea of technical and emancipatory approaches is founded in the belief that ‘effective practice development requires practice developers to be aware of and understand the assumptions underpinning the way they work’ (p.22). Manley and McCormack argue that the theoretical orientation of a practice developer has an impact on the way they work (for example, deductively or inductively) and on the assumptions they make about the people they work with (for example recipients of or collaborators with facilitation) and so on the outcomes of a programme of work (for example, change in a particular area of performance or broader learning derived from critically reflective approaches to practice as well as changes in performance). The contrasting of technical and emancipatory approaches potentially underpins a number of propositions relevant to this study. For the purposes of analysing the theoretical orientation of practice developers in this study, we focus on two approaches to ways of working – ‘working on’ practitioners and associated practices and ‘working with’ practitioners in the development of practice.

In terms of ways of looking for features in empirical practice development studies, therefore we proposed that a review of the ‘by whom’ of practice development should focus on those themes and elements set out in table 3.
2.1 Location of practice developer

- Clinically based
- Trust based
- Externally based – consultancy
- Externally based – higher education

2.2 Access by practice developer

- Invited (entry at initiation of individuals/teams)
- Negotiated (entry in co-operation with individuals/teams)
- Imposed (entry without engagement/willingness of individuals/teams)

2.3 Theoretical orientation of the practice developer(s)

- ‘Working on’ – working with deductively derived ideas, practitioners seen as recipients, practice developer as ‘expert’
- ‘Working with’ – uses inductive approaches to facilitation, practitioners seen as collaborators

<table>
<thead>
<tr>
<th>2.1 Location of practice developer</th>
<th>2.2 Access by practice developer</th>
<th>2.3 Theoretical orientation of the practice developer(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinically based</td>
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<tr>
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<tr>
<td>• Externally based – higher education</td>
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Table 3: The ‘Dimensions of study of the ‘By Whom’ of Practice Development

**Quadrant 3: What/Why?**

The literature on practice development presents a range of starting points for the use of practice development approaches, for example as a response to professional imperatives (such as the individualisation of care) or policy directions (such as clinical governance). Practice development work can result from a range of influences which can in turn have an impact on the strategies necessary to achieve participation and involvement. In terms of developing propositions and explanations about what works, for whom and in what circumstances, this area refers mainly to the idea of ‘what circumstances’. In exploring the dimensions of the influences that underpin the initiation of practice development work, we were looking to explore the degree to which work is inductive, deductive or (more likely) a mixture of both. How can practice development work be initiated? The range can be described as from local ‘good idea’ and seeking help, to policy driven large scale programmes (for example an organisational programme). The importance of ‘matched activity’ at organisational and strategic levels to support activity with patients has been articulated previously and can also be integrated here (McCormack et al, 1999).

Practice development studies, while sharing a number of similar features, may also differ in their focus. Once again Manley and McCormack (2003) demonstrate this in their conceptualisation of
technical and emancipatory approaches. Technical approaches are characterised as focusing mainly on the actual change being addressed, while emancipatory approaches also focus on the impact of the processes used with the express intention of developing practitioners’ knowledge and skills and developing a work environment that is more conducive to practice development in the future. What seems to be the discriminating factor between technical and emancipatory approaches is the presence (or absence) of additional purposes that are linked to the methodological orientation of the practice developer. The focus of activity in practice development can therefore be said to be more intentionally inclusive of a number of purposes depending on the methodological orientation being adopted. Manley and McCormack hypothesise different outcomes based on methodological orientation; it therefore seems to be a worthwhile avenue of inquiry. In terms of ways of looking for features in empirical practice development studies, therefore we proposed that a review of the ‘what/why’ dimension of practice development should focus on those themes and elements set out in table 4:

| 3.1 Initiation of practice development activity | • Locally (e.g. practice setting) initiated – practice based issue(s)  |
|                                             | • Locally initiated – response to strategic/policy issues           |
|                                             | • Organisationally initiated – response to organisational issues (e.g. quality of care) |
|                                             | • Organisationally initiated – response to strategic/policy issues |
| 3.2 Focus of activity                       | • Practice improvement                                             |
|                                             |   + Learning for practitioners (e.g. new knowledge)                |
|                                             |   + Change in attitudes and ways of perceiving practice (e.g. empowerment) |

Table 4: The ‘Dimensions of study of the ‘what/why’ of Practice Development
Quadrant 4: How?

A wide range of possible facilitative approaches are described under the banner of practice development (Garbett and McCormack 2002; Manley and McCormack 2003). For example

- Developing knowledge and skills
- Enabling nurses/teams to transform the culture and context of care
- Skilled facilitation
- Formal critical learning strategies (e.g. action learning, critical reflection)
- Uses evidence as well as generating it
- Matching organisational activity with that which takes place at the client/practitioner interface
- Working with service users

The above ideas can be seen as falling into three dimensions:

- How learning happens
- How change happens
- How knowledge is used and generated

To incorporate the idea of user involvement would require developing a sub-dimension in one of the last two of these dimensions (see text in italics in the boxes below).

The contrasts drawn by Manley and McCormack (2003) (as well as insights derived from the PARIHS papers particularly that on facilitation (Harvey et al., 2002) between the ideas of technical and emancipatory approaches provide us with a range of features that would support an exploratory analysis. For the learning dimension then considering the contrasts between a ‘training model’ and a ‘reflective model’ would help to understand the relationships between learning and practice development, particularly with a focus on sustainability. The same distinctions between technical and emancipatory approaches can be used to explore ways in which change happens.

The main distinction in terms of knowledge use and generation is similarly distinguished by the direction in which knowledge ‘flows’, with technical approaches tending towards one way
deductive approaches and emancipatory approaches using an overtly plural approach.

In terms of ways of looking for features in empirical practice development studies, therefore we proposed that a review of the ‘what/why’ dimension of practice development should focus on those themes and elements set out in table 5:

| 4.1 How learning happens | • Training model – information shared through traditional educational approaches focusing on issues specific to the project being undertaken  
| | • Reflective model – learning needs and knowledge generated through reflective approaches  
| 4.2 How change happens | • Technical – agenda controlled by those who hold power, underpinned by one way transfer of knowledge, focus on practice competence, low focus on understanding of culture and context, restricted consultation of stakeholders including service users  
| | • Emancipatory – high focus on raising awareness of impact of culture and context on practice, collaborative approaches to agenda for and direction of change, emphasis on wide stakeholder collaboration including service users  
| 4.3 How knowledge is used and generated | • Technical – deductive approach to knowledge use – low emphasis on developing new knowledge and theory, evaluation based on technical interests (e.g. numerical evidence) assuming correlation between independent and dependent variables regardless of context,  
| | • Emancipatory – use of both deductive and inductive knowledge – emphasis on developing new knowledge and theory from wide range of stakeholders including service users, evaluation based on practical interests that incorporates a consideration of the impact of context and culture  

Table 5: The ‘Dimensions of study of the ‘How’ of Practice Development

2.2 AN INITIAL EXPLANATORY MODEL

The next stage in realist synthesis is putting the conceptual fragments together into a theoretical model. Pawson et al (2004) suggest that it is the model that does the work of explanatory synthesis as it identifies the primary foci of inquiry from the variety of studies that make up the
evidence base. In addition, the outcomes derived from the use of the model pulls together and shape the advice offered to the review commissioners.

To an extent it can be argued that the formulation of the ‘quadrant model’ provides the basis of this inasmuch as it postulates four components that interact to produce practice development outcomes. This model can be expanded (see figure 5) to incorporate the arguments above as issues to be explored empirically.

**Figure 5: Explanatory model for practice development**

The model suggests four theoretical areas with 13 areas of focus. Within each of these areas the model suggests themes for exploration as follows:

**Theory area 1 – Properties of the people and context in practice development**

a. What impact does the extent of involvement of different stakeholders have on the outcomes of practice development?

b. What impact does the scale of a study have on the outcomes of practice development?
c. How do contextual factors in the study setting have an impact on the outcomes of practice development?

d. How do cultural factors in the study setting have an impact on the outcomes of practice development?

e. How do styles of leadership in the study setting have an impact on the outcomes of practice development?

**Theory area 2 – Properties of the people involved in developing practice**

f. How does the location of a practice developer have an impact on the outcomes of practice development?

g. How do the means by which the practice developer gains access to the practice environment have an impact on the outcomes of practice development?

h. How do the methodological positions taken by practice developers have an impact on the outcomes of practice development?

**Theory area 3 – Issues surrounding the initiation and carrying out of practice development**

i. How do factors involved in the initiation of practice development have an impact on its outcomes?

j. What are the foci of practice development activity and how do they have an impact on its outcomes?

**Theory area 4 – Approaches used to the use of knowledge, bringing about change and supporting learning in practice development**

k. How do approaches taken to support learning within practice development have an impact on outcomes?

l. How do approaches taken to bringing about change within practice development have an impact on outcomes?

m. What forms of knowledge use and knowledge generation are used in practice development and what are the consequences for the outcomes?
The possible areas outlined above clearly suggested a considerable scope and degree of work within the time available. Pawson et al (2004) caution that totally comprehensive reviews are impossible and that the task is to prioritise and agree on which programme theories are to be inspected. The initial steering group meeting provided us with guidance here (see appendix 2). The concerns of the steering group can be characterised as being mainly concerned with three broad areas: the mechanisms of learning, knowledge use/generation and change used within practice development; how it can be differentiated from other approaches to bringing about change and, the mechanisms by which longer term impact can be achieved and evaluated. In addition the steering group identified the need for a coherent database to inform commissioning, funding and dissemination of practice development approaches as well as an ‘evaluation loop’ to support future practice development initiatives.

2.3 FINDING AND APPRAISING THE PUBLISHED EVIDENCE

2.3.1 Identifying the Review Questions

The first stages of a realist synthesis study consist of a clarification of the intended ‘product’; what is it that the study commissioners want to know and to what ends. An exercise at the initial meeting of the steering group helped the group to develop individual and collective questions about practice development (Appendix 1). These have, in turn, informed the identification of relevant programme theories for scrutiny (Appendix 3).

2.3.2 Searching the Literature

As has been reported elsewhere (Garbett and McCormack, 2002) identifying practice development literature is problematic because it is not a thesaurus search term in any of the established databases. Searches of the terms practice and development generate relevant papers as well as those that refer to the other many possible uses of the words ‘practice’ and ‘development’. This difficulty is compounded by the various classification systems used by the different electronic databases.

We therefore needed to develop a theoretically consistent approach to searching the databases. The approach needed also to reflect the concerns of the research methodology being used; realist synthesis (Pawson et al., 2004) which argues that the literature needs to be scrutinised to identify
‘programme theories’. We identified two possible options:

**Search using practice and development as key words** – We have experienced the consequences of this in previous studies (Garbett & McCormack, 2002) where databases search the words ‘practice’ and ‘development’ separately as well as in conjunction. As a result we then have to scrutinise a large number of papers and exclude a large number. This is time consuming and in our experience it does not necessarily identify all publications.

**Map commonly used subject headings onto concepts emerging from commonly used definitions of practice development** – We envisaged this as consisting of matching conceptual ideas from definitions of practice development with subject headings; for example, matching the concept of ‘improvement’ with the subject headings ‘*Quality Improvement’, ‘*Quality Assurance/mt [Methods]’, ‘*Quality Improvement/am [Administration]’ and ‘*Quality of Health Care’. To this end we conducted a preliminary exercise. For this study we worked with a dedicated librarian. Initial discussions of the problem of accurately identifying literature led us to examine 92 papers from our existing database published between 2000 and 2005. Mapping the keywords used indicated that 771 terms had been used for classification of these papers within Cinahl. Of this list the only terms that were used in more than 10 instances were ‘Professional development’ and ‘Nursing practice’; generic and broad search terms that were not specific enough for the purposes of this search. However, on the basis of the exercise that we carried out it would seem that this would find 11 papers out of 5128 for the period 2000-2005 in Cinahl alone.

Neither approach appeared to be neat and straight forward. Despite an emerging conceptual clarity the pathways to finding a comprehensive data set was still hampered by the lack of specificity in the subject headings employed by the various databases. Looking at the second approach as an alternative to approaches that we have used to date it seemed unlikely to be more effective than the previous approach that we have used before. In previous work (Garbett & McCormack, 2002) we accounted for material omitted from the study in terms of the reasons for its exclusion. By taking sources that advance a theoretical framework for practice development (Garbett & McCormack, 2002; Kitson & Currie, 1996; Mallett *et al.*, 1997; Manley & McCormack, 2003; Unsworth, 2000) we were able to account for each paper selected in terms of the features of practice development that it portrayed (see table 2).
<table>
<thead>
<tr>
<th>Concept</th>
<th>Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of improvement (including a focus on quality)</td>
<td>(Garbett &amp; McCormack, 2002; Mallett et al., 1997; Manley &amp; McCormack, 2003; Unsworth, 2000)</td>
</tr>
<tr>
<td>Patient centred care</td>
<td>(Garbett &amp; McCormack, 2002; Mallett et al., 1997; Manley &amp; McCormack, 2003; Unsworth, 2000)</td>
</tr>
<tr>
<td>Facilitation</td>
<td>(Garbett &amp; McCormack, 2002; Manley &amp; McCormack, 2003)</td>
</tr>
<tr>
<td>Professional development</td>
<td>(Garbett &amp; McCormack, 2002; Mallett et al., 1997; Manley &amp; McCormack, 2003)</td>
</tr>
<tr>
<td>Transformation</td>
<td>(Garbett &amp; McCormack, 2002; Manley &amp; McCormack, 2003)</td>
</tr>
<tr>
<td>Emancipation</td>
<td>(Garbett &amp; McCormack, 2002; Manley &amp; McCormack, 2003)</td>
</tr>
<tr>
<td>Service users’ perspectives</td>
<td>(Garbett &amp; McCormack, 2002; Unsworth, 2000)</td>
</tr>
<tr>
<td>Effectiveness (including implementation of plural forms of evidence)</td>
<td>(Garbett &amp; McCormack, 2002; Kitson &amp; Currie, 1996; Mallett et al., 1997; Unsworth, 2000)</td>
</tr>
<tr>
<td>Managed change</td>
<td>(Garbett &amp; McCormack, 2002; Kitson &amp; Currie, 1996; Unsworth, 2000)</td>
</tr>
<tr>
<td>Acting on the culture and context of care</td>
<td>(Garbett &amp; McCormack, 2002; Manley &amp; McCormack, 2003)</td>
</tr>
</tbody>
</table>

We therefore negotiated with our librarian colleague to use the above concepts as a checklist to guide the selection of papers found using the terms ‘practice’ and ‘development’ across a range of databases. While use of these terms was not specific, it had the advantage of at least identifying those papers that used the terms in the specific way that distinguishes practice development from other forms of managed change. Using the concepts helped us to increase the rigour and specificity of the selection of papers for in depth study.
The possible drawback of this approach is that it assumed the quality of the previous studies and ran the risk of ‘closing down’ the possible range of programme theories that would be identified. Nonetheless, it is argued that we needed to look for instances of the term practice development being used as a descriptor for specific ways of working as a precursor to looking in greater depth at the programme theories that are described in the practice development literature.

The search included the databases listed in table 7:

<table>
<thead>
<tr>
<th>Table 7: Databases searched</th>
</tr>
</thead>
<tbody>
<tr>
<td>Database searched (papers filtered using the table above)</td>
</tr>
<tr>
<td>British Nursing Index</td>
</tr>
<tr>
<td>Cinahl</td>
</tr>
<tr>
<td>First Search</td>
</tr>
<tr>
<td>Medline</td>
</tr>
<tr>
<td>National Electronic Library for Health (NeLH)</td>
</tr>
<tr>
<td>Psycinfo</td>
</tr>
<tr>
<td>Social Science Citation Index</td>
</tr>
<tr>
<td>AMED</td>
</tr>
<tr>
<td>HMIC</td>
</tr>
<tr>
<td>Bandolier (<a href="http://www.jr2.ox.ac.uk/bandolier/">www.jr2.ox.ac.uk/bandolier/</a>)</td>
</tr>
</tbody>
</table>

Merging these findings into one database provided a list of 376 references, to which were added 14 papers that we were aware of but not found in the searches (for example, Manley 2000a & b and Bellman 2003) (total 390). However, examination of the list showed that entries in different databases may use different conventions resulting in duplication. In this case 38 papers were entered twice (Appendix 9) and a further 183 papers were excluded because they were descriptive papers, editorials, news stories – or which despite previous searches did not meet criteria as practice development papers. The remaining 169 papers formed the basis of the first phase review. The 169 papers (appendices 4-8) remaining after removing the duplicates can be classified as follows (table 8):
<table>
<thead>
<tr>
<th>Category</th>
<th>Number of papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explicitly use practice development as a study methodology or study the experience of involvement in practice development (appendix 4)</td>
<td>71</td>
</tr>
<tr>
<td>2. Scholarly reviews of practice development literature (appendix 5)</td>
<td>30</td>
</tr>
<tr>
<td>3. Concept analyses (appendix 6)</td>
<td>6</td>
</tr>
<tr>
<td>4. Studies in which practice development approaches are implicit (for example using facilitative approaches to change) (appendix 7)</td>
<td>29</td>
</tr>
<tr>
<td>5. Papers based on empirical research, but did not contain evidence about practice development processes or outcomes (Appendix 8)</td>
<td>33</td>
</tr>
</tbody>
</table>

Table 8: Classification of papers found

This initial analysis consisted principally of material drawn from the first category, although reading did incorporate papers from all categories leading to reallocation to other categories in 14 cases. Papers were read by two of the research team (2 papers were read in parallel) using the data extraction format developed for the study (appendix 10). This format was used in parallel by the two readers to ensure reliability. In addition it was critiqued by the whole research team to ensure congruity with the conceptual framework being used.

2.4 **FINDING AND APPRAISING THE ‘GREY LITERATURE’**

In order to access the grey literature an email was sent so members of networks that the researchers are associated with (table 9). However, few responses were received, so a further email was sent to specific network members (Figure 6) and a more favourable response was received. Thirty-seven items of grey literature was received and in addition four books were reviewed that are widely referenced in the literature because they add to an understanding of PD methodology (Bellman 2003; Bryar and Griffiths 2003; McCormack, Manley & Garbett 2004; Page, Allopp and Casley 1998) resulting in a review of 41 items of grey literature and books (Appendix 11).
Table 9: International Networks

- International Practice Development Collaboration: Members in the UK, Australia and the Netherlands
- The Foundation of Nursing Studies
- Developing Practice Network: Members throughout the UK
- The Professional and Practice Development Nurses’ Forum – Scotland:
- Knowledge Utilisation Collaboration: Members in the UK, Australia, New Zealand, Canada, USA, Holland and Sweden
- International Residential Practice Development School Collaboration: Members in the UK, Australia, the Netherlands and New Zealand. A network of 30 facilitators and more than 500 participants is available to the research team
- Academic Partnerships: Monash University, Melbourne, Australia; James Cook University, Queensland, Australia; Victoria University, New Zealand; Auckland University, New Zealand; University of Melbourne, Australia; Southern Health Network, Victoria Australia; The Alfred Hospital, Melbourne, Australia; The Childrens Hospital at Westmead, NSW, Australia; Northern Sydney Central Coast Health, NSW, Australia; University of Northumbria; Bournemouth University.
- The Virtual Institute [VI]: A Virtual Institute of research and practice development. Lead organisation is the Royal College of Nursing.
- The Virtual Practice Development College, Glasgow Caledonian University

A key component of the literature review is the analysis of the ‘grey PD literature’. Over the past few months we have put out general calls for people to send us copies of grey literature but so far have received very few responses. I am hoping that by targeting you specifically you may be able to ‘dig out’ relevant literature that might be of use to the study. We are particularly looking for:

1. reports of successful practice development projects that have not been published in journals
2. reports of practice development processes (successful or unsuccessful) that have not been published in journals
3. strategic documents pertaining to PD (e.g. commissioning frameworks, policy documents, development frameworks) from your organisation(s)
4. documents re the resourcing of PD (e.g. staff resources, financial plans for PD, costing frameworks) - this is of particular interest as there are few published accounts of PD that consider resources (particularly financial resources)
5. web links to local publications (i.e. reports that are on the web but not in journals)

All material will be treated confidentially and should we need to reference your sourced material we will agree the approach to referencing with you prior to report writing. Please post hard copy of materials to me at the address below or by email at this address before the 17th February 2006.

Your help is greatly appreciated.
With Best Wishes,
Professor Brendan McCormack

Figure 6: email to network members

The literature was read by members of staff of the Nursing Development Team of the Royal Hospitals and the lead researcher. The data extraction sheet (Appendix 10) was explained and worked through using one item of grey literature with staff during a team meeting. Each staff member read at least 2 items of the grey literature and completed a data extraction sheet for each item. Completed data extraction sheets with the hard copy of the grey literature were returned to the lead researcher for checking. Reviewers raised questions and issues on the data extraction
sheets and these were clarified and responded to by the lead researcher.

2.5 **TELEPHONE INTERVIEWS**

This interview stage took the form of a round of telephone interviews with key informants in the field of practice development. Informants were selected via the networks in which the researchers are involved (see table 9) and from prominent authors identified in the earlier stages from the UK, the Netherlands, Australia, New Zealand and Canada.

A snowball sampling technique was used (Burns & Grove 1997). This sampling approach works on the principle of ‘social networks’. When a researcher has identified a few participants who meet the inclusion criteria, their assistance is sought in getting in touch with others who have similar characteristics. An email was sent to a list of 65 people derived from the identified networks asking for their participation in the interview and the identification of further participants who:

- Had engaged in practice development work as a participant or as a project facilitator/coordinator
- Were a key stakeholder in commissioning/funding/managing practice development work
- Had a strategic role in developing practice
- Had successfully completed practice development activities

A total of 72 potential interviewees were identified. Based on the timeframe available for interviews and discussion with the project steering group it was agreed that a sample of 40-50 interviews would be acceptable in order to get a wide range of views on the initial themes emerging from phase 1 of the study.

2.5.1 **Sampling Procedure**

The population (n=72) were grouped according to the role the person had in practice development into one of four groups (Table 10) – organisational, strategic, academic or unit, with the following breakdown:

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>45</td>
</tr>
<tr>
<td>Strategic</td>
<td>9</td>
</tr>
<tr>
<td>Unit</td>
<td>4</td>
</tr>
<tr>
<td>Academic</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
</tr>
</tbody>
</table>

**Table 10: Practice Development Roles of Population**
From this population, interviewees were selected according to the following criteria:

- 50% of people from groups with >10 potential participants
- 100% of people from groups with <10 potential participants
- Geographical spread
- Spread across the identified networks (Table 9)

Using these criteria a sample was selected with the following breakdown (Table 11):

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>25</td>
</tr>
<tr>
<td>Strategic</td>
<td>9</td>
</tr>
<tr>
<td>Unit</td>
<td>4</td>
</tr>
<tr>
<td>Academic</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

Table 11: Sample of participants selected for interview

2.5.2 Interview Management Process

Each selected interviewee was emailed (appendix 12) and details of the project (Appendix 13) provided. Interviewees who had been identified by others were invited to participate in the telephone interview. The sample was divided among the three interviewers so that each interviewer had a sample from each role group. If a telephone contact was not already provided then a telephone number was requested. A time convenient to the interviewee was agreed with one of the three interviewers. The interview schedule was emailed to interviewees in advance of the interview so that they had some degree of familiarity with the process and had some time to think about their answers. Interviews were tape recorded using a ‘Phonopart Telephone Conversation Recorder [model number TL1076]’.

2.5.3 Interview Schedule

An interview schedule was devised following consultation with the steering group. The schedule was designed to reflect themes from the phase 1 report. In addition, following discussion of the phase 1 report with the steering group, other issues were raised that were considered to be of importance but were not explicit in the literature. A final interview schedule was developed that reflected these combined perspectives (see appendix 14).
2.5.4 Data Extraction, Analysis and Synthesis

Data analysis followed an eight step process (Figure 7). The data from the individual data extraction sheets for the published literature were extracted and copied onto ‘theory synthesis forms’ for each of the four theory areas. The data consisted of direct quotes, researchers’ commentaries and impressions. These data were grouped according to the particular emphasis in the data and the researchers’ impressions of the specific meanings in the data (Appendix 15a). Each theory synthesis form was read and re-read in order to gain overall impressions of the data and rough notes were made. The data from each theory synthesis form was then themed (Appendix 15b). In some cases, the original papers were revisited in order to clarify meanings and finalise themes. This stage of the work completed stage 3.2 of the realistic synthesis process and Phase 1 of the overall study. A draft report was formulated and presented to the project steering group for discussion, clarification and challenge. Some ‘gaps’ in the literature were identified (for example the lack of accounts regarding the funding of PD projects) and these were highlighted as important considerations in the review of the grey literature and in telephone interviews.

The grey literature data was then fed into the ‘theory synthesis forms’ for each of the theory areas in order to form a complete data set. The data were re-read and the initial themes reconsidered based on the evidence from the grey literature. Few themes changed significantly but instead the grey literature either strengthened or weakened initial themes. For example, in the published PD literature, accreditation is only considered as a ‘driver’ of PD whilst the grey literature identified a more ‘enabling’ role for accreditation frameworks and a basis for establishing collaborative relationships between healthcare organisations and higher education institutions. The themes were constructed into a narrative and these narratives formed the structure of the findings section of this report.

The final stage of analysis consisted of an analysis of the telephone interviews. The interview data were themed under the questions on the interview schedule. Key quotes and comments were highlighted and these were fed into the discussion of the data in order to highlight particular issues, confirm themes from the literature, verify or contradict the strength of claims made in the literature analysis and identify novel issues and themes. This final stage resulted in the identification of 4 overarching themes and 9 sub themes that synthesised all the data. Table 12 presents the themes and sub-themes and these form the discussion/data synthesis section of this report.
Figure 7: Data extraction, analysis and synthesis

Table 12: Data Analysis Themes and Sub-themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unidisciplinary versus Multidisciplinary Approaches</td>
<td>• none</td>
</tr>
<tr>
<td>2. Stakeholders</td>
<td>• Managers</td>
</tr>
<tr>
<td></td>
<td>• Service users</td>
</tr>
<tr>
<td></td>
<td>• PD Roles and relationships</td>
</tr>
<tr>
<td></td>
<td>• HEI relationships</td>
</tr>
<tr>
<td></td>
<td>• Learning</td>
</tr>
<tr>
<td>3. Methodologies and Methods</td>
<td>• Methodological Perspectives</td>
</tr>
<tr>
<td></td>
<td>• Methodologies in use</td>
</tr>
<tr>
<td></td>
<td>• Methods</td>
</tr>
<tr>
<td></td>
<td>• The cost/funding of PD</td>
</tr>
<tr>
<td>4. Outcomes arising from PD</td>
<td>• none</td>
</tr>
</tbody>
</table>
3. **FINDINGS FROM THE LITERATURE ANALYSIS**

The findings are set out using the programme theories framework (appendix 3). In this framework, four theories are identified and each theoretical area has a number of sub-areas as set out below. The findings from the published literature and the grey literature are integrated in each theory area.

### 3.1 What does the evidence tell us about theory area 1 - Properties of the people and context in practice development?

<table>
<thead>
<tr>
<th>The sub-questions being addressed here are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 What impact does the extent of involvement of different stakeholders have on the outcomes of practice development?</td>
</tr>
<tr>
<td>3.1.2 What impact does the scale of a study have on the outcomes of practice development?</td>
</tr>
<tr>
<td>3.1.3 How do contextual factors in the study setting have an impact on the outcomes of practice development?</td>
</tr>
<tr>
<td>3.1.4 How do cultural factors in the study setting have an impact on the outcomes of practice development?</td>
</tr>
<tr>
<td>3.1.5 How do styles of leadership in the study setting have an impact on the outcomes of practice development?</td>
</tr>
</tbody>
</table>

#### 3.1.1 What impact does the extent of involvement of different stakeholders have on the outcomes of practice development?

The evidence of stakeholder approaches being important in PD is dominant in the literature. However, the literature is not directing any particular kind of stakeholder approach and it could be suggested that instead of any dominant approach being evident, reports of PD tend to adopt a ‘carrier bag approach’ to stakeholder involvement.

Dewing & Traynor (2005a) describe the benefits of an initial unidisciplinary approach to PD but which broadened out to include other stakeholders. Initial assumptions were made by
managers about the willingness of staff (nurses) to engage with the proposed/agreed project processes and it was through the engagement of a wider group of stakeholders that these processes became more real. Page et al (1998) challenge the logic of unidisciplinary approaches to development on the basis that the patient experiences care from a whole team, and it is the whole team’s processes, beliefs and values that have an impact on that experience. Users’ experience was a central part of this. Also bringing together the agendas of service staff and management had an impact on the overall commitment to the PD work as a whole. Page et al reported a feeling of ownership among all grades and disciplines of the unit. Galvin et al (1999) similarly reported on the wide involvement of service users and health professionals – it was part of the broader policy agenda within which the project took place. Service users were consulted about the service they wanted and staff were widely consulted about the kind of service they wanted to provide. However, tension was caused by the impact of this intention within the context of a short study (one year). In contrast Bell & Procter (1998) and Holman & Jackson (2001) reported difficulties with achieving ownership due to the lack of involvement of all staff and ineffective strategies for multidisciplinary involvement. Bell & Procter (1998) highlight the difference between full multidisciplinary engagement and peripheral engagement. In their study, ‘peripheral’ staff took part in data collection – but didn’t really see it as their work.

The effective engagement of senior staff emerges as an important factor in the success (or otherwise of PD. Binnie & Titchen (1999) highlight the importance of engaging productively and creatively with senior staff in order to create a climate where development work can flourish. They describe this as creating the ‘freedom to experiment’, characterised by an, easing of bureaucracy, allowing things to happen (like time for staff to work on projects and spend time discussing work), being creative with funding, decentralisation of decision making, trusting and supporting rather than monitoring and instructing. Binnie & Titchen suggest that ‘the contribution of this management context to the overall success of our project should not be underestimated. In the absence of a hostile management culture, the staff nurses were free to reserve their courage for addressing openly the complex and sometimes distressing problems of their patients’.

