Perspectives: Seeking a novel approach to practice driven transformation through research

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Introduction

I have been working with Practice Development (PD) theory and methodology for nearly 25 years. I first encountered PD during a leadership programme I undertook whilst working as a nurse within a community NHS Trust in 1999. As a result of this experience, I was successfully recruited to pilot a Practice Development Nurse post within the Trust. Later I was invited to join the Gerontological Nurse Development programme (Dewing and Wright, 2003) that was externally facilitated by early pioneers of PD, at the Royal College of Nursing Institute. I took part as an internal facilitator which enabled me to develop and refine my PD facilitation skills using a model of Critical Companionship (Wright and Titchen, 2003). Fast forward to the present day, and I am now leading the practice development intervention element of a large research project (more on this later). This work is informed by an historic evidence base associated with elements of the nursing/practice development units that emerged in the 1980s, which in turn gave rise to subsequent theory and methodology associated with PD. I aim to take you on a brief historical journey exploring what this literature may offer in terms of lessons for a contemporary, novel, practice driven research project, as we embark on this in 2025.

History of Nursing and Practice Development units (NDU/PDUs)

Until the early 1960s, major developmental interests for nursing (in the UK) were directed at the management of nursing services and required educational content for nurse training. The establishment of nursing departments in universities, pioneered at Edinburgh and Manchester, led to a growing interest in the academic/theoretical knowledge base for nursing practice; examining, expanding and valuing the way nurses worked with patients (or clients) in practice (Pearson, 1997).

The term 'Nursing Development Unit' (NDU) was first adopted in 1981 by a group of nurses working in a small cottage hospital at Burford, Oxfordshire (Pearson, 1983; 1992) quickly followed by Tameside, Greater Manchester (Wright ,1989). In the 1990s the King's Fund undertook a pilot of four NDU's, followed by a substantial financial investment in a three-year national programme. At the same time the Yorkshire Regional Health Authority set up a nursing development programme in collaboration with the Centre for the Development of Nursing Policy and Practice at the University of Leeds (Gerrish and Ferguson, 2000).

The intention of the NDU was a uni-professional nursing focus, working to challenge and expand nursing knowledge and practice skills by engaging in research, practice development, practice-driven evaluation and dissemination of findings to a wider audience. The Leeds programme was extended to include a multidisciplinary orientation and led to the establishment of practice development units (PDU), however the differentiation between NDU and PDU was not clearly defined at the time (Gerrish, 2001).

Outcomes from these units were well documented, widely published and the concept spread overseas to Australia. Gerrish (2001) claimed that NDUs and PDUs had made

significant progress in developing both healthcare practice and practitioners, but raised concern that there was little to no evidence from which to substantiate whether these units had directly benefitted patients. As a result, these specialist units were not maintained over time. This raises the question whether they have in fact been subsumed by;

> "*managerial cultures or single top down methodology approaches that often ignore the importance of people or fail to use practitioner's expertise as a source of social capital"* (Manley, Wilson and Oye, 2021,p 7).

The Magnet hospital movement from the USA (Aiken et al.,2008) then rose to a level of prominence being seen as a model to improve care standards in the UK. One example is the Rochdale Infirmary in Lancashire, which was awarded Magnet status in 2002. The case study evaluation claimed there was an improvement in the care environment, nurse outcomes and quality of care (Aiken, et al., 2008). Despite these evidence-based findings, two years later, the trust failed to renew its Magnet status following a Trust merger (RCN, 2015). More recently the Magnet4Europe project (2020-2024) involved fourteen hospitals in England, all participating in implementing the principles of the Magnet accreditation programme that recognises excellence in nursing care. The Magnet model focuses strongly on ensuring front-line nurses have a say in decision-making and are at the forefront of innovation and research (Stephenson, 2021). We await the full report from the Magent4Europe project.

<u>Practice Development (PD) as a theory and methodology</u>

Garbett and McCormack (2002) first described the inconsistent use of the term "practice development" in British Nursing, emphasising its varied application to a wide range of activities including training, education, research, and audit activity. There was no consensus or clarity about what was involved in this work and therefore it proved difficult to differentiate PD from any other improvement initiative. Garbett and McCormack's (2002) concept analysis identified four PD themes, as a process of concept clarification:

1. PD is a means of improving patient care;
2. PD transforms the contexts and cultures in which nursing care takes place;
3. PD is important to implement systematic approaches to effect change in practice;
4. Various types of facilitation are required for change to take place.

This led to a seminal definition of PD :

> *"...a continuous process of improvement towards increased effectiveness in person centred care. This is brought about by enabling healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflects the perspectives of both service-users and service providers*".
>
> (Garbett & McCormack, 2002, p. 88, cited in McCormack, Garbett & Manley, 2004, p. 315).

