1 Introduction

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WHY DEVELOP PRACTICE

Internationally, for the past 15 years, health care has been dominated by an agenda of reformation, modernisation and transformation. During this time, there has been a significant emphasis on person-centred care delivery in a strategic and political context that has been focused on cost containment and cost reduction. For many commentators this is indeed a paradox and one that is not 'healthy' in a health economy (Bechtel & Ness, 2010; Braithwaite, 2010). However, the challenges of delivering person-centred health care are not solely about economic resources, but are as much about the focus of staff and their priorities. Changing the model of care from one that is primarily hospital based, to one that is delivered as a partnership between service users, all care settings and public and private providers has resulted in major changes to the way care services are delivered and operationalised. These changes have been key features of the transformation agenda. Roles have needed to change among all professions, and professional boundaries have been increasingly blurred.

However, whilst there has been an emphasis in policy and strategy documents on the development of person-centred services, this has merely been, at worse, rhetoric, or at best, a simplistic idea based on providing service users and their families with more choices about how their health care is delivered. This view is reinforced by a continuous and sustained focus among patient advocacy groups and media commentators on the poor quality of care in hospitals, the poor treatment of vulnerable patients and a lack of respect and dignity in individual care practices (see, e.g., the UK Patients Association 'Care Campaign', http://patients-association.com/Default.aspx?tabid=237, and the recent 'I' newspaper series on poor nursing, http://www.independent.co.uk/life-style/health-and-families/features/nurses-do-not-wake-up-each-morning-intent-on-delivering-poor-care-7644061.html?origin=internalSearch). Most recently in the United Kingdom, a commission of inquiry into dignity in hospitals and nursing homes has been instigated by three major organisations – AgeUK, The Local Government Association and the NHS Confederation (http://www.ageuk.org.uk/home-and-care/improving-dignity-in-care-consultation/). The investigation has focused on understanding the contextual factors that, on the one hand, have resulted in some of the greatest

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advances in health care, whilst on the other, seem to have eroded the dignity of patient experience – particularly among older people. A key recommendation of the commission is:

> *Hospitals should introduce facilitated, practice-based development programmes – 'learning through doing' – to ensure staff caring for older people are given the confidence, support and skills to do the right thing for their patients.*

This recommendation by the Dignity Commission highlights the need for ongoing development of practice in clinical settings and reinforces the views of key commentators that widespread top-down organisational changes without concomitant bottom-up development programmes result in ineffective change processes and poor outcomes (Braithwaite et al., 2006). Indeed, Braithwaite and colleagues suggest that, without programmes of development at the micro level (clinical practice environment), the large-scale and top-down driven change has a negative impact. Drawing on their work that focused on introducing new information technology, they suggested that the imposing of reorganisations, restructuring and attempting to change corporate culture by senior management instigation frequently fell short and had the potential to create major patterns of dissension and resistance (Westbrook et al., 2007).

This evidence from Braithwaite et al. (2006), which confirms what has been known in the change literature for well over 30 years (see Ottaway, 1976; Beer, 1980), was recently reinforced by a personal story of a colleague who had had a recent hospital experience:

> *I don't think the <hospital name> nurses I encountered were uncaring. They were ill prepared for the tasks they faced, sometimes insensitive, unsupported by the structures and ethos of the service and very overwhelmed, but I wouldn't say they didn't care or that they didn't, for the most part, work hard. They reminded me of the adage 'the road to hell is paved with good intentions' and even if they had known more about dementia and mania, or at least have been aware of what they didn't know, they still couldn't have functioned adequately within the structures and systems (Personal Communication, 2011)*

Since its origins in the late 1970s, practice development has been aware of the pitfalls of top-down change alone, and so it pays attention to these local practices in clinical settings, whilst focusing on the need for a systems-wide focus on person-centredness and the development of person-centred cultures. In particular, practice development pays attention to what are increasingly acknowledged as 'the human factors' in health care – factors that focus on the relationship between staff's well-being, leadership, team relationships, morale, satisfaction and a sense of belonging among staff in the context of clinical effectiveness and patient outcome. For example, Maben et al. (2012) have identified that the quality of care for people in acute settings relies on resilience building and renewal for staff, leadership and support and teamwork. They also highlight the importance of adequate staffing. Whilst initiatives such as 'Transforming Care at the Bedside' (http://www.ihi.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx) address such contextual issues as these, others have commented that it should not be assumed that human factors in health care can be addressed by the transfer of quick-fix solutions (Cooke, cited in Feinmann, 2011). Whilst these initiatives and innovations do have an important role to play in changing practices and ensuring that systems are responsive to the needs of patients and families, developing evidence-informed and person-centred cultures of effectiveness needs a greater focus on understanding the motivation behind practices and working with these motivations to implement solutions as an integrated part of health care service delivery.