However, despite the best intentions of involvement, Ward & McCormack (2000) highlight the problems that arise when managers are not fully supportive of the work being undertaken. Despite the significant problems with the care delivered identified by patients and relatives and audit results suggesting poor standards of care, managers did not really see these as problems, so much as ‘one-off’ concerns. The project ceased before implementation was completed.
because of a number of factors, including questions about the value of the programme in the existing NHS climate of improving efficiency; the two year timescale of the programme when there was a drive for immediate answers to problems and a lack of flexibility by managers in freeing staff up from ‘traditional job roles’ in order to implement a rigorous implementation process.

Binnie & Titchen’s (1999) approach is a good illustration of what Page et al (1998) suggest as the need for empowerment of staff through consultation and engagement in order for meaningful involvement to be achieved. Both Ohlsen et al. (2005) and Reed (2005) highlight the need for genuine engagement and that the systems and processes established for PD need to reflect genuine involvement rather than superficial consultation. This point is reinforced by Bridges et al (2001) in their account of the need to involve multidisciplinary stakeholders in the development of a new ‘care coordinator’ role in accident and emergency. This involvement enabled issues of role overlap and role effectiveness to be addressed in an open and honest way.

Having an explicit intention to involve all stakeholders from the outset appears to be an important factor emerging from the evidence in terms of the success (or not) of ‘involvement strategies’ in PD (Bates 2000). The Warrington Health Visiting Practice Development Unit (Warrington Health Visiting PDU Submission Document (2004) is a good example of the involvement of multiple stakeholders from the outset of their PD work and is credited with being fundamental to their success. The PDU worked in partnership with Borough Councils, Neighbourhood Centres, Fire and Rescue Services, supermarkets, retailers, schools, general practitioners, voluntary services and day centres.

Manley’s work in an intensive care unit of the Chelsea and Westminster Hospital, London, probably provides the best available evidence of the importance of stakeholder involvement (Manley, 2000a and 2000b). The programme of work explicitly used an emancipatory action research design and thus had the involvement of a broad range of stakeholders as a central purpose (as this is a key criterion in emancipatory action research). Participation and involvement was central to all of the processes and activities engaged in. Care was taken not just to ask, but to check back with people about what they had said. The success of the strategies used is evident in the outcomes achieved in terms of a sustained commitment to quality, the achievement of a charter mark and patient feedback on their experience of care in the unit. The explicit participatory approach helped individuals to become more confident to do new things and to recognise that there was a career pathway for them - a future for nurses to stay and progress in practice, using their expertise. Key stakeholders had become aware of the quality of the service the unit provided through specific communication strategies, but this had
been further validated by the observations of others, such as medical staff, who worked directly with the unit's staff. The trust gained kudos from being associated with, and supportive of, the unit and post. The perceived success of the post had made it easier to argue for the establishment of other such posts within the trust. The post and the unit were seen to have a positive impact on the trust and its culture, with the consultancy component of the post noted as contributing widely to the trust. This was demonstrated in relation to a number of initiatives, such as the trust's clinical supervision strategy and its implementation. 'Value added ness' was articulated as reflecting lower sickness, turnover and incident rates compared with other areas, the absence of complaints, effective handling of MRSA outbreaks and better retention, stability and recruitment of staff.

Manley’s work highlights the requirement to involve multiple stakeholders and seek their agreement at all stages of the work, including the overall project methodology. Bellman et al (2003) highlight the importance of this as they outline the tensions that were caused among the different stakeholders because of not being comfortable with the methodology (action research) and feeling threatened by it. The skills of the researcher in maintaining open communication with senior managers and enabling all stakeholders to be involved allowed the development of less hierarchical and more empowering relationships between the co-researchers, managers and the health care team, proving confidence for them to lead on work. However, reduction in corporate management support followed the resignation of the director of nursing.

Dickinson et al (2005) provide an in-depth analysis of a practice development programme designed to improve the nutritional needs and mealtime experience of older patients in a hospital unit. All levels of staff and the Multidisciplinary Team (MDT) within the unit were involved along with catering and portering staff, the chaplain, relatives and patients. External funding and university support was also evident with various members of the MDT, university and outside agencies (Age Concern) making up the steering group. The diverse areas of expertise and commitment involved played a large part in supporting the development of practice and building a team approach. The relocation of the unit mid project, to a different hospital, both helped and hindered, but in general the overall project had an impact on the wider Trust.

The relationship between research and practice development is one that features throughout the literature and when considering ‘involvement strategies’, the need to consider the role that practice developers and researchers play is important. Clarke & Procter (1999) for example speak of the potential for marginalisation of practice developers/researchers from worlds of
practice and research. The consternation experienced by the research participants about the legitimacy of practice development activity within professional practice was reflected in a number of ways in their study results. These include the personal investment in the development of practice (e.g. emotional and resource commitment to a development was felt to exceed the normal limits of commitment to practice), self presentation (e.g. the wearing of a uniform was seen to legitimise presence in clinical areas), and expectations of colleagues and of services (e.g. those active in developing practice challenged conventional models of patient care delivery as their own conceptualisations of health and health care changed). Clarke & Procter suggest that this is an impact of practice development carried out by the few. In a similar vein, Clarke & Wilcockson (2001) suggest a division between those whose focus is local and those who broaden their focus to think about the degree to which the patient is the focus of services, therefore meaning that work with a range of stakeholders is necessary. Users’ views were seen as a vital component of development.

Recognising and valuing the patient’s experience arises as an important theme in the literature. Clarke & Wilcockson (2001) highlight one impact this had was in a shift in the dynamics between practitioners and patients. However, changes in the way that practitioners viewed the needs of service users resulted not only in different services, but also in changes to the relationship between the practitioner and the patient. Kenyon et al (2003) demonstrated how the involvement of stakeholders in their study impacted on the outcomes. Stakeholders involved included children and their families (service-users). Nursing staff on the participating ward were faced with the challenge of developing documentation that would enable partnership in care to become a reality. Kenyon et al report that the changes to documentation that were instigated were a key factor in the outcome of the project. The changes challenged nursing care delivery and shifted the balance of power away from the children’s nurse to the children/families and carers (P3).

Other studies support the need for the involvement of a wide range of stakeholders (Delord, 2003; Carr & Davidson 2004) and the involvement of different stakeholders is also evident in project reports in the grey literature (Manley & Hardy 2005; Titchen & Cox 2004; Masterson & Dewing 2005). The emphasis on stakeholder involvement appears to support what McCormack & Garbett (2003) have described as “keeping plates spinning” and this message is reinforced in strategic documents such as NIPEC (2005 and 2006). McCormack & Garbett (2003) suggest the need to develop a complex social network within an organisation; speaking the language of different stakeholders and establishing credibility with different groups. Reports of the involvement of differing stakeholders include, care workers (Clarke & Procter 1999), medical
staff (Molyneux & Fulton 2003), user groups (Eve 2004) and cross team collaboration (Clinton & Getachew 2003) are evident in the literature.

### Summary of evidence showing the impact of the involvement of different stakeholders on the outcomes of practice development

Overall, the literature is diverse in its views about stakeholder involvement in PD. It is clear that the involvement of all key stakeholders is important but which stakeholders and what processes of involvement appear to be less clear. Many of the studies that espouse the importance of the involvement of stakeholders do not appear to be adopting a systematic approach to this part of the project design. The assumption that stakeholder involvement is a key success factor is evident but with little evidence of models of involvement being engaged with to inform approaches adopted. Studies that do report on stakeholder involvement do little to systematically demonstrate the relationship between involvement and outcomes achieved.

### 3.1.2 What impact does the scale of a study have on the outcomes of practice development?

The scale of practice development projects and the impact of scale on outcomes achieved is given little consideration in the published literature but in the grey literature there is greater evidence of considering the scale of the work planned and the potential impact of scale on the adopted development approaches. However, two distinct scales of activity are reported – projects that involve multiple clinical areas and those that are focused on single units.

In terms of projects that involve multiple clinical areas Ward et al. (1998) suggest that the scale of the study provided challenges. The study involved facilitating 13 distinct clinical areas using a supervisory structure with shared learning at two junctures in the study. This contributed to communication difficulties between the internal facilitators and the external facilitators. Similarly Galvin et al (1999) report that the scale of the study was ambitious and this caused tension for the clinicians involved and lead to role confusion for the internal facilitators who felt pulled between practitioners (their colleagues) and the project. Dewing & Traynor (2005b) undertook a large scale project across a whole service. There do not appear to be any observations or findings that explicitly address the impact of the scale of the study. However, it could be suggested that the initiation of the study at an organisational level contributed to some of the tensions that emerged at a clinical level during the study. In the development of a rehabilitation strategy for a rehabilitation service, Dewing and Brooks (2004) identify that the
scale of the project (across a number of clinical settings) enabled sustained and significant changes to be made in practice including impacting on the organisation’s business and clinical governance plans.

Studies that focus on a unit level include Bell & Procter (1998), Bates (2000), Manley (2000c) and Clinton & Getachew (2003). The volume of work planned appears to be an important issue compared with the size of the study site. See for example Bell & Procter (1998) whose study suggested that the volume of work was large for a small clinical area and that the whole team became less engaged with it as time wore on, especially those aspects concerned with formal data gathering. In contrast the advantage of unit level work relates to the depth of work that is possible (Bates 2000) and the potential for well established and evaluated development processes to be transferred to other units (Manley 2000a&b). In Manley’s work the unit provided a resource for the whole trust and the consultant nurse influenced strategic direction based on the work being carried out in the unit. This is also evident in the work of Dickinson et al (2005). By keeping it small all staff had support provided as needed with internal facilitators being able to work and role model alongside staff. The lessons learned from the small scale approach enabled significant learning to be translated throughout the organisation. Similarly, Burnett & Mort (2001 & 2003) suggest that the clinical findings from their study established a base for developing a general understanding of the unmet health needs of farming communities. The methodologies used helped build an atmosphere of trust and improved access to healthcare for farmers. The authors argue that these methods are applicable generally.

The nursing development unit (NDU) and currently the practice development unit (PDU) movement appears to provide an important basis for establishing PD principles in single units. Reports of PDU work submitted through the PDU Accreditation Scheme of The Centre for the Development of Healthcare Policy and Practice at Leeds University highlight the significant effort made by staff of PDUs to engage with a variety of PD processes at a unit level (see PDU accreditation submission documents from for example: Christie Hospital NHS Trust Chemotherapy Day Services PDU; Nottingham Residential Rehabilitation PDU; East Dean Ward, East Sussex Hospitals NHS Trust; Bebington & West Wirral PCT Community Nursing Service PDU; Oakdene PDU Warrington; Warrington Health Visiting PDU). The submission documents for PDU status by each of these units highlight the use of a wide variety of PD systems and processes and systematic accounts of their use is provided in their supporting evidence. However, little detail is provided about ways in which the work of these PDUs is transferable across organisations. Given that so little emphasis is placed on the importance of ‘scale’ in the published literature and the grey literature appears to replicate standardised
approaches to dissemination (conferences, presentations and publications) perhaps PD is adopting the same approach as research in its approach to the translation of findings, i.e. an over-reliance on the published word.

The work of Page et al (1998) provides valuable lessons in terms of the importance of considering scale of work and the long term aspirations for transferable findings. The study demonstrates changes made to the culture and context of practice in the PDU and ways in which the PDU became a central source of expertise for other nurses within the wider organisation, taking the lead in providing advise and direction to the organisation’s overall research and development agenda. However, the small scale nature of the work of the PDU affected the long-term sustainability of the developments within the larger organisation. The merger of the unit with a larger provider with a different culture resulted in staff confusion and anxiety at all levels in the unit and the shared vision of the unit was impossible to maintain. This study highlights the problem of small scale developments within larger organisations that do not share the same values – something that needs to be given careful consideration when considering issues of sustainability of PD work.

3.1.3 How do contextual factors in the study setting have an impact on the outcomes of practice development?

Context is increasingly recognised as an important factor when considering changing practice, getting research into practice or translating evidence for practice (McCormack et al 2002; Greenhalgh et al 2004). In a previous concept analysis of PD McCormack & Garbett (2003) highlighted the need to systematically analyse context in order to identify the need for change and utilise the most appropriate developmental processes. The PD literature raises a number of contextual considerations including organisational structures, the expertise of practice
developers and contextual barriers to effective change. The impact of context is evident in both the published and the grey literature and indeed the latter provides a richer source of information for ‘getting inside’ the context of practice settings and its impact on PD.

Clarke & Procter (1999) report on the ways in which a rigid organisational structure caused frustration - We seem stuck constantly, we can move from one philosophy to another philosophy but once we establish a philosophy it’s all encompassing and we can’t actually offer flexibility or choice within a philosophy, we just don’t seem to have the facility to do that. Using organisational philosophy as a rigid control is one example of the internal politics that gets played out in development work. Clarke & Wilcockson (2002) suggest that the internal politics within a setting can cause tensions between developmental and organisational imperatives. There is, of course, a tension between development that serves to perpetuate an organisation and development that serves primarily to better the health status of a patient group or population. In their study Clarke & Wilcockson (2002) suggest that participants were well aware of this, but also felt that some of the systems of health care contracting and organisational divisions and boundaries served to negate attempts to develop care of service users at times.

Having a strong context is considered to be important for effective quality patient care (West 2001; McCormack et al 2002; Wilson et al 2005; Rycroft-Malone et al 2002). However, whilst the research utilisation literature has identified characteristics of a strong context there is little evidence of this being accounted for in PD literature. Whether, a strong context needs to exist in order to enable effective PD or whether PD in itself creates the characteristics of a strong culture is still open to debate. Bates (2000) reports on a study where the context seems to have been initially quite strong – with established interprofessional relationships and a commitment to improvement. Part of the context of this study was the use of an accreditation process to frame development. This process was not subjected to any critical analysis, the criteria for using it being on the basis that it ‘doesn’t cost’. The framework has some of the elements (but not all) common to other models of PD, e.g. being systematic, inclusive, communicative but does not incorporate more transformative aspects:

In contrast, the work of Manley (2000a&b) focused on developing a strong context through the establishment of clear role boundaries based on negotiation and shared understanding, democratising decision making in the unit, clarifying roles and accountability. Becoming more effective as a clinical area meant that the unit was in a stronger position to bid for additional resources. By the end of the development period, change was actively embraced and sought.
The outcomes from this work are clear and have been reported extensively (Manley 2000a, b and c). Manley's work highlights the importance of skilled facilitation or 'expert' practice development.

Clarke & Wilcockson (2001) contrast 'novice' and 'expert' practice developers in terms of perceiving the impact of a range of factors. In their study they contrasted novice practice developers (constrained by the limits of existing practice and the location of their thinking within existing structures and barriers such as perceived lack of resources) with those practitioners who seemed to demonstrate 'expert' thinking. Their thinking was holistic and they could see possibilities in situations that were less than ideal. There were several ways in which the 'expert' thinker appeared to address the resource issue: challenging the attitude of practitioners who could only perceive limited resources as a deficit; assessing the resources that were already available and how they were being used; and harnessing less obvious resources to improve practice. Clarke & Wilcockson (2001) surfaced an issue about the extent to which practitioners/practice developers who have been on a journey to becoming emancipated embrace the responsibility they have to make choices about how they use their time. This is contrasted with what they call a competent level of perception where there is a 'defeatist attitude' in the face of limited resources (Clarke et al., 2003). This competent level of thinking is also evident in the work of Clinton & Getachew (2003) and Delord (2003) where contextual factors were largely referred to in terms of obstacles to implementation e.g. shortage of times to meet due to shift patterns, changes in workload and teams, staff turnover etc. Similarly the work of Page et al (1998) appeared to adopt a reactive approach to contextual factors that impacted negatively on the transferability of the PDU work and there is little detail provided of systematically addressing these contextual issues.

Where practice developers align themselves in the organisation appears to be significant in terms of the ability of the setting to overcome contextual barriers. In a previous study, McCormack & Garbett (2003) suggested that there were polarized views regarding the alignment of practice developers with management structures (could present a conflict of interest but alternatively it may help to reinforce the view that practice development is integral to the business of healthcare) with the importance of understanding the practice context in order to achieve credibility. They also suggested that a lack of infrastructure and strategic planning to support PD can diminish the potential impact of PD activity.

The published literature is particularly weak in teasing out the benefits or otherwise of decisions made about where to align PD work and practice developers. Campbell et al (2004)
and Eve (2004b) report positive impacts on practice through involving all stakeholders at a practice level. Outcomes such as increased awareness of the need for continuous development of practice, clarity of purpose, expansion of services and greater mobility of patients between practice settings are reported.

Redfern & Christian (2003) report on a large inter-organisational programme of development work but with a focus on development processes at a practice level. From their work, six key factors for successful change emerged from interviews with project leaders, including, the targeting of staff who are familiar with and understand what is expected of them; ensure staff have received the right training; target staff who are motivated to participate in the change; ensure that the necessary resources are in place; establish support from influential healthcare and university stakeholders; and ensure that plans for sustainability of the change are in place. Some of these characteristics are evident in the reports of PD work by Dewing & Traynor (2005) and Carr & Davidson (2004). Preparing the setting for the PD work and dealing with ambiguity were considered essential factors in these studies. Carr & Davidson (2004) suggest that ambiguity can have both a positive and a negative effect. On the positive side, it provides an opportunity for diversity: allowing freedom for innovation. However, in times of almost continual change and role challenge, the enthusiasm and energy to embrace this opportunity may be limited. The negative aspects of the ambiguity are compounded by the fact that the focus of development activities is often not on specific practical or technical skills but on the development of a practice mindset. Not having clarity of the focus of this ‘mindset’ can lead to confusion, discontentment and erosion of confidence. The making of considerable efforts to ensure that practitioners and managers have the same understanding of the project focus and ensuring that all stakeholders have access to data to comment on (including how it is presented) are key processes to be considered.

The grey literature would support many of the context issues arising in the published literature. Because the majority of grey literature sources are project reports or PD strategies, they are open to a greater depth of analysis regarding contextual issues in PD. Working across several clinical settings (e.g. Dewing 2006; Boomer & McCormack 2006); preventing the loss of skills acquired in training programmes (e.g. Bowers & McCann 2003; Bebington & West Wirral PCT Community Nursing Service PDU); maintaining shared governance in practice (e.g. Masterson & Dewing 2005); developing a culture receptive to innovation (e.g. Titchen & Cox 2004); the project location at different care intersections (e.g. Burnett & Mort 2001 & 2003) and working with limited resources (e.g. East Dean Ward PDU).
3.1.4 How do cultural factors in the study setting have an impact on the outcomes of practice development?

There is some degree of agreement in the culture literature about the elements of an effective workplace culture (Manley 2000a) including clarity of values and beliefs, high regard for individuals, commitment to learning in practice and effective organisational processes that enable the previous characteristics to be realised. In the PD literature these characteristics are evident to a greater or lesser extent. The Warrington Health Visiting PDU (Warrington Health Visiting PDU submission document (2004) draws on the work of Woodward (1997) to help raise understanding of the importance of cultural factors in PD and highlight that culture in this context is more than considering race, religion and ethnicity, but instead is about signifying practices as individuals and communities and is about shared meanings we develop about ourselves and our worlds.

Galvin et al. (1999) questioned the extent to which boundaries between professions were a barrier. The need for greater clarification of skills and roles and focusing on meeting patients needs was identified. Similarly, Bates (2000) identified the need for an explicit set of values and beliefs to enhance cohesion of the project focus among participants. Attention appeared to be more focused on tasks than processes of working together or of interaction. Valuing individuals’ input was apparent through a commitment to promoting involvement and communication. The outcomes from the work largely focus on things being done differently, but whether people had a shift of ‘mindset’ is unclear.

Summary of evidence showing the impact of contextual factors on the outcomes of practice development

The PD literature raises a number of contextual considerations including organisational structures, the expertise of practice developers and contextual barriers to effective change. The impact of context is evident in both the published and the grey literature and indeed the latter provides a richer source of information for ‘getting inside’ the context of practice settings and its impact on PD. Where practice developers align themselves in the organisation appears to be significant in terms of the ability of the setting to overcome contextual barriers. The published literature is particularly weak in teasing out the benefits or otherwise of decisions made about where to align PD work and practice developers.
In contrast Manley (2000b) set out to achieve congruency between espoused beliefs and values and actual practice. The central tenet of the study was that the workplace needs to be understood and developed as a precursor for other work. Early developmental work within the unit focused on making values and beliefs explicit, and using them to develop a shared vision and to guide subsequent action. The espoused values and beliefs can be identified from early publications (Jenkins 1991, Manley 1990, Warfield and Manley 1990). The processes of critique and reflection central to emancipatory action research focused on identifying contradictions between espoused theory and theory in use. They were intended to help individuals and groups live and act out the values and beliefs they articulated. This meant that value-based principles could be used to guide action in unfamiliar situations. The findings strongly suggest that the culture in action was the same as the espoused culture, and that specific configurations of values, such as being people-centred, providing support, enabling development, active participation and devolved decision-making, were evident. Marked differences perceived by returners on their return provide further evidence of the effects of this strong culture. These related to the paradox of being familiar with the culture but unfamiliar with the staff, which were different, and the distinctive amount of change and development.

The marked differences noted by returners were:

- The increased amount of teaching and education.
- The amount of further education and development undertaken by everyone.
- Much greater involvement of everyone in developmental work.
- Involvement of all staff, particularly the more junior staff.
- Initiatives previously talked about when informants left were now up and running.

Marked differences were also noted in team working and individual working. The unit was perceived as being a healthy team where conflict was constructively addressed, compared with experiences of working elsewhere. The culture was also perceived as having a positive influence on the recruitment and retention of staff. Many staff had been exposed to the unit previously, either as agency nurses or through knowing agency or ENB course students who had worked there. Some had read unit publications and were attracted to the values and beliefs espoused about nursing.

Whilst Clarke & Wilcockson (2001) do not have the extensive evidence provided by Manley (2000 a, b and c) they too highlighted the importance of PD that focuses on addressing aspects of workplace culture. They contrasted those locked into a perception that resources restricted their work with those that problematised the relationship between the resources available and the way those resources were used - some did not have a sense of being able to effect this and
saw themselves as passive. By contrast those with a vision of what practice could achieve and problematised the relationship between that vision and day to day experience were more proactive. A participant in their study (Medical Director) described the difference in the following way – “(People shift) from being descriptive and procedural and operant in the way they think, to thinking in a more open way”. This statement reinforces the idea of a favourable culture in identifying the importance of being open and co-operative as an underpinning factor in successful shared inquiry. This focus on developing an ‘open’ culture where there is a shared commitment to the development of practice is evident in much of the grey literature. This may be in part due to the origins of the majority of the grey literature, i.e. from a funded PD scheme and from a PDU accreditation system. Each of these schemes have ‘collaboration’ as a key criterion and thus the majority of studies do endeavour to develop collaborative and open systems for bringing about changes in the culture of practice. Other examples of the grey literature focus on changing established dominant cultures (e.g. Burnett & Mort 2001 & 2003; Dickinson et al 2005; Dewing 2003; Boomer & McCormack 2006). Having an effective learning culture is increasingly seen as an important factor in development work as a key criterion of sustainable change (Denton 1998; Eraut et al 1998; Maurer et al 2003). Some PD studies do focus on the development of a learning culture and are conscious of the importance of this to sustainability.

Wilson et al (2005) describe a systematic analysis of the processes and outcomes of generating an effective learning culture in a practice setting through processes of reflective learning and high challenge/high support. The outcomes arising were summarised as the ‘regeneration of self in learning’ characterised by a proactive approach to reflective engagement in practice as opposed to a passive resistance to new knowledge. Similarly, Clinton & Getachew (2003) point out the emphasis being placed on the notion of learning culture in the NHS, the notion being drawn from the work of Senge (1990). Engaging in work around a particular area of practice raised awareness of cultural factors that encouraged responsiveness such as community meeting and partnership forums with users. Delord (2003) outlines the obstacles and lessons learnt in creating an effective learning culture e.g. need to involve as many people as possible at the outset of the change, ensure regular meetings take place etc.
3.1.5 How do styles of leadership in the study setting have an impact on the outcomes of practice development?

In their concept analysis of practice development, McCormack & Garbett (2003) suggested that the skills and qualities needed for leading practice development bear a close resemblance to those associated with transformational leadership. The qualities of a practice development leader include, vision, motivation, empathy and an experiential approach. Walsh et al (2002) identified in their work that when project groups were led by someone from the ward with authority in terms of the ward structure, that this seemed to fare best in terms of initiating and keeping projects moving. They highlighted the importance of active leadership in the change processes used. Molyneux & Fulton (2003) reported similar findings but the lack of a shared vision about the ultimate aim of the processes used limited the outcomes achieved. Clarity of purpose is something that is reinforced by Dewing & Traynor (2005) and Reed (2005). They suggest that clarity about roles, issues to be addressed, and the direction of travel and access needs to be in place. This reinforces the importance of a leader enabling a shared vision to be achieved in PD work, something that is evidenced in the work of Manley (2000 a, b and c), Binnie & Titchen (1999), Page et al (1998), Boomer et al (2006), NIPEC (2005), Dewing and Brooks (2004). The lack of such a shared vision is seen to have a significant impact on the success of PD outcomes, as evidenced by Freshwater et al (2003) who identified the lack of clear leadership as a barrier – lack of leadership was reflected throughout the project in the context of education, practice and barriers to implementation. Bowers & McCann (2003) reinforce the need for inspirational clinical leadership which encourages and empowers others. They suggest that nurse consultants as ‘clinical champions’ are ideally placed to provide inspirational clinical leadership.
However, effective leadership in PD does not just relate to the leadership skills of the person/people leading the PD work. Corporate and strategic leadership is also important in creating a culture where PD work can flourish and be sustained. Campbell et al. (2004) suggest that the active and willing involvement of business managers is key to the success of PD initiatives – the whole thing being inclusive and enabling. This is reinforced in the work of Barrett (2006) who paints a clear picture of the challenges associated with securing corporate management support for PD work. The lack of support of managers and continuous changing of strategic leaders led to the PD programme and those engaged in it being undermined and frustrated. Whilst outcomes in terms of practice changes were achieved, the personal costs to those engaged in the processes were substantial. Learning the lessons of effective and ineffective leadership in PD needs to be given greater emphasis in the PD literature. For example Galvin et al. (1999) highlighted the lessons learned regarding the need to keep participants and stakeholders ‘in the loop’ and of ensuring greater clarity around roles, expectations and responsibilities. Similarly, whilst Bates (2000) identified positive leadership strategies being used in the PD work being undertaken, ways in which these strategies could be embellished/capitalised upon did not seem to be looked at. Clearly such learning is important as Ward & McCormack (2000) identified that success in one strand of work (that was supported by managers and leaders) does not mean success in subsequent strands of work despite a perceived effective leadership structure being in place.

Summary of evidence showing the impact of leadership factors on the outcomes of practice development

Whilst the majority of the PD literature does make some reference to leadership, it is very unclear from the literature at what level this leadership should be provided, i.e. clinical or strategic, internal or external etc. There does appear to be a consistent view that having inspirational and transformational leadership is an essential ingredient of successful PD work and the leader working to develop a shared vision with participants and stakeholders in PD activity is a key component of that leadership.
3.2 What does the evidence tell us about theory area 2 - Properties of the people involved in developing practice?

The sub-questions being addressed here are:

| 3.2.1 | How does the location of a practice developer have an impact on the outcomes of practice development? |
| 3.2.2 | How do the means by which the practice developer gains access to the practice environment have an impact on the outcomes of practice development? |
| 3.2.3 | How do the methodological positions taken by practice developers have an impact on the outcomes of practice development? |

3.2.1 How does the location of a practice developer have an impact on the outcomes of practice development?

Practice developer roles are conceptualised in a number of ways in the literature, with a variety of insider/outsider roles considered. The distinctions and relationships between different PD roles and relationships with practice settings are considered to have an impact on the conduct of practice development work and the outcomes achieved. Whilst the literature could at one level be contrasted between those roles that are ‘inside’ the PD setting/organisation and those that are ‘outside’ the PD setting/organisation, in reality this is a simplistic distinction that is rarely played out in a pure form in practice. The grey literature in particular highlights a complex matrix of facilitative relationships. Whilst the unpublished PD reports all place a clear emphasis on ‘clinical leaders’ acting as the PD leaders/facilitators, these leadership roles operate within clearly defined support systems, including steering groups representative of key stakeholders, external facilitators from universities and key staff from grant awarding organisations. Whilst it is difficult to extrapolate the impact of this leadership matrix, it does appear to impact on the ability of local teams to engage in effective PD and in contrast with the published literature, there is little evidence of practice developers working in isolation or accounts of facilitators ‘feeling isolated’.

A number of studies report on the relationship between internal facilitators and external facilitators and the successes and challenges of these relationships. Few studies make explicit the impact of particular role functions on the outcomes of the project work. For example, Walsh et al. (2002) reports on a PD project led by a senior lecturer (within or out-with the
hospital setting?), supported by the staff development department of the hospital. No discussion of how this impacted on outcomes is provided. Redfern & Christian (2003) describe a collaborative model where each clinical project was based in a NHS Trust and a university centre operating in partnership. A project leader for each project was appointed to implement research evidence on a clinical topic into a setting. Both Ohlsen et al. (2005) and Walsgrove & Fulbrook (2005) report on partnership models of facilitation between healthcare settings and universities. A commitment to negotiation and achieving familiarity with the politics of the participating organisation appear to have contributed to the success of the projects.

