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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Unravelling the consequence of practice development: an exploration of the experiences of healthcare practitioners

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Abstract

Background: The strong focus on achieving quality, improvement and efficiency in the United Kingdom's NHS is driven extensively by the policies of both the previous and current governments. However, achieving quality and maintaining improvement alongside substantial reduction in resources is a 'tall order'. Practice development has emerged and become refined as an activity focused on developing people and practice for the ultimate purpose of achieving high quality, person-centred care. How practice development achieves this remains a less explored area, alongside the outcomes for practice. This papers draws from the findings of an original research study that explored practice development, the approaches used and the influence it has on the experience of practitioners and their clinical practice in order to share some new perspectives on activities that enable more person-centred healthcare, practice improvement and innovation.

Aims and objectives: The original research involved participants from two practice development projects in separate NHS hospital trusts. The use of a flexible 'generic' descriptive qualitative design, using within-method data triangulation, combining focus groups, narratives, retrospective documentary analysis and field notes, enabled exploration and presentation of practitioners' experiences of practice development in the 'real-world' of practice.

Results: Thematic data analysis revealed that the experience of practice development varies but is characterised by frustration and achievement, an increase in workload but also in effectiveness, and a greater focus on teamwork. From further examination of the data drawing on a concept analysis framework, two typologies emerged representing activity that takes place in practice to develop and improve healthcare. One is service improvement – a means of establishing new healthcare services and/or improving existing ones; the other is emancipatory practice development, which is a process for achieving change characterised by the values of person-centeredness, partnership, enabling, active learning, evaluation and ultimately culture transformation.

Conclusions: The work contributes to understanding of the 'practice' of practice development as a methodology for enabling high quality, person-centred care. It also provides a more positive stance and way forward for ongoing activities associated with improving healthcare; namely, service improvement in the UK NHS.

Implications for practice: This paper offers insight into and contributes to the understanding of:

- The key features and outcomes of practice development and service improvement
- The impact practice development and service improvement activities have on practitioners and the way they practice

- The potential of practice development in enabling culture transformation towards person centredness
- The extent to which the range of methods within practice development methodology strengthen service and quality improvement activity
- The opportunity that emancipatory and person-centred ways of working have for transforming how practitioners work and give care

Keywords: Emancipatory practice development, service improvement, person-centred practice, generic qualitative research

Introduction

The term practice development has become commonly used in nursing and healthcare practice to refer to activities that aim to change practice and improve patient care (McCormack et al., 2006). Over the past four decades, practice development has emerged as a concept, debated alongside the nature of nursing, the delivery of care, the relationship between nurses, patients and other health professionals, the gaps between knowledge and practice, the quality of care and healthcare modernisation. While its nature, purpose and role has been considered (Clarke and Procter, 1999; Tolson, 1999; Thompson et al., 2008), it is evident that practice development has become more firmly established along with other activities that aim to improve and develop healthcare practice (Gerrish and Mawson, 2005). It also represents a key approach for developing and sustaining high quality, patient-centred care (McCormack et al., 2006; McSherry and Warr, 2006).

There has, however, been little exploration on the impact of practice development, especially from the perspective of the healthcare practitioners taking part in and affected by activities. This paper draws from, rather than presents in full, an original research study that sought to address this lack of investigation. A flexible 'generic' descriptive qualitative methodological approach was adopted to take account of the complexity of practice development and practice development research in the real world. Data was collected using within-method data triangulation; combining focus groups, narratives, retrospective documentary analysis and field notes to enable the exploration and presentation of practitioners' experiences of being involved in two separate projects aimed at improving patient care in two NHS Hospitals. Both the projects and the place where they were undertaken represented the kind of practice development and improvement activity seen across the UK. Analysis and critique of the research data reveals some new understanding, presented here, regarding practice development and other activity that seeks to improve patients' experience of care.

The background and context for the research and this paper are set out below, followed by an overview of the literature relating to the nature, approaches and impact of practice development. Key aspects of the research process are then outlined along with details of the research sample. Then there is a summary of the research findings, rather than presentation of the raw data, and a critical discussion where two typologies or approaches for improving and developing healthcare practice are presented.

Background

Over the past ten years, as the demand for a more patient-focused and effective health service has increased, the need for and emphasis on practice development has grown. Investment has grown in structures to support, improve and monitor healthcare practice with, for example, the establishment of the NHS Institute for Innovation and Improvement and the Healthcare Commission. There is also a greater focus on providing evidence for best practice through organisations such as the National Institute for Health and Clinical Excellence. Despite this investment and espoused commitment to practice improvement and change, for many developments in practice progress is slow and difficult

to sustain (McKenna et al., 2004; Tolson et al., 2008). Attempts to unravel the reasons for this are hindered by a lack of good quality evaluation and research into both the process and outcomes of practice development and change initiatives (Wilson et al., 2008). More recently, the increased reporting and publicity of poor practice has indicated that to improve practice significantly, activities must address the fundamental issues of values, attitudes and culture (Francis, 2010; Patterson, 2011; Parliamentary and Health Service Ombudsman, 2011). Such work must be initiated at the front line and be led by clinically based teams (Bevan, 2010; Kings Fund, 2012). Furthermore, as Marshall (2011) emphasises, we need to deepen our understanding of environmental elements that facilitate and/or block improvement, how they connect and how they can be changed.

Such activity is not easy or straightforward. For some it can be a positive experience that transforms ways of working and results in sustained improvement in patient care. For others, however, the demand for change may feel like another unnecessary burden, indirect feedback that current practice is not good enough, or just something that somebody else does.

The pressure of service improvement strategies and policy driven targets with too great an emphasis on quick fix approaches to change and development (Manley, et al., 2008) have, from experience and from the literature, perpetuated these difficulties. The focus on technical/rational approaches that Manley and McCormack (2004) describe, can assume that once practitioners are given evidence of the best treatments or practices, they will 'naturally' work in a different or new way. A further problem is an ongoing assumption that change can be implemented by an individual or change agent who, by virtue of their role, assumes responsibility for achieving the change. It also appears that little account is taken of the views or experience of those practitioners affected by change, beyond whether they accept or reject it. Finally, at both policy and organisational levels, inadequate consideration is given to the context or culture within which change and development is proposed and so, even with a willingness to consider change, practitioners experience barriers that are difficult to overcome. As a result of all these issues, many initiatives have unintended negative outcomes that may mean improvements are not achieved and/or sustained (Manley and McCormack, 2004).

In contemporary healthcare, significant changes are taking place against a backdrop of austerity. To cope with this and continue to improve healthcare it is essential to understand the common characteristic of those workplaces and organisations that are open to continuous improvement and that successfully delivery high quality, safe and effective healthcare. This will enable the development of approaches that offer cost efficient and effective ways of improving the culture within healthcare and the resulting patient experiences. This understanding can then be transferred across healthcare teams that continue to struggle to achieve best practice (Bevan, 2010).

