Introducing practice development to facilitate excellence in care

Introduction

This chapter briefly outlines the drivers for practice development and excellence in practice followed by a detailed outline of what the terms and phrases mean and how this can be facilitated in practice. This is achieved by exploring the key characteristics and qualities required to take practice development forward along with outlining some of the tools and techniques to aid the process.

Background

The rationale for the introduction of phrases or terms like: evidence-based practice, clinical governance, practice development and excellence in practice, according to Pickering & Thompson (2003), could be attributed to a perceived decline in the standards and quality of care provision. This is because all of these phrases or terms are directly and or indirectly focused on promoting individuals, teams and organisations in the delivery of quality care and services. This point is confirmed by McSherry & Pearce (2007) arguing that the origins for developing quality health and social care services arise from a combination of societal, political and professional factors such as the following:

- rising patient/client and carer expectation
- increased dependency of those accessing services
- technological advances
- demographic changes in society
- changes in care delivery systems
- lack of public confidence in healthcare services
- threat of litigation
- demands for greater access to information.

To address and respond to the growing pressures to change, reform or modernise to keep up with the times, it is important that health and social care professionals recognise what, why and how practice development may aid the pursuit of excellence in practice. In order for this to happen it is imperative that we understand what we mean by the terms practice development and excellence in practice.
What do we mean by practice development and excellence in practice?

Over the past decade Page & Hamer (2002) argue that the term practice development (PD) has been associated with supporting modernisation, and organisational, service and quality improvements but more importantly in promoting patient centredness (McCormack et al., 1999). Promoting patient-centred care as advocated by McCormack et al. (1999) could arguably be seen as the kingpin of excellence, as without achieving this could we claim to be providing quality care and/or services? The perceived value of practice development in promoting excellence in practice according to Elwyn (1998) and McSherry & Bassett (2002) is linked to its facilitative approach to engaging patients and users with change and innovation through collaboration, team working and partnership building. Glover (1998; 2002) and McSherry & Driscoll (2004) argue that despite the plethora of literature outlining the relative strengths and weaknesses of practice development to the health and social care professions, professionals, and health and social care organisations, there is limited evidence available substantiating the existence of a knowledge base within the field of practice development and whether it improves or promotes excellence in practice.

Activity 1.1 Reflective question
Write down what you understand by the terms practice development and excellence in practice.
Read on and compare your notes with the activity feedback at the end of the chapter.

What is practice development and how can it facilitate excellence?

In order to understand why and how practice development can facilitate excellence in practice it is imperative to know where the term originated and what it means. The next section is adapted from the working McSherry & Warr (2006).

Practice development – a brief historical overview

Practice development, according to McSherry & Warr (2006), was primarily introduced into the UK by the nursing profession in the late 1970s and early 1980s during a major transitional and reforming period. Nursing at the time was shifting from a traditionalist approach to practice based on tasks, rituals and the division of labour (skill-mix and profiling) towards a patient-centred approach based on quality, standards, education and evaluation (McCormack
et al., 1999). Essentially nursing (through practice development) was trying to break free from the chains of medicine, managerialism and the hierarchy of routines for a professionalism based on providing individualised patient-centred care through the execution of independent accountable and autonomous decision-making and practice (Glover, 2002). The quest for independent, accountable and autonomous decision-making in practice produced an intensity of activity within the field of practice development. Activities have ranged from the introduction of Nurse Development (Lathan & Vaughan, 1997) and Practice Development Units (Page et al., 1998), the establishment of individuals and teams with a remit for practice development (Bassett, 1996; Glover, 2002), the development of a national Practice Development Forum (Mallett, 2000) (known today as The Developing Practice Subscribers Area with Foundation of Nursing Studies (FONS)) and ongoing research and development into practice development to name but a few (Taylor et al., 2002).

Practice development, and methodologies to support it, have been discussed in international literature. In Australia, the literature has emphasised its role as a catalyst for change (Walker, 2003) and the role of facilitating teams to effect change (Walsh et al., 2004). In the USA, Haag-Heitman & Kramer (1998) have proposed a clinical practice development model and Cambron & Cain (2004) suggest that there are lessons to learn from the UK movement. The term ‘practice development’ appears in the literature of other countries occasionally (e.g. Pitkanen et al., 2004), but there is an increasing emphasis on related concepts and alternative phrases (Wong, 2002: Gustafsson & Fargerberg, 2004).

Practice development is an approach that recognises the realities of external influence whilst allowing an individual service to focus on developing excellence in practice in all areas. It is an inclusive ‘bottom up’ approach to review and change the whole service which puts the patient at the centre of the care process. It has many definitions which emphasise different aspects of these qualities but one we have found useful by exploring the literature and for practical delivery and which will be developed further in this and subsequent books is:

Practice development’s primary principles are centred on promoting patient-centredness through the utilisation of a facilitative approach to team working, collaboration and partnership building (McSherry & Warr, 2006:75).

This facilitative approach to innovation and change offers an ideal vehicle to utilise targets and standards through an inclusive and empowering way to develop local practice. As such, targets have a central role in promoting excellence through practice development (Figure 1.1).

Despite the potential benefits of practice development in promoting excellence it is imperative that individuals, teams and organisations understand what the term means.
Defining practice development

The term *practice development* has been defined and conceptualised over the past two decades resulting in numerous definitions (Figure 1.2) attempting to decipher what it means and involves. Practice development according to Kitson (1994:319) can best be described as:

- a system whereby identified or appointed change agents work with staff to help them introduce a new activity or practice. The findings may come from the findings of rigorous research; findings of less rigorous research; experience which has not been tested systematically or trying out an idea in practice. The introduction of the development ought to be systematic and carefully evaluated to ensure that the new practice has achieved improvement intended.

