



## ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

### Advancing the practice development outcomes agenda within multiple contexts

Kim Manley\*, Jackie Crisp and Cheryle Moss

\*Corresponding author: Nursing and Applied Clinical Studies, Faculty of Health and Social Care, Canterbury Christ Church University, England. Email: [kim.manley@canterbury.ac.uk](mailto:kim.manley@canterbury.ac.uk)

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#### Abstract

To-date the major focus and activity has been on clarifying the nature of practice development intervention and in developing and identifying approaches, methods and processes that fit with the intent of practice development work. Further effort has emphasised the importance of achieving this intent while ensuring that practice development work, as a 'complex intervention', is adapted locally and contextually. Whilst a range of outcomes have been achieved from systematic practice development work, the need to develop strategic level evaluation frameworks that reflect the complex and multi-faceted nature of practice development interventions has also been identified. The evolution of practice development as an effective intervention for enhancing practice and workplace cultures is contingent on the explication and demonstration of both the process and health outcomes it achieves. The accumulation of this evidence of effectiveness is required to ensure the uptake of practice development by policy makers and commissioners of quality and research enhancements across both health and academic sectors.

The practice development outcomes agenda calls for consensus around parameters of practice development interventions, process outcomes and the major health outcomes that drive practice development work. The availability of the work on effective workplace cultures, the key process outcome through which practice development values are sustained, provides a useful way forward in relation to identifying a shared set of outcomes that complements practice development's own PRAXIS evaluation framework and provides a meaningful way of engaging those undertaking practice development in locally valuable, and internationally relevant outcome evaluation.

The purpose of this position paper is to challenge the international practice development community to be clearer about the 'fit' between the dominant discourses around quality, health outcomes and research impact, the purpose and intent of practice development work, and our need to pay due regard to both. This purpose is achieved by building on the need to develop a strategic level evaluation framework by:

- Raising awareness of the context of practice development intervention and advancement of an outcomes agenda within the dominant discourses around quality, health outcomes and research impact evaluation
- Furthering the dialogue around the outcomes of practice development to move the evaluation agenda forward

We conclude with a recommendation for a shared agenda in establishing the outcomes of practice development internationally through the creation of shared approaches to outcome evaluation. This approach we argue will deliver on the dominant discourse around quality, health outcomes and research impact, the purpose and intent of practice development, as well as, increase the uptake of practice development so that its potential is fully optimised.

Implications for practice include consideration of the:

- Value of capturing process and outcome data associated with practice development initiatives
- Diversity of approaches available for evaluating practice development initiatives
- Need to consider the interests and expectations of the full range of stakeholders when evaluating practice development work
- Political realities surrounding practice development work, the value placed on it and mechanisms for obtaining funding

**Keywords:** practice development, complex intervention, evaluation, impact, outcomes, quality, sustainability

### **Background**

The evolution of practice development, as an intervention for improving the quality of health care, is particularly remarkable as it has been achieved through the efforts of a relatively small international community. Over the past 10-15 years practice development has undergone extensive theoretical and methodological development, building on its early foundations within the nursing development movement (McCormack et al., 2004; Manley et al., 2008a). Practice development is now achieving greater recognition as a complex intervention that shows promise in health care culture reform within both nursing; for example, the 'Essentials of Care' programme (Nursing and Midwifery Office, 2011) and the wider healthcare team (e.g. McCormack et al., 2010a, b, 2009; Henderson, 2008; Manley et al., 2008a) (See Box 1 for definition of practice development).

#### **Box 1.** Definition of practice development as a complex intervention.

Practice development is a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individual and team practices. This is sustained by embedding both processes and outcomes in corporate strategy.

International Practice Development Colloquium, cited in Manley et al., (2008, p. 9)

The outcomes of practice development as an intervention for transforming healthcare, for those who deliver and receive health services, are arguably substantial and varied. There is evidence of the role of practice development interventions in achieving outcomes such as improved team work, advancement in team based quality improvement initiatives, and advances in teams working for sustainable learning and development (McCormack et al., 2006; McCormack et al., 2007a-c). There is also evidence of growing sophistication in the forms and conceptual bases of practice development as a methodology for workplace intervention; as demonstrated by conceptual and theoretical work, growing levels of research, and international exchange over contextual and process factors involved in practice development implementation and evaluation (McCormack et al., 2007a-c; Manley et al., 2008a; Volante, 2009).