All this underlines the importance of understanding more about practice development as an activity focused on improvement and which can lead to sustainable change and increase commitment to person-centredness.

Overview of literature

The emergence of practice development can be traced from early in the 1970s, with the advancement of nursing (Briggs, 1972; McFarlane, 1976; De la Cuesta, 1983), the development of practice (Pearson, 1983; Griffiths and Evans, 1995; Wright, 1993) and nursing research (Kitson, 1994; Culyer, 1994) through to current healthcare practice. Through selected research (Kitson and Currie, 1996; Binnie and Titchen, 1998; Balfour and Clarke, 2001;), concept analyses (Unsworth, 2002; McCormack and Garbett, 2000; Hanrahan, 2004) and an array of publications relating to practice development activity, the key characteristics defining the nature and purpose of practice development have been identified as a systematic and facilitated process for enabling the following factors (Garbett and McCormack, 2002):

- The development, improvement and sustainability of patient-centred care

- The use and development of knowledge (evidence, research and experience) for the advancement of healthcare practice
- A change and transformation of the context and culture of healthcare practice

More recently, new understanding from contemporary analysis of theory and practice resulted in the revision of the original and widely used definition by Garbett and McCormack (2002) to read:

'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.' (Manley et al., 2008, p 9).

While the nature and purpose of practice development has received a reasonable degree of attention and critique, it is only in the past five to ten years that a similar degree of interest has been given to practice development approaches and methods. There is consensus that practice development should be undertaken systematically (Marsh and MacAlpine, 1995; Kitson and Currie, 1996; Tolson, 1999; Clarke and Procter, 1999; Balfour and Clarke, 2001; Unsworth, 2002; McCormack and Garbett, 2002; McSherry and Warr, 2006; McCormack et al., 2006). Yet, Garbett and McCormack (2003) found approaches were variable and although the literature reported practice development activity, it often lacked detailed information about approaches and methodology.

Unsurprisingly, the links between research and (practice) development resulted in the use of research based methodologies such as action research (Bell and Procter, 1998; Manley, 2001; Balfour and Clarke, 2001; Clarke and Wilcockson, 2001; Bellman et al., 2003; Dewing and Traynor, 2005; Fitzgerald and Armitage, 2005). Along with an action research approach, Binnie and Titchen (1998) used their experience from practice to develop the 'Horticultural' model for practice development, which highlighted the need to support and cultivate growth. The emergence of the Promoting Action on Research Implementation in Healthcare (PARIHS) framework (Rycroft-Malone et al., 2002) with its inter-linked and interdependent elements of context, evidence and facilitation, has much relevance to practice development because of the connection between research use and change. It does not, however, offer a methodology.

The first steps towards a methodology arose from the explorations undertaken by Manley and McCormack (2004) who, drawing on critical social theory and in particular the work of Habermas (1972) and Grundy (1982), proposed the two worldviews of technical and emancipatory practice development. In outlining the principles of both, they emphasis not that one was good or bad, but that each approach may result in different outcomes. For example, in technical practice development a facilitator directs an initiative to a pre-planned endpoint but, as Sanders (2004) found, this may result in variable longer term implementation. Emancipatory practice development acknowledges the complexity of practice and the need to work with people and values to achieve change. As Dewar et al., (2003a, b) discovered, such an approach may result in greater level of engagement but requires commitment to involvement and skilled facilitation.

Over time, consensus increased regarding the need for systematic, facilitated, collaborative and supportive approaches to improvement and change. However, with much variation in the approaches adopted, the need for a systematic review specifically focused on identifying approaches to practice development and critically examining the underpinning evidence base was recognised (McCormack et al., 2006). Two phases of activity were undertaken. The first, a review of published practice development literature and grey practice development literature, used a methodology derived from realist evaluation (Pawson and Tilley, 1997). The second phase involved 47 telephone

interviews. While the selection process is unclear, the interviews were with key informants identified from networks around the world that the researchers had connections with, as well as known authors from the field identified within the literature (McCormack et al., 2006).

The key conclusion from the review was that 'no one methodological perspective' could support 'all practice development functions' (McCormack et al., 2006, p 124). Rather it is suggested that there should be evidence of 'participatory, inclusive and collaborative methodology' in all practice development work (McCormack et al., 2006). The review found little to support a single methodology; instead, interviewees described a plethora of methods and processes being used for practice development. These were themed into 18 essential processes or methods for practice development, as shown in Table 1.

Table 1: Essential processes for practice development (McCormack et al., 2006)

1.	Agreed ethical processes
2.	Stakeholder analysis and agreed ways of engaging stakeholders
3.	Person-centredness
4.	Values clarification
5.	Developing a shared vision
6.	Workplace culture analysis
7.	Collaboration and participation
8.	Developing shared ownership
9.	Reflective learning
10.	Methods to facilitate critical reflection (e.g. action learning)
11.	High challenge and high support
12.	Feedback
13.	Knowledge use
14.	Process and outcome evaluation
15.	Facilitation of transitions
16.	Giving space for ideas to flourish
17.	Dissemination of learning
18.	Rewarding success

Although this was helpful, McCormack et al., (2006) pointed to the need for further research to test both relevance and impact. As part of the research reported here, the literature was used to refine the list of 18 methods or processes into six values or areas of significance for practice development (Table 2).

Table 2: The six refined values for practice development

Value	Processes selected
1. Person-centred care	1, 2, 3
2. Collaboration and partnership	1, 2, 3, 4, 5, 7, 8
3. Enabling facilitation and support	10, 11, 15
4. Commitment to active learning and development	9, 10, 11, 12, 13, 16, 17
5. Transforming workplace culture	6, 18
6. Evaluation	14, 17

These values can be used to inform the decision to use practice development methodology and the subsequent choice of methods. While each value or area can stand alone, there is an obvious

interdependence highlighting how far reaching an effective approach to practice development could be. There is also a need to work flexibly and to use methods that take account of the purpose of the development activity. Henderson and McKillop (2008) differentiated between service improvement and emancipatory practice development and came to the conclusion that technical approaches were a feature of service improvement activity that can be effective in developing new services. They go on, however, to stress that service improvement activity may not have the same commitment to culture change as more emancipatory approaches have and, for more effective improvement, skills in both may be needed.