What Kitson’s (1994) definition highlights is the importance research plays in driving change and that the proposed change may prove or disprove the research theory. It could also be inferred that practice development supports the government’s drive for a more systematic and rigorous approach to NHS research and development through focusing attention on the implementation and utilisation of research findings in practice. In contrast to Kitson’s (1994) definition, Mallett et al. (1997) introduced the notion that practice development should be based on patients’ needs by arguing the case that practice and professional development, although viewed synonymously at times, were distinctively different. This point was endorsed by McCormack & Garbett (2003) who suggest professional development refers to developing the knowledge and skills of the individual whilst practice development is about creating optimal organisational cultures and working environments to aid individuals in applying such skills. By exploring the definitions and distinctions between practice and professional development at best practice development should be defined as:

- continuous process of improvement towards increased effectiveness in person-centered care, through the enabling of nurses and health care...
teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change (McCormack et al., 1999:258).

Furthermore, taking a critical review of Kitson’s (1994), Mallet et al.’s (1997) and McCormack et al.’s (1999) definitions of practice development reveals that the role of practice development is that of facilitator in supporting the creation of optimal cultures and contexts to promote innovation and changes in practice. Practice development is about encouraging individuals, teams and organisations to improve practice through innovation and change (McSherry & Bassett, 2002). Practice development plays a pivotal role in fostering a culture and context that nurtures evidence-based nursing because it is an:

- an approach that synthesises activities and theory of quality improvement, evidence-base and innovations in practice, within a real-practice context, and with a central focus on the improvement of care and services for patients and clients (Page & Hammer, 2002:6).

Similarly practice development is distinctive and unique because it happens within the professional’s ‘own’ practice setting and is about the enhancement and growth of personal, professional and/or organisational standards and quality of services by involving and focusing on the patients’ and clients’ specific needs.

Excellence in practice requires team-working, interdisciplinary collaboration, effective communication, internal and external partnerships and a willingness to learn and share with and from each other; including users of the NHS (McSherry, 2004:140).

To achieve the status of being an effective individual, team and organisation, practice development requires support, investment and most importantly recognition from health and social care professionals themselves; recognition that practice development is an integral part of all of our roles and everyone’s responsibility to advance and evaluate practice. The fundamental aim of practice development is

- to act in partnership, providing support between clinical practice, education and management, enabling them to increase research utilisation (Bassett, 1996:18).

Taking the above definitions and those summarised in Figure 1.1 along with the emerging debates about what practice development is and means, it could be argued that practice development is ideal in promoting quality improvements in care...as well as one’s self! (McSherry & Driscoll (2004).) This is because practice development is pertinent to all health and social care professionals, teams and organisations.

A critical review of the definitions provided in Figure 1.2 and exploring the work of O’Neal & Manley (2007), McCormack et al. (2006), McSherry & Warr (2006), along with A Strategy for Practice Development (Health Service
Introduction to excellence in practice development

Author: Kitson
Year: 1994
Definition: A system whereby identified or appointed change agents work with staff to help them introduce a new activity or practice. The findings may come from the findings of rigorous research; findings of less rigorous research; experience which has not been tested systematically or trying out an idea in practice. The introduction of the development ought to be systematic and carefully evaluated to ensure that the new practice has achieved improvement intended.
Key themes derived from definition:
- Change
- Research
- Experience
- Systematic
- Evaluation
- Improvement

Author: Bassett
Year: 1994
Definition: Practice development is to act in partnership, providing support between clinical practice, education and management, enabling them to increase research utilisation.
Key themes derived from definition:
- Partnership
- Support
- Enabling
- Evidence

Author: McCormack et al.
Year: 1999
Definition: Continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and health care teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change.
Key themes derived from definition:
- Continuous
- Quality
- Person-centred
- Enabling
- Working environment
- Culture
- Systematic process
- Facilitation

Author: Clarke & Wilcockson
Year: 2001
Definition: The ways in which practitioners engage with and create knowledge with which they effect development in their understanding and practice of patient care.
Key themes derived from definition:
- Engage
- Knowledge
- Quality
- Patient-centred

Author: McSherry & Bassett
Year: 2002
Definition: Practice development is about encouraging individuals, teams and organisations to improve practice through innovation and change.
Key themes derived from definition:
- Encouraging
- Innovation
- Change

Author: Page & Hamer
Year: 2002
Definition: Approach that synthesises activities and theory of quality improvement, evidence-based and innovations in practice, within a real-practice context, and with a central focus on the improvement of care and services for patients and clients.

Key themes derived from definition:
- Systematic approach
- Patient-centred
- Evidence
- Facilitation
- Change

Author: Garbett & McCormack
Year: 2002
Definition: A process of increased effectiveness in person-centred care.

Key themes derived from definition:
- Process
- Systematic
- Person centred

Author: McSherry
Year: 2004
Definition: About encouraging and motivating staff to innovate or evaluate practices, regardless of size, in the quest for improved quality.

Key themes derived from definition:
- Encouraging
- Motivation
- Quality

Author: Hynes
Year: 2004
Definition: Questioning practice in the context of evidence to support what it is we, as practitioners, do, why we do it so, and how it can be done differently.

Key themes derived from definition:
- Challenging
- Evidence
- Quality

Author: McSherry & Warr
Year: 2006
Definition: Practice development’s primary principles are centred on promoting patient centredness through the utilisation of a facilitative approach to team working, collaboration and partnership building.