Ward et al. (1998) reported on challenges of the physical distance between the external facilitators and the practice development areas – the internal facilitators all said that they would have welcomed more input from the external facilitators. Bell & Procter (1998) however, suggest that the role of the (external) researcher in collaborative projects raises difficulties. They suggest that the role should be one of catalyst, facilitator of people to develop their own analysis of issues, assistor in the implementation, and ultimately a resource person. Bell & Procter (1998) report that the research project manager found this role difficult as an outsider, particularly as the team wanted a more ‘hands-on’ approach. Whilst it appears that participants in PD work appear to commonly request more integration of external facilitator roles in the participating settings/teams, in reality this is difficult to achieve as reported by Clarke & Wilcockson (2001) and Holman & Jackson (2001). One of the issues that appears to be at play here is the issue of ‘ownership’ of PD work, something that was significant in the work of Bell & Procter (1998) and who commented that ownership was a difficult feature to foster and perpetuate. Similarly, Reed (2005) reported that in her study, the researchers seemed not to be able to cross the boundaries between them and practitioners. A similar tension arose for Dewing & Traynor (2005). Both were external to organisation and a degree of resistance emerged from the researchers remit. This is apparent in the admission that the methodology was agreed with the commissioners not those expected to participate. The conflicts that emerged later on in the study provided an opportunity for participants to question and challenge the approaches used by the researchers.

However, being an internal facilitator comes with its own challenges. Clarke & Procter (1999) raise the conflicts and dilemmas that can arise for facilitators - for example what to wear and how people perceive you in different parts of your role. Practice developers' emotional investment can have personal impact e.g. working longer hours (when working internally) – suggesting that the work is additional rather than integral. Whatever the level of involvement, some form of engagement and investment is necessary. The ‘emotional labour’ of PD is
something that Barrett (2006) identifies as a critical factor in the success of PD work and is something that is given very little attention in the PD literature. Barrett’s work provides a detailed analysis of the impact of developing practice on the ‘self’ of a variety of stakeholders who were committed to the changes being made.

Galvin et al. (1999) reinforce the importance of the internal facilitator but do not emphasise why, particularly as the role did not appear to be entirely successful and did not meet the expectations of the project team. Wilson et al. (2005) report on a successful internal facilitation role, where the lead researcher was able to move between being an insider and an outsider depending on the demand of the project. Prior to this study, the lead researcher (Wilson – a paediatric nurse) had little contact with staff in the SCN; thus, she could act as an outsider during data collection, maintaining some distance from staff whilst ensuring a high level of content knowledge when it came to asking questions about the data and developing dialogues with staff. McCormack and Garbett (2002) suggest that ‘credibility’ of practice developers is a key factor in the success or otherwise of practice development projects. She also had both ‘practice’ and ‘facilitation’ credibility among staff and this enabled engagement with them, whilst simultaneously knowing the boundaries of such interactions in research practice.

The relationship between external practice developers and PD settings appears to be largely one of a ‘facilitative’ and educational/learning role, with little evidence in the literature of external roles being directly involved in bringing about the actual changes in practice. Ward & McCormack (2000) report on a model where four projects, each with a named project leader from within the hospital were identified. Project leaders were supported by an external programme facilitator, acting in a supervisory role and stimulating learning of project leaders e.g. through action learning sets. Clarke & Wilcockson (2001) similarly articulate an educational model through the creation of links between individual and organisational learning; double loop learning affected by the size of the organisation and the number of layers within the organisation and the extent to which changes may have repercussions in other areas i.e. pervasiveness of an individual development is linked to the mode of organisational learning. Delord (2003) refers to a PD network post holder who made regular visits to project sites to offer support and training, although doesn’t state whether this person was employed within or outside of the trust. Tolson et al (in press) describe a ‘virtual community of practice developers’ structured on a model of ‘communities of practice’, supported through facilitated reflection using web resources. Evaluation of the approach from nurse participants suggested that “membership of the community of practice strengthened commitment to the process of
reflection as collectively the group could see possibilities and solutions to most problems, whereas individually the operational burden of changing something might overwhelm (p21)

Garbett & McCormack (2001) raise other issues to do with the location of practice developers, that of the focus of their work according to their location. In McCormack & Garbett’s study, two areas of activity for PD staff were perceived by respondents:

- Working with practitioners – providing advice and support, working with individuals, supervision, providing access to resources.
- Working for the organisation – providing access to training, addressing issues arising from the policy agenda

In community trusts, PD staff tended to be more centrally located in the organisation and were more likely to be involved in professional development activities, whilst in acute trusts, PD posts were more often in clinical directorates and focused on working with individuals and groups. In a further study McCormack & Garbett (2003b) identified the need for facilitative roles at a variety of organisational levels. PD roles are often ‘in the middle’ i.e. in between clinical and managerial structures and that this position of PD roles can help balance both ‘top down’ and ‘bottom up’ agendas, both for external and internal PD roles. White (2005) provides an eloquent account of the role of a service manager who also operated as a ‘Practice Development Unit (PDU)’ Leader in an acute stroke and rehabilitation service spread across three distinct ward areas. White describes the challenges associated with the integration of a management and facilitative role and in particular challenges to leadership, balancing power agendas, maintaining motivation and engaging in effective challenge of poor practice. White (2005) identifies the need for a model of shared leadership to be in place when undertaking complex developments in practice. Page et al (1998) and the Warrington Health Visiting PDU (2004) both attribute democratic and shared facilitation processes by internal facilitators who were also service leaders as one of the reasons why the PDUs were successful.

The challenge of integrating facilitation with a management role is reinforced by Carr (2005) who describe two approaches to the implementation of an end of life integrated care pathway. The work focused on introducing the care pathway in two settings in order to explore the transference of knowledge held by specialist palliative care teams to primary health care team members. Whilst both sites had a high degree of success in implementing the integrated care pathway, significant differences existed between the two sites in terms of how they utilised ‘time’ to achieve the change. Site A bought in specialist time to lead the facilitation of the practice development activity whilst Site B bought out the time of existing generalist staff to
participate in the development work. Each model had its strengths and weaknesses but the paper raises important issues about ‘time’ to undertake practice development, something that is consistently seen as a barrier to participatory models (see for example McCormack & Garbett 2003b). The authors challenged the dominant perceived wisdom of buying in the time of specialists facilitators and suggest that more attention should be given to the buying out of generalist time. They also raise the important assertion that buying time resources should not be seen as a panacea to overcoming barriers to effective PD. Other factors need to be in place such as clear leadership, steering of the development, adequate education about the changes being made and accessible support to nurture practitioners through the change process.

3.2.2 How do the means by which the practice developer gains access to the practice environment have an impact on the outcomes of practice development?

In research and development work, gaining access is a key consideration for success. The literature on PD does not address this specifically in terms of the way the design of projects is reported. However, most reports of PD do raise issues of access particularly when there is an external facilitation relationship in place. The key issues that appear to emerge in this data though are firstly the importance of negotiation and secondly the need for role clarity.

In terms of negotiation, Ward & McCormack (2000) report on the challenges of developing a programme for clinical leaders as practice development associates – the facilitators were
volunteers and were meant to fill criteria related to educational background and experience of PD. Not all of the volunteers met these criteria and thus challenged the efficacy of the supervision model for the practice development associates. Similarly, Binnie and Titchen (1999) report the difficulty of getting colleagues involved – it was always ‘their project’ and strenuous efforts and time were needed for team members to become more actively involved. Walsh et al. (2002) report on the use of a 5 phase process (derived from the work of Ward et al. 1998) for engaging with volunteers in their PD work: orientation; preparation for change; process of change and its evaluation; comparative analysis; refining change and setting new goals. Once groups were set up, education sessions were provided for them on the topics of practice development, practice change and reflective practice. The groups used reflective processes to identify areas for practice change and then went back to their wards to discuss practice change strategies with other staff. Drawing on findings from the same project, Campbell et al. (2004) suggest that credibility of and trust in those facilitators involved in developing the partnership with patients seems to have been important. McCormack & Garbett (2003b) note the importance of working clinically/understanding the practice context that was apparent in the literature and in the interviews conducted in their study of practice developers. Wilson et al. (2005) operated a lengthy period of negotiation with the selected site after the study site volunteered for inclusion into the study when a request for participation was circulated within the health care organization. Information sessions were held to outline what participation involved and to answer any questions.

The majority of the grey literature reviewed for this study was associated with small project grants from the Foundation of Nursing Studies and from the PDU accreditation scheme through Leeds University. These sources gave the literature a particular emphasis in terms of the relationship between internal and external stakeholders. Because of the nature of the funding and accreditation relationships, there was acceptance of external project scrutiny. The PDU accreditation project reports were led by staff internal to the participating organization whilst working within a framework provided by the accrediting organization. In relation to the Foundation of Nursing Studies funded project reports, these represented a mix of internal organization led projects and partnership projects with higher education institutions (e.g. Dickinson et al. 2005; Spiby et al. 2005). Having access to the project sites is not problematised in any of these reports.

The second issue that appears to be important for facilitators of PD is that of ‘role clarity’. Clarke & Procter (1999) report on the challenges of undertaking PD work within a research framework. There were conflicts for some practice developers where the motivation and
benefits for development work were confirmed. The tensions between doing research for personal benefit and for the benefit of clients and the service were considered a challenge. Similarly Galvin et al (1999) reported on the persistent theme of confusion and ambiguity about the role of the researchers in their study. The role of the researcher in PD research and managing responsibilities whilst in the clinical setting are raised. Galvin reflects - *it would have helped me to have a clear structure to my working week so that colleagues understood my role and which hat I was wearing*’. Holman & Jackson (2001) report on a collaborative model in place between the project facilitator and participants. However, the nature of collaboration in terms of roles, responsibilities and ideology is not really explored. There seems to have been difficulty in getting broader participation from other disciplines, ‘There was little involvement in the groups (except from the chaplains) from non-nursing staff and little ‘cross over’ between mental health and general staff. …. Two of this group said they did not attend the group because it was a nurses’ group and not relevant to them’. Froggatt & Hoult (2002) suggest that the external facilitators may only be able to employ a reactive role in PD work. Reporting on their study of Clinical Nurse Specialists working with the nursing and residential care home sector, they suggest that the ability to work in these care settings was seen to be affected by three factors:

- staffing (lack of continuity of staff)
- resources (limited financial support for training and lack of equipment)
- management (lack of commitment by management to support practice development)

**Summary of evidence showing the impact of the means by which practice developers gain access on the outcomes of practice development**

Most reports of PD do raise issues of access particularly when there is an external facilitation relationship in place. The key issues that appear to emerge in this data though are firstly the importance of negotiation and secondly the need for role clarity. It would appear from the literature that the key issue is not that of the role adopted (be it an internal or external role) but more to do with the way that roles are negotiated and clarified consistent with the overall purpose of the developments being undertaken.

**3.2.3 How do the methodological positions taken by practice developers have an impact on the outcomes of practice development?**

The methodologies adopted for practice development are diverse and wide ranging. There is little consensus about the most effective methodology and further, there is little evidence of learning
being transferred from one study to another in terms of methodological effectiveness. A number of methodological approaches appear to be reported most often – ‘participatory models’; action research oriented models; and pedagogical models. These are not mutually exclusive approaches and indeed there are major overlaps between them, however, when there are methodological considerations reported in the literature, they can be seen to fall within these broad methodological perspectives. Fitzgerald & Armitage (2005) set out the overlaps between developments set within the critical paradigm, participatory world-views and action research. They argue that methods adopted in PD such as facilitation, team-building, practice projects and ethical comportment provide a basis for integrating different perspectives and operationalising research and development processes that are set within participatory methodologies. Thus Fitzgerald & Armitage (2005) appear to be arguing for methodological eclecticism in PD.

The work of Binnie and Titchen (1999) was explicitly informed by an action research framework that put the two main protagonists as co-researchers. Action research cycles were developed and systematically implemented and evaluated. The challenges of working in this way are clearly accounted for and different roles and relationships in the project are articulated. The systematic and rigorous approach resulted in the implementation of an explicit patient-centred model of practice that was sustained over time. Similarly, Galvin et al (1999) describe the explicit use of Hart and Bond’s (1995) approach to action research on the basis that it emphasises collaboration, user focus and consultation and empowerment through reflective approaches to working. The authors report that it was very difficult to set clear objectives at the start of the project as the nature of the research required a continuous re-negotiation of roles, group boundaries and relationships throughout. The research practitioner’s role as an ‘insider’ was identified by the practice staff as a clinical nursing role, not as a research role. There were also confusions about the role of the researcher who was also a lecturer in primary health care with teaching commitments.

Manley (2000a&b), Bellman et al (2003) and Burnett & Mort (2001 & 2003) provide further examples of the explicit articulation of a systematic action research approach to PD. Manley’s work achieved tangible outcomes at individual, team and organisational levels (see earlier section 3.1.1 for details of outcomes achieved) and Bellman et al (2003) whilst experiencing greater challenges in bringing about changes in practice report significant changes in the culture of the participating unit. Burnett & Mort (2001 & 2003) used an action research approach to develop a nurse practitioner-led mobile outreach scheme with the intention of improving the health of farmers. The project focused on health promotion and accident prevention. The findings demonstrated the value of such an outreach service in complementing the work of general
practitioners.

Bridges et al (2001) utilised an explicit action research approach in the development of a care coordinator role in an accident and emergency service. The study focused on developing practices and services through better care coordination and improving interprofessional team working. The action researcher (an external university employee) operated as an internal facilitator to the project. The cycles of action and evaluation enabled a move from a managerially dominated steering group to interprofessional workshops where data were shared and innovations planned. Such active participation facilitated the working through of issues and barriers that impacted on the new role developed.

Ward & McCormack (2000) combined approaches of action research, humanistic learning theory and principles of evaluation. The focus was on developing project leaders, whose key learning objectives were self-direction, self-development and self-awareness. The external programme facilitator’s role was to act as a facilitator of the humanistic approach to adult learning. Six requirements for action research articulated by Nolan and Grant (1993) were used to monitor progress via action learning sets:

- shared and explicit set of values acting as a guide for practice
- recognition that a problem area exists
- common understanding of the problem
- perceived need for change
- situation seen as amenable to change
- focus on involvement and team building

Evaluation focused on two key themes - improvements in patient care; and the move towards a learning culture that supported principles of adult learning. Some progress towards achieving outcomes is documented, although the PD programme ceased before implementation was complete.

Clarke et al. (2003) describe an emancipatory approach to practice development that emphasised collaboration. This practice development initiative used a ‘collaborative’ approach whereby the researchers investigated a specific intervention in the clinical setting. Practitioners were central to the research process and were involved throughout the planning, delivery and dissemination of the study. The approach underpinned a journey of discovery for practitioners that underpinned a shift in relationships between staff and between staff, residents and carers. Such relationships formed the basis for the caring context on the unit, resulting in an increased awareness amongst
practitioners of the positive aspects of working with older people, which simultaneously enabled family members to feel more satisfied about the care their relative received. Similarly, Clinton & Getachew (2003) adopted an overt use of action research and appreciative inquiry on the basis that these approaches encourage ownership.

In considering the place of action research in PD, Reed (2005) suggests that because there is an emphasis on participation and articulation of craft knowledge, it is compatible with professional ideals. However, Reed also suggests that issues of project management and funding may conspire against making knowledge generation a more democratic process as achieving shared ownership is not straightforward. Reed suggests that the notion of participation needs to be problematised and thought through carefully. Processes are an important part of the product of action oriented research. This argument can be read as a plea for transparency, less concern about results and more about processes, and one which is especially relevant in studies where researcher and practitioner roles become blurred.

Clarke & Procter (1999) challenge the way that PD knowledge is valued and suggest that in their study the participants talked about their experience of marginalisation as practice developers – that the knowledge they generate is valuable but is largely ignored and under valued by rational empirical approaches to knowledge generation and use. PD is seen as a working with rather than an approach to working on – approaches are based on collaboration, but locally relevant knowledge is not always seen as generalisable – transferability is more conceptual than instrumental. This is similar to the argument made by Fitzgerald & Armitage (2005).

The challenge of developing new knowledge from PD work is gaining increasing significance as stakeholders demand demonstrable outcomes from PD work (Manley & McCormack, 2004). Thus, whilst PD can and does operate outside of the boundaries of research, it is increasingly obvious that there is a need for a close alignment of the two in order to produce learning from projects that can be replicated, refined and further developed through ongoing studies other contexts. Whilst not aligning to an action research methodology, many studies do embrace principles of participation whilst utilising a wide range of methodological principles. For example Wilson et al. (2005) adopted an emancipatory approach to PD set within a realistic evaluation framework (after Pawson & Tilley 1997). Principles of participation and collaboration were developed with project participants and these were used to guide decision-making by the lead facilitator (Wilson). Significant outcomes are reported in terms of changes in clinical practice, the establishment of a learning culture and the creation of a workplace culture that
supported and enabled family-centred care.

Taylor et al. (2002) report on a three year project that was influenced by ideas of collaborative inquiry (Torbert 1981a, 1981b, 1981c). Staff involved in the project focused on issues of mutual concern around which they would devise shared action plans. They then sought to enact these as a co-operative and collaborative venture. However, towards the end of the project period, it had become apparent that the practical problems being experienced within the wards were rendering this collaborative style of working ineffectual. Because of this, those involved agreed to restructure the way work was pursued within the project. It was also agreed that a more formal evaluation of the project’s effectiveness should be pursued. Dewing & Traynor (2005) in reflecting on similar challenges in their PD work, suggested the need for benchmarks against which to reflect on difficult issues that emerge and the need for reflexivity in relation to learning about the degree of facilitation expertise needed to facilitate such work. The implications are that there is need for support strategies that continue after the formal end of a study.

Tolson et al (in press) report on the first five years of a participatory research project the purpose of which was to collaborate with practitioners and older people to develop approaches to promote attainment of evidence-based nursing across Scotland. Whilst the study utilised an overt action research methodology, the design was influenced by realistic evaluation, participatory social learning theory and ideas around ‘communities of practice’. Outputs included the construction of an internet based practice development college and a procedural model to develop and demonstrate care guidance drawn from a diversity of evidence and reflective of an agreed set of participatory principles. A preliminary model of PD was proposed and set out for further testing and refinement. The virtual community created by the overarching approach and resulting model has the potential to provide a model for sustaining practice developments long term.

An emancipatory practice development approach is considered to be the most effective form of PD for bringing about lasting changes in practice and the cultures within which practice happens (see for example Manley & McCormack 2003; Manley & McCormack 2004; Binnie & Titchen 1999; Wilson et al 2006).

Pemberton and Reid (2005) adopted an emancipatory approach based on the ‘Practice Development Diamond’ developed by Binnie and Titchen (1999) in order to systematically bring about changes to the culture of practice in an acute hospital ward.
The work focused on developing ward leadership, the organisation of patient care and the valuing of core nursing skills. The approach used to bringing about change included:

- valuing essential care and being with patients
- strategies for learning from practice
- sharing stories of patients perspectives and how nursing makes a difference
- clinical supervision (supporting staff)
- challenging poor practice
- working with challenging patients (role modelling)
- action planning

Significant improvements were seen in the way patients privacy and dignity issues were addressed; an early warning score for determining acutely ill patients was implemented resulting in increased nursing confidence in assessing acute illness; greater length of time spent with patients associated with an increased knowledge of patients by staff and a reported transformation in the environment of care. The action plans highlighted ways in which the changes implemented were being progressed long term and new issues being identified for further improvement. The
authors conclude that “new initiatives require a substantial amount of preparation and energy but they also require subsequent vigilance and maintenance (p36)”.

Similar approaches to bringing about change through the principles of emancipatory practice development are reported by Caldwell (2004), Golden & Tee (2004), Stokes (2004), Down (2004) and Sanders (2004). These authors all utilised approaches to developing practice that drew on the principles of emancipatory PD (i.e. becoming aware of taken for granted assumptions about practice; enabling groups to identify the influence they have over their own practice [and the limits to this], including the need to change practice; and the facilitation of collective responsibility for bringing about changes to practice). Outcomes evident from the approaches adopted include:

- The modernisation of child health services in line with National Service Framework recommendations (Caldwell (2004)
- Collaborative working between residential mental health service users and carers to improve the culture of care (Golden & Tee (2004)
- The implementation of ‘Essence of Care’ benchmarks (DoH 2001) through an organisation-wide emancipatory practice development strategy (Stokes 2004)
- Creation of a multidisciplinary organisational culture of practice development including impacts on, guidelines development, increased user involvement and the integration of an organisation-wide PD evaluation strategy into the business of the Health Trust (Down (2004)
- Implementing a family health assessment process (Sanders (2004)

These collective studies raise challenges about the evaluation of PD and Gerrish & Mawson (2005) recommend the use of pluralistic methods in order to account for the variety of subjective and objective perspectives that are encompassed in the development of practice. However, whilst this argument is well made, the evidence from the grey literature highlights a ‘hotchpotch’ of methods and approaches being adopted. Whilst there is an intent of emancipation in many of the project reports, this is largely implicit and thus the evaluation methods utilised are often poorly thought through and instigated. Exceptions to this are the work of Dickinson et al (2005), Masterson & Dewing (2005), Dewing et al (2006), Dewing and Brooks (2004), Dewing (2003), Boomer & McCormack (2006), Dewar (2003) and Manley & Hardy (2005). These studies set out an emancipatory PD intent and utilised development approaches and evaluation mechanisms that were integrated and consistent with the stated intent. The integrated developmental and evaluative methodologies largely drew on reflective processes, active learning processes and approaches to gaining consensus (e.g. values clarification, stakeholder evaluation).
Keady et al (2005) argue for the integration of constructivist models of research into emancipatory approaches to PD. In their study, Keady et al (2005) utilised biographical life-story work with people with dementia in order to develop a greater understanding of the ‘diagnosis experience’ of service users of a memory clinic. The study led to the development and implementation of a new assessment process and diagnostic sharing practices in the participating memory clinic. The study utilised a three phase approach – practice reflection, practice modification and practice transformation and these phases were underpinned by time and personal influence factors. Whilst the methodology of the study largely adopts the principles of critical social science and emancipatory PD, the integrated constructivist methodology enabled the systematic collection of a variety of data sources and the identification of outcomes.

A similar case is made by Wilson & McCormack (2006) in their justification for the integration of a critical realism model of evaluation in their emancipatory PD study. The use of realistic evaluation (after Pawson & Tilley) enabled the evaluation of particular PD interventions on practice outcomes. For example, the impact of a high challenge/high support mechanism on the development of a learning culture in practice was systematically evaluated and the outcomes on practice outcomes determined. Previously, Tolson (1999) articulated the case for realistic evaluation in practice development as a means of ‘untangling’ the methodological maze of evaluation of PD.

Adopting strategies that are derived from learning theories is also evident in the PD literature. These pedagogical approaches lean towards using learning strategies as a means of problematising PD activities and developing strategies for effective engagement with participants and key stakeholders. Whilst these approaches are evident, they are not always explicit as a methodological framework in the PD literature. For example, Bates (2000) refers to the adoption of normative/educative approaches to getting involvement from people. There was a commitment to involving people to develop ownership and to the systematic examination of practice. However there were no indications of any theories of learning or change beyond this being used. In contrast Walsh et al. (2002) deliberately used reflective processes to move insight and knowledge from the private to the public domain, to move thinking from the technical to the critical and to be the first step in bringing about practice change e.g. use of poetry and story telling to move the reflective process away from technical issues and to move clinicians out of their ‘health professional’ roles. Reflective processes were seen to be successful in that they helped all the wards to identify an area for practice change and four of the five wards had started to collect baseline data prior to implementation of changes. Redfern & Christian (2003) report on a 2-week training programme followed by 3-monthly seminars aimed at bringing project leaders to a similar level of competence in managing change. The content of the programme included
reviewing the literature on evidence-based practice, managing change, auditing practice, developing evidence-based guidelines, research methods, data analysis, ethical issues and research presentation skills. The project leaders implemented changes to practice in their local centres using clinical guidelines, a staff training programme and support in the practice setting.

Whilst these three methodological approaches are most evident in the literature, a number of other studies do draw upon methodological principles that are derived from a number of perspectives. For example, Clarke & Wilcockson (2001) suggest that their starting point of their work was to focus on the robustness of the evidence base, the effectiveness of the processes of practice change and the pervasiveness of development on the learning of practitioners and organisations. The findings from their study suggest that three processes are fundamental to the development of practice:

- using and creating knowledge
- understanding and practice of patient care
- effecting development

These three processes are underpinned by eight key elements: cognitive skill development; vision; reconceptualising patient care; concept of professional practice; working with boundaries; movement of information; working with and creating context; knowing the process of change. These key elements are consistent with other approaches to PD cited in the literature including, psychodynamic consultation (Holman & Jackson, 2001) and theories of change (Carr & Davidson, 2004).

**Summary of evidence showing the impact of adopted methodological positions on the outcomes of practice development**

The methodologies adopted for practice development are diverse and wide ranging. There is little consensus about the most effective methodology and further, there is little evidence of learning being transferred from one study to another in terms of methodological effectiveness. A number of methodological approaches appear to be reported most often – ‘participatory models’; action research oriented models; and pedagogical models. These are not mutually exclusive approaches and indeed there are major overlaps between them, however, when there are methodological considerations reported in the literature, they can be seen to fall within these broad methodological perspectives.
3.3 What does the evidence tell us about theory area 3: Issues surrounding the initiation and carrying out of practice development?

<table>
<thead>
<tr>
<th>Sub question</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.1 How do factors involved in the initiation of practice development have an impact on its outcomes?</td>
</tr>
<tr>
<td>3.3.2 What are the foci of practice development activity and how do they have an impact on its outcomes?</td>
</tr>
</tbody>
</table>

3.3.1 How do factors involved in the initiation of practice development have an impact on its outcomes?

The initiation of practice developments appears to come from a number of sources. These sources can largely be grouped into three drivers – educational and credentialing drivers; policy drivers; and practice drivers.

In terms of educational drivers, the study reported on by Ward et al. (1998) was initiated by a higher education principle with the intention of developing a cohort of change agents to roll out a long term programme of practice development. A National organisation was approached and a year long programme was developed. The initiation of this programme was set against a background of increasing importance of evidence based approaches to practice. The work of Ward & McCormack (2000) was set against a similar background. Whilst it is not clear how the four PD projects that were the central focus of the work were selected in the clinical areas themselves – the overarching focus of the programme was the creation of a cohort of change agents to roll out evidence based approaches to practice change.

Another form of educational driver reported in the literature is that of accreditation and credentialing. The grey literature is strong in this area with a number of higher education institutions offering accreditation schemes (e.g. Leeds University [http://healthcare.leeds.ac.uk/pages/knowtran/2_about/about.htm](http://healthcare.leeds.ac.uk/pages/knowtran/2_about/about.htm)), Bournemouth University [http://www.bournemouth.ac.uk/ihcs/practicedevelopment.html](http://www.bournemouth.ac.uk/ihcs/practicedevelopment.html) and the ‘continuing interprofessional development framework’ offered by the School of Health, Community & Education Studies at University of Northumbria...
Bates (2000) suggests that the driver for their work was involvement with an accreditation process. There is a sense of the cart being put before the horse to some extent. However, despite this, the strategy would appear to have been effective as a means of generating direction and commitment. However, the issues approached were framed by the requirements of the process (e.g. having a resource room) rather than by any sense of a shared set of values and beliefs amongst participants. Eve (2004a) also used a credentialing schema as a framework to focus the PD work. However, it could be argued that the development measures used did not rely on the credentialing framework and thus there was a mismatch between the focus of the work and the framework in which it was set. Froggatt & Hoult (2002) suggest that their work was largely a reactive response to specific client needs or educational needs on behalf of the staff. Whilst this reactive stance underpinned the initiation of the programme of work, policy drivers were used to reinforce its importance, such as the then White Paper, Primary Care: Delivering the Future (Department of Health 1996) which highlighted three areas for action: better team-working, developing professional roles, and developing partnerships.

These studies are some of the few reports in the literature that are driven by an educational agenda but with the intent of impacting directly on practice. This makes studies different from reports of ‘professional development’ where the development of practice is an indirect consequence rather than a specific intent.

Policy agendas are a key driver for PD work and a range of studies explicitly focus on initiating the implementation of contemporary policy agendas. The work of Galvin et al. (1999) was driven by addressing policy agendas that impact on care. Clarke & Wilcockson (2002) report that national policies were a major influence on the development of practice but these received a mixed response. In one of the case study sites, the policy of reducing junior doctor’s hours was embraced to develop the role of the emergency nurse practitioner. However, policy guidelines were not always accepted at face value and there was some frustration at the primacy of organisations. Having to comply with external policies was viewed as problematic because they limited the responsiveness of a service. However, there were examples of how respondents manipulated policies and guidelines to support the developments for their own patient population. The authors conclude that consistent with the findings of previous studies, the primary driver for developing practice was an awareness of lack of fit between the services provided and the needs of the service users.
This perspective is supported by Clarke & Copeland (2003) who suggest that the demand for development and improvement of healthcare services is driven by a number of factors which include changing healthcare needs, continuing technological advances, concern to provide effective and appropriate treatment, rising consumer expectations and, health policy directives based on these factors. They suggest that healthcare organisations must find ways to ensure their staff have the skills, knowledge and resources required to bring about the desired development and improvement. … Making a commitment to supporting lifelong learning are ways in which organisations and individual practitioners within organisations, can develop the capacity and capability to engage in sustained development of services. Subsequent studies by Clarke et al (2003), Carr & Clarke (2003), Dewing & Wright (2003), Eve (2004a) and Harrison et al (2005) are all consistent with reinforcing this message and report on policy drivers such as delivery of the NHS Plan (DoH 2000), growing user dissatisfaction and increasing expectations, clinical leadership, evidence-based practice, implementation of National Service Frameworks, addressing standards published by Departments of Health, expansion of nursing roles and supporting the development of a new public health roles as key examples of ways in which PD strategies were used to translate and implement policy into practice.

It is perhaps a false distinction to make between policy translation and implementation and practice initiated developments as many practice initiatives are set within a policy backdrop (see for example, Manley & Hardy 2005; Masterson & Dewing (2005). However, it is clear that many practice development initiatives are driven by a variety of dissatisfactions with aspects of practice arising within different parts of organisations.