The development of person-centred cultures cannot be achieved through a focus on implementing solutions that address particular aspects of system ineffectiveness. Instead, sustained and integrated approaches to the creation of person-centred cultures systematically address embedded patterns in workplaces. To bring about fundamental change in complex systems requires the recognition of patterns that drive thinking and behaviour (Plsek, 2001). Patterns are often ignored or go unchallenged despite changes to structures and processes (Plsek, 2001). This is because patterns are associated with distinctive behavioural norms that manifest specific values, beliefs and assumptions within a workplace. These aspects together by definition are termed 'culture' (Schein, 2004), where implicit importance is placed on how things are done and what counts as important. Patterns describe problems that occur over and over again in an environment or operational context and they describe the core of a solution to that problem in such a way that it can be used an infinite number of times – without ever doing it the same way twice. As such, patterns can be much generalised at a conceptual level whilst they are absolutely unique at a local implementation level.

However, in their most recent work, McCance et al. (2012) have identified that despite what is known about the importance of person-centred care and the need for the development of person-centred cultures, the majority of service users only experience 'person-centred moments', that is, moments of time when care is person-centred set within an overarching care experience of routine. McCance et al. (2012) have concluded that person-centredness is a fragile concept and is dependent on a person-centred culture that has consistent care delivery, effective care coordination, good leadership, a knowledgeable and skilled care team, systems-wide support for person-centredness and a flexible model of care delivery. So, this would suggest that even within a stringent economic climate, principles of person-centredness can be maintained and quality systems enhanced if issues such as leadership, facilitation, teamwork and collective vision are held central in service development programmes. All of which are central concerns of practice development.

PRACTICE DEVELOPMENT – ITS ORIGINS

In 2004 *Practice Development in Nursing* was published (McCormack et al., 2004) and its publication was a political act and landmark in making visible significant work that had previously been undertaken in establishing practice development as a movement in the development of nursing practice. Prior to its publication, practice development had been evolving through a range of projects that had each focused on different approaches to improving patient care in different settings, but which had also focused on articulating the contribution of nurses to effective patient care. The term 'practice development' was at that time widely but inconsistently used in British nursing. It was used to address a broad range of educational (McKenna, 1995), research (Rolfe, 1996) and audit (NHSE, 1996) activity. In much of the literature, there was an emphasis on the use of research evidence in practice (e.g. Kitson et al., 1996). Practice development was underdeveloped as a methodology, and whilst there was a lot of enthusiasm for the methods because they resonated with the increased emphasis on quality improvement, clinical audit and using research in practice, there was no coordinated approach, nor indeed common understanding of the most effective methodologies.

In 2002, Garbett and McCormack published the first concept analysis of practice development, and this analysis brought together what had been until then a disparate body of work

that used different methods, but all of which had the shared intention of developing patient care and nursing practice. The principles that underpinned this body of work included:

- an emphasis on improving patient care;
- an emphasis on transforming the contexts and cultures in which nursing care took place;
- the importance of employing a systematic approach to effect changes in practice;
- the continuous nature of practice development activity;
- the nature of the facilitation required for change to take place.

(Garbett & McCormack, 2002)

The concept analysis highlighted that there were clear areas of congruity between work being undertaken by practice developers and the kinds of practice being promoted in the national health care policy at that time. For example, the then England's Chief Nursing Officer launched a publication in the wake of the NHS Plan (Mullally, 2001) that emphasised the importance of learning from practice, being responsive to patients and developing adaptability to change. Clearly, these themes resonated with the principles underpinning practice development, and so the importance of the contribution of staff working in the many and varied practice development roles across the United Kingdom were clearly central to the wholesale cultural shift that was being demanded of the NHS. Networks such as 'The UK Developing Practice Network' were focused on that agenda and did much to advance understanding of the role of the Practice Development Nurse in the United Kingdom.

The publication of *Practice Development in Nursing* in 2004 added to a growing body of conceptual, theoretical and methodological advances in the development of frameworks to guide practice development, including workplace culture (Manley, 2004), person-centredness (Binnie & Titchen, 1999; Dewing, 2004; McCormack, 2004; Nolan et al., 2004), practice context (McCormack et al., 2002), evidence (Rycroft-Malone et al., 2004), evidence implementation (Rycroft-Malone et al., 2004), values (Warfield & Manley, 1990; Manley, 2000a, 2000b; Manley, 2004; Wilson, 2005; Wilson et al., 2005) and approaches to learning for sustainable practice (Dewar, 2002; Titchen, 2003; Titchen & McGinley, 2003; Wilson et al., 2005; Hardy et al., 2006; Wilson et al., 2006).