Key themes derived from definition:
- Patient centredness
- Facilitation
- Change
- Collaboration
- Partnerships

Figure 1.2 A critical review of practice development definitions
Executive Southern Ireland, 2007) reveals an interesting and useful framework encapsulating key themes about what practice development is and how it can facilitate excellence in practice (Figure 1.3).

Figure 1.3 depicts how practice development is about encouraging (McSherry & Bassett, 2002), enabling (Bassett, 1996; McCormack et al., 1999), engaging (Clarke & Wilcockson, 2001) and enlightening (McSherry & Warr, 2006) individuals, teams and organisations to rise to the challenges and demands placed on health and social care services to change and keep up with the times. Practice development is ideal in supporting innovation and change by offering a continuous systematic framework/process for facilitating the advancement and evaluation of individual, team and organisational practice(s) (Kitson, 1994; McCormack et al., 1999; Garbett & McCormack,
2002; Page & Hamer 2002). Ultimately the purpose of practice development is about ensuring that person/patient centredness (McCormack et al., 1999; Clarke & Wilcockson, 2001; Garbett & McCormack, 2002; Page & Hamer, 2002; McSherry & Warr, 2006) is at the heart of all innovation and change. User involvement in care delivery and evaluation is imperative in order to bring about continuous quality (Clarke & Wilcockson, 2001; McSherry & Bassett, 2002; Hynes, 2004) and or service improvements (Kitson et al., 1994) within the context of governance principles (McSherry, 2004). Governance principles are based on ensuring that every health and social care professional and worker focuses on promoting person/patient-centred care through:

- developing knowledge, skills and competency as part of their professional accountability and roles and responsibilities outlined in their job description
- ensuring they support their decision and actions with appropriate evidence.

Similarly, practice development is about generating evidence from practice in order to inform future innovation and change through:

- focusing on providing and developing quality care and services with users and providers of the service
- introducing ways to capture, measure and demonstrate the impact of change on the patient, service or clinical outcome or the efficiency and effectiveness of the change on individuals, teams and organisations
- having the backing of the organisation to offer education and training to support innovation and change.

The value of practice development in promoting governance principles is the fact that it ‘draws on many different and diverse disciplines, which in turn enables all professionals to be integrated for the benefit of patients’ (McCormack et al., 2002:35). Practice development is about enabling health and social care workers, teams and organisations to transform the culture and context in which care is provided. In order to achieve this Bassett (1996) argues it is about developing partnerships, providing support between clinical practice, education and management, enabling them to increase research utilisation. This can only be achieved successfully, according to McSherry (1999), through developing:

- **Team work**: between all key stakeholders (including users and carers) within and external to the team.
- **Multi-professional collaboration**: Involving the multi-disciplinary team members including ancillary team members.
- **Effective communication**: between, within and across all the stakeholders involved with the innovation and change.

Manley & McCormack (2003:23) argue that the ‘raison d’être of practice development is to improve some aspect of patient care or service directly’, regardless of the methodologies used, or the assumptions, beliefs and values
held. To this end Manley & McCormack (2003) and McCormack et al. (2002) illustrate why and how practice development eloquently links to Habermas’s (1972) critical social theory/science.

Critical social theory or science as it is often referred is used as a generic term to describe the attempt to theorise the modern social world in any of its spheres (the psychological, the cultural, the economic, the legal, or the political), then ‘critical social theory’ means firstly, social theory which is capable of taking a critical stance towards itself, by recognising its own presuppositions and its own role in the social world, and secondly, social theory which takes a critical stance towards the social reality that it investigates, by providing grounds for the justification and criticism of the institutions, practices and mentalities that make up that reality (Yacopeth, 2007).

Put simply critical social theory as described by Habermas (1972) is about exploring the world we live in and the structures and systems within it and around it. Critical social theory is a philosophy well suited for practice development because it is

a means to frame enquiry, with the aim of liberating groups from constraints (either conscious or unconscious) that interfere with balanced participation in social interaction (Mooney & Nolan, 2006:241).

This notion of liberation and balanced participation is important within practice development because change and innovation is directly and indirectly linked to the identification of assumptions, values and belief. ‘Assumptions are usually unconscious, but by making assumptions conscious, explicit values and beliefs can be articulated’ (McCormack et al., 2002). Mooney & Nolan (2006) added clarity to the debate surrounding assumptions, values and beliefs by arguing that society is structured by rules, habits, convictions and meanings to which people follow. The notion of liberation and balanced participation is important in practice development because it is about attempting to encourage, empower and engage individuals, teams and organisations through dynamic management and leadership in the quest to improve patient care and/or services. To bring about these types of changes may or may not require a development in self-awareness and knowledge along with a challenge to existing assumptions, values and beliefs held by individuals, teams and organisations. This idea of knowledge is an important factor associated with critical social theory and practice development because by adopting an orientation towards critical praxis that is synchronised reflection and action, we hope to facilitate a review of what knowledge is, the way in which one comes to know and those who provide knowledge (Habermas, 1972; Mooney & Nolan, 2006). McCormack et al. (2002) and Manley & McCormack (2003) expand the different kinds of knowledge debate and how knowledge can be realised within practice development in three ways: technical, practical and emancipatory (Figure 1.4).
Figure 1.4 simply and briefly illustrates how critical social theory or science as a philosophy supports practice development by focusing attention on enhancing three types of knowledge: technical – concerned with enhancing knowledge that will improve skills, competency akin to science such as pain relief, wound care and management; practical – associated with understanding what others know and feel about the care or service received; emancipatory – focuses on self-awareness and reflection and how the individual influences or is influenced by the working environment, culture and context in which they work. It is about empowering and disempowering others and its influence on innovation and change. Practice development is about focusing attention on enhancing these types of knowledge through using one or several methodologies, for example, engaging the research process to review or evaluate a given situation that results in a shift or change in the assumptions, beliefs and values held, thus bringing about a change in culture and context for the given situation. For more information on critical social theory/science and practice development see Box 1.