Clarke & Wilcockson (2001) the problems of non-expert (competent) practitioners being seen to accept existing patterns of service provision. Thinking was located in existing structures and systems of care delivery resulting in the presentation of defeatist attitudes e.g. allow them to be restricted by absence of resources. By contrast, experts demonstrate holistic thinking and can see possibilities in situations that are less than ideal i.e. perceive context of PD as a source of possibilities rather than deficits. Experts challenge existing systems and focus on need to orientate services to meeting needs of patients; see beyond current care and have a vision of what PD could achieve. It was this intention of creating such experts that drove aspects of Clarke & Wilcockson’s work. Similarly, Clinton & Getachew (2003) identified inconsistency in the way that risky incidents were dealt with, with some units having fewer incidents than others. However, there was no analysis or understanding of how near misses were managed to
avoid escalation – the study set out to understand the mechanisms used to prevent incidents to achieve greater consistency in practice.

Further examples of the identification of a need to address inconsistencies in practice include Molyneux & Fulton (2003) who report on the realisation that practice was lacking around discharge of people with haematological disorders – a dissonance between what was desirable and what was experienced – initiated by medical consultants. Campbell et al. (2004) report on a desire to make patient involvement in the development and implementation of care pathways more effective. The work of Dickinson et al (2005) arose from an issue raised by a staff member undertaking a degree course. Similarly, Bruce et al (2006), Palfreyman et al (2002), Dewar (2003), Dewar et al (2003) and Spiby et al (2005) all report on studies that were derived from practitioner initiated practice problems. The initiation of an application for PDU accreditation also appears to largely come from practitioners/clinical leaders who view accreditation as an important vehicle for legitimizing existing development activities and changes to the culture and context of practice (see PDU accreditation submission documents from for example: Christie Hospital NHS Trust Chemotherapy Day Services PDU; Nottingham Residential Rehabilitation PDU; East Dean Ward, East Sussex Hospitals NHS Trust; Bebington & West Wirral PCT Community Nursing Service PDU; Oakdene PDU Warrington).

Other practice initiated examples come from the work of Taylor et al. (2002) whose work was part of an ongoing practice development programme, intended to make the existing collaborative but short term approaches to change more formal and long term. Similarly, McCormack & Garbett (2003) report on work with individuals and teams to identify ways in which existing resources could be used to help clinicians tackle issues for themselves e.g. acting as a gatekeeper to educational resources. Whilst policy documents were used to frame many of these initiatives, the authors suggest that this strategy may have both positive (opportunity to bring professional staff together) and negative (seen as being imposed) consequences. Walsh et al. (2002) established practice change groups and used deliberate reflective processes with these groups to bring about changes in clinical practice whilst Bellman (2003) utilised an initial idea by a clinical leader who wanted to help her staff to ‘update’ and get involved in shared learning and practice development as a means on initiating a large scale action research project.

As Dewing & Traynor (2005) suggest, many of the PD agendas appear to be external to some extent e.g. professionalisation, political and regulation initiatives, while addressing some
internal issues around clarity and perceptions of role and purpose. Therefore the important issue here appears to be not the actual focus of initiation but management of the response to strategic issues that seem to have some relevance to practitioners. This point is taken up by Barrett et al (2005a and b) who report on the challenges of managing the ‘emotional labour’ associated with PD work and health care. In their paper they challenge cultures of practice that allow even expert nurses to be ‘unreceptive’ to patients’ stories in order to protect themselves from burnout. The combined impact of organisationally driven agendas and the need to be responsive to patient need caused ‘cynicism’ among staff and contributed to them cutting off from the real needs of patients.

### Summary of evidence showing how the initiation of practice developments impacts on its outcomes

Practice developments are initiated from three broad sources - educational and credentialing drivers; policy drivers; and practice drivers. These are not mutually exclusive categories as it is evident in the literature that whilst there are few accounts of developments arising from ‘practitioners’, many practice developments may in fact do so but they are shrouded in (for example) a policy agenda in order to legitimise them. Educational and credentialing drivers differ from professional development agendas as they start with the specific intention of impacting on practice.

<table>
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<tr>
<th>Activity</th>
<th>Impact on Outcomes</th>
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<tr>
<td>Promoting and facilitating change</td>
<td>Improving practice</td>
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<tr>
<td>Translation and communication</td>
<td>Enhancing patient</td>
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<tr>
<td>Responding to external influences</td>
<td>Understanding needs</td>
</tr>
<tr>
<td>Education</td>
<td>Fostering learning</td>
</tr>
<tr>
<td>Research into practice</td>
<td>Advancing knowledge</td>
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<tr>
<td>Audit and quality</td>
<td>Ensuring standards</td>
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### 3.3.2 What are the foci of practice development activity and how do they have an impact on its outcomes?

In a previous concept analysis of practice development McCormack & Garbett (2003) identified six main categories of activity from the literature: promoting and facilitating change; translation and communication; responding to external influences; education; research into practice; audit and quality. This analysis was partially informed by a telephone interview survey of practice developers and practitioners (Garbett & McCormack, 2001), the findings of which suggested that there was a difference in the understanding of the foci of PD between the practitioners that were interviewed and the views of practice developers. Practitioners tended to focus on their own professional development needs (skills such as library searching or access to formal education) rather than on activities that empowered them to take control over their own practice and change it if necessary. Data collected from practice developers suggested two main areas of work: promoting and facilitating change (at individual, team or wider organisational group level) and communication (being seen and being known).
In this current study, the literature suggests similarities in focus to the previous study (for example Mallett et al 1999; Grady & Travers 2003; Booth et al 2005) but with more emphasis on formal practitioner research activities and on individual role and team developments. For example, Bridges et al (2001) demonstrate how changes initiated in response to emerging findings through action research cycles enabled increased clarity about the new role (care coordinator) and ways of working towards increased interprofessional working. In an evaluation study of a similar role in a different healthcare organisation, Meyer and Reeves (1998) demonstrated the impact of the role in reducing unnecessary delays in hospital stay for patients.

Bell & Procter (1998) report on the work of a nursing development unit (NDU) where there were both developmental activities going on and ‘formal research projects’. The formal research became the main focus of the work over time and this created a split between clinicians and researchers. The overall aim of the NDU work was to both conduct patient care research implementation projects and develop knowledge and skills for research based practice amongst the team. The first aim was met inasmuch as 3 care projects were completed, lead by particularly motivated staff. However the engagement of other staff members was less active and although there was qualitative evidence (e.g. interview data) suggesting an interest in development activities, the so called peripheral staff were vague about their role or their ability to influence practice.

Bellman et al (2003) provide a detailed account of using action research to help practitioners become more empowered to look at the gap between how they wanted their work to be and how they experienced it. This focus proved useful as changes in the organisation lead to the end of the project work however, practitioners expressed a shift in their own sense of worth, confidence and ability to engage in practice developments.

Wilson et al. (2005) report on the use of multiple methods within an emancipatory practice development framework that integrated realistic evaluation (Wilson & McCormack, 2006) to deliver an understanding of the culture of a specialist paediatric unit. This was seen as a fundamental step in the evaluation of practice development activities over time. The outcome was a shared understanding of unit culture that has helped participants to focus their work, provide a baseline evaluation, systematically change the culture of the practice setting and put in place key strategies for sustaining the changes over time. The formal research approach was considered to be a significant driver in maintaining the focus of the work and in developing sustainable strategies for ongoing cultural change.
A number of studies have as their focus, the translation of existing knowledge into practice. This focus is broad, including a typical focus on ‘evidence-based-practice’ but also including an emphasis on external influences that are derived from theory development (such as the development of person-centred practice).

Ward et al. (1998), Campbell et al. (2004); Harrison et al. (2005); Tolson et al (in press); Bowers & McCann (2003); Palfreyman et al (2002); Bruce et al (2006); Lavender (2003) and Spiby et al (2005) have a dominant focus in their work of implementing clinical changes based on existing evidence. However, these studies highlight a unique focus of PD, that of being also concerned with supporting local facilitators of evidence into practice in developing practice development facilitation skills (McCormack et al 2002b; Clarke & Wilcockson 2001; Manley 2000a; Binnie & Titchen 1999; Tolson et al 2005 and Dewar 2003). Clarke & Wilcockson (2001) involved 29 practice developers who were involved in a range of practice developments. They were involved in projects that focused on using and creating knowledge, understanding and practice of patient care, and effecting development. The interview study invited participants to think about the key relationships of factors and people in performing PD. The findings suggest that practice developers can be characterised in terms of their expertise. ‘Beginners’ are more likely to address concrete changes without thinking about the learning involved for themselves or others. While experts use ‘double loop learning’ and demonstrate an ability to help others to reconceptualize their work rather than change existing approaches. Similarly, Clarke & Wilcockson (2002) involved 41 staff across three sites involved in PD. The study focused on the mechanisms used for knowledge use and knowledge generation. They conclude that practice development is concerned with the development of local knowledge that is seen as more relevant to practitioners with an accompanying responsiveness to policy and propositional knowledge as mediated by the experience of practitioners in their context. This sentiment is reinforced by the work of Tolson and colleagues who created a virtual community of practice developers to support both the generation of new knowledge and the testing of inductively derived propositional knowledge through synchronistic discussion using internet based media.

Manley (2000 a and b) and Binnie & Titchen (1999) developed key strategies for sustaining changes in practice that were both informed by existing knowledge and generated local propositional knowledge. Strategies that were used to affect such sustainability were developing shared values, clinical supervision, critical companionship, role-modelling desired ways of working by leaders, reflective practice, devolution of authority, role clarification and
shared governance. Similarly, McCormack *et al* (2002b) worked with systematic strategies of ‘enlightenment’ in order to develop a sustainable basis for ongoing changes in practice in an acute care setting for older people. The key focus of the work was on developing the skills of clinical leaders to implement a variety of evidence informed practice changes. Whilst Holman & Jackson (2001) had similar intentions, with the aim of providing multidisciplinary education in the clinical environment and to directly influence practice. The approach used was underpinned by a psychodynamic model of group work. The approach assumed the practitioners’ willingness to take part. This was not borne out in practice. Few nurses attended and even fewer staff from other disciplines.

Manley and McCormack (2004) make a distinction between technical practice development (which has a focus on bringing about changes to specific (technical) aspects of practice and emancipatory practice development with a focus on changing the culture of practice to one that is evidence-based and patient-centred. There are few detailed reports of studies that use emancipatory PD as an explicit methodology other than those reported by protagonists of this approach (Manley 2000 a and b, Manley & McCormack 2003, Manley et al 2005, Garbett & McCormack 2001, Ward & McCormack 2000, Wilson, McCormack & Ives 2005, McCormack et al 2002b, Dewing & Traynor 2005). Whilst there are some studies that have emancipation as an intention as reflected in the development methods adopted, these do not explicitly state an emancipatory intention. The work of Dewing & Wright (2003) focused on changing the culture of a unit to one that focused on person-centred care and effective leadership, both systematic and rigorous, and to be sustained over time. The development of senior staff nurses in leadership roles was seen as crucial to making this happen and to ensuring that unit staff had ownership of developing their practice. The impact of this focus was seen to be in terms of the development of a greater sense of worth amongst the clinical leaders and clearer articulation of how they intended to have an impact on practice. Other attempts at changing cultures in mental health settings are reported by Clinton & Getachew (2003) and Jackson *et al* (1999a and b). In these studies reflective learning (using action learning) and psychodynamic approaches to small group work were utilised to continuously improve practice. Whilst Clinton & Getachew (2003) report that the critical learning approaches used resulted in shared learning and the development of guidelines for practice based on craft knowledge as well as propositional evidence, evaluation data by Taylor *et al*. (2002) showed that practice got worse rather than improving. This is attributed to workload pressures that made adherence to action learning model difficult.
A number of PD initiatives focus on developing particular practice roles and/or developing clinical team effectiveness. Galvin et al. (1999) for example focused on using consultation with users and clinicians to develop an agenda for role and team development that would see the development of new roles and services. Specifically this involved redefining nursing roles and developing nurse led services (e.g. clinics). The project was set up to last for one year and this proved too short to fully address all the issues raised. The roles and responsibilities of the facilitators were characterised by unmet expectations which created tensions. However, new services were set up in the setting during the study.

Few studies report on the development of services within a PD umbrella and it could be suggested that the focus of service development (new initiatives that aim to provide a new service to streamline patient care journeys/experiences) is different to that of PD (increased effectiveness in patient-centred care). However, Richardson (2002) describes the initiation and establishment of a surgical recovery unit using principles of PD. The study demonstrates ways in which service development and PD can work in a synergistic relationship, with findings from the experience of establishing the service being used to inform practice developments (e.g. communication effectiveness) when the surgical unit became operational.

Ward & McCormack (2000) appeared to focus largely on the development of project leaders as facilitators and catalysts for change. Data suggest that the four project leaders involved in the project became more self-reliant as the project progressed, became more willing to learn and demonstrated increased knowledge and confidence. Because of tensions between the focus of the project and management perceptions which resulted in the final demise of the project, there is little evidence of the changes initiated being translated into real improvements in practice and patient care.

Carr & Clarke (2003) focused on the negotiation of a public health nurse role into an organisation where there had not previously been one. The impact of addressing this focus using practice development approaches was clarity, shared understandings of the role and its potential contribution to the community and the roles of others. The development of a specific nursing role was also the focus of the work of Dewing & Traynor (2005). The foci were on developing a competency framework for specialist nurses (Admiral Nurses) inductively using reflective learning approaches that were intended to increase participants’ capacity to be critically examining their own practice. The final competency framework reflects the needs of the service, is owned by the majority of practitioners and project commissioners and this has had a positive impact on implementation. There were also
process outcomes associated with combining systematic practice development with emancipatory action research that had an impact on the culture. The main outcomes here were that practitioners engaged in and experienced learning about how to research their own practice and the consequences of doing this. They also learnt about specialist nursing practice more widely than Admiral Nursing. Finally, there was some increase in awareness about the culture within their teams and organizations.

Eve (2000a & b) developed team capacity to work together and a ‘person centred paradigm’, focusing developments on individual patient experience. The impact of this focus is apparent through broad participation in the work from practitioners and service users, a cultural shift in the way the unit works e.g. driven by patient need, increased efficiency of the unit with knock on effect on the broader service because of the replication of the approaches taken.

The focus on the development of joint roles between higher education institutions (HEIs) and health care providers has been transient in the PD literature. In the late 1980s and early 1990s there was much emphasis on the lecturer practitioner (LP) role as a means of bridging the theory practice gap. Wondrak et al (2001) report on recent developments of the LP role in Oxfordshire in line with government intentions to drive up standards of care. Thus systematic developments to the LP role have been undertaken in order to develop a coordinated approach to practice improvement involving educationalists, managers and clinical staff. Strategies have included developing multi-professional team learning within the clinical setting; developing clear policies and procedures for clinical assessment and practice; developing therapeutic intervention skills, preceptorship skills and the skills necessary for implementing clinical supervision. Preliminary findings indicate improvements in LP job satisfaction arising from greater role clarity and reduction of the perceived ‘split’ between the university and healthcare provider.

Summary of evidence showing how the focus of practice development activity impacts on outcome

The evidence concerning the focus of practice development identifies six main categories of activity: promoting and facilitating change; evidence translation and communication; responding to external influences; education; research into practice; audit and quality. How these foci impact on outcomes from practice development work is largely dependent on the clarity of focus among project facilitators, managers and project participants. Having a common vision across these stakeholders is key in order to ensure that there is an agreed focus and targeted outcomes.
3.4 What does the evidence tell us about theory area 4: Approaches used to the use of knowledge, bringing about change and supporting learning in practice development

The sub-questions being addressed here are:

3.4.1 How do approaches taken to support learning within practice development have an impact on outcomes?

3.4.2 How do approaches taken to bringing about change within practice development have an impact on outcomes?

3.4.3 What forms of knowledge use and knowledge generation are used in practice development and what are the consequences for the outcomes?

3.4.1 How do approaches taken to support learning within practice development have an impact on outcomes?

It is recognised in the theoretical and conceptual practice development literature (Garbett & McCormack 2002) that underpinning development activities with learning strategies is crucial for effective sustainability of practice changes and changes in the culture and context of practice. McCormack & Garbett (2003) suggested that learning strategies are essential for enabling practitioners to think creatively and put ideas into practice, as well as providing support, raising awareness and helping create a culture to support change based on perceptions and needs of staff (and service users). Whilst McCormack and Garbett (2003) are critical of the dominant normative-reeducative strategies underpinning most PD work, it is evident that most PD projects include some kind of learning strategy. Clarke & Wilcockson (2002) suggest that practice development is not a time limited phenomenon. Developing practice is rather more like a process of evolution than a time limited project with aims and objectives that were fully known of at the outset. They thus raise challenges to time-limited educational/training strategies being used to influence practice changes. Thus Clarke & Copeland (2003) problematised the impact of professional development on practice. They conclude that it is not always clear that the investment made by the employing organisation brings about tangible benefits to patient care or an aspect of the organisation’s service. Providers themselves may have quite different views about what is required to develop and improve practice in a given area of a health service.
Since the original concept analysis by McCormack & Garbett (2003) there has been a considerable focus on the development of ‘active (reflective) learning strategies’ in PD projects and a much less emphasis on ‘training’.

Wilson et al (2005), O’Connell (2002) and Dewar et al (2003) represent the few studies that systematically evaluate action learning and its impact on practice developments. Findings from these studies suggest that action learning is a successful strategy for bringing about sustainable change through the empowerment of practitioners to take control over their own practice and the context in which it is set. However, action learning is not a ‘quick fix’ to achieving changes in practice. O’Connell (2002) highlights how action learning is a step-wise approach that takes considerable time to develop critical engagement with reflective strategies and Wilson et al (2005) reinforce this point in a detailed analysis of the journey of clinicians through a period of action learning. However, their work illustrates the strength of the approach in developing cultures of learning that enable ongoing developments to occur. The development of these cultural characteristics is evident in the work of Hockley et al (2004) and Dewar (2006 in press). The evaluation of action learning in their practitioner research and development identified a number of beneficial outcomes from the action learning process. It enhanced the quality of the data collected, including greater depth of analysis, supporting the generation of practice based theory and the generation of new evidence to support change and increasing understanding of the applicability of the data to other settings. It made learning much more deliberate and by developing ownership of the learning process enhanced the chances that the learning would be implemented and sustained over time. The skills and confidence of participants as co-researchers and facilitators were enhanced, with potential benefits for all aspects of their practice, including more effective communication strategies and the skills to continue to be researchers of their own practice. Action learning also enhanced the reciprocity of the development and research process as the researchers had an opportunity to collect relevant data about the process of change and could also support facilitated learning amongst the participants. In addition the process of action learning, because of its absolute focus on the person who is presenting the issue, is in itself a powerful structure in shifting the balance of power from the researcher to the real players in the research process – that is those who have to live with the consequences of the change.

Wilson et al. (2005) report on how learning played a central role in the clinical setting and nursing staff were enthusiastic for the additional resources, access to information and educational opportunities that had recently become available. Laschinger et al. (2001) described these elements as the basis for structural empowerment which, together with effective questioning strategies, leads to innovative practice. Despite the evidence of structural empowerment,
nursing staff often appeared reluctant to question one another or members of the multi-
disciplinary team. This is consistent with previous studies, which suggest that nurses have
difficulty in speaking up during ‘rounds’ (Manias & Street 2001). Action learning provided an
essential model for enabling nurses to learn to assert themselves in practice, address issues that
caused oppression and develop strategies for proactive change. Wilson et al (2005) refer to the
success of this strategy as the ‘regeneration of the self in learning’.

In contrast, Taylor et al. also used (2002) used action learning strategies in their study but with
little effect. Action learning was chosen as a method as it is concerned with supporting a process
of continuous learning based upon reflection on action (McGill &: Beatty 1998). The maximum
number of staff participating in the set at any one time was four, although it was commonly less
than this. The action learning set was facilitated by the Trust’s Clinical Nurse Specialist. Within
the project the action learning set met once a week over 36 weeks of the year. This meant each of
the small group facilitators could present a concern and develop an action plan approximately
once a month. The failure of the project clearly raises questions about the effectiveness of action
learning as a developmental method. However, difficulties in pursuing systematic development
of practices in unstable systems have been noted by others (Jackson et al. 1999a & b). Action
learning is likely to be most effective when participants focus on practice concerns that lie
directly within their control. Attempting to use action learning as a vehicle for pursuing change in
wider systems carries high risk of failure and may undermine the individuals involved rather than
support them.

Other PD reports do not focus on action learning as a specific strategy for learning, but instead
describe the use of a variety of approaches to reflective learning that embrace adult learning
models and ‘double-loop learning’. Clarke & Wilcockson (2001) concluded from their study that
the expert (or double loop) thinking of some respondents brings benefits not only to their specific
focus of attention, but also to moving forward the learning of the organization. This added benefit
is beyond the ability of those practitioners whose thinking is locked into perpetuating existing
systems and structures, and challenges the assumed wisdom of evidence-based practice that
promotes conformance to externally derived interventions. Ward & McCormack (2000) adapted
adult learning models, based on humanistic learning theory. The strategy appeared to have a
successful impact in terms of the project leaders who were directly involved in working with the
programme facilitators. The project ceased before the impact on project leaders could be
transferred to other staff within the hospital.

Holman & Jackson (2001) used a variety of group and 1:1 learning strategies in their work and
found that participants found some value in sharing experiences but impact on practice was
limited. Approaches such as one to one working were less effective (no one requested this work despite frequent offers) and overall impact from the learning strategies was limited. Interviewees all said the programme had not changed the way they worked with service users.

Clarke et al (2003) used approaches that helped practitioners to draw directly on their experience of practice. The care workers illustrated their experiences of using the approach with practical examples, thereby helping to allay anxieties such as constraints of time or dealing with painful or upsetting memories. Where appropriate, existing research was highlighted to support such views further. Feedback regarding these sessions was positive; involving support workers in the teaching sessions was seen as preferable to members of the research team providing ‘textbook’ explanations about the use of biography. Similar work was undertaken by Redworth et al (2001) in the education of social services home carers by district nurses. An action research approach was used to evaluate the education strategy implemented. Improvements in the practice of home carers were reported. This self-report improvement was reinforced by an audit of specific aspects of technical care and improvements in all aspects of care were recorded.

Clinton & Getachew (2003) describe an intervention that took the form of critical inquiry based around ‘how’ questions (e.g. how do we know an incident has been missed?) as an overt strategy for ‘awareness raising’. As a group they found that further areas for development were then raised that were ignored previously and made sense of the idea that practice is not a thoughtless set of behaviours but which are underpinned by theory. These approaches had ‘an effect on professional morale and esteem’ leading to the articulation of an array of diversionary interventions that could be tailored to individuals when the antecedents of an adverse incident were observed. Similar strategies were adopted by Walsh et al. (2002) and Partis (2001). Walsh et al (2002) found that these processes enabled clinicians to see the environment in which they work in a different light and envisage how it could be different. This insight led to feelings of empowerment amongst staff and ownership of the change process. Partis (2001) found that the approach encouraged the breakdown of professional barriers and facilitated learning about each other’s professional roles.

Dewing & Wright (2003) concluded from their work that reflecting and learning about leadership enables the conscious application of leadership skills and knowledge in the workplace and, furthermore, recognition of gaps in leadership that need development to become a transformational leader. The reflective framework was developed as a university collaboration academic framework that remained strongly embedded in practice through work-based learning methods. The MSc award was developed after it was realized that many practitioners wished to consolidate their work-based and practice development experiential learning through an academic
pathway. The paper provides a detailed analysis of outcomes arising from the work-based learning framework that was put in place, including, changes to leadership styles, progress towards development of a person-centred culture of practice with older people, changes in specific aspects of practice and the development of a reflective culture in practice.

Eve (2004b) reports on similar developments through learning set within a clinical supervision framework. Participants developed their own learning pathways that contributed to the development of client care supported through appraisal. An accreditation process underpinned the work. An emphasis was placed on helping teams learn together based on models of team learning drawn from health care literature models. Emphasis was placed on the importance of the processes as much as the goal informed by a theoretical model of team learning. The model offered insight into what kind of learning attitudes and behaviours were happening within each of the eight teams, as they applied a practice development framework to their own function. For leaders of teams the model provided a point of reference for where or how the team was learning in the context of individual or cross-team functioning. It assisted understanding of when teams were not developing as quickly as people were wanting and it informed ways of working that could be considered to be a more effective in achieving growth and development. The process was not seen as linear – but as an ebb and flow way of understanding where aspects of team learning were up to. Team learning preceded change, as a form of building block. The favourable conditions of understanding learning, awareness of team dynamics and clarity of purpose began to create the conditions that would generate empowerment across the service. Increasingly individuals were able to develop the skills to work service wide, enhancing team working capacity and support including development of professional autonomy and self-management.

Dewing & Traynor (2005) adopted a reflective strategy to underpin their competency development and implementation study. The study was underpinned by theoretical concepts about the impact of critical reflection that problematise the relationship between practitioners values and beliefs and practice experience. Data collection activities were therefore developed to provide the opportunity for practitioners to learn from their examination of practice. Learning emerged from participation in analysing data but the orchestration of feeding back data so as to manage the discomfort provided a considerable challenge to the researchers. Some of what practitioners saw or heard about their practice appears to have been unexpected, causing them discomfort and requiring effort from the researchers to renegotiate working relationships. This appears to have required effort and time and to have had an effect on timing of the study.
3.4.2 How do approaches taken to bringing about change within practice development have an impact on outcomes?

Findings from empirical studies demonstrate a variety of approaches in use to bringing about change. However, a systematic review of the effect of primary care-based service innovations on quality and patterns of referrals to specialist secondary care services by Faulkner (2003) highlighted the complexity of measuring outcomes from innovations. They suggested that a cautious approach should be adopted to the implementation of innovations considered to improve care at the primary-secondary interface. Problems of the allocation of appropriate resource based on the availability of evidence of effectiveness were evident in studies. In addition, the author highlights the problems associated with defining the ‘end-point’ of an innovation. Whilst this study reported on innovations in service delivery and its impact on practice, the issues raised are equally applicable to practice developments and the challenges associated with defining appropriate interventions for change.

Bell & Procter (1998) report on a developmental model of change, which although theoretically quite nebulous, was operating on the ward to promote the cognitive development of the nursing staff, particularly those that are defined as the ‘core’ group. It was also noticeable that the group of nurses who remained peripheral to the research projects were not peripheral to other aspects of the overall strategy for practice development and that their attitudes to practice and its development had become more positive.
Ward et al. (1998) developed a programme that utilised processes modelled against the variables identified for successful R & D, i.e. systematic review and development of rigorous and supervised practice change. In the operation of this framework, the project performed favourably. Yet in other areas it was less successful; in particular, and in differing degrees, those areas of transferability of findings, corporate ownership, finance and staff support. This finding highlights a point raised by Clarke & Procter (1999) which is that externally driven processes can create conflict for the internal practice developer in challenging established practices. This challenge is further reinforced by Galvin et al. (1999) who found tensions between participants and researchers in terms of perception of the latter’s role e.g. change should come from the practitioners but that can take longer. Collaboration was achieved but considerable effort was required to maintain this throughout the research cycle. The relationship between external and internal facilitation was difficult – expectations of the internal role in particular was not clear and caused conflict for the post holder.

Bates (2000) suggests that change seems to be underpinned by using persuasive methods to get people to participate in small changes to practice. Bates’ (2000) work provides an example of the limited impact of technical approaches. There was no real sense of people changing, rather a tightening up of what people were already doing. The accreditation framework was similarly limited in the directions that it encouraged people to take.

Clarke et al. (2003) are partly guided by the belief that practitioners needed to find their own way of applying an intervention. The suggest that when the purpose is for practitioners to explore for themselves the ways in which a particular approach to practice can be implemented then the context in which this practice is set needs to be given primary consideration. Thus practitioners need to establish implementation mechanisms that are context specific. Strategies for affecting such context specific implementation strategies include critical learning approaches, encompassing inductively derived approaches to managing situations, regular reflective learning, cultural impacts such as a structured activities programme and increasing familiarity with a wide range of interventions (Clinton & Getachew 2003). These strategies are consistent with those suggested by McCormack & Garbett (2003) as being important. They stress the importance of working clinically (modelling practice, building credibility, bargaining), being concerned with process of change as a means to develop individual skills and confidence as much as with achieving an outcome for its own sake and working alongside individuals (counselling) as a source of support and mentoring (and can help to understand clinicians’ perspective on issues that concern them) but it may overlap with clinical leadership roles. However, in their research, McCormack & Garbett (2003) found that there were differing views of PD educational
activities. Research participants who were in PD roles seemed to see these strategies as less central/important than the clinical staff they worked with. Dewing & Traynor (2005) attempted to overcome these challenges by utilising data collection activities as opportunities for practitioners to learn from their examination of practice. Learning emerged from participation in analysing data but the orchestration of feeding back data so as to manage the discomfort provided a considerable challenge to the researchers.

Walsh et al. (2002) argues that reflection itself is insufficient to bring about change. Dewing & Wright (2003) explored the use of inductively derived objectives reinforced through emancipatory principles. The participants who were all clinical leaders and staff nurses, made explicit their understanding of a situation they were trying to change. Thus, the emancipatory model formed a framework in which to facilitate practice development and achieve sustained change.

Facilitation per se is poorly articulated in the PD literature and reference to facilitated activities includes a broad church of roles, systems and processes. Harvey et al (2002) consider the facilitation role to be an appointed role as opposed to that of, for example, an opinion leader who acts as a change agent through his or her own personal reputation. The role may be internal or external (or encompass a combined internal-external approach) to the organization in which the change is being implemented. The role is about helping and enabling rather than telling and persuading. The focus of facilitation can encompass a broad spectrum of purposes, ranging from the provision of help to achieve a specific task to the use of methods that enable individuals and teams to review their attitudes, habits, skills, ways of thinking and working. Given the broad focus of the facilitation concept, a wide range of facilitator roles is possible, with corresponding skills and attributes needed to fulfil the role effectively.