Practice development was defined as:

> *A continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by enabling health care 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 reflect the perspectives of both service users and service providers. (McCormack et al., 2004, 316)*

This definition has been widely used internationally in shaping practice development programmes. The specific focus on the culture and context of care was one of the unique characteristics of practice development compared with other quality improvement methods, but even more significant was the emphasis on 'emancipatory change'. Previously, Binnie & Titchen (1999) and Manley (2001) had illustrated the impact of change processes that had as a central focus the emancipation of individual staff to take control of their own practice and the practice context, and develop knowledge and skill in freeing themselves from perceived and real barriers to effectiveness. Processes such as developing shared values among team members, having a shared vision for ideal practice, developing team relationships, using work-based reflective learning strategies, engaging in critical questioning and adopting a

systematic approach to changing everyday practice were developed into facilitation strategies that set out to help individuals become empowered with the knowledge, skills and expertise to develop practice. This approach was also different to action research as the emphasis was not on the answering of particular research questions through the taking of action and its evaluation, but instead the focus was on enabling practitioners to answer their own questions that they had about their practice. Whilst the development of transferable knowledge is the primary purpose of participatory action research, this is a secondary purpose of practice development.

PRACTICE DEVELOPMENT NOW

It is clear that, as practice development methodology has evolved and matured, there is greater consistency among the methods used, set within a shared understanding of methodology (as multiple authors in this book will testify). The work of *The International Practice Development Collaborative (IPDC)* – a collaboration between practice developers in Europe, North America and Australia – has added a significant body of knowledge to the field and enabled greater understanding of methodological perspectives, systematic approaches to evaluation, formal programmes of facilitation development and international collaboration on practice development programmes. The evaluation of these activities and the evidence derived has resulted in the identification of common 'transferable principles' that underpin all practice development activities. These principles were first published in *Practice Development in Nursing: International Perspectives* (Manley et al., 2008a). These principles continue to guide contemporary practice development activities, including much of the work presented in this book:

Principle 1: Practice development aims to achieve person-centred and evidence-based care that is manifested through human flourishing and a workplace culture of effectiveness in all health care settings and situations.

The aim of practice development is to develop effective workplace cultures that have embedded within them person-centred processes, systems and ways of working.

Principle 2: Practice development directs its attention at the micro-systems level – the level at which most health care is experienced and provided, but requires coherent support from interrelated mezzo and macro-systems levels.

Whilst many approaches to developing quality services emphasise organisational approaches to achieving change and development, practice development has as its primary focus, the settings themselves (wards, departments, clinics, etc.) in which health care practice is experienced by service users. It is at this level that service users most closely interact with practitioners, practice teams and patient pathways, and in which their experience of health care systems is directly influenced.

Principle 3: Practice development integrates work-based learning with its focus on active learning and formal systems for enabling learning in the workplace to transform care.

Practice development uses approaches to learning in and from practice as a key strategy for transforming practice. Skilled facilitation and formal systems for enabling learning as well as its assessment, implementation and evaluation in the workplace are instrumental to effective practice development. Engaging in these activities goes some way towards

generating learning cultures that sustain developments in practice and individual, team and organisational effectiveness.

Principle 4: Practice development integrates and enables both the development of evidence from practice and the use of evidence in practice.

Practice development is one methodology for the systematic implementation of practice change and innovation as well as providing a person-centred approach.

Principle 5: Practice development integrates creativity with cognition in order to blend mind, heart and soul energies, enabling practitioners to free their thinking and allow opportunities for human flourishing to emerge.

Contemporary practice development has embraced creativity with much enthusiasm and indeed some of the exciting advances in practice development relate to the way creative and cognitive processes are integrated in development strategies. McCormack & Titchen (2006) have led the development of the methodology of 'critical creativity', which blends the creative art forms used in practice development with reflexivity located in the critical paradigm. This is facilitated through the blending and weaving that is evident in skilled facilitation in order to achieve the outcome of human flourishing.

Principle 6: Practice development is a complex methodology that can be used across health care teams and interfaces to involve all internal and external stakeholders.

Whilst the purpose and impetus for practice development is simple, namely improving care for the users of health care in a way that enables all to flourish by working with practitioners and health care teams, its methodology is complex. The complexity stems from working with a number of complementary methodologies and a set of associated methods in a systematic and intentional way. The complexity arises because practice development is not a single intervention but a collection of interventions based on specific philosophical principles drawn from a number of methodologies that inform it, with a particular stance about how people change, develop, learn and transform their practice in a way that is sustainable and continues to be effective.

Principle 7: Practice development uses key methods that are utilised according to the methodological principles being operationalised and the contextual characteristics of the programme of work.

Previous work (McCormack et al., 2006) has identified key methods used in practice development (Box 1.1).