Box 1.1 Critical social theory/science and practice development

More detailed information about critical social theory/science and practice development can be found in the following publications:


Having identified what practice development is along with its underpinning philosophical foundations it is imperative to highlight the characteristics and qualities required to take practice development forward in any given health and social care setting.

Characteristics and qualities required to take practice development forward

A description of the characteristics, qualities and skills in practice development based on the work of McCormack & Garbett (2003) outlined in Figure 1.5 reveals that the characteristics and qualities of practice developers is about encouraging and motivating staff to innovate or evaluate practices regardless of size of the project in the quest for improved quality. Successful practice development is dependent upon encouraging and supporting individuals to develop certain essential skills and attributes so that they can advance and/or evaluate practice as part of the change processes.

A review of the characteristics and qualities of the work of McCormack & Garbett (2003) along with the works of McSherry & Bassett (2002) and McSherry & Driscoll (2004) highlighted in Box 1.2 reveals several key qualities and individual personal attributes that seem to make practice development occur. For practice development to occur a blend of the essential qualities and individual personal attributes are required within the process of change.

Box 1.2 Essential and individual attributes associated with practice development

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Motivate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect</td>
<td>Facilitate</td>
</tr>
<tr>
<td>Experience</td>
<td>Innovate</td>
</tr>
<tr>
<td>Approachable</td>
<td>Inform</td>
</tr>
<tr>
<td>An agent of change</td>
<td>Encourage</td>
</tr>
<tr>
<td>Supportive</td>
<td>Support</td>
</tr>
</tbody>
</table>

For some health and social care organisations, practice development facilitators, advisers or developers are available to support and facilitate change. However, for other organisations and individuals this is not the case, placing pressure on individuals and teams to take responsibility for advancing and evaluating their own or team’s practice as part of an ever-changing agenda. The introduction of named ‘practice developers’ is essential if health and social care organisations and teams are to modernise within busy, stressful and time-pressured practice areas. Several models have been reported and commented upon which could be used as exemplars in developing these posts further within the NHS (Glover, 2002). It is also worth considering the
importance of ensuring that the introduction of new practice development positions are not tied in with other aspects of the governance agenda because this makes the posts too big and difficult to operationalise successfully (Garbett & McCormack, 2001). To meet the health and social modernisation agendas it could be easy to say that all health and social care professionals have or should possess the skills outlined in Figure 1.5 and Box 1.2. However, within practice development they become even more important when facilitating the development and evaluation of new or existing ways of working. To advance and evaluate practice within the context of health and social care it is imperative for individuals and teams to be familiar with the various tools and techniques to aid the process of change.
This section defines facilitation along with relating this important term to practice development. The section then goes on to provide several individual, team and organisational tools and techniques that may support the advancement and evaluation in practice.

**Facilitation – its importance to achieving excellence in practice**

Facilitation is undoubtedly an important factor for effective practice development and is an essential concept to understand in relation to supporting innovation and change. Simmons (2004) argues that facilitation is a widely used concept within health and social care, for example psychology (Burke et al., 2000), social care (Hunter et al., 1996), education (Cross, 1996) and research (Soltsis-Jarrett, 1997) to name but a few. Generally facilitation is defined as ‘to make easy or easier’ (Collins, 1987:308). Facilitation within the context of practice development is more difficult and challenging to define because it is poorly articulated and understood (Simmons, 2004). At best practice development ‘facilitation’ is a term ‘frequently referred to as a strategy for enabling the process of developing nursing practice’ (Simmons, 2004:36) but should be used to support innovation and change for all health and social care. Simmons’s (2004) concept analysis of facilitation of practice development highlighted a need for practice developers to reflect critically upon their use of the term facilitation. Rycroft-Malone et al.’s (2004) work associated with the Promoting Action on Research Implementation in Health Services (PARIHS) framework makes inroads into the importance of facilitation within the context of getting evidence into practice which is transferable to practice development. This is achieved by exploring the:

- role of facilitation
- purpose of facilitation
- facilitator role
- skills and attributes of facilitators

a sound tool kit of skills and personal attributes for any practice developer to embrace when supporting innovation and change. Alternatively, Titchen’s (2000) ‘critical companionship model’ offers excellent insight and ways of facilitating learning for individuals and groups in practice. Collectively the works of Simmons (2004), Rycroft-Malone et al. (2004) and Titchen (2000) offer sound insight into the role and purpose of facilitation within the context of practice development. Information on facilitation and practice development can be found in Box 1.3 alongside understanding what facilitation means and involves, and the skills and personal attributes required by a practice developer to support change in practice.
It is imperative to be able to describe a particular activity, that is to say what were you doing, how you did it and what tools and techniques were employed to support the activity. These questions are critical in order to repeat elements that are effective and to share knowledge with others (Simmons, 2004). To this end it is essential that individuals, teams and organisations familiarise themselves with the tools and techniques to facilitate the advancing and evaluating of practice.

Tools and techniques for advancing and evaluating practice

The challenge facing practice developers, nurse consultants/therapists, specialist practitioners and teams in facilitating innovation, change or to evaluate practice(s) is seeking out the various and most appropriate tools and techniques to support the process, and in highlighting how, why and what the effectiveness of the change was. This is important so that others can learn and share from experience and to avoid reinventing the wheel. Prior to beginning and managing the process of change or in developing, implementing and evaluating a new role, innovation or an evaluation of practice ask: Is there anything already available to support you with the project or innovation, change or evaluation? There are many different and diverse individual and organisational assessment tools and techniques to assist in this process as highlighted in Figure 1.6.