Larsen et al (2005) undertook a review of PD facilitator (PDF) roles spread across a large geographical area of England. Whilst the authors do not specifically articulate the dimensions of activity of the facilitators, they suggest that the role was educationally focused but operationalised within emancipatory principles of facilitating group processes. The PDFs worked with strategic groups as well as supporting clinicians in practice to undertake practice developments. They suggest that the strategic component of the facilitator role has to be carefully handled as clinical staff can perceive the intention of practice development as a negative critique of existing practice and a judgement of the competence of staff members. However, the advantage of such roles was considered to be that of the provision of a balanced approach between working with strategic insight whilst simultaneously being rooted in practice.
Eve (2004b) describes a facilitative approach that was emancipatory in intent and structure, incorporating baseline data, discussion, support, personal action and responsibility supported by continuing feedback. Clarity of purpose was developed across eight teams, using a variety of approaches including, appraisals of team members, individual management supervision, regular forums for sharing practice development and ongoing assessment of team functioning through the use of quality assurance programme applied to mental health care (QUARTZ) team functioning scales. Developing a vision of PD as work rather than additional work was integral to the processes used and the outcomes achieved.

The issue of lasting change and the maintenance of practice improvements beyond the life of the initial project is an issue that concerns all practice developers (Bellman, 2003). With this in mind Harrison et al. (2004) embedded the production of an Integrated Care Pathway (ICP) within a practice development framework. This allowed for explicit signup from practitioners, managers and educators at the beginning, and enabled those involved to work through both anticipated and actual problems as they occurred. The project illustrates the continuous nature of practice development, demonstrated, in part, by the various outputs that resulted from the work. Some of these outputs were planned and envisaged as part of the practice development cycle, whereas others came as a surprise and led on to new strands of practice development activity. The knock-on effect was that practitioners reported increased levels of self-confidence and skill relating to a number of aspects of mental health work.

Similarly, Leighton (2005) found that the effort of developing new approaches and putting them in place appeared to have been shared by the whole group. As a result, a new philosophy of care, nursing model, admission criteria and assessment tool were the products of ‘representative democracy’, rather than ‘total democracy’, as some research group members were given greater responsibility or exploring the literature and selecting appropriate ideas than others. Reed (2005) comments that ownership is difficult to achieve in participatory research and development. She reports on the tensions that can occur where research agendas, practice agendas and the need for involvement can clash. Meyer et al (2003) highlight the way that practitioners imbue their practitioner research with their own local theories derived from their own constituencies and institutional contexts that influence their interpretations of excellence and effectiveness. Therefore researchers need to be aware of the need to negotiate and re-negotiate joint goals.

Participants having a sense of ownership and feeling able to suggest changes may take a development far from its original goals. Handing over a development to the people who are implementing it may therefore involve the originators relinquishing control over future developments (Reed 2005).
3.4.3 What forms of knowledge use and knowledge generation are used in practice development and what are the consequences for the outcomes?

A general finding of the PD literature is that it does not pay much attention to the forms of knowledge underpinning the development activity. McCormack & Garbett (2003) highlighted that practice developers seemed to place little emphasis on getting research into practice and quality/audit activities within their role. Indeed a particular weakness of the literature is the ‘evidence’ underpinning many of the developments undertaken. There is little evidence of practice developers making explicit the evidence underpinning their work and this is particularly the case when it comes to the use of empirical evidence.

Clarke & Procter (1999) suggest that the epistemological and methodological positions taken and the relative messiness of PD means that its outcomes are less evident or ‘respectable’. Knowledge creation by practitioners is notably different from the contemporary emphasis on knowledge, or evidence, use. They highlight the way in which technical rational knowledge is afforded higher status than practitioner generated knowledge and thus has created a divide between research and practice. Practice development which emphasises the longer-term engagement with practice means that it is difficult to see the outcomes as they are often hidden within the ‘everydayness’ of practice. This challenges the ways in which practice developments are accounted as to legitimise them they often need to be re-conceptualised as ‘technical knowledge’ in order to identify transferable findings. Further, Clarke & Procter (1999) suggest that care developments are very often something which evolve over time and so the nebulous start and end dates of developments in practice make it something that is quite intangible – there is not necessarily a ‘project’ which is neatly defined by start and end dates, but rather a generative
form of research whose outcomes can not be anticipated. Participants in their study found it difficult to engage with traditional approaches to knowledge use and described these as “stultifying” and thus it is argued that there is a need for a more reflexive approach to developing and using knowledge – one that interacts better with practice.

Similarly Bell & Procter (1998) reported that in their work, participants engaged in the research processes being used to develop practice wanted the research to stop so that they could try and implement some of it and evaluate it. Some participants expressed the view that if they had used action research then they wouldn't want it all to stop because the research findings wouldn't have been separate from the development. There was evidence from the data that the NDU did facilitate the development of nursing practice and skills in existing and new areas. While the resources attained by the NDU were used constructively to support new areas of activity such as aromatherapy, cardiac support group, self medication and noise control, the development of existing and new practice was not wholly linked to research activity. New spheres of activity were derived from both research activity and practice development activity both of which appeared to incorporate a cluster of individual characteristics which might influence staff participation in any development work.

Other studies have used a variety of data collection approaches to generate knowledge to underpin development programmes. For example, Galvin et al. (1999) collected a range of quantitative and qualitative data from a range of stakeholders (e.g. focus groups with health care practitioners, validated questionnaire with service users) as well as visioning work (task analysis). Bates (2000) used shared approaches to education and critique of evidence in order to generate a PD agenda. Clinton & Getachew (2003) used a range of evidence – learning/inquiry theories, grand theories about ontology and epistemology (congruity theory from psychology); policy around learning organisations and locally derived theory based on an analysis of practices. Wilson et al. (2005), Molyneux & Fulton (2003), Eve (2004b), Boomer & McCormack (in press), McCormack & Wright (1999) all developed evidence to support change through inductive techniques (e.g. observation) that involved practitioners. The strength of the links made between what was observed (for example) and the developments undertaken varies in these studies.

The use of reflective strategies as a means of translating knowledge for use in PD work is also evident in the literature. This is consistent with the Critical Social Science assertion that theory per se does not result in emancipation, but ‘self in the context of theory’ (after Fay 1987) enables a critical engagement with the world of practice. Walsh et al. (2002) used reflective processes (e.g. story-telling) that enabled staff to see the ward from a non-professional perspective and
this also generated powerful insight from a service user perspective. Dewing & Wright (2003) incorporated narrative methodology into the programme because it provided an approach for valuing both programme participants’ and service-users’ articulation of their experiences. The narrative methodology gave older people a valid voice with which to contribute evidence and become involved with developing practice.

Walsh et al (2005) report on the development of a tool (the BEET Tool) to guide clinicians in the process of engaging with each other in the development of practice. Engagement is seen to be an essential element of emancipatory practice development and the authors that whist it is seen as important, it is very under-theorized and under-explored. The theoretical basis of the tool is derived from the PARIHS Framework (Kitson et al 1998) drawing on conceptual analyses of evidence, context and facilitation as essential factors in translating and utilising knowledge in practice. The tool is diagnostic in nature and the authors suggest is a potentially effective means of designing collaborative development strategies with clinicians. The tool has not yet been tested in practice and only anecdotal evidence from users of the tool currently exists.

Dewing & Traynor (2005), Hockley et al (2004), Clarke & Copeland (2003), Meyer et al (2003), Bridges et al (2001), Manley (2000a&b) and Binnie & Titchen (1999) all represent examples of knowledge use integrated with knowledge generation through emancipatory and participatory methodologies of PD. These studies all utilise methods to systematically use empirical evidence through reflexive approaches to analysis and decision-making, incorporating:

• a clear focus on reflective learning to make sense of a variety of sources of evidence
• the use of formal structured approaches to planning development and learning outcomes
• a concern to ground the development, research and learning activities within the context of existing theory and practice
• The generation of evidence from the development activities that is capable of assessment and validation
• The identification of transferable principles.

These studies offer useful examples of ways in which knowledge can be used and generated in practice development programmes. However, these studies are largely led by academic staff working collaboratively with health care staff and service users. The difference between the systematic approaches adopted compared to what is possible from practitioner-led developments (without academic support) is evident. This does raise issues highlighted earlier about the focus of PD work and the distinction that should be made between PD work undertaken by staff ‘on the ground’ and PD work led by academic/research staff. It would be unrealistic to expect all PD work to generate this kind of knowledge without the need to address the knowledge, skills and expertise of practice developers and their infrastructure support in organisations. Bell & Procter
(1998) suggest that there is a need to tap into the knowledge creation potential of practitioners in order to maximise their role beyond that of translating existing knowledge into practice. Practitioners need self-confidence and to experience a sense of participation in a supportive group who share similar clinical interests in order to actively engage in knowledge use and knowledge generation activities.

Summary of evidence showing how forms of knowledge use and knowledge generation are used in practice development and the consequences for outcomes
A general finding of the PD literature is that it does not pay much attention to the forms of knowledge underpinning the development activity. Indeed a particular weakness of the literature is the ‘evidence’ underpinning many of the developments undertaken. There is little evidence of practice developers making explicit the evidence underpinning their work and this is particularly the case when it comes to the use of empirical evidence. The knowledge generation potential of practitioners/participants in practice developments is largely untapped.
4. DISCUSSION OF FINDINGS/DATA SYNTHESIS

Following the analysis of the published literature and the grey literature, the telephone interviews were undertaken in order to verify, extend, expand or contradict the initial themes derived from this body of literature. In addition, the interview schedule provided opportunities for participants to identify ‘novel’ issues that had not been addressed in the schedule and thus the opportunity to identify new themes. The discussion is presented following the 4 themes and 9 sub-themes derived from the analysis of all data sets.

4.1 UNIDISCIPLINARY VERSUS MULTIDISCIPLINARY APPROACHES:

The evidence reviewed leans strongly towards the strength of multidisciplinary approaches to practice development over that of unidisciplinary approaches. For example Page et al (1998) challenge the logic of unidisciplinary approaches to development on the basis that the patient experiences care from a whole team, and it is the whole team’s processes, beliefs and values that have an impact on that experience. Page et al (1998) suggest that the impact of a multidisciplinary approach is a broad commitment to the work of the unit with all grades/disciplines feeling like they have an input. Similar reports of the benefits of multidisciplinary approaches are reported by Manley (2000b) and Molyneux & Fulton (2003) who reported on PD work initiated by medical staff but which was subsequently picked up by nurses.

The dominant focus on unidisciplinary approaches largely lies in the nursing profession where PD has a longer tradition than in other professional groupings. This was particularly evident in the telephone interview data, where the majority of interviewees highlighted the benefits of multidisciplinary PD over unidisciplinary activity but in reality engaged in unidisciplinary PD. Most people tend to say that much of their PD work is initially unidisciplinary but then the initiative needs the perspectives of other members of the multidisciplinary team and thus they tend to come on board later. Interviewees suggested that nursing staff don’t necessarily feel confident to get other team members on board at the start. Many talked about multiprofessional rather than multidisciplinary activity and perhaps there is a need to make a distinction between these perspectives in PD projects. One person said that just securing the buy in and time out for nursing to get involved was hard enough and she could not see that other professionals would be able to do this. Also there are extra sets of dynamics with different groups – different beliefs and
values different understandings of care practices (e.g. what rehabilitation means) that could get in the way and overall there is the view that professional groups work in silos and work to their own agendas.

However, the general feeling was that multiprofessional practice development would be good but most people are doing unidisciplinary work:

“A unidisciplinary approach isn’t really tenable if you take in a patient centred approach. Patients don’t interact with disciplines they just have their needs and what they don’t get is the fact that we can’t just respond to that ...” (SH)

The data highlights the need for practice development activities to mirror the ways in which health and social care is delivered, i.e. an integrated whole systems approach to PD work. A number of interviewees highlighted the ‘context specific’ nature of PD work and thus there may be occasions when unidisciplinary PD is appropriate:

“... it seems wholly right that personal professional development quality improvement can happen in a team atmosphere, but I absolutely see uniprofessional work as well, largely because we work, we have such a wide work load so much of it is purely nursing”

“I think there are times when it happens because the workforce that you are looking at is made up of a single discipline in what you are trying to do, so I am doing some work currently with a Neo-Natal nurses network and they are the dominant discipline and if they change their practice and change their approach then the rest come into place, so it would be false for a multidisciplinary development pathway because it isn’t how they operate in that context, so inevitably it is unidisciplinary”

Most participants highlighted though that even if PD starts off as a unidisciplinary endeavour, it is likely to become multidisciplinary as the work evolves and develops.

“... I think unidisciplinary is your first line of approach, if you approach an organisation or they approach you usually it is around a unidisciplinary subject and I think that’s most of our experience at the moment ...”

“... somewhere down the line there will be a requirement to scrap the concept of only unidisciplinary approaches but I think that at the minute sometimes a single profession needs to
take the lead in the first instance and as a result of that then there is that requirement for some single disciplines to forge forward using that approach. It’s about creating a ripple effect in relation to the use of the approach”

However, there is little empirical evidence in the literature to highlight the benefits of one approach over the other, as few studies have evaluated the impact of only focusing on a uniprofessional agenda and those studies that have evaluated multidisciplinary practice development report favourable results (Campbell et al 2004, Eve 2004b). Galvin et al (1999) suggested from their work that “the extent to which boundaries between professions were a barrier was identified by health professionals in the baseline data” and that this realisation lead to greater multidisciplinary commitment. The PDU reports clearly adopt a multidisciplinary approach. How far the activities reported as part of the PDU development programme lead to sustained effective multidisciplinary practice is difficult to extrapolate from these documents.

The evidence however, does suggest a need for staff empowerment through consultation in order to develop multidisciplinary development agendas and strategies for empowerment are evident in the grey literature (such as reflective engagement processes, consensus seeking, values clarification and the involvement of stakeholders in the planning of practice changes (Page 1998), i.e. it cannot happen by chance and the important recommendation of an overarching multidisciplinary focus in practice development but with strands of work that facilitate single professional activities to enable multidisciplinarity. A sentiment echoed by Dewing & Traynor (2005a) who found a unidisciplinary approach to be effective but with the involvement of multiple stakeholders. This is a sentiment that was echoed in the telephone interviews where the view that nurses often lack the confidence to involve other professionals in PD work was evident:

“I think nurses do not feel confident at the start of a project to invite others on board. The nurses need to get their head around what they are doing first before they start involving others”

Holman & Jackson (2001) highlighted the dangers of not adopting a multidisciplinary approach and the need to ensure key stakeholder involvement from the outset. The programme was not seen as multidisciplinary. Compared to other studies where there was better MD involvement it would appear that there was a clear split between researchers and practitioners – ‘we have come to do to you’, the progress from there on appears to have been reliant on the researchers persuading people to be involved.

Overall, the telephone interviewees were unanimous in their view that PD should always be multidisciplinary unless there is a clear uniprofessional reason for not doing this, but recognised that the current reality is that most PD is uniprofessional (nursing) focused. Interviewees
usually cited the fact that if the intent of PD is to improve patient care, then this has to imply a multidisciplinary methodology as patients receive care from a variety of multidisciplinary staff. However, whilst they also recognised the need on occasion to develop practice with uniprofessional groups, they largely viewed this as a ‘step’ towards multidisciplinary PD and that there is always value in adopting a multidisciplinary perspective – …” 

at this point in my career the longer I am in it the more I want multidisciplinary input even into a nursing focused study, so I would have to say that the multidisciplinary perspective provides a look at yourself as others view you and I think both are important to developing things to be successful”

This strength of feeling raises serious issues about the resourcing of PD activities that only focus on a single profession (such as nursing) and the need for clarity about where such activities ‘fit’ within an overarching PD methodology that focuses on improving patient care. It would appear that the discussions that currently exist regarding the development of interprofessional learning will also need to extend to include the development of practice. Key principles of interprofessional learning include developing an understanding of role boundaries, erosion of unnecessary boundaries for effective practice, learning together and developing shared strategies for implementation of learning into practice (Banks & Janke 1998, Parsell & Bligh 1998). These principles can be seen to have relevance to the development of practice and ways in which multidisciplinary development of practice can be advanced.

4.2 STAKEHOLDERS

A clearly emergent theme in the data is that of the need to involve multiple-stakeholders. Two stakeholders in particular are highlighted in this body of evidence – managers (e.g. Campbell et

4.2.1 Managers

A number of studies highlight the importance of involving managers in decisions about the methodological approach being proposed, the range of development activities engaged in and decisions about ‘levels of empowerment’ facilitated in development programmes. The importance of management involvement in these ‘design’ decisions was reinforced by telephone interviewees:

“... for example I am writing a study right now to get a little bit of money for a pharmacy/nursing project ... but I’m thinking who needs to be on the team to make change and I would not do it without the service leaders/managers because system change can’t happen without them. They have the best understanding of how systems work, day to day, 24 hour, 7 days a week ...”

Some studies report on the negative impacts of not involving/including/facilitating managers to be involved in terms of conflict about pace of project work, disagreement concerning desired/required outcomes and the ultimate sanction of ‘early closing’ of projects. Some interviewees talked about ‘benevolent support from managers’ without the managers being really involved or thinking through the potential impact of the PD initiative:

“There is often benevolent support from managers where they are not really involved and where they have not really thought through if the work is going to have any impact”

The importance of senior managers engaging productively and creatively with staff engaged in practice development work is seen as crucial in order to create a developmental climate where there is decentralised decision-making, high levels of support and a reduced emphasis on monitoring and reporting – in essence, emancipation! “You can’t do practice development without engagement of managers or you won’t have the context or the contextual support to do it or say it or spread it”. However, some interviewees suggested that one of the outcomes of PD is more empowered staff and that sometimes the implications of this is not thought about in advance by managers:

“Once staff become emancipated this is challenging for the managers as they did not expect this as a consequence”
Some studies highlight the intent of empowerment and emancipation among corporate managers when in reality the work-climate is not ready for this approach. An example of this is one participant in the telephone interviews who talked about a project where the manager is truly involved with the participants in the PD process, but this has had a constraining impact on some of the staff. Interviewees were generally non-specific about strategies that would effectively engage managers in PD processes. Most talked about writing to managers to inform them of the work and usually involved them in steering groups. Those in strategic positions were very clear that PD could not happen effectively without management support and involvement. However, ‘benevolent support from managers’ is not enough:

“I think they [managers] are key when you are looking at any development especially when you look at the culture and context of any organisation and I think if you look at it from a strategic perspective the modernisation agenda clearly requires a collective approach using concepts like practice development. I think management need to understand and buy into the requirements for specific developments and the rationale behind them and I think PD actually does that because it explores in the first instance what the goals are under the need for practice development but as well as that looks at the rationale behind them. There is a requirement placed in an organisation to actually change the way in which they do something but then the approach that’s taken which would hopefully be emancipatory means that managers need to understand the rationale behind them and also to understand the rationale behind the approach taken in relation to the change”

Another stated:

“… managers can come with a single focus, they can be very operationally driven, they can frequently work in a different time frame to people involved in PD work or quality improvement work, so if they don’t see immediately the role of PD in solving issues you know, it can be difficult to sustain”

Clearly there is a need to understand how best to involve managers in PD work and to ensure that this is participatory and inclusive. A lot of the literature highlights the ‘vulnerability’ of PD initiatives (for example Page et al 1998; Ward & McCormack 2000) and thus it would appear to be imperative to have managers actively involved in PD initiatives so that they can be secured within the business agendas of organisations. However, some of the interview data would suggest a need for more proactive work than that and suggests the need for managers to be ‘taught’ about PD processes, their underpinning philosophy and ways in which these processes contribute to the meeting of strategic agendas. One example of this
proactive work is the International Practice Development Collaborative [IPDC]¹. Currently there is an increasing trend for senior managers in Ireland, Australia, New Zealand and The Netherlands to attend residential Practice Development Schools hosted by the IPDC. This development has had the benefit of introducing managers to the concepts of PD and in particular raising their understanding of ways that the processes can be embedded in corporate agendas. The modernisation of healthcare systems and processes is a key agenda for governments and healthcare organisations nationally and internationally. The ‘Centre for Change and Innovation’ of the Scottish Health Executive (http://cci.scot.nhs.uk/cci/) is an example of this and there are equivalent initiatives in the other health departments of the UK. However, a search of the websites of these departments demonstrates that there is currently no connection being made between the modernisation of health care systems and the processes utilised in the development of practice, despite the fact that increasing evidence suggests that ‘soft systems’ in health care are as important (if not more important) in the development of high quality services (McCormack et al, 2005). The practice development literature suggests that little systematic effort has been made to connect practice and service/systems development and this would appear to be a key agenda for the future.

**Key Message**

The involvement of managers in PD is crucial to the successful implementation of PD processes and the sustainability of outcomes. However, the evidence would suggest mixed-support from managers for PD work. This can be attributed to a lack of understanding of PD in a healthcare world that is driven by short-termism and practice cultures that continue to be suspicious of managers. Practice development has an important role to play in the modernisation of health and social care services because of its focus on ‘practice’. Managers need to understand how PD can contribute to the modernisation and development of effective services.

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¹ The International Practice Development Collaborative is an collaboration between national organisations, academic institutions and healthcare organisations in the United Kingdom, Australia, New Zealand and The Netherlands with expertise in practice development. A key focus of activity is the hosting of residential practice development schools in each country with between 30-60 participants in each school.
4.2.2 Service Users

The benefit of involving service users at all stages of development work is universally applauded in the evidence. Much of the evidence recognises the importance of the patient’s experience of illness and partnership working. Impacts of user involvement include a shift in dynamics between practitioners and patients, changes to the relationship between the practitioner and patient, deeper change with higher levels of ‘goal orientation’, greater and more focused responsiveness to patient complaints/expressed views, absence of complaints, effective handling of ‘risk’ situations (e.g. MRSA outbreak) and fewer incidents. The telephone interviewees largely applauded the benefits of involving service users in PD, as the data below illustrates:

“I really think the service users bring some realism, they ask some wonderful realistic questions which can actually catch us short, I do believe they bring accountability because they really do challenge us in a way that collectively we may not actually challenge ourselves all the time and then that is, they also bring challenges, they challenge us all the time, they challenge why not and why do we and why not and why can’t we and not withstanding that I think good for the staff can sometimes say well sure why are we doing it this way, why don’t we try something else, I think the public will very quickly say that”

“... they provide the experience of the service at the sharp end, you get honest open opinions, but there are limitations when they bring in all their problems”

“The things users come up with are visionary and passionate”

Although there was generally a universal acceptance of service-user involvement in PD work, some interviewees felt that practitioners were reluctant to really engage with service users and that PD groups still wanted their private space – “I have not been successful in getting service users into core practice development groups. The practitioners still want their own private space”. Engaging with service users as opposed to involvement was considered to be a better approach as it is more active and implies a sustained relationship of participation rather than sporadic involvement:

“I prefer to use the term engagement with service users – it is a more active concept and deeper than involvement...it is a more connected process”
Interestingly, there emerged a cultural difference concerning the involvement of service users, with interviewees from the USA only seeing user participation in the development of practice being relevant at the level of ‘process and outcome evaluation’:

“You’re checking and getting feedback or ‘formative evaluation’ across the whole continuum that you have focused with patients, you know affirm their needs and understand their needs, so in that way yes, but in terms with them participating with work groups, no”

Interviewees from the USA had little or no experience of involving service users in all stages of development work other than in evaluation. Other interviewees from around the world were more receptive to the involvement of service users in all stages of PD work but there was a commonly expressed view that it was difficult to achieve in reality. Few practical strategies for actively involving service users were offered. User involvement in research is increasingly becoming an important agenda and is actively promoted by most research funding organisations, although the value of lay participation in research is beginning to be questioned by others (McCall, 2005). The telephone interviewees were less emphatic about the benefits of service users in PD work and some suggested that whilst it is espoused, in reality it is tokenistic. Gaining a representative service user voice appears to be a key challenge. Many participants talked of using established groups where service users participate, but then did not feel that they got representative views. Examples of service-user involvement included, focus groups, open space events, linking with user organisations, representatives on steering groups, encouraging practitioners themselves to consult users as part of the change process and consulting local health and social care groups. It could be suggested that, overall, much of what was discussed in the interviews and which is evident in the PD literature could best be referred to as consultation rather than involvement. This raises the issue of ‘levels of involvement’ of participants in PD work. Whilst a universal acceptance of involvement is encouraging, knowing the appropriate level of involvement is essential – something that has been previously addressed in the user participation in research literature (Meyer 2000, Dewar 2005, Truman & Raine 2001) and the purpose of involvement (McCall, 2005). There is increasing guidance available to researchers on different strategies for engaging service users and much of this is transferable to a PD context. Currently Dewar and McCormack http://www.qmuc.ac.uk/opa/hm/Default.asp are evaluating the impact of a learning and development programme undertaken jointly between service users and practice developers on practice development processes and outcomes (The Partnership in Practice Project [PIP]).

User involvement in research requires the adoption of person-centred principles
(McCormack 2003, Dewar 2005) and many of these principles can be seen to be transferable to the involvement of service users in PD work. Principles include:

- Investment in the time needed for active user involvement.
- The preparation of the PD setting for user participation in PD.
- The socialisation of practice developers to working in partnership with service users.
- Recognition of mutuality in the involvement process
- Negotiation and renegotiation of boundaries with users.
- Seeking and gaining consent.
- Representing views authentically.
- Disengaging from the setting

Other evidence of the importance of stakeholder involvement focuses on the need to include all levels of staff (e.g. care workers). The need to involve care workers is consistent with the multidisciplinary focus that is evident in the literature and among telephone interviewees.

4.3 PRACTICE DEVELOPMENT ROLES AND RELATIONSHIPS

Interviewees identified the need to support practice developers (in whatever role capacity they are in) and to ensure that the roles established to develop practice are ‘doable’:

“... and again I think they were all over the place, every possible model and it’s a term that’s in lots and lots of job descriptions but not with a boundary and not done very effectively as a
consequence ...”

The isolation of practice developers in their role is a significant issue and one that has historically plagued practice developers. Evidence from the interview data suggests that there is little recognition from management stakeholders of the challenges associated with being in a ‘lone-role’ in an organisation when the focus of that role is bringing about changes in practice.

“... this role that I am in, I mean it’s a one man show at the moment which is incredibility difficult. I don’t think Practice Development is a one man show ... the ability to have somebody to bounce ideas to, where you can actually express your emotions and say what you think out loud so that you can actually hear, because again I mean I say that I’m an expert practitioner but the reality is that you don’t hear what you are saying until you actually say it I think, and I mean there are times where you are sitting in a office all by yourself and your sitting talking to yourself because you’ve not got anybody you know ...”

And another commented on her experience:

“I think within the structures that I work inside the directorate, I do have a conflict of roles which all of us find, we can’t spend as much time doing things within the directorate or the same things that we would like to but I think that’s more of a resource issue the fact that there’s only me. I’ve got the biggest directorate in the trust; you know I have two thirds of beds and half the nursing staff work within my directorate ... so being inside and being actually able to get out into the wards and work with the staff and actually see what’s happening with regards changes and practice and developing practice, its quite difficult ...”

This data raises a question of the morality of placing people in isolated roles, without the necessary resource infrastructure and with the expectation that they will facilitate developments across a variety of practice contexts. Further, there were very few examples in the data of organisations having a strategic infrastructure to support practice developers.

Some evidence suggests that practice developers operate within two dominant roles. In some organisations practice developers are employed to work with the everyday worlds of practitioners by providing advice and support, working with individuals, supervision and providing access to resources. On the other hand roles that are more centrally located in organisations have a tendency to ‘work for the organisation’ by providing access to training and addressing corporate issues arising from policy agendas, contributing to corporate governance and developing (technical) practices following risk assessments/investigations. In community trusts, PD staff
appear to be more centrally located in the organisation and are more likely to be involved in work for the organisation. Whilst in acute (hospital) trusts, PD posts are more often in clinical directorates/divisions and focused on working with individuals and groups. However, PD roles can often find themselves ‘in the middle’ between clinical and managerial roles. Many of the telephone interviewees who operated in a lone-role were employed through a variety of organisational directions (e.g. as members of training teams in personnel departments; as members of an organisational quality improvement team or as a member of an organisation-wide training team). These differing role directions would appear to contribute to role confusion as clearly the different departmental functions operate a different philosophy of practice and have different strategic agendas. Thus practice developers are pulled in different directions with their role being constantly under threat as organisational agendas change.

The literature also reports on a variety of models of working and even where practice developers start off with a unit-specific development project there appears to be an expectation that they will facilitate the roll-out of the development in other parts of the organisation or across an organisation. However, there appears to be little recognition of the differing facilitation skills needed for these two different sets of activities. Some interviewees talked about the fact that it takes a great deal of maturity to be able to do both and this is consistent with the distinction that Clarke and Wilcockson (2001) make between competent and expert practice developers. As one interviewee commented:

“The naïve practice developer will see themselves as working with practitioners. It takes maturity to work with both. We need people to see the bigger view, people have to have increased tolerance and understanding”

The skills involved in expert practice development are consistent with those skills evident in the knowledge translation and utilisation literature (Rycroft-Malone 2006, McCormack 2006) and this perspective was reinforced by interviewees in more strategic roles:

“... I think I am increasingly persuaded of the value of a change agent intermediary brokerage role as a way of enabling change in helping the dialogue between different worlds and I think where I see more effective roles I think it’s because they are very good at doing that so they have usually gone in because of a problem that requires a solution and what these individuals do is broker the solution into language all parties can live with ...”