Moving to literature on the impact of practice development, one of the biggest and longest term challenges for practice development is evaluation and demonstration of the outcomes for practice (Pearson, 1983; Cole and Vaughan, 1993; Garbett and McCormack, 2003; McSherry and Warr, 2006; McCormack et al., 2006; Moss et al., 2008). While there has been some growth in literature broadly reporting outcomes (McCormack et al., 2006) in terms of the experience of practitioners, there is a much smaller volume – only one research study – (Garbett and McCormack, 2001) specifically focused on the experience of practitioners. What is available has shown that practice development can be intense and demanding for all involved (Garbett and McCormack, 2001; Bellman et al., 2003). Practitioners find it means extra work and is time-consuming (Clarke and Procter, 1999; Flood et al., 2006; Stickley, 2004). It demands a personal commitment (Carradice and Round, 2004) and this can be challenging and provoke anxiety (Dewing and Traynor, 2005). Facilitation and support is central to helping practitioners make changes to their practice (Bellman et al., 2003; Moss et al., 2008) although the demands of the facilitation role should also not be underestimated (Dewing and Traynor, 2005). Practice development does have an impact (positive and negative) on practitioners personally (Barrett et al., 2005) and there is some evidence to suggest that it does increase the commitment to patient-centred care (Binnie and Titchen, 1998; Clarke et al., 2003; Moss et al., 2008).

This overview of literature gives some insight into the immense development of activity and knowledge in the field of practice development. With ongoing emphasis on developing and improving patient-centred care, it is essential that the role of practice development is widely explored, evaluated and demonstrated. Within the literature there is some indication that practice development that uses emancipatory processes is more likely to be effective.

The need for further research and exploration

As the literature indicates, more research is needed to demonstrate the impact of practice development and to explore the place, if any, for approaches that are underpinned by technical-rational processes and methodology. One effective way of achieving this is through practice, and more specifically through the experiences of practitioners; this prompted the development of an original research study, with the following aims.

- Explore, critically, what it is like to be involved in practice development
- Explore, critically, in what way, if any, involvement in practice development influences the clinical practice of individual practitioners
- Identify and analyse links, if any, between the experiences of being involved in practice development and the approach taken to practice development

Overview of the research process

Methodology

Theoretical and practical influences contributed to the selection of a generic qualitative research methodology (Caelli et al., 2003), which, in simple terms, enables researchers to uncover or explore the perspectives of individuals in a particular situation or taking part in a particular process. In research, just as in clinical practice and practice development, it is not always possible ritualistically to adhere to a particular approach, because of the complexity of healthcare practice (Kitson, 1996; Moss et al., 2008) and the 'messiness' of practice development (McCormack et al., 2006). Therefore, having a more 'flexible plan of inquiry' (Avis, 2005, p 5) that can adjust to unexpected outcomes is important. Alongside this flexibility it is also essential that steps be taken towards quality, transparency and robustness (Avis, 2003). This includes giving attention to the theoretical positioning, the appropriateness of methodology and methods, engagement with data, and giving attention to the credibility and rigor of the overall process (Caelli et al., 2003).

Sample selection and recruitment

The participants in the study were a mix of healthcare practitioners (qualified nurses, healthcare assistants and allied health professionals) involved in two practice development projects as part of an externally funded practice development programme for which the researcher was responsible. Both projects took place within NHS hospital clinical settings and the participants who took part in the research were drawn from the clinical areas involved and the project team members (many of whom were also part of the clinical team). The projects and the staff involved were appropriate for the research study because they represented the kind of practice development initiatives commonly found within healthcare. However, using this opportunistic sample presented challenges because of the researcher's roles in terms of both the practice development programme and the research. There was a need to be watchful for any impact this could have on the participation of individual practitioners/teams and the research process. Equally, the links with the teams offered greater opportunity for meeting with and gaining insight into the experience of the individuals. An overview of each project, the key characteristics of the team and context of care and the number of participants involved in the research is provided in Boxes 1 and 2.

Box 1: Practice development Project 1

Project 1: Introducing a ward based exercise programme for older people across three inpatient care areas. This project focused on promoting exercise and aimed to make a contribution to healthy ageing by helping prevent falls, improving physical wellbeing, and promoting social interaction and positive mental health. The team's approach to the project was underpinned by the principles of evidence based practice, training and education.

Key characteristics:

- Small project team with experienced clinical leader
- Commitment to improving patient care
- Strong evidence base
- New role development and training
- Complex context

The total number of healthcare practitioners in the clinical area where the project took place was 90, of which eight volunteered to take part in the research.

Box 2: Practice development Project 2

Project 2: Improving mealtimes for older people in a ward within an acute trust. The purpose of this project was to implement patient-focused mealtimes for older people within a hospital unit/ward. While the team members were directly focusing on nutritional care, they planned to tackle the issue by addressing the unit culture and so it was anticipated there would be a wider impact on patient care and other dimensions of older people's health. The team's approach to the project was underpinned by participatory action research and emancipatory practice development principles.

Key characteristics:

- Ward based team with two lead facilitators
- Involvement of all ward staff
- Wide evidence based including patient experience
- Focus on learning in and through practice
- Complex context

The total number of healthcare practitioners in the clinical area where the project took place was 31 of which 10 volunteered to take part in the research.

Data collection methods and analysis

Taking account of the research aims and methodology, within-method triangulation of data collection methods included focus groups, narratives, documentary analysis and field notes.

Focus groups

Focus-groups offer the opportunity to listen to groups of practitioners talk about their experience (Kitzinger, 2005) of being involved in practice development and can be effective in practice development research to evaluate outcomes (Moss et al., 2008). A total of four focus groups were undertaken, two for each project, taking place midway through (focus group 1) and at the end (focus group 2) of each project in the workplaces of the teams to aid attendance.

A co-facilitation model was used, including the researcher and another facilitator involved in the practice development programme. With the permission of participants, each group was recorded and additional written notes made by each facilitator. All the audiotapes were transcribed by the researcher. While not conforming to a strict convention of verbatim, words were transcribed as faithfully as possible, pauses noted, with times added where these were longer than two seconds.

While the focus groups yielded the largest amount of data, the process was not without difficulty. Participants interacted well on a personal level but found it hard to talk in a detailed way about their experiences. The expertise in listening and use of questions of the researcher and co-facilitator proved valuable in helping uncover detail.

Retrospective documentary data sources

Collection and analysis of documentary data sources was to add understanding about the context, progress and outcomes of the two projects, as well as provide further insight into the experience of those involved. The following written records and documents were collected for this study.

- Project proposals and plans
- Project team records
- Project steering group notes/minutes
- National steering group notes/minutes

- Progress reports
- Final projects reports

While, as Atkinson and Coffey (2004) suggest, documents cannot stand alone, they do provide additional data, representing some aspect of reality that may not emerge via other methods.

Participant narratives

The idea of drawing on narrative research knowledge and exploring the value of participants' written stories can provide additional insight into the real experiences and feelings of individuals (Holloway and Wheeler, 2002). Participants were invited to provide a narrative, or story, of their experiences at the end of the focus groups, when it was envisaged their thinking might have been stimulated by the discussions. However, as Nygren and Blom (2001) suggest, writing can present problems for some and, even for the most able, complex issues can be difficult to articulate readily in writing. A total of eight participants contributed an individual narrative.