It is evident from Figure 1.6 that there are various individual and organisational self-assessment tools and techniques available from the business, marketing and health and social care organisations to aid individuals, teams and organisations with prioritising and developing a strategy for:

Box 1.3 Facilitation and its importance to practice development

The following publications offer excellent information about what facilitation means and its importance to practice development in supporting innovation and change:

Introduction to excellence in practice development

1. Assessment tool and technique: Political, Economical, Social and Technological Assessment (PEST analysis)
   Brief description: An organisation’s operating environment can be analysed by looking at:
   - External forces (those factors that an organisation has no control over)
   - Internal forces (factors that an organisation has direct control over)

   The external environment of an organisation can be analysed by conducting a PEST analysis. This is a simple analysis of an organisation’s political, economical, social and technological environment.
   Potential use for practice development: Useful technique to be undertaken when exploring the long-term developments of the of new role, position or service development, redesign or review.
   Useful resource details:

2. Assessment tool and technique: Strengths, Weaknesses, Opportunities and Threats (SWOT analysis)
   Brief description: SWOT analysis is commonly used in marketing as a tool to define plans and set strategies. The SWOT analysis (identification of strengths, weaknesses, opportunities and threats) can help define what needs to be done to adapt to new roles.
   Potential use for practice development: Technique to be undertaken at the commencement of a new role or innovation and change as well as periodically throughout the project. The use of development/action plans could be applied to support individual personal/professional development or of the team and the strategic development of the organisation.

3. Assessment tool and technique: Reflective practice
   Brief description: Reflective practice described as a ‘process of internally examining an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self and which results in a changed conceptual perspective’ (Boyd & Fales1983). Reflective practice is an ideal way of encouraging individuals, teams and organisations to question and ‘confront the social, political [professional] forces which provide the context of their work, and in questioning claims of ‘common sense’ or ‘the way things should be’ (Reynolds, 1998:198).
   Potential use for practice development: Reflective practice is ideal in supporting practice development because:
   - Various models/frameworks generate different approaches for reflective learning to be accessed and applied to different situations and contexts.
   - Reflective practice is an essential component of self-awareness and professional practice.
   - Reflection in action enables individuals to utilise their current knowledge in support of decision-making.
   - Reflection on action enables individuals to define and respond to challenging situations after the event and to evaluate the effectiveness of their action.
   - Reflective practice promotes problem-based learning, critical thinking etc.
   - There are various strategies to facilitate reflection.

   Useful resource details
Figure 1.6 Tools and techniques to support practice development in health and social care. Adapted from the works of Renshaw (2005) in McSherry & Johnson (2005) and the Health Improvement Network (2003)
the wrong problems in the first place we are wasting our time.) It is an excellent way
for a team of people to start thinking about a problem and it often serves as an early
pointer to possible solutions. Like all of the tools and techniques, it is easy to do but
can make a big difference (NHS, 2003).

**Potential use for practice development:** Excellent technique to use for seeking
views and opinions in the early stages ‘for getting started’ in the role or new
innovation and change.

**Useful resource details:**
The National Health Service – The Improvement Network.

8. **Assessment tool and technique:** Corporate, Management and Clinical Self
Assessment Tools

**Brief description:** The assessment tools provided by the Commission for Health
Inspection and Audit (CHIA) known today as the Healthcare Commission (HC)
could provide useful tools and templates for establishing the overall systems and
processes and standards and quality at an individual, team and organisational level.

**Potential use for practice development:** These self-assessment tools and
techniques could be modified and used to assist you in establishing the initial or base
line assessment.

**Useful resource details:**

9. **Assessment tool and technique:** Leadership Qualities Frameworks

**Brief description:** For self and team assessing.

**Potential use for practice development:** Ideal for self and team assessing prior
to and during innovation and change.

**Useful resource details:**
National Health Service Leadership Qualities Framework
http://www.nhsleadershipqualities.nhs.uk/

10. **Assessment tool and technique:** Innovation and Change in Health and Social
Care

**Brief description:** ‘The NHS Institute for Innovation and Improvement supports
the NHS to transform healthcare for patients and the public by rapidly developing
and spreading new ways of working, new technology and world-class leadership
(NHS Institute for Innovation and Improvement, 2007); ‘to improve the experience
of people who use social care by developing and promoting knowledge about good
practice in the sector. Using knowledge gathered from diverse sources and a broad
range of people and organisations, we develop resources which we share freely,
supporting those working in social care and empowering service users’ (Social Care
Institute for Excellence, 2007).

**Potential use for practice development:** Both these organisations are ideal
resources to access in supporting innovation and change in health and social care.

**Useful resource details:**
NHS Institute for Innovation and Improvement.
http://www.institute.nhs.uk/organisation/about_nhsi/about_the_nhs_institute.html

SCIE. http://www.scie.org.uk/

Note: This is not an exhaustive list (presented in no particular order) to supporting
innovation, change and or evaluation. It is important that you prioritise, establish and
employ the tools and techniques most suitable to support the activity.
• getting started in a new role or service
• changing existing practice through review or redesign
• evaluating care.

Self-assessment tools within the context of practice development are about adopting and applying a suitable approach to enable individuals, teams and the organisation to explore the systems that are in place in order to identify strengths and areas for further development (Renshaw, 2005). It is a structured tool asking individuals, teams and the organisation to look at themselves against clearly defined measures, reflect on progress and think about future action, and to help plan and devise a strategy to progress one’s role in the future.

