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Make or Break: factors influencing the development of nursing
practice within the UK National Health Service

JOHN UNSWORTH

A thesis submitted in partial fulfilment of the requirements of
The Robert Gordon University
for the degree of Doctor of Philosophy

This research was carried out in collaboration with
Northumbria Healthcare NHS Trust

December 2002

○ Abstract

The development of nursing practice has become a central feature of modern healthcare. The advent of clinical governance has resulted in the development of an organisational climate where practitioners are encouraged to develop direct care and health services. Despite the desire of many professional groups to develop practice within the NHS, there has been a shortage of research which has specifically examined the processes of practice development in such a way as to identify the factors which facilitate or hinder developments.

This study examines the nature of practice development and how this process is influenced by organisational, structural, individual and contextual factors. Using techniques developed by Walker and Avant (1995), the critical attributes of practice development were identified and it was contended and accepted that practice development was a specialist form of innovation. The study identified positive and negative factors which were shown to influence practice development using two principal methodologies. Firstly, a UK-wide Delphi survey was carried out with 139 Directors of Nursing in order to identify their perceptions of key influences on practice development. A total of 24 positive and 23 negative categorisations was identified from the surveys; these were grouped using principal component analysis into 8 components. Following on from this a series of case studies was carried out to examine which factors influenced the development of practice, and how this influence manifested itself. Findings from the case studies highlighted that there was some congruence between the perceptions of Directors of Nursing and the factors which were found to influence development. Several factors were identified as having a positive influence including championship, participation, ownership and flat management structures; whereas factors such as leader dependence, pressures and

inter-professional tensions had a negative influence in some developments. In addition the study identified that the influence of other factors such as personal interest, merger and organisational transition are often underestimated.

○ Acknowledgements

I would like to sincerely thank my supervisors Dr Bernice J. M. West and Dr Sally Lawton for their support, advice and never ending encouragement over the last three plus years. I would also like to acknowledge the support of two colleagues who acted as advisors, Liz Hardy and Sue Spencer, who together provided advice and suggestions which proved invaluable during the development of the study.

I am grateful to Bill Watson, Senior Lecturer and Professor Paul Garthwaite Professor of Statistics for their advice on statistical methods and for reviewing the methods used and the interpretation of the results.

I must also thank my many friends and colleagues who have supported me during the moments of despair as well as keeping my feet on the ground during the moments of inspiration. In particular I must thank Liz Hardy, Joy Cairns and Les Morgan from Northumbria Healthcare NHS Trust who generously supported me both financially and practically during my studies.

My grateful thanks are also due to the many individuals who participated in the study.

Finally, to my family who encouraged me to register for a research degree, thank you for believing in me and supporting me when the going was tough.

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○ List of Abbreviations

CD	Compact Disk
CD-ROM	Compact Disk Read Only Memory
CIT	Critical Incident Technique
GP	General Practitioner
NDU	Nursing Development Unit
NHS	National Health Service
PCA	Principal Component Analysis
PDU	Practice Development Unit
RCNI	Royal College of Nursing Institute

○ Chapter 1: Introduction

The development of nursing practice is not a new phenomenon, although in the last ten years it has become a prominent feature of modern nursing with a proliferation of practice development facilitator posts and the establishment of a network of nursing and practice development units. Despite the prominence given to practice development, little is known about what actually constitutes a development in practice and what aspects of organisational structure, culture and the characteristics of individuals working within them contribute to the successful introduction of such changes. This study aims to examine the concept of practice development and to identify what factors facilitate or hinder the process.

This chapter will start by exploring why the study of practice development is important. Following this the specific aims and objectives of the study will be outlined and an overview of the thesis will be presented in order to orientate the reader.

□ Why focus on practice development?

The author has been involved in the development of practice for a number of years. This has included leading practitioner, organisational and government initiated developments across primary and secondary care. Throughout his involvement in practice development the author has struggled to define his role because of confusion about what constitutes practice development. In addition, the lack of role clarity has

resulted in problems in articulating to colleagues and managers what a practice development facilitator does, which has occasionally resulted in threats to posts. The author has focused upon practice development because of a desire to address these issues and because he believes that the continual improvement and advancement of practice is essential if the services offered to patients are to be of the highest standard.

In addition the study of practice development is also important for a number of reasons. Firstly, practice development appears to be gaining in importance and it is now seen as an important component of clinical governance (McCargow, 2001). Additionally, practice development will become increasingly important as organisations start to implement the wide ranging service modernisation agenda (Department of Health, 2000). Many NHS organisations have made considerable investments in their practice development infra-structure, whether this is through the establishment of practice development facilitator posts or the development of practice support units. Joyce (1999) reports that the concept of practice development is often unclear, not least because of the use of the term to describe different types of activity including training, skill and policy development. Additionally, there is a lack of clarity around practice development facilitator posts which makes any evaluation of their role problematic. Clarification of what practice development is and how it contributes to care delivery will enable practitioners and managers to evaluate such activity as well as the work of post-holders. If the NHS modernisation agenda is to be addressed effectively then work needs to be undertaken to identify what factors are important in facilitating the development of practice. Equally important is an identification of what organisational, structural, contextual and individual factors can

facilitate or hinder this process. Through this process it should be possible to identify what factors assist practitioners to develop practice, what causes problems and how, if at all, these problems can be overcome.

□ Aims and objectives of the study

With these rationales in mind, the aim of this study was to examine both the antecedents of practice development and the factors which can facilitate or hinder the process of planning and implementing developments in nursing practice. The study also aims to delineate the concept of practice development from other related concepts such as innovation and professional development. Moreover the specific objectives of the study were to:-

- Identify what Directors of Nursing believe are the factors which can influence the development of nursing practice
- Examine if and how practice development differs from innovation and change
- Examine how organisational, structural, contextual and individual factors impact on developments

More specifically the study aims to answer the following research questions:-

- What do Directors of Nursing perceive to be the optimal organisational structure to promote the development of nursing practice?
- What factors can facilitate or hinder the process of practice development?
- What influence do positive and negative factors have on the process of developing practice?

The research objectives require that the concept of practice development is examined and if and how practice development differs from innovation needs to be articulated. While this is an important first step towards answering several of the research questions, it does require that the thesis is presented in quite an innovative way. In the next section the structure of the thesis will be described both to explain why such a creative structure is optimal and as a guide for the reader.

□ Structure of the thesis

The thesis is constructed in eight chapters; following this brief introduction, the first main chapter seeks to answer the question “What is practice development?” This chapter utilises methods of concept analysis to delineate the concept of practice development from other related concepts. This is an important first stage because the concept of practice development is poorly articulated and in actual practice often consists of an eclectic mix of change, innovation and professional development activity. This chapter will not only seek to identify what practice development is but will also make explicit related concepts. As part of this process a range of literature about practice development within nursing, health care and other professional groups is reviewed. The chapter concludes by stating that practice development is a type of innovation, identifying the ideal attributes or essences of practice development in its purest form, thereby providing a framework for comparative analysis.

Chapter 3 provides a critical review of literature related to practice development and innovation. This review allows for the establishment of what is already known about

those factors which can lead to effective innovation and development. The chapter also explores some of the change theories and models which, may be used to introduce health care change and innovation. In addition, the literature assists in the identification of potential approaches for this current research study through the analysis of the relative strengths and weaknesses of previous research.

In another departure from the standard thesis layout, Chapter 4 describes in detail the theoretical underpinnings of the current study. This chapter relates the choice of paradigm to the earlier review of the literature. It covers issues around the reasons for the chosen methodology as well as how the research design optimises transparencies and trustworthiness. This chapter is distinct from the subsequent methods chapter so that an in-depth exploration of the rationale for the choice of the theoretical framework is explicit.

Chapter 5 provides a detailed review of the methods used to identify and select the sample as well as to collect and analyse the data. While the study itself was conducted in two separate but related phases, the methods and subsequent results are discussed together. This allows the author to draw comparisons between the stages of the research as well as identifying where similarities and differences exist between perceptions (identified through the Delphi survey) and the knowledge of experience of carrying out a development in practice (identified through the case studies).

The results chapter (Chapter 6) presents the results obtained. This chapter includes a considerable amount of rich description about the context of the developments

examined as part of the case studies, thereby enabling the reader to identify how some of the findings may be transferred to other similar contexts.

Chapter 7 presents a discussion of the results including an analysis of how the phases of the study relate to one another. This chapter identifies several previously unconsidered factors and, as a result, it includes a short review of some literature relating to these factors. In addition to discussing the results, the chapter seeks to identify the contribution the study has made to the body of nursing knowledge as well as articulating some of the limitations of the current study both in approach and the methods used.

Finally, the conclusion (Chapter 8) draws together the findings and relates their importance to nursing practice development. This chapter also presents the recommendations for individual practitioners, organisations, policy makers and professional educators. The chapter ends by making recommendation for future research.

□ Conclusion

Despite the fact that practice development activity has been a feature of nursing practice for several years, there is no clear understanding of what constitutes the development of practice and little is known about what factors may facilitate or hinder this process. Given this lack of clarity about what actually constitutes practice development, the logical starting point for this study should be to clarify what is meant by the term. As a result, the next chapter attempts to create conceptual

meaning by examining how practice development differs from other concepts such as change and professional development.

○ Chapter 2: What is Practice Development? ♦

□ Introduction

The concept of practice development within nursing is nebulous and poorly articulated. This is due in part to the fact that there is little evidence of uniformity in the way in which the development of practice has been approached within NHS organisations. In some organisations practice development facilitators concentrate largely on training and professional development activity, while in others facilitators lead on specific developments such as the introduction of new services. Page (1998) describes how the focus on action in practice development results in it being less tangible than other more easily categorisable activities such as audit and research. In essence, within the literature there is a concentration on the description of specific developments rather than discussing the process of, or the conceptual framework which supports, practice development.

From an organisational perspective, practice development activity is very important as it can contribute to the reduction of the risks associated with outdated practice. Furthermore, practice development is often associated with health commissioning processes which may subsequently attract additional funding. Additionally, practice development activity is regarded as an essential component of clinical governance. It is promoted because the ideas underpinning practice development advocate that

♦ Excerpts from this chapter have been previously published by the author – Unsworth, J (2000) Practice Development: a concept analysis. *Journal of Nursing Management*, 8, 317-326

practitioners address issues of concern, reduce risks and improve the quality and effectiveness of services offered to users (Cook and Ayris, 2001). The NHS White Papers (Department of Health, 1997; Scottish Office, 1997; Welsh Office, 1998) set out a number of reforms including a requirement that NHS organisations monitor the quality of care they provide. Effective corporate and clinical governance is dependent upon a synthesis of many existing strands of work within NHS organisations including audit, research and development, complaints management and practice development. Practice development is seen as an important part of clinical governance because it is the process by which practitioners and the organisation can respond to unidentified need, complaints and risks (McCargow, 2001).

Practice development activity within health care can be grouped into three broad categories; these are: -

Individual developments – some developments in practice are initiated and implemented by single practitioners without assistance from a facilitator. Such developments are common amongst practitioners working largely alone e.g. specialist nurses or community practitioners.

Work group developments – these developments are either initiated by a member of the team or are identified by an individual external to the team. Where the development is identified by an external source, that individual will often act as the facilitator guiding the implementation of the development. Examples of

developments within work groups which may be identified by external sources include developments associated with reducing risk or addressing complaints. Where the development is initiated by someone within the team, that person may act as the facilitator or facilitation from an outside source may be sought e.g. using practice development nurses.

Organisation wide developments – These are usually top down in nature and are often initiated in response to organisational concerns about standards of care or clinical risk or as a response to national guidance. However, occasionally an individual's own or a work group's development may be disseminated across the organisation following a positive evaluation.

□ Approaches to practice development

McCormack and Garbett (2000) outline how practice development activity can be broadly described as either deductive or inductive. Within deductive practice development the source of the change is from outside the environment in which the development is expected to occur. Examples of deductive practice developments include the implementation of nurse prescribing and the implementation of clinical guidelines produced by external agencies. Inductive practice development, on the other hand, uses information from the environment in which the development will occur as the source of the proposed change. This may be the result of either participatory research or reflection on practice. Both the inductive and deductive approaches have their advantages and disadvantages as highlighted in Table 2.1

Table 2.1 Approaches to development

	Deductive	Inductive
	External to the environment where the development will occur	Internal to the environment where the development will occur
Advantages	What needs to change is often explicit May be subject to external evaluation of progress May be accompanied by resources to support implementation	Creates understanding and facilitates debate amongst change participants Proposed development relevant and deemed as important by practitioners
Disadvantages	How the change should be implemented is rarely articulated Assumes that people will change when presented with a rational argument or with empirical findings	Difficult to engage practitioners in the process Organisational wide development more problematic

Adapted from McCormack and Garbett (2000)

Given the political and managerial importance attached to the development of practice, it is essential that the nature and scope of such activity is clearly articulated. Such a clear conceptual understanding is useful not only in terms of describing the process which will subsequently be researched as part of this study but also because it enables organisations themselves to plan and evaluate such activity.

Such structures and approaches to practice development indicate that the concept may have multiple meanings; be context dependent; and be difficult to investigate.

Thus it is necessary in this research to make an explicit conceptual definition of

practice development which can be utilised in analysing literature and the subsequent original research findings of this study.

□ **Creating conceptual meaning**

Concept analysis is one of the stages of concept development and involves the “definition” of existing concepts (Rodgers and Knafl, 1993; 12). Concept analysis is therefore useful not only in the development of theory but also to define the focus of research. The philosophical foundations of concept analysis lie in what is known as the classical approach to analysis. Aristotle (McKeon, 1973) suggested that the purpose of scientific enquiry was to identify “*essences*” or in other words the fundamental attributes which set a thing apart from all other things. Rodgers and Kanfl (1993; 12) describe how this approach is typical of entity theory. Classical approaches to analysis are open to criticism because of their focus upon reduction and a failure to examine the context in which the concept exists (Rodgers, 1989). This view is supported by Morse (1995; p31), who describes how “the attributes identified are devoid of context so that the practical application is lost”. Furthermore, the approach has also been criticised because of a reliance upon the unrealistic rule that all examples of the concept are equally good because they possess all of the requisite defining features. This insistence on uniformity does not allow for either exception or ambiguity (Medin and Smith, 1984).

In the current analysis the framework described by Walker and Avant (1995) is utilised. The approach used is illustrated diagrammatically in Figure 2.1. The stages

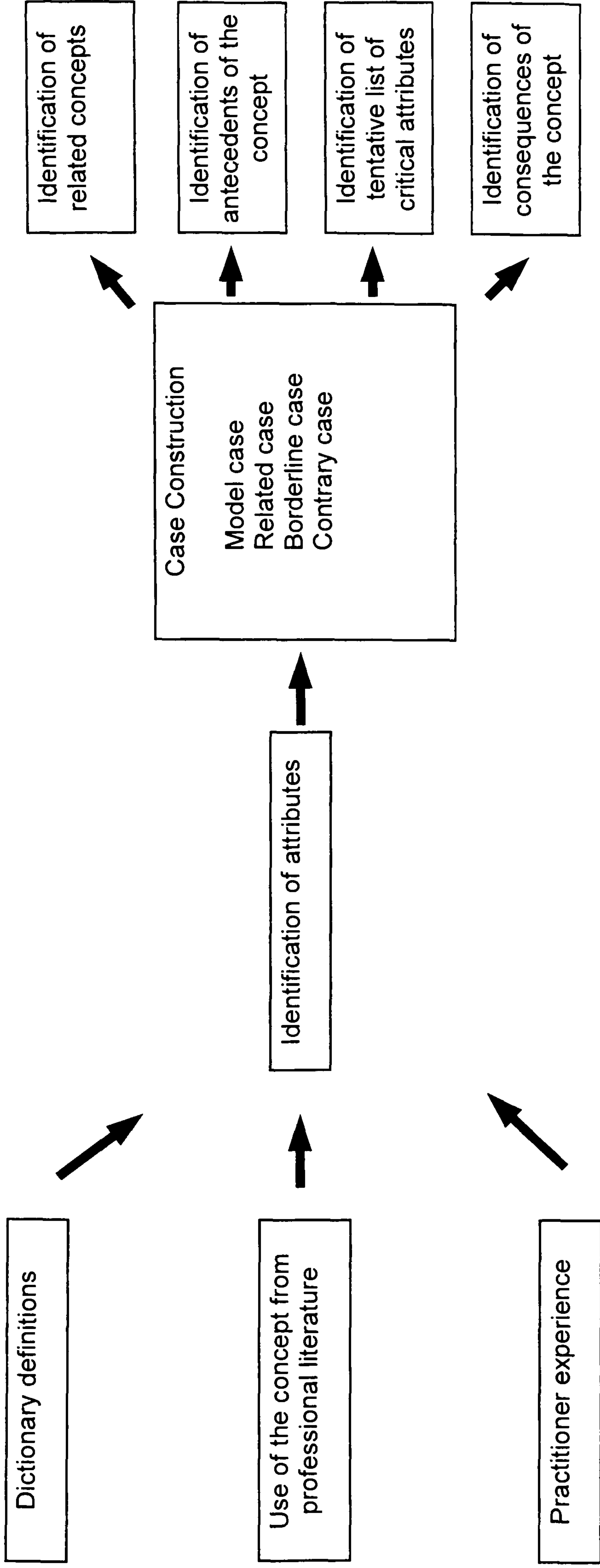


Figure 2.1: Stages in the creation of conceptual meaning

of the analysis involve the progressive focusing of the concept so that critical attributes can be identified. The process begins with the selection of the concept. In certain situations this can be problematic and even when there is a common language the concept may still be poorly articulated. Once the concept to be analysed has been isolated, it is important to clarify the purpose of the analysis. Concept analysis may be undertaken for several reasons; for example, it may be used to define a term for subsequent research or to examine how a concept is used within current literature or in actual clinical practice (Chinn and Kramer, 1995). Clearly this concept analysis is being undertaken to clarify the nature of practice development prior to the investigation into the way in which NHS organisations influence the process of practice development.

The framework developed by Walker and Avant (1995) was used for this analysis for several reasons. Firstly, the close inter-relationship between practice development and other concepts means that a reductionist approach to analysis should allow for the isolation of a single concept. Thus areas of overlap may be separated out. Secondly, the approach allows for the identification of antecedents and consequences which are both essential components of the wider research study. Additionally, practitioner experience was used to overcome some of the limitations inherent in the methods of concept analysis selected. A group (n=9) of practitioners working in the role of Practice Development Facilitators was used to construct and test out cases within small groups. Chinn and Kramer (1995) advocate the use of practitioners as a source of evidence. Such an approach can strengthen the validity and reliability of

the analysis and allow for the exploration of the concept within different contexts (Chinn and Kramer, 1995).

Furthermore it is contended that practice development can be considered as both a process and a product and that any concept analysis must take these two components into account. Similarly the concept can exist at several levels; for example individual, service or teams / workgroups and organisational. Thus the present concept analysis was carried out with the aims of: -

- Exploring the use of the term practice development, both within health care and by other professional groups
- Identifying the critical attributes of practice development as both a process and an end product
- Distinguishing whether practice development differs from the concept of innovation.

□ Definition of terms

Chinn and Kramer (1995) describe how examining the use of the terms which are commonly used to describe a concept is a useful starting point in identifying the breadth of usage. This, in turn, sets clear terms of reference for the examination of the concept from both professional literature and through to the construction of cases.

There is little literature which defines the term practice development. Kitson (1994; 5) provides a useful definition of clinical practice development; she describes how practice development is

“a system whereby identified or appointed change agents work with staff to help them introduce a new activity or practice. The new practice 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 be carefully evaluated to ensure that the new practice has achieved the improvements intended”.

This definition highlights several possible themes. One omission is that this definition does not suggest that practice development is about meeting an identified need. The emphasis is instead upon the professional, with the definition promoting the identification or appointment of a change agent. There is clearly the idea that practice development involves planned systematic change and that professionals need someone to lead or facilitate this process. Finally, there is a strong emphasis on the use of evidence related to the proposed development. This evidence is presented almost as a continuum from empirically based research through to the testing out of a good idea.

In addition to established definitions of the term ‘practice development’ it is important to consider other definitions such as those provided in dictionaries.

Dictionary definitions are useful because they provide an indication of how the

words “practice” and “development” are commonly used within language. However, such definitions are unable fully to account for how words are used by particular professional groups or within certain circumstances (Chinn and Kramer, 1995).

Another problem with dictionary definitions is that relatively new concepts may not have developed common enough usage to be included in the dictionary. In the case of practice development the actual term is not defined and therefore it is necessary to define the two words which make up the term. Definition of single words brings its own problems, not least the temptation to bridge together the two definitions to produce a new definition of the term being analysed. Given that the term practice development is not included in the dictionary, it is appropriate that the words are defined separately. The definitions of the two words can then be used to inform future work related to the search of the literature as well as during case construction. For example, the following definition of practice suggests a previously unidentified meaning that related to the business of a professional. As a result, the subsequent literature search and case construction were extended to include the wider use of the words.

The Oxford English Dictionary (1989 p 1219) defines practice as

“the action of doing something; performance, execution, working, operation; method of action or working”.

This definition suggests that practice is about the performance of work or on action. For example, in nursing the word ‘practice’ is used in relation to the delivery of patient care or patient services. Thus nurses working in management or in education

are not deemed to be working in direct practice. However, taken more literally, the word could be used to describe the practice of teaching or management. The term is also used to describe the business of a professional; for example General Practice, Law Practice etc.

“the carrying on or exercise of a profession or occupation, especially law, surgery or medicine; the professional work or business of a lawyer or medical man”

Oxford English Dictionary (1989; 1219)

This suggests that the term ‘practice’ is used to denote our actual work or our business. This definition is useful in framing the terms of reference for the review of the professional literature. Given the multiple meanings attached to ‘practice’ the literature review must include the use of the term by other professional groups and examine the use of the concept practice development within other professions.

The term development is defined as

“gradual advancement through progressive stages, growth from within”.

The Oxford English Dictionary (1989 p 281)

This definition contains several useful themes. The idea of gradual progression is interesting as this could be likened to systematic development as described earlier by Kitson (1994). Additionally, the idea of growth from within suggests ownership by the person or thing which is developing. As well as examining definitions of the

terms it is important to look for evidence about how the concept is used within a range of published literature.

□ Uses of the concept within the professional literature

A literature search was conducted using Medline (Index Medicus), CINAHL (Cumulative Index of Nursing and Allied Health Literature) and ABI Inform (Association of British Industries Information). A key word search was performed on each database, using the following words/phrases:-

- Developing practice
- Developing nursing practice
- Developing health care practice
- Clinical practice development
- Practice development

The search examined the period from the year 1993 to 2000. It was felt that this period covered the time when the term 'practice development' was commonly used to describe innovation and change within health care practice. Additionally, Altavista, Google, Mamma and Yahoo search engines were used to identify relevant Internet information. The OPAC Catalogues of the British Library and two University Libraries were used to identify published and conference material.

The review of the literature revealed several uses of the concept. Firstly, the concept was used to describe a change in clinical practice (Health, Social Work and

Counselling) and service delivery. Secondly, the concept was used to describe the utilisation of research evidence into practice. Finally, the concept was used to describe the development of business practice within the professions of medicine and accountancy. Using diverse sources of literature is useful because it allows for the examination of the concept in different contexts and avoids the inherent biases which may be introduced by using indexes and databases.

McCormack and Garbett (2000) highlight how there are differing perceptions of what practice development is between practitioners and academics. These perceptions can be summarised into different schools of thought. One school of thought views practice development as a process of introducing changes or innovations into clinical practice. Changes introduced in this way may be underpinned by appropriate change theories or models such as Lewin's force field theory (Lewin, 1951). McCormack and Garbett (2000) suggest that this school of thought is most commonly subscribed to by practitioners involved in practice development. The second school of thought is that practice development relates to changes introduced in practice as a result of research activity. This type of practice development draws heavily upon the use of participatory methods of research. The author contends that while such polarisation of approaches does occur there is a third approach which utilises a hybrid model. The hybrid model allows practice to be developed using a variety of approaches including the use of action research methods or change theories as frameworks for development. This approach will be examined in greater detail later in the chapter. At this point it is worth considering the literature

related to some of the approaches to practice development which have evolved in nursing since the 1980s.

□ Approaches to practice development in nursing

Several approaches to nursing practice development have evolved since the 1980s. Each approach has strengths and limitations and is useful for implementing specific types of development. These studies also suggest the presence of particular attributes of the concept of practice development.

Developing practitioners as practice development facilitators

The literature highlights a number of examples of successful practice development programmes which centre on building a sustainable capacity amongst practitioners to lead innovation and development within clinical practice. Amongst these is work by the Royal College of Nursing Institute (RCNI). Wright and McCormack (2001) report on a project facilitated by the RCNI which was designed to develop the role of the ward leader as a key facilitator of practice development work. The project commenced in 1997 on a specialist ward for older people. The ward leader was released from her post for three days per week to develop clinical practice. Support for the leader was provided by the RCNI through a facilitator. The project utilised a four phase framework (Ward et al, 1998) which was derived from action research methodologies. The initial phase involved orientation where the external facilitator became familiar with the practice setting and the organisation. At the same time the

clinical leader gained support from the organisation and established a steering group to assist in the leadership of the developments. During the preparation for change stage, the clinical leader was assisted to secure ownership, develop an action plan and transform the perspectives, attitudes and beliefs of her staff. Wright and McCormack (2001) reported that the process of change in this instance was facilitated by a culture of openness and through action learning circles. The outcomes of the project included measurable improvements in the quality of care and documentation, together with increased staff satisfaction. At the end of the project the clinical leader returned to her ward role and continued to develop practice within the ward.

The project described by Wright and McCormack (2001) suggests that practice development using the approach described has amongst its key components an element of external facilitation. In addition, the approach suggests that practice development involves a key individual working to transform people's perspectives on an issue and thus encouraging them to be involved in and own the actual development. Similar work has been described by Ward et al (1998) who reported on a multi-project practice development programme, again involving the RCNI. This project commenced in 1994 and included 13 nurses as key change agents (Practice Development Associates – PDAs) who were nominated and selected. A total of 11 nurses completed the programme. PDAs could negotiate time out for project work but were still required to fulfil their normal duties. Each PDA was responsible for selecting and carrying out a project and they could choose at least two Development Partners to work with. The programme consisted of two structures, one for practice

development and one for the supervision of PDAs. Again the study used the 4 phase approach outlined earlier.

The evaluation of the programme showed that the Development Partners' role was crucial to success as they acted as a go between for the PDA and other personnel. Together these people formed the nucleus of the change team. Ward et al (1998) report that the programme was partially successful in introducing developments. Problems were experienced in some cases with transferability, corporate ownership, finance and staff support. The authors reported that selection of PDAs was a major issue and, to some degree, this could be attributed to the fact that the programme had to commence very quickly. Some PDAs were placed at a disadvantage because they had little prior experience of change management, practice development or recent educational study.

Ward et al's (1998) work suggests that practice development may involve a partnership between the person leading the development and key individuals within the clinical setting. This partnership appears to allow the person leading the development to communicate effectively with grassroots staff and also allows their questions, issues and concerns to be expressed back to the leader.

Perhaps the best known report of the development of a practitioner as a change agent is the work undertaken by Binnie and Titchen (1999). It is beyond the scope of this chapter to explore the work of Binnie and Titchen (1999) in depth but the process of developing the ward sister and others as practice development facilitators will be

explored. Binnie and Titchen (1999) undertook a large scale practice development project utilising an action research methodology. The project, which commenced in 1989, arose out of “the challenge to develop a patient centred nursing service within a busy and somewhat demoralised medical unit” (Binnie and Titchen, 1999; 3). The project had a dual purpose, the support of major change and the investigation and analysis of the complexity of developing practice within a busy acute setting. Binnie and Titchen (1999) report that an action research methodology was selected because they wished to capture and report the perceptions and experiences of the participants. The methodology would also allow for the development of a collaborative change strategy which was considered as essential if cultural norms were to be changed and staff were to be encouraged to participate to ensure the sustainability of any change achieved.

The findings of the study represent a number of parallel journeys for the organisation and its culture, the leader of the change, the practice setting and the doctors and nurses involved. The change involved evolutionary change from a task orientated approach to care delivery. At the start of the project this was masquerading as patient allocation, and then it moved to a more patient centred approach involving, for a while, team nursing and then ultimately primary nursing. During this process the ward climate and the beliefs and values of the individual practitioners were explored and staff were developed through a process of professional development and experiential learning. As a leader, the ward sister used techniques such as role modelling to develop the nurses’ ability to innovate and question aspects of practice. During the lifetime of the study the ward sister played a number of roles, including

acting as a change agent, role model and ongoing supporter of staff to assist in the “bedding down” of the changes introduced. During the study the use of an action research methodology assisted in the professional development of both the participants and the co-researchers. Binnie and Titchen (1999; 231) state

“the action research process provided a discipline which made us more thoughtful, sensitive and rigorous than we might otherwise have been as change agents”

These three studies illustrate how research approaches such as action research can be used to support practice development activity. This support can be either related to identifying what needs to change as in the case of the Binnie and Titchen (1999) study or as a framework used by practitioners to guide them through the process of development. The Binnie and Titchen (1999) study suggests that practice development is an evolutionary process which is not static but constantly changing over a period of time. This is an interesting suggestion and it raises the issue about whether the sustainability of a development is less likely if the change is viewed as a single project which once completed can then be left to its own devices. The work also suggests a close link between practice development and professional development and learning.

Nursing / Practice Development Units

The term Nursing Development Unit (NDU) was first adopted in 1981 by a group of nurses working in a small community hospital in Oxfordshire (Pearson, 1983). From

this initial work to develop prototype units based upon the notion of nursing as a therapy a whole range of NDUs and later multi-disciplinary Practice Development Units (PDUs) were developed. In 1989 the King's Fund established a NDU programme to assist interested parties to establish and develop units. A total of four of these units received core funding and a further 20 received small grants. While the Burford / Oxford and Tameside NDUs focused upon new territory work by generating and testing new ideas and approaches, the King's Fund NDUs sought to replicate good practice (Pearson, 1997). The King's Fund NDUs work included the monitoring and systematic improvement of quality, evaluation of the effect of the unit's activities on patients and staff, the personal and professional development of staff and the sharing of knowledge and good practice with others. In 1991 the government invested £3.5 million to establish further NDUs. This programme was also run by the King's Fund and included the allocation of additional resources to those NDUs identified as part of the programme.

The use of NDUs and PDUs as an approach to practice development has been the subject of a number of evaluation studies. Despite the focus on evaluation the impact of units on patient well-being has not been substantiated (Turner-Shaw and Bosanquet, 1993). However, there is some evidence that development units lead to increased patient satisfaction (Pearson et al, 1992), reduced length of stay (Turner-Shaw and Bosanquet, 1993) and improved patient compliance with interventions (Williams, 1993). Pearson (1997) undertook an evaluation of the progress made by those units which were part of the King's Fund network. A total of 80 sites were included in the study which involved data collection via interview and survey.

Pearson (1997) found that most NDUs were based within acute settings with certain specialities e.g. care of the elderly, medicine and surgery being over-represented. Almost all of the NDUs studied were small in size and usually focused around traditional organisational boundaries e.g. a single ward / community team. Many of the developments which had been undertaken by the NDUs appeared to be focused around professional development, for example setting up a research group, democratising the team and changes in uniform. Malby (1992) believes that a major criticism of the NDU concept is that they emphasise professional practice rather than patient outcomes and that they often exist to increase the professional status of nursing with improvements in care and services being a secondary consideration. This is supported by Salvage (1992; 268) who states

“it cannot be assumed that nursing development units are concerned exclusively with improving the care of patients, but that they should also be seen as opportunities to claim higher status for nurses”.

Gerrish (2001) undertook an evaluation of the Leeds NDU / PDU programme using a sample of six accredited units. She found that their work could be categorised into four major categories; these included striving to achieve optimum practice, establishing patient orientated services, dissemination of good practice and team working. Gerrish (2001) found that, despite these major parts of the role, many units failed to achieve full dissemination of their activities within their own organisations, with the units being regarded as elitist.

The evaluations of NDU activity undertaken by Turner-Shaw and Bosanquet (1993) and Gerrish (2001) identify how practice developments initiated using this form of model are usually either related to professional development or are patient orientated. Turner-Shaw and Bosanquet (1993) identify how most NDUs seek to replicate developments previously introduced in other locations and this suggests that practice development activity need not be new to the unit adopting it. Finally, Malby (1992) suggests that practice development may also be linked to improving the status and standing of the professional involved.

The literature related to NDUs / PDUs suggests several possible attributes of practice development including a professional focus for the developments and the introduction of changes which are led by an identified leader within the team.

Having examined some of the models used to support practice development activity, the literature related to the use of the concept practice development as it applies to clinical practice and other professions and research and development will now be reviewed.

Use of the concept in clinical practice

Mallet, Cathmoir, Hughes and Whitby (1997) describe how practice development is both a process and an outcome. The authors go on to outline how practice development is the advancement of patient focused care, which may be achieved by professional development or progress by other means. The English National Board

(ENB, 1995) believes that practice development can be best achieved through research, teaching and professional support. This link between continuing education and professional development as a catalyst for the development of practice is a common thread in the literature from the nursing profession. Indeed the National Board for Scotland (NBS, 1997; 38) clearly articulated the relationship between a continuing professional development strategy, its implementation and the impact on practice development. While there may be a link it does not always follow that because practitioners have attended a course or updated their skills and knowledge, improvements in practice will follow. However, the literature related to practice development nursing roles clearly identifies a link between the development of both clinical work and the professional development and growth of the practitioners engaged in this work (Weir, 1995; 10). Therefore it is unclear to what extent professional development is an antecedent and attribute or a consequence of practice development. It is essential, therefore, that the concept of professional development is defined to examine its similarity to practice development.

Madden and Mitchell (1993; 12) describe how professional development

“ is the maintenance and enhancement of the knowledge, expertise and competence of a professional throughout their careers according to a plan formulated with regard to the needs of the professional, the employer, the profession and society”.

This definition suggests that professional development relates to the development of knowledge and skills in practitioners in order that they can perform their role. As in

earlier definitions of practice development there is also a notion that the development takes place as a response to an identified need. Again this appears to neglect the needs of patients in favour of the needs of the professional and the employer. This view would be supported by Glen (1998) who believes that in essence professional development is about personal development. However, a survey amongst 20 professional groups conducted by Madden and Mitchell (1993) found that the majority of respondents believed that professional development was about updating knowledge and skills for practice (95%) while only 15% also felt that it was needed for personal development.

It is likely that professional development is a related concept which impacts on practice development. The best way to identify where professional development fits with practice development is to consider it when constructing cases. It is anticipated that the case construction will shed light on the inter-relationships between professional and practice development.

Use of the concept in different contexts

Chinn and Kramer (1995) recommend that the concept being analysed should be examined within different contexts. This is useful in both the development of critical attributes and in identifying previously unconsidered meanings. Outside of nursing and health care, the term practice development is used in relation to clinical work and service delivery by both social workers and counsellors. In social work, the term has been used in relation to improving aspects of work, for example the production of

social inquiry reports in line with national guidance and recommendations (Bottoms and Stelman, 1988). While in counselling, the term is used to describe the process of examining and improving certain key areas of work (Dryden and Feltham, 1994). Within both of these contexts it is possible to identify a notion of improvement in client care and services. The social work example also suggests that practice development may occur as a response to national guidance and recommendations. This could be regarded as an antecedent to practice development, although it is unlikely that this would be present on every occasion.

Use of the concept in the Professions of Medicine and Accountancy

In medicine the term practice development is frequently used to describe the implementation of new work systems or services which are designed to improve the business of a general practice. An example of this is the Practice Development Toolkit developed by the National Health Service Training Authority (NHSTA, 1994) to assist general practices to assess, plan, implement and evaluate the introduction of new information technology systems. Again this example suggests a notion of improvement. However, this example also suggests that an additional previously unidentified attribute of practice development may be present here. The development of information technology could be regarded as important in improving or maintaining the business of the organisation. General practice computer systems not only improve services to patients through the provision of better information but

they are also used to generate “item of service¹” claims. These claims provide income for the practice (business) thereby maintaining or improving its financial position. This attribute is further illustrated by the use of the concept of practice development in the accountancy profession. Within this context it is used to describe the advancement of business through marketing. Cowley and Mountford (1985; 4) describe how practice development is the “management process responsible for identifying, anticipating and satisfying client requirements profitably”. This definition suggests that the attributes of practice development in marketing are responding to client needs and improving the business of the accountancy practice. Furthermore, there is a suggestion from the idea of “satisfying client requirements profitably” of effective service provision.

Brody (1989) discusses professional practice development theory at some length, largely from a business angle concentrating on professionals in the United States. In this context doctors either work within their own business or are employed by business orientated health organisations. Despite the differences, it is possible to draw upon this work to provide several useful comparisons with the practice of medicine in the UK. Brody (1989; 14) describes how practice development is a strategic process involving the identification of opportunities for practice growth, determining which of these offer the greatest potential in the long term and preparing to capitalise on them. Overall, the development process is designed to produce controlled but continuous growth in pre-selected areas. The objective is optimum

¹ An item of service relates to the delivery of care or a service which forms part of the General Practitioner contract to a registered patient. Items of service, which include immunisation and vaccination, attract remuneration and claims are made by GP practices to their local health authority.

economic reward with minimal risk. He goes on to detail how formal research may, or may not, be necessary to assist the decision making process (Brody, 1989; 16). If we compare this with how the term practice development is used in the UK, evidence for development is not always based upon research but can be based upon evidence such as user perspectives and the identification of unmet need. It is contended that central to practice development in both cases is the notion of improvement, the meeting of unmet need and effectiveness, whether this is related to marketing, business development or clinical care.

Use of the concept in relation to Research

Within the NHS the terms research and development are used collectively to describe a process of original research and the utilisation of existing research findings to develop practice. Eve et al (1997) suggest that the historical use of the terms 'research' and 'development' together owes its origins to the industrial model of innovation where research is used ultimately to develop products for sale. The term subsequently became widely used in health care and was most closely aligned to its original use when applied to the development of new drugs and surgical materials. Eve et al (1997) outline how there are several problems with the use of research and development synonymously with practice development and innovation within professional practice. The problems centre on the fact that traditionally development referred to the point at which a product was ready for selling. Dissemination and utilisation after this point was left to the market and, while efforts may be made to get people to buy the product, the company developing it has less interest in whether

people change their behaviour and actually use the product. Within health care practice the results of research may be less tangible or product-less and, as a result, the development phase is made much more complex and difficult to manage. The complexities associated with the development of practice using research findings centre on translating the research results and recommendations into a useable format for a particular clinical area. This gap between dissemination and utilisation is acknowledged as a major barrier to research utilisation and the development of evidence based practice. The Department of Health (1994; 33) identifies that “the gap between dissemination and implementation is huge and we do not know how to bridge it”. Within the NHS there has traditionally been more emphasis on research than development, although work is in progress to ensure that development has equal status and resources. One of the driving forces encouraging a greater focus on development has been the clinical effectiveness agenda (Department of Health, 1996). The production of evidence based clinical guidelines has formed part of the drive towards the utilisation of research into practice as part of clinical effectiveness. Such guidelines are one way of developing practice and this can be driven either locally or nationally (Clarke 1998). If we consider practice development from this context we are able to identify several of the attributes alluded to earlier, including the notions of improvement and effectiveness.

Clarke (1999) describes a specific approach to practice development using a range of interventionist research methods such as action research. This process referred to by Clarke (1999) as practice development research adds to the confusion about what constitutes practice development. The author contends and accepts that the use of

action research and similar methods when developing practice provides a framework for the planning, implementation and evaluation of the development in a similar way as change theories might when introducing innovation. As outlined earlier, practice development research is one school of thought about how nursing practice should be developed. Indeed, as an approach, practice development research may be particularly well suited to the development of practice issues where there is little prior knowledge about the subject. As a result the action research cycle can be used to examine the issue being considered, so that the question “what needs to be changed?” can be addressed. Other approaches using change and innovation models are more likely to be beneficial when developing practice about which there is a body of knowledge. In day to day use most practice developments move between these approaches and this combined approach is what has been described earlier in this chapter as a hybrid model, where the specific approach adopted is in response to the presenting problem around which the development is focused.

Finally in this section related to the use of the concept of practice development in research, the issue of what evidence sources are used as the basis for practice development needs to be addressed. As highlighted earlier research results are often used to develop practice either directly or through the production of clinical guidelines. One survey of practice development and research activity was conducted by Kitson and Currie (1996). The survey suggested that generally nurses did not think about practice development in a structured way. That is, development was often not based upon scientific evidence but resulted from a good idea or hunch. Kitson and Currie (1996) found that very few respondents quoted research evidence

as the rationale for change. They go on to argue that the approach used by nurses is consistent with an attitude more sympathetic to experiential knowledge than scientific method. This supports the earlier view of Kitson (1994) that the development of practice can be based on a variety of evidence from empirical research to trying out what is considered as a good idea in practice.

The literature reviewed so far suggests that practice development may be closely aligned to other similar or related concepts. In order to separate out what constitutes practice development and what constitutes the related concepts, it is important to examine how the related concepts are defined and used within the literature.

□ Related concepts

It is important to consider whether practice development is simply another way of describing innovation. The Oxford English Dictionary (1989) defines innovation as “to bring in novelties, make changes”. However, the idea that innovation is always a novelty has been refuted by Damanpour (1987) who believes that innovation is not necessarily new. One of the most widely used definitions of innovation is that provided by West and Farr (1990; 9)

“the intentional introduction and application within a role, group or organisation of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, organisation or society”.

West and Farr (1990; 11) describe how innovation has the intentionality of benefit. While the definition above describes a broad range of people or groups who may benefit from the innovation in practice development, the emphasis is on improvement. While these words are similar, benefit is defined as “advantage” while improvement implies “making better” (Oxford English Dictionary, 1989). Therefore, practice development does not necessarily make the delivery of care or services more advantageous but it should always be perceived as an improvement by the patient/client. An innovation, on the other hand, might be advantageous to both the practitioner and the patient/client. This is illustrated through King’s (King, 1989; 17) definition of innovation within a health care setting.