Researchers' field and reflective notes

The collection of field and reflective notes by the researcher, as part of the research process, was a valuable way of: (i) maintaining an audit trail of the research process (Jasper, 2005); (ii) examining the role and interventions of the researcher (Holloway and Todres, 2005); and (iii) capturing thoughts and feelings (Jasper, 2005) about every aspect of the process.

Data analysis

A thematic descriptive analysis process, congruent with the generic qualitative methodology underpinning this study, was used with all data sources to enable the production of rich, clear and in-depth descriptions of the participants' experiences (Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

A systematic process with all the data (focus group, narrative and documentary) was essential. Drawing on Colaizzi's (1978) seven overlapping steps for data analysis. With reference to the adaptation by Hantikainen (2001), five stages were used: (i) reading each document/transcript afresh; (ii) re-reading and highlighting significant statements; (iii) formulating meanings; (iv) creating clusters and themes; and (v) development of rich descriptions. Once this was complete, the co-facilitator was invited to critique the key statements and themes for the focus group data in order to provide a level of challenge to the process and help to validate the findings.

Ethical issues related to the research process

The study was subject to and gained approval from an NHS Multi-Centre Research Ethics Committee and the local research and development management committees of the two NHS trusts hosting the practice development projects. The key issues attended to included: achieving informed consent; freedom of participation or not; clarifying the area of confidentiality and anonymity; and being mindful of and addressing issues in relation to the researcher role as mentioned earlier.

Overview of findings

The analysed finding revealed a number of themes and sub-themes relating to the three research areas, as shown in Table 3.

Table 3 – Overview of the research findings

Research area	Themes and sub-themes
Taking part in practice development (*the experience*)	1. Frustration and satisfaction Frustration ▪ Involvement, apprehension and resistance ▪ Organisational barriers, constraints and inconsistencies Satisfaction ▪ Achievement and pride ▪ Interest and motivation
	2. Increased workload and increased effectiveness
	3. Individual role and responsibility versus teamwork and collective responsibility
The influence of practice development on practitioners and practice	1. Patient care ▪ Improvements to care ▪ Practice and care becoming more patient-centred
	2. Reflection, confidence and personal growth
	3. Professional development
	4. Attitudes and culture
Practice development approaches and methods: do they make a difference?	1. Task or process
	2. Supportive roles for practice development ▪ Leadership ▪ Facilitation
	3. Strategies for development and learning ▪ Training ▪ Learning through practice
	4. Stakeholders and ownership
	5. Context and culture
	6. The role of evidence
	7. External support and funding

It was evident that participants taking part in the projects were all involved in the type of practice development initiatives that can be said to be common in healthcare practice, with an overarching commitment to improve the care of patients. The data indicated that they all also experienced the highs (positive outcomes/experiences), lows (negative experiences/challenges) and complexity of taking part in practice development that are exemplified within the literature, see for example, Bellman, et al. (2003). The practitioners experienced varying levels of frustration related to levels of involvement, resistance and organisational constraints. They also experienced a sense of satisfaction as they could see changes happening and recognised that their efforts were making a difference to patient care.

Just as seen in the literature, being involved in practice development was at times viewed as extra work, either as a direct result of the implementation of a new practice/task or because of the additional activities required to support and sustain change. Some practitioners experienced the benefit of having a specific role to help move the practice development forward. Other benefits resulted from the creation of greater teamworking and collective responsibility.

In terms of the effect on practice, there was a strong sense that the practice development was reaching patients and having an impact on direct care. However, there was significant transition for one group of participants who appeared to become more aware of and sympathetic to the 'person'

for whom they cared. Other influences related to a change in attitudes and perceived progress in altering the workplace culture. It was also interesting to note that one group experienced more professional development and the other more personal growth and development.

From early on in the projects, it was evident that one project took a more task or outcome focused approach (i.e. implementing the ward work-out programme) and the other a more process focused approach. As a result, differences in impact emerged. While both groups experienced the value of strong leadership, the emphasis on facilitation with one group of participants influenced the progress of and involvement in the project overall. The challenge of transferring knowledge and skills from training was experienced by one group, whereas the other group seemed to benefit from the opportunity to learn through practice. Both groups experienced the value of some form of stakeholder involvement but, significantly, through wide participation and collaboration, one group appeared both to sense and achieve greater ownership. The influence of context was relevant for both groups, with one feeling the significant benefit of organisational support. However, this group also experienced the tentative nature of context in a healthcare climate where organisational structures can quickly change. Values regarding and decisions related to evidence also influenced experiences, the progress of the projects and sustainability of their practice development. Finally, both projects highlighted the benefit of having some form of external backing and support at a time when resources for practice development were limited.

Both groups of participants had experienced journeys in the pursuit of improving patient care, but despite common experiences, there were also some broad differences. Project 1, began with a strong impetus for change and development. There was a cohesive project team, a task to implement (exercise programme) and organisational support. The potential for achieving sustainable change seemed moderate to good but throughout the project, participants' experiences remained a mix of positive and negative. By the end, it was evident that some impetus had been lost and with limited wider uptake of the exercise programme, participants were thinking about how to revitalise the initiative.

In Project 2, the impetus at the beginning appeared more tentative, with a more open focus on mealtimes and patient-centred care. The facilitators embarked on a whole care team approach and involved a wide range of stakeholders. The early experiences were a mix of positive and negative but towards the end of the project this became more positive than negative. The impetus for change appeared stronger and ongoing, suggesting a greater likelihood of the new practice being sustained.

Critical discussion

Through scrutiny, a number of micro-level distinctions emerged which, when clustered together with the aforementioned broader variations in the two projects, crystallise both fundamental and tangible differences in approaches used, with resulting variance in terms of consequences or practice outcomes. Indeed, it is possible to see a relationship between the practice development approaches observed in the two projects and the methodological perspectives relating to practice development described and explored by Manley and McCormack (2004) – namely, technical (Project 1) and emancipatory (Project 2) practice development (Manley and McCormack, 2004).

However, with further critique of these 'live' examples of activity to improve practice and patient care, greater insight regarding the similarities, differences and consequences of the activities emerges. The two projects represent characteristics of the two typologies or approaches for improving and developing practice, which resonate with current practice and have specific and significant consequences or outcomes for practitioners and practice. The first, Project 1, while more aligned to technical practice development, would be better referred to as 'service improvement' – a means of improving healthcare services that has a tendency to be both task focused and technical in

its approach to achieving change or implementing a new service. There are connections here with the experiences of Henderson and McKillop (2008), who distinguished between practice development and service improvement as part of their work developing cancer services, which, arguably, could have a much wider application to healthcare practice. Project 2 is more aligned to emancipatory practice development, as defined by Garbett and McCormack (2002), Manley and McCormack (2004) and McCormack et al. (2006) – a facilitated and collaborative process for enabling effectiveness in patient-centred care.