The utilisation of these self-assessment frameworks/tools within the context of practice development has the potential to promote effective collaboration by identifying and resolving:

• Organisational issues: implementing a new service or reviewing and redesigning existing services
• Conflicting expectations: reviewing conflicts of interest between professional groups, teams and individuals
• Communication issues: between and within individuals teams and organisations
• Cultural differences: between services and departments
• Resource availability: for existing or planned service developments.

The benefits of such approaches by extension could be:

• Improved quality
• Enhanced communication
• Shared working
• Complementary standpoints
• Enhanced productivity/outcomes.

McSherry & Johnson (2005)

In order to achieve excellence in health and social care practice it is imperative to understand what we mean by excellence in care and whether or not it is a myth, reality or a continuum attached to expectation.

What do we mean by excellence in care?

The term ‘excellence’ is being used widely throughout organisations, professionals and businesses as well as health and social care professions. Yet the reality of achieving excellence is fraught with challenge and difficulty; so why do we continue to seek excellence within fields of practice? The pursuit of excellence in health and social care practice according to McSherry (2004) requires:

• team-working, interdisciplinary collaboration, effective communication, internal and external partnerships and a willingness to learn and share
with and from each other; including users of the NHS (and social care) (2004:140).

To achieve excellence in personal, professional, organisational, managerial, educational, clinical, research and development it is imperative to understand what the term means and how it has been applied in practice. The use of the word ‘excellence’ or phrase ‘excellence in practice’ has grown significantly over the past decade. We see excellence, which is undoubtedly increasing in popularity in practice, being advertised and mediated through journalism, business, organisation, management and leadership. Yet the reality of aspiring and achieving this noble goal for every health and social care professional, team and organisation is fraught with difficulty and challenge. This is because despite the importance and use of the word ‘excellence’ the term is fraught with confusion, misunderstanding and misinterpretation.

### Excellence within the context of health and social care

**Defining the term ‘excellence’**

Generally the term excellence is defined by Collins (1987:299) as:

- **Excel** excellere, rise to be better or greater than (others)
- **Excellence** the fact or condition of excelling; superiority
- **Excellency** a title of honour applied to various dignitaries
- **Excellent** outstandingly good of its kind.

What the Collins (1987) definition seems to indicate is that excellence is a difficult concept or term to define and articulate for several reasons. Firstly, the term is symbolic with achieving a desired standard or goal which could be individual, team or organisational in nature. Secondly, achieving excellence is indicative of working through a process in order to achieve a desired outcome which again could be individual, team or organisationally orientated. Thirdly, excellence seems to be an outward expression of achieving a status or award which recognises an acquired standard or performance of practice or achievement against a given criterion. Fourthly, excellence is a concept that is associated with outstandingly good performance which is above those of its kind.

By comparing and contrasting the Collins (1987) general definition of excellence with some offered by institutes and departments across health and social care some similarities and differences do emerge. For example the Social Care Institute for Excellence (SCIE) associate excellence with improving the experience of people who use social care services, by ensuring that knowledge about what works is readily accessible. We pull together knowledge from diverse sources through working with a broad range of organisations and people. We share this knowledge freely, supporting those working in social care and empowering service users.
Similarly the Department of Health (DH, formerly DoH) link excellence to the clinical governance framework defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (1998a).

Taking the Collins (1987), SCIE and DH definitions and interpretations of excellence into account it is evident that several key themes emerge about what excellence is and is not.

Firstly, excellence is an outward expression of an achievement of a desired outcome against a set of criteria which is above the given or expected standard of practice. Secondly, excellence is a very nebulous concept making it difficult to define because it is associated with individuals’, teams’ and organisations’ visions, goals and aspirations which could change and shift with acquired experience, knowledge, and education and training. Thirdly, achieving excellence in practice is challenging and difficult because it is hard to isolate and differentiate what it is that makes an individual, team or organisation stand out from others based on a given set of criteria, standards and frameworks. Fourthly, excellence is associated with having robust frameworks, systems and processes in place for the gathering and presentation of evidence against a given set of criteria. Finally, given the fact that there are so many different accreditation bodies describing what excellence in health and social care is and is not makes it both challenging and rewarding for individuals, teams and organisations to work with and across the various systems and processes in order to demonstrate an acquired standard of practice. It is without doubt that excellence is and will remain a difficult concept to define and recognise in health and social care. However, as Moul- lin (2002:1) suggests, the ‘vast majority of people working in health and social care are concerned with the quality of the service they provide, indicating that the strive for quality and excellence are interchangeable and may vary depending on the perceptions, experiences and attitudes and behaviours of people notwithstanding the systems and processes required to gather and present the evidence against a set of standards or performance indicators. The challenge for health and social care is in developing, implementing and evaluating the systems and processes to denote an acquired level of excellence.

Achieving excellence (the process) for oneself, team and organisation

The challenge facing individual health and social care professionals, teams and organisations is how to start advancing or evaluating practice in a busy, stressful and time-conscious environment like those of the health and social care environments of today. The key to resolving these and other obstacles is to ‘recognise the complexity of the practice environment if they want to
effect change and tailor any developments to suit the local context’ (Page, 2001).

Despite the proliferation of information highlighting the value of practice development to encourage lifelong learning and professional development, minimal research as suggested by McCormack et al. (2006) has been undertaken to demonstrate the overall impact practice development has had on improving the outcomes within the practice setting. The challenge and difficulties facing individuals, teams and organisations is in selecting a suitable organisational framework or accreditation framework that illustrates the efficiency and effectiveness of their practice(s) or service(s).