Principle 8: Practice development is associated with a set of processes including skilled facilitation that can be translated into a specific skill set required as near to the interface of care as possible.

Whilst practice development is now associated with the specific set of methods identified in Box 1.1, practitioners and practice teams require help in developing their expertise in the use of these methods in practice (Manley & Webster, 2006). Once this expertise is developed, practitioners and practice teams become self-sufficient in their ongoing use of practice development methods. This is because methods integrate the self-sustaining skills of learning in and from practice or learning as inquiry (Manley et al., 2009), evidence use, evidence development and systematic evaluation of practice change and innovation necessary for a changing health care context.

Box 1.1: Practice development methods

- Agreeing ethical processes
- Analysing stakeholder roles and ways of engaging stakeholders
- Being person-centred
- Clarifying the development focus
- Clarifying values
- Clarifying workplace culture
- Collaborative working relationships
- Continuous reflective learning
- Developing a shared vision
- Developing critical intent
- Developing participatory engagement
- Developing a reward system
- Evaluation
- Facilitating transitions
- Giving space for ideas to flourish
- Good communication strategies
- Implementing processes for sharing and disseminating
- High challenge and high support
- Knowing 'self' and participants

Principle 9: Practice development integrates evaluation approaches that are always inclusive, participative and collaborative.

Being systematic in practice development work differentiates it from ad hoc ways of changing practice and emphasises the need for evaluation. The principles of participation, collaboration and inclusivity always underpin evaluation activity in practice development (McCormack et al., 2006).

WHAT THIS BOOK HAS TO OFFER

If you are interested in developing your knowledge and skills about practice development, then this is the book for you. We see this book as 'foundational', as it addresses the building blocks of effective practice development, that is, key concepts and frameworks that bring those concepts to life, applied theories that can be used to make sense of the experience of practice development and a range of practical experiences shared through case studies, metaphors, images and reflective accounts. In doing this through a diversity of writing styles, the book is relevant to everyone who is interested in practice development – undergraduate students studying evidence-informed practice (for example), registered practitioners who are developing their facilitation skills, people in formal practice development facilitation roles who want to advance their expertise, managers who want to understand the need to support practice development in their service(s) and researchers who are engaged in the co-production of knowledge with all key stakeholders.

This book builds upon the practice development foundations already established and extends and further develops many of the conceptual and theoretical perspectives, methodological approaches, methods, tools and processes of the previous work undertaken in the evolution of practice development. We use the definition of practice development that arose from the work presented in Manley et al. (2008b) (Box 1.2).

Box 1.2: Practice development definition

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., 2008b, 9)

Each chapter of this book picks up various dimensions of this definition and brings it to life conceptually, theoretically, creatively, reflexively and practically. In doing this, the book is guided by three frameworks:

1. Practice development conceptual framework.
2. Person-centred practice theoretical framework.
3. A framework for holding on to the whole practice development journey.

Practice development conceptual framework

The conceptual framework of Garbett and McCormack (2002) (Figure 1.1) has been developed and adapted as our knowledge of practice development has evolved and grown. This framework identifies the key components of practice development and provides a visual representation of the key components and their interconnections.

On the outside of the figure are 'shared values and vision', representing the importance of practice development activity being built upon a collective vision for ideal practice and the values underpinning this vision. At the centre is the ideal situation of having a 'person-centred culture'. However, we know that this is something that is always in transition and is rarely achieved as an ideal state. However, having a shared vision for what this could look like begins the process of identifying 'where we are now' in terms of the reality of that vision and the existence of a person-centred culture. So the part of the figure that focuses on 'transforming individuals and contexts of care' addresses the methodologies, methods, processes and tools that can be used to help teams to move closer to the vision of a person-centred culture and respond to issues that need to be changed to do so. The two 'arrows' in the figure represent the key facilitation strategies used – 'authentic engagement' as a facilitator and the adoption of 'facilitated active learning' processes. You will see in this book that the issue of authenticity as a facilitator is critical, and facilitators need to know themselves in order to develop authentic relationships with teams. Authentic engagement also encompasses the importance of using evaluation strategies that are consistent with the values of the practice development programme and the principles of collaboration, inclusion and participation. Active learning embraces different learning styles and the use of the whole