“innovation is the sequence of activities by which a new element is introduced into a social unit, with the intention of benefiting the unit, some part of it or the wider society. The element need not be entirely novel or unfamiliar to members of the unit, but it must involve some discernable change or challenge to the status quo”.

These definitions suggest that innovation differs from practice development in several respects. Innovation is not necessarily a response to an identified patient/client need, nor is it directly related to the development of effective services. It could be argued that an innovation which is of benefit to the group or organisation should relate to effectiveness. Despite these subtle differences there are several similarities. These include the fact that both innovation and practice development are planned processes which have an intentionality of benefit to both society and individuals.

□ Attributes of practice development

Having examined the use of the term in the literature and the definitions of the term, it is possible to identify several attributes of practice development. These are outlined in Table 2.2. Many of these attributes are common to a number of different concepts such as professional development and change. Additionally, not all of them are present in every case of practice development; for example not every development in practice is facilitated through an identified or an appointed source. In order to articulate clearly the concept of practice development, it is necessary to refine this list to identify which attributes pertain to practice development. Walker and Avant (1995) refer to these attributes as “critical” and state that such attributes are present in every case of practice development. The initial list of attributes is refined through a process of case construction and modelling.

Table 2.2 Attributes of practice development identified from the literature

Practice development involves:

- Facilitation through an identified or an appointed source (*Ward et al, 1998*)
- Planned systematic change (*Kitson, 1994*)
- Evolutionary change (*Binnie and Tichen, 1999*)
- Transformation of the perspectives of the people who need to work with the Change (*Ward et al, 1998*)
- Change which is new to the unit or individual adopting it (*King, 1989*)
- Utilisation of evidence (*Kitson, 1994; Kitson and Currie, 1996*)
- Encouraging participation and ownership (*Eve et al, 1997*)
- Responding to identified client need (*Cowley and Mountford, 1985*)
- Improving services to the client (*Brody, 1989*)
- Improving the professional’s role or skills (*NBS, 1997; Weir, 1995*)
- Improving the business of the professional or the organisation (*Cowley and Mountford, 1985*)
- Improving the effectiveness of the service (*Brody, 1989*)

□ Case construction

Case construction was used to identify which of the attributes identified from the literature and definitions were critical to the concept of practice development (e.g. present in every example of the concept). Case construction involves the utilisation of experience to develop a scenario which illustrates the concept, as well as other cases which serve to demonstrate what the concept is not. Through this process attributes which define the concept can be identified and tested by practitioners.

Several types of case have been described. Walker and Avant (1995) describe several types of cases including model, contrary, related and borderline cases. A multi-stage process was used during case construction and analysis. In the first stage a series of scenarios was constructed for each type of case and these were analysed to identify which of the attributes described in Table 2.2 were present. In addition, practitioner experience was used both in the construction of the cases and the subsequent vignettes. As part of this process a group of practice development facilitators was invited to attend a workshop. The purpose of the workshop was to review the evidence collected on the use of the term 'practice development' from the literature, assist in the construction of cases and identify a tentative list of critical attributes.

During the workshop a presentation was made to the participants of the main findings of the review of definitions and the literature. Following this the facilitators were divided into small groups to review the draft model, related, borderline and contrary cases. The groups were asked to identify from the overall list of attributes identified during the literature review which attributes were present. In addition, the groups were asked to construct their own cases using their own experience of

practice development. Through this process the cases and vignettes were refined and a list of critical attributes identified. The use of practitioner experience as part of concept analysis is advocated by Chinn and Kramer (1995) who suggest that such methods can strengthen the validity of the analysis.

Model Case

A model case is a “real life” example of the use of the concept that includes all of the critical attributes and no attributes of another concept (Walker and Avant, 1995). A model case is used to represent the author’s best understanding of the concept at the time. It is generally regarded that the author should be able to construct a model case which allows him/her to state “If this is not X, then nothing is”. Figure 2.2 describes a model case of practice development.

Figure 2.2 – A model case

A GP Practice decides to fund a piece of research to examine how users perceive the range of services the Practice provides. The research highlights a number of areas but one of the principal concerns is that patients often do not know about the full range of services provided. The Practice meets to discuss the findings and decide to produce a practice information booklet. This booklet is distributed directly to all patients who make up the practice population. An audit is undertaken six months later and this shows that there has been an increased uptake of several services including Citizen’s Advice Bureau sessions, Counselling and Well Man and Well Woman Clinics. A total of 57% of patients attending these sessions state that they did not previously know that the services existed.

This model case (Figure 2.2) illustrates the development of practice in both clinical as well as business terms. The example demonstrates how the development was a

clear response to an identified patient need, for example the need for more information. This need was partially met through the provision of written information which led to an improvement in the uptake of services. Such an increased uptake suggests that patients had subsequently become more aware of the range of services provided by the practice. Finally, the development can be regarded as maintaining the business of the practice and ensuring a more effective use of resources because practice staff will now spend time running clinics where previously only half of the appointments were taken.

Related case

A related case is similar to a concept being studied but it does not have the critical attributes of the concept. Figures 2.3 and 2.4 outline related cases providing examples of a change and an innovation respectively.

Figure 2.3 – A related case

The hospital is concerned about the number of car thefts which are occurring in the staff and visitor car parks. The General Manager decides to introduce car parking charges for both staff and visitors. The justification for these charges is that it will pay for additional security to monitor the car parks. The new charges are planned and introduced but, six months later, there has been no reduction in car related crime.

This is an example of the concept of change. Though similar to practice development, change does not necessarily lead to a direct measurable improvement in client care/services and is not necessarily a response to an identified need or client

problem. From the case we are also able to identify that the change has not been effective in reducing car crime. Additionally, it is unlikely that such a change would increase the business of the organisation, as some people will use alternative methods of transport or park outside of the hospital grounds.

As suggested earlier, another related concept is that of innovation. Innovation has more similarities to practice development than change but it does not have the critical attributes identified through this analysis.

Figure 2.4 – A related case

The Surgical Unit Manager is concerned about the 45 minute hand over period between the morning and afternoon shifts. She decides to shorten this to 20 minutes and, after a period of consultation, the change is agreed. The resultant new shift patterns mean that the day staff now work longer until 9pm and the night shift work an hour less.

This example of innovation (Figure 2.4) clearly produces benefit for certain groups of staff. However, not all groups would perceive the new system as beneficial. While the night staff work shorter shifts, the day staff now work longer. Additionally, while the innovation produces benefits for some staff, it is more difficult to see how the new shift patterns have directly improved care for patients. However, it might be possible to utilise the salary savings and use these to improve patient care. In practice, however, such savings are not easily released as staff are still required to work the same number of hours per week.

The example of innovation was also not driven by an identified patient need. In fact, the main driving force was probably a desire to see resources used more effectively. To what extent this led to the development of a more effective service is also debatable as there would be a shorter period for shift overlap, with the result that the temporary increase in staffing is now more short lived. Finally, the innovation does not have any direct effect on the employer's business position. However, the change might increase the number of night staff available because, taken over a longer period, the shorter shifts should lead to staff having to work an extra night to ensure that they can meet their contracted hours.

Borderline case

A borderline case has some, but not all, of the defining attributes of a concept. Such a case therefore provides an example of what the concept is not. Figure 2.5 outlines a borderline case demonstrating a case of professional development.

Figure 2.5 – A borderline case

A ward nurse is interested in finding out more about wound assessment and she is concerned that the current wound care assessment is not considering all of the potential underlying pathologies. She seeks sponsorship from her manager to attend a wound care course which she completes several months later.

This case (Figure 2.5) is an example of the concept of professional development.

While the nurse may have developed new skills in response to a specific patient problem, there is no evidence that she uses these skills following completion of the

course. As a result, this case does not contain the defining attributes of a direct measurable improvement in client care/service, nor does the case indicate how the development leads to more effective services or improve or maintain the business of the organisation.

Contrary cases

A contrary case provides the best example of what the concept is not. Such cases contain none of the defining attributes of the concept. Chinn and Kramer (1995) warn against simply reversing the model case as this adds little to the overall analysis of the concept. Figure 2.6 outlines a contrary case.

Figure 2.6 – A contrary case

At a partners meeting the General Practitioners from a large GP Practice discuss the problems related to the Medical Centre's telephone system. The large number of incoming calls means that lines are often not available for staff to telephone out. One particular concern is the possibility that someone who requires urgent medical attention would not be able to get through to the Medical Centre. The Practice Manager informs the partners that a new telephone system would cost a minimum of £4,000 as the existing system is already working to its maximum capacity. The Practice feel that they are unable to finance such a development at this time but they agree to explore other funding sources.

This contrary case (Figure 2.6) has none of the attributes of practice development. Firstly, the scenario does not indicate any development to overcome the actual patient problem or identified unmet need. The lack of development also means that there is no direct measurable improvement in the service to patients/clients and that

there is no improvement in the effectiveness of the service offered. Finally, the scenario suggests that it is unlikely that the outcome will have any influence on the business of the Practice.

Following the development of the above case examples, it quickly became clear that a contrary case could easily have become a borderline or related case if certain antecedents were present. The author therefore decided to develop vignettes which would illustrate contrary, borderline, related and model cases using the same scenario. These vignettes serve to illustrate the conditions necessary to facilitate the development of practice. They also highlight the relationship between the concept and the other aims of the research, namely the identification of organisational influences and antecedents.

Four vignettes were developed to provide a broad cross section of different approaches to practice development. None of these examples are based upon real life developments but are constructed by the author using his experience. Each vignette presents a development from a different perspective, some being organisationally driven developments with others been developed by individuals or teams.

Case A

Case A (Figure 2.7) highlights an organisational development. The vignette starts by identifying how the organisation was slow to respond to developments in

Antecedents	Vignette	Case Type	Consequences
Awareness of a better method of service / care delivery	<p>Anytown NHS Trust's Continence Service currently centres around District Nursing staff assessing patients, instigating interventions and providing incontinence products. Patients or their relatives collect products from clinics or the nurse delivers them. A neighbouring NHS Trust has developed its service and offers both community based treatment services and home delivery of all incontinence products.</p>	Contrary	
Awareness of a specific client need / unmet need	<p>Following several complaints from patients a Primary Care Group decides to review its contract for continence services. It invites tenders from both the current provider (Anytown) and neighbouring NHS Trusts.</p>	Borderline	
	<p>Anytown Trust reviews its service and identifies the need to improve treatment services and the need to re-examine the clinic issue system for incontinence products.</p>	Related	
	<p>The Trust Board approve the service development plan.</p> <p>The service development plan is operationalised and the first Primary Care based continence treatment services commence. A home delivery service is established. The contract is retained and an additional contract from a neighbouring Health Authority is obtained.</p>	Model	Improvement and expansion of the organisation's business

Figure 2.7 : Case A

neighbouring organisations. This both led to the identification of a better method of service delivery as well as potentially placing in jeopardy the contract. The tendering of the contract is a borderline case of practice development which is initiated by the Primary Care Group. The case is borderline because it is a response to an unmet need identified by service users. These complaints and the identification of unmet need can be regarded as contextual issues which impact on the organisation's desire to develop practice. Such influences could be regarded as positive or negative because they could either stimulate development or the organisation could view the situation as a lost cause and decide not to take any action. In this scenario the organisation produces an action plan which requires approval by the Trust Board. This approval could be regarded as an administrative change and, thus, it can be regarded as part of the related concept of change. Finally, all of the stages build to produce the final outcome which is an example of the model case. In this case the attributes of improvement, response to a specific need, effective service delivery and the maintenance or expansion of business are all present.

Case B

Case B (Figure 2.8) demonstrates how an individual can develop practice. The vignette starts with a description of the current situation. This situation describes how the nurse continues treatment even though there has been little improvement. Information from colleagues and subsequent training increase the nurse's awareness of other treatment modalities. This is a response to the patient's need and could be regarded as the related concept of professional development. Despite this increased

Antecedents	Vignette	Case type	Consequences
Awareness of a specific client need / unmet need	<p>Mr Jones, a patient with a long standing arterial leg ulcer, has been visited regularly by his District Nurse. Despite her best efforts using a variety of treatments, the ulcer refuses to heal. Mr Jones had been seen by a Vascular Surgeon but refused surgery. The District Nurse continues to visit twice weekly to change his dressings.</p>	Contrary	
Awareness of a better method of care delivery	<p>The District Nurse is concerned about the ulcer not healing and she discusses this with her colleagues when she attends her course at the local University. One of her colleagues mentions an article she had been reading about Low Level LASER Therapy. The nurse locates this and contacts the company for further information. The company offer her a free place on their next LASER training course. The nurse attends the course and feels that LASER may benefit a number of her patients, including Mr Jones.</p>	Borderline	Professional Development
	<p>Following the course, the nurse collects together relevant literature about the value of LASER therapy and approaches her manager. The manager subsequently presents a case to the Trust Board and they agree to consider the purchase of a LASER during the next budget review. They agree that a small pay underspend can be moved and used as capital expenditure for the purchase of this equipment.</p>	Related	
	<p>The LASER is purchased and the nurse commences the treatment of Mr Jones' leg ulcer which improves by granulating and reducing in size.</p>	Model	Direct improvement in the care / service to a client

Figure 2.8 Case B

knowledge at this stage, the care of the patient remains unchanged. The nurse is able to convince her manager to seek funding for a LASER machine and eventually the machine is purchased. This represents an administrative change (a related case) as it involves the relocation of finances within the budget. Finally, the Practice Development occurs as a result of all of the above stages, Mr Jones commences treatment and his leg ulcer subsequently improves. Again this case has the attributes of improvement, response to need and effectiveness. Additionally, the fact that the nurse is able to continue treating the patient without needing to refer him on to another professional, means that the business of the organisation is maintained.

Case C

Case C (Figure 2.9) highlights both group and organisational practice development. In this vignette the team leader is reluctant to develop practice and this provides the scenario for the contrary case. However, the organisation is influenced by contextual issues to bring about administrative change and this supplies the related case. The appointment of a co-ordinator to lead skill development is a reaction to both contextual influences and patient need and, because of this, it can be regarded as a borderline case. Such skill development also leads to Professional Development which, in this scenario, is a consequence of the development. Finally, the ward team undergo training and an audit reveals that patients are receiving more timely treatment. This aspect provides the final piece of the jigsaw to make the scenario a model case.

Antecedents	Vignette	Case Type	Consequences
<p>Policy</p> <p>Concern about delay</p>	<p>Sister Miggins in vehemently opposed to her staff taking on the delegated responsibilities of other health care professionals. She believes that this reduces the time available for nursing care. Recently, the shortage of Junior Doctors means that patients often have to wait a considerable time before they have their intravenous drugs administered. Despite offers of training, she refuses to allow her staff to develop skills in this area.</p> <p>Following publication of the New Deal for Junior Doctors, the Trust Board decide that extending the Scope of Nursing practice is to be given priority.</p> <p>The Director of Nursing is concerned about delays in treatment and employs a co-ordinator to audit the problem and develop a programme of skill development.</p> <p>The co-ordinator works with staff to ensure that they are aware of the necessity of developing this aspect of practice. Sister Miggins discovers from her colleagues that this training can actually reduce the time spent chasing up Junior Doctors and she eventually decides that she and her team will undergo the training.</p> <p>Once the majority of staff are trained, a further audit reveals that patients are now receiving more timely treatment.</p>	<p>Contrary</p> <p>Related</p> <p>Borderline</p> <p>Model</p>	<p>Awareness of a better method of service/care delivery</p> <p>Awareness of a specific client need/unmet need.</p>

Figure 2.9: Case C

Case D

Case D (Figure 2.10) again illustrates a development from a team perspective. The vignette starts by describing how the pressure of work prevents an individual from developing her practice. Again the related case is an example of administrative change following a workload analysis. The new health visitor undertakes to update the community profile and identifies the need for a new method of service delivery by identifying unmet needs. This is a borderline case because it contains the attribute of a development in response to unmet need. Finally, the establishment of the new Saturday morning clinic increases attendance and is popular with parents.

The production of vignettes as a form of case construction serves to illustrate how practice developments can be influenced by organisational, structural and individual factors. For example, in Case B professional development in the form of attendance at a course, and the securing of funding and resources, progress the case from a contrary case through borderline to a related case. In addition, case construction using vignettes assists in the identification of both antecedents to and the consequences of practice development. The use of vignettes appears to be well suited to the study of practice development and other changes. What is not certain is whether the method is applicable to case construction when examining other concepts. The use of vignettes as an original method will be discussed in greater depth in chapter 7.

Antecedents	Vignette	Case Type	Consequences
Awareness of unmet need	<p>A Health Visitor working in a General Practice which has a large number of working parents has noticed a falling number of parents bringing their children to the child health clinics. She would like to change the way she delivers services but finds that because of the pressures of work it is difficult even to keep up-to-date with her routine work.</p> <p>The new Primary Care Group examines workloads and staffing levels for all of the General Practices in its area. They decide that this practice needs an additional full-time Health Visiting post.</p> <p>A new Health Visitor is appointed and she sets about updating the community profiling and examining attendance rates at the current clinics.</p> <p>The new Health Visitor and her colleague decide to establish a new Saturday morning clinic. This clinic results in increased attendance rates and is more popular with parents.</p>	Contrary	
		Related	
		Borderline	
		Model	<p>Awareness of a better method of service/care delivery</p> <p>Awareness of a specific client need/unmet need.</p>

Figure 2.10: Case D

❑ Critical attributes of the concept of practice development

As highlighted earlier, both the literature review and the definitions were used to develop an overall list of attributes (Table 2.2). This list contained a number of attributes, some of which may not be present in every case of practice development. For example, some developments may be facilitated through an identified or appointed source, while others are taken forward by an individual practitioner as part of improving his / her own practice. In order to identify those attributes which are critical to practice development (e.g. those which are always present in every example of practice development), it was necessary to advance the analysis by constructing and testing out cases.

Once this process was completed it was possible to produce a tentative list of attributes. These are: -

Practice development involves....

- New ways of working which lead to a **direct measurable improvement** in the care or service to the client.
- Changes which occur, as a **response to a specific client need or problem**.
- Changes which lead to the development of **effective services**.
- The **maintenance or expansion of business/work**.

These attributes should be present in all examples of practice development and can be used to define or measure when practice development has occurred. In addition, some of the attributes such as the new ways of working leading to a direct

measurable improvement in care and the service to the client could be used as proxy measures of whether practice development had occurred. Full measurement is only possible when the outcomes for each individual development have been identified. One of the key critical attributes identified in this analysis is the implementation of new ways of working which lead to a direct measurable improvement in the service to the patient or client. As highlighted earlier, this attribute is important as it differentiates practice development from other related concepts such as innovation. The attribute, together with the fact that development should be based upon an identified patient/client need, provides a clear patient focus for practice development. McCormack et al (1999) state that the majority of developments in nursing practice in the 1980s centred around the development of the profession and attempts to measure the impact on patients were fraught with methodological problems. They proceed to state that the 1990s have seen the re-emergence of humanistic caring and thus a move toward more patient focused practice development with greater emphasis on clinical effectiveness and patient outcomes. This concept analysis suggests that the outcome of practice development activity should always be patient related. It is acknowledged that there may be other related “spin offs” from such activity, for example, professional development. However, in the past people have been guilty of confusing what is essentially professional development with the direct development of patient care and this has resulted in practice development activity being difficult to quantify. Joyce (1999; 109) states that “practice and professional development are two different concepts, yet in the literature and in job titles they are often used interchangeably”.

□ Antecedents and consequences

The identification of antecedents and consequences are important, although sometimes ignored, steps in the analysis of a concept. Walker and Avant (1995; 45) define how “an antecedent is an event or incident which occurs prior to the occurrence of the concept”. Several antecedents to practice development were identified during case construction. Firstly, all practice development activity appears to commence with an awareness of either a better method of service/care delivery or an awareness of a specific client need. Practitioners can use several techniques to assist them to identify unmet need or a better method of care delivery including clinical supervision, reflective practice or health needs assessment. Similarly, many developments in practice occur as a result of professional development activity. Professional development as an antecedent may take several forms; for example reflective practice or clinical supervision may prove to be the catalyst of the proposed development. Alternatively attendance at an educational event or course may raise the practitioner’s awareness of a better method of service delivery or care provision. Finally, any practitioner intending to introduce a development into practice must make sure that the proposed development is congruent with the aims of the organisation. Unless this antecedent is present the development is likely to be blocked by managers within the organisation.

A consequence is an event or incident which occurs as a result of the occurrence of the concept (Walker and Avant, 1995; 45). Some of the consequences of practice

development are highlighted in the critical attributes of the concept; for example, the development of effective services and the introduction of a new way of working which leads to a direct measurable improvement in the care or service to the client. Similarly, practice development would also be expected to maintain or expand the organisation's business. The changes to the internal market may have made this attribute less important for health care practice. However, recent changes related to performance measurement, for example more funding for organisations which develop their services and deliver on waiting targets, provides added impetus to develop clinical practice. Finally, professional development can also be seen as a consequence of practice development activity because the professional would have enhanced his / her own knowledge and skills as a result of the implementation of the new way of working.

□ Empirical referents

Empirical referents are categories of actual phenomena which demonstrate the occurrence of the concept itself (Walker and Avant, 1995). Empirical referents can be used to measure whether practice development has actually occurred and, as such, they can be very similar to the critical attributes of the concept itself. This is true of the empirical referents of practice development. However, to facilitate measurement the empirical referents have been reworded. The empirical referents for the concept of practice development have been identified as: -

- a change in the way of working
- a clear client focus for the development

- cost or clinically effective service delivery.

Each of these referents can be measured within the practice setting to identify a development in practice. Firstly, there should have been a change in the way of working. This could be anything from an alteration in ward routine to the development of a new service. The practitioners implementing the development should be able to articulate why they felt the need to change, giving an example from practice of how a client related incident raised their awareness of the issue. Even nationally driven developments such as nurse prescribing are said to have their origins in the identification of client need, i.e. the need for more timely treatment (Department of Health, 1989a). Finally, it is possible to identify if a development is cost effective through financial assessment. In a similar way clinical effectiveness can be judged by examining the evidence base for the proposed treatment or development.

□ Relationship between this analysis and the wider study

This analysis is an important part of the subsequent study for a number of reasons. Firstly, the delineation of the concept of practice development from other related and similar concepts will allow the researcher to study how practice development and related concepts such as professional development interact to produce a change in practice. As highlighted earlier, practice development has previously been regarded as an eclectic mix of professional development, change and innovation. For the first time it is possible to identify how professional development triggers practice

development and vice versa. Additionally, the concept analysis has allowed for the identification of both antecedents and consequences of practice development. The identification of these factors is the first step towards producing a tentative list of positive and negative influences. It remains to be seen whether the antecedents and consequences identified in this analysis are highlighted in the subsequent Delphi survey and case studies.

The similarities between practice development and innovation are undeniable and the author contends that practice development is a specialist form of innovation. Like innovation, practice development has an intentionality of benefit, inasmuch as it should lead to a direct measurable improvement in the care and service to a client. Similarly both practice development and innovation are designed to lead to the development of effective services / processes and are designed to maintain or expand the work or business of an individual or organisation. Another interesting feature of innovation is that the proposed change only needs to be new to the people adopting it. It could be argued that the same could be said of practice development, where the vast majority of developments introduced into practice are either repackaged ideas or ideas which have been tried and implemented elsewhere.

□ Conclusion

This analysis provides a comprehensive overview of practice development in its purest form. The attributes, antecedents and consequences identified during the analysis suggest that practice development is very similar to innovation. Where

practice development and innovation differ is that practice development is a response to a specific client need or problem. It is this patient focus for the development which sets practice development apart from innovation and it is for this reason that practice development is regarded as a specialist form of innovation. The acceptance of practice development as a specialist form of innovation has important consequences for the subsequent literature review as it widens the range of literature which should be searched and reviewed. Additionally the notion that, as with innovation, the vast majority of practice developments are only new to the Trust or Unit adopting them is important for the sampling methodology when selecting case study sites. This is discussed in more depth in chapter 5.

The concept analysis has identified that practice development in its purest form is an approach which involves new ways of working which lead to a direct measurable improvement in the care or service to a client. This approach involves changes which occur as a response to a specific client need or problem and that the changes lead to effective services and the maintenance or expansion of the business or work of the professionals involved. However, the analysis also highlights that practice development rarely, if ever, exists in its purest form and that often developments are an eclectic mix of professional development and change.

○ Chapter 3: Literature Review

□ Introduction

As outlined in the introduction, the majority of the pertinent literature is reviewed in this chapter, with literature related to practice development within nursing being reviewed in the previous concept analysis (Chapter 2). This chapter reviews a range of literature related to both practice development and innovation and also reviews some of the major change theories and models that are currently used to underpin the development of nursing practice. The literature is divided into sections relating to studies and models which relate to antecedents to development, the process of development or combined antecedent and process work. The review also includes an overview of three major change theories as well as an exploration of studies related to the effect of culture and climate on innovation adoption. The division of the literature into these groups has been done both to improve clarity and to provide a clear critique of the strengths and weaknesses of the different approaches. This critique will be used to inform the selection of the paradigm and methods for the current research study.

Given that practice development is accepted in this thesis as a type of innovation, the following review of the literature will include studies, which have identified and examined factors that can influence innovation, initiation and implementation.

King (1990) identifies how the literature related to innovation can be divided into two groups, antecedent or process research. Antecedent research is concerned with

the identification of factors which facilitate or inhibit the initiation of innovation. On the other hand, process research utilises an historical or longitudinal approach using qualitative methods, principally case studies, to examine the sequence of events which constitute the process of implementing innovation. The majority of studies have focused upon antecedents to innovation; for example, what organisational, structural and individual characteristics make one organisation more innovative than another. Process research, looking at what factors hinder or facilitate the implementation of an innovation, is a more neglected area. Finally, there are very few studies which have combined both an antecedent and process approach to examine the whole process of initiating and implementing innovation. King (1990) suggests that there is a need to integrate approaches with the aim of making it possible to identify and understand influences on the process of innovation throughout its development.

□ Format and structure of the review

A comprehensive review of the literature related to both practice development and innovation was conducted. This chapter critically reviews the literature related to factors which can facilitate or inhibit innovation as well as theories and models that can support the implementation of innovation in an attempt to identify what is already known about the subject area and to inform the selection of methods used in the subsequent research. The review involved the location of published literature using the following bibliographical databases:

- Cumulative Index of Nursing and Allied Health Literature (CINAHL)
- Index medicus (Medline)
- ABI / Inform (Association of British Industries Information)

- Kings Fund Database

A search for literature containing the key words of practice development, clinical practice development, health care innovation, innovation, creativity and entrepreneurship was undertaken using search criteria varying from three to ten years. This search revealed a large volume of published work in the field of innovation and creativity, so the search criteria were narrowed to factors influencing innovation / creativity. Once completed, key articles were located and critically appraised. This included several key papers which were outside of the search criteria but which were frequently cited as important early works in the field of innovation, for example Mohr (1969).

King (1990) believes that the most daunting feature of the literature on innovation is not simply its size but its sheer diversity. Studies range from innovation driven and implemented by individuals to those which examine the organisational factors that allow one organisation to become more innovative than another similar one. Clearly, it was necessary to set clear boundaries about the type of literature which would be identified and reviewed as part of this research. The focus of the study is how organisations influence the process of developing practice, including factors which assist in the identification of areas for development / innovation (antecedents), together with those that have a positive or negative influence during the process of implementation. The following literature review is therefore restricted to literature from these areas. A number of studies were selected for in-depth analysis and review. The criteria for selection included those studies that identified a range of antecedent and process factors which influence innovation. While the majority of the literature

reviewed relates to health care, some studies are related to other public services within the UK and the USA. Such studies provide useful comparisons between different organisations and across different contexts.

In the same way, the literature related to change theories and models is vast and, as a result, it has been necessary to restrict the range of literature reviewed. Three major change theories are discussed in detail within this chapter. These theories were selected on the basis that they reflect different approaches such as change introduced by diffusion, change introduced by an external change agent and change introduced following an analysis of the organisational, individual and contextual factors which may drive or hinder the process.

The models of change are discussed within the framework highlighted earlier in this chapter. As a result those models which concentrate on antecedents are located at the end of the section related to antecedent studies, those which concentrate on the process of implementation in the section on process studies and so on.

□ Antecedent studies

Research which examines the organisational, structural and individual antecedents to innovation tends to concentrate on what factors make one organisation more innovative than another similar organisation. The majority of studies in this field tend to use variables identified by earlier researchers, with the most commonly cited previous study being that undertaken by Mohr (1969). In his study, Mohr (1969) examined the determinants of innovation in local public health departments in the

United States. The departments were selected because they had had the opportunity to respond to several changes and challenges. A total of 93 departments was selected for the study and all of the departments had a Chief Officer or Local Health Officer who had been in post for four or more years. Using interviews, the following hypothesis was examined:

“Innovation is directly related to the motivation to innovate, inversely related to the strength of the obstacles to innovation, and directly related to the availability of resources for overcoming such obstacles” (Mohr, 1969; 114).

The study identified a number of factors which influence innovation within public health departments. Size, wealth and resources were found to be strong predictors of innovation, as were education and training, both in terms of the educational level of the public health officers and the availability of education within their departments. The interviews disclosed consensus about attitudes towards innovativeness. Specifically, the public health officer’s ideology and inclination towards activism were the best indicators that the organisation would introduce innovation. Mohr (1969) concluded that the motivation of the health officer is indeed related to the innovation of the department.

One of the strengths of Mohr’s (1969) work was that it combined interview and survey methods within the same study. Triangulation of this nature can be used to provide a greater depth of contextual information and allows the researcher to seek clarification on previously collected data. However, the use of self report methods such as surveys and interviews when collecting information about whether people are planning to introduce innovation is likely to be open to bias. It could be argued that

when faced with a question “Do you plan to introduce an innovation?”, most people would provide a positive response. This has important connotations for the choice of method within this study inasmuch as any survey needs to include questions which will encourage respondents to identify negative influences as well as positive ones.

While the study is old, its findings are used as the basis of more recent studies such as those undertaken by Kimberly and Evanisko (1981) and Damanpour (1987).

Another limitation when considering the applicability of Mohr’s work to the present study is that it is very focused around the American public health system. Translation of the results between cultures, especially given the lengthy time since the study was conducted, would be problematic. In addition, the study is devoid of information about what potential innovations the public health practitioners were planning to introduce. Despite the study’s limitations, it does provide the basis for the identification of variables in subsequent studies and supports the notion that organisational size, resources, individual motivation and educational level are possible predictors of innovativeness.

Kimberly and Evanisko (1981) sought to identify individual, organisational and contextual variables and the contribution these make to the adoption of administrative and technological innovations. Several possible variables were identified from previously published literature and these are shown in Table 3.1

Table 3.1: Predictors of innovation adoption (Kimberly and Evanisko, 1981)

Individual	Organisational	Contextual
Organisation's position / role Leadership approach Educational background Longevity in role Cosmopolitanism Involvement in policy	Structure - functional differentiation - centralisation - specialisation Size	Competition Size of locality Length of time the organisation has existed

Using a database of innovation in respiratory medicine, the researchers identified 12 new developments. Postal surveys were sent to hospital administrators and chiefs of medicine in order to identify the presence of the 12 innovations in their own hospital.

The results suggest that there is a positive correlation between organisational size (whether measured on budget, beds or number of employees) and the introduction of technological innovation. In addition, the individual factors of being highly educated, involved in medical activity and the length of time in post were positive predictors of innovation. Kimberly and Evanisko (1981) also found that innovation adopting hospitals were specialised and highly differentiated into departments and specialities with key staff taking an active role in decision making. Finally, the researchers found that competition between hospitals was a significant positive contextual influence in the rate of adoption of the 12 innovations. Kimberly and Evanisko (1981) concluded that “organisational variables are indisputably better predictors of innovation than individual or contextual level variables”.

The findings of the Kimberly and Evanisko (1981) study suggest that larger organisations are better equipped to initiate and implement innovation. This finding

bodes well for the recent drive within the UK, where NHS organisations are being merged together to form larger NHS Trusts. The proposed mergers are presented upon the premise that larger NHS Trusts have lower management costs and that savings realised after mergers can be invested back into patient care.

Another significant finding was that pertaining to functional differentiation. Within the NHS functional differentiation can be likened to directorate structures within organisations. While the study (Kimberly and Evanisko, 1981) suggests that functional differentiation can assist with the identification and implementation of innovation, it can also make the introduction of whole organisation innovation more difficult, principally because of the artificial boundaries and separate management structures which such differentiation may promote.

While the study by Kimberly and Evanisko (1981) identifies several positive variables which influence innovation adoption, it is not without its weaknesses. The study identifies that innovation is more likely when the hospital administrator and the Chief of Medicine are highly educated and when they have been in their posts for a length of time. However, the article does not provide any indication of what constitutes highly educated or how long the participants who were innovative had been in post. Additionally, the contention that organisational size is associated with more technological innovation is open to question about whether it is in fact the size of the organisation which is important or whether the introduction of innovations is associated with additional resources and organisational slack. There is an argument that large health care establishments have economies of scale when compared to other smaller hospitals. Finally, the fact that the study was carried out in the United

States makes comparison with the UK NHS difficult, not least because of different funding methods but also because of differences in the management structures and because the UK has a system of regional and sub regional specialisation. Despite these concerns, Kimberly and Evanisko (1981) provide a useful insight into organisational, individual and contextual factors which may be useful when predicting innovation within organisations.

A similar study was carried out by Damanpour (1987) to examine the influence of organisational variables on the adoption of technological, administrative or ancillary innovation within American libraries. Through a literature review and a series of interviews and focus groups with librarians, Damanpour identified 61 innovations.

A survey was developed to identify which of the six organisational variables (Table 3.2) were associated with the adoption of different types of innovation. The survey was distributed to 150 Library Directors. A total of 75 surveys were returned giving a 50% response rate.

Table 3.2: Organisational variables (Damanpour, 1987)

Variable	Definition	Measure for study (Damanpour, 1987)
Functional differentiation	The extent to which an organisation is divided into different units	Number of supervisors with two or more employees reporting to them
Specialisation	The different specialists found within an organisation	Number of job specifications for non supervisory personnel
Professionalism	The professional knowledge of the organisation's members	Number of certified librarians

Size	The size of the organisation in terms of budgets / staff / beds etc.	Budget over past 5 years
Slack	The difference between the resources the organisation has and what it needs to maintain services	Difference between income and expenditure
Administrative intensity	Number of managers and their degree of involvement	Percentage of supervisors over non supervisors

The results suggest that organisational size was more positively correlated with administrative innovation than any other group, while administrative intensity was shown to be the only predictor variable to reveal zero order correlations with all three types of innovation. Furthermore, administrative intensity was expected to have a stronger association with administrative innovation but the data suggested an equally strong correlation with ancillary innovations. This can in part be explained by the fact that managers have a degree of control over the way in which the organisation functions within its environment. Damanpour's (1987) work supports the findings of Kimberly and Evanisko (1981), even though the research was conducted in different work environments. Interestingly, Damanpour (1987) also found that the adoption of administrative innovations tends to promote the subsequent adoption of technological innovation.

The translation of the findings of Damanpour (1987) from the public library sector to health care is complex. The fact that public libraries are smaller organisations with smaller budgets makes comparisons between the adoption of certain types of innovation virtually impossible. Additionally, some of the measures of specialisation and functional differentiation could be regarded as flawed. To measure specialisation

by the number of different job specifications is questionable. It is highly likely that over a period of time new roles have developed and, as people have moved on to other jobs, the posts they vacated have been changed. As a result, there is likely to be a myriad of different job specifications, although Damanpour (1987) does not provide information about the number of posts identified. If the same measure of specialisation were applied to any hospital in the UK, the results would suggest many more specialisms than actually exist. The alternative approach would have been to count the range and type of functions performed, for example biographical indexing, stock control etc. Similarly, to define functional differentiation and the number of supervisors who have two or more employees reporting to them would create more differentiated units than may have existed in reality. Finally, the method used fails to account for “local” innovation because it uses a predetermined list of innovations developed by the researcher. This restriction may have affected the results as it assumes that the only innovations that may have occurred within the organisation are those which are common to a number of organisations and therefore included on the list. With this limitation in mind the current study should allow participants to identify their own innovations and the factors which influence them rather than using a pre-determined list of developments.

A study conducted by West (1989) examined the characteristics of a group of 102 health visitors from one health authority area. Participants were sent a questionnaire which examined innovation, role discretion, knowledge of results, workload and systems of social support. Innovation was measured using a series of questions (Table 3.3), with discretion and knowledge of results being measured using 4 item Likert scales.

Table 3.3: Innovation questions used by West (1989)

<p>How much have you needed to develop new ways of doing things? How important is it that you have a chance to initiate new things? How do you rate yourself in terms of innovativeness? Within the last year how much have you</p> <ul style="list-style-type: none">- Changed working methods- Changed how you deal with people- Learned new skills <p>Describe the innovations you have introduced in the last year?</p> <ul style="list-style-type: none">- Rate each from minor to major impact
--

A total of 92 health visitors completed the survey (90% response rate). West (1989) found a positive correlation between freedom to do their job and innovation amongst the health visitors studied. The majority of staff involved in innovations gained support from colleagues, husbands, friends or their senior nurse. A total of 53 respondents reported that they had introduced innovations into their work. These included:

- Changes in objectives – reprioritising workloads (38%)
- Changes in working methods (31%)
- Changes in relationships and how they work with others (17%)
- The development of new skills (8%)
- Other (6%)

Several barriers to innovation were identified by the respondents. These included overwork and the pressures of time (27%), lack of resources (17%), management policies and style (15%) and other reactions including job specific factors (6%).

West (1989) concluded that health visitors were more likely to change their roles than other occupations. However, this statement is open to debate as West (1989) based his conclusions on a comparison between health visitors and employees working in steel and textile industries. To what extent it is possible to make such inferences across such groups (professional and manual workers) is debatable.

The strength of the West (1989) study is that it is one of only a few studies which identify negative factors as well as positive ones. At the same time, the study has a number of limitations, including the fact that it studies a single professional group within one Health Authority area. This, combined with the fact that the report provides little contextual information related to the innovations implemented, makes it difficult to identify how the findings may be transferred to another similar setting. Additionally, the results show that just over half of the participants had introduced an innovation. The range of innovations introduced supports the suggestion within the concept analysis that both innovation and practice development involve the implementation of changes, which are new to the unit of adoption, rather than original to the wider profession.

Despite the limitations, the study suggests several additional positive and negative influences on innovation initiation. The study highlights how freedom to do their job is an important consideration for the participants. This hands off approach can probably be related to devolved management responsibilities, where individual practitioners are given more freedom to manage their own work and how they deliver care. While the study identifies negative factors (pressures, lack of resources and management style) which act as a barrier to innovation, it is unclear how these might

also influence the process of implementing an innovation. This limitation suggests that the current study should examine antecedents to practice development as well as factors which influence the process of implementation.

Another study by West (1987a) examined how organisational change could be achieved by the development of role innovative behaviours in new post-holders. The study was carried out using a previously developed measure. Subjects were asked to indicate in what ways they now do their job differently from the person who did the job before them across six areas. These included setting work targets / objectives, deciding the methods used to achieve the targets, deciding work priorities, choosing who to work with, initiating new working procedures and developing innovative ways of working. Each area was rated in the survey using a four point scale ranging from doing work in the same way to doing work completely differently. A sample of 20 part time Diploma in Management Studies students from a wide range of backgrounds and 17 supervisory staff from the wool textile industry was selected.

A response rate of 81% was achieved. The results suggested a highly significant correlation between individual perception of discretion and role innovation. West (1987b) later conducted a further study using a two stage longitudinal questionnaire (career development survey) to identify independent predictors of role innovation. The results suggested that role innovation is lower in younger staff and that the rate of innovation rises with age, peaking around the age of 40-50 years before falling off. Another important finding related to the level of education qualifications. The study suggested that the lower the level of the highest qualification, the lower the level of innovation. Additionally, as well as supporting the earlier finding related to

role discretion (West, 1987a), the study suggested that innovation was higher where staff displayed higher levels of satisfaction post role transition.

The study is not without its limitations, including the fact that it fails to provide contextual details about the organisation's culture, as well as details of the Diploma student's backgrounds and current positions. Additionally, the study is not directly health related but it does suggest that role clarity, educational level and the length of time a person has been in their role may be important antecedents to innovation.

In the later study by West (1987b) a number of methodological questions are raised related to the conclusions drawn about innovation rates amongst people over 40 years. Such a conclusion does not take into account the person's position within the company, the length of time they have been in post or the opportunities they have had to innovate. Many of the other studies cited in this review suggest that innovation adoption is correlated with length of time in post as well as organisational position.

Clarke, Proctor and Watson (1989) carried out a survey to identify and examine those factors which influence and sustain the development of health care practice. A postal survey was sent to practitioners within one English NHS Region (n= 479) who were identified as practice developers. The survey questions sought to understand the pervasiveness of each practice development in relation to

- multi-professional involvement
- academic links
- framework of practice development

- organisational support

A total of 219 surveys were returned giving a 45% response rate. The results showed that while the majority of responders were nurses (66%), a significant proportion of the developments (29%) involved three or more professional groups.

Numerous reasons were identified for the initiation of practice developments with over half of all development (54%) being initiated in response to patient need or an awareness of the limitations of existing practice. A smaller number were initiated as a result of role changes (13%) or because of the imposition of national guidelines (9%).

A high proportion of respondents were educated to first degree or higher degree level (48%) and the majority of developments were initiated by practitioners who had a relatively stable employment history with a peak of around four years in the same organisation.

Support for practitioners developing practice came from a variety of sources including in-house support within the organisation. Only 25% of development had an established link with a higher education establishment. However, the authors do not indicate why they think such a link would be beneficial and its inclusion as one of the questions within the survey suggests possible bias on the part of the researchers.