**Case study 1.1 Facilitating and accrediting excellence in practice: the opportunities and challenges surrounding accreditation**

A specialist learning disabilities residential home caring for six clients with a diverse range of needs sought to demonstrate that the service and care they provided to their users and local public was of the highest quality and standard of practice.

The challenge facing the team was in selecting an appropriate accreditation scheme that could both facilitate and accredit the service.

The information in this section is designed to illustrate how organisational accreditation and practice development may support a team such as the one above in responding to the challenges and difficulties associated with demonstrating excellence in practice.

**Organisational accreditation and practice development**

Over the past 15 years the development of organisational standards and the measurement of practice have emerged as challenges for teams and organisations in demonstrating best practice against a rigorous set of criteria or standards. Different organisations have developed schemes that help practice areas to measure the quality of the service they provide. The Royal College of Nursing Dynamic Standard Setting System (Kitson, 1994) was one such measurement tool. Total Quality Management and the Qualpac system were favoured by management in the early 1990s. Today different bodies measure different aspects of service provision such as the Investors in People scheme (IiP Scheme), which measures how good the organisation is in supporting its staff. More recent initiatives include Nursing Development Unit and Practice Development Unit accreditation schemes (Lathan & Vaughan, 1997).

Initially Nursing Development Units (NDUs) were seen as one way in which excellent practice could be developed by practitioners and showcased to the
wider nursing body. NDUs were units that were given financial support, initially by the King’s Fund, to develop and extend nursing practice. One of the earliest units was at the Burford Unit, in Oxford, where practitioners provided holistic patient-centred care to elderly patients in one particular unit. The notion of NDUs has grown and in the Durham and Tees Valley area NDUs were verified by a local nursing forum. The development of new and innovative practice is encouraged and units are measured against a set of criteria based on clinical nursing practice.

Practice development units emerged based on schemes similar to NDUs but having a multi-professional approach rather than focusing on nursing care. To gain the status of a Practice Development Unit wards or departments had to demonstrate to external assessors their application of multi-professional practice in their area. This was measured against set criteria that had been developed by the awarding body. Local universities developed Practice Development Centres that would accredit departments using their set criteria. To gain external validation of practice was seen by some to be a useful tool in developing their practice. One fundamental drawback to this system was in the maintenance of best practice once the accreditation had taken place.

Within health and social care many other organisational standards and accreditation frameworks have emerged to assist health and social care professionals in demonstrating an achieved level of quality for a given service(s), for example:

- The Healthcare Commission (HC)
- European Foundation Quality Management (EFQM)
- Investors in People (IiP)
- Clinical Negligence Scheme for Trust (CNST) and Litigation Health Authority
- Charter Mark
- Social Care Institute for Excellence (SCIE).

The potential benefit of each of these frameworks is in offering a set of criteria for measuring a given practice to a set standard or level of excellence. For example, IiP relates to assessing organisational support for staff and staff development. HC and SCIE review how health and social care organisations are meeting the challenge of implementing clinical governance. Both of these examples are different, but yet equally valuable in advancing and evaluating practice.

The disadvantages of organisational standards and accreditation within health and social care today is in the duplication of time, resources and support needed for individuals, teams and organisations in collecting, collating and providing the evidence to demonstrate the standard(s). Health and social care organisations seem to be pressurised not just for meeting the criteria for one award but several at any one time. Organisational standards and accreditation schemes are essential for demonstrating acquired levels of
excellence within any organisation. They provide excellent frameworks for promoting quality improvements and as a result support practice development, making practices open and accountable. Organisational standard measurement is an integral part of any quality improvement and therefore an integral part of developing practice. Practice areas need to provide evidence to the accrediting bodies to show how they have achieved a particular standard. To put all of these standards into practice and to develop a framework that demonstrates to each awarding body the achievement of the standard is time-consuming and confusing to many health and social care professionals. Yet despite the upsurge in organisational schemes and associated standards many health and social care professionals struggle to understand and appreciate the potential value of these schemes in promoting excellence in practice (McSherry et al., 2003).

**Potential value of seeking excellence in practice on future health and social care practices**

Excellence in practice is about promoting and developing practice that creates a working organisational culture that acts in partnership, providing support between clinical practice, education and management, enabling them to increase research utilisation’ [and the practising of evidence-based care] (Bassett, 1996:918).

Based on the critique of the excellence-based terms and phrases it would appear that ‘excellence in practice’ provides a foundation for individuals, teams and organisations to use in the quest for quality. This is because the phrase ‘excellence in practice’ encapsulates the principles of evidence-based practice within the clinical governance agenda because excellence is about minimising risks through the development of a learning organisation (Stanton, 2007). Excellence in practice is about encouraging and facilitating the development of best practice based on ensuring effective communication, collaboration and team building. Furthermore, excellence in practice should form part of everyone’s role and responsibility as part of their job description, contract of employment and professional code of practice. Finally, excellence in practice according to McSherry (2004) is interdependent on the unification of several important aspects of an organisation’s systems and processes that denote excellence as outlined in Figure 1.7.

- Working in organisations
- Collaborative working
- User-focused care
- Continuous quality improvements
- Performance management
- Measuring efficiency and effectiveness

**Figure 1.7** Key factors for achieving excellence in practice
Working in organisations

Working in organisations is about exploring the initiatives under the policy outlined in *Improving Working Lives* (DH, 2006b) and concentrates on team development, communication and the sharing of information. It is about working towards creating a working environment and culture upon which excellence can flourish (McCormack et al., 2002).

Collaborative working

Collaborative working focuses on multi-professional working and development as the main issue for achievement of quality improvement.