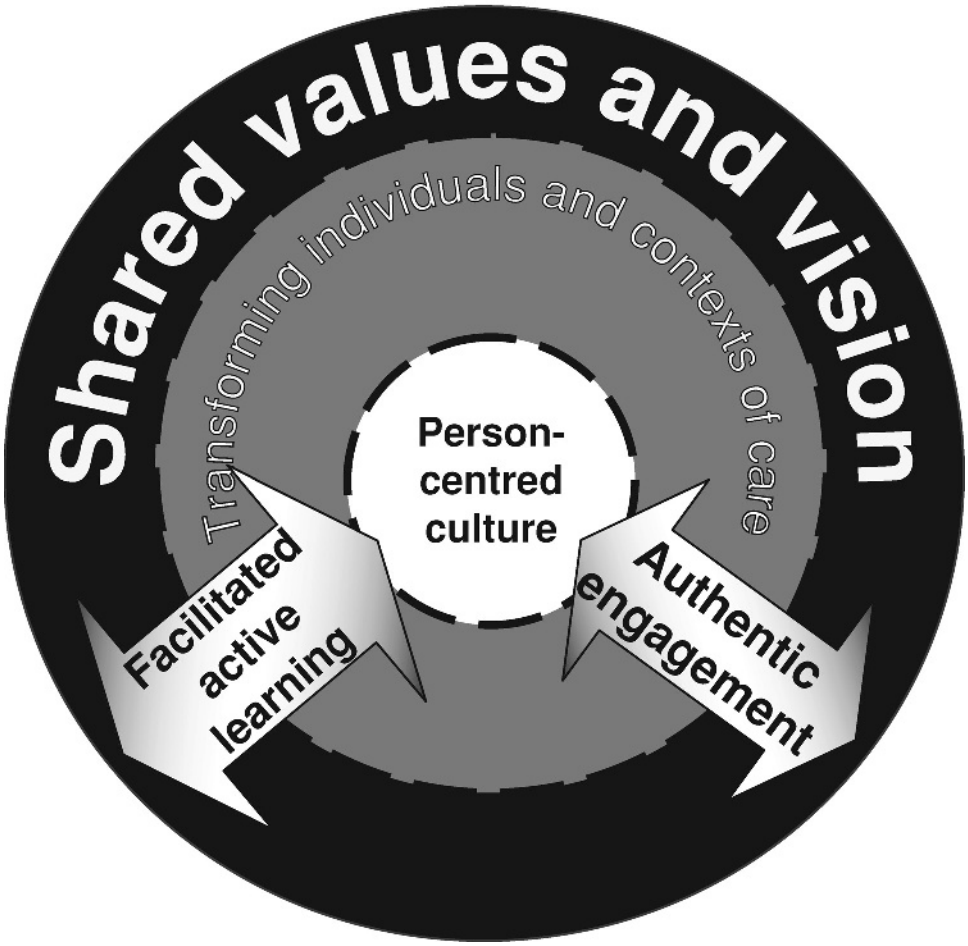

Fig. 1.1 Practice development conceptual framework.

self and not only the mind in learning. Throughout this book, you will see reference to this framework and its use illustrated in a variety of ways.

Person-centred practice theoretical framework

The definition of person-centredness below, adapted from McCormack et al. (2010), identifies the essential characteristics of person-centredness, whilst also highlighting the importance of the development of culture to support person-centredness:

> *Person-centeredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, older people and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.*