The study by Clarke, Proctor and Watson (1989) is wide ranging, examining multi-disciplinary development across a large sample within one English health region.

While the study claims to examine sustainability, the actual results appear to be more related to antecedents to development than those designed to ensure its continued

success. The study does not indicate the length of time the developments used as the basis for the study had been in existence or indeed the range of developments included. This dearth of contextual information makes it difficult to ascertain whether the antecedents to practice development are transferable to similar practice settings. Despite these limitations, the study does support some of the suggested positive influences such as educational level and length of time in post. In addition, new factors such as stability of the organisational structure and of individual post-holders are suggested as another positive influence. Again, the study supports the idea that this current study needs to provide contextual information about both the organisations and developments studied.

As identified earlier, the degree of educational preparation of individuals is thought to be a significant factor in the subsequent initiation or adoption of innovation.

Ehrenfeld and Bergman (1992) examined the influence of degree level preparation on the subsequent introduction of change amongst nurses in Israel. A sample of 709 registered nurses who had undertaken the undergraduate programme were recruited to the study. Using a survey, the authors sought to examine the number of changes introduced, as well as information about the length of time since initial qualification, further study undertaken since that time and current job position. A total of 360 responses were received representing a 50% response rate. The results suggest a positive correlation between the length of time between qualification and the rate of change implementation. Additionally, positive correlations were found between further study and the rate of change introduction. Those who had undertaken a Master's Degree had introduced three or more changes. Job level was also positively correlated with the rate of change introduction.

This study appears to support the work of Clarke, Proctor and Watson (1989) which suggested that effective practice developers had been qualified and in post for several years. However, the notion of more change being introduced by individuals who had been in post a long time is open to criticism as this tells little about the rate of innovation. If someone has introduced three changes in the 20 years since qualification, they cannot really be regarded as more innovative than an individual who has been qualified for only six months but who has initiated two changes. Additionally, there was no attempt to assess the quality or complexity of the changes introduced. An individual who has implemented only one change which was complex and spanned an entire organisation could be regarded as more innovative than a person who has implemented several very small scale and less complex changes. Another weakness in this study relates to the use of self report questionnaires. Such an approach could be open to allegations of potential bias with respondents wanting to be seen in a positive light by their former lecturers.

Several authors (Luckenbill-Brett, 1989 and Coyle and Gallino Sokop, 1990) have examined methods of disseminating research findings as a way of increasing the adoption of innovations. The study by Luckenbill-Brett (1989) sought to identify if there was a relationship between mechanisms to increase information flow (integrative mechanisms) and the subsequent adoption of innovation by nurses. The study was conducted within 19 hospitals in the USA. The hospitals ranged in size from 34 – 1337 beds. Using two questionnaires, the nursing department form and the nursing practice questionnaire, data were collected about the nurses' awareness, use

and adoption of innovation and the availability of integrative mechanisms and policies within the organisation.

In the first phase of the study the participating hospitals were stratified on the basis of bed compliment into small, medium and large hospitals. The Directors of Nursing within the hospitals were then asked to complete the nursing department form. Analysis of the data allowed the researchers to classify the hospital's use of integrative mechanisms as low, medium and high. Only 10 of the 19 hospitals provided information using the nursing department form. The remaining hospitals did not provide information and nursing practice questionnaires were simply sent to registered nurses within departments. A total of 438 questionnaires was sent to registered nurses within the 19 hospitals, from which a 63% response rate was achieved.

The results suggested that large hospitals (more than 500 beds) had the highest innovation adoption score. This supports the findings of Kimberly and Evanisko (1981) that large organisations display more innovation. Surprisingly, the second highest level of innovation was found in small hospitals (less than 250 beds), with medium size (250-500 beds) hospitals having the least innovation. A positive correlation was found between the number of integrative mechanisms and the amount of innovation in small hospitals. However, the correlations for large and medium size hospitals were not significant. Luckenbill-Brett (1989) states that Rogers' (1989) assertion that increased information flow into an organisation results in more innovation can only be partly supported by this study as this finding was only identified within small hospitals. However, the author fails to acknowledge the

fact that the larger the hospital the more complex the dissemination of information becomes and this could account for the results. It might have been more appropriate to review in detail the methods used to disseminate information and how effective these were perceived to be. Additionally, this study relates to the adoption of top down innovation only and takes no account of the amount of innovation being implemented by individual practitioners or work groups. Finally, the study has several methodological weaknesses, including the fact that just over half of the participating hospitals provided details of the range of integrative mechanisms used within their organisation. Despite this limitation, the authors appear to have pressed ahead to include registered nurses from all establishments, thus making any inferences about the level of innovation in hospitals with high, medium or low levels of integrative mechanisms a little suspect. Overall the study does suggest that the dissemination of evidence and research within an organisation can act as a positive influence on the initiation of subsequent practice developments. However, the study does not provide information about what the most appropriate integrative mechanism is to promote research dissemination within an organisation. This would require a more in-depth study, possibly using case study approaches to gather information about the mechanisms used.

This section of the review has critically evaluated several studies which seek to identify antecedents to innovation. Several of the studies have suggested that similar factors may act as positive triggers to innovation adoption. These include organisational size with larger organisations appearing to introduce more innovation, educational level of the person leading or driving the innovation and the length of time the person has been in post within the organisation. The majority of studies have

identified positive factors which are thought to make individuals or organisations more innovative. Few studies have identified negative factors which hinder innovation, although the few that have examined this issue suggest that factors such as resources, service pressures and management style, including giving individual staff freedom, are important barriers to development. Several of the studies provide confirmatory results although, because of some of the methods used, it is not possible to generalise the results across populations. It remains to be seen whether the factors identified within some of the studies are thought to be influential within the context of developing nursing practice in the contemporary NHS.

In addition to the findings within this section of the review, the studies reviewed provide considerable insight into the potential methods which could be used within the current study. Firstly, the work of Kimberly and Evanisko (1981) which groups variables together into broad categories (individual, organisational and contextual) is useful when considering the development of a survey. Any survey used in this study would need to contain questions which were designed to collect data about factors which influence development across these three categories. Another major issue is how a survey can be structured to elicit negative factors. Within the majority of studies the respondents identify positive influences on innovation and those studies which have identified barriers tend to do so when respondents report they have been unable to introduce any innovation. The work of Damanpour (1987) suggests that using a pre-determined list of innovations can limit and introduce bias into a study.

The survey, which will form part of the current study, should consider this issue and allow participants to use their own locally developed innovations / developments as

the basis of identifying positive and negative factors which can influence innovation. Deciding whether the results of several of the studies reviewed were transferable to other settings was problematic because the studies provided little or no contextual information. In order to improve the potential for transferability, the current study needs to select a methodology which will allow for the inclusion of detailed contextual information. The work of Clarke, Proctor and Watson (1989) raises the important issue of sustainability, although the study itself fails to examine this issue in-depth. An examination of sustainability would require the use of case study methods with data collected longitudinally over a period of time. Such methods need to be considered within the current study if the influence of factors which affect sustainability can be identified.

There is a dearth of change models which concentrate entirely on the antecedents to change. Most models tend to address antecedents and the process of implementation together. However work by Pettigrew and Whipp (1991) identified observable differences between the way in which high performing firms manage change compared with their lesser performing counterparts. Pettigrew and Whipp (1991) articulated how there are five central factors for managing change and achieving competitive success. These factors are environmental assessment, leadership of change, links between strategic and operational change, human resources as both assets and liabilities and a coherent structure for the management of change.

The environmental assessment is essential for competitive success. This assessment should enable the company to understand how it operates, its strengths and market position. The environmental assessment will be stronger if all departments and levels

within a company are involved in its development. The strategy of the company needs to be developed in relation to this environmental assessment. Within health care the environmental assessment would include understanding the health needs of the population served by the organisation as well as identification of what the organisation does well and who its main competitors are.

Pettigrew and Whipp (1991) articulate how the leadership of change needs to be incremental and should ideally involve action by several individuals at different levels within the company. The prime responsibility of the change leader is to prepare the ground for the proposed change by developing the climate in which the change is to be introduced.

Another factor identified by Pettigrew and Whipp (1991) is the linking of strategic and operational change. This involves ensuring that operational change relates to the overall strategic direction of the company as well as learning from the implementation of changes and using this to further refine the company's strategy. As with many changes they often rely upon people within an organisation for their success or failure. Competitive advantage can be gained through a long term workforce development programme as part of the organisations Human Resources strategy. Finally, achieving coherence in the management of change is highly complex as it involves the management by the organisation of the other four factors within a clear organisational strategy.

Pettigrew and Whipp's (1991) model is based upon several empirical case studies from the automobile industry, book publishing, banking and life assurance. The

model stresses the importance of the interacting components, with successful change occurring as a result of an interaction between the content of the change (the what), the process (the how) and the context in which the change occurs.

This original model was refined and further developed in a subsequent large scale NHS study by Pettigrew, Ferlie and McKee (1992). This study identified factors associated with a higher rate of strategic service change by NHS organisations. The study involved eight health care organisations (four matched pairs e.g. facing similar agenda but seeking different outcomes).

Through this study Pettigrew, Ferlie and McKee (1992) were able to identify receptive and non receptive contexts for change which consisted of eight factors that influence receptivity and change in the NHS. These eight factors can be used by organisations to develop a structure which is able to support strategic change. The factors are:

Factor 1: Quality and coherence of policy

The quality of locally generated policy is important as it is often not appropriate to take “off the shelf” central policies because such policies may require adjustment to ensure they fit with the local context. In addition to this, there is a need to link strategic and operational policy by breaking down the proposed change into smaller actionable pieces thereby promoting successful implementation.

Factor 2: Availability of key people leading change

Successful change is dependent upon key people who can lead its implementation. Such leadership needs to be exercised in a subtle and pluralistic fashion rather than in a macho management fashion (Pettigrew et al, 1992). Such an approach will reduce the likelihood of resistance as it makes the change leader much more approachable and allows individuals to discuss concerns and make suggestions about how the ideas can be improved. Another key feature of change leadership is the requirement that the leader continues throughout the period of the change implementation to ensure the effective integration of the new idea into practice.

Factor 3: Long term environmental pressure

Pettigrew et al (1992) outline how studies from outside of the NHS have highlighted the significant role which increased environmental pressure can play in triggering radical change. However, the NHS is more complex and in some cases environmental pressure can restrict change. In particular, financial pressures have a negative influence causing delays, decline or collapse of morale, scapegoating and a perception of defeat.

Factor 4: A supportive organisational culture

It takes tremendous energy and commitment to achieve cultural change and although opinion leaders within an organisation can help to work towards successful cultural transformation the change only becomes fully integrated over a long time period. Receptive organisations exhibit flexible working across boundaries and have flat structures which are often specially designed for the purpose of market success. In addition, receptive organisations have a strong value base where employees share

similar values and work to a common sense of purpose. Within such organisations there is a culture of openness and risk taking to achieve the corporate aims.

Factor 5: Effective managerial / clinical relations

Pettigrew et al (1992) articulate how within the NHS good manager and clinician relationships were critical to successful change. The best relations occurred where the negative stereotypes held by both sides are broken down and where each side understands the others' drivers and values.

Factor 6: Co-operative interorganisational networks

Those organisations which had developed joint working relationships with social services and the voluntary sector were more successful at introducing certain changes which cross interagency barriers. One of the key findings was that in most cases the networks were established by individuals within organisations and as a result they were fragile and vulnerable to staff changes.

Factor 7: Simplicity and clarity of goals and priorities

Successful organisations narrow the change agenda and set key priorities instead of trying to change too many different things at the same time. It is also important that an organisation insulates the change they are trying to introduce from short term pressures. In addition, persistence and patience in the pursuit of the change objectives over a long period of time period are associated with achieving strategic change.

Factor 8: The fit between the change agenda and its locale

Within the NHS several factors associated with the locale impact on its ability to implement change. These factors include co-terminosity with the social service department, teaching hospital status, strength and nature of the local political culture and the nature of the local NHS workforce. While many of these factors are beyond the control of the organisation it is vitally important that the organisation is aware of the influence they may exert.

Pettigrew et al's (1992) eight factors provide a useful framework about the optimum NHS structure to encourage innovation. The key elements of this work relate to the development of a coherent strategy and ensuring congruence between this and operational attempts to implement innovations. Pettigrew et al's (1992) work also highlights the important role which the people leading change play in reducing resistance to the proposals and encouraging both adoption and a sense of ownership. The eight factor content, context and process model can be used by NHS organisations to assess their current structures so that changes can be made to improve the organisations readiness to adopt innovation.

The next section of the review will examine those studies which have looked at factors that influence the process of implementing practice developments and innovation.

□ Process studies

Process studies seek to identify factors which influence the implementation of practice developments or innovation. As already highlighted earlier in this chapter there has been less research which has examined the innovation process, however, a couple of longitudinal studies looking at health care development and innovation have been undertaken. Amongst these is the work of Pettigrew, McKee and Ferlie (1989) who undertook case study research to examine the introduction of change into the NHS in the post Griffiths era. The study took place after the introduction of general management principles into the NHS. Prior to this time Health Authorities were managed by a group of senior executives representing different disciplines. This form of consensus management was replaced by general management principles and the imposition of such an approach was perceived as a threat by many professionals. The study involved eight District Health Authorities and the cases studied were two strategic service changes in each Health Authority. Data collection involved in-depth interviews with key informants who either held lead positions in the organisation or were affected by the changes. Additionally, documentary and archive data were used together with observation records.

Several themes emerged and the most significant of these, in terms of the influence on the change process, was the fact that the ability to secure change is linked to the availability of key people within critical posts. As well as having key people in critical posts, it is important that there is continuity of these people so that long term direction can be maintained. This is essential in relation to the sustainability of the change in the longer term. Another theme was the importance of having a sense of

strategy which can be broken down into actionable pieces. Not surprisingly, given the changes that had occurred prior to the study, managing relationships with clinicians was thought to be vital to the introduction of change. Finally, it was important that the organisation took limited risks and circumvented bureaucratic impediments as well as introducing change which was sensitive to local and national contexts.

As already highlighted, the study by Pettigrew, McKee and Ferlie (1989) has a number of strengths, amongst which is the fact that it was one of very few process studies which related to change and innovation in UK healthcare. The study also identifies several factors which can influence the process of innovation. These factors include the important role played by champions and facilitators. In addition to these groups of key players, the researchers identify that the continuity of staff in support posts is important. Finally, another potentially significant finding is the suggestion that change is best managed when broken down into actionable pieces. However, while the study identifies several potential influences, it provides little information about how they influence an innovation and in what context.

While this study provides useful information about the introduction of organisation wide change, it is somewhat dated by the fact that it examines the impact of the Griffith's reforms which took place in the mid 1980s. This makes certain parts of the study redundant, for example, the concerns about relationships between managers and clinicians. This is no longer relevant in terms of the need to overcome sensitivities as most UK health trusts have moved to combined service management by clinicians and managers. As a result, the clinical director and lead nurse should be

equally involved in the planning and implementation of service development as the manager. Other potential limitations of the study include the fact that data were collected from only one English region. Finally, the statement that data were collected from people affected is rather vague and provides little insight into how subjects were selected. Despite this, the work of Pettigrew, McKee and Ferlie (1989) raises important issues about implementation of innovation particularly around the areas of involvement and sustainability.

Overall the study by Pettigrew, McKee and Ferlie (1989) suggests that case study methods, particularly where they include the use of in-depth interviews, is an appropriate method of conducting innovation process research. Again, the fact that it is difficult to identify in what context the identified influences affect an innovation strengthens the case for the use of a constructivist paradigm. This would provide relevant contextual information so that the reader can identify the potential for transfer of the findings to similar contexts.

Another study which explored the issue of ownership and involvement was that undertaken by Eve et al (1997) relating to lessons learned from introducing a framework for appropriate care related to cardio and cerebro-vascular disease in Sheffield. Little detail is given about the methodology used to collect data and the paper is written more as a reflective account of the process and outcomes of the project. However, the subsequent discussion paper does outline how the successful introduction of change can be facilitated where the team or person promoting the change has the trust and credibility in the eyes of those who are being asked to change. In addition, it is useful if the person can be seen as being independent from

other organisational agenda. This suggests that the use of internal change agents from within the service, which is commonplace throughout the NHS, may not be the best approach to achieving sustainable change. Eve et al (1997) go on to suggest that a number of processes can be employed to encourage participation and reduce resistance. These include the active translation of language and jargon between different cultures. This is especially important when implementing change across organisational boundaries, such as when developing intermediate care services which involve several agencies across health and social care. Furthermore, Eve et al (1997) suggest that change is best promoted on the basis of agreement, which can be achieved by addressing the concerns of different stakeholders and through active marketing. Eve et al (1997; 18) state that

“widespread change is most likely to occur when it has the support and endorsement of local coalitions of influential people”.

The importance of identifying opinion leaders when introducing a change or innovation has been articulated by Olivier (2001) who suggests that the influence which these individuals can exert on a change can be either positive or negative. Opinion leaders who support a proposed change can be used to sell the idea to their colleagues, while those opinion leaders who are negative about the proposals can be targeted individually either gradually to change their mind or to reduce their negative influence on the majority.

Ownership is a major area of concern for any organisation introducing innovation or developing practice. Without a sense of ownership, the proposed development is likely to be dependent upon one or two people. This can create a problem when the

leader leaves, as the development can stall or even cease to exist. Part of the problem with promoting ownership is that a development is often originated by a single practitioner who then needs to convince others of the merits of the proposal.

“Typically, attempts to give a sense of ownership have involved the promoters of a particular change convening meetings with those they wish to influence and encouraging them to express their opinion about the initiative’s acceptability” (Eve et al, 1997; 18).

The Facts Report (Eve et al, 1997) provides the following suggestions about how a sense of ownership can be developed. They suggest that the proposers should get a trusted and credible source to present the message while at the same time making sure the message is consistent with what people already know about the subject.

When presenting the message it is important that it is stressed that the proposal is a local initiative and it is shown how it might benefit participants. In addition to this initial approach, it is suggested that the project proposers need to keep people informed about the development by providing facts. This may be best achieved by using other forms than a discussion at a meeting, as this can quickly be hijacked by people who disagree with the proposals.

The study by Eve et al (1997) appears to involve the collection of case study data during the process of implementing chronic disease management for coronary heart disease within primary care. Again, this study supports the notion that case study methods are an appropriate approach for a study which examines the process of development. It is unclear whether the study is actually formal research or reflections upon the process of introducing the innovation. There is little information about the

methods used to collect data from key informants. Additionally, there is no information about the degree to which the people seeking to introduce the development experienced problems with ownership. Despite these limitations, the study suggests that ownership is a key influence during the process of development. The paper also goes beyond simply highlighting the influences, as it provides some advice on how issues such as ownership can be addressed. Finally, the study suggests that individuals involved in a development can be used as key informants providing a rich source of data about how factors can influence both the development and each other to produce an effect.

Much of the innovation research concentrates on the views of managers and has traditionally neglected the views of individuals at lower levels within an organisation. Sauer and Anderson (1992) undertook a study to redress this imbalance. They investigated the individual's perspective of the innovation process by using qualitative methods including interviews, observation and secondary data sources to examine a number of innovations within NHS hospitals. A total of two innovations was selected from each of the two hospitals included in the study. At each site an imposed innovation related to the changes brought about by the government White Paper "Working for Patients" (Department of Health, 1989b) was examined. The principal focus for the imposed innovation was how the organisations implemented the new financial framework to ensure cost effectiveness. Additionally, each organisation was able to identify another emergent innovation which they would like to include within the study.

Over a period of six months a series of 26 semi-structured interviews was carried out with a variety of respondents from senior managers to non-management staff, although a greater proportion of the respondents were managers. During the interviews participants were asked to name significant incidents which had occurred during the innovation process and to describe the impact that the innovation had had on their own work role.

The results indicated that out of 85 incidents cited during the interviews only ten were mentioned by two or more staff. This suggests that the majority of the incidents cited were unique to the individuals involved. Overall the change process related to developing financial accountability (related to the imposition of the White Paper – Department of Health, 1989b) was more complex than the emergent changes within the organisation. Additionally, in the emergent innovations, there was more positive participation in the process than there had been in the innovation which had been imposed on the organisation, and three factors are cited as playing a part in this: -

- Degree of involvement – establishment of a working group including staff from all levels for the emergent innovation
- Unavoidability – less involvement associated with the imposed innovation because it was presented as a fait accompli
- Expected impact – the emergent innovation had the advantage of being viewed in a positive light because of the benefits it could bring

The Sauer and Anderson (1992) study suggests that there are considerable differences in the perception of the innovation process between and within groups.

Involvement is critical to both successful implementation and the sustainability of the

innovation. The study has a number of strengths including the fact that it examines the process of innovation from two perspectives. Additionally, the longitudinal nature of the research provides insight into how perceptions can change as the innovation progresses. Finally, the use of critical incident reports during interviews allows for the identification of negative factors which can influence the process.

The study (Sauer and Anderson, 1992) has a number of methodological and other weaknesses. Firstly, the authors state that the study was undertaken to address an identified imbalance between the views of managers and lower level individuals within an organisation. The selected sample suggests that rather than the study addressing an identified imbalance, it actually builds on the body of knowledge which provides a greater management perception on innovation. The study sample consisted of ten top or middle managers compared with only four non managers. During the study participants were asked, during interviews, to recount significant events which had impacted on the process of introducing an innovation. Such an approach to data collection is likely to be affected by the time lag between the event / incident and the subsequent interview. In addition, trying to identify congruence between critical incidents assumes that all factors affect every individual in the same way. Finally, the cited result that out of 85 incidents identified only ten were described by two or more staff is questionable, not least because it is unclear about the scope of each of the innovations and how many people who were interviewed were actually involved in each incident. If the majority of the innovations were led by lone managers / practitioners, then it is likely that any event or incident impacting on the innovation may be experienced by only one person.

Sauer and Anderson's (1992) work supports the notion that case study methods are an appropriate way of examining factors which can influence the process of development. They also suggest that there is a need to select case study sites which are implementing both imposed (top down or policy driven) developments and local developments which originate from practice. The study also highlights that critical incident recording may be a suitable method of collecting data about factors which influence a development, although there is a need to address the inherent weakness associated with a time lag between the event and the data collection.

The final process study seeks to examine the influence of management style on innovation implementation. Knox and Irving (1997) studied how nurse managers perceived the support they received from the Executive Director of Nursing when introducing change. The study sample was drawn from one large 700 bed hospital which was undergoing a series of organisational changes. A total of 15 managers was asked to participate in the study. The study used a survey consisting of 10 statements relating to health care executive's behaviour drawn from the literature about innovation. Participants were asked to rate statements from 1-10 with 1 representing the most important aspect of support which executives could provide. An unidentified number of interviews was then held with participants to provide clarification and to collect other data. There is no information within the paper related to what types of data were collected and the paper simply describes the outcome of the ranking exercise. The results show that the managers involved in the study ranked the communication of plans by the executive as the most important contribution which could be made. This was followed by the executive being visible in practice areas, verbalising the organisation's commitment to quality and

commitment to staff respectively. Providing rewards for performance of staff and the empowerment of managers to assist them to deliver were ranked 5 and 6. The final categories were the opportunity to seek clarification, following up on queries, supporting problem solving and finally the presentation of information and education prior to implementation.

The study by Knox and Irving (1997) provides useful insight into how managers can support innovation and development. Additionally, it relates to UK healthcare and is fairly current. It has a number of limitations, including the fact that the sample was very small and it is impossible to identify how participants relate within the management structure to the executive. The lack of contextual information also means that it is not possible to identify how complex the organisational changes which the management team were attempting to introduce were. Additionally, the authors provide no information about the content of the interviews or the results obtained from the interview data. The use of predetermined categories devised using the literature provides little scope for the provision of additional information and it would have been useful to ascertain whether the subsequent interviews revealed any other categories.

Knox and Irvine's (1997) study does suggest that different management styles may have a positive or a negative influence during the implementation of a development. In addition, the study supports the use of survey methods as a way of identifying what people think are important factors during the implementation of an innovation or change.

One factor which was not identified during the literature review but was found to have a significant impact on the process of developing practice during this study was merger and transition. There has been little empirical work undertaken to study the effect of mergers within the UK NHS. Smith and Bowens (2000) undertook a review of the literature related to NHS and not for profit company mergers. They identified that mergers influenced finances, clinical quality, teaching research and organisational morale. The literature suggests that, despite the reason given for most mergers being a reduction in management costs and overheads, significant savings are rarely realised because of costs associated with the changed employment status of individuals affected by organisational change (Newchurch and Company Limited, 1997). Additionally, any savings related to changes in economies of scale assume that the pre-merger hospitals are operating efficiently. Where this is not the case, any savings are simply absorbed into running an organisation which has excess capacity. Earlier in this chapter the importance of organisational size in relation to the capacity for innovation and development was outlined. Essentially, the larger the organisation the greater the capacity for development because of organisational slack and a better developed infra-structure to support practice development activity. As a result, merged organisations often have more resources to develop a wider range of clinical services and to invest in capital programmes such as new diagnostic scanning equipment (Smith and Bowens, 2000). However, in some cases these benefits can be outweighed by the problems associated with the rationalisation of services and centralisation, which often occurs in merged organisations. This may result in reduced uptake of services by the local community because of the distances needed to travel to access such services.

Larger NHS organisations can also lead to improvements in the quality of care provided. Indeed NHS Trusts treating large volumes of patients have better outcomes in terms of mortality rates than those Trusts who perform certain treatments infrequently (NHS Centre for Reviews and Dissemination, 1995). Most important in terms of this study are the effects of merger on organisational morale. Smith and Bowens (2000) report that mergers have a destabilising effect on staff, preventing them from fully contributing to service reconfiguration and development.

McClenahan, Howard and MacKnight (1999) describe how, following a merger, organisational performance always suffers in the short term and that staff in the newly formed organisation have to learn to “live together” before progress can be made.

The review of the literature about NHS mergers reveals that there has been no work to examine directly the influence of merger on practice development or innovation within the NHS. A review of the literature about mergers in commercial companies also suggests that the influence of such acquisitions on innovation has been a neglected research area for some years. However, there is some suggestion that a merger has a negative impact on development and innovation in the commercial sector. Bridgeman (1996) suggests that innovation and development is dependent upon the maintenance of a competitive market and that mergers between the market leaders stifles the development of new products. Bridgeman (1996) cites the classical work of Schumpeter (1942) in which he argues that the main driver behind a commercial company investing in research and development is to gain a position of market power. He goes on to suggest that large firms which have market power are more likely to commit more resources to research and development. However,

Bridgeman (1996) disagrees because, although large firms have more resources to commit to development, by doing so they can bring about “creative destruction” where their own market position is destroyed and replaced with a new one. While the outcomes of commercial mergers cannot be directly compared with the outcomes of NHS mergers, there do appear to be some similarities in the influence of merger on development. In commercial organisations, development is reduced because of less competition and in the NHS development is reduced because of organisational transition and chaos. One can speculate that within the NHS the effect of merger on development activity may be short lived. It is not possible to provide answers to this within this study and further research work is needed within this area.

Within commercial organisations merger and acquisition are shown to reduce research, development and innovation (Skarzynski, 2000). There is no literature related to the effect of merger and acquisition on developments in progress during merger negotiations. One possible explanation as to why merger within NHS organisations affects practice development may lie within the influence of organisational cultures. Organisational culture represents a shared system of interrelated understandings shaped by members as a result of the history and expectations of the organisation (Pratt, 1998). When two or more organisations are brought together as a result of a merger the cultures of the organisations are likely to be different and this can result in culture clashes. McConnell (2000; 5) states

“Cultural change is always difficult, usually painful, and invariably much more involved and time-consuming than anyone expects. Following a merger it is necessary to create a blended culture, and doing so requires plenty of time”.

Cultural differences can result in conflicts and emotional problems which influence the way in which managers and employees react. As highlighted earlier, even within NHS mergers, there appears to be a dominant organisation and this can result in a sense of conquest amongst managers of the dominant organisation. Other managers may either conform to the new culture or shirk their responsibilities and demonstrate lower commitment to their given role (McConnell, 2000). Clashes of organisational culture are less common where the organisations share the same norms and values. Recently Veiga et al (2000) have developed an index for assessing cultural compatibility. The index uses 23 statements and 3 questions to identify how senior executives view the current organisational culture, how they perceive that things should be and how they perceive that things are in the acquiring firm. The index provides a perceived cultural compatibility index score and identifies where further work to integrate cultures may be required. To date, the tool has been tested in post merged commercial companies and has been found to be reliable across national contexts (Veiga et al, 2000). While the index may have potential in the business community in deciding whether a merger is worthy of consideration, it is unlikely that it could be used in the same way within the NHS as most mergers take place amongst neighbouring organisations. Such mergers would go ahead irrespective of whether the organisational cultures were compatible. However, the index could be used by organisations to identify those areas where organisations differ, so that efforts can be concentrated on developing a single culture for the newly merged organisation.

The process studies reviewed in this section have identified how opinion leaders, champions and facilitators can play an important role of developing the involvement of others and thus a sense of ownership of the development. Other studies have identified how staff continuity and the division of the change into actionable chunks both assist with implementation. In addition, it is suggested that management style can play a role in how a development is implemented, both in terms of support for staff and the articulation of a vision for how the change fits with the overall direction of the service. The process studies have also provided a considerable number of pointers towards the selection of an appropriate methodology. These include issues already identified, such as the need for the collection and articulation of relevant contextual data. In addition, the studies suggest that the process component of any study may use case study methods combined with in-depth interviews and critical incident technique to study how factors influence a development as it is being introduced into the practice setting. Finally, the study by Knox and Irvine (1997) appears to suggest that survey methods can be useful to collect data about which factors individuals perceive as influencing development and innovation.

Models of change which concentrate exclusively on the process of implementation tend to be based on the premise that the decision of what to change has been made by either the individuals involved or the organisation prior to work starting to implement the process. As a result, such models are often used to implement top down change within an organisation. There are several change methods and models which can be used to provide a useful framework of the introduction of change and innovation. It is beyond the scope of this review to examine each method or model in detail; instead this section will provide an overview of two of the most commonly

used approaches within the NHS, namely project management and organisational development (Iles and Sutherland, 2001).

Project management is one the most frequently used change implementation models. Despite the fact that project management is commonplace there is little published evidence related to its effectiveness at producing sustainable long term change within health care (Iles and Sutherland, 2001). Project management is defined by the British Standards Institute (2002) as

“planning, monitoring and control of all aspects of a project and the motivation of all those involved in it to achieve the projects objectives on time and to the specified cost, quality and performance”

Rosenau (1998) outlines how a project has four distinguishing characteristics which set it apart from more mainstream management activity. Firstly, all projects have objectives and some of these three dimensional, insomuch as they involve a performance specification element, a time schedule and a cost or resource element. Secondly, projects are unique either because they are performed only within a given context or with a group of people. Thirdly, projects are accomplished by resources e.g. equipment, people and in most cases only some of these are under the control of the project manager. The management of human resources and convincing people of the need for change is the single most challenging component of project based management. Finally, project management takes place in an organisation which has a multiplicity of other purposes. As a result, the project manager often has to compete within the organisation which is running different services to gain recognition for his / her project.

In addition to these characteristics, projects always have a clearly defined beginning and end point. This has important connotations as it assumes that change has an end point and, as a result, project management appears to reject the notion of incremental change which is adapted over a period of time.

The project management process involves a number of stages. The first stage involves identifying the purpose of the project and articulating this through clear goals which are both measurable and achievable. During this stage the project manager has responsibility for selling the idea to others and to engage their co-operation and reduce resistance. Once the goals have been set the project manager needs to define the scope of the project including identifying stakeholders and assessing risks.

The next stage involves the planning of the work programme or change ensuring that the change objectives are achieved within the specific timescale and within the available budget / resources. During the planning stage the project manager may use a number of tools including a Work Breakdown Structure, Milestone Plan or Gantt Chart to specify what needs to be achieved and by which date. In addition, these tools can be used to allocate responsibility for achieving objectives to individual employees.

Throughout the process of implementation the project manager and project team are involved in monitoring progress towards the stated objectives and project plan.

Deviation from the original project plan may require corrective action and additional resources may be required to get the project back on schedule.

Finally, completion and evaluation involves identifying whether the original project objectives have been achieved and what the benefits of change are. Completion also involves wrapping up loose ends, and most importantly for sustainability, embedding the change into the mainstream work of the organisation or team. Although the stages of project management are presented as a sequential and linear process, in practice the process often involves both an iterative process with one stage involving another and occasionally returning to the earlier stage to make amendments to the planning of a project.

While project management provides a clear framework for the implementation of a change or innovation as an approach it has a number of limitations. Firstly, it assumes that the decision about what to change has been taken by someone outside of the group who is expected to adopt it. This top down approach is likely to increase resistance and reduce the sense of ownership amongst the individuals effected by the change. The other significant limitation relates to the change having a clear end point. This suggests that once implementation is completed the new way of working is adopted and is capable of being sustained once the project manager moves on to another project.

Another frequently used method of introducing organisational change is organisational development. There are various definitions of organisational development although they all typically outline how organisational development is a

fusion between knowledge and organisational practice (King and Anderson, 1995).

Cummings and Worley (1993: 2) define how organisational development is

“a system wide application of behavioural science knowledge to planned development and reinforcement of organisational strategies, structures and processes for improving an organisation’s effectiveness”

Organisational development incorporates a number of key activities and assumptions these include:

Planned intervention: including the diagnosis of the need to change and prediction of the final outcomes

Organisation wide programmes: although some aspects of an organisation development intervention will focus on specific departments or teams the main focus of development is organisation wide

Knowledge based action: interventions are drawn from the behavioural sciences and are based upon assisting individuals to change while at the same time developing their knowledge and skills to deliver this change

Pragmatic improvement of organisational capabilities: organisational development aims to enhance both efficiency and performance

The classical approach to the organisational development process is based upon the force field model (Lewin, 1951). This involves an analysis of the driving and restraining forces prior to any attempts to introduce a change. Huse (1980) proposes a seven stage model of organisational development which is managed by an external consultant. The first stage involves scouting where the external consultant identifies

and explores the need to change. During this and the subsequent entry stage the external consultant and the organisation negotiate the consultants remit, role and contract. Following this, a diagnostic phase commences where the consultant works with individuals and teams within the organisation to diagnose the underlying problem and to outline a preliminary set of interventions to remedy the problem. The planning phase involves the organisation agreeing to a series of interventions and a proposed timescale for implementation. In addition, potential and actual sources of resistance are identified and actions put in place to lessen the impact these have on the proposed changes. As the project moves into the action stage the proposed interventions commence either as multiple strands or as several shorter actions which are linked together as part of a coherent programme. The final two stages involve stabilising the change and terminating the relationship between the external consultant and the organisation. Stabilisation and evaluation involves attempts to make the new way of working or the change part of the everyday action. Following stabilisation the outcomes of the change can be measured and the process of implementation evaluated. Finally, the external consultant terminates his / her relationship with the organisation or team and moves on to another project.

As a process, organisational development is very dependent upon the front end diagnostic phase. Unless this phase is done in a comprehensive way to identify all of the factors which influence the problem then it is unlikely that the proposed change will produce the desired results. Similarly, the process of organisational development is presented as very neat and linear and this suggests that introducing change can be simply achieved following a cook book approach. For example, the process outlines how it is important to identify stakeholders but provides little advice about what to

do if the stakeholders object to the proposals and wish to maintain the status quo. Another weakness of organisational development as a method of introducing organisational change is that it assumes that organisations will make changes and then have a period of stability. Within the NHS the pace of change often means that change is continual throughout the organisation and that several changes may be competing with each other.

Both project management and organisational development outline the process of implementing specific or organisation wide changes. While the models provide information about what needs to be done at each stage of the process they provide little insight into factors which can affect the process of change. In common with most change theories they assume the process is linear and uni-directional and this can serve to confuse practitioners involved in complex “stop start” change where returning to earlier stages to reclarify goals is often helpful in achieving success.

□ Combined antecedent and process studies

King and Anderson (1995) suggest that, of all the research examining factors influencing innovation, studies which combine an antecedent and process approach are less common. This is surprising, given the commonality already identified between several of the antecedent and process factors, such as management style, which acts both to facilitate the adoption of innovation and to implement specific developments. West and Wallace (1991) conducted research which sought to examine both antecedent and process factors. Using Primary Health Care Teams (PHCT) as the work group for the study, they aimed to assess the extent to which

variables cited in the literature as being characteristic of innovative groups are indeed so. Several variables were identified, including climate, team collaboration, leadership style, participation, cohesion, organisational commitment, feedback, discretion and role autonomy. The researchers initially selected 14 GP practices and grouped these as either traditional (n=6) or innovative (n=8), although there is no mention of the criteria for the grouping of these practices. When approached six practices declined to participate and questionnaires were sent to the remaining eight practices (n=60 participants).

A total of 43 questionnaires was returned, giving a 72% response rate. A wide spectrum of occupational roles was sampled ranging from 12 GPs to one housekeeper (sample size per practice 3-8 with a median of 5). This wide spectrum meant that it was not possible to compare perceptions across occupations because of the low representation of some occupational groups. The results suggest that GPs have less role ambiguity than health visitors do. Additionally, the GPs were more aware of how they were doing their job than health visitors were. There was a significant positive relationship between practice innovativeness and team collaboration, peer leadership, group cohesiveness, participation in decision making, commitment and team climate. No relationship was identified between individual role factors and innovation. Of all of the variables, climate, commitment and collaboration were best at discriminating the innovative from the traditional teams. The most frequently cited innovations were screening services and chronic disease management and this raises the issue of contextual influences. Around the time of the study general practices were encouraged to develop many of these services and the introduction of them was tied in with the GP contract and therefore associated with

an incentive scheme. These and similar drivers are not identified or discussed by West and Wallace (1991).

The study by West and Wallace (1991) supports the notion that a development or innovation need not be totally new, as long as it is new to the unit of adoption. This notion was outlined in the previous chapter (chapter 2) during the discussion related to the similarities between innovation and practice development. The study outlines how team climate and collaborative working are possible positive influences on the adoption of an innovation. However, some of the findings of the study are questionable, not least the attempts to estimate the level of role ambiguity between professionals (notably health visitors and GPs). West and Wallace (1991) state that the wide spectrum of respondents meant that it was not possible to compare perceptions across groups but, at the same time, suggest that health visitors have greater role ambiguity than GPs. This statement is made despite the fact that the study included 12 general practitioners and only 2 health visitors. Another limitation is that it is not possible for the reader to identify which of the factors identified function as antecedents and which facilitate or hinder the process. This is partly related to the dearth of contextual information about the developments being studied and how the factors influence these.

Mason et al (1991) use a combined antecedent and process approach to study the influence of empowerment of individual practitioners on innovativeness. Mason et al, (1991; 5) believe that

“most healthcare institutions are highly complex organisations where change does not come easily. Many nurses have been frustrated in their attempts to

bring about changes that would improve and facilitate their every day practice. It cannot be assumed that nurses have the confidence or skills to make changes in politically astute, effective ways”.

Mason et al (1991) undertook an evaluation of a two day educational programme designed to empower nurses to introduce work place change. A total of 59 nurses participated in the programme. Evaluations were completed at the end of the course (n = 50) and the majority of participants felt that the course had provided them with skills to enable them to instigate or cope with organisational change. A follow up questionnaire was sent to participants seven months after the programme. A total of 55 surveys was sent out and 33 (60%) were returned. The results suggested that 32 out of the 33 respondents felt that the programme had increased both their power base and their networking activity. Over half of the respondents had subsequently entered into a mentoring relationship. Only three of the respondents (9%) reported that they had instigated no change since the programme. Several reasons were cited for this, including a lack of strategic planning within their organisation and the fact that they worked in a largely reactive organisational culture. Despite the fact that practitioners may feel empowered, the organisational factors may still mitigate against the introduction of innovation. Manion (1993; 41) states

“not all individuals who are empowered in their daily practice accept responsibility for innovation. In some cases, the individual may not have the specific skills needed, or the traditional, bureaucratic system they are in has too many barriers to innovation”

Other reasons for not initiating innovation cited by respondents included poor planning, economic constraints and a lack of support within the organisation. With regard to the respondents who had introduced change, the changes could be classified as those relating to systems of working, for example no smoking policies, appraisal and those centred around educational provision.

The Mason et al (1991) study is particularly strong because it not only examines the process of innovation from initiation to implementation but it also identifies some negative influences related to why people feel they are unable to initiate change. Like many other studies, the lack of contextual information about the length of time the individuals had been qualified and their current job level raises concerns about whether empowerment is the only positive influence or whether this combines with other factors to produce an effect. Additionally, there is no information about the type of organisations in which the participants work or about the content of the educational programme which they undertook.

Despite the limitations, the study (Mason et al, 1991) suggests that empowerment may act as a positive factor during both the initiation of the innovation and the subsequent implementation. Although the study deals with a single factor, it does strengthen the earlier argument that several factors influence at more than one level both during initiation and implementation.

This section has reviewed two studies which seek to combine both antecedent and process research approaches. Both studies identify fewer factors than those which concentrate on a single approach, although new factors related to collaboration

between team members and empowerment are identified. It is contended and accepted that research looking at positive and negative influences on the development of practice needs to take a combined approach. There are many reasons for this, including the fact that several factors serve as antecedents and also exert influence during the implementation phase. In addition, a combined approach should allow the researcher to examine how antecedents influence the initiation of a development. All too often the antecedent studies suggest factors which make an organisation more likely to adopt an innovation but they fail to provide information on how the factors identified interact to produce an innovation. Simply because an organisation has a structure which may promote innovation does not mean that the organisation will adopt innovation. This is illustrated in the next section in the study by Nystrom (1990) who found that the most innovative division of a large chemical company was not necessarily the one which appeared to have the best culture, climate and antecedent factors.