User-focused care

The main theme of the modernisation and reforming agenda is about encouraging user participation and representation so that users’ views and feedback are both directly and indirectly incorporated into the development of practice. This theme focuses on the standards to be reached to achieve this in practice.

Continuous quality improvements

Within all quality improvement systems that have been introduced into the health service over the past 12 years the inclusion of improving the quality of care has always been an issue. Can the individual and the team incorporate the concept of quality issues in everything that they do? This standard aims to make quality part of everyday working practice.

Performance management

To manage effectively is to improve performance and user satisfaction. This key component should concentrate on how this can be achieved in practice.

Measuring efficiency and effectiveness

To demonstrate efficiency and effectiveness in practice is to show how the systems can be measured and audited to illustrate developments and improvements in practice.

Having identified the key factors that appear to denote the degree of excellence in practice it is imperative to highlight ways of making this happen in reality.
Achieving excellence in practice

Several important factors appear to be essential for achieving excellence in practice. Ensure you have a sound vision and philosophy for the organisation that transcends through the various departments and teams to the individual. To facilitate this process the use of one of the various models/frameworks/schemes described previously is ideal in promoting best practice within the context of clinical governance. This is because the use of a model/framework/scheme focuses attention on achieving the vision by strategically focusing the goals to become pertinent to all health and social care professionals, teams and organisations and builds upon current practice developments. The scoring framework for many of the excellence in practice frameworks supports the notion that benchmarking is viewed as a process of seeking, finding, implementing and sustaining best practice. It is a continuous process of measuring services and practices against set criteria that demonstrate best practice. The use of excellence in practice frameworks provides a useful method and approach in demonstrating the contribution practice development makes to teams and organisations by adopting a proactive style to measuring and evaluating new or existing practices (McSherry and Bassett, 2002). In this instance benchmarking provides an opportunistic structured approach to promoting best practice by encouraging health and social care professionals, teams and organisations to share and network via an identified area of care. A benchmark is the desired standard or level of performance an individual, team or organisation is aspiring to emulate.

Different methods of benchmarking can be undertaken, dependent upon the practice under review. For example:

- Internally, by comparing similar processes but within different sections of the organisation, for example, patient waiting times in different parts of outpatients.
- Externally, through competitive benchmarking, used to compare similar size organisations’ performance against certain standards such as the cost of treatments or interventions.
- Functional benchmarking, the isolation of functional processes and comparison of the findings, such as non-attendance for outpatients’ appointments.

Benchmarking within the Excellence in Practice Accreditation Scheme (EPAS) (McSherry et al., 2003) uses a combination of benchmarks to assess the level or standard of practice. To quantify this a rating, based on each benchmark, is awarded. The ratings are then processed to enable an overall score to be awarded to the team or organisation. The level scored is then used to identify good practice for dissemination or where a team or organisation needs to develop the practice to improve the quality of provision. This is an effective way of demonstrating evidence-based practice within the context of clinical governance as the star awarding system is recognised throughout quality enhancement schemes.
Conclusions

By focusing on what practice development is and is not, it is possible to illustrate how individuals, teams and organisations could embrace the underpinning philosophies, principles, purposes, methodologies, tools and techniques to promote and demonstrate excellence in health and social care practice. Excellence is an ever-changing term and a very nebulous concept to define and articulate making it perhaps never achievable because it is always changing as practice and practices changes as a direct and indirect consequence of change itself. Furthermore, organisations, teams and individual aspirations and motivation change as a part of personal and professional experience, which again shifts goals and vision and the way we regard the term ‘excellence’. What is emerging is the fact that excellence in health and social care practice can be enhanced or inhibited by focusing attention on the hidden ingredients contained in practice development and by exploring the following core themes:

- Working in organisations
- Collaborative working
- User-focused care
- Continuous quality improvement
- Performance management (integrated governance)
- Measuring efficiency and effectiveness.

The emphasis of the series of books will be based on demonstrating how and why these core themes are applied to reveal a framework for promoting excellence in practice.

Key points

- To address and respond to the growing pressures to change, reform or modernise, it is important that health and social care professionals recognise what, why and how practice development may aid the pursuit of excellence in practice.
- Despite the potential benefits of practice development in promoting excellence it is imperative that individuals, teams and organisations understand what the term means.
- Ultimately the purpose of practice development is about ensuring that person/patient centredness is at the heart of all innovation and change.
- Practice development is about enabling health and social care workers, teams and organisations to transform the culture and context in which care is provided. In order to achieve this it is about developing partnerships, providing support between clinical practice, education and management, enabling them to increase research utilisation.
- Facilitation is undoubtedly an important factor for effective practice development and is an essential concept to understand in relation to supporting innovation and change.
- Self-assessment tools within the context of practice development are about adopting and applying a suitable approach to enable individuals, teams and the organisation to explore the systems that are in place in order to identify strengths and areas for further development.
Excellence is an ever-changing term and a very nebulous concept to define and articulate making it perhaps never achievable because it is always changing as practice and practices changes as a direct and indirect consequence of change itself. Excellence in practice should form part of everyone’s role and responsibility as part of their job description, contract of employment and professional code of practice.

Activity 1.2 Feedback
The terms practice development and excellence in health and social care practice are difficult and challenging to define and operationalise on a daily basis. Practice development offers a new, dynamic and creative way of promoting excellence in practice through collaboration, team working, communication and by involving the users and providers of care. Practice development is a way to achieving excellence by encouraging people to embrace innovation and change at an individual, team and organisational level.

Further reading

Useful links
Developing Practice Subscribers Area. Foundation of Nursing Studies: London. www.fons.org/dp/

References