Concept analysis provides the foundation for identifying and evaluating concepts and specific approaches. By adapting stage 3 of an approach offered by Walker and Avant (1995), it has been possible to structure and critique the specific features that discriminate between service improvement (Table 4) and practice development (Table 5) approaches, using what is known from Projects 1 and 2 (research data) and the emerging themes and sub-themes. This includes identifying the following.

- The antecedents, or the conditions that precede the manifestation of a concept; in this case what was in place in relation to the two projects and therefore might need to be in place for the typology or case to take place?
- The critical attributes or characteristics of the concept; in this case what key approaches, processes and strategies were used by the two projects and may be a feature of the typology?
- The consequences or outcomes relating to the concept; in this case what where the key outcomes and consequences for the two projects and could therefore be likely when using adopting the typology?

Adapted from: Walker and Avant (1995)

Table 4: Typology/case 1 – service improvement

ANTECEDENTS What may need to be in place for the typology to take place?	**CRITICAL ATTRIBUTES** What key approaches, processes and strategies may be a feature in this typology?	**CONSEQUENCES** (positive (+ve) and negative (-ve) What are the likely key outcomes for practitioners and practice?
▪ Patient need identified from practice and policy ▪ Leadership (project leader) ▪ Cohesive project team with shared values relating to the project and to improving patient care ▪ Research the main evidence base and/or rationale for the service improvement ▪ Organisational drive and management support ▪ Team support process ▪ External support desirable	▪ Focus on new service provision ▪ Project team responsible for implementing service improvement ▪ Research evidence acts as the driver for change ▪ Systematic project plan is developed and followed ▪ Project team members extend their knowledge, skills and roles, and develop new expertise to deliver the service improvement ▪ Training provided for staff ▪ Specific team delivers the new service *(in this case the exercise programme)* ▪ Link nurses used as champions ▪ Support processes used by project team *(in this case the team talked of action learning)*	**For practitioners:** ▪ Apprehension (-ve) ▪ Frustration (-ve) ▪ Achievement and pride (+ve) ▪ Professional development of project team members (+ve) ▪ Staff interested in the new service but levels of participation variable (+ve on a continuum/going in the right direction) ▪ Lack of staff involvement and ownership (-ve) ▪ New service perceived as extra work by staff (-ve) ▪ Differing agendas *(in this case lack of common vision and purpose)* (-ve) **For practice/service:** ▪ New service/development implemented by project team (+ve) ▪ Care/practice improvements experienced by patients participating in new service/development (+ve) ▪ Wider involvement variable (+ve and –ve, albeit moving in the right direction)

Table 5: Typology/case 2 – practice development

ANTECEDENTS What may need to be in place for the typology to take place?	CRITICAL ATTRIBUTES What key approaches, processes and strategies may be a feature in this typology?	CONSEQUENCES (positive (+ve) and negative (-ve) What are the likely key outcomes for practitioners and practice?
▪ Patient need from practice, service users and policy ▪ Leadership (ward team leaders) ▪ Whole team approach with willingness (in principle) to improving patient care ▪ Wide range of evidence* to underpin development **staff/clinical experiences, patients, policy, research* ▪ Supportive ward manager and espoused organisational and management support *(staff may be ambivalent about the degree to which this is lived or experienced)* ▪ Supervision and support seen as essential ▪ Internal facilitators available and predisposed to the following core values and beliefs: - Whole team approach - Inclusion and participation - Contribution of patient and staff experience - External support valued	▪ Focus on becoming patient-centred ▪ Collective responsibility for practice development ▪ The patients' experience as ongoing driver for development and change ▪ Systematic plan focusing on processes and outcomes ▪ Learning takes place through and in practice ▪ Facilitation approach was enabling ▪ Reflective practice used ▪ Facilitators are role models ▪ Inclusion and participation strongly evident ▪ Full stakeholder involvement ▪ Action learning principles used by facilitators to work with staff groups	**For practitioners:** ▪ Frustrations (-ve) but decreasing (+ve) ▪ Increase in person-centred attitudes toward patients and colleagues (+ve) ▪ Personal growth (+ve) ▪ Increased confidence (+ve) ▪ Increased reflectivity (+ve) ▪ Overcoming barriers to change (+ve) ▪ Achievement and pride (+ve) ▪ Sense of ownership (+ve) **For practice:** ▪ Care/practice improvements across practice with evidence of care becoming more patient-centred (+ve) ▪ Movement of workplace culture towards being patient-centred (+ve) ▪ Perceived improvement in clinical effectiveness (+ve) ▪ Team development: increased cohesion and understanding (+ve) ▪ Participation and inclusion *(became a lived value)* (+ve)

The key elements of the typologies are further critiqued with reference to Manley and McCormack (2004) and the six values (see Table 2) refined from the systematic review of practice development (McCormack et al., 2006) as part of this research. As previously stated, these values should inform the decision to use practice development methodology and the subsequent choice of methods. It is possible to determine the extent to which the work undertaken by the projects represents service improvement (typology 1, Table 4) as experienced in healthcare or practice development (typology 2, Table 5); in turn, this may help those seeking to improve healthcare practice to consider how best to approach activity. New perspectives about the role and impact of service improvement are highlighted, along with new insights about practice development as a methodology and the identification of implications for future practice and healthcare quality improvement.

Person-centred care

In both typologies, there are several features that show the extent to which the activities are underpinned by the value of person-centred care. It is important to highlight that, in general, the projects and participants (therefore the typologies) referred to patient-centred care rather than person-centred care; this was similarly reflected in much of the literature and findings of the systematic review (McCormack et al., 2006).

As Manley and McCormack (2004) suggest, improving patient care is a shared value whether the focus is a technical one as in service improvement or (emancipatory) practice development. Both projects identified an area for improving patient care based on a need that had been identified from practice. The additional influence and value of policy in typology 1 is also commonly found in task focused service improvement, where the impetus for change can come from policy directives and targets (Manley and McCormack, 2004). As Sanders (2004) experienced, the link with policy or targets can ensure support from the organisation as seen in typology 1. However, the use of policy and targets can establish and perpetuate the use of strategies where the dominant focus is the new service provision only (Sanders, 2004), as was the case in typology 1, with less, if any, regard for wider issues related to patient care. A new service may subsequently be implemented with some benefits for patients but, as seen in typology 1, the long-term sustainability may be variable (Sanders, 2004; Hooke et al., 2008).

In typology 2, service users had influenced the identification of the need for change. Patient and service user involvement, as Dewar et al. (2003a, b) found, can help embed an initiative in practice and patient care and it is arguably an essential feature of practice development (McCormack et al., 2006). In typology 2, the influence of the patient was seen as part of a strategy to focus on becoming patient-centred and this helped drive progress. As a consequence, the research findings indicated a movement toward more person-centred attitudes and behaviours, together with movement towards a more person-centred workplace culture.