Several models of implementing change which combine an antecedent and process element exist. Many of these are used within the NHS as part of quality and service improvement programmes. Two of the approaches, Business Process Reengineering (BPR) and Breakthrough Models will be discussed here. Business Process Reengineering is defined as “the critical analysis and radical redesign of existing business processes to achieve breakthrough improvements in performance measures” (Malhotra, 1998). As an approach BPR originates from Total Quality Management and while broadly similar they differ inasmuch as Total Quality Management focuses on incremental change and gradual improvement of processes and services while BPR tends to go for “big bang” change which can involve radical redesign of

processes. Additionally, BPR suggests that organisations should be organised around key processes rather than specialist functions and also assumes that change is proposed unequivocally from top management.

Porter (1980) identified five forces which may influence either the desire to change a business process or may affect the process of Business Process Reengineering. The first factor is the degree of rivalry amongst suppliers or organisations. The greater the perceived competition between suppliers the more likely an organisation is to change its business processes to maintain its competitive advantage. Another factor closely related to this is the bargaining power of the purchasers who, because of the market, may choose to take their business to another supplier. These factors together with the potential threat from new suppliers and the potential for customers to substitute one product for another can act as triggers for Business Process Reengineering. Within health care in the UK these factors exert less influence although some market principles still apply. For example, service commissioners use their purchasing power to promote changes to services although the possibility of substituting services is unlikely in some areas because of the availability of other NHS providers etc.

Davenport and Short (1990) suggest a five stage model of BPR. The first stage involves the development of a vision and process objectives; this vision should then drive the redesign of services. The next stage involves the identification of the processes to be redesigned. While this sounds relatively straightforward it can in practice be quite complicated because most organisations are not formed around processes but around departments. Davenport and Short (1990) outline how there are two approaches to identifying process which may require redesign. The first, called

the high impact approach, involves focusing upon the most important processes in terms of the end product or the customer. The other method is to use an exhaustive approach which involves looking at all processes within an organisation and prioritising them in order of redesign urgency. Once the process to be redesigned has been selected work can commence to develop an understanding of the existing process. This involves benchmarking how the current process operates, thus providing a baseline for the measurement of future improvement. Following this phase a plan related to which elements of the process need to change and what changes are needed is developed and then implemented. Once the new process is operational and embedded into the work of the organisation, the processes performance can be re-examined to ensure that it has improved. If the desired improvement has not been achieved then a further examination of the process will be required.

Newman (1997) reports on the use of BPR to change the nature of pathology service provision to an out-patients department in a UK Hospital. While the methods employed produced the desired outcome it did raise a number of issues. These issues centred on the radical and revolutionary nature of the change methods employed. In practice the hospital achieved organisational change through an evolutionary process. In addition, it was often difficult to identify the processes and separate these out from other activity. This can be partly explained by the fact that health care is differentiated into specialisms and support departments rather than around specific processes or functions. For example, while pathology is responsible for processing blood results the process of taking the blood, getting it to the laboratory, testing it

and delivering the results is dependent upon a large number of people managed by different managers.

Iles and Sutherland (2001) report how the techniques of reengineering have been applied in other ways within NHS organisations. The National Collaboratives within England aim to implement change through an improvement science model. Kerr et al (2002) describes how the key components of this model which is also known as a breakthrough approach include a flexible system for testing, adapting and implementing change, the clear identification of best practice, a series of plan-do-study-act cycles and shared learning between project teams. The introduction of change within this process is dependent upon the plan-do-study-act cycles. The first stage of this process involves the testing and prediction of outcomes. In practice this involves examining the clinical problem to be addressed and predicting the level of improvement which can be achieved using baseline data related to the incidence of the problem. The “do” stage involves testing the plan and collecting some initial data. Following on from this, the results of the testing stage are compared with the initial predictions to see if the anticipated outcome can be achieved. Finally, if the testing has been successful the project can move to full scale action to achieve wider quality improvement across the organisation.

Business Process Reengineering and associated approaches of quality improvement can be useful when implementing quality related changes. Such approaches assume that issues can be addressed by examining the processes within an organisation which are designed to deliver care. While Business Process Reengineering is useful in many organisations within the field of health care, problems can occur because

service delivery is rarely organised around processes. As a result the process of sending a patient an out-patient appointment involves several separate services including Administration, Information Management and Postal Services. Each of these services may have a separate set of processes to manage the service they deliver.

□ Using change theories in the development of practice

Lancaster (1999) describes how most types of change can be divided into two broad categories, planned and unplanned. Planned change involves the intentional and deliberate introduction of a new idea. Unplanned change on the other hand, is the introduction of a new idea or way of working without any preparation. Such change may be either haphazard change or spontaneous, for example a reaction to an event, incident or complaint.

Carson (1999) describes how there are numerous theories of planned change, but all of these involve four key stages. These stages are the recognition of, either the innovation or the unmet need, implementation of the innovation, and finally, consolidation and evaluation. While change theories can provide a clear framework for practitioners and managers introducing developments into practice there is a dearth of literature about their use and effectiveness within health care. The literature which does exist tends to concentrate on anecdotal accounts of how changes were planned and implemented. Despite this limitation three change theories will be examined in detail in this section and links made between the change theory and the literature reviewed earlier in this chapter.

Field Theory

One of the earliest writers about change theory is Lewin (1951) who developed field theory, which is essentially a way of describing a here and now situation, in which an individual participates (De Rivera, 1976). The notion of field theory, in relation to change, is important, because, as the field or situation changes, the change agent will need to alter his or her approach accordingly. As such, the field is not static, but changes over time, and is influenced by internal and external forces. These influences, which consist of both driving and restraining forces, can be considered as a force field. In situations where the driving forces are greater than the restraining forces, change can be implemented. Careful assessment of the factors which may drive or hinder the implementation of change is vitally important if the proposal is to be successful.

Lewin (1958) later went on to explore individual and group relationships when introducing change. Lewin (1958) postulated that groups don't make conscious decisions about a proposed change, rather individuals, within the group, make decisions, after a group discussion. Therefore, it is possible to gain approval for a proposed change, by influencing a number of key individuals within a group. Many practitioners, who have introduced change into community or practice teams, will have already realised that discussions with key individuals, prior to a large group presentation, can smooth the introduction of a new way of working. Similarly, if presenting to a group of managers, it is often useful to discuss your proposal with one or two members of the group. This will enable people to champion your cause

during the meeting and subsequent discussion. Lewin (1951) described how ideas about change, travel in channels through a social system. These ideas do not automatically enter or move through channels by themselves, and often, they need someone to drive them forward. Within any social system or organisation, there are points of entry for new ideas. Gatekeepers, such as team leaders and managers usually control these entry points. The rate, at which communication about a new idea travels through a social system, can be influenced by these gatekeepers, who can speed up or impede the progress of a new idea.

Lewin also described the sequence of strategies designed to bring about change. Within most changes permanency and sustainability are the desired outcomes. In some cases contextual and organisational factors negate against this, for example, fixed term funding. The problematic nature of achieving permanency represents a challenge to Lewin's (1951) theory as refreezing may only be partly possible. Lewin (1951) describes how the first phase in the change process involves a shaking up of the status quo, which Lewin described as unfreezing. Unfreezing involves increasing the motivation of the participants in preparation for the change. This stage also involves identifying and articulating the need for change. Lancaster and Lancaster (1983) identify that credibility and mutual trust are essential characteristics for the change agent during this part of the process. The second stage, "moving to a new level", involves the participants accepting the need for change, and collaborating to produce an action plan for the implementation of the new way of working. The final stage "refreezing" involves the new way of working being integrated into the participant's culture and pattern of working.

Lewin's (1951) work is useful inasmuch as it articulates the part played by contextual, individual and organisational factors on the implementation and sustainability of change. The theory also articulates how opinion leaders and champions can assist with the implementation of change within practice.

While the theory is useful it is also open to criticism on a number of fronts. Principal amongst these is the linear nature in which the process of change is presented. The theory appears to suggest that organisational and contextual influences only exert their influence during the unfreezing stage of the model. Clearly this force field of influences can effect change at all of its stages and as a result a continuous process of force field analysis is required so that the change process can be adapted and altered during implementation. As highlighted earlier, to what extent refreezing is possible in every case is questionable given issues around sustainability and during periods of continuous change within an organisation.

Diffusion Theory

Diffusion theory (Rogers, 1995) focuses upon both diffusion (dissemination) and adoption (acceptance) of innovations. Rogers (1995) describes how individuals do not make an instantaneous decision about an innovation, but rather, decisions are made over a period of time. He described five stages to the process of decision making about an innovation or idea. While each of the stages is sequential in nature in practice many of them overlap.

Knowledge stage

During the knowledge stage the individuals involved in the change become aware of the existence of an innovation or new way of working, and understanding how the innovation works in practice. Becoming aware of an innovation can happen in a number of different ways. This can include individuals being involved in a network, attendance at a conference or contact with peers. In addition, personal interest and existing attitudes play a role in seeking information about and the subsequent adoption of innovation. Rogers referred to this as selective exposure. Finally, perception of a need for a change is another important bearing upon whether an individual will be receptive to communication. Rogers (1995) described three types of knowledge; awareness, how to, and principles knowledge. Of these, change agents tend to concentrate on awareness knowledge, but greater emphasis needs to be placed upon “how to knowledge” because this is the essential information, which practitioners need to be able to try out the innovation, before full adoption.

Persuasion stage

The persuasion stage is concerned with the formulation of feelings and attitudes towards an innovation amongst the people involved in the proposed change. Rogers (1995) assert that an individual's perception of an innovation can be shaped by the characteristics which the innovation possesses. Rogers and Shoemaker (1971) have identified five essential characteristics a change should have, if it is to be successful:

- Relative Advantage

The degree to which the new idea is considered superior to the old way of doing things.

- Compatibility

How different is the new way of doing things? Major changes may require to be introduced slowly, because of the need to change behaviour, attitudes and organisational culture. To assist in the formulation of an attitude towards an innovation the individual may mentally apply the new idea to his or her own particular situation.

- Complexity

How difficult is the new way of doing things? Refusal to adopt the new way of working may be a way of avoiding admitting that we don't understand.

- Trialability

Can the idea be tried out on a small scale? Trialing an idea often demonstrates its usefulness to participants.

- Observability

Can we tell if anything has changed?

Even if the individuals have positive feelings towards the proposed innovation it does not automatically follow that the innovation will be adopted. Rogers (1995) identified that several factors can support adoptive behaviour in these circumstances, these include contact with a peer who has adopted the same or a similar innovation or feedback from an initial pilot.

Decision stage

This stage involves each individual either adopting or rejecting the proposed innovation. During this stage individuals may be anxious about the potential consequences of the proposed change. Rogers (1995) suggests that anxiety can be reduced by providing feedback from small scale trial or pilots of the innovation. Individuals involved in these trials or demonstrations, can be very effective at encouraging adoption, especially if they are credible, respected or leaders. Often the identification of such opinion leaders can be a crucial part of successful marketing of the proposed innovation to colleagues. It is important to remember that rejection of the new idea is also possible at this stage. Such rejection can be either active, which involves the individual considering and even trialing the idea before rejecting it, and passive rejection, which involves either not really considering the idea, or simply forgetting about the initial communication of the idea.

Implementation stage

At this stage the idea or new way of working is put into use. It is, at this stage, that previously unforeseen problems can occur, and the change agent plays a pivotal role in troubleshooting and providing technical assistance. The implementation stage may continue for a long period of time. This may occur as a result of the change agent working to integrate the new idea into the organisation or team's everyday work. Rogers (1995) describes how re-invention can occur during implementation. This is where the individual changes the original innovation to fit their own circumstances.

Whether this re-invention is considered good or bad, depends upon the individual's viewpoint. From the perspective of the adopter, re-invention is beneficial because it can reduce the complexity of the innovation and increase compatibility with current practice. However, organisations are often reluctant to allow re-invention, because it can cause problems with outcome measurement and evaluation.

Confirmation stage

During the confirmation stage, an individual seeks reinforcement about the decision made. This can be either reinforcement that the decision to adopt was right, and it subsequently produced the right outcomes, or that the decision to reject the innovation was right. If the individual is uncomfortable about the decision that he or she made, they will be motivated to do something about it. It is possible at this stage for a person, who had adopted the innovation, to decide to abandon or significantly alter it, or alternatively a person, who had previously rejected an innovation, to decide to adopt it after all.

Rogers (1995) work supports the view articulated within the concept analysis that a key antecedent to practice development is awareness or knowledge of a better way of working or that something needs to change. Diffusion theory suggests a number of factors which may positively influence the adoption of an innovation and amongst these are the five characteristics identified by Rogers and Shoemaker (1971). These characteristics could be used as a checklist against which a change agent could judge the degree to which the proposed innovation is likely to encounter resistance from the change participants. In addition, Rogers (1995) also identifies the role played by

peers and opinion leaders in encouraging adoption behaviour amongst other individuals within the organisation. Another interesting feature of Rogers (1995) theory is that implementation often takes place over a long period of time. This feature is often forgotten within health care innovation although it is designed to improve sustainability. All too often within health care the change agent moves on to another project, and as a result, the sustainability of the change is affected because it had not been given time to become embedded into the culture of the organisation.

Lippitt's Theory of Change

Lippitt's theory (Lippitt, 1973) relates to the facilitation of change within an organisation by an external change agent. The process has seven stages, these are:

Stage 1 Diagnosis of the problem

The first stage of the change process should involve the identification of the issue to be addressed. The process of problem identification should involve the systematic collection and analysis of data, rather than be based solely on a hunch. During this stage, it is helpful if the change agent is able to encourage discussion, and invite suggestions on the way forward, from the people who will be affected by the subsequent change. At the same time key stakeholders are identified and initial discussions take place about both the issue and the potential solutions.

Stage 2 Assessment of motivation and capacity for change

During this stage the people involved in the change and the environment in which the change will take place are assessed to identify resources, constraints, change

supporters and potential facilitators. Using the information gained from the assessment, the change agent should be able to draw up a list of possible solutions to the problem, and appraise the available options. While an assessment of motivation and capacity for change is an important stage, it is often poorly managed in the health service. Changes are often introduced with little regard for either workload or physical resources, such as space. Clarke (1998) describes how nurses are often required to develop their practice while at the same time, continue to deliver the services they have always provided. There appears to be little understanding about the capacity of teams to develop, and many teams are encouraged to continue with innovations, rather than consolidate already established developments.

Stage 3 Assessment of change agent's motivation and capacity for change

This stage involves an analysis of both the change agents credibility as well as the make up of the implementation team. It is important that any deficits in the knowledge and skills of the change agent are compensated for by members of the wider implementation team.

Stage 4 Selection of progressive change objectives

The planning stage involves the identification of sequential change objectives which eventually build up to the full implementation of the idea or new way of working. These change objectives, which are usually time bound, may be divided amongst members of the wider implementation team.

Stage 5 Choosing the appropriate role for the change agent

Lippitt (1973) identifies three roles which the change agent could adopt. These are expert role model, catalyst teacher and group leader. A change agent who is experienced in the field in which the change is being made, may be able to take on an expert role. However, if the change agent is external to the organisation, he or she would need to be widely recognised as an expert or leader in the field, to maintain credibility within the organisation. A catalyst teacher role would involve the change agent working to keep the change on track, and would utilise the experience, skills and knowledge of the participants. Finally, a group leader role could be used if the proposed change had an identified steering group, which had been charged with leading the change. The use of such a group is common when introducing large scale or organisational change. Whatever role the change agent has, it is important that both managers and the participants in the change, have similar expectations of that person.

Stage 6 Maintenance of the change

Once the change has been implemented, interest and enthusiasm may wane and practitioners may lapse into their old behaviour, thus affecting the sustainability of the new way of working or idea. The change agent can encourage continued participation, by having regular contact and discussion with the participants.

Stage 7 Termination of the helping relationship

Finally, the change agent gradually withdraws from the organisation or moves on to another project. It is important that ongoing responsibilities, related to the monitoring

and maintenance of the change, are handed over to other people to ensure the sustainability of the change.

Lippitt's theory (1973) is similar to Organisational Development because it emphasises the role of an external change agent and starts with a diagnostic phase to assist in the identification of what needs to be changed. However, Lippitt's theory (1973) differs from Organisational Development because it can be used to implement a change within a specific team rather than having an organisation wide focus. The theory also fails to take into account permanency and sustainability issues associated with having an external change agent who at the end of the change implementation moves on to another project or another organisation. Several studies reviewed in this chapter have concluded that leader dependency and problems with ownership can have a significant influence on whether any change implemented continues over a longer time period.

□ The influence of culture and climate

The social environment of an organisation is sometimes referred to as its culture.

According to Cummings and Huse (1989; 421) organisational culture is

“the pattern of basic assumptions, values, norms and artefacts shared by the organisation's members.... These elements are generally taken for granted and serve to guide members' perceptions, thoughts and actions”.

The culture of an organisation is created not only by the organisational members but also by its leaders. Indeed, Schein (1985) articulates how the creation, management and eventual destruction of an organisation's culture is the only thing of real importance which a leader does. As highlighted earlier in this chapter, organisational culture and climate is thought to play a role in encouraging practice development and innovation as well as facilitating or hindering the implementation of changes in practice. There is a large body of literature related to organisational culture and innovation, although much of it is not directly relevant to health care or nursing. For the purpose of this review a general overview of models of organisational culture will be briefly presented. This will be followed by a review of the specific literature which has examined the effect of culture on innovation within health care.

Approaches to organisational culture can be either structural or interpretative (Wilson, 1992). Structural models focus on the link between culture and structure. One of the main structural models is typology, developed by Handy (1993), in which he identifies four types of organisational culture comprising power culture, role culture, task culture and person culture.

Power culture

In a power culture there is a central power source, often the person who established the organisation. Cultures of this type are frequently found in small entrepreneurial organisations, where the central power source has selected like-minded people to work with. These individuals generally share the founder's values and the organisation exists on trust and empathy as there are few rules or procedures and little or no bureaucracy. The key features of this type of culture are that they react

well to challenges and that the organisation itself is strong and proud with a high level of self belief. Individuals employed within a power culture often prosper and they tend to be calculated risk takers who are very politically astute. One of the problems with this type of culture is that it is best suited to smaller organisations as larger organisations tend to be more difficult to control from a central source. Within power cultures innovation is facilitated when the organisation is small but, as it grows, innovation is less likely as the individual employees look to the centre for a lead.

Role culture

Role cultures are often referred to as bureaucracies. Cultures of this type are often strongly differentiated into departments, functions or specialities and the work of the individuals within them is controlled by procedures and role definitions. The main source of power within a role culture is related to a person's position and a narrow band of senior managers who co-ordinate the work of the organisation. Other forms of power, such as expert power, are tolerated if it is used in its proper place. Role cultures flourish in stable environments but are slow to change and this can be frustrating for individuals who want to forge ahead to develop. King and Anderson (1995) describe how role cultures are not effective at encouraging innovation because of their emphasis on environmental stability.

Task cultures

Task cultures are also referred to as matrix organisations and are often job or project orientated. The emphasis within such cultures is on getting the job done and, as such, people with the right skills are sought to achieve the goals of the organisation. The

source of power within a task culture is expertise and, as a result, it is not vested in one individual. Task cultures have been popularised by management writers including Peters and Waterman (1982) who used task culture as the basis of their excellence model. The excellence model espouses several of the values of a task culture, including their bias for action, hands on and value driven climate and the notion of productivity through people. However, the work of Peters and Waterman (1982) has been subject to considerable critical debate, not least because the writers provide little information on the methods used to identify the attributes of innovative companies. The work relies heavily upon reports from the Chief Executive Officers and Guest (1992) questions whether these people are the most appropriate to report the reality of what goes on within the organisation. Additionally, there is little acknowledgement that success is dependent upon other factors and the context in which the company operates. Several of the leading companies cited by Peters and Waterman (1982) have subsequently become less innovative and have failed to maintain their market position. Despite the criticisms, the work has been widely accepted within management and Guest (1992) questions whether this is because the work was timely and valid or simply perceived by managers as being valid.

Task cultures can experience problems as occasionally teams compete for resources and power and, as a result, they can be difficult to control. Such cultures are not large scale but can sometimes be found as single departments within a larger organisation. Despite the potential problems, task cultures are the most innovative, although this is very dependent upon the circumstances in which the culture operates.

Person cultures

Person cultures are rare although several of their values can be found within hybrid cultures. Individuals form the centre of the organisation and its culture and structure therefore serve to assist the individuals within it. A common feature of a person culture is that individuals band together but pursue their own interests. This can create problems and some of these stem from the requirement to manage the organisation by consensus. The most common form of person culture is a professional practice, for example Law Practice or General Practitioner Medical Practice. Often within a person culture the individual is creative and innovative rather than the organisation.

One study which has attempted to describe how different organisational cultures influence innovation in health care is that undertaken by West and Anderson (1992). They studied innovation and organisational culture within the management teams of 27 UK hospitals drawn from three regions. The study sought not only to ascertain the content of the innovations but also to examine what they tell us about the culture and climate of UK NHS hospitals.

Data were collected using several methods including a survey of team climate (using the Team Climate Inventory), minutes of meetings and monthly returns relating to innovations in progress. Out of the 27 sites, 10 were selected for more intensive study and they had all of their management meetings recorded on tape.

The results revealed that there were 184 innovations across the 27 hospitals with a range of between 3 and 25 innovations in each hospital. The innovations were

categorised into administrative and technological. There were 131 administrative innovations during the study and 53 classed as technological.

The data were analysed by two researchers working independently to identify the cultural value which each innovation represented. The descriptions of organisational culture developed by Quinn and Spreitzer (1991) were used for the categorisation.

The four categories of culture are outlined in Table 3.4

Table 3.4: Categorisation of organisational culture (Quinn and Spreitzer, 1991)

<p>Rational culture (<i>task culture</i>)</p> <p>The organisation is a very production orientated place where people are concerned with getting the job done. There is an emphasis on the accomplishment of tasks and achieving goals.</p>	<p>Hierarchical culture (<i>role culture</i>)</p> <p>The organisation is a formal and structured place with emphasis on formal rules and policies. The organisation emphasises permanence and stability.</p>
<p>Developmental culture (<i>power culture</i>)</p> <p>The organisation is a very dynamic and entrepreneurial place with people willing to take risks to develop new products. The organisation has high commitment to innovation and development and there is a desire to be first with new products or services.</p>	<p>Group culture (<i>person culture</i>)</p> <p>The organisation is a very personal place and people share a lot of themselves. There is an emphasis on loyalty and tradition with high levels of commitment. There is an emphasis on human resources and morale is considered very important.</p>

- Additional labels in brackets added by author. These relate to the typology developed by Handy (1993)

Each culture category was assigned a total innovation score based upon the dimensions of magnitude, radicalness, novelty, patient care, staff wellbeing and administrative effectiveness of each innovation assigned to the category. The results show that rationale cultures produced more innovations (score 1004.5), followed by

developmental cultures (score 754.6) and hierarchical cultures (736.3), with group cultures showing the lowest innovation score (193.7). The innovations assigned to the radical culture consisted of income generation, cost cutting, quality control and those related to the White Paper (Department of Health, 1989b). Many of these innovations are the result of “must does” from policy and, as a result, a culture which centres around getting the job done will be most effective at delivering such top down innovations. Within the hierarchical culture, the developments were largely related to human resource management and administrative innovations. A culture which emphasises control through policies and procedures is likely to concentrate on such innovations. Innovations assigned to the developmental culture category were largely those relating to improving patient care and developing new services for patients. Interestingly, the innovations assigned to developmental and group cultures were identified as being more innovative in terms of magnitude, novelty and radicalness, although they were smaller in number than other forms of innovation. Overall, the researchers found that the predominant culture in UK hospitals at the time was radical or hierarchical.

West and Anderson’s (1992) work identifies how an organisation can have more than one culture and how certain types of culture are more appropriate for the introduction of particular types of innovation. West and Anderson (1992) also suggest that the predominant culture within the UK hospitals was either rationale or hierarchical.

Although the study by West and Anderson (1992) purports to study the culture in UK hospitals, the sample used does not accurately reflect the UK as it relies upon two English regions and does not include hospitals from other countries. The suggestion

that the predominant culture in UK hospitals was radical or hierarchical may reflect the methods used to identify the innovations in progress. These methods assume that only managers are involved in innovation and that practitioners would not be introducing new ways of working. Given that the study concentrates on a top down management led innovation agenda, it is hardly surprising that the predominant culture is described as hierarchical. Finally, another limitation with the study is that it does not consider the influence of the context in which the innovations occurred. Many of the innovations studied will have been driven by government policy and decisions around their introduction would have been beyond the local hospital management team's jurisdiction although the team would have been able, to some degree, to decide the method of implementation. Furthermore, the methods selected to assign an innovativeness score are a little suspect as they rely upon retrospective analysis of secondary data and there is no evidence of member checking in order to improve the reliability of this phase of the data analysis.

The study does provide empirical evidence which supports the typology developed by Handy (1993) and it suggests that culture does not exist in isolation but rather it interacts with other factors to influence innovation adoption and implementation.

As described at the beginning of this section, culture can be viewed from two theoretical approaches. The structural approach has already been described and the other approach is interpretative. This approach views culture in terms of the rituals and myths which pervade an organisation. Proponents of this approach believe that innovation requires the manipulation of these elements and the communication of the need for change to the participants. There is little empirical work in this area but

Nystrom (1990) undertook a wide ranging study of a leading Swedish chemical company using case study methods to examine each of its divisions. At the time of the research the company was facing major changes as environmental policies altered its work and changes in the market meant it needed to diversify into new markets. Using a variety of psychological tests, individual semi-structured interviews and company focus groups, the researchers sought to identify how organisational culture influences innovation.

Nystrom (1990) found that the company was split into four divisions. One division was very traditional and the staff employed in this section were the least likely to change and innovate. Another division had introduced some innovation and had diversified into a new sector. Of the remaining two divisions, one had the most creative and innovative climate with high levels of challenge, idea support, freedom to take risks and employee harmony. However, they had not realised any of their ambitions to innovate. The remaining division was new and had originated from an externally funded and influenced research and development programme. This division was found to have produced the most innovation.

The key finding from Nystrom's (1990) study appears to be that external factors combine with the culture of an organisation to produce innovation. This suggests that culture alone is not necessarily the main indicator of innovativeness. This is interesting as it appears to support the notion outlined earlier that single factors often interact to produce an effect.

The influence of organisational culture on the adoption of innovation within nursing has been less widely articulated. Van-Ess Coeling and Simms (1993) identify how the effect of culture is very broad and its influence is often underestimated. While organisational or work group culture is based upon values, it manifests itself in behaviours. Such behaviours can be grouped into work group priorities, such as deciding what aspects of care takes precedence over others and power displays, for example, who is responsible for what and who can work with whom.

Van-Ess Coeling and Simms (1993) also describe how culture and climate are different, despite the fact that they are frequently used interchangeably. Climate reflects the individual's perceptions or feelings about the organisation, whereas culture consists of common belief and expected behaviours. It is important to acknowledge that organisations also have multiple cultures with sub-cultures occurring at different levels within an organisation. One reason for this is that the culture of a group relates to how a group solves work related problems and survives its workload.

Organisational and work group cultures will impact on all changes / innovations and this impact often manifests itself as resistance. However, because culture is unique, it is often impossible to tell how a work group will react to a proposed change. Given the widespread influence of culture, it would be useful if the person proposing a change could undertake some form of cultural assessment before proceeding. Such assessments are possible and, in their most complete form, they involve a period of participant observation, where an individual from outside the culture would become immersed in it over a prolonged period. This type of unstructured approach is

exceptionally time consuming and is rarely used in the process of innovation planning. There are several structured methods of assessing a work group or organisational culture and these are significantly less time consuming. Van-Ess Coeling and Simms (1993) describe one such method, the “Nursing Unit Cultural Assessment Tool” (NUCAT). This tool is moderately structured and assesses 50 different cultural behaviours. Each behaviour is scored using a six point Likert scale and when the tool is administered to a team a mean score can be identified for each behaviour. Van-Ess Coeling and Simms (1993) have developed and refined the tool over a six year period, testing its validity using a series of qualitative and quantitative studies.

The tool can be easily administered and would provide the facilitator of any innovation with invaluable information about the priorities and beliefs of a particular team. Using this information it might be possible for the facilitator to target communication with particular work groups to present the benefits of the new way of working or of a particular innovation. This in turn may reduce resistance and assist with the introduction of developments in practice.

The study by Van-Ess Coeling and Simms (1993) suggests that cultural assessment may be useful, especially when considering interpretative approaches to culture and innovation. However, it is unclear whether the tool developed by Van-Ess Coeling and Simms (1993) assesses the culture of the organisation or of individual teams within it. The current study will not seek to measure organisational culture as part of the study of the initiation or implementation of practice development because the researcher believes that cultural information can be obtained using other methods

such as interviews with key informants. Additionally, this decision was made because of the suggestion that culture rarely exerts influence by itself but rather it manifests itself alongside other factors which then combine to produce an effect. As a result, case study approaches should identify how culture interacts with other factors and how these influence development.

□ Conclusion

The literature reviewed in this chapter has identified a number of factors which are said to influence either the initiation of innovation or practice development or to facilitate or hinder the process of implementing the associated changes. A total of 19 positive factors has been identified from the literature, although not all of these factors relate to studies involving innovation in health care. Only three negative factors have been identified and this highlights that a significant weakness in the studies reviewed is that they tend to concentrate on what factors act as antecedents to innovation. Of the positive factors identified, the majority of these can be categorised as relating to the characteristics of individuals, with the most commonly cited factors being educational level, motivation to innovate, involvement and ownership, job level and empowerment. Several of the factors are organisational, including all of the negative factors identified, for example resources, service pressures and reactive organisational culture. The positive organisational influences from the literature include organisational size and freedom to innovate. Only two cultural factors are cited in the literature and these are the presence of competition between hospitals and external business factors. Although the literature identifies a number of factors, it is unclear how these relate to the UK health service and how the factors influence a

development. This current study seeks to explore these connections and to answer specific questions about the positive and negative factors.

In addition to providing an overview of what is already known about factors which influence innovation and practice development, the literature has provided a great deal of information about the possible structure of this research study. Firstly, the study by Kimberly and Evanisko (1981) and, in particular, its distinction between organisational, individual and contextual factors provides a useful framework for the initial Delphi survey design. In addition, other considerations for the survey of UK Directors of Nursing include the need to identify negative influences as well as positives and the contention that predetermined lists of innovations / developments can have an impact on the results obtained. Both the literature and the gaps in the range and scope of the studies available suggest that what is needed is a combined antecedent and process study which is conducted longitudinally, so that issues such as the sustainability of a development can be examined. A range of methods is suggested including surveys, interviews and critical incident techniques and ideally these will be combined to ensure the widest possible range of data is collected. Some of the methods used in the studies reviewed require further refinement so that some of the weaknesses associated with them can be reduced. One very clear message from the studies reviewed is that any study needs to provide contextual data about both the organisation being studied and the development being implemented. The provision of such rich description and contextual information is challenging in terms of research design. In the next chapter the underlying research paradigm will be outlined together with the reasons for its selection. Then in chapter 5 the research methods will be discussed in more detail.

○ Chapter 4: Theoretical foundations

□ Introduction

This chapter explores in detail the philosophical basis of the research study, together with the research approaches adopted and the rationale for these. The study is underpinned by the constructivist paradigm¹ and the key features of this paradigm are described and discussed in relation to this current research study. The aim of the present research is to identify the factors which influence the development of nursing practice and to ascertain what Directors of Nursing perceive to be the optimal organisational structure for the development of practice. The constructivist paradigm has been chosen because it enables the researcher to develop an understanding of how various factors influence practice and the management of development. To conduct such an investigation the methods used must be flexible and adaptable in order to allow for an understanding of the development within the context in which it occurs. Several studies from the literature have highlighted the importance of context, both in terms of identifying the potential for transfer to other similar situations and in understanding how factors influence development (Pettigrew McKee and Ferlie, 1989; Knox and Irving, 1997; West and Wallace, 1991). In addition, as this thesis is investigating a range of complex organisations within the acute and primary care health sectors, a single ethnographic approach is not viable. In order to collect rich contextual data from a number case study sites the researcher

¹ Within their earlier writing Lincoln and Guba (1985) refer to the naturalistic paradigm;, however they later describe this as the constructivist paradigm. As a result, within this chapter the terms constructivist and naturalistic paradigm are used interchangeably

needed to utilise key informants. Using a variety of data collection methods the researcher was able to construct the informant's version of reality and develop an understanding of the factors which influence the development of practice.

□ **Constructivism**

The constructivist paradigm developed from a feeling that positivist and post-positivist paradigms were flawed for the following reasons summarised by Guba (1990). Firstly, the theory ladenness of facts is presented as an important flaw in positivist thinking. For empirical tests to be valid, objectivity is required between the propositional (theory) statements and the facts. However, it is now widely believed that facts are only facts within a theoretical framework (Guba, 1990). As well as being theory laden, facts are also value laden and Guba (1990) argues that no enquiry can be value free; indeed the very selection of a topic for study requires the use of the researcher's value and belief system. Another flaw with the positivist viewpoint is the fact that the development or identification of an unequivocal explanation is rarely if ever possible. Finally, empirical enquiry requires interaction between the enquirer and the enquired; this further compounds the problems of objectivity. Guba (1990) also highlights how the generation of knowledge is a consequence of human construction and is therefore open to subjective judgement on the part of the inquirer.

Additionally, positivism is criticised because it strips away the context in which a phenomenon occurs. Guba and Lincoln (1998) describe how positivism strips from consideration other variables that exist in the context, which if they were

allowed to exert their influence may greatly alter the findings of the research. Positivism also excludes the identification of the meaning and purpose which humans may attach to their behaviour. Guba and Lincoln (1998) also suggest that positivist and post positivist paradigms are unable to deal adequately with local (emic) case based (idiographic) meanings because of the need to produce findings which can be generalised. The concentration of etic (outsider) theory may have little or no meaning for the people involved in the individual social situation and, while generalisation may be statistically meaningful, there may be no applicability within an individual case.

Schwandt (1998) identifies that constructivist approaches are unified by their opposition to positivism and their commitment to the study of the world from the point of view of the interacting individual. Constructivist perspectives are distinguished more by their commitment to questions of knowing and being than by their specific methodologies which promote an emic, idiographic approach to enquiry (Denzin and Lincoln, 1998).

Lincoln (1990) describes how the constructivist paradigm can be summarised by examining the ontological, epistemological and methodological axioms.

□ Ontological axiom

Within constructivist enquiry reality is viewed as a social and multiple construction. As a result, a position of relativism is taken. Realities are apprehensible in the form of mental constructions which are socially and

experientially based and local and specific in nature. However, elements of the construction, although specific in origin, can be shown to be shared between individuals and across cultures. The reality is constructed by the individuals experiencing a phenomenon including a construction by the researcher as he / she sees it (Lincoln and Guba, 1985). The development of each reality is dependent upon the context in which it is experienced (context bound) and, as a result, there is no attempt to study a phenomenon outside of its context. Thus there is a need for the researcher to understand the context if an attempt is to be made to develop a working hypothesis and to describe the possible transferability of findings or analysis between settings.

Within this study it is considered vital that developments in nursing practice are studied within the context in which they occur, not least because of the influence that context can have on the planning and implementation of such developments. Additionally, the collection of data to develop insight into the constructed reality of the practice development facilitator should provide some insight into how individuals and organisations influence development.

□ Epistemological axiom

The epistemological axiom centres on the relationship between the knower and the known. Within naturalistic enquiry there is interaction between the researcher and the phenomena being studied; such interaction is essential if the researcher is to construct a reality. This relationship can be regarded as very subjective, especially if the researcher is involved as the data collection instrument and data

analyst. However, objectivity in any enquiry can be regarded as a fallacy because the researcher influences the research in a number of different ways, whether this is through the choice of topic for study or the choice of research instrument used for data collection. Denzin (1989) describes how complete objectivity is not possible in the social sciences and, as a result, researchers should not subscribe to the fallacy but acknowledge potential bias and areas where subjectivity plays a part in both the research design and the interpretation of data. It is accepted that the use of practice development facilitators as key informants during the case studies means that there will be a degree of subjectivity in the subsequent constructed reality. Similarly, the researcher's input into this construction of reality without making explicit his main assumptions, premises and definitions could also introduce potential bias.

□ Methodological axiom

Constructivist studies are conducted in the natural setting and, while the methods used may be variable, constructivist enquiry displays a number of common attributes. These include the use of a human instrument to develop the construction of reality. Lincoln and Guba (1985) describe how the use of a human instrument in naturalistic enquiry provides maximum adaptability, allowing for adjustment to the variety of realities that may be encountered. No other research instrument would be capable of such adaptation or be able to understand and evaluate the impact and meaning of interactions. Finally, the human instrument is probably more able to identify and describe possible biases than other types of research instruments. Shank (1995) supports the claim that

the researcher's values guide and shape the research conclusions but warns that the researcher needs to be sensitive to the realities created by other participants involved; after all, it is the respondent's construction of reality which the researcher is primarily seeking to represent to others. Using such an approach allows the researcher to negotiate with others the consensual final reality.

Negotiations of this type involve joint interpretation of data with the respondent and verification of the end point. Checking and negotiation are important parts of this study. During the data collection related to the case studies, a series of realities will be constructed as causal networks and narratives. These realities will be returned to participants for checking and amendment thus allowing for the development of an understood reality. This process is also part of strengthening the credibility of the research findings and will be discussed in more depth later in this chapter.

Another methodological feature of the constructivist paradigm is the possibility that the results identified from a particular development and within a particular setting (context) may be transferable to other similar settings. While the purpose of positivist enquiry is to develop a body of knowledge in the form of generalisations, this is of little relevance in constructivist enquiry because the aim is to discover the reality of a particular situation within a particular context. Lincoln and Guba (1985: 110) describe how there is an intermediate position, between generalisation and knowledge of the particular. This position is known as the working hypothesis. A working hypothesis is a tentative supposition that a situation which exists within one context may be possible within another similar

context. The hypothesis is tentative insomuch as it may change over time as the researcher constructs his / her view of reality.

To decide whether a working hypothesis developed in context A may also be applicable in context B, the researcher examine the degree of transferability.

Transferability depends upon the degree to which there is congruence between the sending and receiving contexts. To assist this process the researcher may produce some tentative applications for the findings. However, most researchers will be unable to identify the entire range of contexts to which a reader may wish to transfer research findings. Consequently the researcher must provide as much information about the context (referred to as dense or rich description) as possible when writing the final case report.

One criticism of some of the literature reviewed in Chapter 3 was that it was impossible fully to identify the influence of the factors identified because the reports were devoid of contextual information. The desire to overcome this limitation through the provision of rich contextual description contributed to the decision to use a constructivist approach in this research.

Another feature of constructivist enquiry is the notion of mutual simultaneous shaping. Guba and Lincoln (1989: 97) “reject the traditional concept of causality and replace it with a different human construction, that of mutual simultaneous shaping”. They argue that the conventional view of causality is flawed, for, among other reasons, the impossibility of divesting causality from the influences of human experience. All decisions about cause and effect are dependent upon

making a judgement that it was a particular cause which produced that particular effect. Multiple factors often play a part in an effect and it is therefore not always possible to say that A caused B.

The alternative view is that of mutual simultaneous shaping where everything influences everything else. As a result, several elements may be implicated in a particular action or outcome. The issue of directionality, often referred to as temporal precedence in the conventional sciences, no longer exists as a particular element and may or may not produce an action or outcome depending upon the setting in which the phenomenon occurs. All of the elements involved in simultaneous shaping contribute to an outcome or action and are therefore regarded as contingently necessary as part of a synergistic relationship.

Therefore, to produce a particular effect, an element needs to occur within a particular situation (context) and is often tied into other elements being present at the same time. Lincoln and Guba (1985: 155) state that “each element is activated in its own way by virtue of the particular configuration of all other elements... present at that time in that place”.

The identification of whether mutual simultaneous shaping is occurring in a situation requires the researcher and respondent to identify interactive shapers, elements and outcomes or actions which may be linked. This can be achieved only in conjunction with the respondent because only he / she is aware of the outcomes which were originally proposed. Finally, it is important to acknowledge that the particular pattern of elements that give rise to a particular

situation are unique and may never exist in that form again and, as a result, it is impossible to imply either predictability or control (Guba and Lincoln, 1989).

The use of a modified approach to causal network construction to analyse data from case study sites fits well with the idea of mutual simultaneous shaping. In most cases it is difficult to attribute an effect to one particular factor but several factors can act together to influence a development and produce a particular effect. Additionally, the use of member checking where participants review networks and narratives will further strengthen the identification of factors which simultaneously shape other actions or outcomes.

□ Critique of the constructivist paradigm

While positivist enquiry is regarded as value free and objective, naturalistic enquiry is value bound in several different ways. These include the fact that the researcher expresses his values in the choice of research problem and methodology. The enquiry is also influenced by the values which are inherent in the context in which the phenomenon being studied occurs. The constructivist paradigm has been criticised on a number of different levels. The main areas of criticism relate to the subjective nature of inquiries which are based on this kind of research approach. As highlighted earlier, many social scientists (Denzin, 1989 and Blaikie, 1993) argue that complete objectivity is never really possible even in conventional enquiry because at some point a human being has to make a decision about which methods to use and which aspect of a phenomenon to study. Further criticisms relate to the lack of rigour within constructivist enquiry.

These criticisms continue, despite the attempts by Lincoln and Guba (1985) to address them through the development of criteria for establishing the trustworthiness of such studies.

In addition to the criticisms which are based upon the axioms of conventional enquiry, some writers are offering criticisms about failures to consider all sources of knowledge in relation to the social construction of reality. Heron and Reason (1997) describe how constructivists tend not to acknowledge experiential knowing, that is knowing by acquaintance, meeting or through participation. This is regarded as a significant flaw in naturalistic enquiry and methods of participatory research are suggested as a way of overcoming these weaknesses (Heron and Reason, 1997). Within such approaches the researcher and the participants collaborate as co-researchers and co-subjects, to design the study, collect and analyse data and produce the final report. Denzin and Lincoln (1994) draw attention to the crisis of legitimation in qualitative research where researchers claim to speak for the people they have studied. While participatory research reduces the need for the researcher to speak on behalf of the studies' participants, naturalistic enquiry does not, as the researchers are required to construct multiple realities on behalf of themselves and others.