The success of this early work has brought the practice development community to a point where the demonstrable outcomes of practice development can now be extended in a way that aligns them strategically with current and future healthcare drivers – the dominant discourse - and that policymakers and commissioners can recognise that practice development addresses these drivers in a sustainable way (Manley et al., 2008a). The main purpose of this paper is to argue for the development of strategic level evaluation frameworks that reflect the complex and multi-faceted nature of practice development interventions and deliver on both the dominant discourse and practice development's purpose and intent. We argue that as members of the international community involved in practice development intervention and research, we are well placed to create collaborative means of establishing the effectiveness of practice development as a complex intervention at a strategic level in a manner that fits comfortably with the philosophical, theoretical and practical realities of practice development. We seek to achieve this purpose through:

- Raising awareness of the context of practice development intervention and advancement of an outcomes agenda within the dominant discourses around quality, health outcomes and research impact evaluation
- Furthering the dialogue around the outcomes of practice development to move the evaluation agenda forward in a way that complements practice development's own evaluation PRAXIS framework (Wilson et al., 2008)

### **Contextualising the outcomes of practice development**

While the ability of practice development to light the fire and passions of practitioners and some health services continues to be a defining characteristic (reflecting practitioner empowerment), broader recognition and engagement by external stakeholders, particularly senior managers, policy developers, commissioners, quality improvement scientists and researchers is relatively low key. Uptake of practice development by these groups continues to be minimal despite the increasing recognition of the role of workplace culture in consistent failings to provide person-centred care (Mid Staffordshire NHS Foundation Trust Inquiry, 2010; Patients Association, 2009, 2010; NSW Department of Health, 2009); an increased need for dignity charters; and a dearth of strategies for transforming such cultures. Additionally, the role of the workplace, specifically workplace culture is being linked to staff experience, well being and commitment, which in turn impacts on the patients' experience and patient outcomes (NHS National Institute of Innovation, 2010; West et al., 2006; NSW Department of Health, 2009), so that person-centred ways of working apply to staff as well as to patients and service users.

Funded practice development usually arises through local and/or national commissioning from healthcare providers; government bodies; higher education; research commissioners or related stakeholders such as national charities aiming to improve quality, learning, development and research through local and national strategies. The importance of evaluation in practice development in relation to influencing policy makers was first recognised in the early concept analysis undertaken on practice development where the role of rigorous and systematic approaches was emphasised (Garbett and McCormack, 2002). This evaluation focus discriminated effective practice development from other haphazard approaches to developing practice for the purpose of: increasing the impact on policy makers and future potential funders; enabling processes and outcomes from practice development projects to contribute to the body of knowledge; and demonstrating accountability in the use of public funding. Funding from the full range of sources is more likely to be achieved when the practice development community provides evaluation evidence that demonstrates how our work contributes directly to the outcome agendas of relevant stakeholders.

The forms of investigation and translation of the outcomes that practice development work achieves spans practice development theory and concepts as well as process and outcomes more generally

utilised in health services and academic contexts. At the very least we need the ability to compare and contrast practice development outcomes with outcomes associated with different types of health service developments and change initiatives, and to be able to satisfy the academic conditions associated with knowledge generation, translation, utilisation and research impact. The contexts within which practice development work, and required outcomes, occur are framed by three significant stakeholder groups: those involved in the organisation and delivery of health services, those involved in the activities associated with the academic sector and those who are directly involved in shaping, leading and delivering practice development as an intervention.

For joint appointments and clinical chairs leading practice development work, the demands are for explicit links between outcomes and policy, from both clinical and academic perspectives (Duke et al., 2009). The tensions that this can set up in relation to definitions of 'appropriate' academic endeavours have led some to argue that practice development outcomes, reported only in health service terms, do not fulfil the conditions of the academic sector (Thompson et al., 2008); although, refutation of this position has been advanced by Dewing and others (2009). Politically, this is also linked to the imperatives of relating to, engaging with and satisfying those who commission practice development activities (Manley et al., 2008b). The processes and outcomes of practice development work and activities are, therefore, subject to the expectations of those providing funding or those accountable for their commissioning either in direct outcomes or in productivity and return on investment; and for academics working in universities the core outcomes must also satisfy knowledge generation, knowledge transfer and/or conditions of knowledge utilisation (Kitson et al., 2010; Luker, 2007) and research impact (Anthony, 2005; James and Clark, 2007).