Collaboration and partnership

The value of collaboration and partnership, as indicated by McCormack et al. (2006), embraces the notion of practice development being an inclusive and ethical process where person-centredness, shared vision, values and ownership are achieved through wide participation. An explicit example of partnership is stakeholder involvement and this featured in both typologies, perhaps indicating a wider recognition that cross-boundary working is more effective in complex healthcare systems (Henderson and McKillop, 2008). However, in relation to other aspects of participation and involvement there were significant differences in the typologies.

Service improvement, as shown in typology 1, is often enabled by a small project team whose members work well together and have a shared commitment to patient care. The project team acts in a similar way to the single authority figure or project leader in technical practice development (Manley and McCormack, 2004), taking on responsibility for the change. This was demonstrated in the findings relating to typology 1, where the project team members extended their skills to be able to initiate the programme and support its delivery; intentionally or unintentionally they became the main practitioners delivering the programme. Consequently, as Sanders (2004) experienced, the new service was not owned at the practice (in this case ward) level and there was limited participation by the ward staff. This was frustrating for the team, who had been enthusiastic about the project, and is an indication of the kind of negative consequences that can occur as part of service improvement.

In typology 2, the use of a practice development approach worked purposefully to involve the whole ward team. This was reflected in the methods they adopted and while, within the team, a very small number of people had specific roles and responsibilities, the use of action groups helped achieve

collective responsibility for activity overall. Here positive consequences are seen, with participation and inclusion becoming 'a value' as well as 'an experience'. A further consequence of the 'whole team' participatory approach characterising typology 2 was the evidence of wider improvements in patient care (Clarke et al., 2003; Moss et al., 2008).

Enabling facilitation and support

The value of, or commitment to, facilitation is mostly seen in typology 2. Within the literature, there are many references to the presence and the importance of a skilled facilitator role (Manley and McCormack, 2004; Dewing et al., 2004; Webster and Dewing 2007; Shaw et al., 2008). Facilitation that is holistic (Harvey et al., 2002) or enabling (Shaw et al., 2008) is a strong value and an intentional process in practice development, which is also demonstrated in typology 2.

In typology 2, facilitators needed to be predisposed to a number of core values and beliefs; specifically, participation and inclusion that comprised patient and staff experiences (McCormack et al., 2006) was an enabling factor. It is also important to note that the core values held by the facilitators were not simply espoused, rather they were 'lived by' and experienced by others taking part. Linked to active learning, the facilitators of typology 2 worked as role models and focused on learning in and through practice. Consequently, practitioners experienced personal growth, increased confidence and, as previously demonstrated, attitudinal shifts towards person-centred care (Moss et al., 2008). Some of these features are also experienced in service improvement (typology 1), but are often limited so that only a few key individuals benefit; for example, in Project 1 (typology 1), it was only the project team that experienced the team support processes.

Leadership has a role in supporting and maintaining project progress in both typologies. Shaw (2005) suggests there is evidence of a close relationship between the role of leadership and practice development facilitation. In Project 1 (typology 1), the leader was noted to be essential to the success of the project. In contrast to what might be expected in technically focused service improvement, the leader was experienced (by other participants) to be visionary, influential and resourceful. These are all characteristics of transformational leaders (Manley, 2001), recognised as supportive of practice development (Binnie and Titchen, 1998), as well as qualities required for practice development (Garbett and McCormack, 2003). It could be argued that without strong and effective leadership Project 1 may have floundered. Although not strongly featured in the data of Project 2, leadership was present as a value that enabled practice development.

Commitment to active learning and development

A commitment to active learning and development embraces a range of methods (Dewing, 2008) for enabling purposeful learning through experience and practice. In the context of this value, typology 1 is shown to be strongly consistent with service improvement in many ways because the processes and activities do not encourage active learning. First, training was used as the key process for sharing information and gaining involvement in the new service. The Project 1 team members (typology 1) benefited from professional development as a consequence of taking part in the initiative but, as described by Manley and McCormack (2004), in technical practice development there was little explicit commitment to develop individuals outside of the project team. This remains true of many service improvement activities, despite a growing appreciation that new skills and knowledge are unlikely to be transferred by teaching and training alone (Harvey et al., 2002, Rycroft-Malone et al., 2004; Karlsen, 2007). Second, the strategy of having link nurses, which is quite commonplace as part of service improvement, reduces the opportunity for others to learn, as the link person is seen as the expert advisor. In Project 1 (typology 1) it was often the case that the link nurses delivered the exercise programme rather than promote its use by others in practice. Finally, active learning can be stifled where there is a focus on research evidence only and the technical rational belief that this should ensure practice change. It can be argued that all three aspects contributed to the

consequences of apprehension and frustration, resulting in the lack of wider staff involvement experienced by the team in Project 1.

In typology 2, commitment to active learning and development was demonstrated in a number of explicit ways, including the use of action learning principles, reflective practice, role modelling and peer learning. Active learning was also evident in the way this typology used knowledge and evidence from patients and practice and created opportunities for practitioners to generate ideas for ongoing development. It became clear that a commitment to active learning resulted in a number of positive outcomes consistent with practice development, including personal growth, increased confidence, greater reflectivity and, interlinked with all of these, a sense of achievement (McCormack et al., 2006; Dewing, 2008; Moss et al., 2008).

Transforming workplace culture

Practice development has the potential to transform workplace culture (Garbett and McCormack, 2002; Manley and McCormack, 2004; McCormack et al., 2006) and is often an aspiration of reported practice development projects (Dewing and Wright, 2003). Service improvement, however, does not share this aspiration. Henderson and McKillop (2008) also suggest that service improvement may not have any commitment to culture change. Rather, the focus in typology 1 was the implementation of a new service directly focused on an area of patient need. While there was a sense of achievement and pride because of the benefits seen to care, there was also frustration as is often the case when the 'surface' rather than the 'culture' of practice is tackled. This relates to the limited involvement of the ward staff, which, from the findings, the project team recognised had implications for the sustainability of the initiative. Sustainability is a key challenge for service improvement, as found when using most technical strategies (Manley and McCormack, 2004).

While in typology 2 the aspiration of culture change is not explicit, participant data from the research indicated that it was an important outcome. The presence of several of the enabling factors, although not explicitly related to culture change, may have increased the opportunity in typology 2 for culture transformation, for example, the whole team approach, the value placed on wide evidence (Manley and McCormack, 2004) and valuing the patient experience (Dewar, et al., 2003a and b; Tolson et al., 2006). Further opportunity for culture change may also have been facilitated by the use of strategies for inclusion, reflective practice and learning in and from practice. Overall, there was evidence of some shift in the workplace culture towards a greater focus on patient-centred care.

Evaluation

Evaluation that focuses on both the processes used and outcomes achieved is another key element of practice development (McCormack et al., 2006; Wilson et al., 2008). This contrasts with service improvement, which, like technical practice development, tends to focus on audit and measurement of outcomes only (Manley and McCormack, 2004).