The credibility of facilitators and trust in their motivation and expertise appears to be important and whilst the there appear to be similarities between PD roles at an organisational level and
knowledge brokerage, many interviewees supported the need for diversity of role:

“... I come from a place where broadly diversity can be rich but I don’t mean diversity as in people, with everything from somebody who can’t do it well to somebody who does it very well. I mean what ever they do they do well but they might be orientated from a different place, so people who came through an audit type of approach to things will have evolved their approach and I would expect to see qualities in that type of person that I would expect to see in a PD facilitator., such as facilitation, tenacity, vision, enthusiasm. They are the qualities you expect to see, I really don’t mind if people come through different avenues but it doesn’t undermine the quality of the initiative of activity. Again it must be credible must be systematic, must use best evidence, must give good leadership, must be very responsible and accountable so I don’t mind a diversity but I do mind if somebody is called a PD Facilitator but actually can’t do it”

This comment raises the issue of the focus of PD activities and the need for PD roles and relationships to be consistent with the focus of the development activities being undertaken. The debate about the ‘insider’ versus ‘outsider’ roles in research and development work has prevailed for many years. Insiders are those research and development staff that are internal to the organisation where the work is taking place. Whilst outsiders are those from external agencies (usually Higher Education Institutions [HEIs]) coming into an organisation to undertake research and development work. In reality these role divides are nebulous at best and confused at worst! The evidence from the literature suggests the often blurring of these roles with the combined ‘insider/outsider’ role being used as the fall-back position to justify the way roles were operationalised in projects. Others have viewed the relationships between researchers/practice developers and participants/staff in terms of ‘peripheral’ and ‘core’ staff. Whilst these terms can reinforce a hierarchical and status perspective of roles, some evidence suggests that whilst the researcher who is peripheral can engage/lead innovative work and take full responsibility for this, their distance from the immediacy of the project work is problematic. However, in the interview data, there are examples of very effective working relationships with HEI’s – “I have learnt from [external facilitator’s name] she had the time to do a lot of things. I suppose by the time she left, my skills were developed more to carry on with the work. It’s become everyday practice rather than when she first came, it was all new and took a lot of time to learn”. One participant talked about how senior nursing students analysed policies for hospitals and worked at collating evidence to support these policies, before working with staff in hospitals to adapt the policies to their workplace. Others commented on collaborative grants between practice settings and HEIs:

“... we ended up putting this grant in and it was so exciting ... I told them what I needed to be
part of it and so I think there needs to be more opportunity to work together like that but I guess it depends on your institution and their relationship, I have to go out and make my own relationships”

Key Message
The evidence continues to suggest that practice developers in ‘formal’ PD roles continue to experience isolation and role ambiguity. The expertise required by practice developers to undertake particular roles is largely unknown and unrecognised. There is a need to develop a greater understanding of the particular knowledge, skills and expertise needed to operate in differing PD roles. Clarity about ‘what is in and what is out’ of specific PD projects is needed in order to maximise available expertise and evaluate outcomes. However, there is also a need to discontinue the dominant focus on PD roles per se and instead develop transferable principles for the facilitation of PD within and across organisations.

4.4 HEI RELATIONSHIPS
A few studies report on partnerships for research and development work between care organisations and higher educations institutions (HEIs). In this model, HEI staff act as supervisors of named project workers who are allocated or volunteer to lead particular strands of project work. In this model staff that are internal to the organisation appear to play a lead role in coordinating/doing the research and development activity. This data is also reflective of the view that there is a need to work more closely with HEI’s to get expertise and assistance for evaluation:

However, some tensions are evident in the literature regarding the ‘motivation’ for doing the research and development work and this was reinforced by some interviewees. The tension between doing research for personal/professional benefit and doing research for the benefit of clients and the service has been considered with evidence of confusion and ambiguity about the role of researchers reported – “I don’t think HEIs have really got their head around PD yet”. The evidence suggests that perhaps there is a need to make a more formal distinction between practice development that is driven by researchers with a commitment to the development of research profiles (this work can be seen in the same context as any other kind of research) and practice development that is ‘pure’, i.e. initiated and undertaken by clinical teams, organisational teams or individual practitioners. It would appear that the motivations for undertaking the work are different and this difference may contribute to the tensions and challenges in working collaboratively – “I was the token person from practice on validation panels that was all, so I
pulled that relationship to a close”, but can equally be a platform for effective collaborative relationships that nurture different but complementary agendas:

“The nursing home that we have got - straight away they have let me know that they have bought it for two years and have two facilitators from our Faculty [names]. We have had our first two away days with the project team within the organisation, that went down really well, really enthusiastic and they are really open in a new creative way but at the same time we still set our goals and we still agreed about certain stages that need to be gathered to prove they were actually achieving the changes we wanted to achieve …”

The need for practitioners to be enabled to inject ‘personal meaning’ into the development and evaluation of their own practice does appear to be important. Problems with the physical distance between outside researchers/facilitators and project sites are evident whilst others have reported that being in practice creates conflicts and dilemmas. All studies highlight the challenges and difficulties encountered with ‘partnership’ models of working and this was reinforced in the telephone interviews:

“… I think it’s a collaborate partnership as opposed to working together. I mean fundamentally a HEI will have very clear agenda for being involved in that work and they are not going to be involved in that work to meet the governance arrangements of another organisation so I mean there’s a tension there, there’s always going to be a tension there and probably what might help would be a very up front rationale for involvement in the collaborative partnership …”

The emotional investment in the work by practice developers appears to be an important criterion in developing ways of supporting staff in their work. Overall, the evidence does not come out in favour of one role over another (insider or outsider), but it does suggest the need to pay attention to the establishment of effective ways of working, shared goals, clarity of purpose, clarity of roles and clarify the personal meanings attached to the work prior to any development work happening.

**Key Message**

Collaborative relationships with HEIs can provide an important means of reducing isolation for practice developers, but also a way of extending the potential for systematic and rigorous processes to be adopted. However, the principles upon which such relationships are established are crucial to the success of such collaborations.
4.5 LEARNING

The initial review of the literature suggested that the foci of practice development could be categorised into two broad perspectives – activities that focus on the development of knowledge and skills of staff and activities that focus on bringing about particular clinical changes. There is no evidence in this literature of formal (traditional) education approaches resulting in improvements in practice (indeed in one study practice got worse!) and this literature predominantly focuses on the challenges associated with non-attendance at courses, securing commitment to participate and dealing with ‘discomfort’.

Interviewees were consistent in their view that professional development (focuses on development of knowledge and skills among staff) and practice development (bringing about particular clinical changes) were different but related things:

“... The one thing that gets me really mad is when people use the term professional development and practice development interchangeably, I just bottom line see them as entirely different things coming from entirely different philosophies ...”

“I think its unfortunate that there is this separation because I think PD activity can achieve both and I would nearly argue [that] ... any quality activity should be about professional development as well as achieving standards and I absolutely see them interlinked ... I think part of the problem is funders of activities, commissioners seeing what are they going to get for their money, what are they going to get from their investment and if they see something, well knowledge and skills is pretty tangible but particularly if they saw knowledge and skills which will effect particular clinical changes, particularly in the way our roles are changing then we might have more of an inroad ...”

The unanimous view that knowledge, skill and developing practice cannot be separated but that all three are interlinked, does provide both opportunities and challenges for the future development of the PD field. On one hand PD (at least those approaches that have an emancipatory intent) has been committed to the integration of reflective adult learning strategies into PD programmes as a means of developing sustainability but has largely struggled to locate this learning in formal education structures and processes. On the other, the ways in which PD interfaces with mainstream higher education systems and processes may require compromises to be made in terms of the linkages to be made between the acquisition of knowledge, skill and expertise for developing practice. There are only a few examples of knowledge acquired through
development activities being formally accredited by higher education institutions.

Whilst accreditation frameworks do appear to play an important role in legitimising PD activities in organisations, there is little evidence currently to suggest that the process leads to greater sustainability of developments. Whilst the grey literature provides evidence of ways in which PDUs have met standards and criteria set by accrediting organisations, none of the evidence (published literature, grey literature or interview data) provides evidence of sustainability. However, a key question emerging is that of ‘what do we mean by sustainability in practice development?’ and addressing this question might help to advance our understanding of models and strategies for PD.

The learning approaches reported in PD studies are wide and varied, but could be classified as those that fall within a formal education and training model and those that are informed by a reflective model. This divide represents the debate that exists in the literature regarding ‘single loop’ and ‘double loop’ learning (Argyris 1976) and is reflected in the evidence underpinning reported PD studies. Reflective approaches, be they formalised or not appear to result in greater levels of reported self-direction and self-confidence. Reported formalised models of reflection draw on theories of reflective learning, action learning, adult learning, humanistic learning and problem-based learning. Some debate is evident about the focus of such reflective activities, i.e. whether they are driven by the concerns of practitioners drawn from their immediate practice experiences or drawn from organisational goals (e.g. to change a particular practice). Attempting to use reflective learning as a vehicle to pursue change in wider systems carries high risk of failure and may undermine the individuals involved rather than support them. Outcomes that are reported from reflective learning include:

- self-direction and self-confidence for personal development activities
- a sense of participation in a supportive group who shared a similar clinical interest
- Linking of theory and practice
- Gaining a voice for developments that were previously ignored
- Increased professional morale and esteem that impacted directly on practice (e.g. articulation of an array of diversionary interventions that could be tailored to individuals when the antecedents of an adverse incident were observed)
- Feelings of empowerment among staff and ownership of change processes;
- Conscious application of skills (e.g. leadership);
- Articulation of craft knowledge;
• Development of individual learning pathways;
• Greater team effectiveness and application of specific learning attitudes and behaviours to enable cross-team functioning;
• Increased challenge and support in practice;
• Structural empowerment

Only one study specifically reviewed the use of ‘formal education and training models’ and concluded that training courses in areas of practice recognized by staff to be problematic (such as counselling bereaved relatives or lifting and handling heavy patients) are valued by staff given the opportunity to pursue these courses. However, this does not mean to say that they use the information they received appropriately or that they are able to incorporate the knowledge into the pre-existing conventions for practice found within any clinical area. There is some evidence of learning through participating in formal research projects that focus on participation and inclusion. New skills in data collection and analysis are reported as well as more skill in critical evaluation. Evidence of the effectiveness of action learning refer to outcomes such as enhancing critical thinking, finding creative solutions to problems in the workplace as well as increasing self confidence and developing communication skills (Booth et al., 2003). This process is increasingly being used in action research or practice development initiatives to support practitioners throughout the change process (McCormack et al., 2002b; Meyer et al., 2003, Ashburner et al., 2004). The evaluative evidence from O’Connell (2002), Hockley et al (2004), Dewar (2006) and Wilson et al (2005) offers encouraging signs of the beneficial outcomes from action learning processes in PD and further studies are required in this area.

4.6 METHODOLOGIES AND METHODS

4.6.1 Methodological Perspectives

Some studies focus explicitly on emancipatory approaches to the development of practice, i.e. the facilitation of a culture that sees all things as ‘possible’ by confronting oppression at
whatever level it occurs (adapted from Oliver, 1992). A few studies have provided detailed accounts of such an approach through action research and claim significant changes in workplace cultures. All of these studies place significant emphasis on ‘transformational leadership’, i.e. the practice developer/action researcher working in a way that facilitated the transformation of individuals, teams and workplaces as a whole. Key to this way of working is the development of shared values and beliefs and a unified vision. Outcomes arising include, increased participation and ownership across a team; increased confidence among staff to ‘do new things’; recognition of a potential clinical-career pathway; increased challenging of practice; greater understanding, use and critique of research; the view of the leader as a ‘key resource’; lower sickness levels; lower staff turnover; better retention, stability and recruitment of staff; and kudos for the organisation. Some interviewees spoke passionately about this kind of PD:

*I am passionate about emancipatory practice development, I think there is long term sustainability with this type of practice development and although it takes more time it has important long term benefits”*

However, many of the interviewees struggled to identify particular methodologies in their work and this lack of methodological focus has been evident in the PD literature for many years. Indeed McCormack & Garbett (2002b) identified this as a key challenge to the sustainability of PD, i.e. the focus on ‘adhoc’ practice development as opposed to the utilisation of a systematic methodologically located approach.

The scale of the study is considered in the literature with pros and cons identified for ‘single-unit’ and ‘multiple-unit’ focused practice development projects/programmes. Multiple-unit programmes of work report difficulties with communication between internal and external facilitators; the resources needed to manage multiple-unit programmes; role confusion in large programmes and tensions emerging between different parts of the organisation. Studies that are single-unit focused report on the importance of getting the volume of work right for the size of the unit, i.e. not to over-burden a limited pool of staff with formal data gathering and the resulting participatory activities. Others focus on the ‘depth’ of developments that can be achieved at a unit level with the potential for wider organisational involvement/impact through the establishment of effective communication and dissemination activities. Demonstration of effectiveness in one unit can lead to shared learning across other units. However, contextual factors do appear to have an impact with ‘rigid organisational structures causing frustration’ and ‘strong’ contexts nurturing interprofessional relationships and a commitment to improvement. However, the ability of an organisation to transfer learning from a single context to multiple contexts appears to be challenging for many organisations. Whilst some studies relate this challenge to a ‘clash of
values’ (see for example Page et al 1998) it may also be a difficulty associated with the focus of PD itself. Practice development is focused on developments at the patient interface, i.e. changes in practice at the point of care delivery (McCormack & Garbett 2004) and therefore is contextually bound. It could be argued therefore that the transferable element of PD is the learning that arises from the PD activities rather than the actual developments itself. This point is reinforced by the grey literature pertaining to the accreditation of Practice Development Units (PDUs). There is little evidence from this literature, of the processes established in single-unit PDUs being transferred across organisations and despite the accreditation process being a driver for nurturing a strong context, the published evaluations of PDUs do not show the transferability of these contextual characteristics across organisations. The previous challenges associated with engaging managers in PD and the lack of linkages between practice and service developments needs to be considered. This is a further reason for identifying strategic drivers to increase awareness of PD processes among service managers:

“Each practice development initiative is going to be so different from another because it takes account of the context within which care takes place so every single one will be bespoke to some extent but having said all of that, the outcomes of practice development-v-traditional development of skills and knowledge, need to be dealt with. Research like this to some extent needs to be able to demonstrate the effectiveness of the approach but I think as initiatives are developed they really need to be packaged in such a way that they will be able to say what potential outcomes will be in a sort of a business case sense. For example, we need to be able to say that although we will take this PD approach, here is what we will deliver on at certain points within a time frame”

Adopting a ‘business’ approach to PD does challenge organisations to develop infrastructures that support practitioner initiated innovations and translate them into systematic development agendas. The evidence from the published literature suggests that few practice developments are initiated by staff in clinical practice. The dominant focus for studies reported is either responding to policy and/or strategic agendas or organisational recognition of particular practice problems. The range of policy agendas being responded to are vast and reflect the growth in policy developments in contemporary healthcare systems. Policies identified in studies include local policy agendas (such as the development of new roles to respond to service developments) or national policy initiatives (such as the National Service Frameworks; The NHS Plan or primary care developments in the UK). In these studies, authors report on the adoption of practice development processes to change practice in line with these policy agendas through collaborative and participatory approaches.
However, interviewees suggested that there are many more practice developments initiated by practitioners that are not accounted for in the literature and the reason for this is primarily to do with ‘publication criteria’ set by journals:

“How projects are initiated is not necessarily talked about in publications, journals expect the author to frame the development in the policy context and this is what happens, we don’t necessarily hear about who initiated this and how they did this”

Another interviewee suggested that the lack of accounts of practice developments initiated by practitioners that was identified in the published literature is also due to the skills needed in getting work published and the infrastructure support needed in getting work published, which is largely absent in healthcare organisations:

“... our colleagues in higher education have had more of a culture that encourages and promotes publication, there is so much activity happens on the ground floor around our profession that they neither have the where-with-all nor motivation to publicise and unfortunately there is no infrastructure, rarely an infrastructure that encourages that, so there’s not even an infrastructure that would collate all that activity and look to publicise it, so the literature your picking up on this may be a false indication, it may well be that a whole lot of activity is happening but there not in a culture out there actually publicising it ...

This is an important point in terms of the espoused values of ‘collaboration and participation’ underpinning emancipatory and participatory approaches to PD work. If these values are to be lived then systems and processes need to be in place that enables the voices of participants to be heard as a central part of dissemination and translation processes. This clearly is an important agenda for the future support of PD as development activities that arise through ‘organisational recognition’ of the need for change arise from a variety of avenues, including experts challenging existing systems of care delivery and the need to orient services to meeting the needs of patients; a reactive response to a deficit in staff competence or knowledge; technological advances; concern to provide effective and appropriate treatment; inconsistencies in the way that ‘risky incidents’ are dealt with and reforms in specific services (e.g. emergency care services). The majority of these developments arise from practice in its widest sense, yet the reporting of them tends to start from the perspective of responding to external drivers for change.

Some studies have reported on the difficulties in designing an effective methodology for practice development projects, including the challenges associated with ‘keeping plates spinning’; the need to develop complex social networks within an organisation; speaking the language of differing stakeholders and establishing credibility with different groups. The Plan, Do,
Study, Act (PDSA) cycle designed by the Institute for Health Improvement http://www.ihi.org/IHI/ in the USA and adopted by the Modernisation Agency http://www.wise.nhs.uk/cmswise/default.htm of the Department of Health (England) was cited as a specific methodology used in PD, whilst others talked about using action research, whole systems and soft systems methodology as well as appreciative inquiry. Some interviewees suggested that the methodologies we currently use are too limited because practice developers do not have enough knowledge about methodology and so they tend to ‘roll out’ the same thing repeatedly with little evidence of learning from previous experiences - “there is an acceptance of a very limited range of methods in practice development”. Whilst others saw this as a kind of naivety that exists – “You know they’ll get a goal and they’ll jump in the water and sometimes that’s ok but sometimes they’ll forget to look if they are in the shallow or the deep end”.

4.6.2 Methodologies in Use

The evidence in the literature is not particularly strong in terms of informing methodological perspectives for PD. The evidence suggests that there are three dominant methodologies in use - ‘participatory models’; action research oriented models; and pedagogical models. Whilst these methodologies are not mutually exclusive and indeed they overlap, it is their intent that is of most significance. For example, participatory models capture a broad range of systems and processes that focus on maximising opportunities for participation and inclusivity in development work without following a specific methodology. Action research in contrast, whilst also being participatory and inclusive, makes more explicit the cycles of action and reflection. Pedagogical models view teaching and learning as the dominant activities for bringing about change. The initial analysis suggested that there appeared to be two themes of activities underpinning these models – activities that focus on the development of knowledge and skills of staff and bringing about particular clinical changes. However, responses to this question in the interviews yielded the same response from all interviewees, i.e. that these are not mutually exclusive activities but are interrelated and that they are both equally necessary for effective practice development:

“I think you can’t distinguish between the two and there’s no point in developing skills and knowledge if they are not going to be used because then its just waste of an investment and for knowledge and skills to be used they have to be facilitated in implementing that. In the same respect if you want to have a continuous and learning environment the latest thing that’s flying around here is the learning organisation, you need to have the culture wherein that can take place so that’s why we tend to work from both perspectives; my personal preference is to start
looking further, what they are experiencing and where are they running against problems and what would they like to work on to work from the practitioners’ motivations first and then starting looking at how can we improve existing skills, incorporate new skills to actually improve your primary process which is your care giving and then at the same time make the resolve explicit by collecting data”

The overlap between practice development and action research is evident. Some authors overtly locate their work in an action research approach. The versions of action research being used include, emancipatory action research, participatory action research, appreciative inquiry or cooperative inquiry. The majority of interviewees struggled to distinguish between action research and practice development. Previously Manley & McCormack (2004) highlighted the similarities and differences between emancipatory practice development and emancipatory action research in terms of commitment to knowledge generation. However, they argued that action research is one strategy for evaluating practice developments. The evidence from the literature and the interviewees is that there is little understanding of this distinction and that those practice developers who are ‘formalising’ their PD work are doing so through action research approaches. Clearly some PD work starts from within an explicit action research methodology whilst others appear to ‘borrow’ action research processes as the work progresses. Whilst there are clearly overlaps between emancipatory practice development and action research, the implications of labelling all PD as action research need to be carefully considered given the stringent research governance, ethics and funding systems in place in contemporary health services. If all PD becomes action research then this would seriously impact on the ability of practising nurses to engage in PD work and would change the fundamental ethos of PD. Clearly there is a need for further systematic study of PD and perhaps this is the key role that action research has to play.

What is common to all studies that refer to methodology is an overt acknowledgement that participatory and collaborative approaches are most effective. However, few studies provide evidence from their work to support these assertions and instead draw on ‘mid-range’ or ‘grand’ theories to justify these claims. The few studies that do, have demonstrated specific strengths of collaborative working and outcomes in terms of developmental processes that have some degree of transferability to other contexts. An example of this is the influence of consensus seeking processes derived from ‘Constructivist Methodology’ (e.g. Guba & Lincoln 1989) that is evident in some of the literature and in interview data – “...its really important to work with peoples’ values and beliefs so we can understand and challenge different assumptions”.
4.6.3 Methods

Many interviewees were able to identify PD methods, for example:

“... I try to be as creative as possible and that seems to work well in terms of achieving participation, we have just started that [project name] work that I was talking about ... we are using a workshop in order to help staff express how they experience workplace culture”

Whilst few studies make little reference to an overarching methodological perspective in their work, many focus on describing various ‘batteries’ of methods used to frame the work, including education sessions, training programmes, seminars, reflective processes, action learning, cognitive skill development, visioning, psychodynamic consultation, quality improvement activities and clinical audit. Most interviewees were committed to participatory methods, consistent with the methodological perspectives discussed earlier – “I try to use data collection methods that everybody can get something out of ... and every research encounter is a learning encounter”. Methods accounted for in the literature and that appear to be transferable are:

1. Using and generating knowledge
2. Involvement of stakeholders,
3. Developing participation and shared ownership
4. Effecting development of patient care: interviewees were asked to elaborate on what they saw as ‘essential’ processes for developing practice. The answers to this question were themed and the following list of essential methods derived:

   • Agreed ethical processes
   • Stakeholder analysis and agreed ways of engaging stakeholders
   • Person-centredness

Key Message
There is consensus in the data that effective practice development requires the adoption of participatory methodological approaches. No one methodology is favoured and thus promoting one as a favoured methodology would not help to advance practice in this field. The diversity of approaches appears to enable new knowledge about effective processes to emerge.
• Values clarification
• Developing a shared vision
• Workplace culture analysis
• Collaboration and participation
• Developing shared ownership
• Reflective learning
• Methods to facilitate critical reflection (e.g. action learning)
• High challenge and high support
• Feedback
• Knowledge use
• Process and outcome evaluation
• Facilitation of transitions
• Giving space for ideas to flourish
• Dissemination of learning
• Rewarding success

However, none of the published studies formally evaluate the effectiveness of particular methods and this is a particular weakness of this literature. In addition, the lack of understanding and recognition of the importance of methodology (theory) that underpins choice of methods is a serious concern:

“... if we engage people in a process that is somehow organic and let move along by its self as it were, I don’t believe it will get anywhere and I believe the risk is that the people involved might believe they have just been through a quality improvement initiative that hasn’t worked and their view of quality improvement initiatives are that they don’t work, so there’s a real danger of not being systematic and not being credible and not saying we are involved in something, here’s what we are doing or else understanding if it fails there are very clear reasons for it failing, not that the effort itself was not worthwhile. So that’s what I think about being systematic ... I have no problem with whatever approach is adopted as long as it’s a credible processes and again I have no problem with the methodology of PD as I can see the results of it”

**Key Message**

There is growing consensus concerning the practice development methods that are effective in ensuring participatory engagement and in bringing about changes in the culture and context of practice. The complexity of PD militates against the correlation of any one method with PD outcomes. Further research is needed to advance the development and testing of these methods in order to inform outcome measurement.
4.6.4 The cost/funding of PD

There are no published economic analyses, cost-benefit analyses or costing models in the literature. It was anticipated that the grey literature would shed more light on the financial costs of PD, but again, none of the literature reviewed had costs included. Participants in the telephone interviews were asked about their experience of being involved in securing resources for PD. The majority of people had not been involved in securing funding. Some people had secured resources from local education commissioners, charitable organisations and ‘left over monies’ from a variety of organisational financial sources. However, what was consistent across the majority of interviews was that the funding for practice development was not for the development itself but for PD roles with the assumption that the existence of a PD role would enable the developments to happen – “My actual job is, the resource is me and in it and that’s it, so one whole time equivalent ...”. Whilst this is a rational assumption to make, it reinforces the large responsibility placed on practice developers to bring about complex change without resources beyond their salary. As one strategic manager commented – “... all they are doing here is putting money into PD posts and those PD posts are very technical ...” This is a challenging situation for practice developers to be placed in as few other health care workers are required to undertake a role without any designated resource beyond their salary. As a consequence, a ‘beg, borrow and steal’ attitude was referred to by many interviewees whereby they drew on existing organisational resources to undertake the development work itself – “If I am doing corporate work, I am allowed to use admin staff in the cooperative office but I am very much on the end of the pecking order, so I always get the young apprentice, there are no dedicated admin hours for Practice Development ...”

Some interview participants suggested that there have always been sources of funding for PD, such as through the educational route and some had managed to secure small amounts of funding to release staff to participate in workshops related to PD activity. This is seen as a legitimate use of education money as there is a requirement for modernising learning and PD is consistent with a modernised approach to learning in practice. One interviewee commented:

“... PD at least needs to be given a chance to demonstrate its effectiveness and there needs to be a re-focus of some educational monies into the approach and the value of that approach both at strategic and operational levels ...”

Consistent with previously expressed views about the role of managers in PD, some interviewees expressed the view that PD struggles to find its place on the agenda in part because senior managers have not got a full understanding of what the approach is about, so when they are
actually bidding for funding they are not putting good cases forward and thus not necessarily convincing funders about the value of the approach. Previous discussions about differing perspectives on an overarching methodology for PD appear to get in the way of PD finding its place in being considered by funding organisations. However, this review has identified three dominant methodological approaches (participatory models; action research oriented models; and pedagogical models) and a set of methods that appear to be common across all methodologies. It should be possible in the future therefore to develop a costing model to match these methodologies and methods.

4.7 OUTCOMES ARISING FROM PRACTICE DEVELOPMENT

Measuring practice development outcomes appears to be one of the biggest challenges faced by most people involved in PD. The realistic synthesis approach utilised in this study focused on how each of the theoretical perspectives reviewed contributed to PD outcomes. However, the issue of outcomes and the systematic evaluation of outcomes were also picked up in the interviews. In this data there was a consistent view that measuring outcomes from PD work was complex and challenging and that much more work in this field was needed. Some of the complexity and challenge arose from the expectation that practice developers would also have the skills of evaluation necessary to demonstrate outcomes. The literature suggests that ‘expert’ practice developers are able to do this, but there was less confidence about this among the interview participants. One interviewee who undertakes a lot of work as an external evaluator said “so when you want to do something and you want to do it reasonably systematic and rigorous, usually they called me when the horse was out of the barn”, suggesting that evaluation of practice developments was often an afterthought, and continued, “you know you need to have a vision, you need to know where it is you want to go, then you break it down and start doing
when you decide what your priorities are then you start doing good programme planning which includes good formative evaluation and good outcome evaluation or process evaluation, you know outcomes meaning, processes, needs and result”.

Another interviewee suggested that much of the problem of outcome evaluation in PD is to do with its complexity. One way of viewing PD is as a ‘complex intervention’, i.e. an intervention that is multifaceted. There is little doubt that from the evidence thus far, PD is multifaceted and therefore, more traditional linear models of evaluation will not capture this complexity. The alternative is to adopt a reductionist approach and tease out particular development strands and subject them to individual evaluation. Whilst this approach may serve PD well from a ‘knowledge generation’ perspective, i.e. the generation of new knowledge about the effectiveness of particular interventions and further could legitimately be funded through research grant award schemes, it does not reflect a ‘knowledge utilisation’ perspective, i.e. the effectiveness of interventions in the real-world of practice. One interviewee was very clear that this agenda needed a very different perspective to be adopted:

“I think I more commonly look to some of the methodologies which people use around some of the new sciences and some of the complexity thinking and I think some of the methodologies and those favoured by a positive approach don’t fit for multiple reasons, I think because generally PD is context specific and context depended then its really hard to come up with generalisable outcomes. You’re much more likely to come up with things that are transferable particularly ‘how to knowledge’ and I think that sort of process knowledge is possible to capture and then to evaluate in terms of impact ... I think single case methodologies are under-used and I think the ones that get us the most gains are some of the action research methodologies. I think we know enough about PD now that we actually could do some really interesting work around measurement against particular impacts both local and more broadly, so local in terms of what actually happens in terms of clinical outcome or local in terms of things like the workforce, like sickness absence, retention, so I think there are features of the workforce that you could say that PD had an impact on. I think there are features around the health outcomes but I think there are features around the broader impact of the unit on an organisation or in a community that you could also start to measure ...”