Similarly, those working for health services or in policy contexts must be able to translate outcomes in terms of their service and policy contexts (Kitson et al., 2010). McCormack and colleagues (2006) identified three reasons that practice development was alienated from service development, innovation and improvement strategies: containment of practice development to a nursing context, making it apparently irrelevant to others; challenges around the language of practice development making it difficult to describe its impact for key stakeholders; and, the reality that practice development is a complex intervention, demanding a range of evaluation approaches for the production of strong evidence for commissioning associated skills investment and capacity building (Manley et al., 2008b; MRC, 2006). The explication and demonstration of practice development processes and outcomes in ways that external stakeholders would recognise, value and commission is therefore a priority.

Internationally, the practice development community is well placed to examine the arguments, determine the 'quality of science' needed; and to design studies that clarify the important intervention-process-outcome relationships so that we can move forward with the identification of cumulative data in relation to the outcomes of practice development work. It is difficult to imagine the development of recommendations for the adoption of practice development programmes for national or health sector intervention by policy analysts without demonstration of the effectiveness of the intervention and associated cost analyses. To date, sustainability has not been an outcome measure that has been included or one that is defined. We propose that sustainability could be defined as an attributable impact from the practice development intervention that continues to be present over time (months and years) associated with the continued presence of process outcomes which we argue are encompassed by the attributes of an effective workplace culture (Manley et al., 2007). While the focus and intention of practice development are a range of health related processes and outcomes, evaluation of its impact also calls for consideration of the higher education and research context.

### **Key distinguishing features of practice development**

The contribution that practice development can make to contemporary healthcare has been argued by international practice developers concerned about the lack of strategic uptake and recognition of the potential that practice development offers, in six deliverables: keeping persons at the centre of care; involving patients and clients in decision-making; developing systems and cultures for quality services; investing in staff towards new ways of working; enabling evidence-based practice; and systematic change and evaluation (Manley et al., 2009). Examination of the material in three of the key practice development research and practice books (Manley et al., 2008; McCormack et al., 2004; McSherry and Warr, 2008) and in the eight years of publication of the journal 'Practice Development in Health Care' (Volante, 2009) reveals a substantial array of self reporting and research into the outcomes of practice development as an intervention in healthcare. There is general agreement that the definition and methodologies associated with practice development interventions have sharpened and are linked to a broad set of methods and underpinned by specific principles, values and beliefs for developing and designing systems that can sustain person-centred and clinically effective care, integrate learning in the workplace and transform workplace cultures (McCormack et al., 2007a-c; Manley et al., 2009, p.379).

However the relationships between these concepts and process outcomes have not as yet been clearly explicated within an impact framework. Although, it is proposed that the assumptions in Box 2, get to the heart of understanding *how* practice development achieves the six deliverables, and its impact, which we argue are achieved and sustained through establishing an effective workplace culture that reflects a set of values and beliefs around key practice development outcomes such as person-centred and effective care, as well as, ways of working such as providing support and challenge, learning, etc. These assumptions or more accurately, linked values and beliefs, are often taken for granted by practice developers or are invisible to others as the means through which outcomes are achieved, although achieving such a culture is the intent of practice development.

**Box 2.** Assumptions underpinning practice development work – the ways through which it is proposed that practice development achieves its impact.

1. Working 'with' people (staff, patients and service users at the frontline and other stakeholders) rather than 'on' them in a way that is inclusive, collaborative and participative develops ownership for change and direction as well as self-empowerment
2. Agreeing values and beliefs about what is to be achieved, as well as, ways of working (including creativity) provides a shared vision and frame of reference that enables self-direction as well as mutual challenge and support for agreed behaviours
3. Involving all in decision-making accords value to those involved, enables engagement, joint responsibility, and multiple perspectives and differences to be recognised
4. The primary purpose of practice development is to provide care that is both person-centred and effective. Person-centeredness applies to all relationships with patients and staff. Effectiveness includes using the best evidence available blended with the knowledge of the patient, their healthcare needs and their context
5. Systematic evaluation, active and workplace learning is an integral part of practice development activity and contributes to ongoing change, improvement, adaptability, innovation and knowledge derived from practice
6. Sustainable change is achieved through enabling shared values and beliefs and related patterns of behaviour to be embedded in the workplace culture through social systems that reduce dependence on specific individuals

The assumptions therefore identify the intent of practice development and the relationship between practice development interventions and the attributes of an effective workplace culture (Manley et al., 2007). These attributes we argue capture the complete spectrum of process outcomes from practice development. However to test this argument out further it is useful to compare practice development with other approaches that set out to achieve more explicitly some of the 'big outcomes' reflected in the current dominant discourse.