□ The relevance of a constructivist paradigm to this study

The constructivist approach was the paradigm of choice within this study for a number of reasons. Firstly, the author agrees with the assertion that there is no single version of reality and that reality is socially constructed by the human

actors within a situation. Within practice development what is an issue for one individual when implementing a new way of working may not be an issue for a colleague working on the same project. Additionally, to what degree managers and practitioners engaged in practice development agree on which factors exert influence on a development remains to be seen. Similarly, the study of phenomena related to practice development within the context in which they occur is vital. The context in which practice development occurs will have a significant bearing on success and what organisational, structural and individual factors may influence the development.

The use of a human instrument to collect data within this study was also seen as an important element, not least because it allows the researcher to negotiate the construction of reality and also to verify his / her own construction. Additionally, the use of a human instrument provides the adaptability which is necessary in a study of this nature which involves multiple case study sites.

A desire for transferable findings rather than generalisable findings also influenced the approach. The author believes that within practice development there is rarely a generalisable development, rather certain developments within a particular context can be transferred either in part or in whole to a similar context. With this belief in mind, the author feels that the identification of transferable positive and negative influences on developments is more beneficial than the identification of generalisable influences. As highlighted earlier, what may have an influence within one context may pass without incident in another

context. This also highlights the need to identify those factors which contribute to mutual simultaneous shaping rather than cause and effect characteristics.

While the majority of this study is based upon a constructivist paradigm there are deviations from this, particularly the use of a Delphi survey. This deviation was necessary in order that the first research question (about what Directors of Nursing perceive as the optimal organisational structure) could be answered.

Bradley (1995) outlines how the selection of a research approach should not be made on the basis of tradition or because of allegiance to one particular paradigm but on the basis of the best approaches to addressing the particular research questions.

□ The nature of constructivist enquiry

Constructivist enquiry has a number of features, some of which have already been described. Within constructivist enquiry it is impossible to design the entire study before it commences (Lincoln and Guba, 1985), although the researcher is likely to have some notion of the preferred approaches to the research problem from the outset. Streubert and Carpenter (1995: 249) describe how

“the naturalistic domain dictates an emergent design because of a belief in phenomena as consisting of multiple, context dependent realities. Only after these realities become apparent can the most appropriate design for the study be determined”

The emergence of the design is achieved through a series of successive iterations (Lincoln and Guba, 1985). This series consists of four elements, purposive sampling, inductive data analysis, theory development and projection into the next step of the emergent design. In this way each stage of the study is used to inform the next and the study design becomes an iterative process. While the term iterative design is used regularly in qualitative research the exact method of iteration is poorly understood. Within this study iterative methods were used to inform the sampling strategy both for the Delphi survey and for the subsequent case studies. Additionally, methods such as Delphi can be regarded as iterative inasmuch as they are developed using data from subsequent rounds. Within the case study phase of the research, data collection centred on identifying areas for exploration, either using data from the Delphi survey in the early stages or from subsequent data analysis of the previous interview transcript or critical incidents. Lincoln and Guba (1985) describe how iterations within naturalistic enquiry are repeated until redundancy or until information saturation has been achieved e.g. no new data emerges (Streubert and Carpenter, 1995). In this study data were collected from the case study sites for a one year period and, although many of the developments had not been fully implemented in that time, all of them had either made progress with implementation or had stalled or been shelved for one reason or another. As a result, all sites achieved either redundancy or information saturation.

Another feature of naturalistic enquiry highlighted earlier is that of negotiating the outcomes and the construction of reality with the research participants. Such member checking may occur immediately following data analysis and at the end

of the study. Member checking is a crucial technique for establishing credibility of the researcher's construction of reality and it allows the respondent to correct errors of fact immediately and challenge what they perceive to be wrong interpretations (Lincoln and Guba, 1985). Within this study member checking served several purposes which included: -

- Allowing the respondent to check the accuracy of the data analysis which had been undertaken by the researcher
- Providing a useful recap of previous discussions prior to the next round of interviews
- Enabling the respondent to provide additional clarification around specific issues
- Enabling the researcher to establish the exact chronological order of events and identify which factors are involved in mutual simultaneous shaping.

The fact that member checking may lead to the respondent providing additional information about events or about the chronological order of such events meant that member checking was done with the researcher present and when the tape recorder was running. The discussions about the data analysis and the event state networks were therefore recorded and included in the transcript of the interview.

Lincoln and Guba (1985) recommend that the constant comparative method be used for the analysis of the data generated through naturalistic enquiry. Glaser and Strauss (1967) developed the constant comparative method as part of the Grounded Theory approach. Lincoln and Guba (1985) report that the intention when using this data analysis method is not to produce a theory which can

explain or predict behaviour but to produce a case report which describes what the researcher has learned about the phenomena being studied. In this way the constant comparative method is used to construct categories which describe the phenomena. Constant comparative method was not used to analyse data within this study, as the desire was to move beyond description of the phenomena to examine the influence of events on the development of practice. This, together with a desire to identify how factors influence one another and ultimately the development, was the rationale for using causal network analysis as the method of data analysis for the data from the case studies (Miles and Huberman, 1994). Causal network analysis is discussed in more depth in chapter 5.

□ Establishing credibility

Lincoln and Guba (1985) describe several techniques for establishing the credibility of constructivist enquiry. They describe how prolonged engagement is essential, as it allows the researcher sufficient time both to learn the culture of the area being studied and to build trust with the research participants. Unless sufficient time is invested in these two activities the study may fail to identify all aspects of the phenomena being studied. Prolonged enquiry also allows the researcher time to test out misinformation which may have either been collected or may be the result of the researcher's error in data analysis or understanding. Lincoln and Guba (1985) also argue that spending time within a particular culture or context may assist the researcher to check for distortions which he / she may have introduced.

Triangulation is a technique through which the credibility of a study can be increased. Triangulation can concentrate on either the data, the investigator, the theory or the methods (Denzin, 1978). Methodological triangulation is the most common and this is typically used by researchers to provide greater confidence in the validity of results. When used in this way triangulation attempts to overcome the deficiencies inherent in a single method by using two or more methods to measure the same variable / phenomenon. Problems may occur when the findings from each method contradict each other and convergence cannot be achieved. Clearly, the search for convergence contradicts the earlier axiom of the nature of reality within the constructivist paradigm. As described earlier, the author subscribes to the notion that there is no single version of reality but rather that individuals construct their own reality. With this thought in mind, a naturalistic researcher is unlikely to use methods which seek to establish a single version of truth using different methods of data collection. The answer to the use of triangulation within naturalistic enquiry lies with the two broad aims of triangulation described by Breitmayer et al (1993). Breitmayer et al (1993) describe how triangulation aims to establish either confirmation (where methods converge on a single variable) or completeness (where various dimensions of a phenomenon are examined). Knafl and Breitmayer (1989) believe that triangulation of confirmation has limited importance for social scientists, as researchers in these fields are seldom interested in a discrete or single concept. As a result, triangulation within this study aims to provide a complete and holistic picture of the phenomena being studied rather than confirmation of a single meaning.

Additionally, triangulation provides a structure for combining research methods, whether these be more than one qualitative method, more than one quantitative method or a combination of both. When combining methods in this way it is important that the research methods are selected on the basis of the research question rather than because of an allegiance to any particular paradigm or philosophy (Bradley, 1995). The use of both quantitative and qualitative approaches in the examination of one concept or variable is described as between method triangulation. This approach was used within this study to examine the series of research questions, with qualitative and quantitative methods being used in phase one to examine the perceptions of Directors of Nursing and qualitative methods being used in phase two to examine antecedents to and the process of practice development. Morse (1991) describes how between method triangulation can be either simultaneous, with the methods being used together and at the same time or, in the case of this study, sequential, where different methods are used at different times within the study.

Finally, data source triangulation may also be used to improve the credibility of the research. Data source triangulation can involve the use of different data sources to examine the same phenomenon; for example, this may include interviews and documentary data. However, it may also include the use of one or more human data sources, such as more than one key informant from a particular case. The use of such data sources within naturalistic enquiry would strengthen the research approach and subsequently the credibility of the findings because it would enable the researcher to construct more than one version of reality. Within this study the use of more than one key informant would have been beneficial, as

the realities constructed, by and large, rely upon one person's version of events. The choice of a single informant was a difficult one for the researcher principally because, at the time of entry into the field, the researcher was not aware of the scope of the developments being studied. The next chapter outlines how, within the case studies, the informants could select the development which would be examined over the next year. While all of these developments involved other people, only three involved more than one person in the leadership of the project. The use of a single key informant could be regarded as a limitation in this study. However, the fact that within several of the case study sites the key informant changed during data collection (mainly because of changes in employment), the new informants reported similar versions of the process of developing the projects, strengthens the assertion that the findings are credible.

Duffy (1987) outlines several problems with triangulation; these include the additional resources required in both time and money when using more than one method. More troublesome, though, are the problems associated with data analysis and presentation when using mixed qualitative and quantitative methods. Mitchell (1986) reports that few researchers have highlighted ways of overcoming these problems but suggests that the process can be made easier by analysing each type of data separately and then identifying the most appropriate way either to analyse or present the data together.

Other methods of establishing credibility include peer debriefing, where the research is exposed to a peer not previously involved in the study. Such debriefing serves a number of purposes. It enables the researcher to identify and

make explicit areas which may otherwise remain within the researcher's mind. This is very important in developing an audit trail which will be discussed later in this chapter. Often, when people are engaged in a research activity over a prolonged period, they can take for granted many of the decisions they made as the study progressed. Such decisions are important if readers are to make sense of the research and are to decide if the study is credible. Debriefing can assist a researcher to identify areas where they have not made their decision making process explicit. Debriefing can also assist with the identification of researcher bias and, when used during the process of the research, it can assist in the development of the emergent methodology (Lincoln and Guba, 1985).

Finally, negative case analysis is used to revise the working hypothesis until it takes account of all known cases without exception. The fact that the researcher includes negative cases strengthens the case that the research is credible, rather than simply disregarding data because it does not fit with the hypothesis developed.

As already discussed, within naturalistic enquiry transferability between contexts and respondents may be possible. Responsibility for deciding what aspects of a study are transferable to other contexts and situations is left to the reader of the research. However, the researcher has responsibility for setting out any working hypotheses which are developed from the research data. These hypotheses are set out together with a thick description of the time and context. It is this thick description which enables readers to make a conclusion about what might be transferable. Lincoln and Guba (1985) describe that what constitutes a thick

description is not completely resolved but a comprehensive case report is suggested as an appropriate method. Within this study the data from the case studies were analysed using causal network construction; these networks are accompanied by a comprehensive narrative which describes the context in which the developments in practice occurred. The researcher believes that these narratives constitute a thick description as it is described by Lincoln and Guba (1985).

Both dependability and confirmability are established using an enquiry audit. Such an audit is not possible unless the researcher develops an audit trail during the process of enquiry. Such an audit trail must include all of the decision making records and other documentation, such as raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes and instrument development records (Lincoln and Guba, 1985). Within this study an audit trail was established during data collection and analysis as proposed by Streubert and Carpenter (1995).

□ The case study as a research approach

Yin (1994; 13) defines a case study as “an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and context are not clearly evident”. This definition clearly describes how case study research involves collecting data about a phenomenon which is bounded to the context in which the phenomenon exists. The development of modern case study research is associated with the

work of the Chicago School of Sociology, although earlier pioneers included Le Play who used similar methods to study families. More recently researchers have chosen to describe case study research by another name such as fieldwork. One of the reasons for this is the widespread use of the term 'case study' to describe several different approaches. This has resulted in confusion about what constitutes case study research and whether it is a research approach or a particular method (Bryar, 1999).

Several authors (Yin, 1994; Stake, 1995 and Merriam, 1998) have described the use of case study methods using various qualitative and quantitative approaches. Clearly case studies cannot be described as purely qualitative or quantitative and it is this ambiguity which fuels the debate about what constitutes case study research (Hakim, 1987). Mehier and Pugh (1986) suggest that case study research cannot be considered as a method or design unless the investigator refers to a discipline and makes a specific adaptation of the basic definition. This adaptation requires the investigator to identify the philosophical stance used within the study which, in turn, helps to determine the research question, or the question determines the philosophical stance. In this study both the philosophical stance and the selection of case study methods was based upon the research questions and the subsequent literature review. As such, a case study is not a standard methodological package but a framework which is determined by the focus of the particular study. Yin (1994) supports this notion, describing case studies as pluralistic in nature with uses from description to evaluation. Case study design has been defined by Burns and Grove (1997: 184) as

“the intensive exploration of a single unit of study: a person, family, group, community or institution or a very small number of subjects who are examined intensively”.

Case study research has a number of distinctive characteristics; these include: -

- Boundedness, where the phenomenon being investigated is not separated from its real life context
- Intensive exploration of a single unit or a small number of subjects
- The examination of a large number of variables which have an impact on the situation being studied
- The use of multiple methods of data collection (triangulation)

Additionally, Yin (1994) believes that case study research benefits from the prior development of theoretical propositions to guide data collection and analysis. In this study, the theoretical propositions include the need to study practice development in the context in which it occurs and the construction of several realities. Additionally, the approach is also founded on the need to study antecedent and process factors associated with development and the use of a human instrument for data collection.

Within this study, case study methods were selected because they would enable the exploration of the influence of the factors identified in the earlier Delphi survey and also, as a research approach, it allows the researcher to use several different research methods for data collection. It also allows for the study of a phenomenon within its bounded context. This was particularly appealing for this

study as it seeks to examine the influence of organisations on individual developments in practice. Shaw (1978; 2) describes how

“case studies concentrate on the way particular groups of people confront specific problems, taking a holistic view of the situation. They are problem centred, small scale, entrepreneurial endeavours”.

Additionally, case study methods will allow the researcher simultaneously to collect data about antecedents to practice development, as well as factors which influence the process of introducing the new idea or way of working.

□ Types of case study research

Hakim (1987) describes how case study research can be categorised into three groups. Intrinsic case studies are used where the purpose is to develop a greater understanding of the case and to generate theoretical propositions. Instrumental case studies aim to provide information in terms of theory building. Finally, collective case studies provide information about a number of cases, examining similarities or developing theoretical understanding. The delineations between these categories are not always clear as the researcher may have more than one purpose within the study. Stake (1994) considers that these categories are merely heuristic devices and should not be regarded as exclusive categories. This study has both an instrumental and collective basis in that it seeks to provide information from a number of cases in terms of both understanding and theory building.

Case studies can be used to examine phenomena from a number of different perspectives, the choice of perspective being defined by the research aims / question. Yin (1994) suggests that case studies can be differentiated into the following groups: -

- Descriptive – where the purpose is to examine the case from different perspectives
- Explanatory – where the purpose is to identify aspects of causal arguments
- Exploratory – where the purpose is to examine a hypothesis or proposition

These case studies are both descriptive and explanatory in nature as they seek to examine developments from different perspectives, using different methods, such as interviews and critical incidents. Additionally, the research seeks to examine the processes involved longitudinally over a one year period to see how different factors influence the process of planning and developing practice. At the same time, the study also seeks to identify aspects of causal arguments by identifying which factors form together to shape other factors or outcomes.

□ Challenges in case study research

The use of case study research presents a number of challenges for the researcher. As highlighted earlier, one challenge is the identification of the case to be studied. Many authors (Merriam, 1998; Stake, 1995 and Yin, 1994) refer to the case as an individual, group or institution. However, it is not uncommon to find that, while the individual or institution is the case, the collection of data is

concentrated upon a particular incident or aspect of the case. Within this study the cases are NHS Trusts with a record of innovation and practice development, but data are collected around one or two particular developments which are either being planned or are in the early stages of introduction. The bounded system within each case is therefore wider than the team involved in the project but includes the context in which the project is being developed e.g. ward / department and institution.

Another challenge for the researcher is deciding whether to study a single case or to study multiple cases. Cresswell (1998) suggests that where multiple cases are studied they are invariably studied in less depth than a single case would be. Indeed, within this study a single case would have allowed the researcher to approach the study from a different perspective using ethnographic methods to collect data. This would probably have resulted in more detailed data being collected about a particular organisational culture. Cresswell (1998) suggests that researchers who use multiple cases may be motivated by the idea of generalisability, seeking to collect data from a number of areas in an attempt to improve external validity. However, there are a number of other reasons for the decision to select multiple cases, including the desire to seek maximum variation within the study. Indeed, in this study, sites were selected to ensure that there was variation between sites identifying acute, community and combined NHS Trusts as well as Trusts located within different UK health departments. The results of the Delphi survey suggested that there were different approaches to development within the different countries which make up the UK NHS and any

cross case comparison would need to identify potential similarities and differences in these approaches.

□ Conclusion

This chapter has articulated the reasons for the choice of a constructivist paradigm as a guiding philosophy of science for this research. The approach should allow for the identification of factors which influence the development of nursing practice, both as antecedents and during the process of implementation. The constructivist paradigm is considered to be sufficiently flexible to cope with the demands placed on the design of a study where participants are intensely involved in the whole process.

○ Chapter 5: Methods

□ Introduction

This chapter examines approaches to data collection and analysis which are used to answer the following research questions:

- What do Directors of Nursing perceive to be the optimal organisational structure to promote the development of nursing practice?
- What factors can facilitate or hinder the process of practice development?
- What influence do positive and negative factors have on the process of developing practice?

The chapter also explores the identification and recruitment of the sample as well as access and ethical issues. The construction, administration and analysis of the Delphi survey is described, together with the data collection methods used during the subsequent case studies. This study is structured into two distinct but inter-related phases. Phase one was designed to identify what factors may facilitate or hinder the development of practice. Following the identification of these factors, the research progressed into phase two which was designed to examine how these factors influence development using in-depth case study methods over a one year period.

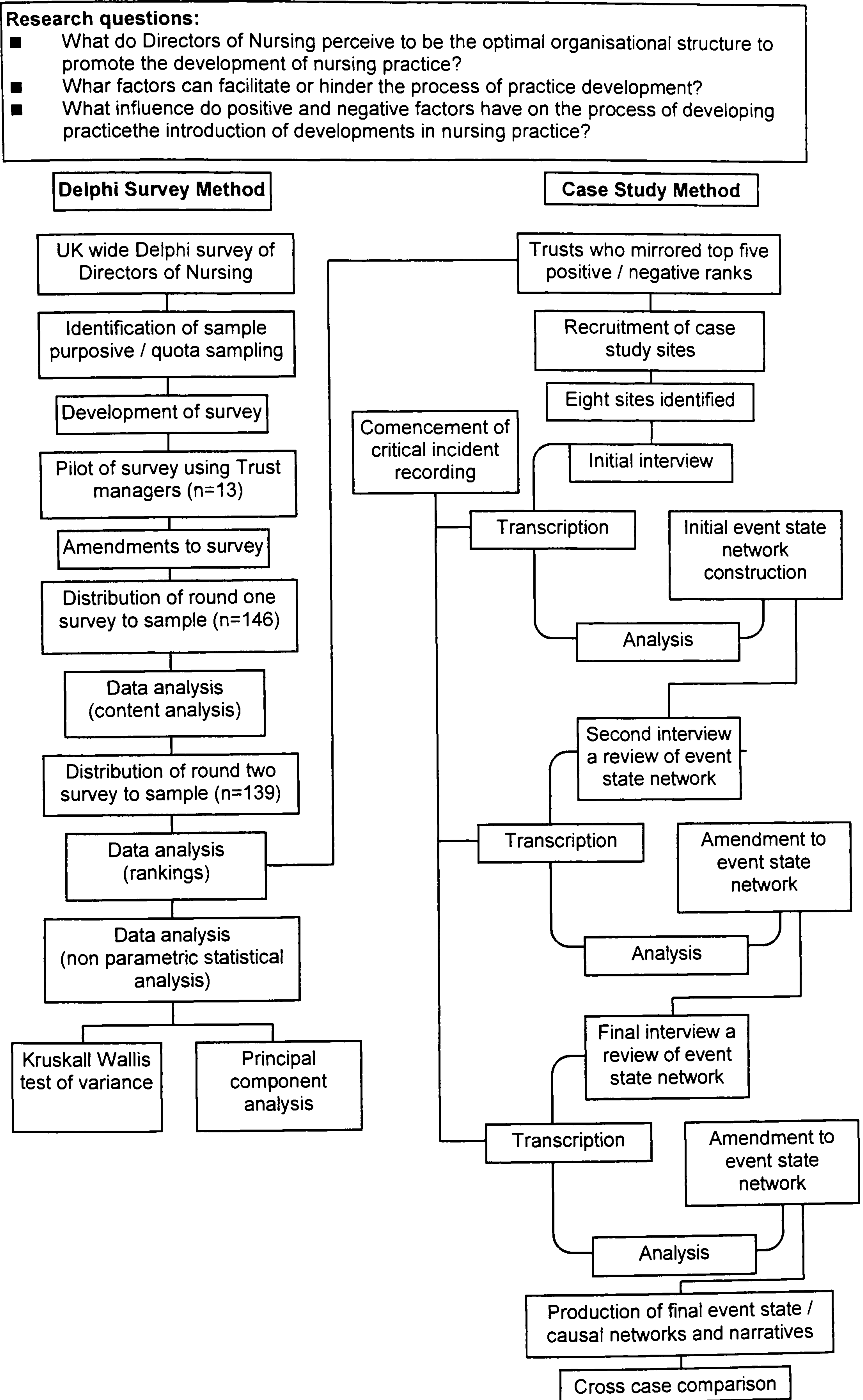
The chapter ends with a discussion about the issues associated with longitudinal research in health service organisations. In this chapter the methods and procedures are described collectively rather than in separate phases; for example, sampling looks

at both the Delphi and the case study sample. The overall methodology is relatively complex and, to assist the reader, it is presented diagrammatically as Figure 5.1.

□ Sampling strategy

Both phases of this study utilised a purposive sampling technique. Burns and Grove (1995: 243) state that “purposive sampling, involves the conscious selection by the researcher of certain subjects or elements to include in the study”. Such sampling methods are often used when the researcher wishes to include “typical” subjects or situations. Within this study it was necessary to sample those organisations with a record of developing practice, as they were deemed to be key informants on the subject. Within phase one, the Delphi sample utilised combined purposive and quota sampling. Quota sampling is frequently used to ensure that groups which may be under-represented are included in the research (Burns and Grove, 1995). While quota sampling may assist the researcher to sample a wider and more representative population, the sampling strategy is not free from bias because the researcher is still free to select the sample (Blacktop, 1996). While the likelihood of bias is acknowledged, the use of quota sampling was selected because it would enable the Delphi survey to sample subjects across the UK. Sample selection for the Delphi survey took two forms; either participants were selected because the organisation had an established track record of practice development / innovation or they employed a practice development nurse who was a member of the Professional and Practice Development Nurses Forum.

Figure 5.1 Diagrammatic overview of the research methodology



In order to identify organisations with a track record of Practice Development, several databases were used; these included: -

- The Practice and Service Development Database (NHS Centre for Reviews and Dissemination, University of York)
- The Queen's Nursing Institute, Scotland – Innovation Award Winners
- Nursing Times Good Practice Network Database
- The Golden Helix Award Database

No attempt was made to judge the quality of the practice developments recorded on these databases and the only inclusion criterion was that the project had involved a nurse working within an NHS Trust. The fact that the developments were not judged to identify whether they fitted the critical attributes of practice development could be regarded as a limitation of this study. However, given that in chapter 2, the fact that practice development in its purest form rarely if ever exists in isolation from other associated activity (for example, professional development), a decision was made that activity regarded as practice development by practitioners would be used within the sample selection.

For ethical reasons none of the Trusts which were adjacent to the researcher's employing NHS Trust was selected. The reasons for this are discussed in greater depth later in this chapter. A total of 146 Trusts was identified, 77 acute Trusts and 69 community or combined acute / community Trusts. The sample included five Trusts from each English NHS region and a proportion from each Health Authority in Wales and Health Boards in Scotland and Northern Ireland depending upon their

size. Following distribution of the first survey, seven organisations withdrew or declined to participate, giving a final sample size for the Delphi survey of 139 Trusts.

The second phase of the research involved case study methods and, as a result, the sampling strategy for this phase involved the selection of cases. While this process may sound straightforward, it can often prove problematic (Stake, 1998). The identification of what constitutes the case to be studied can prove difficult. Stake (1995) outlines that, while a teacher may be a case, his / her teaching is less tangible and cannot be classed as a case. A case is therefore something specific, a complex and functioning entity. In this study, while NHS Trusts are used to identify areas for the case studies, the cases themselves are the individual developments in practice. A decision was made that the development selected would be at an early stage of implementation or still being planned. A key informant (usually a practice development facilitator) was sought for each development via the Trust's Director of Nursing. Each case would be studied for a one year period using a variety of methods; case sampling of the specific development(s) occurring on entry, at six months and at twelve months. Between these periods, data were collected using critical incident technique.

Cases were selected using the responses to the Delphi survey and subsequent data analysis. A list of Trusts (35 in total - 24 from England, 4 from Scotland, 5 from Wales and 2 from Northern Ireland) which mirrored the overall consensus was drawn up. Each Trust was contacted by letter (addressed to the Director of Nursing) to invite them to take part in the second phase of the study. Each letter contained details of the second phase of the study, together with a pre-paid reply postcard which

allowed the Director of Nursing to detail a contact person for the second phase of the research. A total of eight NHS Trusts was selected from the responses obtained, using a combined convenience and quota sampling approach. This included four Trusts from England, three Trusts from Scotland and one Trust from Wales. The Trusts were selected on the basis that they were relatively accessible using major road or rail links. Following initial contact, one Trust withdrew from the study with a further Trust withdrawing after the initial interview. The possible reasons for the withdrawal of these participants are discussed later in the chapter. As a result, a total of six cases was studied within the second phase with data being collected on a total of eight developments.

□ Access and gatekeeping issues

Gaining access to research sites or individuals within them involves several steps. Regardless of the method of enquiry, permission needs to be sought through the appropriate gatekeepers (Cresswell, 1998). As described earlier, the development of the sampling strategy relied heavily upon the use of a number of databases of NHS Trusts which are involved in the development of nursing practice. These databases are maintained by a variety of organisations including professional journals, NHS Centres and professional organisations. Permission was sought from each of the database administrators to access the database for the purpose of developing a sampling frame. Once access had been granted, the sample was selected and the Director of Nursing (or equivalent) for each Trust was identified using the Directory of Hospitals and NHS Trusts (Financial Times Healthcare, 1998). Letters were sent, together with the initial Delphi survey, to each Director of Nursing (Appendix 01).

The letters were accompanied by a leaflet setting out the purpose of the study, its aims, the methods to be used and an invitation to participate in the first phase of the study. Directors of Nursing were also invited to nominate another individual to participate if more appropriate. Where a third party was nominated, they simply completed the box on the rear of the reply envelope to ensure that future surveys were sent to the correct respondent.

Access in the second phase of the study was more problematic because of the need to contact individual practice development facilitators within Trusts. The second phase Trusts were selected using the sampling strategy described earlier. Once the list of eligible NHS Trusts was drawn up, the researcher telephoned each Trust to ascertain the name of the practice development facilitator. This was incredibly time consuming and posed a number of difficulties, not least because of a lack of uniformity in relation to job titles. It was possible to identify the names of some of the facilitators through membership lists provided by the Professional and Practice Development Nurses Forum, while some other NHS Trusts refused to supply this information despite an explanation as to why it was required. Eventually all but four of the practice development facilitators were identified and letters (Appendix 02 and 03) were sent to both the Director of Nursing and the practice development facilitator. Where possible, these letters were personalised to the individual and set out details of the research to date before describing phase two of the research. Individual practice development facilitators or Directors of Nursing were invited to indicate their willingness to participate by returning a pre-paid postcard indicating a contact name, address and telephone number. This proved very successful and 16 cards were returned. Those Trusts selected as phase two sites were subsequently contacted,

while the remainder were sent a letter thanking them for their interest and promising to keep them informed of the outcomes of the research as it progressed.

□ Ethical issues

Participants in the study were informed that the data which were collected would remain confidential and that any direct quotations used would be suitably anonymised to protect their identity. To facilitate this process each participant was given a unique identification number during the Delphi survey and an identification letter in the case study component of the research.

In order to encourage participation by other NHS Trusts, the researcher produced a study information leaflet which set out the aims of the research, rationale for it being conducted and the methods used. Potential participants were informed that the data collected would not be identifiable to individuals or individual NHS organisations. Additionally, participants were informed that they could choose to opt out of the study at any time.

Within the Delphi survey direct written consent was not sought from the participants. The return of a completed survey was taken as implied consent from the participant. A small number of blank surveys was returned during the survey. In these cases it was assumed that the individual did not wish to participate. The organisations were traced, using the database code number on the survey, and the individual's details were removed. As a result, they were not sent any further reminders or surveys from

any of the subsequent rounds of the survey. Verbal consent was recorded on the audio-tape before each interview during the second phase of the study.

As discussed in chapter 1, in 1989 the then Conservative government introduced quasi market principles into the NHS. The introduction of self governing NHS Trusts and purchasing organisations brought about competition amongst NHS Trusts. While this was instrumental in improving patient care, it also brought with it a climate of competition. This resulted in NHS Trusts becoming increasingly reluctant to share information about their services with other Trusts because of the risk of divulging commercially sensitive material and thus losing contracts. Although, at the time of the study, the internal market had been dismantled and competition was no longer an issue, suspicion continued. This continued suspicion raised a number of ethical issues for this study, not least because the researcher worked for an NHS Trust and the Trust was a collaborating institution in the research study.

Prior to the development of the sampling strategy, a decision was made that no neighbouring NHS Trusts to the researcher's own would be included in the study. To include these organisations might have seriously affected the degree of participation in the study and also the quality of the information gained during data collection.

□ Delphi survey

The Delphi technique is a method of systematically collecting and aggregating informed judgements from a group of experts on specific questions or issues. Repeat rounds of the process can be carried out until full consensus is reached (Reid, 1988;

p323). In this study Delphi survey methods were used to identify perceptions about those antecedent and process factors which can positively or negatively influence practice development. Although there have been several variations on the original technique, most share the same basic characteristics, in that they: -

- use panels of experts for obtaining data
- are conducted in writing, using sequential questionnaires interspersed with summarised information
- systematically attempt to produce a consensus of opinion and identify opinion divergence
- guarantee anonymity of both the panel members and their statements

(Strauss and Zeigler, 1975).

Delphi technique, however, also has several advantages over similar methods of data collection e.g. focus groups and committee meetings. Delphi removes the influence of dominant personalities in achieving consensus. The technique also overcomes the barriers of geographical location and allows more people to take part than could possibly interact face to face. There are several reasons why the Delphi technique was selected for the first phase of this study. Firstly, there was a dearth of empirical data on the subject of practice development and the factors which may influence this process. While a standard survey might have resulted in the collection of similar data, the use of largely open questions would have produced a considerable volume of responses which would have been difficult to analyse, especially given the size of the sample. Additionally, it would have been impossible to ascertain from a standard survey the relative importance respondents attached to each factor identified.

Secondly, it was felt that what was needed was a description of the factors which were considered to influence practice development within NHS Trusts. Thus, precise analytical techniques which would have sought to measure the influence of these factors were not considered of value in this case. Finally, while the sample population were all Directors of Nursing, they were drawn from a diverse range of organisations covering very different geographical areas and indeed, since devolution, from countries with different health systems. Linstone and Turoff (1975) support the use of the Delphi technique in these cases.

Delphi technique, like all research methodologies, has limitations. Many of these centre around the fact that Delphi is regarded as subjective and unrepresentative. Thus the issues which it identifies cannot be generalised to the wider population. Subjectivity can be compounded by the charge that repeated rounds force participants to produce an artificial consensus because of peer pressure and respondent fatigue. Whitman (1990) describes how critics of Delphi suggest that it is unclear whether individuals change their opinions on the basis of new information or, despite the protection of anonymity, feel pressure to conform to their group in their responses. Finally, it is felt that repeated rounds may also lead to considerable attrition of participants and produce poor response rates which can result in response bias (Williams and Webb, 1994).

Another major methodological debate in relation to the use of Delphi is in the meaning of consensus. This is often poorly explained, with many researchers not attempting to set a level prior to the enquiry. Instead they make a decision after the data has been analysed; thus the concept of consensus is arbitrary. Loughlin and

Moore (1979) suggest that consensus should be equated with 51% agreement among respondents. In this study consensus was defined as being achieved when more than 50% of respondents voted for a category.

Testing the method

The format of a classical Delphi starts with open-ended questions, thus allowing participants complete freedom in their answers. However, some authors report eliminating this step and presenting participants with pre-prepared statements gleaned from the literature (McKenna, 1994). The dearth of literature related to practice development in the UK NHS meant that it was impossible to develop a survey consisting of pre-prepared statements and, as a result, the survey was developed using open ended questions. The questions were divided into three sections, with each section being based upon the work on Kimberly and Evanisko (1981). While Kimberly and Evanisko's (1981) work was conducted in the United States, it does provide a useful framework for examining the influence of factors on practice development within the UK. The survey sections were: -

- Organisational and structural influences
- Contextual influences
- Individual influences

To test the method an initial questionnaire was developed consisting of eight questions (Appendix 04). These questions asked respondents to draw the organisational structure of their organisation and then describe how such structures impact on the development of practice. The survey then asked respondents to outline key developments which had been introduced in the last year and then to identify the

drivers and the barriers to this change process. The influence of local policy and national policy was explored by asking respondents to consider the organisation's function as a health provider locally and as part of the wider NHS. Finally, respondents were asked to look at how they and other managers influenced the development of practice.

The questionnaire survey was sent to 13 senior nurses from a single NHS Trust. A total of 7 (53.8%) responses was received following a reminder at three weeks. The results were not analysed nor included in the final data for the project. Rather, the aim was to test the format and sequencing of the questions to avoid ambiguity and to test the validity of the questions. Following the test questionnaire, it was apparent that section one (drawing management structures) was of little value in identifying the influence organisational structure had on practice. Amendments were made to the questionnaire before proceeding with the main study. The questions related to organisational structure elicited a variety of answers and were described by respondents as difficult to complete. Additionally, the variety of responses made analysis virtually impossible. These questions were replaced with the questions *What words describe the structure of your organisation?* and *How does the structure of your organisation influence practice development?*

Round One

Once the questionnaire had been finalised (Appendix 05) it was distributed with a covering letter, study information leaflet and reply envelope to a total of 146 participants. Each survey had an identification number to allow the researcher to

identify respondents for the purpose of sending reminders. Reminders, which included an additional letter and survey questionnaire, were distributed three weeks after the first mail shot. The timing of the survey (January, 1999) could be regarded as problematic because of the winter pressures on the NHS. Indeed several respondents contacted the researcher by letter to apologise that they were not able to participate in the research because of the pressures of work.

Round Two

The data from the first round questionnaires was analysed using thematic content analysis to construct categories. This process is discussed later in this chapter. A total of 24 positive and 23 negative categories was identified. These, together with illustrative quotations from the first round responses, were used to develop the survey questionnaire for round two. The resultant round two questionnaire was distributed three weeks later to the original sample, minus those Trusts who had withdrawn (n=139). This approach was similar to that taken by Macmillan et al (1989) in her Delphi survey and it allowed all the participants a chance to rank the categories.

The use of identification numbers on each of the surveys allowed the researcher to identify how many of the second round surveys were returned by respondents who had also participated in round one and the number who had simply participated in round two. A total of 55 (39%) of participants had responded to rounds one and two, while 22 (16%) responded to the round two survey only.

As mentioned earlier, the second phase survey consisted of 24 positive and 23 negative categories with illustrative quotations. Participants were asked to rank the positive categories using A for the most influential category, B for the second most influential and so on. Participants could rank as many or as few categories as they wished. The participants were then asked to repeat these steps for the negative influences. These instructions were given to participants both inside the front cover of the survey and in the accompanying letter (Appendices 06 and 07). The instructions caused some confusion amongst respondents and generated a number of telephone enquiries. Additionally, some respondents misunderstood the instructions, using only the letters A and B in the ranking of responses (n = 5), although many other respondents used only three or four ranks throughout their survey. This is obviously a limitation of the survey data which impacted on the subsequent analysis of the data. Other limitations include the possibility of response bias. It is notable that respondents, when ranking the categories, identified far more positive than negative influences.

Many Delphi studies restrict the number of categories that participants may rank to ten, although none of the authors gives any indication of the reason for the selection of this number (Delbecq et al, 1986 p98). In this study it was decided that participants could rank as many or as few categories as they wished as the desire was to identify all of the influences rather than just the ten most important. However, this decision produced a large volume of data, although subsequent analysis using non-parametric statistical methods allowed the researcher to refine categories down into components.

□ Case studies

The second phase of the research involved in-depth case studies. During this stage data were collected using semi-structured research interviews on three occasions (entry, six and twelve months). Additionally, data about individual incidents were collected using critical incident technique, where respondents used dictation equipment to record detail about incidents shortly after they had occurred.

Multiple case study sites were selected on the basis that they mirrored the top five Delphi responses for either positive or negative factors. Multiple case approaches of this kind allow for comparison between cases (Vallis and Tieney, 1999). Cresswell (1998) describes how multiple case study approaches generally follow a typical format of a detailed description of each case, including the context in which it exists. This is followed by a within case analysis which identifies the variables and factors within the case. Finally, an analysis is undertaken across cases producing a cross case analysis which identifies factors which are common to all, or more than one, of the cases which have been studied. Most case studies involve the researcher narrating the case through an exploration of the context in which the case exists and a chronology of major events, which is often followed by an up-close and detailed examination of a few incidents (Merriam, 1998). This approach was used within this study, with the context being explored during the initial research interview on entry into the study. The chronology of major events was collected during each of the interviews and the detailed examination of a few incidents in each case was achieved using either a

semi-structured interview or a combination of interview and critical incident recording. Burns and Grove (1997: 185) describe how

“the subjects’ history and previous behaviour patterns are usually explored in detail. As the case study proceeds, the researcher may become aware of components important to the phenomenon being examined that were not originally built into the study”.

It is for this reason that the semi structured interview schedules (appendix 08) for the six and 12 month interviews were originally left as rough drafts and updated as the study progressed. Following each interview, or when critical incidents were submitted, the tape recordings were transcribed and analysed prior to the next interview. This allowed the researcher to refer back to previous data to identify areas for further clarification or exploration during the next interview. This iterative process is important as it enables the researcher to explore important issues in more depth as well as seek confirmation that the interpretations attached to events are correct.

□ Data collection methods used within the case studies

There are two principal methods of data collection which were used during the case studies. These are semi-structured interviews at set points over a one year period and critical incident technique. However, while these were the principal methods used, some of the cases supplied documentary evidence to support discussions during the

interviews. These documents added to the researcher's understanding of the issues being discussed.

Critical incident technique

Critical incident technique (CIT) was devised and first used by Flanagan (1954) almost half a century ago. Flanagan (1954) describes CIT as a set of procedures for collecting observations about human behaviour. Although he describes the procedures followed in his initial study, he goes on to suggest that the procedures should be flexible enough to allow them to be adapted to meet the specific issues under investigation. Initially CIT was used for scientific study, although more recently it has undergone a resurgence as a research technique and is used in interpretative and phenomenological studies (Chell and Adam, 1994). Several methods of conducting critical incident data collection have been described and these include interviews, surveys and observation (van Post, 1996).

Within this study critical incident technique was used to collect data about incidents which had either a positive or negative influence on the developments being studied. Similar methods were used by Sauer and Anderson (1992) to study innovation in UK hospitals. Participants were provided with dictation equipment on which they were asked to record incidents as soon as possible after they had occurred. CIT was chosen as a method because the researcher wanted to examine the influence of factors on individual developments, before the participants had been able to resolve the issue or alter the development in order to circumnavigate the problem or issue. Other methods of data collection, such as participant or non-participant observation, would

have allowed the researcher to gather this data. However, these were considered impracticable because of the geographical spread of research sites and the time constraints which would prevent the researcher from becoming immersed in the culture of the organisations being studied. Chell (1998; 55) reports that

“the question must arise as to whether other methods, for example participant observation and unstructured or semi structured interviews, might not be more effective as research tools”.

While interviews have been used to record critical incidents, such an approach was viewed as inappropriate because such interviews are retrospective in nature. The use of interviews might have allowed the participants time to resolve the issue. To some degree the recording of critical incidents using dictation equipment is also retrospective, although the data collection is probably “closer to the action” than an interview, which may occur some time later. Additionally, Chell (1998) reports that the fact that such incidents are deemed as critical means that recall by the participant will be improved.

Critical incident technique has a number of advantages and disadvantages over other data collection methods. These include the fact that CIT facilitates the revelation of those issues which the participant feels are important within a study. Additionally, the focus on specific incidents allows the participant to provide clarity and attach meaning to such events, which may not be available using other methods such as surveys or observation. Disadvantages of CIT include potential problems with the participant’s ability to recall events, which may affect the reliability of the data

obtained. Another major problem, especially in studies involving health care professionals, is that participants tend to concentrate on critical patient incidents or crisis events and as a result, many critical incidents relate to the impact of negative incidents (Norman et al, 1992).

Flanagan (1954) outlines five steps when conducting critical incident enquiries; three of these steps relate to data collection and will be described here. The remaining steps relate to data analysis and reporting respectively and the methods used are described later in this chapter.

1. Determining the aim of the activity

Participants were asked to record positive and negative events which influenced the development during the year. Each participant was supplied with a laminated card detailing what information they should record (Appendix 09). Woolsey (1986) suggests that it is important that the directions indicate exactly the kind of incidents required, as this will facilitate later data analysis. Participants were also supplied with a dictaphone recorder, a supply of tapes, spare batteries and a supply of stamped addressed envelopes to allow the participant to dispatch the tape to the researcher as soon as possible after recording. In addition to the written information, the researcher discussed the nature of critical incidents and the type of information to record with each respondent during the initial research interview.