Later, McCormack et al., (2009) argued that the uniqueness of practice development is its explicit person-centred focus. Person-centredness is defined as valuing each individual as a unique being with rights, which enables them to actively participate in a way that promotes

their dignity, sense of worth and independence. This, I would argue is the essence of caring and fundamental to nursing but is significantly dependent on the staff who provide the care. It is the staff and their values, beliefs, and attitudes who influence the care environment unknowingly/subconsciously by how they behave. Workplace culture can simply be defined as "*the way things are done round here*" (Drennan, 1992, p9) and is therefore created by the people who lead and contribute to the workplace, which is then directly experienced by colleagues, patients, and families. PD is a systematic approach that facilitates healthcare teams to critically and consciously recognise, then breakdown and recreate different routines, habits and patterns of behaviour, and associated attitudes that create the culture of care.

PD is underpinned by a philosophy of critical social science, described by Fay as " *the processes of enlightenment, empowerment and emancipation*" (Wilson and McCormack, 2006, p. 49). PD is focussed on the culture and context, where practice occurs and the translation of research findings, as evidence, into practice. Most frequently PD work is achieved through the use of an 'action research' approach, encouraging active participation from both staff and patients through reflecting on and in practice, exploring experiences of care, enabling leadership and facilitation of safe and effective team working (Garbett and McCormack, 2002, Pryor and Forbes, 2007, Hardy et al., 2021).

Over the past 20 years, the theory and practice of PD has been developed, refined and evaluated, as more knowledge has been generated internationally about different ways of working to achieve sustainable change for the better. Yet, in my experience, despite evidence that demonstrates the transformational impact of PD on individuals, their teams and the people they care for, PD it is still not widely recognised as a methodological approach of choice from which to change and improve health and social-care systems. Manley, Wilson and Oye, (2021) argue that the emphasis for "*PD still remains on person centred care, cultures and systems as well as working with complexity and research practice "with people" rather than "on" people"* (Manley, Wilson and Oye, 2021, p7).

<u>Introducing the Therapeutic Optimisation (THEO) research project</u>

The THErapeutic Optimisation (THEO) project developed by the NICHE Anchor Institute at the University of East Anglia, is a novel and complex intervention study aimed at optimising nursing care and the patients' experience of care. THEO is providing an uplift of two registered nurses working as embedded researchers, combined with a process of participatory action research (PAR) (Lloyd-Evans et al., 2023). PD methods will be used within the PAR framework, as a facilitated and participatory approach to inquiry, engaging with staff and patients, within two NHS clinical wards. Wrapped around the implementation of PAR are three other research elements; i) quantitative ii) qualitative and iii) process evaluation, all being led by an external collaborating research partner. The aim of these various elements of research is to comprehensively gain an understanding of how the different components of the THEO intervention interact with each other, thereby influencing patient and staff related outcomes, in a live clinical study setting.

The THEO intervention is influenced by evidence arising from:

1) The Magnet ethos; in that "more qualified nursing staff" improves patient outcomes. Hirose et al., (2021) discusses that studies on Magnet hospitals showed that higher nurse staffing levels were associated with better patient outcomes, including lower patient mortality (Aiken et al., 2014), lower hospital-acquired complications (Morioka et al., 2017), shorter length of stay (Kane et al., 2007), and less frequent nurse burnout or job dissatisfaction (Aiken et al., 2024).

2) An emancipatory, systematic and rigorous process philosophy; drawing upon both PAR and PD combined, where PD methods and approaches will be used within a PAR framework. This will involve recruiting volunteer co-researchers from the existing ward nursing team as bringing expertise in this innovation; they will be working alongside the newly recruited embedded nurse researchers. The co-research team will have time and space to work in collaboration, to "look" (i.e., gather evidence about a situation or context), "think" (i.e., reflect together to critically analyse the evidence), then "act" (i.e., develop a shared action plan, from which to take informed action) (Cusack, 2018). This process will generate both knowledge and co-created action from which to improve the experience and care for both the ward staff and the people who receive care on the ward.

I am excited and hopeful that this novel intervention approach, based on the previous evidence highlighted and then blended to combine various elements of research, has formed a substantial and influential contemporary study. This project will not only enable innovations and improvement in care to be co-created and implemented, but the research will offer a robust evaluation providing strong evidence of success. We hope that this will also provide a new model for embedded practice driven research across complex integrated care systems in the UK and beyond.

Conclusion

The latest Darzi report (NHS Providers, 2024) describes a "broken NHS" where staff feel disempowered, and cultures of care exist where patients' and families' voices are not being heard. Now is the time to capitalise on using emancipatory and participatory approaches to change, where staff are the key to this change process, and are also recognised as the key to engaging the voices of the people they care for. Demonstrating impact, effectiveness, and economic viability of this work requires a variety of robust evidence and the generation of new knowledge to influence a variety of stakeholders. I am hopeful that using a blended approach and a wide variety of philosophical stances to research will help us to generate this new knowledge, which will be widely relevant and influential.

The THEO research involves an exciting collaboration between three universities and two local NHS trusts and relies very much on the relationships, expertise, open and honest critical conversations we need to enable this practice driven transformation to happen. I will leave you with a quote from Mistry et al., (2024) "*Staff knowledge, expertise and passion to improve services is an untapped well of innovation energy. To have an NHS and social care that is able to innovate and thrive means changing how we make change happen.*" Now is the time to act!

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