Three differences seem to distinguish practice development from other approaches to impacting on the deliverables identified above, such as; LEAN methodology (Institute for Healthcare Improvement, 2005); quality improvement science (Varkey et al., 2007); social movement theory (Morris and McClurg-Mueller, 1992; Brown and Zavestoski, 2005) and knowledge transfer and utilisation science (Bowen et al., 2005; Canadian Health Services Research Foundation, 2003; World Health Organisation, 2005). These are discussed below.

*Practice development is led by practitioners and practice teams working for person-centred care and for better patient outcomes and generates a resonance with practitioners (Manley et al., 2008b).* Self-empowerment, energy and creativity enable self-direction and an ownership of practice that is rarely achieved through direction by senior managers and policy developers. While the Institute of Improvement and Innovation (UK) promotes social movement theory (Bate et al., 2005) to develop and engage practitioners across wide populations to win over 'hearts and minds', it does not integrate *how* healthcare should be experienced or evaluated by the recipients of that care.

While many quality improvement approaches seem to have achieved greater success than practice development in strategic uptake and policy influence, there are a few exceptions. Notably, in Scotland where a national strategy for practice development has been established based on evaluation of the outcomes of practice development (McCormack et al., 2006); Northern Ireland where practice development is commissioned widely as a result of close working between health services and higher education providers and systematic evaluation, and New South Wales where there is also strategic uptake at the state level (Thoms, cited in Manley et al., 2008b).

*Practice development's main intent is transformation of individuals, teams, practices and cultures for effective and sustainable workplaces.* The explicit focus on workplace cultures is essential if changes are to be sustained as it is through embedding new ways of working into local cultures, and through specific learning and development approaches that sustainability is achieved. No other approach explicitly aims to address workplace culture and patterns of behaviour as an approach to achieve sustainability; although, others have recognised that behaviour needs to be the focus of improvement activity rather than structures and processes (Plsek, 2001). No other approach or method currently integrates both the achievement of person-centred care and effectiveness with active and workplace learning, linking the two together through the achievement of cultures of effectiveness. Translation science focuses on getting best evidence into practice but does not consider evidence in the context of person-centred care and cultures, and workplace learning, although the role of context and facilitation are recognised as the basis of a number of approaches to knowledge utilisation (Harvey et al., 2002; Rycroft-Malone et al., 2002a, 2002b, 2004a, 2004b).

*Practice development encompasses a plurality of outcomes based on an integrated approach that can be applied to any healthcare context, underpinned by ways of working with practitioners and patients that are inclusive, participative, and collaborative.* It is a 'whole package' or in technical terms 'a complex intervention' that integrates several interacting components with a number of outcomes in a range of different settings flexibly (MRC, 2006). Practice development does not just focus on one aspect of healthcare provision at the interface with patients and clients, but multiple aspects:

*'The contribution of practice development is not linked with any specific healthcare trend but to all areas of healthcare. This is because of the specific way in which practice development works with people regardless of the healthcare issue and also the way that patient/person in healthcare is viewed.'* (Manley et al., 2009, p.384)

Whereas, LEAN methodology through the 'productive series' (Institute of Healthcare Improvement, 2005; Wilson, 2009) focuses on efficiency of activities and processes to free up time promoted as 'releasing time to care', prescribing specific foci in its implementation and evaluation rather than starting with where each team is. The productive series is a useful approach in terms of using valuable human resources effectively but does not guide how the time that is freed up is used in terms of the patients' experience and care. Similarly, quality improvement science is associated with a set of change tools and processes that are systematically applied (Berwick, 2008) rather than the ways of working that will embed values and beliefs and behaviours in the culture of care or achieve sustainable change; although increasing interest in values and beliefs related to quality improvement science is emerging (NHS Institute, 2011).