2. Setting the plans, specifications and criteria

This stage involves identifying who will make the observations or record the incidents, what information will be recorded and when it should be recorded.

Participants were asked to self-report using the dictation equipment. However, they were informed that they would have the opportunity to clarify what had happened after the incident during the next interview. Indeed, appendix 08 outlines how critical incidents would be used as part of the interview schedule during the six month and one year interviews.

3. Collecting the data

The most commonly used method of collecting the data is critical incident interviews. Self report using questionnaires, diaries and recording equipment is less widely reported in the literature. When using self reporting methods, the issue of compliance and response rate is of major concern. Within this study compliance was considered to be a potential problem. In an attempt to improve this, the researcher devised a number of methods of prompting participants to remember to record incidents. This included the regular dispatch of postcards to remind participants of the need to record information. Additionally, as participants returned incidents, a letter was sent by return of post to thank them for their contribution and to ask them to keep the researcher posted of any further developments related to issues discussed or any other issues of importance. Despite these attempts at encouraging compliance, only three of the six sites sent critical incidents to the researcher. While this is a poor response rate, the nature of the data obtained using CIT was very powerful and useful in shaping both future data collection and facilitating data analysis.

Semi-structured interviews

Semi-structured interviews were scheduled to be conducted with the practice development facilitators within each of the case study sites three times during the one

year period. Within semi-structured interviews the researcher asks certain major questions but is free to alter the sequencing of questions and to probe for more information (Fielding, 1994). This method allows the researcher to talk around a topic thus exploring more dimensions of the phenomenon being studied than would otherwise be possible. Semi-structured interviews require careful planning to ensure that the researcher is able to elicit all of the information required from the participant. Such methods often utilise open ended questions and, as such, they can allow the participant to drift away from the phenomena being studied. To facilitate the interview process, semi-structured interview schedules were developed for each of the three interviews (Appendix 08). These schedules were sufficiently open to enable the researcher to explore issues of interest from each of the different research sites. In particular, the schedules needed to allow the researcher to explore in detail the impact of critical incidents and how these had subsequently been resolved or dealt with.

Each of the interviews was tape recorded, using portable recording equipment. Permission to record the interviews was sought prior to each interview and the fact that permission had been granted was recorded on the tape at the beginning of each interview recording. Participants were informed that they would not be identifiable from the tape in any way and that, after the research, either the tape could be returned to them or it would be destroyed by the researcher. All respondents were happy for the researcher to destroy the tapes. Each interview was set up by telephone after an initial letter indicating that an interview was scheduled to occur in the next month. Once the date and time had been established, the researcher sent the participant a

letter confirming the arrangements and indicating the questions / issues to be explored during the interview.

Interviews lasted between 45 minutes and 1 hour and following recording were transcribed verbatim by the researcher. Several of the research sites provided documentary data such as assessment tools, models etc. and these were used to support the interview data collected. These documents greatly assisted the researcher to identify the issues to be addressed during the next interview and subsequently to analyse the data.

□ Issues in longitudinal research within health service organisations

During the case studies data were collected longitudinally in order that the process of developing practice could be examined. Ruspini (2000) describes longitudinal research as a process whereby data is collected over a period of time for each item or variable for two or more periods. Longitudinal research designs are particularly useful when measuring change over time and when seeking to locate the cause of a social phenomenon (Menard, 1991).

As mentioned earlier, interviews were held on entry to the study and at six months and one year later in most of the research sites. Table 5.1 outlines the process of data collection from the case study sites during the year. This table clearly shows that for some of the sites data collection ended early. The reason for this is that in these sites the respondent either no longer worked on the project or no longer worked in a practice development role within the organisation. Indeed, in only two of the six sites

was the same respondent involved in each of the three interviews. Attrition of this nature is a common feature of longitudinal studies and can occur for a number of reasons, such a refusal to participate or moving on from either their address or workplace (Ruspini, 2000). Attrition in this study may have occurred for a number of reasons, including promotion to another role, change of role, organisational transition as a result of merger or re-organisation and maternity leave. In those sites where interviews were conducted with other individuals, the researcher was able to ascertain that they were key informants for the work as they were leading the development in the absence of the original research participant. Menard (1991) outlines how longitudinal research requires that subjects or cases analysed are the same or at least comparable from one period to the next. In those sites where changes to participants were necessary, the cases analysed remained the same and the informants were in comparable roles to the original participant.

Table 5.1 Data collection from research sites

Site	Location	Initial interview	Six month interview	Twelve month interview
A	Scotland – Acute Trust	✓	✓	✓
B	Scotland – Primary Care	✓	✓	✓
C	England - Acute	✓		
D	Wales - Combined	✓	✓	
E	England - Acute	✓	✓	✓
F	Scotland - Acute	✓	✓	✓
G	England - Acute	✓	✓	✓
H	England - Acute			

Longitudinal studies have a number of disadvantages, including the fact that they are very time consuming and can prove to be very expensive. Additionally, problems can occur with panel conditioning, with participant's responses being influenced by

previous interviews. This may have been a very real problem within this study. Prior to each interview the researcher talked the participant through the data analysis and event state networks from previous interviews and critical incidents. The participants found this very useful in recapping the previous discussions. However, in some cases participants used these documents as a guide to planning the next stage in the development. To some degree the research may have been responsible for driving the development forward by providing information which assisted the participant to identify the current state of play and plan the next stages for implementation.

□ Data analysis

Analysis of the Delphi survey data

The first round Delphi survey data were analysed using thematic content analysis to construct categories. Cavanagh (1997: 5) suggests that content analysis “allows the researcher to test theoretical issues to enhance understanding of the data”. Although it owes its origins to quantitative data analysis, where the frequency of words and phrases is counted, content analysis in qualitative terms is about the distillation through analysis of words into fewer content related categories (Cavanagh, 1997). The responses to the first round survey were examined and coded. Each of these codes and their associated illustrative quotations were then cut into strips and then placed together into broad categories. Once all of the codes had been allocated to a group a category description was developed. This resulted in the identification of 24 positive categories and 23 negative categories. Each of these categories, together with illustrative quotations, were then used to design the second phase survey.

The second round survey data were analysed to identify the overall ranking for both positive and negative influences. This was achieved by converting each letter to a corresponding number of votes. For example A = 24 votes, B=23 votes and so on for each of the possible letters. The total number of votes was then calculated for each item and the overall ranking placed the category with the largest number of votes as number one. At the same time, two other percentages were calculated. These were the percentage of participants voting for the category and the percentage of participants voting the category as one of their top five influences. Further analysis was then undertaken to compare the overall rankings by Acute and Community / Combined NHS Trusts. This involved the use of a Kruskal-Wallis test to identify whether there is a difference in the way in which the three types of NHS Trust (acute, community and combined) ranked the factors. The Kruskal-Wallis test is used to compare the number of times a score from one of the samples is ranked higher than a score from the other samples. The Kruskal-Wallis test is a non parametric test which compares three or more unpaired groups. In this test all values are ranked high to low with tied ranks being replaced by averages. The ranks within each group are compared and reported. In this study the Kruskal-Wallis test is used to identify whether one type of Trust (acute, community or combined) ranked categories higher than other Trust types.

Relationships between the variables

Principal Component Analysis (PCA) was used to identify if there was a relationship between the variables identified in the study. PCA is a statistical technique applied to

a set of variables where the researcher is interested in discovering which variables form into coherent subsets (Tabachnick and Fidell, 1996). There are two major types of PCA, exploratory and confirmatory. In exploratory PCA, the relationship between various variables is examined without determining the extent to which the results fit into a particular model, whereas, in confirmatory PCA the results are compared against a hypothetical model.

The positive and negative factors were subjected to exploratory PCA and a correlation matrix was constructed using the factors from the Delphi survey. Kaiser's criterion was used to identify those positive and negative variables with an Eigenvalue of more than 1. Those factors which explained most of the variance were retained in four negative and four positive components. The next stage of analysis involved the rotation of the factors using orthogonal rotation (varimax). This method of rotation was selected because it produces unrelated components. In the next stage, the results from the rotated component matrix are analysed to determine which factors load most highly on to it. Those factors which correlate less than 0.3 were omitted from consideration because they account for less than 9% of the variance. Finally, a concept label was developed which describes all of the variables within a particular component. The development of such a label is an attempt to understand the underlying dimension which unifies the group of variables loading onto a component. The component labels were developed by re-examining the original meaning attached to each factor during the first round Delphi survey. Through this process it was possible to select a word or phrase which encapsulates all of the factors which have loaded onto each particular component.

Analysis of the case study data

Within the case studies data were collected using a series of semi-structured interviews and using self report critical incident technique. Each of the interviews and the critical incidents was transcribed verbatim by the researcher. These were then coded to identify themes. This involved the examination of each transcript and the noting of marginal remarks about important themes within the progress of each development. Each of these marginal remarks or themes was then considered for inclusion within the causal network. Miles and Huberman (1994; 153) describe how “a causal network is a display of the most important independent and dependent variables in a field of study together with the relationship between them”. In Chapter 4, an alternative view of causality was outlined. This involves the concept of mutual simultaneous shaping, where factors combine to produce an effect rather than the simpler view of A causing B. Miles and Huberman (1994) acknowledge that a causal relationship involves mutual factors interacting with their context to produce an effect. They recommend that causal links are identified through the plotting and analysis of the whole story rather than simply considering distinct elements of it.

In this study causal network analysis was selected as the method of data analysis for the case study data for the following reasons: -

- It allowed for the identification of the antecedent and process variables (factors) and the influence these have on practice development
- It enabled the researcher to identify which factors combine to produce specific events / states

- It provided a succinct and clear way of processing a large quantity of data gathered as part of a longitudinal study
- It facilitated cross case comparison between study sites.

Format of causal network analysis

An adapted format of the causal network analysis method described by Miles and Huberman (1994) was used within this study. Miles and Huberman (1994) describe how approaches to building causal networks can be regarded as inductive or deductive. Within the inductive approach the researcher discovers recurrent phenomena and identifies relations among them. As fieldwork progresses the local cause map emerges in a piecemeal manner with names and labels clustering into probable causes and the effects. The deductive approach involves the researcher starting with a theory or a preliminary causal network. In this study an inductive approach was used. The researcher had some data from the Delphi survey, which could have been used to develop a preliminary causal network. However, the intention of the case study research was to collect data about the process of developing practice, rather than to test a hypothesis based upon those factors which Directors of Nursing felt were likely to have an influence.

The first step in the analysis involved the coding of the transcripts described earlier. Unlike the process described by Miles and Huberman (1994), no attempt was made to rate the factors within the causal network. Miles and Huberman (1994) suggest that ratings such as low, medium and high can be used to define how much of a particular factor there was in a particular case. While this is useful in certain

situations where one can have a high degree of participation, it is less useful when describing variables such as transition.

Once this coding was completed the themes identified were used to construct interim case summaries. These case summaries were useful inasmuch as they enabled the researcher to determine possible causal linkages and to start to construct the story (narrative) which would provide the final explanation about the causal network.

Additionally, these interim case summaries were used to obtain feedback from informants. This served two purposes. Firstly, it enabled the researcher to check with the informants the construction of reality, thereby contributing to trustworthiness by assisting with credibility. Secondly, the interim case summaries allowed the researcher to identify areas which required further exploration at later interviews. In this way the production of interim case summaries was an important component of the iterative design of this study.

At the same time the researcher constructed event-state networks as these provided a great deal of information about the context in which the developments were occurring. Additionally, the event-state networks made the identification of causal linkages much easier and allowed the researcher to identify those factors which were important in the overall causal network. The event-state networks were constructed on each occasion after the first interview and these were also returned to the participants for checking. Following the participants' comments, changes were made to the event-state networks, particularly those related to the chronological order in which events occurred. Each event-state network had an associated narrative which served to tell the story of the development.

The next stage involved the generation of the causal network variable list. This stage precedes the drawing of the final causal network and is undertaken late in the data collection. The drawing up of the variable list was made considerably easier by the previous event-state networks. The variable list consists of those factors which are antecedents to the development, those which are intervening factors and those which relate to outcomes. Using the variable list, the final causal network is drawn and the associated narrative produced to describe the events.

Cross case comparison

Miles and Huberman (1994) describe how cross case causal network analysis is a powerful way to move from case specific explanations to findings that aid discovery or reinforce constructs. The basic operations related to cross case comparison are similar to those used within single causal network analysis. The first phase is to construct individual networks for each site. Once this is completed, comparative analysis of all cases can occur starting with an initial examination of the factors estimated to be the most influential. During this comparative analysis, causal streams are identified and compared to identify whether they match with streams in other cases. On some occasions it may be possible to identify similar causal streams across all of the cases.

□ Data presentation

In Chapter 6 the results are presented in a variety of ways. The Delphi survey data is initially presented in tables showing the overall rankings and descriptive statistics. These tables are described and the rankings illustrated with a number of quotations taken from the surveys. Following this the Delphi data are subjected to further statistical analysis, including Kruskal-Wallis tests and Principal Component Analysis. These results are presented in table form and the outcome of the tests is described. It has not been possible to include all of the tables from the Principal Component Analysis output; as a result some of the tables can be found on the statistical files on the CD-ROM inside the back cover of the thesis.

The case study data is presented for each site. This includes the background to each organisation and the individual developments studied. This is followed by a detailed event state network (which can again be found on the CD-ROM) and its associated narrative. These networks were used to develop the variable lists and the final causal networks. Finally, the cross case comparison draws together the major findings from the case study sites.

□ Conclusion

This chapter has outlined the methods used in the two phases of this study. In addition, it has articulated many of the practical issues associated with gaining access to the research sites and understanding longitudinal research within health care organisations. In the next chapter the results of the two phases will be presented,

together with a discussion about how the results from both phases fit together. This chapter has identified some of the limitations associated with the methods used and many of these will be covered in greater depth in the discussion (Chapter 7).

○ Chapter 6: Results

□ Introduction

This chapter presents the results of both phases of the research study which were outlined in the previous chapter. The chapter begins by presenting the results of the UK wide Delphi survey, including the non-parametric statistical analysis which was designed to test both whether there was a difference in the ranking of factors between Trust types and to aggregate data into coherent subsets through Principal Component Analysis. Following this, the chapter moves on to present the case study findings, using causal networks and their associated narratives. The major findings from each case study site are then compared as part of the cross case comparison. This reveals several factors which are common to many or all of the sites. Finally, the chapter presents a comparison between the data collected during the two phases of the study.

□ Delphi survey results

The Delphi survey consisted of two rounds. Surveys were distributed to 146 Directors of Nursing in round one with a subsequent response rate of 56.8% and 139 in round two with a response rate of 57.5%. The round one questionnaire consisted of several open questions which were analysed using thematic content analysis to form categories. A total of 24 positive and 23 negative categories was identified as a result of this data analysis. These categories were subsequently presented to participants in the second round survey. Participants were asked to rank these, using the letter A for the most influential, B the second most influential and so on, using as

many or as few letters as they wished. As highlighted in chapter 5, the results of the second round survey were then analysed by attributing a number to each letter, for example A = 24 points, B = 23 points and so on. This provided a total number of votes for each category. In addition to this data analysis, descriptive statistics were produced to identify the percentage of respondents ranking each category (using any rank) and the percentage of respondents ranking each category in their top five rankings. The overall ranking, votes and other descriptive statistics are shown in Table 6.1 (positive categories) and in Table 6.2 page 194 (negative categories).

Before expanding upon the data in the Tables (6.1 and 6.2), it is important to highlight that many of the categories identified are not mutually exclusive and several of these link. For example, risk taking is often associated with management style. For this reason the following section does not sequentially present the rankings but rather links categories together in terms of how they interact with each other. Links such as these are similar to the notion of mutual simultaneous shaping, where factors interact to produce an effect or outcome. How many of these categories link is illustrated further in both the case study results and the discussion (chapter 7).

Table 6.1 Overall ranking and descriptive statistics for positive influences

Words in **bold** are the original category labels within second Delphi survey

Rank	Category	Votes	% of respondents ranking category	% of respondents ranking category using their top 5 ranks
1	Patient focus of the development	1675	92.5	83.7
2	Culture of the organisation	1673	95	81.2
3	Empowerment of practitioners to develop	1367	83.7	61.2
4	Multi-disciplinary organisational structure	1284	77.5	58.7
5	Motivation of practitioners to develop	1278	75	56.2
6	Management style within the organisation	1268	78.7	51.2
7	Education of practitioners	1242	63.7	47.5
8	Risk taking allowed within the organisation	1160	70	51.2
9	Stability of the organisational structure	1129	70	50
10	Devolved management responsibilities within the organisation	1097	66.2	47.5
11	National agenda	1076	73.7	36.2
12	Credibility of the manager or person leading the development	1071	71.2	41.2
13	Manager's openness	1048	67.5	41.2
14	Manager's political awareness	919	61.2	38.7
=15	Local agenda	903	62.5	32.5
=15	Medical support for the proposed development	903	62.5	33.7
17	Flat management structure within the organisation	891	65	33.7
18	Public expectations of the services provided	841	55	33.7
19	Directorate structure within the organisation	817	53.7	32.5
20	Centralised decision making within the organisation	748	50	28.7
21	The organisation's relationships with stakeholders	709	48.7	30
22	Other providers of health care	655	46.2	27.5
23	Combined Acute/Community Trust	543	40	21.2
24	Hierarchical structure within the organisation	439	32.5	20

Table 6.1 illustrates how patient focus for the development is identified as the most influential of all of the categories. Many respondents identified how this was at the forefront of all of the current developments in nursing practice and how organisations considered the impact of the proposed development on patients.

“we need proof that the development would have net benefits to both patients as well as the organisation”

[Respondent 113 – Acute Trust]

Organisational culture was identified as the second most influential category. Indeed, several respondents felt that this category is responsible for providing many of the other essential ingredients which are necessary to develop practice e.g. motivation and risk taking. Essentially, the category was characterised by a feeling that the organisation needed to develop a culture which would foster innovation.

“organisations need to develop a forward thinking and motivated culture which supports innovation and development”

[Respondent 113 – Acute Trust]

Similarly, the degree of risk taking within the organisation (ranked 8) was identified as an important part of risk taking within practice development

“a blame free culture which allows nurses to take risks and develop”

[Respondent 002 – Acute Trust]

Empowerment (ranked 3) and Management style (ranked 6) were also closely linked. Many of the respondents felt that staff should be empowered to take a lead role in developments and that this could be facilitated by the management style.

“managers need to nurture staff with ideas while firmly managing them to ensure that any development is in keeping with organisational need”

[Respondent 002 – Acute Trust]

A multi-disciplinary focus for development (ranked 4) that could be facilitated through the development of multi-disciplinary structures where staff from different disciplines are managed around a patient grouping, for example stroke services, was felt to be important. Such a grouping facilitates development which is patient focused and breaks down the barriers between professions.

“the emphasis should not be on pushing the nursing agenda but keeping focused on clinical development”

[Respondent 003 – Combined Acute / Community Trust]

Despite a feeling that a multi-disciplinary structure was important, the most common method of achieving this in the health service, via the Directorate structure, was ranked significantly lower at 19. The possible reasons for this are discussed in chapter 7.

Devolved management responsibilities was ranked 10 while a similar category relating to a flat management structure was ranked much lower at 17. Some

respondents articulated that the rationale for this was that devolved management responsibilities allowed staff to lead development and make decisions about implementation. Despite some respondents describing how a flat management structure can facilitate this by preventing hierarchical interference and making management more accessible, the majority felt that a flat structure did not provide human resources to drive forward developments.

Contextual influences such as the national and local health development agenda (ranked 11 and 15 respectively) and public expectations (ranked 18) were all ranked towards the lower end of the table. Of these, the national agenda was thought to be the most influential category. This is illustrated by national policies such as clinical governance driving forward the development of practice.

“Clinical Governance initiatives will facilitate the development of nursing practice”

[Respondent 011 – Combined Acute / Community Trust]

Several structural factors were identified and of these, stability (ranked 9) was thought to be important. Several respondents identified how their organisations were currently undergoing restructuring and how this had created problems in developing practice.

“working in an environment which is well structured and established facilitates development”

[Respondent 113 – Acute Trust]

The individual factors of the manager's credibility, openness and political awareness were ranked as 12 to 14 respectively. Respondents felt that managers could influence developments if they were

“accessible... aware of political and professional contexts... and were able to act as a positive role model ‘viewing change as a challenge’”.

[Respondent 091 – Acute Trust]

Negative Influences

Table 6.2 (over the page) shows the rankings and descriptive statistics for the negative influences. The top two negative influences appear to be closely linked (Table 6.2). Resources relates to funding, administrative support and staffing levels. Many people felt that NHS Trusts were too finance orientated and this had a negative impact on proposed developments.

“there are often not enough staff in development areas with the energy and motivation to take projects on board”

[Respondent 017 – Acute Trust]

“the current business orientation means that practice development is often secondary to finance at times”

[Respondent 126 – Acute Trust]

Table 6.2 Overall ranking and descriptive statistics for negative influences

Words in **bold** are the original category labels within second Delphi survey

Rank	Category	Votes	% of respondents ranking category	% of respondents ranking category using their top 5 ranks
1	Resources for development	1502	85	77.5
2	Emphasis on finance within the organisation	1351	76.2	53
3	Pressures on the service and staff	1208	71.2	53.7
4	Attitudes of staff towards development / change	1186	73.7	51.2
5	Pace of change within the NHS and the organisation	1147	68.7	47.5
6	Reactive culture within the organisation	1118	66.2	51.2
7	Hierarchical structure within the organisation	1075	65	48.7
8	Recruitment and retention problems	1039	66.2	41.2
9	Education for practitioners	1037	66.2	43.7
10	Multiple management responsibilities	1020	62.5	45
11	Lack of support for practitioners wanting to develop	1010	62.5	46.2
12	Disempowerment of practitioners	1005	60	46.2
13	Management style within organisation	975	58.7	42.5
14	Directorate structure	947	57.5	43.7
15	Geographical spread of the organisation	869	55	41.2
16	Need for rapid visible change	836	51.2	36.2
17	Legal aspects of developing practice	803	51.2	36.2
18	Transitional structure within the organisation	746	46.2	35
19	National agenda	659	45	25
20	Flat management structure within the organisation	645	40	31.2
21	Commissioners/contracts	628	42.5	27.5
22	Other providers of NHS services	578	37.5	28.7
23	Devolved management responsibilities	572	37.5	27.5

Pressures (ranked 3), pace of change (ranked 5) and a reactive culture (ranked 6) all figured in the top 10 rankings. Pressures mainly centred on bed occupancy and the constant pressure to do more in response to waiting lists. This resulted in conflict between National driving forces in the form of policy and targets and local driving forces often identified by managers or practitioners themselves.

“there is conflict between the ‘must do’ from policy and the ‘like to dos from nurses”

[Respondent 028 – Acute Trust]

Such driving forces also resulted in a reactive culture where developments were initiated in response to an event or incident. Some respondents felt that this resulted in ‘short termism’.

“it is easy to get bogged down in what is happening today rather than looking towards the future”

[Respondent 102 – Acute Trust]

Education (ranked 9) was considered a key negative influence and this was both the result of staff lacking certain skills, as well as the problems with providing training to a large number of staff. While it was felt that a sound continuing education policy was a useful positive factor, some respondents felt that training strategies were often a hit and miss affair.

The attitudes of staff towards change (ranked 4) were thought to be an important influence and one respondent felt that the current situation was often the result of many years of not managing under performance by staff. Resistance to change was also identified as a significant influence.

The organisation's ability to recruit and retain staff (ranked 8) also figures prominently in the ranking. This, together with transitional organisational structures (ranked 18), can stifle development. Additionally, rapid staff turnover or changes in management can affect the sustainability of previously implemented developments.

“continuity of staff is important if development is to happen or be sustained”

[Respondent 070 – Acute Trust]

The fact that transitional structure is ranked so low (ranked 18) is very surprising, especially given that this is identified as a major influence on development in the case study results (discussed later in this chapter). This suggests that the Directors of Nursing who participated in this study may underestimate the importance of this factor and its negative influence on practice development. This issue will be discussed in more detail in the next chapter.

Not surprisingly, respondents reported that hierarchical structure (ranked 7) was a significant negative influence, together with other related management styles such as authoritarianism. The reasons identified included the fact that such structures make communications problematic and disempower nurses, making it more difficult for

them to influence development. Indeed, disempowerment also figures prominently in the ranking (ranked 12) and many respondents identify that this centres on the manager's need for control.

“the managers often need to command rather than empower”

[Respondent 077 – Community Trust]

Similarly, development can be affected by a lack of support from other professional groups (ranked 11). Resistance from these groups was attributed to a perceived loss of power and a traditional view of what nurses do.

Surprisingly, multiple management responsibilities are ranked as the tenth most influential negative category. These responsibilities often mean that nurses are managed by General Managers who are also responsible for other professional groups as well as support services. Such posts are symptomatic of the move towards multi-disciplinary structures, which was ranked as the fourth most influential positive category.

As with the positive influences, most of the contextual categories are ranked at the bottom of the table. One interesting category is the need for rapid visible change, (ranked 16) which may be symptomatic of transitional structures, and this is discussed further in chapter 7.

“there is a desire to get things done quickly to be able to tick the box, the long term sustainability of the development is often sacrificed as a result”

[Respondent 126 – Acute Trust]

The divisive nature of a Directorate structure (ranked 14) resulted in it being ranked as a more influential negative category than the other structural issues.

“a Directorate structure makes it difficult to attain any uniformity, coherence or shared strategic vision for nursing”

[Respondent 077 – Community Trust]

Uniformity is also affected by the geographical spread (ranked 15) of the Trust and this was thought to be a considerable negative influence on the implementation of certain developments. Such a wide spread of services may also result in problems with the sharing of best practice between groups.

“the complexity of services over a wide area can lead to difficulties in sharing best practice”

[Respondent 132 – Combined Acute / Community Trust]

□ Results of the non-parametric statistical analysis of the Delphi data

A Kruskal-Wallis H test was performed on the Acute, Community and Combined Acute / Community data from the round two Delphi survey. This test was performed to identify if there was a difference between the ranking of categories between Trust types. Ranks and full test statistics can be found on the CD-ROM located inside the back cover of this thesis.

Kruskal-Wallis test of overall scores (positive categories)

The results of the Kruskal-Wallis test of the overall scores grouped by Trust type suggest that there is a statistical significance (Chi-square = 54.0; df = 2; $p < 0.01$) between the way Acute, Community and combined Trusts rank the variables which influence the development of nursing practice. Acute Trusts tend to score variables higher than both Community or combined Trusts.

Kruskal-Wallis test to compare the mean ranks of each individual positive variable

The mean rank for each variable was calculated. This was then used to undertake a further Kruskal-Wallis test to compare the mean ranks for each of the 24 variables.

Table 6.3 shows the mean ranks by each of the individual Delphi variables. Only the variable “Patient Focused Development” shows a significant difference ($p = 0.050$) between the mean rank awarded by the Acute, Community and combined Trusts (see Table 6.4).

Table 6.3 Kruskal-Wallis ranks for positive categories

Variable name	Acute Trusts		Community Trusts		Combined Trusts	
	n	mean rank ¹	n	mean rank ¹	n	mean rank ¹
Flat management structure	29	25.16	12	22.08	7	25.93
Multi-disciplinary structure	37	30.16	15	32.40	8	28.50
Hierarchical structure	16	11.78	7	15.79	3	17.33
Devolved management responsibilities	29	28.36	17	24.62	6	22.83
Directorate structure	30	22.07	6	22.92	8	23.81
Stability of the structure	36	29.56	12	24.50	7	26.00
Patient focus of the development	45	40.17	17	34.09	10	24.10
Centralisation of decision making	27	20.93	9	21.22	5	21.00
Medical support for development	36	28.29	11	23.32	6	26.00
Risk taking within the organisation	31	27.18	15	27.30	9	32.00
Culture of the organisation	44	38.76	19	33.74	11	38.95
Motivation of the individual	38	28.84	13	28.58	8	37.81
Education of practitioners	37	31.58	13	28.15	9	26.17
Combined Acute/Community Trust	19	15.16	8	18.69	4	14.63
Public expectations of service provision	26	21.83	11	20.73	5	21.50
Influence of national agenda	38	33.07	14	24.11	7	25.14
Influence of local agenda	31	26.98	11	18.50	7	26.43
Other providers of health care	21	17.62	9	17.72	5	20.10
Relationships with stakeholders	22	19.80	9	16.56	6	19.75
Manager's political awareness	31	24.47	10	23.30	8	29.19
Manager's openness	34	27.81	13	24.00	7	32.50
Empowerment of the practitioner	40	32.00	14	29.64	10	38.50
Management style	39	30.63	13	26.19	9	39.56
Manager's credibility	37	27.99	12	26.50	6	31.08

¹ Mean rank – During analysis SPSS ranks all values high to low with tied ranks being replaced by averages. Hence the output in this column does not reflect the rankings given by the respondents to the Delphi survey

Table 6.4 Kruskal-Wallis test statistics for positive categories

	Chi-Square	df	Asymp.Sig
Flat management structure	.504	2	.777
Multi-disciplinary structure	.306	2	.858
Hierarchical structure	2.239	2	.326
Devolved management responsibilities	1.076	2	.584
Directorate structure	.126	2	.939
Stability of the structure	1.045	2	.593
Patient focus of the development*	5.978	2	.050
Centralisation of decision making	.004	2	.998
Medical support for development	.914	2	.633
Risk taking	.688	2	.709
Culture of the organisation	.843	2	.656
Motivation of the individual	2.032	2	.362
Education	.933	2	.627
Combined Acute/Community	.970	2	.616
Public expectations	.063	2	.969
Influence of national agenda	3.453	2	.178
Influence of local agenda	2.995	2	.224
Other providers	.250	2	.883
Relationships with stakeholders	.618	2	.734
Manager's political awareness	.885	2	.642
Manager's openness	1.419	2	.492
Empowerment of the practitioner	1.438	2	.487
Management style	3.121	2	.210
Manager's credibility	.332	2	.847

*only factor demonstrating a statistically significant difference

Kruskal-Wallis test of overall scores (negative categories)

The results of the Kruskal-Wallis test of the overall scores grouped by Trust type suggest that there is a statistical significance (Chi-square = 53.3; df = 2; $p < 0.01$) between the way Acute, Community and combined Trusts rank the variables which influence the development of nursing practice. Acute Trusts tend to score variables higher than both Community or combined Trusts.

Kruskal-Wallis test to compare the mean ranks of each individual negative variable

The mean rank for each variable was calculated. This was then used to undertake a further Kruskal-Wallis test to compare the mean ranks for each of the 23 negative variables. Table 6.5 shows the mean ranks by each of the individual Delphi variables. There is no significant difference between the mean rank awarded to each variable by the Acute, Community and combined Trusts (see Table 6.6).

Table 6.5 Kruskal-Wallis ranks for negative categories

Variable name	Acute Trusts		Community Trusts		Combined Trusts	
	n	mean rank ¹	n	mean rank ¹	n	mean rank ¹
Flat management structure	18	14.25	9	18.94	4	17.25
Hierarchical structure	30	26.35	14	24.29	7	27.93
Devolved management responsibilities	17	13.15	7	18.36	4	13.50
Directorate structure	28	22.02	12	25.58	5	22.30
Geographical spread	27	20.20	10	27.50	6	20.92
Transitional structure	22	15.32	7	20.71	6	24.67
Reactive culture	34	27.69	12	26.71	7	24.14
Organisational emphasis on finance	39	30.44	16	32.59	6	30.42
Resources for the development	42	33.75	15	29.37	10	42.00
Legal implications of the development	24	20.19	11	22.50	4	12.00
Multiple management responsibilities	32	24.53	11	27.32	5	18.10
Lack of support from others	31	25.19	9	25.06	8	21.19
Recruitment & retention problems	34	27.40	14	25.25	5	29.20
Education of the practitioner	35	25.60	8	24.69	8	29.06
Attitude of practitioner	38	31.22	12	23.38	9	33.67
Commissioners and contracts	19	16.66	11	18.41	3	14.00
Influence of national agenda	25	18.48	7	18.86	4	18.00
Pace of change	36	30.81	13	25.04	7	23.07
Pressures on the service	36	29.61	13	28.46	7	22.86
Other providers of health care services	19	15.58	8	16.63	3	12.00
Need for rapid visible change	29	23.21	8	17.44	6	22.25
Disempowerment of the practitioner	30	25.32	13	26.27	7	24.86
Management style	31	25.90	12	26.33	7	22.29

Note – no significant differences between Trusts on any of the variables

¹ Mean rank – During analysis SPSS ranks all values high to low with tied ranks being replaced by averages. Hence the output in this column does not reflect the rankings given by the respondents to the Delphi survey

Table 6.6 Kruskal-Wallis test statistics for negative categories

	Chi-Square	df	Asymp.Sig
Flat management structure	1.733	2	.420
Hierarchical structure	.38	2	.845
Devolved management responsibilities	2.113	2	.348
Directorate structure	.658	2	.720
Geographical spread	2.579	2	.275
Transitional structure	4.767	2	.092
Reactive culture	.322	2	.851
Organisational emphasis on finance	.182	2	.913
Resources for the development	2.689	2	.261
Legal implications of the development	2.553	2	.279
Multiple management responsibilities	1.530	2	.465
Lack of support from others	.551	2	.759
Recruitment & retention problems	.312	2	.856
Education of the practitioner	.433	2	.805
Attitude of practitioner	2.427	2	.297
Commissioners and contracts	.561	2	.756
Influence of national agenda	.018	2	.991
Pace of change	2.179	2	.336
Pressures on the service	1.045	2	.593
Other providers of health care services	.629	2	.730
Need for rapid visible change	1.356	2	.508
Disempowerment of the practitioners	.056	2	.972
Management style	.415	2	.812

□ Results of the Principal Component Analysis of Delphi data

In order to identify if a relationship existed between the variables identified in the Delphi survey, a Principal Component Analysis (PCA) was performed. As explained in chapter 5, PCA is a statistical technique used to identify which of the identified variables form into coherent subsets. There are a number of stages within PCA, the first of which is the construction of a correlation matrix. Given the large number of variables involved, it has not been possible to reproduce the correlation matrices here. As a result, the correlation matrices for the positive and negative PCAs can be found on the CD-ROM [as an SPSS Version 8 file].

Using Kaiser's criterion, those components with an Eigenvalue of more than 1 are retained while the remaining components are rejected at this stage. This process is shown diagrammatically on a Scree plot [see PCA output on CD-ROM]. Finally the variables are rotated to increase the interpretability. Table 6.7 shows the positive rotated component matrix and Table 6.8 the negative one (explanation of the variable labels used in these tables can be found as appendix 10). Each factor is loaded to a particular component, for example the highest score. Once the factors which load onto each component are identified, a component label is developed which represents the grouping.

Table 6.7 Positive Rotated Component Matrix

Factors	Component			
	1	2	3	4
STAB_STR	.934	-3.869E-02	.179	.128
DEVMANR	.921	.232	-.102	.181
MD_STR	.906	5.329E-02	.372	8.623E-02
FLAT_STR	.826	.240	.391	7.291E-02
MED_SUPP	.798	.573	.115	-5.628E-02
COMBINED	.791	.294	.512	5.525E-02
HIER_STR	.780	.257	.465	7.071E-02
DIR_STR	.778	.383	.330	9.918E-02
CENTRAL	.707	.346	.560	.185
CULTURE	8.900E-02	.893	-5.845E-02	-2.198E-02
EMPOWER	.256	.880	8.652E-02	-8.691E-02
MAN_STYL	-.117	.876	.352	.107
CREDAB	.258	.866	.251	-1.366E-02
LOCAL_A	.368	.753	.485	-2.994E-02
MOTIVAT	.311	.732	.514	-.179
MAN_OPEN	.207	.714	.522	.239
REL-STAK	.365	.703	.577	-1.993E-02
OTHER_P	.481	.643	.464	.264
NAT_AGEN	.310	.637	.582	.302
RISK_TAK	.590	.628	.196	-9.115E-03
EDUCATE	.426	.210	.763	-.293
PUBLIC_E	.478	.328	.715	9.142E-02
MAN_POL	.288	.515	.705	.197
PT-FOCUS	.288	-3.277E-02	2.655E-02	.936

Table 6.8 Negative Rotated Component Matrix

Factors	Component			
	1	2	3	4
EDUCAT	.893	.127	.214	.328
ATTITUDE	.856	1.131E-02	.178	.437
DISEMP	.782	.437	.231	.191
RESOURCE	.748	.111	.388	.116
RECRUIT	.684	.482	.142	.414
TRAN_STR	.642	.273	.497	.467
MAN_STYL	.640	.418	.547	.241
DIR_STR	.630	.571	.367	.315
PACE_CH	.143	.917	-.165	.211
RAP_VIS	.111	.898	.268	.101
PRESSURE	.351	.762	-5.940E-02	.494
N_AGENDA	.249	.708	.606	.213
DEV_MAN	.467	.671	.512	.195
GEO_SP	.330	.605	.523	.466
FLAT_STR	.547	.563	.440	.184
HIER_STR	.326	.559	.539	.369
EMP_FIN	7.165E-02	-1.995E-02	.975	4.786E-02
REACTIVE	.212	.115	.932	7.522E-02
COM_CONT	.558	.242	.693	.363
LACK_SUP	.154	.339	.230	.872
MULT_MAN	.386	.143	-9.560E-02	.868
LEGAL	.117	.343	.449	.767
OTH_PROV	.375	.505	.519	.545

Tables 6.9 and 6.10 show the four positive and the four negative components identified through the Principal Component Analysis. The variables which load onto each of these components are listed together with the component label. The component label is designed to illustrate all of the variables which are loaded onto that component. The component labels are developed by re-examining the original meaning attached to each factor, using the quotations from the earlier Delphi surveys. Through this process, it is possible to identify a word or phrase which encapsulates all of the factors, which are then loaded onto each individual component.

A further PCA was performed, transposing the data set, thereby using the cases as variables. This was undertaken to see if the variables formed into coherent sub-sets as a result of Trust type. A total of 25 cases with less than three missing values was identified. The missing values were replaced by the mean rank for that score. The results suggest that neither the negative nor the positive components related to Trust type.

Table 6.9 Components identified following principal component analysis of positive variables

	Component 1	Component 2	Component 3	Component 4
Variables loading onto component	Stable management structure Devolved management responsibilities Multi-disciplinary structure Flat structure Medical support Combined Acute / Community trust Hierarchical structure Directorate structure Centralisation	Culture Empowerment Management style Credibility Local agenda Motivation Manager's openness Relationship with stakeholders Other providers National agenda Risk taking	Education Public expectations Manager's political awareness	Patient focused development
Component label	Organisational structure	Culture and context	Anticipation of change	Focus
Illustrative quotations related to variables	“provides strong leadership” “Working in a well structured environment facilitates development” “Allows for collaboration rather than competition”	“Move away from an autocratic system to one which fosters innovation” “Drive towards quality and service development from the centre”	“Local people value the service and want to see it develop” “Aware of the political and professional context”	“Proof that a development will have net benefits to both the patient and the organisation”

Table 6.10 Components identified following principal component analysis of negative variables

	Component 1	Component 2	Component 3	Component 4
Variables loading onto component	<p>Education of staff Attitudes of staff Disempowerment of staff Resources Recruitment Transitional structure Management style Directorate structure</p>	<p>Pace of change Need for rapid visible change National agenda Devolved management responsibility Geographical spread Flat management structure Hierarchical structure</p>	<p>Emphasis on finance Reactive culture Commissioners and contracts</p>	<p>Lack of support from other professional groups Multiple management responsibilities Legal considerations Other providers</p>
Component label	Interpersonal and structural	Pressure	Restricted and reactionary responses	Tensions
Illustrative quotations related to variables	<p>“Reluctance to try something different” “Glory taking and focusing on self achievement” “Evolving organisational structure is detrimental to the continuity of clinical leadership”</p>	<p>“Feels like you have not had time to implement one thing before you’re expected to introduce something else” “Minimal human resources for practice development”</p>	<p>“Business orientation means practice development is secondary to finance” “Development is a response to an event or incident” “Contracts are tight with little room for manoeuvre”</p>	<p>“Tensions between primary and secondary care” “The medical voice can limit development as many doctors have a traditional view about what nurses do” “Anxiety about increased litigation”</p>

□ Causal Networks from Case Study Sites

Data from the six case study sites were analysed using causal network analysis. This involved the production of event state networks and their associated narratives, together with variable lists, causal networks and their narratives. Each network is preceded by a brief background to the NHS Trusts selected as the case study sites and the background information related to the practice developments studied.

Regrettably, owing to the requirements of binding, full page reproduction of the event state networks is not possible within the body of this thesis. As a result the event state networks can be found as a portable document format (pdf) file on the compact disk which is located inside the rear cover on this thesis.

The event state networks on this disk can be viewed using adobe acrobat reader.

Both the narratives and the network diagrams contain numbers which are designed to orientate the reader. While the numbering is sequential within the narratives, it is not possible to number the networks sequentially. The reason for this is that, within the networks, several factors outside of the main development can influence the process; for example Trust merger is a common occurrence in many developments and, while it has an influence, it is not a direct part of the development.

Case Study Site A

Background to Site A

Site A is a small hospital which is part of a geographically spread acute NHS Trust in Scotland. The hospital was previously a NHS Trust serving the local population. However, following the formation of a Primary Care Trust, the hospital merged with a neighbouring, much larger acute Trust. The Trust was formed on 1 April 1999 and has an annual budget in excess of £200 million. There are over 3,000 in-patient beds on 7 hospital sites across the area. The Trust has a well established network of practice development facilitators providing support to practitioners wishing to develop practice and providing continuing professional development. However, these facilitators continue to work along the old organisational boundaries and there was little cross site development at the time of the research.