This assertion by this interviewee largely reflects how the evaluation of outcomes is being reflected in the literature with the majority of studies evaluating the effectiveness of processes set against local contextual factors and adopting action-oriented evaluative methods. It could be suggested that a greater emphasis on single case study methodology might help to consolidate and systematise the existing methods of evaluation being adopted. The outcomes data, in terms of ‘outcomes from PD’ is much stronger than that available to evidence the relationship between particular development mechanisms/interventions and resulting outcomes. This might suggest that practice developers are more focused in their evaluation strategies on a global approach to evaluation rather than isolating particular mechanisms used and determining their impact.
This assertion probably reflects the state of practice development models and expertise in their use currently. It further might lean towards the view that if practice development has an overall ‘emancipatory or transformational intent’ then multiple strategies (mechanisms) are required. Thus isolating the impact of particular mechanisms may not be helpful. Outcomes from particular interventions that are reported include:

- An external/internal facilitation model led to collaboration
- An approach to using evidence in practice with anecdotal evidence of better interprofessional relationships
- Implementation of three PD initiatives using a variety of individual and group facilitation approaches leading to greater interpretation of evidence in the light of patients’ particular circumstances.
- Shaping of practice at a national and regional level and ideas disseminated through contact with patients, practitioners and organisations.
- Implementation of a facilitated work-based learning practice development programme resulting in the implementation of a model of patient-focused rehabilitation in a service for older people and the transfer of the model to other settings.
- Implementation of a biographical assessment tool with nursing home residents.
- Use of an appreciative inquiry approach resulting in increased staff morale and reduction in violent/self harm incidents involving patients.
- Use of action learning and facilitated reflection framed within an accreditation process showing evidence of ‘cultural shift’ after 1 year.
- Development of an interdisciplinary care pathway that included service user input.
- The use of a model of facilitation resulting in a shared understanding of roles, forging relationships among team members and identification of areas of joint working.
- A three year emancipatory PD project in a rehab setting for older people with enduring mental health problems - resulted in an increased throughput of patients, increase in the size of the service and transfer of the processes to other parts of the organisation.
Facilitated group work resulting in a new philosophy of care, nursing model, admission criteria and assessment tool as a part of an emerging culture of ‘representative democracy’.

Reported general outcomes from PD and not related to specific interventions include:

- Implementation of patient care knowledge utilisation projects
- Development of research knowledge and skills of participating staff
- Development of facilitation skills among staff
- Development of new services
- Increased effectiveness of existing services or expansion of more effective services
- Changing workplace cultures to ones that are more person-centred
- Developing learning cultures
- Increased empowerment of staff
- Role clarity and shared understanding of role contributions
- Development of greater team capacity
- Development of frameworks to guide ongoing development (e.g. competency framework; integrated care pathway)

The complexity of practice development as an activity in itself highlights many difficulties in systematically evaluating practice development methods. Sridharan et al (2006) however, drawing on the work of Pawson & Boaz (2004) and the Medical Research Council (MRC 2000) suggests that in order to evaluate complex interventions (such as practice development) there is a need to recognise such complexity, but in doing so to ‘isolate’ the components that might be seen as simple or more stable within the overall complexity. Sridharan suggests that the stable components should be subjected to rigorous ‘scientific’ measurement whilst other components should be evaluated in order to explicate their theoretical foci and the components that can inform learning. As these less stable components become more stable (simple) then these too can be subjected to rigorous scientific testing. Sridharan et al (2006) argues that to do this successfully there is a need to work with theory as the unit of analysis (as in realist synthesis) and to build better connections between strategic planning, evaluation and monitoring as well as the need to build evaluation capacity.

These arguments and positions postulated by Sridharan could serve to take forward the evaluation
of practice development. With the growing consensus that exists about the particular methods that are essential to practice development then any one of these could be subjected to a rigorous evaluation and testing. With the need to develop greater knowledge about methodology/theory of practice development and processes for the transferability of learning, then other theory generating and knowledge development activities could be separated from evaluation studies in practice development. Such a refinement of theory testing and theory generating activities would significantly advance the evidence base of practice development.

Key Message
Outcome measurement in PD is complex and does not lend itself to traditional methods of outcome evaluation. The evidence suggests that outcome measurement needs to be consistent with the espoused values of ‘participation and collaboration’ where data collection and analysis is an integral component of the development itself. A wide range of outcomes are evident from published practice developments and there is a need for the replication of these in further studies. In addition, consideration needs to be given to the ‘stable’ methods of PD through scientific measures as separate activities from theory generating and knowledge development activities.

5. CONCLUSIONS

This is the first systematic review of practice development. The methodological approach adopted has enabled the review of a wide range of evidence and data sources. We are confident that we have provided a contemporary and thorough analysis of practice development, whilst recognising that practice development knowledge and frameworks are continuously evolving and developing. Nevertheless, the review provides some important insights into the world of practice development and offers direction for future developments. Whilst the evidence of the effectiveness of processes and outcomes of practice development is weak in many areas, there is still much to be celebrated. Despite the lack of clarity and agreement that exists regarding methodologies and methods, much has been achieved by those committed to changing practice cultures and improving healthcare practices. The next era of advancements in practice development should focus on developing methodologies, testing out methods and adopting systematic approaches for evaluating processes and outcomes. The recommendations made are intended to take forward such an agenda.
6  RECOMMENDATIONS FOR THE DEVELOPMENT OF A PD MODEL

Policy and Strategy

6.1 A seminar should be held with interested stakeholders to explore ways in which the findings and recommendations from this study could be developed into a PD model for Scotland.

6.2 Practice development needs to be recognised as a methodology that can contribute to the modernisation of health and social care services through its focus on improving workplace cultures. Key policy and strategy stakeholders need to be targeted in order to develop a strategic way forward for connecting practice development methods with service/systems developments, set within a modernisation and risk management agenda.

Methodology and Methods

6.3 No one methodological perspective can serve all PD functions. However, all PD work should have evidence of a participatory, inclusive and collaborative methodology being used.

6.4 Practice development evaluation frameworks need to embrace the methodological principles of participation, collaboration and inclusivity.

6.5 A programme of education and awareness raising needs to be implemented for service and practice managers in order to improve understanding of the methodologies and methods of PD.

6.6 Strategic level work needs to be undertaken to explore the nature of the relationships between higher education institutions and health care organisations in order to establish core collaborative principles for joint working.

6.7 Practice development programmes need clarity of focus and on this basis decisions made about their unidisciplinary or multidisciplinary focus.

6.8 Practice development projects should be able to demonstrate evidence of using all the following methods:

- Agreed ethical processes
- Stakeholder analysis and agreed ways of engaging stakeholders
- Person-centredness
- Values clarification
- Developing a shared vision
- Workplace culture analysis
• Collaboration and participation
• Developing shared ownership
• Reflective learning
• Methods to facilitate critical reflection (e.g. action learning)
• High challenge and high support
• Feedback
• Knowledge use
• Process and outcome evaluation
• Facilitation of transitions
• Giving space for ideas to flourish
• Dissemination of learning
• Rewarding success

6.9 Further research is needed to advance the development and testing of these PD methods in order to inform outcome measurement.

Roles and Relationships
6.10 Further development and training should be undertaken with practice developers and service users in order to develop meaningful engaged relationships in PD.

6.11 There is a need to balance the dominant focus on PD roles with the development of transferable principles based on the methods outlined here (recommendation 6.8) for the facilitation of PD within and across organisations. Organisations should review the variety of roles in place/needed that can operationalise PD methods and develop an infrastructure to enable senior staff to coordinate this work.

Learning Strategies
6.12 If PD processes and outcomes are to be sustained beyond the life of particular project timeframes, then there is a need to embed practice development activities in learning strategies. Reflective learning strategies and in particular ‘action learning’ appear to have more to offer the sustainability of PD. However, there is a need to evaluate action learning as a ‘method’.

Funding
6.13 PD costing models should be based on the funding of PD methods alongside the funding of roles that can facilitate the transferability of these methods across different contexts.

6.14 A practice development costing model should be developed that focuses on the resourcing
of particular PD methodologies and the PD methods outlined in recommendation 6.8.

**Evaluating Effectiveness**

6.15 A strategic level evaluation framework should be developed that is consistent with the theory of complex interventions and their evaluation. This would enable the evaluation of the impact of PD frameworks and generate new knowledge about the effectiveness of PD processes and outcomes derived.
7. REFERENCES


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Carr S. & Clarke C. (2003): Guiding small-scale evaluation: a critical step in developing practice. (The evaluation framework developed for a health action zone project in Tyne and Wear and 10-step evaluation tool to assist in evaluations. 4 refs). *Practice Development in Health Care* 1, 2, 104-117


Fontys Hogescholen Knowledge Centre for Evidence-Based Practice Strategic Plan for Research & Practice Development: 2002-2012 (2002) Excerpts from Draft (Mission, strategic aims, objectives and examples of milestones) Fontys University, Eindhoven, The Netherlands


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Manley K. (2000a): Organisational culture and consultant nurse outcomes: part 1 -- organisational culture... first published in Nursing Standard; 14:34-38... including commentary by Scholes J. Nursing in Critical Care. 5, 4, 179-86


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http://www.cdhpp.leeds.ac.uk/services/practice2.php


Spiby H, Bratten C, Deane L and Wright G (2005) *Incorporating Evidence into Practice to Improve Perineal Care*, A report to the Foundation of Nursing Studies, Mother and Infant Research Unit, Department of Health Sciences, University of York, England.


Tolson D.; Schofield I.; Booth J.; Kelly TB. and James L. (in press) Constructing a new approach to developing evidence based practice with nurses and older people. *Worldviews on Evidence Based Nursing* [due to be published in 2006]


& Sons, Chichester, pp 333-348.


Truman C and Raine P (2002) Experiences and meaning of user involvement: some explorations from a community mental health project, Health and Social Care in the Community, 10, 3, 136-143


White C (2005) My development as a PDU leader: leadership and power, Practice Development in Health Care, 4, 4, 225-230


Appendix 1

Steering group meeting 1: clarifying the question and purpose of the review

WHAT ARE YOUR QUESTIONS ABOUT THE NATURE/CONTENT OF PRACTICE DEVELOPMENT AS AN INTERVENTION?

1. How does education as a process fit with practice development?
2. How does practice development work as a mechanism or process for using research evidence?
3. How do practice development processes help practitioners to identify concerns/issues for practice development work?
4. What forms of facilitation help practitioners to address their practice issues?
5. How do innovations get diffused most effectively?
6. How far do practice development approaches compare with similar work in change/innovation work?
7. What distinguishes practice development from similar work on service development?
8. What kinds of theories may inform our understanding of context?
9. How do practice development approaches effect sustainability in terms of impact on practitioners/practice?
10. What are the longer term impacts of practice development?
11. What theories of replication are in use?
12. How does practice development innovation have a knock on effect on other areas of practice?


1. What are the resource implications? What evidence is there around cost effectiveness?
2. There is a need for an evidence base to inform commissioning and funding
3. There is need for an evidence base to support:
   o Consistency of approach
   o A national strategic direction
   o Transferability for other health care disciplines
4. Programmes of learning and research/evaluation to support practice development
5. There is a need for better shared understanding of:
   o Terminology
   o Generalisable lessons
6. We need an evaluation ‘loop’ for similar activities in the future

WHAT SHOULD THE OUTCOMES OF THIS STUDY BE?

1. Increased value attached to practice development within NHS Scotland (practice development is always to go – an ‘added extra’)
2. Increase understanding of what practice development is – what are its commonalities?
3. To improve impact on patient care
4. To have a study that can be held up as an example of how policy making can be rooted in evaluation
5. Clarity around what practice development is – the variety of approaches used, an illumination of the complexity of the work in practice and making what is being achieved visible
6. Translation of practice development into the NHS mainstream
## PRACTICE DEVELOPMENT REVIEW: KEY CONCEPTS/DIMENSIONS TO BE EXPLORED IN THE LITERATURE

| 1. Degree of patient/service user involvement | • ‘Token’ involvement  
|• Participative approaches  
|• Partnership approaches |
|---|---|
| 2. Level and scale of activity | • Unidisciplinary, small-scale (local) activity  
|• Multidisciplinary, local level  
|• Organisational level; involvement of all relevant stakeholders |
|---|---|
| 3. Rigour of approach | • Unsystematic, ad hoc  
|• Project focused  
|• Continuous, systematic, attention to rigour and transparency |
|---|---|
| 4. Practice developer (facilitator) role | • Separate, external  
|• Separate, internal  
|• Integrated with existing role |
|---|---|
| 5. Level of impact | • Practitioner  
|• + patient/service user  
|• + team  
|• + workplace  
|• + organisation |
|---|---|
| 6. Focus of activity | • Improving patient care  
|• Professional development  
|• Combination |

**Other possible dimensions**  
- Use of evidence (could be incorporated in Box 3?)  
- Method/style of facilitation?  
- Change process (emancipatory etc)?
APPENDIX 3

Programme Theories

Theory area 1 - Properties of the people and context in practice development

i. What impact does the extent of involvement of different stakeholders have on the outcomes of practice development?

ii. What impact does the scale of a study have on the outcomes of practice development?

iii. How do contextual factors in the study setting have an impact on the outcomes of practice development?

iv. How do cultural factors in the study setting have an impact on the outcomes of practice development?

v. How do styles of leadership in the study setting have an impact on the outcomes of practice development?

Theory area 2 – Properties of the people involved in developing practice

vi. How does the location of a practice developer have an impact on the outcomes of practice development?

vii. How do the means by which the practice developer gains access to the practice environment have an impact on the outcomes of practice development?

viii. How do the methodological positions taken by practice developers have an impact on the outcomes of practice development?

Theory area 3 – Issues surrounding the initiation and carrying out of practice development

ix. How do factors involved in the initiation of practice development have an impact on its outcomes?

x. What are the foci of practice development activity and how do they have an impact on its outcomes?

Theory area 4 – Approaches used to the use of knowledge, bringing about change and supporting learning in practice development

xi. How do approaches taken to support learning within practice development have an impact on outcomes?

xii. How do approaches taken to bringing about change within practice development have an impact on outcomes?

xiii. What forms of knowledge use and knowledge generation are used in practice development and what are the consequences for the outcomes?
APPENDIX 4

Empirical papers where practice development is the explicit approach being used

15. Clinton C. & Getachew H. (2003): Learning from near-misses. (Practice development through action research and appreciative enquiry used in introduction of a near-miss adverse incident reporting scheme in a psychiatric inpatient unit in London). *Practice Development in Health Care* 2, 3, 156-165
23. Dewing J. & Wright J. (2003): A practice development project for nurses working with older people. (1st phase of a practice development project in Portsmouth in which work-based learning and narrative methodology was used to move towards a more person-centred environment on an elderly unit, with 'critical companions' helping develop other nurses. 24 refs). *Practice Development in Health Care* 2, 1, 13-28
44. Manley K. (2000a): Organisational culture and consultant nurse outcomes: part 1 -- organisational culture... first published in Nursing Standard; 14:34-38... including commentary by Scholes J. *Nursing in Critical Care*, 5, 4, 179-86
and potential of nurses to work as case managers, including commentary, p364-5. 38 refs). NT Research 4, 5, 340-352.


APPENDIX 5

Analytical or review papers

   Excellence in Practice Accreditation Scheme. *Practice Development in Health Care* 3, 1, 4-14
Person-centredness in gerontological nursing: an overview of the literature. *Journal of clinical nursing* 13, s1, 31-38


Empirical research about practice development and its approaches as concepts

APPENDIX 7

Empirical research where practice development approaches are implicit in the approaches being used

7. Chapman L. & Howkins E. (2001): Developing a learning culture. (Workplace-based educational programme in Berkshire called Leading and Developing Clinical Practice which aims to allow nurses to implement changes and develop their practice with the support of their managers. 5 refs). Nursing Management UK 8, 4, 10-13
12. Dunning M.E. (2001c) Getting to grips with the detail Learning to implementing change in clinical practice. In Bandolier, pp. 11.10.12005
16. Faulkner A. (2003): A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. (Systematic review of the impact of interventions such as use of guidelines, educational programmes, open-access schemes, new service provision, and patient education. 60 refs). Br J General Practice 53, 496, 878-884


APPENDIX 8

Empirical papers seen but not containing evidence about practice development processes and outcomes


APPENDIX 9

Duplicates

1. (1996): Practice Development: Sara Christian and Sally Redfern continue their review of nursing development units. *Nursing times* : *NT* 92, 50, 34
2. (2000): Practice development in cancer care: Self-help for men with testicular cancer - A joint initiative between health professionals and patients to provide support and information. *Nursing standard* 14, 50, 41
5. Bishop V. (2002): Focus. Commentary: practice development must benefit patients and professionals -- is information technology a means towards achieving this goal? *NT Research* 7, 2, 116-117
11. Christian S. (1996): Practice Development: The experiences and outcomes of the 30 nursing development units are being examined by nurses and policy-makers. *Nursing times* : *NT* 92, 47, 35
# Appendix 10

**Data Extraction Form**

## FULL REFERENCE:

<table>
<thead>
<tr>
<th>THEORY AREA 1 - PROPERTIES OF THE PEOPLE AND CONTEXT IN PRACTICE DEVELOPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>What impact does the extent of involvement of different stakeholders have on the outcomes of practice development?</td>
</tr>
<tr>
<td>What impact does the scale of a study have on the outcomes of practice development?</td>
</tr>
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<td>How do contextual factors in the study setting have an impact on the outcomes of practice development?</td>
</tr>
<tr>
<td>How do cultural factors in the study setting have an impact on the outcomes of practice development?</td>
</tr>
<tr>
<td>How do styles of leadership in the study setting have an impact on the outcomes of practice development?</td>
</tr>
</tbody>
</table>

## THEORY AREA 2 – PROPERTIES OF THE PEOPLE INVOLVED IN DEVELOPING PRACTICE

<p>| How does the location of a practice developer have an impact on the outcomes of practice development? |</p>
<table>
<thead>
<tr>
<th>Theory Area 3 – Issues Surrounding the Initiation and Carrying Out of Practice Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do factors involved in the initiation of practice development have an impact on its outcomes?</td>
</tr>
<tr>
<td>What are the foci of practice development activity and how do they have an impact on its outcomes?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theory Area 4 – Approaches Used to the Use of Knowledge, Bringing about Change and Supporting Learning in Practice Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do approaches taken to support learning within practice development have an impact on outcomes?</td>
</tr>
<tr>
<td>How do approaches taken to bringing about change within practice development have an impact on outcomes?</td>
</tr>
<tr>
<td>What forms of knowledge use and knowledge generation are used in practice development and what are the consequences for the outcomes?</td>
</tr>
<tr>
<td>CRITIQUE</td>
</tr>
<tr>
<td>---------</td>
</tr>
</tbody>
</table>

**Was there a clear statement of the aims of the research?**

*Consider:*
- *what the goal of the research was*
- *why it is important*
- *its relevance*

**Was the research design appropriate to address the aims of the research?**

*Consider:*
- *if the researcher has justified the research design (e.g. have they discussed how they decided which methods to use?)*

Write comments here

**Was the recruitment strategy appropriate to the aims of the research?**

*Consider:*
- *if the researcher has explained how the participants were selected*
- *if they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study*
- *if there are any discussions around recruitment (e.g. why some people chose not to take part)*

Write comments here
Were the data collected in a way that addressed the research issue?

Consider:

– if the setting for data collection was justified
– if it is clear how data were collected (e.g. focus group, semi-structured interview etc)
– if the researcher has justified the methods chosen
– if the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, did they used a topic guide?)
– if methods were modified during the study. If so, has the researcher explained how and why?
– if the form of data is clear (e.g. tape recordings, video material, notes etc)
– if the researcher has discussed saturation of data

Write comments here

Has the relationship between researcher and participants been adequately considered?

Consider whether it is clear:

– if the researcher critically examined their own role, potential bias and influence during:
  – formulation of research questions
  – data collection, including sample recruitment and choice of location
  – how the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Write comments here
## Was the data analysis sufficiently rigorous?

**Consider:**
- if there is an in-depth description of the analysis process
- if thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- if sufficient data are presented to support the findings
- to what extent contradictory data are taken into account
- whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Write comments here

## Is there a clear statement of findings?

**Consider:**
- if the findings are explicit
- if there is adequate discussion of the evidence both for and against the researcher’s arguments
- if the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst.)
- if the findings are discussed in relation to the original research questions

Write comments here

### Additional comments

Would it be useful to get hold of the full report for this study:

Yes:                               No:

**REFERENCES TO FOLLOW UP:**
Appendix 11 Grey Literature

**Authored Reports and papers**


18. Hockley J, Dewar B and Watson J (2004) *Developing quality end of life care in eight independent nursing homes through the implementation of an integrated care pathway for the last days of life.* St Columba’s Hospice Bridges Initiative Project Phase II. Royal Bank of Scotland Centre for the Older Person’s Agenda, Queen Margaret University College, Edinburgh.


**Organisational Reports and Papers**


36. University of Louisville Hospital Behavioral Health Department Practice Development Submission Document, Louisville Kentucky, USA (2004) Practice Development Unit [PDU] Submission Document for Accreditation as a PDU to the Centre for the Development of
http://www.cdhpp.leeds.ac.uk/services/practice2.php

**Books**


Dear Colleagues,

I am writing to you with regards to the above project - "A Realist Synthesis of Practice Development" which I have been commissioned to lead a research team to undertake on behalf of 'NHS Education Scotland' and 'NHS Quality Improvement Scotland'. Information about the project is presented in the attachment titled 'Brochure'. Phase 1 of the study is now nearing completion and we are moving into Phase 2. This phase is largely focused on conducting 40-50 telephone interviews with key informants (internationally) in the field of practice development/developing practice. The interview format will be designed to test out the emerging conclusions of the literature based work (Phase 1), inviting a 'reality check' from a broad range of people working with practice development ideas on a day by day basis. Details of the interview process are outlined in the attached documents 'A realist synthesis of Practice Development' and 'Invite Letter'. Ethical approval has been applied for but was deemed unnecessary by the 'Multi-Centre Research Ethics Committee for Scotland' (REC Reference: 05/ MRE00/ 97). The themes emerging from the interviews will be mapped onto the analysis of the literature. As part of the acknowledgement of their input participants in the interviews will receive a summary of their input and will receive a short report as part of the dissemination of findings.

We are seeking your help in identifying an initial sample for interviewing, as follows:

1. we would like to invite you to participate in an interview and would be grateful if you could confirm by return of this message if you would be willing to do so. Please could you reply to Sinead Kelly (sinead.kelly @ royalhospitals.n-i.nhs.uk) and please provide a contact telephone number.

2. could you please provide details to Sinead (email and/or telephone details) of 2-4 people from your networks who would be willing to participate in an interview. Inclusion criteria are:
   - have engaged in practice development work as a participant or as a project facilitator/coordinator
   - are a key stakeholder in commissioning/funding/managing practice development work
   - Have a strategic role in developing practice
   - have successfully completed practice development activities

We will write to each potential interviewee, individually inviting them to participate. A semi-structured interview schedule will be devised and this will be forwarded to participants in advance of the interview. **I would be grateful for a reply by the 13th January 2006**

I would like to thank you in anticipation of your support with this work. This is the first project to try to systematically synthesise the PD literature and is thus of major significance. I look forward to hearing from you and in the meantime would like to wish you all a very Happy Christmas.

Brendan

PROFESSOR BRENDAN MCCORMACK
DIRECTOR OF NURSING RESEARCH & PD
NURSING DEVELOPMENT CENTRE
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BOSTOCK HOUSE
GROSVENOR ROAD
BELFAST
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FAX: +44(0)2890633484
EMAIL: BRENDAN.MCCORMACK@ROYALHOSPITALS.N-I.NHS.UK
APPENDIX 13

Project information

A REALIST SYNTHESIS OF PRACTICE DEVELOPMENT

Thank you for interest in our study! This sheet provides a brief outline of the research and details the part that we are inviting to take part in it. Should you have any questions or queries please feel free to contact Rob Garbett on +44 (0)28 9063 5824 or robert.garbett@royalhospitals.n-i.nhs.uk.

THE BACKGROUND TO THE STUDY

NHS Education Scotland (NES) and NHS Quality Improvement Scotland (NHS QIS) have commissioned a team drawn from the University of Ulster, Queen Margaret University College and Manchester Business School to carry out a systematic review of practice development. The research team have used a research approach known as ‘realist synthesis’ to design the study. Essentially this approach consists of identifying and testing the theoretical ideas behind a complex intervention – for example, practice development literature makes claims about the importance of context; what evidence do we have to support these claims?

HOW THE STUDY WORKS

The study has two parts. The first consists of a systematic literature review based on published literature. The second stage will draw on this analysis and consist of two further stages of data collection and analysis; telephone interviews with practice developers and an analysis of ‘grey’ literature (unpublished papers and reports).

WHERE YOU COME IN

We would like you to consider being a participant in a telephone interview; you have been approached because you are someone who has experience of and expertise in aspects of practice development. We will use an interview schedule drawn from the first stage of the study. Interviews will last for no more than an hour (probably less). With your permission we would like to record the interview using a digital recorder.

After the interview the recording will be transcribed and analysed. A copy of the initial analysis will be made available to you for comment within 14 days of your interview. Your identity will be kept off any material contributed by you. All names of individuals and organisations will be omitted from transcripts. No individuals or organisations will be identifiable in any publications or presentations about the study. Your understanding and consent will be recorded as part of your interview, should you agree.

WHAT DO I DO NOW?

If you would like to take part please look at the attached list of interview slots. Could you identify which of these would be convenient to you and return by e-mail/ mail to:

Rob Garbett
Nursing Development Centre, Level 3 Bostock House
Royal Hospitals Trust
Belfast BT12 6BA

Or

robert.garbett@royalhospitals.n-i.nhs.uk.
We look forward to talking to you!!

6 June, 2006

[Click here and type recipient’s address]

Dear Colleague,

A realist synthesis review of practice development

On behalf of the research team conducting the above study I would like to invite you to take part in a telephone interview that will contribute to our understanding of practice development.

I have attached details of the study and of your involvement, should you wish to take part.

The attached documents explain the purpose of the study and also give a timetable of available time slots for the interviews. Please let us know all the slots that would be convenient for you and we will confirm the exact time as soon as possible after your reply.

I do hope that you choose to participate in the study.

Yours sincerely,

Brendan McCormack
Professor of Nursing Research and Practice Development
APPENDIX 14

TELEPHONE INTERVIEW SCHEDULE

NHS EDUCATION FOR SCOTLAND AND NHS QUALITY IMPROVEMENT FOR SCOTLAND

Practice development – An in-depth Literature Review and Comparative Analysis

Semi-structured interview schedule

Introduction to the interview
Thank you for agreeing to participate in this interview. It is hoped that the interview should not last more than 30 minutes. The questions below are set out as a guide only and should I think that you have already answered a question in response to a different question then that question will be omitted. The questions are derived from the initial findings from the literature (phase 1 of the study) and the purpose of the interview is to help us to elaborate/corroborate these initial findings.

The interview will be tape recorded and transcribed by a secretary. The data will be held in a locked cupboard and only the research team will have access to the transcriptions (Brendan McCormack, Belinda Dewar, Gill Harvey, Jayne Wright)

Interview Questions
1. The evidence from the literature suggests the strength of multidisciplinary approaches to practice development over unidisciplinary approaches, what are your views about that/experiences of this?
   a. Do you see a place for unidisciplinary PD? If yes, for what reasons?

2. A clearly emergent theme in the literature is that of the need to involve multiple-stakeholders. Two stakeholders in particular are highlighted in this body of evidence – managers and service-users. What is your experience of involving these stakeholders in particular?
   a. What works – evidence to support this?
   b. How have you approached involvement of these stakeholders?
   c. What are the challenges?
   d. What were the benefits?
   e. Other stakeholder you consider essential to involve?

3. What challenges have you experienced in designing/using a systematic and rigorous methodology for PD work:
   a. Are there particular methodologies you are drawn to?

4. The literature highlights the diversity of roles involved in PD. What is your view re PD roles?
   a. Are there particular roles that you consider to be more effective than others?
   b. What are you views re the insider/outside roles debate?

5. A few studies report on partnerships for research and development work between care
organisations and higher educations institutions (HEIs). What are your views about the effectiveness of these partnerships?
   a. What works?
   b. What hinders partnership working
   c. Who benefits?

6. The literature suggests that practice developers either work in a role that mainly focuses on ‘working with practitioners’ or roles that focus on ‘working for the organisation’ – what do you think about this?

7. The evidence in the literature is not particularly strong in terms of informing methodological perspectives for PD. The overlap between practice development and action research is evident. Could you comment on this?

8. The foci of practice development can be categorised into two broad perspectives – activities that focus on the development of knowledge and skills of staff and activities that focus on bringing about particular clinical changes. Could you comment on this?

9. The evidence suggests that few practice development initiatives are initiated by staff in clinical practice. The dominant focus for studies reported are either responding to policy and/or strategic agendas or organisational recognition of particular practice problems. Could you comment on this?

10. There is little evidence in the literature of the relationship between particular development processes and outcomes achieved. Why do you think this is?

11. Have you been involved in securing resources (especially financial) for PD?
    a. What was the source of funding?
    b. How was the work costed (i.e. what elements of cost were included)?
    c. From what sources do you secure PD Funds?
    d. Any other resources secured?

12. If you were to summarise the key processes involved in PD work, what would you include in your list of ‘essential’ processes?