While factors such as leadership (Thoms, cited in Manley et al., 2008b), influential national champions, close relationships between higher education and healthcare practice, and close alliance between strategic objectives of healthcare providers and practice developers have influenced local commissioning, the profile of practice development within main stream policy initiatives and other commissioning power bases continues to be relatively low. To further the dialogue around the outcomes of practice development and their relationship to the practice development intervention as well as move the evaluation agenda forward, it is important to consider what can be learned from external stakeholders working within the dominant discourses of quality, health outcomes and research impact for example those in academia; as well as internal stakeholders such as those using or facilitating practice development themselves.

### **Quality and health outcomes**

The major health outcomes sought by global health organisations, governments, health funders may vary in terms of language and possibly emphasis, but fundamentally remain consistent. Common definitions of health outcomes reflect that developed by the World Health Organisation in 1997: *A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status* (WHO, 1998).

Contemporary health care outcomes fall broadly into the domains of safety, effectiveness, and patient experience (e.g., UK DOH, 2010; NSW Dept of Health, 2009). Practice development is a complex intervention which is generally directed at achieving these same 'big' health outcomes, albeit emphasising person-centred approaches and achieving sustainability through developing cultures of effectiveness. While the major focus of traditional quality healthcare improvement activities has been on achieving these major outcomes, large and complex data sets and analyses are required to avoid false conclusions about the quality of care associated with any specific outcome measure; and, such evaluations involve massive investments of time and resources (Mant, 2001). In addition, a feature of concern around all complex approaches is over and under attribution, as well as, the timeframes when attribution of impact should be judged (Grant et al., 2009).

Process outcomes, sometimes called intermediate outcomes (Manley and Hardy, 2005), on the other hand, are more easily demonstrated, and their meaning more easily interpreted. For instance, establishing a causal relationship between a practice development intervention related to communication within a multidisciplinary team and improved health outcomes for whom those

teams care would be extremely complex and difficult to achieve; however, establishing more effective team functioning and co-ordination of care among team members would be far less so. Table 1 captures the intervention, process outcomes and health outcomes relationships that we believe to be relevant to practice development work that could guide the development of a strategic evaluation framework that links practice development to the bigger health outcomes.

**Table 1.** Intervention, process and health outcome relationships relevant to practice development work.

<b>INTERVENTION</b> – based on the key intents of practice development work	<b>PROCESS OUTCOMES</b> – based on the attributes of effective workplaces (Manley et al., 2007)	<b>HEALTH OUTCOMES</b> – based on existing major outcomes sought by health services world-wide
<p><i>Practice development as a complex intervention; using collaborative, inclusive and participatory approaches to support the transformation of individuals, teams, practice and cultures to enhance the effectiveness of practices enabling all to flourish</i></p>	<ul style="list-style-type: none"> <li>• Shared values and beliefs held:               <ul style="list-style-type: none"> <li>○ Person-centredness</li> <li>○ Lifelong learning</li> <li>○ Support and challenge</li> <li>○ Leadership development</li> <li>○ Involvement/participation of stakeholders</li> <li>○ Evidence-use and development</li> <li>○ Positive attitude to change</li> <li>○ Open communication</li> <li>○ Teamwork</li> <li>○ Safety (holistic)</li> </ul> </li> <li>• Shared values are realised in practice – there is a shared vision and individual and collective responsibility</li> <li>• Adaptability, innovation and creativity maintain workplace effectiveness</li> <li>• Appropriate change is driven by the needs of patients/communities</li> <li>• Formal systems exist to enable and evaluate learning, performance and shared governance</li> </ul>	<p>Patient satisfaction</p> <p>Patient safety</p> <p>Effective health care – evidence through patient outcomes</p> <p>Effective systems – resource utilisation</p>

### Higher education and research impact assessments

Higher education in relation to healthcare and public services is currently undergoing increasing scrutiny as the focus swings from a liberal philosophy of education to one that is focused on social utility augmented by austerity measures to address the international financial crisis. The purpose of higher education is increasingly focused on preparing the workforce required by society, and for health and social care this is about growing capacity and capability. Commissioning of healthcare learning and development is influenced by the need to grow competent practitioners who are self sufficient in their own learning, can embrace change and the needs of the service so that they use knowledge for decision-making intelligently, intuitively, creatively and reflectively, and can embed these changes across increasingly diverse teams with members working at different levels. Such a swing should theoretically benefit the uptake of practice development because practice development assists the integration of learning in and from practice with systematic inquiry in the workplace (Manley et al., 2009; Manley and Titchen, 2011). Further, practice development interests



are embracing of both the generation of knowledge from practice, knowledge transfer and the utilisation of evidence in practice. Practice development as a complex intervention bridges practice, research and education through simultaneously; transforming practice, contributing to the body of knowledge; improving capacity and capability, achieving knowledge exchange and practitioner empowerment (McCormack et al., 2006; Manley et al., 2008a) – the same ‘big’ goals of higher education and research impact imperatives.