Nature of the Development

The passage of fine bore naso-gastric tubes has traditionally been the role of the medical practitioner. The use of enteral feeding carries a risk of aspiration of food into the lungs if the tube is placed in the wrong position. For this reason doctors have traditionally passed these tubes and then checked their position using a chest x-ray.

Most nurses have experience of naso-gastric intubation using larger bore tubes to drain stomach contents either before or after surgical intervention. These tubes are

used for drainage rather than feeding and, therefore, there is less risk of damage from an incorrectly placed tube.

Enteral feeding is becoming increasingly common both within hospital and the community. Feeding via this route, rather than using a direct parental route, is less expensive and carries none of the risks of sepsis and embolism.

Site A: Event / State Network Narrative

Figure 6.1 (compact disk) shows the event state network for Site A².

The development of the nurse's role in the passage of fine bore naso-gastric tubes came about as a result of a number of related factors. Prior to the development, there was a general acceptance that feeding was a problem because of the type of surgery which was being undertaken (1). This notion of a problem was heightened by the appointment of a new Consultant (2), which resulted in gastric surgery and, therefore, enteral feeding becoming more common (3). This, together with an audit of the nutritional support of patients across the hospital (4), revealed that nutritional support was a major issue, with patients waiting several days before their nutritional support commenced. In addition, the past experience of the practitioners involved in the development highlighted the inconvenience often experienced by patients who were scheduled to commence enteral feeding (5).

² Numbers in brackets in the narrative relate to the numbers shown at the top corner of each box on the network diagram. These numbers serve to orientate the reader and are not intended to signify the importance of each event

At the same time, nursing staff felt that the increasing demand for enteral feeding was placing additional pressure on junior doctors around the time that the government was placing pressure on NHS organisations to reduce junior doctors hours (6).

Several nurses had identified that nurses could pass the naso-gastric tubes (7) and therefore speed up the process of nutritional support and reduce the inconvenience to patients. The change agent suggested this to staff on the wards and to the Director of Nursing Services (8). This was accepted, mainly because the change agent was seen as credible (9) and had the respect of her colleagues and because the new responsibility was sold as a key component of care rather than simply another delegated task from medical staff (10). At the same time, some staff raised the issue of why other professional groups should not be involved in passing the tubes (11). This centred on the performance of the procedure by Dieticians, as it was this group of professionals who usually made the decision that nutritional support should be initiated. Many Dieticians were keen to be involved but felt that they would need approval from their statutory body before they could perform the procedure. Approval was sought (12) and outline approval was granted, though not formally in writing (13). Despite this, the Dieticians did become involved in the development and participated in the training (14).

Before the development could progress further, the change agent needed approval from the multi-disciplinary nutrition team (15). Following this approval, the change agent set about getting permission for nurses to request a chest x-ray to see if the tube was in the right place (16). Permission for this was requested via the Radiology

Department but resistance from Radiographers proved to be a stumbling block (17). However, the change agent was able to overcome this initial resistance through negotiation, the development of risk management procedures (18) and using precedent which related to earlier approval for Emergency Nurse Practitioners to order x-ray tests (19). Finally, the Radiology Department gave approval for nurses to order but not interpret the x-rays (20).

At this point the change agent started to plan and deliver the training (21). However, the day before the first cohort commenced training, the change agent was informed that permission for nurses to order the x-ray had been withdrawn (22). It was felt that the decision to withdraw permission had been instigated by managers at the larger hospital (23) as, since the merger (24), there had been a feeling in the hospital that the larger of the two former Trusts controlled the smaller peripheral hospitals (25). Both the change agent and the Consultant Gastro-enterologist were very frustrated by the last minute change in mind about x-ray requests (26). The change agent decided to press ahead with the training and recommended that pre-signed x-ray requests would be used to circumnavigate the decision to withdraw permission (27).

The training was delivered to a group of ten practitioners, one of whom had previously undertaken the procedure within another Trust. The experienced practitioner agreed to act as a supervisor for the others within the group (28). Supervision was offered to all nine remaining practitioners (29).

After a three month period an audit was performed to ascertain the state of play at that time (30). The audit disappointingly revealed that no one was practising

independently (31). The change agent felt that there could be several explanations as to why this might be the case. These included the fact that it was still early days (32) and that each practitioner had to perform three procedures under supervision. There would certainly need to be an element of serendipity in relation to the patient, nurse and supervisor all being in the right place at the right time for the supervision to occur. The training had been delivered during the peak winter period when pressure on services was at its greatest (33). Another problem identified, which may have influenced the uptake of supervision, was the fact that one person had changed jobs after the initial training and was now working in an area where she would be less likely to be in a position to pass a tube on a patient (34). The change agent decided to re-audit after six months (35) and to hold further training courses until the success of the initial development had been identified (36).

The re-audit at six months (37) showed that almost everyone was practising independently or was in the final phase of supervision (38). The fact that some practitioners were now performing the procedure meant that others were enquiring about training (39) and as a result, a further course was organised (40).

Figure 6.2: Site A: Variable List

Antecedent	Intervening	Outcome
New post	Need approval	Almost practising independently
Commonplace surgery	Need x-ray approval	
Delays	Local approval	
Identification of problem	Merger	
	Control	
	Circumnavigation	
	Director of Nursing support	
	Practitioner support	
	Other professionals	
	Informal approval	
	Need formal approval	
	Plan	
	Deliver	
	Supervised practice	
	Audit	
	Low uptake	
	Timing	
	Pressures	
	Re-audit	
		Almost independent
	Further course	

Site A: Casual Network Narrative

Figure 6.3 shows the casual network for site A

The appointment of a new Consultant Gastro-enterologist (1) resulted in a previously uncommon type of gastric surgery becoming more commonplace (2) within the hospital. This type of surgery requires that the patient be provided with nutritional support via enteral feeding after the operation. As the number of patients having enteral feeding increases, the staff notice that some patients are experiencing delays

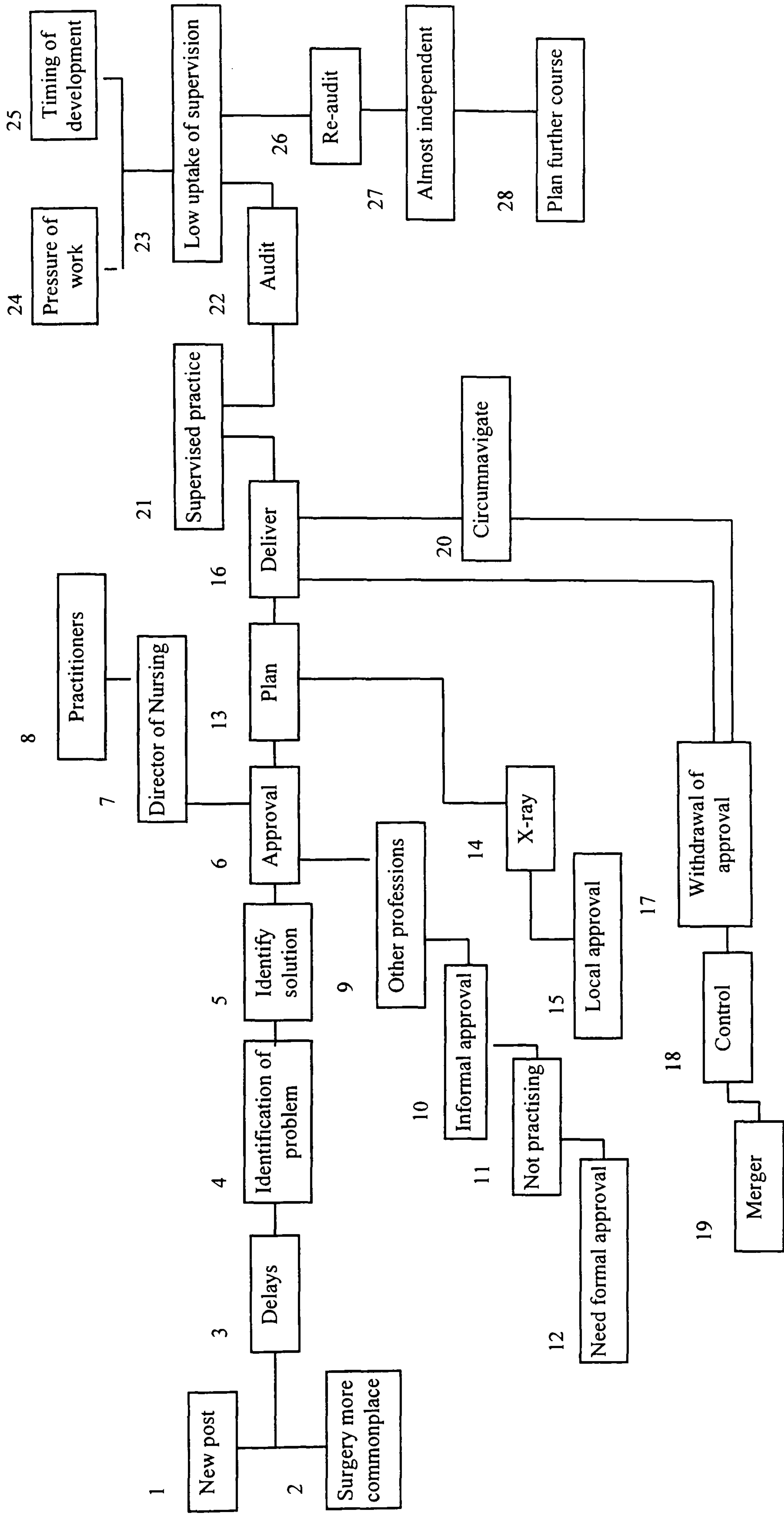


Figure 6.3 Site A Causal Network

in commencing their nutritional support (3). These delays are attributed to increasing demands upon the junior doctors' time, at a time when there are national moves to reduce the number of hours this group of staff work in a week. The problems of delayed nutritional support were identified (4) and the change agent sets about identifying a solution (5).

The identified solution was to allow nurses and dieticians to pass fine bore naso-gastric tubes and initiate enteral feeding once the position of the tube has been ascertained. The change agent sought approval (6) for this through both the Director of Nursing (7) and the Nutrition Team. The development was also presented to practitioners (8) as part of a package to improve patient care, rather than simply taking on a delegated medical task. At the same time, the Dieticians sought approval from their professional body to allow them to perform the procedure (9). Informal approval (10) was granted by the professional body, although the Dieticians are unable to practise (11) until they have full formal approval (12).

Once the development had been approved, the change agent set about planning its implementation (13). This implementation involved the training of staff and the identification of a programme of clinical supervision. In order for the development to be successful, nurses needed to be able to request a chest x-ray so that the position of the tube could be checked. If nurses had to wait for a junior doctor to order the x-ray, the patient would still have experienced delays in commencing his/her feeding programme. The change agent negotiated approval for nurses to order the x-ray (14), although the Radiology Department were unhappy to allow nurses to check on the

position of the tube. Local approval (15) was made possible through negotiation, the use of precedent and the presentation of a risk assessment.

Training was delivered in December (16). Just prior to delivering the training, the change agent learnt that the main Radiology Department at another Trust hospital had decided to withdraw permission for nurses to order the x-ray (17). The change agent believes that this decision had more to do with control by the larger hospital (18) following the Trust merger (19). While the change agent and the Consultant were frustrated by the decision, they decided simply to circumnavigate the decision through the use of pre-signed x-ray requests (20).

The training was delivered and the participants then entered a period of supervised practice (21). Practitioners were expected to have supervision when performing the procedure on at least three occasions before they are able to perform the procedure alone. Supervision was provided by a member of staff who had previously undertaken the procedure while working within another Trust.

An audit was undertaken three months later (22) to identify whether anyone was practising independently. This revealed that very few people have done even one supervised practice (23). Several possible reasons why this may have occurred were suggested by the change agent, including the pressures of work (24), the fact that supervised practice was occurring over the winter period (25) and that three months was a short timescale for people to have mastered the technique. A further audit was planned for six months after the training (26). This audit was carried out, revealing that almost everyone had performed two supervised procedures (27) and were

expected to be practising independently shortly. At the same time, many other practitioners had enquired about training and a further course was planned (28).

Case Study Site B

Background to Site B

Research site B is a moderate sized Primary Care Trust encompassing primary / community care services and mental health care. The Trust was created in 1999 from a former Mental Health and Community Services NHS Trust. It has a budget of over £40 million and runs a network of 13 mental health in-patient and community hospitals. Like many other Primary Care Trusts, the organisation is responsible for the provision of support and professional development for practice nurses, although they remain employed by individual General Practices. The Trust has a track record of innovation and has a small infrastructure of practice development facilitators to support practitioners engaged in such activity.

Nature of the Developments

Development i – In July 1998 the Scottish Intercollegiate Guideline Network (SIGN) produced a national guideline on the care of patients with chronic leg ulceration. The Network was established in 1993 with an objective of improving the quality of care for patients in Scotland by reducing variation in practice and outcome through the development and dissemination of national guidelines and recommendations about evidence based practice. While the guidelines were developed by a multi-disciplinary team of professionals, responsibility for their

implementation lay with individual health organisations. SIGN provided local NHS organisations with guidance on methods of implementation. The guidance included suggestions on identifying a co-ordinator, establishing an implementation group, auditing the current situation, preparing the environment and the practitioners, deciding upon implementation through action planning and the evaluation of progress.

The leg ulceration guideline addressed issues around assessment, treatment, specialist referral, secondary prevention, methods of care provision and recommendation for further audit and research work.

Development ii – The development of integrated nursing teams within primary care has become a common phenomenon since the mid 1990s. There are several driving forces behind the development of such approaches to working, including areas of considerable overlap, where several practitioners are working with or visiting the same patient to deliver care. Additionally, integrated working allows practitioners to develop wider and more comprehensive public health services without the workload falling on a single professional group. Other more cynical views about the drive towards integrated working include the fact that it is merely a method of plugging shortfalls in existing services or it is a way of replacing certain professional groups with more flexible and, occasionally, less expensive workers. The Community Practitioners and Health Visitors Association (CPHVA, 1996: 2) defined integrated nursing as “a team of community based nurses from different disciplines, working together within a primary care setting, pooling their skills, knowledge and ability, in order to provide the most effective care for their patients with a practice and the community it covers”. Integrated nursing offers opportunities for primary care

practitioners to develop services and practice outside of the constraints of traditional role boundaries.

Site B: Development i - Event / State Network Narrative

Figure 6.4 (compact disk) shows the event state network for Site B – Development i⁴.

Practitioners within the Trust identified that there was a lack of uniformity (1) in the way in which leg ulcer care was provided. Evidence for this was provided by the fact that treatment suggested by Consultant Dermatologists is often outdated (2) and assessment and care planning is often not completed in a multi-disciplinary way (3). The general impression was that care for this client group could be improved (4), as could the rates of non-compliance amongst patients having certain forms of treatment (5).

The Trust completed an audit in 1998 (6) which identified deficits in several areas including assessment, training and patient information. The change agent was interested in doing something about the problems (7), as were several practitioners (8). The change agent approached the Director of Nursing to identify whether there would be organisational support for development in this area. The Director of Nursing was very supportive of the proposals (9). Around the same time, the Scottish Intercollegiate Network produced guidelines on the treatment and management of leg ulceration (SIGN) (10).

⁴ Numbers in brackets in the narrative relate to the numbers shown at the top corner of each box on the network diagram. These numbers serve to orientate the reader and are not intended to signify the importance of each event within the network

The change agent decided to establish a multi-disciplinary cross organisation group to develop leg ulcer care within the Trust (11). This group included representatives of the neighbouring secondary care Trust, as well as representatives of patient groups (12) who had considerable experience in developing clear, concise patient information (13). The group set about redesigning the assessment tools, patient information and guidelines (14). In order to support this work, the change agent sought resources from the clinical effectiveness group (15).

Once developed, the documentation was piloted in four localities (16). However, despite the formation of a Primary Care Trust (17), practice nurses still remained outside of the formal structure (18). During discussions with one pilot site involved, the practice nurses decide to opt out of the development (19) because the assessment process would take too long (20). As a result, the practice involved was removed from the pilot (21).

It was anticipated that the new documentation would improve patient care and treatment outcomes and also result in a reduction in the number of referrals to the Consultant Dermatologist (22). However, the acute Trust perceived the development as a threat (23) and, despite invitations to attend the meetings of the multi-disciplinary group, no-one attended any of the meetings.

During the pilot stage the change agent organised some initial training for staff in Doppler technique, bandaging and general leg ulcer assessment and treatment (24). At this point the change agent went on maternity leave and the project temporarily passed to a colleague (25). The new change agent was unable to progress the

development for one month (26) because of pressure of work (27) and the fact that several practices had low numbers of patients with leg ulcers (28), which slowed down progress.

Eventually, the change agent called a meeting of link nurses (29) to identify how the development was progressing. The link nurses were well placed to ascertain how practitioners were using the assessment documentation (30) and to identify training needs. Evaluation forms to identify any deficits in the new documentation were sent out (31) and this proved invaluable in further refining the assessment tool etc., as some very important areas of the assessment process had been missed from the original tool (32). Additionally, the need to develop patient information further was clearly identified during the meeting (33).

Following the meeting, the change agent was able to decide how to take the development forward and roll out (34) the assessment tool and guidelines to all practices. The assessment tool was amended (35) and a comprehensive training programme for all staff drawn up (36). During this phase, the change agent became disillusioned because it was unclear within the new PCT structure how cross Trust developments should be rolled out (37). The change agent approached the Director of Nursing to ask him to endorse the new assessment tool etc. in a letter to practices (38). The Director of Nursing was happy for the roll out to go ahead but appeared unwilling to endorse it (39). As a result, the change agent decided simply to press ahead with the roll out (40).

Figure 6.5 Site B (i): Variable List

Antecedent	Intervening	Outcome
Awareness of better method Lack of uniformity Audit Personal interest SIGN guidelines	Establish Group Involve secondary care Adapt guidelines Pilot Change of facilitator Delay Pressure Evaluation Re-visit assessment tool PCT formation Structure Practice Nurses outside Opt out Education Agree roll out Seek formal support Support not forthcoming	None achieved by the end of data collection

Site B: Development i – Causal Network Narrative

Figure 6.6 shows the causal network for Site B – Development i

Staff within the Trust identified that there was a lack of uniformity in the care (1) and treatment of patients with leg ulceration. This lack of uniformity was confirmed by an audit of the care and treatment delivered to patients (2). The change agent and several staff were interested in doing something about the problem (3) in the light of the publication of the Scottish Intercollegiate Network (SIGN) Guidelines (4). All of these factors together served to raise awareness amongst practitioners and within the organisation that there was a problem with the way care was provided (5).

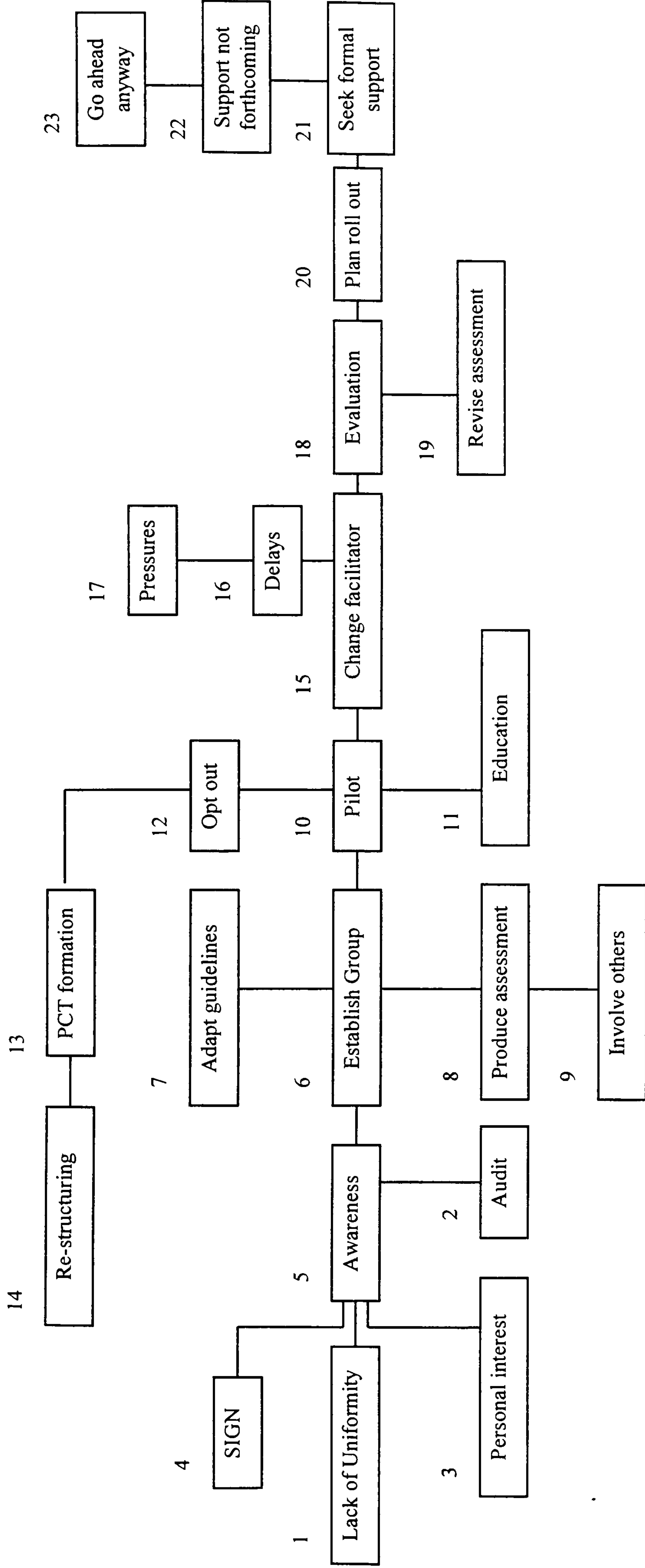


Figure 6.6 Site B Development i Causal Network

The change agent decided to establish a multi-disciplinary group (6) to adapt the guidelines (7) and produce an assessment tool and patient information (8). In order to achieve this, the change agent involved colleagues from the acute Trust and representatives of patient organisations (9).

Once the documentation was drafted, the group decided to pilot the development (10) in four areas. Education was provided to practitioners from the pilot sites (11).

During discussions with one pilot site the change agent was informed that the practice nurses had decided not to take part as the new assessment was too time consuming. The practice nurses were able to opt out (12) of the proposed development because, despite the Primary Care Trust formation (13) and the new structure (14), they continue to be employed by the individual GP practices.

At this stage the change agent went on maternity leave and responsibility for the development passed to a colleague (15). A short delay occurred (16) because of the pressure of work (17) for the new change agent. However, the change agent eventually called a meeting of link nurses to discuss the pilots (18). Following this meeting the assessment documentation etc. was redesigned (19) and the roll out of the development to all practices was planned (20).

The change agent sought formal support for the roll out through her Director of Nursing (21). While he was supportive, he stopped short of formally endorsing the development (22). Despite this, the change agent pressed ahead with the roll out (23).

Site B – Development ii – Event / State Network Narrative

Figure 6.7 (compact disk) shows the event state network for Site B – Development ii

The network shown in figure 6.7 is divided into two routes. Each route was developed separately and, although very similar in process and outcome they have different antecedent triggers to the development. Route A was instigated by the practice development facilitator because of concerns about the use of resources. Route B, on the other hand, was instigated by practitioners and individual primary health care teams.

Route A

The manager decided that because of staffing problems there was a need to examine how the community nurses were working in terms of meeting the overall needs of the population (1). This decision was taken upon the basis that there was unlikely to be any new resources coming into the service in the foreseeable future, yet demand continued to rise. As a result, the Trust was keen to make the best use of its existing resources (2) by breaking down some of the barriers between the different disciplines within community nursing. The facilitator (the acting manager) decided to examine integrated working (3).

As a starting point, she presented a paper on this to the Local Health Care Co-operative (LHCC⁵) (4). At the LHCC meeting the facilitator received a very negative

⁵ LHCCs are local committees of health professionals and lay representatives who are involved in developing the strategic direction of a Primary Care Trust

reaction to her proposals from the General Practitioners on the basis that the whole idea of developing integrated working is likely to result in more work for them (5). Following the meeting she decided to abandon the title integrated working (6) and press ahead with the notion of practice development (7). However, this term is also open to misinterpretation by General Practitioners as it is used in General Practice to indicate the development of their actual practice or premises. To progress the development, the facilitator decided to get the community nursing staff and the GPs from the locality together to identify priority areas (8). This meeting took the form of a half day workshop (9) where teams worked together to identify priorities (10). Unfortunately, the meeting was interrupted by someone becoming ill and it ended abruptly with no clear action plan.

The facilitator talked to lead GPs and asked them to canvass views (11) after the initial workshop. After a few weeks it became clear that none of the teams wanted to participate (12) as the whole notion of integration / development was seen as a management agenda (13).

Route B

In this example there were several drivers. From some teams, there was the notion of threat (14) as a result of the formation of the Primary Care Trust. The staff from these teams felt that it would be better to do it first (15); for example, to integrate rather than waiting for this to be imposed by the practice. Other teams were interested in the concept (16) and welcomed the opportunity to look at better ways of working (17). However, even in these teams, not everyone was committed (18). Most teams acknowledged that they needed organisational support (19) to help them match

their own aspirations with those of the GP practice and the Trust. Another driver to the development was the restructuring of the Trust as a Primary Care Trust (20).

While the new Trust fostered closer co-operation, the practice nurses continued to be employed by their individual practices (21). This closer co-operation led to the Trust negotiating with the GP Practices to identify priorities for the development of nursing (22). Some GPs (23) and practice managers (24) were interested in being involved, as they saw this as an opportunity to do something about the past failures of the Trust's managers (25).

In order to support developments, the Trust identified a facilitator (26) who held an awareness day. Following this day, Practices were asked to sign up (27) to the idea of working towards integrated working and three Practices started to examine the process (28), but this eventually frittered out (29). One of the reasons for this failure was thought to be that some of the Practices were not ready even to examine integration at this stage. The perception was that Practices needed to be at a certain level before they embarked on an integration process (30).

One Practice decided to go it alone (31) without the facilitator. This led to some joint working (32), largely instigated by an interested GP within the practice. However, when the GP moved to another post (33), the developments stopped and the existing developments frittered out (29).

Another practice which came forward had particularly poor working relationships between the GP Practice and the nursing staff (34). The nurses had expressed concern to the Director of Nursing that the Practice wanted to take over the running

of the nursing team (35). As this concern increased, the Director of Nursing and the facilitator were approached (36) about what was felt to be a seriously deteriorating position. The Director of Nursing decided to seek external facilitation (37) for the Practice and, with the GPs, sets this facilitation in process. The facilitators undertook to examine the workings of the Practice (38) through observation and interviews (39) with staff. Following the data collection the external facilitators presented the data to the Director of Nursing and GPs, highlighting several problems (40) within the Practice. Recommendations were made (41) relating to how working relationships could be improved. The Practice was informed that it needed to sort out several other issues before it could look at integrated working (42). Clearly, the GPs felt that integrated working was the answer to all their ills (43). The nursing staff were delighted with the outcome of the external facilitation because they felt that everyone was now aware of the issues within the Practice (44).

A few months later the Trust organised a staff development away weekend for staff from the Practice (45). As a result of this and continued work, the nursing staff and GPs felt that things had become much better within the Practice (46). The nursing team had started to look at some developments (47) with the practice nurses, health visitors and district nurses working on a joint men's health day.

Figure 6.8 Site B (ii) – Variable List

Antecedent	Intervening	Outcome
Effectiveness	Awareness	Better working including shared developments
Finite resources	Sign up	
Frustration	Opt out	
Restructuring	Do not sign up	
Threat	Facilitation	
Relationships	Examination	
Interest	Change of driver	

Site B – Development ii – Causal Network Narrative

Figure 6.9 shows the causal network for Site B – Development ii

Finite resources (1) and rising demand led to a decision to examine integrated working to ensure the best use of resources and effectiveness (2). This was coupled with an organisational restructuring (3) into a Primary Care Trust which highlighted previous frustration (4) at managers’ failures to allow service development (5).

While individual practitioners felt threatened by the proposed integration, some practitioners were interested (6) in examining new ways of working and closer co-operation between disciplines. All of these factors led to an increased awareness (7) of the need to examine how practitioners worked to meet the health needs of the local population. Following an awareness raising session, during which the whole philosophy of integrated working was debated, Practices were asked to sign up to a facilitated process designed to create more joint working. After the awareness raising session, some practices signed up (8) while others decided not to (9).

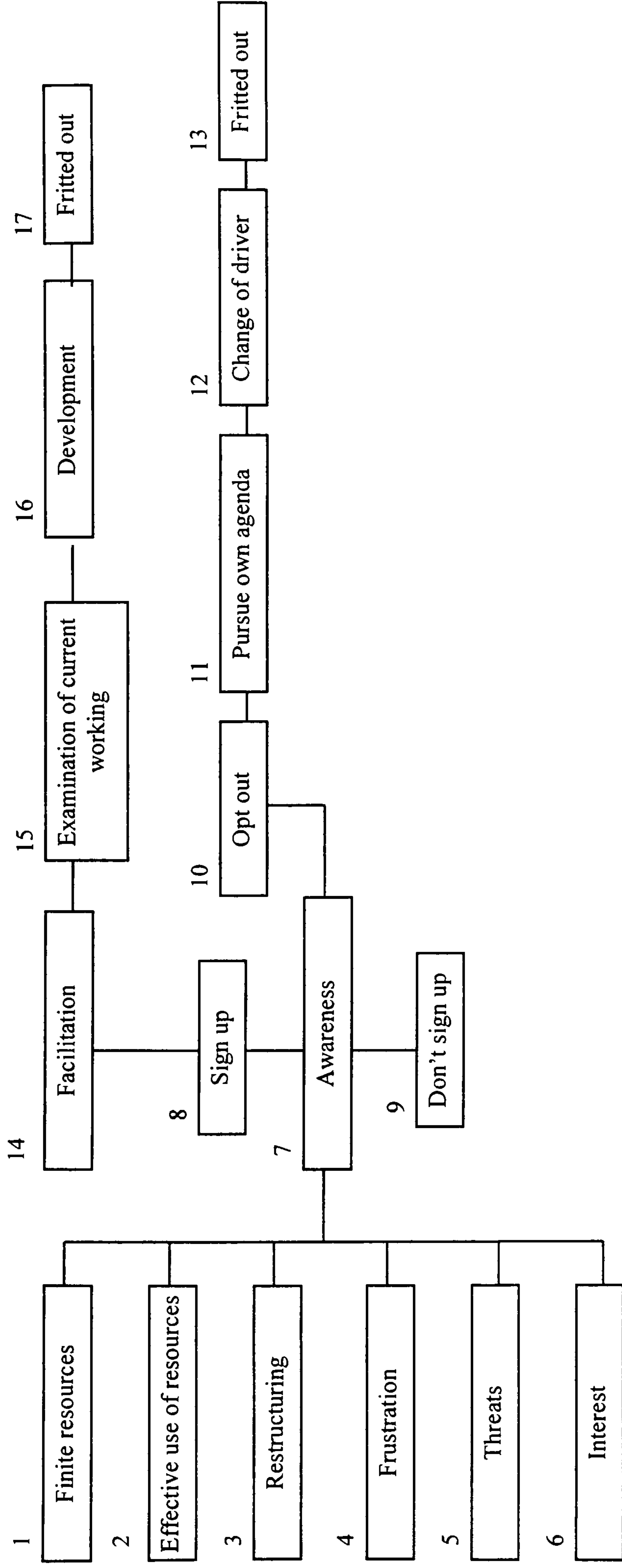


Figure 6.9 Site B Development ii Causal Network

One practice decided to opt out (10) and go it alone. They pursued their own agenda (11) and were relatively successful in creating joint working and developments until the GP who had driven the developments decided to move to another job (12).

Following this, the practice took less of an interest in the previous work and new developments frittered out (13), while established developments were neglected and eventually disappeared.

Several practices signed up and received a period of facilitation (14). This in turn led to an examination of current methods of service delivery and working (15). Most practices achieved some degree of improved integrated working which, in turn, resulted in some localised developments in practice (16). However, this eventually frittered out (17) also.

Case Study Site C

Case study Site C withdrew following the first interview. To avoid confusion in identifying the original data, for example interview transcripts, a decision was made to continue with the original site codes. This decision was important because of the need to have a clear audit trail throughout the study as outlined in chapter 4.

Background to Site D

Site D is a combined acute and community NHS Trust in Wales. The Trust was established in April 1999 following the merger of several acute Trusts and the community Trust. The Trust has over 1000 in-patient beds spread across 11 sites, with the largest concentration being at the District General Hospital. The Trust has a mixed practice development infrastructure with certain units / directorates having practice development facilitators and others having no formalised provision.

Nature of the Development

In 1998 the Government White Paper “Putting Patients First” (National Assembly for Wales, 1998) was published. The document recommended that new systems for clinical governance were introduced to enhance clinical care and to protect patients. Clinical governance was described as a framework through which NHS organisations are accountable for continuously improving the quality of the services which they provide (Department of Health, 1998a). In order to implement clinical governance arrangements, organisations were required to review their current systems for quality improvement, audit and practice development and to develop action plans which promoted integrated working between these departments.

Site D: Event / State Network Narrative

Figure 6.10 (compact disk) shows the event state network for Site D

Following the publication of the White Paper “Putting Patients First” (National Assembly for Wales, 1998) (1) NHS Trusts were instructed by the Health Department to develop local plans for implementation. To achieve local implementation the Trust decided that it needed to encourage ownership (2) of the plan. This was achieved by asking people what they felt was important (3) and seeking their views on the priority areas for the initial clinical governance activity. This level of participation (4) was thought to be crucial to success if the Trust’s clinical governance plan was to be operationalised. In order to achieve participation, the Trust organised a number of awareness sessions designed to sell the idea (5) and overcome some of the common misconceptions (6) about clinical governance being a form of control over the activity of health professionals.

The publication of the White Paper “Putting Patients First” (National Assembly for Wales, 1998) coincided with a merger (7) which brought together the community and acute Trusts. Following the merger, an interim structure (8) was introduced with managers being temporarily slotted into posts pending a review of the management structure. The interim structure resulted in no single person being given responsibility (9) for clinical governance. A senior manager was delegated responsibility (10) and he in turn asked the Senior Nurse for Practice Development to take a lead (11).

A working group was established (12) as a sub group of the clinical governance committee. This group decided to undertake a survey of staff's views on how clinical governance should be implemented. In order to undertake the survey, the group negotiated resources and assistance from various Trust departments (13), including information technology and audit. The survey was drawn up and distributed widely throughout the organisation (14) during the first two weeks in August. The data analysis commenced four weeks after the distribution of the survey (15) and the strengths and weaknesses of the current systems were identified (16).

Following the analysis of the data, the Senior Nurse produced a lengthy report to the clinical governance committee (17). This report was also distributed to other key stakeholders such as local health groups. The Senior Nurse was disappointed that she put so much work into the survey and subsequent report yet no one came forward to provide her with feedback (18). After three weeks, she decided to make appointments with key people to obtain feedback. The Senior Manager with responsibility for feedback told the Senior Nurse that, although the work was of good quality, the report was too long and should have been a maximum of four pages (19). Around the same time, the Senior Nurse received feedback from a colleague that the medical director was pleased with the report (20). In addition, the Senior Nurse argued that anything less than such a comprehensive report would not have been acceptable to the medical staff (21).

Following the meeting with the Senior Manager, the Senior Nurse decided to produce a four page discussion paper (22) which was circulated to members of the clinical governance committee together with a list of the ten key action points

identified in the report (23). Some weeks later the Senior Nurse still had not had any feedback (24) about the discussion document. This proves to be very frustrating (25) to the Senior Nurse, as progress on the development of the infrastructure was effectively stalled at this stage.

To add to this frustration, the lead Senior Manager left the organisation for a post at the Health Authority (26) a month later. A new organisational structure was then announced (27), including a new post of clinical governance manager (28) for which the Senior Nurse applied. However, she was not appointed (29) to the post and this resulted in a new facilitator (30) taking over the role of developing the clinical governance infrastructure. The Senior Nurse was naturally upset (31) that she did not get the post and attributed her lack of success to the fact that someone from the acute sector was preferred (32).

The newly appointed facilitator set about drawing up an implementation plan (33) in consultation with stakeholders from local health groups during a series of meetings (34). The plan was submitted to the Trust Board (35) who, in turn, provided feedback to the National Assembly for Wales on local implementation (36).

Figure 6. 11 Site D – Variable List

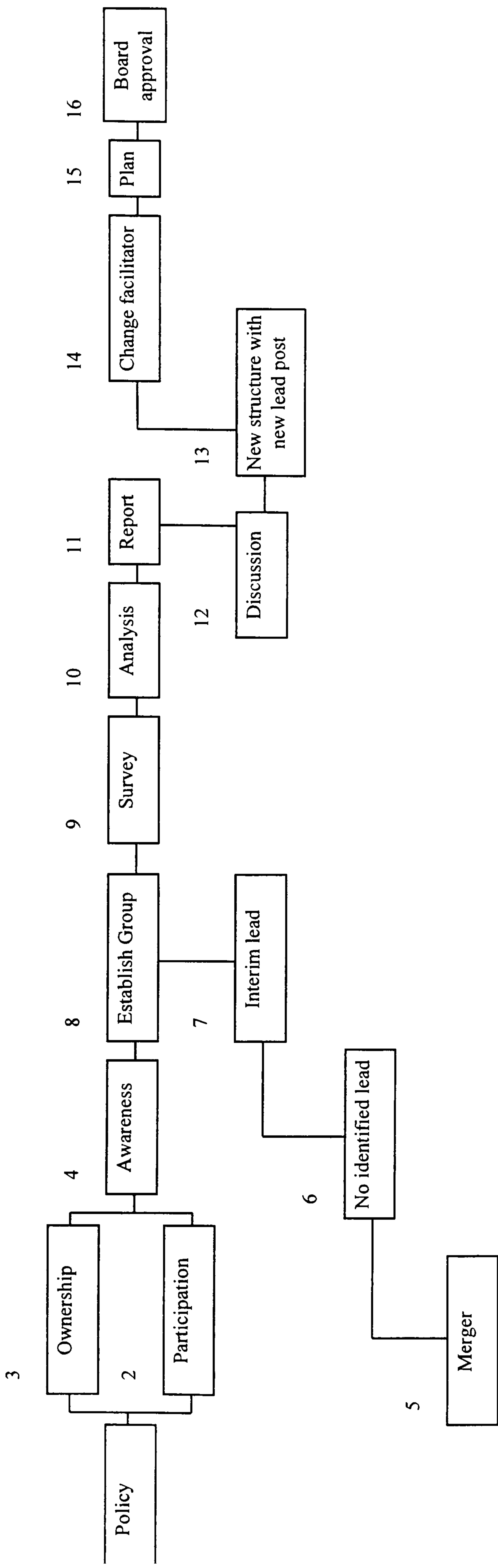
Antecedent	Intervening	Outcome
Policy	Ownership Participation Awareness Merger No identified lead Establish Group Survey Analysis Report Discussion Change of facilitator Plan Approval	Report to Health Authority

Site D: Causal Network Narrative

Figure 6.12 shows the causal network for Site D.

The White Paper “Putting Patients First” (National Assembly for Wales, 1998) (1) recommended that NHS Trusts establish clinical governance within their organisations. In order to achieve the effective implementation of clinical governance in the organisation, the Trust was keen to encourage maximum participation (2), which in turn should lead to a sense of ownership (3). A series of awareness raising sessions (4) was held to promote participation in the planning process.

The recent merger (5) of former Trusts into the new NHS Trust has resulted in no one identified Senior Manager taking responsibility for clinical governance (6). Until the new structure can be developed, various managers from the previous organisation were temporarily slotted into posts. A Senior Manager was asked to lead on clinical governance (7) and in turn he asks the Senior Nurse for Practice Development to



268 Figure 6.12 Site D Event / State Network

undertake the operational work. A small sub-group (8) of the clinical governance committee was established and this group debated the need for a baseline assessment to identify the priority areas. The group decided to undertake a survey (9), which was developed in conjunction with the audit and information technology departments. This was produced and circulated to all departments within the Trust. Additionally, the Senior Nurse sought the views of key stakeholders, including local health groups.

A month later the survey data was analysed (10) and a report was produced (11) and circulated to all members of the clinical governance committee. A few weeks later the Senior Nurse reports that she was frustrated as, despite the fact the report has been discussed (12) at the clinical governance committee, she has not received any feedback. When provided, the feedback proved to be largely negative, particularly in relation to the length of the report, although indirect feedback was received from the medical director to say he was pleased about progress.

Over the next month the new structure was announced. The new structure included a clinical governance manager (13) and the Senior Nurse and another colleague were invited to apply. Following interviews, the Senior Nurse learns that her colleague had successfully gained the post. This results in a change in the facilitator for the project (14).

The new facilitator developed an implementation action plan (15) and presented this to the Trust Board for approval (16).

Background to Site E

Site E is a large acute services NHS Trust within Central England. The Trust was established in 1991 and is based on a single general hospital site. The Trust has over 1200 in-patient beds and a total budget of £130 million. Several regional speciality services are provided within the Trust. The Trust has a proven track record in innovation and has a considerable infrastructure to support this, including practice development facilitators, nursing information departments, a nursing academic department and audit / research and development units.

In 1999 negotiations began between Site E and a neighbouring large acute Trust about a merger of the two organisations to form a single acute Trust serving the city.

Nature of the Development

Site E was one of the first organisations in the UK to develop a computerised care planning and nursing documentation system in the 1980s. At the start of the development the system was still operational, although it was widely acknowledged that it was no longer 'fit for purpose' and that much of the evidence base for the care plans was very out of date. While negotiations within the organisation are ongoing about an organisation wide replacement for the hospital information technology system, the Director of Nursing had requested that the use of nursing documentation across the organisation was examined and changes made to ensure that it was, where possible, evidence based.