13. Is there anything else you would like to add that has not already been addressed in this interview?
Appendix 15a - Theory Area 1

Theory area 1 - Properties of the people and context in practice development

What evidence is there of the impact of different stakeholders?
(Page, 1998)
Challenges logic of unidisciplinary approaches to development on the basis that the patient experiences care from a whole team, and it is the whole team’s processes, beliefs and values that have an impact on that experience. Users’ experience a central part of this. Also bringing together the agendas of service and service management. Impact is a broad commitment to the work of the unit with all grades/disciplines feeling like they have an input. Empowerment seen as crucial and this is developed through consulting/asking.
(Bell & Procter, 1998)
Focus is almost entirely on nursing staff. Ownership achieved within a relatively small group of people with a key interest. ‘Peripheral’ staff took part in data collection – but didn’t really see it as their work.
1999
(Binnie & Titchen, 1999)
Importance of engaging productively and creatively with senior colleagues – ‘freedom to experiment’, easing bureaucracy and allowing things to happen like time for staff to work on projects and spend time discussing work, being creative with funds freed up – decentralisation of decision making, trusting and supporting rather than monitoring and instructing
223 ‘The contribution of this management context to the overall success of our project should not be underestimated. In the absence of a hostile management culture, the staff nurses were free to reserve their courage for addressing openly the complex and sometimes distressing problems of their patients’
(Galvin et al., 1999)
There was a wide involvement of service users and health professionals – it was part of the broader policy agenda within which the project took place. Service users were consulted about the service they wanted and staff were widely consulted about the kind of service they wanted to provide. Tension was caused by the impact of this within the context of a short study (one year).
(Clarke & Procter, 1999)
Speak of potential for marginalisation of practice developers/researchers from worlds of practice and research
‘The consternation experienced by the research participants about the legitimacy of practice development activity within professional practice is reflected in a number of ways in the study results. These include the personal investment in the development of practice (e.g. emotional and resource commitment to a development was felt to exceed the normal limits of commitment to practice), self presentation (e.g. the wearing of a uniform was seen to legitimate presence in clinical areas), and expectations of colleagues and of services (e.g. those active in developing practice challenged conventional models of patient care delivery as their own conceptualisations of health and health care changed).’ 980 – this is an impact of practice development carried out by the few
Similarly they also found themselves marginalised by the research world, where the criteria of good practice emphasise objectivity and the ability empirically to generalise the research results (Department of Health 1996, Rolfe 1998). Practice development lies outside the technical rational model of research and, by virtue of its generative and reflexive nature, can adopt none of these characteristics (Fish 1998).
For example, practice development research may not be a project which is clearly identifiable by time boundaries, and therefore may be particularly complex to evaluate and disseminate (Phillips et al. 1994).
(Ward & McCormack, 2000)
Managers did not seem to be particularly supportive of the development programme, which reportedly ceased before implementation was completed. Reasons for this included:
questions about the value of the programme in the current NHS climate of improving efficiency two year timescale for programme when there was a drive for immediate answers to problems possibility of achieving the desired outcomes and rigorous completion of the process whilst maintaining traditional job roles.
Patients and relatives had identified significant problems with the care delivered; also audit results suggested poor standards of care. However, management did not really see these as problems, so much as ‘one-off’ concerns
(Bates, 2000)
An important aspect of the paper – the initiative was intended to be md from the outset. Innovations have incorporated single profession activities and made them more inclusive (e.g. journal clubs). Effort appears
to have been made to elicit support and raise awareness in a number of ways (e.g. seminars, newsletters) to make sure that people are on board. This appears have resulted in acceptance and participation from university and different groups. (Manley, 2000a)

The claim that an understanding of and working organisational culture through transformational approaches to leadership means that working with all relevant stakeholders is essential to practice development. In this case the development of a consultant nurse role was enabled by identifying the interests of key stakeholders using fourth generation evaluation tools. Central to ensuring unified approaches to working is the notion of values and beliefs; these are frequently tacit and so not harnessed to provide focus and direction. Drawing on the business literature Manley argues that Kotter and Heskett's (1992) research demonstrated that over an 11-year period, those organisations emphasising leadership and key stakeholders increased their revenues by an average of 682 per cent, compared with an increase of 166 per cent in those organisations that did not. Other financial indicators showed similar trends. Although the general features identified by Kotter and Heskett (1992) are supported by Denison's hypotheses, Brown (1998), who considers their research to be pioneering, suggests further validation and notes their focus has only been on commercial organisations. (Manley, 2000b)

Use of an emancipatory action research design explicitly implies the involvement of a broad range of stakeholders as the purpose is the greater sense of ownership and participation across a team. This is expressed firstly through the development of shared vision that provides focus and direction for the whole team. Care taken not just to ask but to check back with people about what they had said.

A sustained commitment to quality is evidenced by the achievement of a charter mark and the words of the Patient Advocate (Chelsea and Westminster Healthcare NHS Trust 1999): 'I have worked in five countries for many companies as chief executive or non-executive director, but working with this unit has opened my eyes. The professionalism, dedication and camaraderie - with discipline - are quite outstanding. The way the unit responds to and interacts with individuals and "grows" them is truly remarkable. Many commercial and industrial companies would be green with envy.

'Finally, I have been very impressed by your reaction to questionnaires completed by patients and relatives. On receiving sometimes negative feedback, you have reacted positively, rather than negatively. Your response was in effect "we must change that practice, we must do more in that direction," or "what a good idea". You listened, you learned and you acted. That says it all.'

Impact was apparent:
The post-holder helped individuals to become more confident to do new things and to recognise that there was a career pathway for them - a future for nurses to stay and progress in practice, using their expertise. The post impacted on practitioners' work and role in a number of ways:

'Her influence has definitely influenced me in my work, and her role has changed my opinion. I'm more enthusiastic about coming to work now. I would think seriously before I change job now, because I would need to be very careful about where I work after being in such an autonomous environment, where I am able to say a lot for my grade. I would need to think very seriously about going to some place that would be more hierarchical again. You can be more autonomous here and say a lot more about how you feel, and feel a part of big decisions. Before, with the overall impression that the unit gave, you felt that it was up to senior people to make management decisions. Now you feel that it is up to the whole team and, again, I think that has filtered down through the people in management on the unit, but also through the consultant nurse's influence as well' (IE4).

Everyone challenged their practice, and understood used and critiqued research. This was linked to the post-holder as a resource, someone who helped them to make research more real, to act on it and develop their evidence base:

'In other units, I'd done things just because that's the way it's done, but since coming here and then spending the day actually working with the consultant nurse, who says "We do it this way here because research has shown... and I can show you the articles..." This applied to even small things, like drawing up fluid from a syringe bag - research shows that the maximum you should do it is five times. A little thing like that, or maybe a bigger thing like eye care - it's every detail of patient care that we've looked at now and we know there's a reason why we do it' (E12).

Key stakeholders had become aware of the quality of the service the unit provided through specific communication strategies, but this had been further validated by the observations of others, such as medical staff, who worked directly with the unit's staff.

The trust gained kudos from being associated with, and supportive of, the unit and post. The perceived
success of the post had made it easier to argue for the establishment of other such posts within the trust. The post and the unit were seen to have a positive impact on the trust and its culture, with the consultancy component of the post noted as contributing widely to the trust. This was demonstrated in relation to a number of initiatives, such as the trust's clinical supervision strategy and its implementation:

'I suppose it was having someone with an expertise in clinical supervision within the trust, who was willing to help us start clinical supervision on a broader scale across the trust. That's been invaluable because I'm sure we would have still been working on the theory, rather than the practice, and we really needed the practice as well. And you started it with the clinical supervision groups and your successor is carrying it on. The rest of the nurses in the NDU have been good about sharing their experiences and knowledge of clinical supervision. We've run a number of study sessions on clinical supervision for various people and it has been invaluable to us as a trust. I suppose the knowledge base across the trust is expanding quite dramatically because of that' (O4).

'Value added ness' was articulated as reflecting lower sickness, turnover and incident rates compared with other areas, the absence of complaints, effective handling of MRSA outbreaks and better retention, stability and recruitment of staff. The post also offered the trust an opportunity to enable others outside of the NDU to achieve their potential through accessing the post:

'One can get very tied up with the pressure of work coming through - it is terribly important to have one person standing outside those pressures who can actually support the individuals in the unit to reach their potential' (O3).

(Clarke & Wilcockson, 2001)

Suggest a division between those whose focus is local and those who broaden their focus to think about the degree to which the patient is the focus of services, therefore meaning that work with a range of stakeholders is necessary.

(Holman & Jackson, 2001)

It is apparent that despite invites, stakeholder involvement was limited. The programme was not seen as multidisciplinary. Compared to other studies where there was better MD involvement it would appear that there was a clear split between researchers and practitioners – ‘we have come to do to you’, the progress from there on appears to have been reliant on the researchers persuading people to be involved. There does not appear to have been the stage of identifying common areas of values, beliefs and interests to promote cohesive working together.

(Clarke & Wilcockson, 2002)

Users views were seen as a vital component of development by these respondents:

402 Recognising and valuing the patient’s experience of illness were considered an essential element of planning services. For one practitioner, patient involvement was regarded as a partnership that involved the key players in the patient’s recovery. …if you are going to develop practice you do it in partnership, you do it within equity so there is no one person patient, carer or practitioner who has all the answers. Together they have all the answers and they have all the knowledge… (Senior Manager for Development)

Another plea for broad involvement:

402 … what I believe strongly is that developing practice and developing care should be in the hands of the people who are doing it, because those people are the ones who are with the patients and the public on a daily basis. These are the people who should under- stand the job and should understand how the job grows… (Charge Nurse/Practice Development Nurse)

One impact this had was in a shift in the dynamics between practitioners and patients. However, changes in the way that practitioners viewed the needs of service users resulted not only in different services, but also in changes to the relationship between the practitioner and the patient. The following example illustrates a shift in patient responsibility following introduction of a physiotherapy service development.

…we are trying to do it more on the teaching of the patient and advice to the patient and putting some of the onus back on the patient care, we will give them advice and we will treat them but they’ve got to get back to us if there is a problem. (Physiotherapist)

(Bellman et al., 2003)

Within the culture where the study took place the involvement of multiple stakeholders (e.g. managers, university) in an action research created tensions based on not being comfortable with the methodology and feeling threatened by it.

Involvement of key stakeholders is an essential part of the AR process – the director of nursing played a key role in the study at operational and strategic levels. ‘The open communication process both enabled and empowered the front-line researchers to directly influenced the development of the study’

Relationships allowed the development of less hierarchical and more empowering relationships between the
co-researchers, managers and the health care team, proving confidence for them to lead on work:
‘That’s a very significant piece of work (audit tool for pre-operative fasting) and really, really valuable.
Reduction in corporate management support followed the resignation of the director of nursing.
(Clarke et al., 2003)
In the area being developed (using biographical approaches) it was reported that not much attention had
been paid to the interventions needed with care staff, and some attention was given to this area in the study.
The care workers illustrated their experiences of using the approach with practical examples, thereby
helping to allay anxieties such as constraints of time and listening to (and acting upon) painful or upsetting
memories. Where appropriate, existing research was highlighted to support such views further. Feedback
regarding these sessions was positive; involving support workers in the teaching sessions was seen as
preferable to members of the research team providing ‘textbook’ explanations about the use of biography
(Clinton & Getachew, 2003)
A team with apparently more effective practice was facilitated to work with other teams that did not seem to
be as effective at managing ‘near misses’ – the teams worked together to develop greater insight into
strategies and craft knowledge leading to the dissemination of effective practice throughout the unit. The
result was increased patient satisfaction and reduction in the incidence of near misses.
(Delord, 2003)
Wide range of stakeholders invited to project launch. Level of continuing involvement/impact unclear
(McCormack & Garbett, 2003)
Highlights need to work with a range of different stakeholders – ‘keeping plates spinning’
Need to develop a complex social network within an organisation; speaking the language of different
stakeholders and establishing credibility with different groups.
(Molyneux & Fulton, 2003)
MD pt focused work initiated by medics but picked by nursing staff – little evidence of clear project plan
(Eve, 2004)
User groups and the MD team working together – the change has gone ‘deep’ and made the service far
more goal oriented
(Dewing & Traynor, 2005a)
Unidisciplinary in focus but with multiple stakeholders

The impact of this is apparent in:
The initiation of the study came from the managerial structure who made assumptions about the readiness
of practitioners to work with emancipatory processes;
‘This might have led to a participatory approach being taken which would have been more in keeping with
the nurses’ experience of the cultures they worked in. It could be suggested that the commissioners had a
vested interest in creating the impression that the nurses were willing to work with emancipatory processes.
However, it was later felt by the researchers, that this approach was not the most helpful for the project and
was too challenging for some of the nurses.’ P.697

The impact of carers’ involvement in the study which added an additional core competency (p.700)
p.701 Discussions started with practitioners but broadened out to include other stakeholders
(Ohlsen et al., 2005) Very much a study where people were informed rather than collaborated with (616) –
‘informed of and consulted with’ and ‘joint working agreements’. There was apparently no consultation
with other stakeholders, including service users. That said there were positive impacts on problematic areas
of peoples’ lives such as dietary intake which improved with the intervention.
(Reed, 2005) Here the impact is more one of the impact of there not being real involvement from some
practitioners due to the tensions between the processes of setting up funded research and the changing
practice environment making it difficult to maintain involvement
(Carr & Davidson, 2004) Although practice development has a considerable history, to date it has largely
been reported in relation to single-client groups or needs. The application described here locates practice
development within a broader framework where the population forms the client and the identified needs
relate to health inequalities.

What impact did the scale of a study have on the outcomes of the development activity?
Scale of the study provided challenges. Study involved facilitating 13 clinical distinct clinical areas using a supervisory structure with shared learning at two junctures in the study. This contributed to communication difficulties between the internal facilitators and the external facilitators.

The work took place on a single 27 bedded unit. Three different strands of work took place and appear to have drawn some staff in while leaving others on the periphery with a degree of tension between the groups as a result. It would appear that the volume of work was large for a small clinical area and that the whole team became less engaged with it as time wore on, especially those aspects concerned with formal data gathering.

The scale of change involved was considerable and the team needed to provide additional resources to support change in the practice. The scale of the study was seen as ambitious within the timescale available (12 months) and this caused tension for the clinicians involved and lead to role confusion for the internal facilitators who felt pulled between practitioners (their colleagues) and the project.

This work took place on a unit level. It appears to have nonetheless involved a lot of people and effort. It appears that the focus has had a positive effect in the depth of the impact with broad involvement in the bid for PDU accreditation.

Although the study took place only in the ICU the impact was felt throughout the organisation as a result of the communication strategies by the staff on the unit to ensure a high profile for their work. The unit provided a resource for the whole trust and the consultant nurse influenced strategic direction based on the work being carried out in the ICU.

It was a unit wide study where the awareness that one unit was more effective than another in terms of ‘near misses’ was used to encourage shared learning.

Large scale project – there do not appear to be any observations or findings that explicitly address the impact of the scale of the study. It could be argued that the initiation of the study at an organisational level contributed to some of the tensions that emerged during the study.

How is the impact of contextual factors articulated?

Rigid organisational structures cause frustration:

We seem stuck constantly, we can move from one philosophy to another philosophy but once we establish a philosophy it's all encompassing and we can't actually offer flexibility or choice within a philosophy, we just don't seem to have the facility to do that.

The context seems to have been initially quite strong – with established interprofessional relationships and a commitment to improvement. There isn't much discussion of how the unit is managed although the project was co-ordinated by a staff nurse indicating some form of flattened structure. Part of the context of this study is the use of an accreditation process to frame development. This process is not subjected to any critical analysis the criteria for using it being on the basis that it ‘doesn’t cost’. The framework has some of the elements (but not all) common to other models of PD, e.g. being systematic, inclusive, communicative but does not incorporate more transformative aspects.

1. Multi-disciplinary collaboration is evident in the current practices and developments of the PDU
2. Holistic care is underpinned by evidence based practice
3. Staff are involved in individual and collaborative research activity
4. There is evidence of dissemination of research findings within the local and national arena
5. Staff development for the PDU is planned, actioned and evaluated and meets the needs of the individual and the multi-disciplinary team
6. Users and carers are actively involved in the planning, delivery and evaluation of care and the co-ordination and development of patient services
7. Effective collaboration with academic institutions is evident within the PDU
8. The unit has developed a comprehensive communication strategy which addresses communication issues at both a local and national level

(Aintree Hospitals NHS Trust & Edge Hill College, 2000)
Manley 2000 The emphasis of the development work was on developing a strong context through the establishment of clear role boundaries based on negotiation and shared understanding, democratising decision making in the unit, clarifying roles and accountability. Becoming more effective as a clinical area meant that the unit was in a stronger position to bid for additional resources. There was a shift so that change was actively embraced and sought.

(Clarke & Wilcockson, 2001) The evidence suggests a contrast between ‘novice’ and ‘expert’ practice developers in terms of perceiving the impact of a range of factors for example:

‘The majority of people who were interviewed located their thinking into existing structures and resourcing levels, thus limiting their ability to see the potential to develop practice. They focused on the finality of the absence of resources and, most often, resources were central to their conceptualization of the process of developing practice (as Figure 2 typically shows).

I think time and resources go together because I think it's probably one of the hardest things about practice development, is no matter how enthusiastic and motivated you can get about that so sometimes you find that time becomes a barrier (Clinical Teacher)

This was in stark contrast to those practitioners who seemed to demonstrate `expert' thinking. Their thinking was holistic and they could see possibilities in situations that were less than ideal. There were several ways in which the `expert' thinker appeared to address the resource issue: challenging the attitude of practitioners who could only perceive limited resources as a deficit; assessing the resources that were already available and how they were being used; and harnessing less obvious resources to improve practice.’ 267

They surfaced an issue about the extent to which practitioners/practice developers who have been on a journey to becoming emancipated (my interpretation) embrace the responsibility they have to make choices about how they use their time:

‘You know ’we haven't time to do research', `we haven't time to read research on the knowledge part' damned excuse! Because people have time but don't want to, don't choose to it’s what you value as important. (Senior Manager for Development)

This is contrasted with what they call a competent level of perception where there is a ‘defeatist attitude’ in the face of limited resources

(Clarke & Wilcockson, 2002) The internal politics within a setting can cause tensions between developmental and organisational imperatives:

404 There is, of course, a tension between development that serves to perpetuate an organisation and development that serves primarily to better the health status of a patient group or population. The study participants were well aware of this, but also felt that some of the systems of health care contracting and organisational divisions and boundaries served to negate attempts to develop care of service users at times.

(Clarke et al., 2003) Workload, staffing and sickness etc became barriers

(Clinnon & Getachew, 2003)

(Delord, 2003) Contextual factors largely referred to in terms of obstacles to implementation e.g. shortage of times to meet due to shift patterns, changes in workload and teams, staff turnover etc.

(McMornack & Garbett, 2003) Polarized views re alignment of practice developers with management structures: could present a conflict of interest; alternatively may help to reinforce the view that practice development is integral to the business of healthcare

Importance of understanding the practice context in order to achieve credibility

Lack of infrastructure and strategic planning to support PD can diminish the potential impact of PD activity

(Campbell et al., 2004) The groups that work on pathways integrate all disciplines as well as patients but privilege patient experience rather than professional interests – starting the work has started a continuous process of looking at issues arising from practice

(Eve, 2004) There was initially a lack of clarity about the function of the unit – although nominally a rehab setting there was also a sense of it being a ‘dumping ground’ without clear rationale or evidence base

The move was to a unit with a clear sense of purpose, an expanded service and far greater patient mobility into the community.

(Dewing & Traynor, 2005b) Preparation and entry – the researchers suggest that the overall study approach might usefully have been negotiated with the participants. As it is they agreed the approach with the research commissioners and this seems to have created a mismatch between expectations of participants in the study, e.g. some lack of clarity in boundaries and roles – although these were negotiated and renegotiated (p.698).

There is a suggestion that willingness to entertain scrutiny of practice and the potential for change was overestimated by the project commissioners and that even by the end of the study not all the participants felt
that they had not been coerced to some degree.
The study methodology explicitly linked to the researchers making considerable efforts to ensure that practitioners had access to data and were able to comment on it, and had control over how it was analysed and presented.

(Redfern & Christian, 2003) Six key factors emerged from interviews with project leaders as important in achieving successful Change.

- Target staff are familiar with and understand what is expected of them;
- Staff have received the right training;
- Staff are motivated to participate in the change;
- Necessary resources are in place;
- Influential Trust and university stakeholders are supportive; and
- Planning for sustainability of the change is in place.

Five centres (1, 3, 5, 7, 9) had to cope with disruptive organizational restructuring or trust mergers. Five (1, 3, 5, 6, 8) had insufficient numbers of staff or they lost staff through turnover. Two (3, 4, 5, 7), inadequate resources threatened implementation.

Congruence was particularly low in centres 1, 4 and 5 and these three were affected more than the others by contextual barriers to the implementation of the project guidelines. That is to say, even though centres 1, 4 and 5 were awarded the most in additional funding, two of them suffered from organizational restructuring (1, 5), insufficient or loss of staff (1, 5), inadequate resources (4, 5) and inflexible communication. Channels in the Trust (4, 5).

(Carr & Davidson, 2004) Ambiguity can have both a positive and a negative effect. On the positive side, it provides an opportunity for diversity: allowing freedom for innovation. However, in times of almost continual change and role challenge, the enthusiasm and energy to embrace his opportunity may be limited. The negative aspects of the ambiguity are compounded by the fact that the focus of development in public health nursing is not on specific, practical or technical skills but on the development of a practice mindset that moves the focus of care from individuals to populations.

Community nurses have experienced a degree of ‘role threat’ as a consequence of recent policy developments and the establishment of new roles, such as that of the public health nurse. In such a climate it is reasonable to expect a level of reluctance, reticence and guardedness.
- Some community nurses were enthusiastic, whereas others were in ‘change overload’, facing another challenge to the way the community nursing role had been practised for many years.

This created a complex and demanding scenario, which was influenced by a surge in governmental policy in relation to public health and the subsequent urgency and quantity of change.

How is the impact of cultural factors articulated?

(Galvin et al., 1999) The extent to which boundaries between professions were a barrier was identified by health professionals in the baseline data. They identified a need for greater clarification of skills and roles and focusing on meeting patients needs. A point reinforced by patient feedback.

(Bates, 2000) Although there is a sense of cohesion it is not part of the journey that they took or the accreditation process they were working towards that there should be an explicit set of values and beliefs. However the steering group did draw up a frame of reference for its work. Attention appears to be more focused on tasks than processes of working together or of interaction. Valuing individuals’ input is apparent through a commitment to promoting involvement and communication. The outcomes here seem to be that some things are done differently, but are people and the way they work that different?

Manley (2000) The central tenet of the study was that the workplace needs to be understood and developed as a precursor for other work.

- Congruency between values and beliefs espoused and actual practice was identified, with specific values being identified as:
  - The primacy of the patient and patient-centredness.
  - Providing support to staff.
  - Devolved decision-making in relation to both patient care and unit activity.
  - Openness to suggestions/involvement of everyone.
  - Education and personal development.
  - Role of nursing.

Early developmental work within the unit focused on making values and beliefs explicit, and using them to develop a shared vision and to guide subsequent action. The espoused values and beliefs can be identified from early publications (Clayton and McCabe 1991, Jenkins 1991, Manley 1990, Warfield and Manley 1990).

The processes of critique and reflection central to emancipatory action research focused on identifying
contradictions between espoused theory and theory in use. They were intended to help individuals and
groups live and act out the values and beliefs they articulated. This meant that value-based principles could
be used to guide action in unfamiliar situations.
The findings strongly suggest that the culture in action was the same as the espoused culture, and that
specific configurations of values, such as being people-centred, providing support, enabling development,
active participation and devolved decision-making, were evident.
Marked differences perceived by returners on their return provide further evidence of the effects of this
strong culture. These related to the paradox of being familiar with the culture but unfamiliar with the staff,
which were different, and the distinctive amount of change and development. The marked differences noted
by returners were:
The increased amount of teaching and education.
The amount of further education and development undertaken by everyone.
Much greater involvement of everyone in developmental work.
Involvement of all staff, particularly the more junior staff.
Initiatives previously talked about when informants left were now up and running.’

‘Marked differences were also noted in team working and individual working. The unit was perceived as
being a healthy team where conflict was constructively addressed, compared with experiences of working
elsewhere.’
‘The culture was also perceived as having a positive influence on the recruitment and retention of staff.
Many staff had been exposed to the unit previously, either as agency nurses or through knowing agency or
ENB course students who had worked there. Some had read unit publications and were attracted to the
values and beliefs espoused about nursing.’
(Clarke & Wilcockson, 2001) Contrasted those locked into a perception that resources restricted their work
with those that problematised the relationship between the resources available and the way those resources
are used - some did not have a sense of being able to effect this and saw themselves as passive:
‘Now I don’t know, and ideally the organization should have the patients’ interests at heart and so if we do
what the organization wants us to do, then we should be doing what is good for the patient. I can’t think of
any specific thing where somebody is looking in to ensure that we are doing it for the patient. (Pharmacist)’
This also reflects a limited view of the influence that patients can have
By contrast those with a vision of what practice could achieve and problematised the relationship between
that vision and day to day experience were more proactive:
‘Through reviewing the whole picture, practitioners were able to respond in a more holistic way and
consider other essential needs of the patient. This ability to perceive the broader view of patient care
enabled practice to be developed in ways that responded more fully to the patient. In developing the care of
patients, several respondents recognized an association with developing practitioners themselves as carers.
This is a perspective that forms the cornerstone of the original Nursing Development Unit movement (Page
et al. 1998).’ 269
The journey in practice development is described as:
‘This change in level of thinking was described in the following way and reflects the critical nature of the
level of thinking of individual practitioners on their understanding of patient care:
(People shift) from being descriptive and procedural and operant in the way they think, to thinking in a
more open way. (Medical Director)” 269
Reinforces the idea of a favourable culture in identifying the importance of being open and co-operative as
an underpinning factor in successful shared inquiry
(Clarke & Wilcockson, 2002) The people contributing to the study saw a permissive culture as important
The importance of having an organisational culture supportive of questioning and challenging thinking
were emphasised. The following respondent spoke of the need to support the implementation of learning
from taught courses. And that is about us taking the risk because we actually want these people to make
decisions. We have to support them when there is a wrong decision and then encourage them to make the
right one but is an organisation I think we are trying to change that culture. (Chief Nurse)
(Clinton & Getachew, 2003) Points out the emphasis being placed on the notion of learning culture in the
NHS, the notion being drawn from the work of Senge
Engaging in work around a particular area of practice raised awareness of cultural factors that encouraged
responsiveness such as community meeting and partnership forums with users
(Delord, 2003) Again, mainly referred to in terms of obstacles and lessons learnt e.g. need to involve as
many people as possible at the outset of the change, ensure regular meetings take place etc.
(Eve, 2004) No clear sense of values/beliefs and vision initially – this was replaced by the use of a rehab
model that focused on strengths of the pt and the nature of the pt/nurse relationship
As group work developed it was characterised by providing challenge within a blame free environment 84
With an emphasis on reflective strategies
The author notes the shift in attitude towards people with enduring mental illness and noted a more positive
and optimistic culture 87
(Dewing & Traynor, 2005b) Part of the processes of the study involved looking at values and beliefs, it
appears that there was a degree of mismatch between espoused values and practice = a source of
discomfort for some participants. Practice development is concerned with addressing the consequences of
such mismatches.
The study seems to have contributed to a more learning oriented culture – part of the work involved
facilitating participants to address needs for change in practice.

How do styles of leadership in the study setting have an impact on the outcomes of practice development?
(Galvin et al., 1999) Lessons learnt the need for more effort still to be made with updating people regularly
and for greater clarity around roles, expectations and responsibilities:
Boundaries needed to be identified for the research team in terms of completing data analysis and write-up
and clearly locating this type of decision-making with the m project manager. How
(Bates, 2000) The leadership approach seems to be inclusive and communicative and is linked to the level
of participation and involvement. People appear to be working together. However, the processes by which
they do this and how these may be embellished/capitalised upon does not seem to be looked at.
(Ward & McCormack, 2000) Following a successful PD project on one ward, which demonstrated
improvements in standards of care, alongside changes in attitudes to and organisation of work, decided to
roll out the PD programme throughout the hospital (130 beds). Four projects aimed at changing nursing
practice were established.
(Holman & Jackson, 2001) There seems to have been little leadership from clinical staff or indeed
ownership. Although the staff reported enjoying the developmental activities involved, little actual change
could be identified in clinical practice
(McCormack & Garbett, 2003) lls and qualities identified as important for practice developers seen to bear
a close resemblance to those associated with transformational leadership.
Qualities: affective skills, vision, motivation, empathy, experiential approach
(Walsh et al., 2002) Project groups led by someone from the ward with authority in terms of the ward
structure seemed to fare best in terms of initiating and keeping projects moving; importance of active
leadership in change processes
(Molyneux & Fulton, 2003) There were some transformational techniques being used but thee ultimate aim
of the process does not appear to have been shared and agreed
(Campbell et al., 2004) The active and willing involvement of business managers is seen as being key in the
success of the initiative – the whole thing being inclusive and enabling
(Dewing & Traynor, 2005b) Leadership issues were around the issues raised by emerging clarity about
roles
Issues for practice developers
Issues about access
(Reed, 2005) There does not seem to have been a unified form of leadership for the study, e.g. a united
sense of shared direction
### APPENDIX 15B

**Example of Themed Data from Theory Area 1**

<table>
<thead>
<tr>
<th>(Page, 1998) Challenges logic of unidisciplinary approaches to development on the basis that the patient experiences care from a whole team, and it is the whole team’s processes, beliefs and values that have an impact on that experience. Users’ experience a central part of this. Also bringing together the agendas of service and service management. Impact is a broad commitment to the work of the unit with all grades/disciplines feeling like they have an input. Empowerment seen as crucial and this is developed through consulting/asking.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unidisciplinary/Multidisciplinary</strong></td>
</tr>
<tr>
<td><strong>Stakeholders</strong></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
</tr>
</tbody>
</table>

| (Bell & Procter, 1998) Focus is almost entirely on nursing staff. Ownership achieved within a relatively small group of people with a key interest. ‘Peripheral’ staff took part in data collection – but didn’t really see it as their work. |
| **Stakeholders** |

| (Binnie & Titchen, 1999) Importance of engaging productively and creatively with senior colleagues - ‘freedom to experiment’, easing bureaucracy and allowing things to happen like time for staff to work on projects and spend time discussing work, being creative with funds freed up – decentralisation of decision making, trusting and supporting rather than monitoring and instructing |
| **Methodological approaches** |
| **Stakeholders** |

The contribution of this management context to the overall success of our project should not be underestimated. In the absence of a hostile management culture, the staff nurses were free to reserve their courage for addressing openly the complex and sometimes distressing problems of their patients.

| (Galvin et al., 1999) There was a wide involvement of service users and health professionals - it was part of the broader policy agenda within which the project took place. Service users were consulted about the service they wanted and staff were widely consulted about the kind of service they wanted to provide. Tension was caused by the impact of this within the context of a short study (one year). |
| **Stakeholders** |
| **Methodological approaches** |

<table>
<thead>
<tr>
<th>(Clarke &amp; Procter, 1999) Speak of potential for marginalisation of practice developers/researchers from worlds of practice and research</th>
</tr>
</thead>
</table>