However, we recognise that the traditional divides between the interests of higher education in the development of ‘new knowledge’ and those of health services in the ‘use of evidence’ and ‘practical quality improvement’ are challenged by the very nature of practice development intervention. These issues are compounded by ‘soft’ and ‘context-based’ framing of practice development intervention, and by the realisation that most frequently the reporting of impacts by those undertaking practice development work takes the form of case examples and self-reported processes and outcomes. While there is evidence of realist evaluations (e.g., McCormack et al., 2006; Wilson and McCormack, 2006), concept analyses (e.g., Garbett and McCormack, 2002), fourth generation and pluralistic evaluations (Moss et al., 2008), being undertaken these are not common to the body of practice development evaluation; and programmes of systematic research are required.

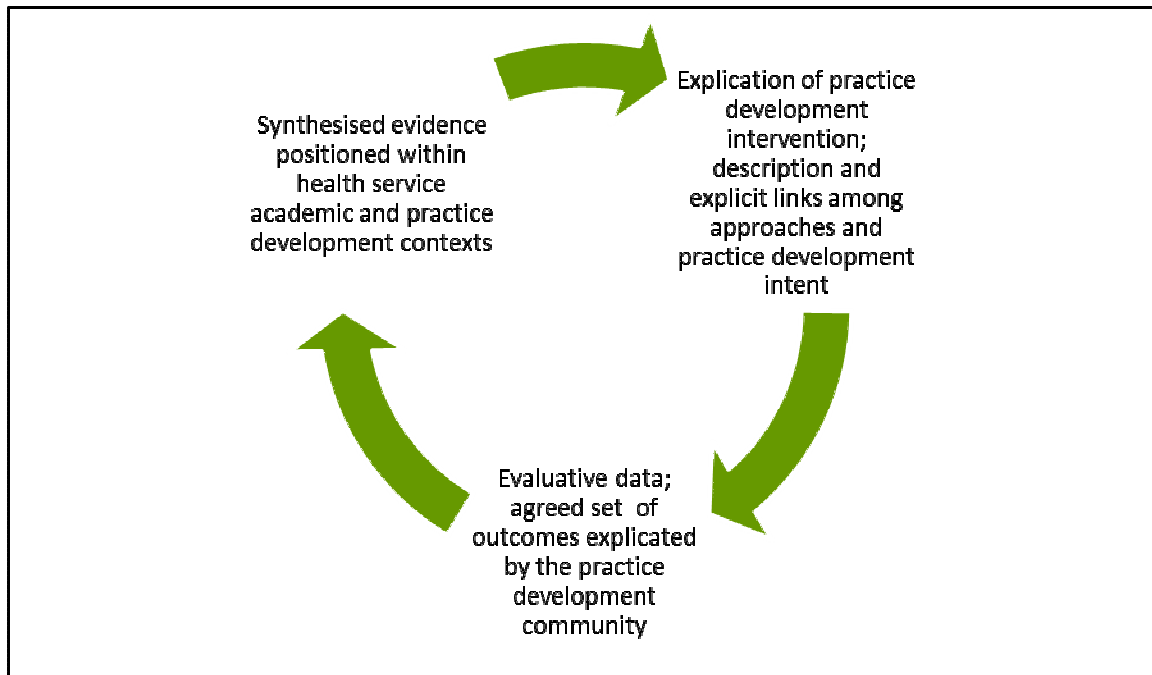
Demonstrating the relationships between research outputs, outcome and impact (social, economic, public policy, welfare, environmental and/or cultural issues and quality of life impacts) is the current focus of research quality assessment exercises internationally (Grant et al., 2009). Significantly, only those who can demonstrate consistent quality and social impact for stakeholders and end-users will be assured of continued funding, and influence on strategic decision-making (Grant et al., 2009). The international review undertaken by RAND Europe identified four evaluation approaches for capturing research impacts and therefore intervention-outcome and impact links: case study; indicator development; self-evaluation; and a mixture of the three (Grant et al., 2009), providing insights that can guide evaluation foci in practice development research.