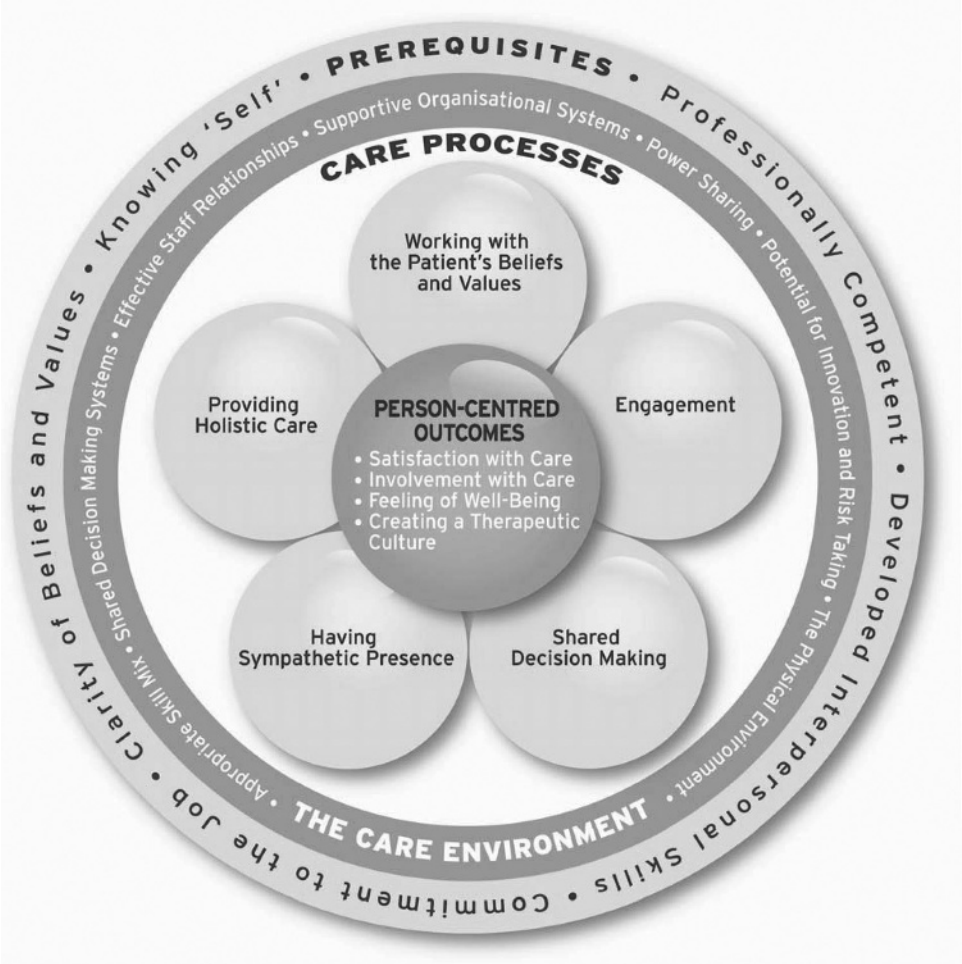

Fig. 1.2 Person-centred nursing framework (McCormack & McCance, 2010).

The second framework is the *person-centred practice framework* of McCormack & McCance (2010) (Figure 1.2).

The person-centred practice framework was first developed in 2006 (McCormack & McCance, 2006) and then further developed in 2010 (McCormack & McCance, 2010). It was derived from previous empirical research focusing on person-centred practice with older people (McCormack, 2001) and the experience of caring in nursing (McCance, 2003). In summary, the framework comprises the following four constructs:

1. ***Prerequisites*****,** which focus on the attributes of the practitioner and include the following: being professionally competent; having developed interpersonal skills; being committed to the job; being able to demonstrate clarity of beliefs and values; knowing self.
2. ***Care environment,*** which focuses on the context in which care is delivered and includes the following: appropriate skill mix; systems that facilitate shared decision-making; effective staff relationships; organisational systems that are supportive; the sharing of power; the potential for innovation and risk taking; the physical environment.

3. ***Person-centred processes,*** which focus on delivering care through a range of activities and include the following: working with patient's beliefs and values; engagement; having sympathetic presence; sharing decision-making; providing holistic care.
4. ***Outcomes,*** the central component of the framework, are the results of effective person-centred practice and include the following: satisfaction with care (in particular 'experience of good care'); involvement in care; feeling of well-being; creating a therapeutic environment.

The relationship between the constructs suggest that, in order to deliver positive outcomes for both patients and staff, account must be taken of the prerequisites and the care environment, which are necessary for providing effective care through person-centred processes.

A framework for holding on to the whole practice development journey

We know from experience that 'holding' on to the whole practice development journey is a challenging thing to do, and for a novice practice developer, it can seem like an overwhelming task, due to the variety of activities, issues and relationships involved all the way along. Further, as you engage with this book you will come to see that practice development is not a linear approach to change but instead requires cycles of action and reflection with multiple and key stakeholders all of whom have a particular perspective to offer. Thus, some activities get repeated time and time again and sometimes it is necessary to 'go backwards in order to move forwards!' This can feel frustrating at times, but holding on to an overall plan for the journey and accepting that small steps are necessary will help to maintain motivation. This theme is picked up more substantially in Chapter 3.

Figure 1.3 sets out a representation of the practice development journey as a *continuous process* and we offer it as a metaphorical representation of practice development and a support mechanism for aiding reflection on progress. It also helps to reinforce the significance of each stage of the journey and the connections between each as a systematic approach is adopted. The key stages of the practice development journey are:

- Knowing and demonstrating values and beliefs about person-centred care.
- Developing a shared vision for person-centred care.
- Getting started together: measuring and evaluating at each stage.
- Creating a practice development plan.
- Ongoing and integrated action, evaluation, learning and planning.
- Learning in the workplace.
- Sharing and celebrating.