Surprisingly, within the research findings and hence the two typologies, there was little referral to evaluation as a process. However, there was evidence in relation to both typologies that some evaluation of practice was undertaken; for example, practice outcomes are included in the reports produced by the project teams. Those outcomes referred to in the typologies arose mainly from research data gathered during focus groups with participants.

Process evaluation appears implicit in typology 2 because of the commitment given to use methods such as reflective practice to gather evidence about the process, consistent with practice development. In typology 1, the team support process was an opportunity to discuss and evaluate activity. What cannot be judged is the level to which this contributed to the project's evaluation.

Overall, Project 1 does appear to be more closely aligned to service improvement (typology 1). It made a contribution to the improvement of practice and the development of those involved but the methods and processes used did not enable collaboration, inclusion and participation. As a result, the overall impact of the practice was diminished over time. Project 2 has a range of features consistent with the values of practice development (typology 2). The project was enabled by facilitators who valued inclusion and participation as well as the experience and contribution of patients and staff. The range of methods that enable participation in learning through practice contributed to outcomes that are consistent with practice development, including development of staff, improvement in patient care and movement toward a more patient-centred culture (McCormack et al., 2006).

Summary and implications for practice

The typologies at this stage may be tentative; they cannot represent complete types or cases because they were developed using the findings of this research and as such may not contain all the features of practice development and service improvement. However, in their current form they provide new insight into practice development as an emancipatory methodological approach for enabling improvement in person-centred healthcare practice and transformational, person-centred cultures. They also show the role and value of service improvement as an activity that contributes to the development and improvement of healthcare services.

While McCormack et al. (2006) suggest that no one methodology best serves practice development, this research offers arguments for some re-thinking. Practice development is informed by a range of methods but the methodology has become much clearer. It is also evident that some initiatives referred to as practice development do not achieve the key outcome of increasing person-centred care, validated as part of practice development (McCormack et al., 2006) and seen in reported examples and research from practice (Dewar et al., 2003a and b; Tolson et al., 2006; Moss et al., 2008). So perhaps, rather than being seen on a continuum with activities such as service improvement, practice development should stand independently as a methodology (underpinned by the six key values in Table 2) for enabling the development of healthcare practitioners and practice through collaboration, inclusion and participation for the ultimate purpose of achieving person-centred care as defined by Manley et al. (2008).

It is time to cease using the phrase ‘technical’ practice development, as this misrepresents both technical activities undertaken to improve healthcare service and practice development. Instead, those activities often called technical practice development are better represented by the term ‘service improvement’ – an activity that makes a valuable contribution to the development of quality healthcare services (Henderson and McKillop, 2008). Making such a distinction may enhance understanding about what enables improvement and change and how different ways of working may result in different outcomes. It is also possible that such activities may move toward becoming practice development when the processes used and outcomes achieved demonstrate integration with the values of practice development.

At the time of this research and in practice now, improvement activity across healthcare continues to rely on traditional approaches to change, often at pace and in response to targets and policy (Kings Fund, 2012). There needs to be a radical shift in values, attitudes and culture at all levels to move toward the use of practice development approaches that work with people and enable transformation.

Conclusion

This research, through identification of the typologies, has enabled us to understand more about the significant elements of practice development that contribute to increasing sustainable healthcare

delivery. It makes a small but significant contribution to understanding the 'practice' of practice development and its underpinning values and theoretical principles.

Bearing in mind the original research question 'does the approach to practice development in healthcare influence the experience of practitioners and their clinical practice?', the research process and outcomes contribute somewhat more than this rather simplistic question might suggest. First, it adds to the knowledge and gives new insight regarding the role of practice development in improving patient care through collaborative, inclusive and participatory approaches. It also offers clarity and a way forward for practice development (in the context of healthcare) by proposing that it stand independently as a methodology that uses a range of methods. Finally, there is evidence of the positive contribution practice development could make to other activity aimed at improving healthcare services, such as service improvement, which continue to be vital to the ongoing work in healthcare to give patients a timely, effective and high quality experience.

For individuals pursuing high quality patient-centred care through practice development and the enablement of others, it is perhaps time to embrace fully the values that underpin practice development in order to achieve effective person-centred practice. Furthermore, rather than dismissing some of the more technical and task orientated service improvement activities as potentially ineffectual, the adoption of a more positive and supportive stance is required. At a time when improvement activities are widespread but variable in terms of outcomes, the application of knowledge and skills from practice development can enable the ongoing development of healthcare services alongside activity to transform workplace and organisational cultures, towards a growing aspiration for person-centred healthcare.

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A commentary by Rob McSherry appears on the following page.

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COMMENTARY

Unravelling the consequence of practice development: an exploration of the experiences of healthcare practitioners

Rob McSherry

The article offers an interesting and important contribution to practice development, raising and reaffirming major issues for health and social care practitioners who are contemplating or already engaging in innovation, change and or improvement, and for those who have a designated position associated with facilitating these initiatives. These issues include engaging and involving patients, users, carers and health and social care professionals in fostering and demonstrating working organisations and environments that are founded on person-centred attitudes and behaviours. Collaboration and partnership working are vital in promoting stakeholder engagement in achieving cross-boundary teamworking. Authentic sustainable leadership and management plays a significant role in transforming workplace cultures and in demonstrating a commitment to active learning and development.

However, alongside the importance of the above findings, the article highlights two central debates that are worthy of mention: whether practice development is the same as service improvement; and the importance of embedding evaluation to demonstrate impact and/or outcomes in strategic and project planning.

Globally, some health and social care organisations are responding to the economic crisis by focusing attention on the Quality, Innovation, Productivity and Prevention (QIPP) programme (Department of Health, 2010), to establish where any cost effective savings can be made.

Interestingly, the British Medical Association (2010, p 1) suggests:

> *'QIPP is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the economic climate. By assessing reforms against the four components – Quality, Innovation, Productivity and Prevention – the NHS is meant to provide better quality services in the most productive and cost effective way possible, making the best use of the potential of innovation and targeted investment in prevention. The four QIPP elements can be seen as both distinct and inter-related. There will be initiatives which focus on particular elements or which bring some or all of the components together.'*

The key objectives of the QIPP programme are to improve quality and productivity, engage, inspire and empower staff and create a legacy of change leaders and a quality culture (Department of Health, 2010).

The principles of QIPP are:

- To encourage effective engagement with clinicians and other key stakeholders, through the adoption of the philosophy of co-production
- An ability to challenge established thinking and current practice
- The application of knowledge of national and international best practice
- A drive to share knowledge and learning
- Clear and honest communication at all stages of change
- Focus on benefits measurement and realisation
- Application of robust programme management and assurance arrangements

When reviewing these key objectives and principles, the importance of highlighting the differences and similarities of practice development and service improvement is brought to the fore. This is because the fundamental objectives and principles of QIPP emulate many practice development and service improvement type positions, roles and responsibilities (Manley et al., 2008; McSherry and Warr, 2008, 2010). In addition, health and social care organisations that have teams and/or individuals who occupy practice development and service improvement roles should review and align these with QIPP to maximise their potential to demonstrate efficiency and effectiveness of service(s) and to ensure continued resourcing and funding. Finally, to advocate and ensure the sustainability of practice development over service improvement will require substantial evidence of impact and outcome, which this article begins to illuminate.