Research assessment exercises in the United Kingdom, Hong Kong, Australia and New Zealand are manifesting significant challenges over who sets the research agendas, what constitutes appropriate scholarly inquiry, and how impacts of academic work should be captured and measured (Anthony, 2005; James and Clark, 2007; Luker, 2007; Watson et al., 2007). Clinicians working in the academic sector recognise the political and practical difficulties in addressing the needs of healthcare services for care development and evaluation, and at the same time meet university imposed requirements for research (Duke and Moss, 2009; Seifer and Calleson, 2004). Conversely, clinicians leading health service change and evaluation report difficulties in engaging academics in these processes because of the shared difficulties in reconciling differences between local data and local implications and the implications for wider theoretical and conceptual development.

There is no surprise, therefore, in the fact that the assessment of impact has been extended from simplistic measures such as a general impact measure associated with the journal in which the research was published, to more comprehensive assessments of impact, such as: the social, economic, environmental and/or cultural benefit of research to end users in the wider community regionally, nationally and/or internationally (Peacock et al., 2006). Funding agencies such as the Arthritis Research Council in the UK (one of the four best practice models identified by Grant and others (2009)), to this end, now gather impact data about: further research that has developed from the grant, research tools that have been developed, dissemination activities that have been carried out, impacts on health policy that have occurred, information on how the grant has affected education and health interventions, and changes in service delivery or health advice produced through the research (Wooding, 2008). Grant and others (2009), in their review of research impact models call for mixed evaluation approaches. Translating this shift to practice development,

however, flags two priorities for the practice development community to address. The first, relates to clarification of the mechanisms through which practice development outcomes and impacts are achieved; the second, is the development of reporting templates to capture agreed outcomes, impact data and case studies at the end of each local and national practice development project which can be pooled across the international community to build the quality of evidence required to demonstrate practice development's impact conclusively.

**Figure 1.** Strategic approach for generating evidence of the effectiveness of practice development work.



### Shaping, leading and delivering practice development

Frameworks and methods for evaluating practice development driven by the first concept analysis of practice development (Garbett and McCormack, 2002), which identified the importance of a systematic and rigorous approach, were drawn from other disciplines that involved stakeholder participation and collaborative processes (McCormack et al., 2004; Titchen and Manley, 2006). The introduction of the PRAXIS model (Wilson et al., 2008) maintains this emphasis on stakeholder involvement, while facilitating a systematic approach for generating evaluation frames that are inline with both the intent of practice development and the complexities involved in achieving meaningful evaluation of the work. The PRAXIS model suggests that effective evaluation in practice development always includes six core components: purpose (basing evaluation activity around a clear and shared purpose of the practice development initiative being evaluated), reflexivity (that is, on going critical review of all actions within the evaluation process so as to develop new insights and opportunities for transformations of self and others); approaches (the range of evaluation approaches and methods used and their fit with the context, values and beliefs, and purpose of the practice development initiative being evaluated); context (paying attention to the contexts in which evaluation is taking place and the political contexts that may need to be addressed for evaluation outcomes and impact to be profiled and learned from); intent (to look more deeply at evaluation processes and data than the surface level and develop insights about how purpose, reflexivity and approaches relate); and finally stakeholders – identifying and working with the groups of stakeholders who have a stake in the evaluation. The PRAXIS model guides 'how' practice development evaluation is undertaken rather than prioritising demonstration of impact. We believe that a more strategic approach demands the inclusion of impact in future evaluations of practice development to be recognised more strategically.

There are also a number of internal factors impacting on practice development evaluation from within the practice development community that inform the current position of practice development, these can be themed around: methodological development linked to capacity; the type of evaluation data historically used balanced against the range of evaluation data required to achieve greater strategic influence; and, maintaining practice development's moral imperative to realise person-centred values.

The major focus to date has been on explicating practice development to describe what it is and isn't, and building capacity and capability to deliver the practice development intervention. However, a greater focus is now required to strengthen and clarify how practice development achieves healthcare outcomes, impact and sustainable change. Figure 1 and the attributes of an effective workplace provide a starting point for this journey and a framework to focus these efforts. To grow capacity and capability there will be a need to help practice development facilitators, understand practice development as a complex intervention at different levels and grow their expertise in systematic evaluation simultaneously with; active and workplace learning in and from practice; developing individual, team and organisational effectiveness; and embedding person-centred outcomes within workplace cultures and patterns of behaviour that enable everyone to flourish.