Each chapter of this book works with these frameworks in a variety of ways. We begin in Chapter 2 with a focus on learning. In order to begin the practice development journey and enjoy the unfolding and unfurling of practice development and all its intricacies, it is good to be equipped with key foundational knowledge, skills and processes. In this chapter, Kate Sanders and Jo Odell from the Foundation of Nursing Studies (an organisation dedicated to the advancement of practice development; http://www.fons.org/) work with Jonathan Webster (an experienced health service manager and practice developer) and share their journeys of learning to be a practice developer. They illustrate through their own reflexive experiences

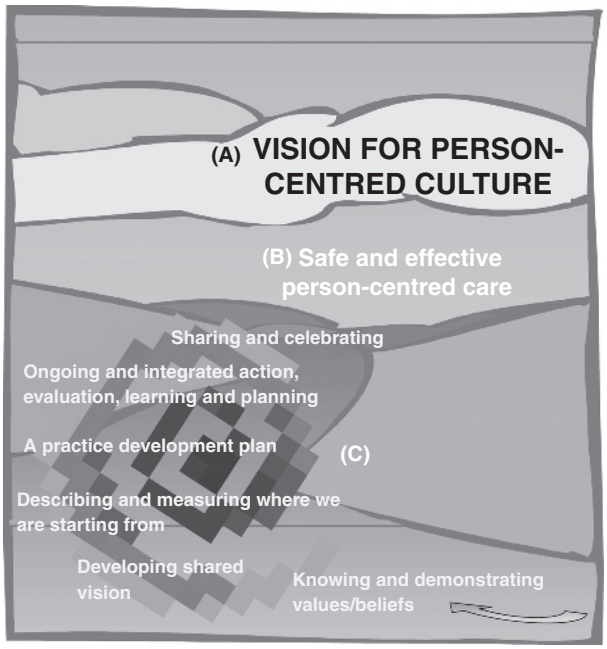

Fig. 1.3 The practice development journey. (A) Ultimate outcome; (B) outcome; (C) elements of a practice development journey; spiral: symbolising multiple starting points (but always keeping the outcomes in mind) and re-iterative movement between the elements of the journey.

each of the practice development stages presented in the book and show how learning to be a practice developer never ends and is indeed a lifelong process.

Having considered the learning needed to be an effective practice developer, we apply this to the fundamental elements of practice development. Chapter 3 explicates the essences of practice development in contemporary health and social care, explaining how practice development can be operationalised in the context of shared governance, safe and effective care and patient pathways. Since Edition 1 of this book, there is no doubt that the health and social care context has changed significantly and health and social care practice exists in highly pressurised environments.

Theresa Shaw picks up this issue in Chapter 4 when she addresses the issue of 'methodology'. In Edition 1 of *Practice Development in Nursing*, we put forward two distinct but complementary methodologies (technical and emancipatory practice development), and this representation of methodology has had a significant impact on shaping practice development programmes. Since then, we have learned a lot more about methodological principles that guide practice development activity, and so, this technical and emancipatory distinction is less helpful. Theresa addresses this issue and shows how different methodological perspectives can be helpfully applied in different contexts and cultures.

The big challenge for many, however, is 'getting a feel' for practice development, and our experience in our development programmes is that many novice (and indeed some experienced!) practice developers struggle to understand the practice development journey and what a complete journey might look like. The 'framework for holding on to the whole practice development journey' offered in this book should help to some extent with this issue,

and Chapter 5 has been deliberately positioned early in the book so as to show a complete journey over a 3-year period. Whilst the case study presented is a large national programme of work, the essential practice development ingredients are all there and can be extrapolated to any project, no matter how big or how small.

The case study set out in Chapter 5 requires consistent and effective facilitation at a variety of levels, due to its complexity as a programme of work. However, it is now widely accepted that facilitation is key to all practice development. In Chapter 6, Angie Titchen, Jan Dewing and Kim Manley take the reader through a journey of understanding particular tools that are used in practice development work. Remember that in the conceptual framework for practice development, 'active learning' and 'authentic engagement' are key strategies. Having a repertoire of tools and processes to enable effective action and reflection on action is important. Whilst the tools and processes are not the 'be all' in themselves as they need to be used intentionally within the particular methodological perspective adopted, they provide a useful resource to enhance our real 'self' as facilitators. You will probably notice that this chapter is written in a different style – that of a 'novelette'. This style of writing enables the reader to enter the experience of the facilitators in the chapter and to go on the journey with them.

Chapter 7 revisits one of the frameworks presented in Edition 1 of *Practice Development in Nursing* and gives it a modern twist! The *promoting action on research implementation in health services* (PARIHS) framework has influenced practice development work internationally and is one of the most often cited frameworks in use in knowledge utilisation, knowledge translation and research implementation activities. Jo Rycroft-Malone is a leading player in these knowledge fields and has also been instrumental in the development of the PARIHS framework. In this chapter, she provides an overview of the PARIHS framework and how it is being used currently. In practice development, working with different forms of evidence, in different contexts, requires different and adaptable facilitation approaches, and this is a key focus of this chapter.