The article seems to concur with McSherry and Kell's (2007, p 246) suggestion that:

> *'Practice development and service improvement target innovation and change by having in place robust systems and processes for change to occur. Practice development seems to be more individual and team orientated, where service improvement is more organisationally and corporate focused.'*

Furthermore, the article reaffirms that practice development is about facilitating and supporting innovation and change in the quest for quality improvement and the provision of person-centred care. On the other hand, service improvement, as suggested by Bevan (2005), is effectively about tackling productivity, efficiency and fiscal issues. Although practice development and service improvement are undoubtedly different while sharing some similarities, the future is about harnessing the strengths and weaknesses of both typologies for promoting person-centred attitudes, behaviours, cultures and working environments. However, whatever we do, we should be mindful of the fact, that we do it for the benefit of patients, carers, and health and social care professionals and colleagues (Kell and Mudd, 2006).

The article also highlights the importance of demonstrating 'consequence', which, interestingly, is not defined. Collins (1986, p 334) calls it 'a result; effect; a logical result or conclusion; importance'. The incorporation of the word consequence in the title to demonstrate the importance practice development plays in facilitating 'a continuous process of developing person-centred cultures' (Manley et al., 2008, p 9) is an interesting one for several reasons. The initial appearance of the word would seem somewhat dissonant for illuminating the impact and/or outcomes of practice development. This is often because the word is associated with identifying and managing risks (National Patient Safety Agency, 2008) and maintaining patient safety (Patient Safety, 2010), giving it an outwardly negative and disengaging connotation.

Establishing consequence as suggested by Collins (1986) is about highlighting and/or demonstrating the results, importance or effect of something that, in the context of the article, is about practice development. Practice development, and indeed service improvement – although improving has struggled to select appropriate evaluation and associated methodologies and methods to

demonstrate impact and outcomes, a point underlined by the article. What is fundamentally important about the article, though, is that it highlights the fact that whether you are using either a practice development or service improvement typology to instigate innovation and change, evaluation of impact and/or outcomes should always be integrated in the strategic, project and research plans.

To conclude, it is reassuring to see further evidence of evaluation surrounding the significant contribution practice development has played over the past two decades in facilitating and supporting the provision of high quality, safe care and services aligned to person-centred experiences, attitudes, behaviours, cultures, and organisational and working environments.

Given the global economic, political and societal pressures on health and social care organisations, teams and individuals to improve quality while reducing costs, practice development takes centre stage by reaffirming its ability to facilitate and support person-centred innovation, change and improvement. The latter will only be attestable by demonstrating the uniqueness of the typology and by offering appropriate evaluation methodology and methods to highlight impact and outcomes.

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A response to this commentary appears on the following page.

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RESPONSE TO COMMENTARY

Unravelling the consequence of practice development: an exploration of the experiences of healthcare practitioners

Theresa Shaw

I welcome this commentary, which has both stimulated my thinking and created an opportunity to say more about the value practice development can bring to the ongoing and wide ranging activities in healthcare that aim to make improvements and reduce expenditure alongside ensuring people experience high quality, safe and compassionate care.

Along with offering further challenge regarding the clarity of practice development, the commentator has highlighted contemporary contextual challenges, including the global economic climate and the emphasis this has placed on health and social care organisations finding solutions, such as the Department of Health's (England) Quality, Innovation, Productivity and Prevention (QIPP) Programme (www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp/).

The commentary raises for me three key questions, which I hope to address in this response.

1. Are practice development and service improvement the same or different?
2. What is the role of practice development and service improvement in contemporary healthcare practice?
3. What can practice development and service improvement add to programmes such as QIPP?

Before addressing these, it is perhaps useful for clarity to reiterate that the paper critically discussed two projects or initiatives that are representative of the kind of activity seen in healthcare to develop and improve practice in some way. By adapting and using an approach to concept analysis developed by Walker and Avant (1995) as a framework, the activities and approaches of the initiatives were presented as two typologies. For each it was possible first to show what needs to be in place to enable the initiative to take place, and second to identify the key features or characteristics of the initiative, including methods, approaches and strategies. Finally, the consequences of the initiative were extrapolated; in other words, as Walker and Avant (1995) explain, the key likely outcomes of the activity were presented.

Reflection on the consequences relating to the two typologies highlights the central differences between them, and arguably between service improvement and practice development. This is the emerging transition towards culture change in the form of more person-oriented practice and attitudes. Drawing on the commentary, there is some consistency with this and how McSherry and Kell (2007) define practice development and service improvement. However, the aspects the definition seems to have overlooked are the explicit commitment within practice development to (i)

work with values towards a shared vision, (ii) to develop people and, most centrally, (iii) to transform culture.

All three are key to achieving and maintaining the momentum of change and also feature prominently in contemporary policy and guidance on healthcare development and improvement. For example, the King's Fund has challenged the extent to which change at scale and pace is effective; rather they highlight the value of engagement with people as a means of galvanising commitment to change (King's Fund, 2012). Similarly, the NHS Institute for Innovation and Improvement has emphasised the need to understand people, attitudes and values in order to create a culture of innovation (Bevan, Plsek and Winstanley, 2011). Most recently, in England, the Chief Nursing Officer and Nursing Director have highlighted culture change in calling for compassion in healthcare (Cumming and Bennett, 2012)

In the light of this, what is the role of practice development and service improvement in contemporary healthcare practice? In simple terms, service improvement should be considered an umbrella term, under which can be found the raft of activities undertaken in practice to make improvement and changes in healthcare practice. Practice development should be viewed more as a methodology that is underpinned by a set values that:

- Enables the ongoing development of healthcare practitioners and practice
- Fosters collaboration, inclusion and participation
- Inspires changes in the culture as well as the 'task' of healthcare provision and delivery

In terms of how practice development and service improvement relate to programmes such as QIPP, the answer is perhaps in the statement of purpose of such programmes. If it is about making improvement to the quality of patients' experiences and the productivity of healthcare, there are clear indications that both can contribute. If however, in the case of QIPP, it is a commitment to engaging and empowering staff and creating a legacy of change leaders who inspire a culture of improvement, then the role of practice development could be most significant.

To conclude, further exploration and critique of practice development and other related activity would be of value. However, I would offer some caution on continuing to seek perfect clarification of terms and purpose. Rather, at a time when there needs to be a radical shift in values, attitudes and culture at all levels, I would encourage a greater emphasis on using practice development to strengthen work already under way in healthcare and help healthcare practitioners get back on track to deliver high quality, compassionate and safe care.

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