A preference for specific forms of data/feedback because of the person-centred nature of practice development (e.g. qualitative evaluations of participant learning and patients' experiences of care) may have limited the confidence and capability to work with the complex outcome data required to position practice development within more traditional evaluation frameworks. However, a balance needs to be struck if we are to influence strategy positively and increase uptake. Translating qualitative data arising from practice development projects into a set of measures around the process outcomes identified in Table 1 will enable a consistent and agreed data set to be established which when combined with complementary case study around impact data will reflect best practice for demonstrating research impact. We believe this first step should be a priority for the practice development community so that all outcome data can be pooled. The potential outcome measures and key performance indicators being developed around the concept of person-centredness associated with the person-centred nursing framework (McCormack and McCance, 2010) provides clear direction for person-centredness, but other foundation values, beliefs and attributes of an effective workplace culture also require parallel development.

In many ways the focus on data that conveys the patients' experiences is an extension of the above preference to a 'moral imperative' to stay true to the complexity associated with individuality and thus avoiding reductionist models that are associated with the failure of systems to be person-centred in the first place. This can account for a lack of desire to line up with the dominant strategic imperative required to demonstrate outcomes and impact. Unless the practice development community is able to influence strategic direction then its contribution will only be piecemeal and it will never be in a position to deliver the potential it has to offer.

### **The need to develop process indicators**

McCormack and colleagues (2008) have argued that the full potential of what practice development has to offer is yet to be realised. and, we believe that the international community of practice development researchers can best achieve this by: consolidating 'what is known' about the outcomes of practice development; identifying what outcomes of practice development need further theorising and testing, which aspects of these can be related to the most common impact and outcome measures in health services and academic arenas; and, establishing a programme of international work that will achieve stronger articulation of the outcomes of practice development as an intervention within healthcare.

Two implications for the international practice development community have emerged in relation to evaluation and demonstrating the outcomes of practice development as a complex intervention. The first involves clarifying the relationships between process outcomes, health outcomes and impact including sustainability by using the five attributes of an effective workplace culture as the process outcomes that can be identified from practice development interventions. The practice development community then over time will be able to demonstrate more conclusively the links between process outcomes and the ultimate outcomes as the process outcomes enable the big outcomes to be achieved and sustained. The second involves establishing a way to collect standardised qualitative and quantitative data as an international community, which can be pooled within an international dataset. This will require the process outcomes across multiple practice development projects to be captured. The lessons from the Rand Review (Grant et al., 2009) discussed earlier point to the development of an internationally acceptable template for capturing these process outcomes by project leaders/practice development facilitators at the end of local, national and international projects as a logical first step. This would then complement the development of context and outcome statements using case studies to illustrate the main impacts achieved.

In conclusion, the advancement of the practice development outcomes agenda within multiple contexts will be more easily achieved when we build consensus around parameters of practice development interventions, process outcomes and the major health outcomes that drive practice development work. To this end, priorities are to strengthen practice development evaluation in a way that will complement the focus of the PRAXIS framework on evaluation processes, by strengthening those aspects that will enable outcomes and impact to be demonstrated, through:

- Agreeing a framework for explaining the relationship between practice development as a complex methodology, process outcomes, and health outcomes, drawing on the attributes of an effective workplace culture as the process outcomes that will facilitate this
- Collectively establishing and contributing to an international data set that would begin to demonstrate the sustainability of practice development as well as its impact, thus informing the evaluation of local, national and international practice development initiatives and increasing its uptake

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**Kim Manley** (CBE, PhD, RNT, PGCEA, RCNT, DipN Lon, BA, MN, RN), Visiting Professor, Department of Nursing and Applied Clinical Studies, Faculty of Health and Social Care, Canterbury Christ Church University, Canterbury Christ Church University, England.

**Jackie Crisp** (PhD, FCN, RN), Professor of Child and Adolescent Nursing, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney; Head, Practice Development Unit, Sydney Children's Hospitals Network, Randwick; Conjoint Professor, University of New South Wales, Sydney, Australia.

**Cheryle Moss** (PhD, MSc, BApp Sc, Grad Dip Ed Admin, RN, CCU Cert, FRCNA), Associate Professor, Nursing Research and Practice Development, Director of Community Engagement, School of Nursing and Midwifery, Monash University, Melbourne, Australia.