In Chapter 8, Kim Manley and Carrie Jackson, members and leaders of the 'England Centre for Practice Development' (http://www.canterbury.ac.uk/health/EnglandCentreforPracticeDevelopment/Home.aspx) join with Annette Solman (an experienced Director of Nursing) to explore the issue of culture. They draw on the original conceptual framework of an effective workplace culture by Manley et al. (2011) and unpack it in the context of what an effective culture looks like, feels like and is experienced, and how it is facilitated. An effective workplace culture is also a person-centred culture – one that values the humanity of all and as such is a key consideration in practice development work.

A key issue in exploring workplace culture is being clear about how to evaluate developments in the effectiveness of the culture of person-centredness – the main focus of Chapters 9 and 10. In Chapter 9, Sally Hardy, Val Wilson and Tanya McCance explore how evaluation methodologies can be integrated into practice development programmes and show the importance of considering evaluation methods at each stage of the practice development journey. Chapter 10 continues the evaluation theme, but this time with a particular focus on evaluating outcomes associated with person-centred practice. 'The conceptual framework for practice development' has as its central focus, the development of person-centred cultures. However, as yet there are few frameworks available for evaluating person-centred outcomes. The framework offered by the authors not only builds on the previous work of Brendan McCormack and Tanya McCance but also includes the innovative work of Jill Maben and colleagues who have a focus on nurses' work-life and how practice cultures sustain and nurture excellence in practice. This is one of the first times that these perspectives have been combined, and

we believe that it offers a unique opportunity to combine different development approaches with a focus on person-centred cultures.

Practice developers pay particular attention to 'process', and the saying 'trust the process' is often the key mantra of practice development facilitators – particularly when they are being challenged about not focusing on outcomes enough! Chapter 11 is process orientated, but with a particular focus on challenging how we engage in facilitation work, that is, the challenge of being creative in our facilitation practice in order to create space for alternative and novel experiences and solutions. When practice developers think about being creative in their work, it is likely that they will source the work of Angie Titchen as one of the key informants and creative thinkers in the field. Angie has worked for over 20 years with creative and artistic approaches that ease people (or sometimes even push them!!) out of usual ways of thinking and being. In Chapter 11, Angie works with Ann McMahon (an experienced practice developer and researcher) to show how creative processes can be brought to facilitation processes. The idea of the 'radical gardener' is an inspirational idea that is lived through the chapter, and so the reader can get a real feel for not only creativity itself but also its enactment as part of a practice development process. However, all good gardeners need to take stock of what they have done and need to stand back and admire or critique their work and what has been achieved. Most gardeners will tell you that this should happen as we go along rather than waiting until the end and deciding that the design was all wrong!

Chapters 12 and 13 place practice development in the different contexts in which it operates. Whilst practice development focuses on the 'micro' level in organisations (i.e. the clinical setting or the place where practitioners work and patients receive care), it cannot ignore the organisational, strategic and policy context. Contemporary health and social care practice is a political activity and it would be naïve to assume that these can be ignored in practice development activities. So in Chapter 12, Jan Dewing, Jill Down and IrenaAnna Frei consider the organisational context and approaches we can use to locate practice development within an organisational context. Of particular interest is the way strategic development is seen as a dynamic, creative process of weaving connections that enable shared meanings between people and working with complexity and chaos. In Chapter 13, Randal Parlour and Joan Yalden (both experienced practice developers) worked with Kim Manley to synthesise their different approaches to practice development in different contexts (teams and organisations). They show how the outcomes arising can be blended into a single unified approach that extrapolates the methodological essences of their studies into a single set of evaluation 'triggers' that transcend particular settings/contexts, and strategies that can be transferred to achieve specific outcomes. Their work was informed by 'action hypotheses' – a particular approach used in action research and their use here shows how these kinds of 'tools' can enable the development of an outcomes and impact framework from multiple case studies that blends individual, team and organisational perspectives.

In the final chapter, we (hopefully) provide some informed commentary on the overall book. We use a framework derived from our work in 'Critical Creativity' (Titchen & McCormack, 2010) to frame our commentary and provide some reflection on where we are now as practice developers and a potential direction of travel.

We hope that this book provides you with support, insight and, more than anything else, inspiration to engage with practice development processes and work towards creating cultures that are genuinely person-centred and respectful of individual humanity. We have provided a text that is rich with resources, tools, processes, reflections, insights and personal sharing. However, no matter what tool or process you draw upon, never forget that it is the passion and

determination that *you* have for effective and person-centred health and social care practice that will be your key resource. For as John O'Donohue reminds us:

> *All the possibilities of your human destiny are asleep in your soul. You are here to realize and honour these possibilities . . . Possibility is the secret heart of time . . . In its deepest heart, time is transfiguration. Time minds possibility and makes sure that nothing is lost or forgotten . . . Possibility is the secret heart of creativity . . . (O'Donohue, 1998, pp. 30–31)*

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