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COMMENTARY

Advancing the practice development outcomes agenda within multiple contexts

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Demonstrating outcomes from our work is an essential consideration in all walks of professional life. We are all employed to do a particular job and the success or not of that job is whether we achieve what is required of us. So having to show outcome from practice development work should be no surprise to anyone. Kim Manley, Jackie Crisp and Cheryle Moss make the case for the advancement of a practice development outcomes agenda. The rationale for such an agenda are twofold – that practice developers have been poor at paying attention to outcome and secondly that the published outcomes have largely been ‘process [intermediary] outcomes’. The authors argue the case for practice development as a complex intervention and thus there is a need to locate outcomes from practice development interventions in a broad health outcome agenda.

It would be hard to argue against such a stance and I am certainly not going to do so. However, two key issues for me are:

- 1) Has practice development been poor at demonstrating outcome?
- 2) What do we mean by health outcome?

Has practice development been poor at demonstrating outcome? The simplicity of the question (which essentially elicits a ‘yes’ or ‘no’ response) hides the complexity of the issues underpinning it. The evolution of practice development would suggest that it started from a positivist position where the focus was on evaluating tangible outcomes from particular changes in practice (*see for example* Pearson, 1992). The interventions were clear and specific, the evaluation instruments validated and the outcomes discernible. However, was this practice development as we know it – well perhaps not? Such work would not meet the now largely accepted criteria for ‘good’ practice development of Collaboration, Inclusion and Participation (CIP) (McCormack et al., 2006) as it was researcher driven with clinicians being the instruments of data collection and the users of the prescribed changes. The processes of change were controlled by the researchers/practice developers and the ownership of the work largely lay with them. Whilst such work demonstrated health outcomes for service users and care workers (mainly nurses), the reality is that it had limited long-term impact. Compare that with the complexity of outcome evaluation in emancipatory and transformational practice development work where the key emphasis is on making CIP principles work, resulting in messy non-linear processes, complex relationships and engagements, slow progress, emotional labour and the taking account of an ever changing context (micro, mezzo and macro). Evaluating outcome in these situations is far more complex and requires a degree of sophisticated thinking that is not always engaged with. Process/intermediary outcomes become essential in this work as without them it would be impossible to determine any final outcomes arising.

However, this contrast is not posed as an excuse for sloppy (or no) outcome evaluation, but instead highlights the challenges faced when we as practice developers commit to emancipatory and transformational practice development in a healthcare world that is obsessed with short-term and

immediate outcome. The systematic review of practice development undertaken by McCormack et al., (2006) highlighted the range of outcomes that are possible from systematic emancipatory practice development. However it also highlighted as the authors of this paper rightly state, the need for a more sophisticated approach to outcome evaluation to be developed. But what should such a framework look like?

Answering (if indeed I manage to do that) this question takes us to the second question I pose, i.e. what do we mean by 'health outcome'? Kim Manley, Jackie Crisp and Cheryle Moss suggest that there is universal acceptance of what is meant by health outcome, derived from the World Health Organization (WHO, 1998) – *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*. Major global programmes of healthcare reform rightly focus on changing the health status of populations, particularly where there are serious health inequalities, even in countries with sophisticated health systems. It is completely understandable to me that such reforms focus on these agendas and outcomes. However, when I think about many of the client groups that I and colleagues work with, then changing the health status of these people is less straightforward or obvious. I am mindful of some of my own practice development work which enabled a resident in a care facility to meet his dog for the first time since he entered the facility (some years earlier), or facilitating older people with dementia living on the first floor of a building to go outside for the first time in years, or challenging an acute care area to provide some recreation/diversion activities for older people in acute care ... to name but a few, but some of the 'outcomes' I am most proud of. In the grand scheme of things, these outcomes are unlikely to feature on a WHO global list of outcomes that have altered the health status of individuals, yet to those individuals, these were significant and meaningful outcomes. All of us working in practice development have similar outcomes to communicate and most of us are able to demonstrate the linkage between the intervention(s) we used, the process outcomes achieved and the resulting overall outcome that may have gone beyond the immediate impact on an individual. Essentially this is an epistemological argument, i.e. what is the dominant world-view of health, being healthy, health status and health outcome? Practice development explicitly focuses on micro-level change and it is at this level that we need to develop a more sophisticated approach to outcome evaluation. Epistemologically, our view of 'health' I believe to be different to the dominant discourse (with an emphasis on 'being', flourishing, personhood and authenticity) and as such requires a different approach to outcome evaluation; An approach that compliments other models and adds depth and richness to 'service user experience' (an outcome that is used by most healthcare systems).

So whilst I have some sympathy with the approach that Kim Manley, Cheryle Moss and Jackie Crisp propose, i.e. the development of a composite framework for outcome evaluation, I have some concerns that we buy into a dominant epistemological position that does not serve well, the purpose of practice development. I absolutely agree that we need to be able to undertake more sophisticated analysis of small projects and aggregate them to population level in order to show this level of outcome from the work. Equally we need to ensure that where there are major programmes of practice development work in place that these are used to develop and test out new approaches to outcome evaluation that advance our knowledge.

However, a word of caution – we need to be careful not to get too 'caught up' in outcome evaluation at the expense of the engagement processes we are committed to in practice development. I believe strongly that one of the reasons why practice development appears to 'struggle' to find its place in the broader arena of healthcare reform is because of the commitment to CIP principles. Few of us are prepared to compromise these at the expense of expedient

outcomes, so a key challenge in moving forward is to engage higher education partners in partnering health services in a way that ensures neither process nor outcomes is compromised.

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