Site E: Event / State Network Narrative

Figure 6.13 (compact disk) shows the event state network for Site E

The Trust decided to re-examine its nursing information system following the publication of the Information for Health Strategy (1). A review of the computerised assessment and care planning system (2) revealed that the computer documentation was of poor quality and, as a result, was unable to support the implementation of clinical effectiveness (3). A decision was made to start updating the care plans, patient profile (4) and practice related protocols (5). The development of new care plans and a profile was supported by the Trust's evidence based practice framework (6) which was developed in response to the clinical governance (7) and the evidence based practice agenda (8). Work on the evidence based practice framework had identified that practitioners needed assistance to develop their practice (9) and this was the primary purpose of the framework.

The development of a new profile (10) was made easier as a team of staff from the hospital had seen a profile at a conference (11). The Trust sought permission to adapt this profile (12) for their own needs. Permission was granted and the group set about redesigning it. As the group were working on the redesigning of the patient profile they quickly realised that it would not be possible to satisfy all areas' preferences (13).

Once developed the profile and the new care plans were piloted in two clinical areas (14). Throughout the pilot period, the new documentation was refined and updated regularly (15) following meetings with the staff involved. After six months of piloting an audit was undertaken (16) revealing that, in the majority of cases, the profile was completed correctly (17) and made some aspects of practice better and, more importantly, nothing worse (18). One area of concern was that the new core care plans were not completed any more comprehensively than the old computerised care plans (19). The practice development support team who had conducted the audit were concerned that the audit had been too broad and had examined more than just the documentation (20). A decision was made that a further audit should be undertaken in three months time (21) and during this period the new documentation should continue to be used within the two pilot wards but not rolled out.

In addition to the audit, the practice development support team undertook a survey of the nurse's perceptions of the new documentation (22). This revealed that staff liked the new profile (23). However, concern was expressed that the survey was biased as those staff who particularly liked or disliked the profile were more likely to respond (24). However, one major finding from the survey was that the profile was not seen as extra work (25) which was a major issue if the proposed roll out was to be a success.

Around this time a decision was made not to procure a new nursing information system (26) as the Trust planned to merge with another neighbouring acute Trust (27). As a result of this planned merger, the proposed second audit was abandoned

(28) and the proposed roll out delayed indefinitely (29). However, the two pilot wards continued to use the new documentation.

During this period the documentation was further refined (30), although this was largely led by the surgical directorate (31). The practice development support team were rather taken aback by this and there was a general feeling that they were going it alone (32) while medicine just tagged along (33). Shortly after a meeting of the project group, surgery completed an audit (34) and redesigned the documentation without consulting anyone (35).

Figure 6.14 Site E: Variables List

Antecedents	Intervening	Outcome
Identification of need	Adaptation	Draft profile
Awareness of existing	End of routine data	Data related to
Profile	collection	usefulness
Policy	Development of an	Staff's
	Evidence based practice	perceptions
	framework	
	Update care plans	
	Develop tools	
	Pilot profile	
	Audit	
	Amend	
	Merger	
	Hold roll out	
	Audit to broad	
	Re-audit	
	Abandon	
	Liked	
	Not extra work	
	Refinement	
	Directorate takes running	
	Changes profile	
	Other Directorate tagging	
	along	

Site E: Causal Network Narrative

Figure 6.15 shows the causal network for Site E.

The publication of the information for health strategy document (1) resulted in the Trust reviewing its current clinical information systems. This review revealed that there are several areas where the quality of the information collected was poor (2). Both of these factors served to heighten awareness of the need to change (3). One area which needed to be addressed was nursing documentation and the collection of information through the current computerised nursing information system. In particular, care plans had been identified as providing poor quality information and lacking any firm evidence base. This problem had been highlighted as a result of the implementation of the new evidence based practice framework (4). The Trust decided that core care plans should be updated (5) and a new nursing assessment tool implemented. The Trust's nursing information team undertook the task of developing new documentation and reviewing the current nursing information collected.

The nursing information team became aware of an existing patient profile (6), which they felt may be suitable. Several members of the team attended a conference and heard about the use of the profile in acute care settings. A small working group was established to adapt the profile and develop new care plans and assessment tools to be used alongside it. The profile was adopted (7) and piloted (8) in two areas, one medical ward and one surgical ward. An audit was undertaken by the nursing information team (9) and the views of practitioners on how user friendly the profile was were sought. The audit revealed that the new profile was liked (10) but the team

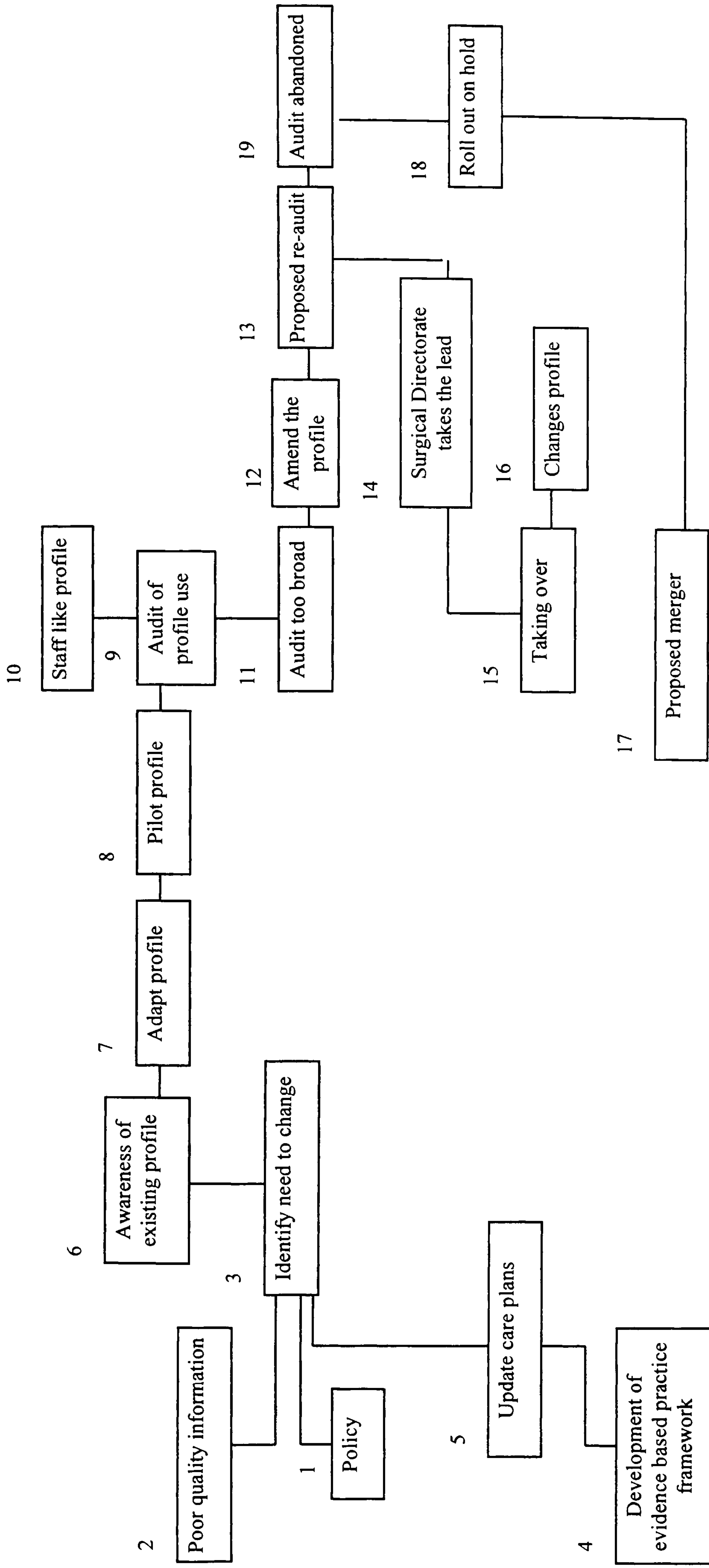


Figure 6.15 Site E Causal Network

felt that the audit was too broad (11) to measure what it set out to do. They decided to continue to amend the profile (12) and re-audit (13) it in three months time.

At the next meeting of the working group, the proposed amendments were discussed. However, the representatives from the surgical directorate informed the meeting that they had made the amendments already (14) and had sent the amended version for printing. There was a general feeling that the surgical directorate was taking over (15) by changing the profile (16) and that the medical directorate was being left behind. The issue of re-audit and roll out of the profile to other areas was discussed but the proposed merger (17) meant that these plans were put on hold (18) or abandoned (19) until the merger had gone through.

Case Study Site F

Background to Site F

Site F is an acute hospital NHS Trust in Scotland. The Trust was formed on 1 April 1999 following the merger of several large acute Trusts. The newly formed Trust has a budget of £165 million and consists of over 3,000 in-patient beds spread across 13 sites. Prior to the merger, Site F had been a smaller NHS Trust providing general hospital services to a part of the area. Prior to the merger Site F had had a track record of innovation and a reputation of risk taking when developing new and innovative services. The Site has a network of practice development facilitators attached to directorates and, since the merger, some collaborative working with colleagues from other hospital sites had begun.

Nature of the development

The concept of nurses acting as endoscopists is not a new one and it appears to originate from developments in nursing and gastroenterological practice in the United States of America (USA) in the early 1980s. In the UK the performance of endoscopy procedures by nurses is relatively common, although this is often restricted to certain procedures such as sigmoidoscopy. Less common, both within the UK and the USA, is the performance of bronchoscopy by nurses. There may be several reasons for this but principal amongst these is the risks to the patient because of the nature of the procedure and the likely underlying medical problems of a patient who would require such a procedure. Other problems centre around the use of sedation by nurses during such procedures. The British Society of Gastroenterologists (1995) recommends that nurses should perform only non-sedated endoscopy.

Site F: Event / State Network Narrative

Figure 6.16 (compact disk) shows the event state network for Site F.

Within the bronchoscopy unit there was increasing concern amongst the nursing staff that the doctors were not very patient focused (1) when they were performing bronchoscopies. Often they needed reminding that the patient's condition during the procedure should be checked. Additionally, patients often received less explanation about the procedure from medical staff. The nursing staff felt that they could provide a much more holistic service to patients (2). The Consultant felt that the nurses could

undertake the role (3). One nurse in particular was keen to develop her role in this area (4).

The interested nurse approached the practice development facilitator (5) for assistance in developing the idea further. The facilitator set about laying the foundations for the development including the production of protocols (6), identification of competencies (7) and risk assessment (8). At the same time the nurse and the facilitator negotiated the role with key stakeholders (9) including anaesthetics, the medical director and the Director of Nursing.

The Consultant was keen to use the newly developed protocols as part of the medical staff education programme (10) but he seemed unaware of the other stages (11) which were required in order to implement successfully a development of this type. However, the Consultant was willing to assist with education and training for the nurse, which was useful, as the facilitator was unable to identify an appropriate training programme provided by outside agencies (12).

Around the time that the facilitator was working on the foundations of the development, she was asked to become involved in a bid to develop ambulatory care within the Trust. The facilitator felt that the development could become part of a new ambulatory care centre (13) and felt that this might provide a funding stream (14) for the development. However, the initial plans for this were vetoed by the Consultant (15). While the reasons for this veto were not fully known, it was felt that this was probably the result of the Consultant wanting to keep control (16) of the bronchoscopy unit rather than passing it over to a colleague.

Despite the fact that this possible funding source had proved fruitless, the facilitator set about making a case (17) for the proposed development. She quickly found that making a case for this development was hampered because there were no easily identifiable financial benefits (18) associated with nurse led bronchoscopy for the organisation. Eventually, the line manager decided that any development in this area will be dependent upon the use of existing resources (19). Around this time the organisation was going through a period of transition, merging with several other neighbouring Trusts (20). The merger created a large organisation spread across the city (21). It was hoped that the merger would not stifle development (22) as, up until now, the organisation was a risk taker which encouraged development (23).

The merger went ahead and the new senior management team put in place an interim structure (24). This interim structure made the managers anxious about their future employment (25). As a result, they became increasingly cautious (26) and did not want to rock the boat and introduce anything which might be seen as too risky. The cautious attitude of the interim managers resulted in a hold being placed on the proposed development (27). The Consultant was angry (28) about the lack of progress in relation to the development. As well as placing the development on hold, the merger also resulted in uncertainty about the procedure for approval of new protocols and guidelines (29). It was unclear whether the protocols approved by the former organisation would still stand (30) and, if not, how approval would be granted for the already written protocols. The facilitator felt that re-working the protocols, which she has only just finished writing, was like going back to the beginning (31).

All of these factors result in a considerable time delay (32) in taking the development forward.

After several meetings between the acting manager, the Consultant and the facilitator, a decision was made that the nurse could commence a period of taught and supervised practice (33), although no final decision had yet been made about funding or additional resources to implement the development completely. The period of taught and supervised practice threw up its own problems because, while the nurse was undertaking the procedure, the only person available to assist her was the doctor (34) and the Consultant was unhappy for the medical staff to act as an assistant to the nurse (35). The facilitator felt that, although the medical staff were happy to teach the nurse, they were not happy to assist her as this was a reversal of roles (36). The facilitator had a discussion with the Consultant and eventually the Consultant agreed that the medical staff might assist as part of their role as a supervisor (37).

Around this time, the new management structure (38) was put in place and this resulted in several changes for the development. Firstly, the directorate got a new manager (39) who was initially appointed for six months. The new manager was not from this hospital (40) and the facilitator was quick to meet with her to explain about the development and flag up the business case for funding (41). At this point the facilitator was changed (42) because of a re-structuring of the practice development team. The new manager was supportive of the development (43) and encouraged the team to continue with the supervised practice (44) while she sought funding via the business planning process (45).

Figure 6.17 Site F: Variable List

Antecedents	Intervening	Outcome
Desire for change Awareness of a better way of doing things	Tap funding source Control Veto Facilitation Protocols Risk Negotiation Education Make case Merger Interim structure Caution Supervised practice Uncertainty Facilitator changes New manager	Final outcomes not achieved during the period of data collection

Site F: Causal Network Narrative

Figure 6.18 shows the causal network for Site F.

Several factors, including the nurses identifying that junior doctors were often not very patient focused, combined together to raise awareness (1) amongst senior medical and nursing staff that the bronchoscopy service could be nurse led. In addition to this, one nurse in particular was interested in developing her role to include bronchoscopies and she had the full support of the Consultant (2). The nurse sought assistance to develop the initial idea further. This facilitation (3) was provided by the practice development facilitator. One of the first tasks the facilitator did was to try and identify possible funding sources (4). At the time, the facilitator was working on plans to develop an ambulatory care centre and felt that it might be possible to

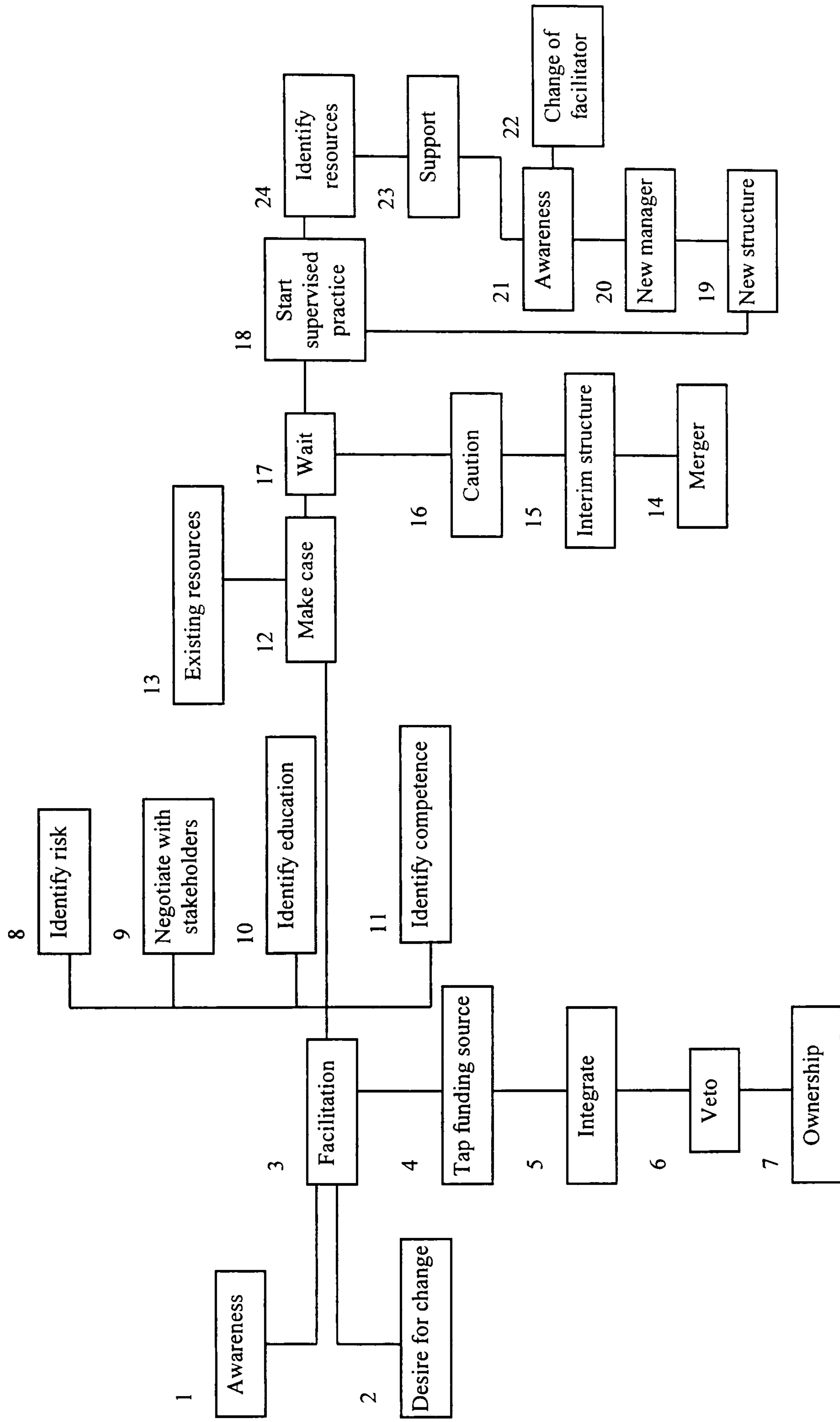


Figure 6.18 Site F Causal Network

integrate the proposed development into this centre (5). However, any plans to integrate the two were blocked by the Consultant (6) as he was keen to retain control and ownership (7) of the service.

Despite the failure to identify a funding source the facilitator set about doing some of the ground work essential for the implementation of the development. This included a risk assessment (8), negotiation with key stakeholders (9), including anaesthetists, and working with the nurse to identify possible education (10) and the competencies required to undertake the procedure (11). Once this work was completed the facilitator put forward a business case (12). When developing this case, the facilitator found it difficult to identify how the development would benefit the organisation. As a result, the managers decided that the development must be financed from existing resources (13).

Around this time the organisation was going through a period of transition while merging with several other neighbouring Trusts (14). The merger went ahead and the new senior management team was put in place within an interim structure (15). This interim structure made the managers anxious about their future employment. As a result, they became increasingly cautious (16) and did not want to rock the boat or introduce anything which may be seen as too risky.

The cautious attitude of the interim managers resulted in a hold being placed on the proposed development (17). After several meetings between the acting manager, the Consultant and the facilitator, a decision was made that the nurse could commence a period of taught and supervised practice (18), although no final decision had been

made about funding or additional resources to implement the development completely.

Around this time, the new management structure (19) was put in place and this resulted in several changes for the development. Firstly, the directorate got a new manager (20) who was initially appointed for six months. The new manager was not from this hospital and the facilitator was quick to meet with her to explain about the development and raise her awareness (21) of the business case for funding, although at this point the facilitator was changed (22) because of a re-structuring of the practice development team. The new manager was supportive (23) of the development and encouraged the team to continue with the supervised practice while she sought resources (24) via the business planning process.

Case Study Site G

Background to Site G

Site G is an acute hospital NHS Trust serving a town in Eastern England. The Trust was established in 1993 and consists of two general hospitals approximately five miles apart. The Trust has around 800 beds and an annual budget of £70 million.

Within the Trust the Director of Nursing has established a strong nursing infrastructure to support practice development and other activity. Each Directorate has a practice development facilitator and there is cross directorate working on several projects. The work of the practice development facilitators is co-ordinated by

the Director of Nursing, although the staff also work to individual directorate action plans.

Nature of the developments

Development i – The development of a specific procedure manual for the operating theatre has received little attention in the professional literature. Most NHS organisations produce policies designed for standard wards and departments and it is often left to theatre staff themselves to translate what this means for operating department practice. Articles written by two nurses from the USA address this problem. Lehr and Palmer (1989) describe how the evidence base around operating room practice is often difficult to identify because of a dearth of research in this field. The American Journal “Same Day Surgery” (Anon, 1998) provides a useful guide to producing an operating room procedure book, by developing specific policies or adapting existing ones to ensure that they emphasise operating department practice.

Development ii – In 1993 the Department of Health (DoH, 1993) recommended that the concept of clinical supervision within nursing be further explored and developed. Following this, many NHS Trusts implemented clinical supervision for nurses, using a variety of approaches. Despite this and other drivers, arrangements for clinical supervision remained patchy and there are few good examples of clinical supervision from some areas of practice, notably operating theatres and community nursing. One of the reasons for this could be the problem of establishing systems in areas where staff do not work as part of a wider team or where there are large numbers of staff.

Within the Vision for the Future document (Department of Health, 1993), clinical supervision has been described as a formal process of professional support and learning which enables practitioners to develop knowledge and competence and assume responsibility for their own practice while enhancing protection for patients.

Site Gi: Event / State Network Narrative

Figure 6.19 (compact disk) shows the event state network for Site G – Development i.

Several specific cases raised awareness amongst the theatre team that often there was little or no relevant guidance on practice issues (1). Where guidance did exist, such as in the case of MRSA and infection control, it was often difficult to relate to theatre practice (2). The theatre team raised these issues with the practice development facilitator for critical care and she decided that there was a need to take national and local policy / guidelines and translate these into a manual for theatre staff (3). In order to achieve this, the practice development facilitator established a guidelines group (4). The group developed guidelines (5) which were then submitted for approval to the theatre users group (6).

Initially, the group met monthly and, although many practitioners were keen to be members of the group, most of the work was undertaken by the facilitator. The fact that the facilitator was seen as the driving force made her question whether the continued development of guidelines was sustainable in the long term (7).

Additionally, the facilitator was concerned that, while staff were motivated to attend

meetings, they were reluctant to volunteer (8) to write guidelines because of the extra workload involved. The facilitator felt that some staff had obviously volunteered because membership of the group gave them additional influence (9).

Despite these reservations, the facilitator pressed on with work to develop the manual. More encouraging was the fact that the development made practitioners question what they do and how they do it (10). In turn this helped to identify previously unconsidered areas of practice (11). Some guidelines crossed departmental boundaries; for example intra-venous access (12) and the development of a Trust wide policy was indicated in these areas. To achieve this, the facilitator established small cross departmental working groups (13). In an attempt to encourage more ownership of the work, the facilitator decided to attend the first meeting and then leave the group to get on with developing the guidelines (14). This also allowed the group to be a company of equals rather than the facilitator being seen as influencing policy across the organisation (15). Despite efforts to encourage ownership, the facilitator found that little progress was made unless she was involved (16) and she decided to take up the reins again to maintain momentum (17).

Some of the guidelines produced had clear resource issues, for example pressure sore prevention (18). For the guidelines to be effective, the facilitator knew that she would need to flag up resource issues with managers (19). At the same time the facilitator was aware that other areas, such as wards, had recently had new pressure relieving equipment (20). This helped her to make a case for theatre to have additional resources, which were secured and the guidelines and new equipment were introduced (21).

Approval for the initial guidelines happened quickly (22) as these were simply adapted from guidelines which already existed within the Trust. However, as the work progressed and the issues raised became increasingly complex, the approvals process became more problematic. One of the issues was that the guidelines were so far down on the Theatre Users Group agenda that the meeting was closed before they were discussed (23). This made the facilitator increasingly frustrated and undervalued for the work she had been doing (24). She approached her manager for advice, which was that she should simply include the guidelines and not seek approval from the Theatre Users Group (25). While the facilitator was flattered that she was trusted in this way (26), she had mixed feelings about following this path (27). On the one hand, she felt that if the Theatre Users Group strongly disagreed with the guidelines they would certainly be discussing them (28), while, on the other hand, she was unsure of pressing ahead without their approval (29). The whole issue of approval for policies was very unclear in the Trust (30).

A short while later the facilitator was moved into another role (31) within the theatre and the guidelines group was placed on hold (32).

Figure 6.20 Site Gi: Variable List

Antecedent	Intervening	Outcome
Identification of problem No guidance	Translation Production Establish group Motivation Attendance Influence Cross departmental Awareness Cross departmental group Resources Flag up need Approval Unclear Frustration Change agent changes role Hold	Guidelines New equipment

Site Gi: Causal Network Narrative

Figure 6.21 shows the causal network for Site G – Development i.

Several specific cases raised awareness amongst the theatre team that often there was little or no relevant guidance on practice issues (1). This can present a problem (2) when the team is faced by a specific patient, for example a patient with body piercings. To overcome the problems, a guidelines group was established (3) to rework existing policies and guidelines or produce new documents where no guidance existed. Initially the group set about translating existing policy (4).

The group met monthly and was facilitated by the practice development facilitator. The facilitator was concerned that, while staff were motivated to attend meetings,

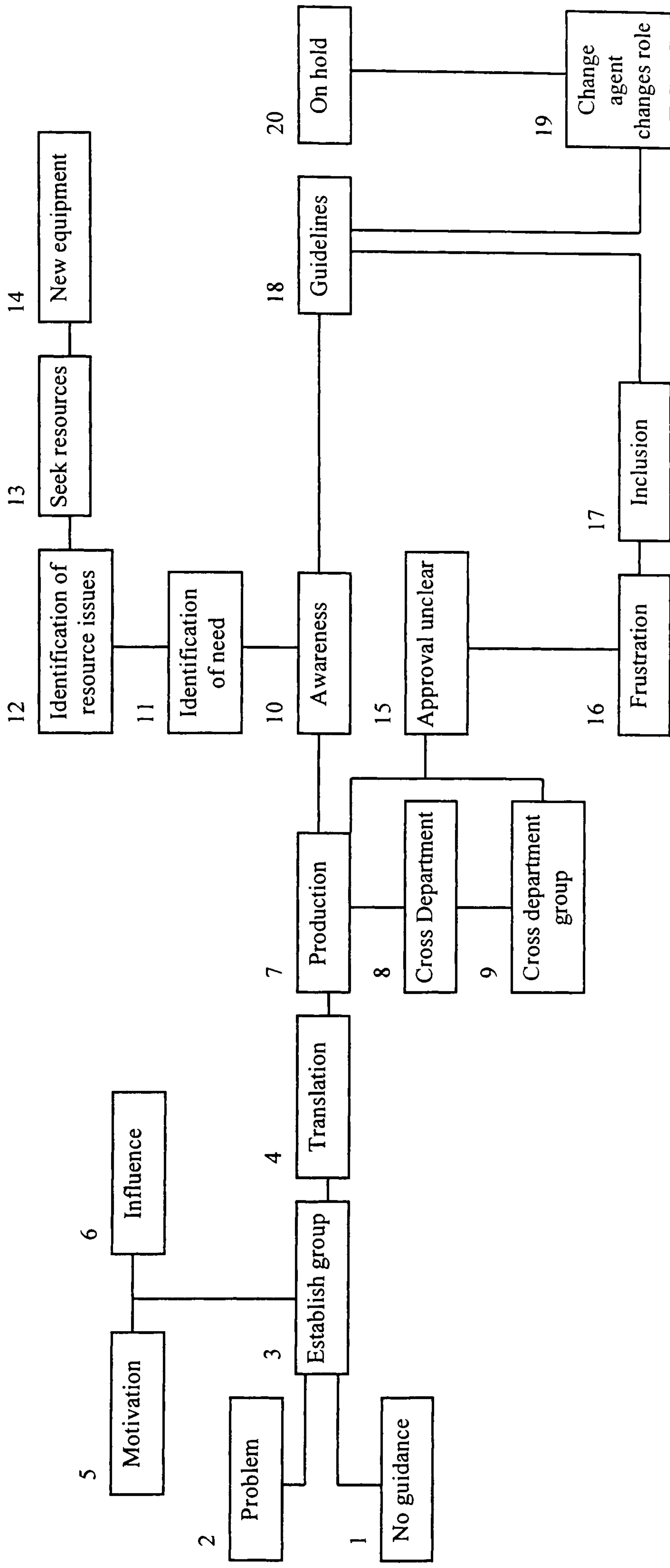


Figure 6.21 Site G Development i Causal Network

they were reluctant to volunteer (5) to write guidelines because of the extra workload involved. The facilitator felt that some staff have obviously volunteered because membership of the group gave them additional influence (6).

Despite these reservations the facilitator pressed on with work to develop the manual (7). Some guidelines crossed departmental boundaries (8), for example intra-venous access and the development of a Trust wide policy was indicated in these areas. To achieve this the facilitator established small cross departmental working groups (9). Once produced, the guidelines were submitted to the Theatre Users Group for approval.

The production of some guidelines raised awareness (10) of other problems such as resource issues. The guidelines identified an unmet need (11) which required additional resources (12) so that evidence based care could be implemented. The facilitator raised the issue with her manager and flagged up the need for resources (13). Resources were identified, new equipment was secured (14) and the guideline were fully implemented.

Approval for the initial guidelines happened quickly, as these were simply adapted from guidelines which already existed within the Trust. However, as the work progressed and the issues raised became increasingly complex, the approvals process became more problematic (15). One of the issues was that the guidelines were so far down on the Theatre Users Group agenda that the meeting was closed before they were discussed. This made the facilitator feel increasingly frustrated and undervalued for the work she had been doing (16). She approached her manager for advice, which

was that she should simply include the guidelines and not seek approval (17). The facilitator reluctantly agreed to include the guidelines (18) citing the fact that, if the Theatre Users Group disagreed, they would have put them at the top of the agenda.

A short while later the facilitator was moved into another role (19) within the theatre and the guidelines group was placed on hold (20).

Site Gii: Event / State Network Narrative

Figure 6.22 (compact disk) shows the event state network for Site G – Development ii.

Initial interest in developing clinical supervision in theatre occurred after the practice development facilitator and two colleagues attended a clinical supervision module (1) at a local university. During the supervision module the practitioners received support from a health psychologist (2). However, some of the staff thought this was of little help (3) because the psychologist had little understanding of operating department work. After the module this support ended (4) and, while the support offered previously was less than optimal, all of the supervisors felt they could do with ongoing support (5).

Once the initial one to one supervision developed during the module was well established, the facilitator started to consider how to roll out supervision to the wider theatre team (6). Early in the planning process the facilitator decided that any supervision scheme must include more than just nursing staff (7) and in particular

operating department assistants. However, many of the facilitator's practice colleagues thought that the scheme should be restricted to nursing staff (8). The initial plan was to develop a pilot in one theatre team (9). The success of the pilot involved navigating around some existing issues within both theatre and the Trust. Firstly, the Director of Nursing had been a driving force behind the implementation of supervision (10). She had taken this forward within a single Directorate and this was led by another practice development facilitator (11). A large pilot of one to one supervision (12) had already taken place and this model had been adopted across the surgical Directorate. The first challenge the proposed theatre pilot faced was how to get an alternative model accepted. One to one supervision would have been impossible in theatre because of the sheer numbers of staff involved (13) and there was the potential for conflict between the existing model and the proposed new model (14). Another issue which needed to be addressed before the pilot could commence was support from management (15). While the manager was broadly supportive of the proposal, she was clear that the needs of the service must come first (16). The facilitator was frustrated that the manager could not see that supervision would be beneficial to the service (17) and was not just an optional extra. While the facilitator was frustrated, she was also aware of the considerable pressure that theatre services were under because of recruitment difficulties (18). The potential problems with the pilot were further compounded after the manager informed the facilitator that she will select the supervisors and supervisees for each group (19). The facilitator challenges this, saying that any pilot will involve self selection (20).

Before the pilot can commence the facilitator was keen to raise awareness amongst staff of the proposal (21) and to address some of the misconceptions (22) some staff

had about what supervision is. The misconceptions came to a head before the facilitator was able to run the awareness sessions when her supervisee was accused of making a mistake. A senior member of staff decided that the mistake should be investigated through a supervision session (23) and the facilitator's next supervision session was high-jacked by the team leader so that the issue could be examined. The facilitator was angry that she was being forced to collude with the team leader and take sides against her supervisee (24). Eventually the issue was resolved to everyone's satisfaction but the facilitator was concerned that she did not handle things very well and that the whole incident had done little to dispel the myth that supervision was about discipline.

Eventually the facilitator planned the first awareness session but attendance was very poor (25) with only two people attending out of a team of 15. The facilitator was frustrated (26) about this but set about planning another session. Additionally, the facilitator set about writing a strategy for the supervision pilot (27). This document raised time and time again resource issues (28) that had not really been addressed yet.

Around the same time the facilitator became increasingly aware that some staff were in desperate need of supervision (29) and these needs were acutely highlighted by several recent difficult and emotionally charged patient cases (30). Additionally, it would have been useful to try and start to change the culture of blaming each other for any failings that certain teams personified (31). In order to commence the pilot the facilitator pressed ahead with plans to train more supervisors (32). A single theatre team was selected (33) and a meeting arranged. Again attendance was very

poor (34) with no one from the team attending the meeting. The facilitator was increasingly concerned that she was going round and round in circles (35) and getting nowhere. The development was further affected by one of the supervisors, trained at the beginning of the development, leaving to work for another NHS Trust (36). As a result of this departure the facilitator and her other colleagues had to pick up her supervision workload (37).

Several weeks later the facilitator changed role (38) and became the acting team leader for recovery and the entire project was put on hold (39).

Figure 6.23 Site Gii: Variable List

Antecedent	Intervening	Outcome
Interest	Support needed	No final outcome achieved during data collection period
Education	Support provided	
Director of Nursing driver	Support ends	
Pilot in one Directorate	Conflict	
	Support	
	Service priority	
	Value	
	Manipulation	
	Misconceptions	
	Enforce discipline	
	Attendance poor	
	Busy	
	Not a priority	
	Plan	
	Review strategy	
	Select team	
	Change role	
	On hold	

Site Gii: Causal Network Narrative

Figure 6.24 shows the causal network for Site G – Development ii.

Initial interest in developing clinical supervision in theatre occurred after the practice development facilitator and two colleagues attended an educational course on clinical supervision (1). All three of the staff who attended the course are interested (2) in developing clinical supervision within the operating theatres as they felt there was an acute need (3) to provide staff support and to supervise the work of others.

The practice development facilitator took a lead role in developing an initial pilot of supervision for theatre. The facilitator sought support (4) from managers and the organisation for an initial pilot. While the organisation was committed to developing supervision, it was keen to do so in a structured way. The Director of Nursing had been a driving force behind the implementation of supervision (5). She had taken this forward within a single Directorate and this was led by another practice development facilitator. A large pilot of one to one supervision (6) had already taken place and this model had subsequently been adopted across the surgical Directorate. There was the potential for conflict between the existing model and the proposed new model (7). The surgical Directorate model was of one to one supervision which would be unworkable in theatre because of the large numbers of staff.

Another issue which needed to be addressed before the pilot could commence was support from management. While the manager was broadly supportive of the proposal, she was clear that the needs of the service must come first (8). The

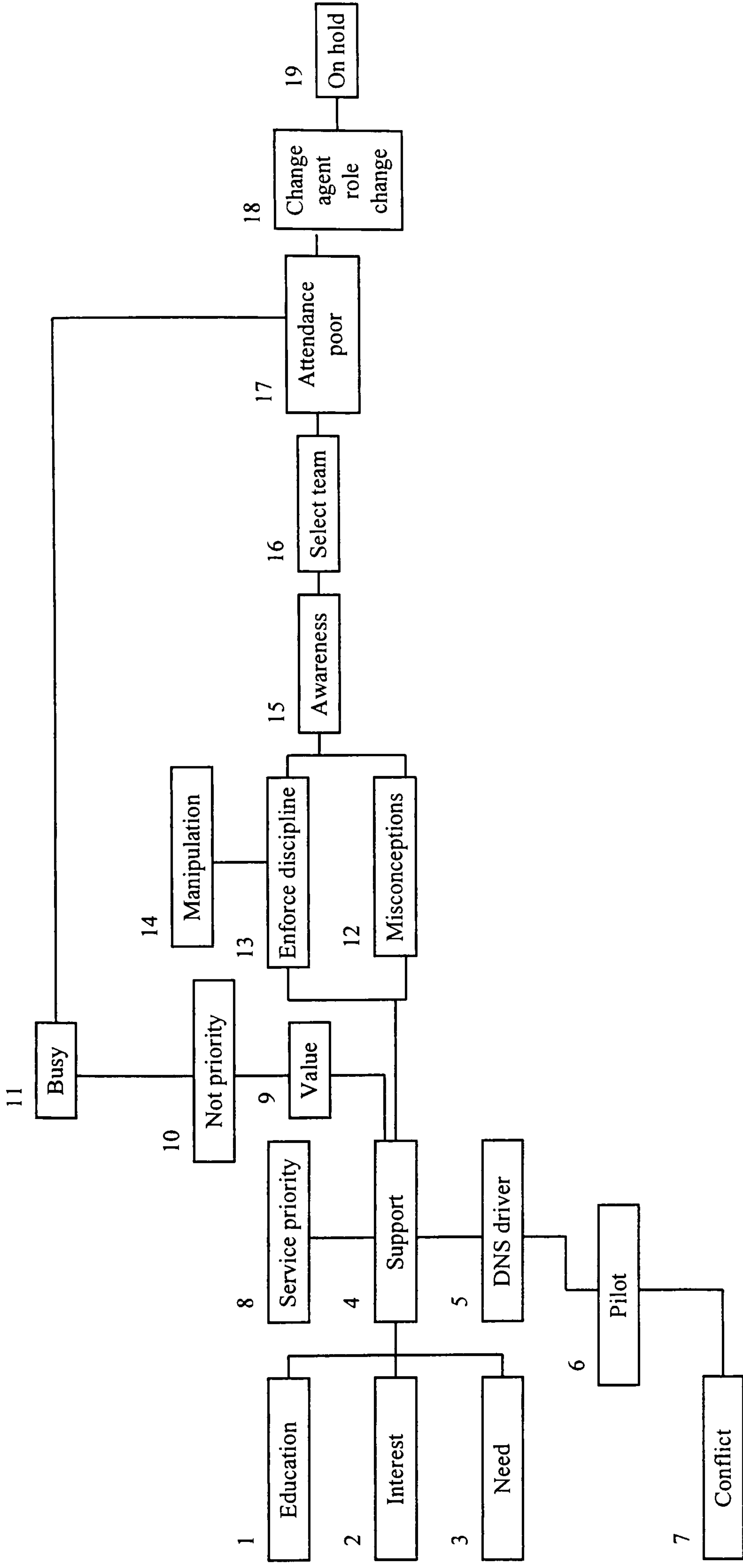


Figure 6.24 Site G Development ii Causal Network

facilitator was frustrated that the manager could not see the value of supervision (9). The manager's view that supervision was not a priority (10) is echoed by staff who subsequently fail to attend awareness sessions and planning meetings because they are busy (11) delivering patient care.

In addition to this feeling that supervision was not a high priority, the manager and several senior staff had misconceptions about what supervision is (12). Some senior staff felt that it should be used to enforce discipline (13) within teams and this led to (14) manipulation in the way in which the existing supervisor / supervisee relations were managed. These misconceptions came to a head when the facilitator's supervisee was accused of making a mistake. The senior member of staff tried to use the supervision process to investigate and reprimand the junior nurse.

Eventually the facilitator planned the first awareness session (15) and produced an action plan for the implementation of the pilot. A single team (16) of 15 staff was selected as the initial pilot. However, attendance at the awareness session was very poor (17).

Several weeks later the facilitator changed role (18) and became the acting team leader for recovery and the entire project was put on hold (19).

Following the construction of all of the causal networks and their narratives, the networks were re-examined to identify similarities between the case study sites.

❑ Cross case comparison

Analysis of all of the causal networks revealed several themes which occurred within many or all of the developments. These themes can be divided into those which were antecedents to the development and those which influenced the planning, implementation and evaluation of the development.

Antecedent factors

Awareness – all of the developments contained some degree of awareness as an antecedent to the development. Such awareness was either identification of unmet need, dissatisfaction with the current way of working or an awareness of a better method of care delivery. Both Site A and Site F provide the clearest examples of how various factors interact to produce awareness. Within Site A, the appointment of a new consultant, an audit of nutritional support and reflection upon practice combine to stimulate awareness of both unmet need and a possible better method of care delivery.

Approval and champions – approval for the development was often sought early in the process of planning. In some cases several layers of approval were necessary, for example from the Director of Nursing, service manager and other professionals.

Again Site A demonstrated how some developments need to go through multiple approval processes involving other departments and professional groups, as well as line managers. In addition to approval, many of the developments had a champion. This champion was a senior figure who supported the proposed development and

assisted with its implementation. In many cases the assistance was merely the raising of issues with managers or taking an active interest in the progress of the development. Most of the developments had the Director of Nursing as the champion, although some developments were championed by other professional groups, for example consultant medical staff. The Site F development was championed by a consultant who worked with the practice development facilitator to raise awareness amongst managers of the need for the development. Site F represents one of the strongest cases of championship of all of the case study sites.

Personal interest and desire – several of the developments originated from the change facilitator’s initial interest and a desire to improve practice. In all of these cases the change facilitator sought support from colleagues before implementing the development. Site B – development i provides the clearest example of how the practice development facilitator’s personal interest can shape the development. In this Site it was the practice development facilitator’s desire to tackle a problem that triggered the development.

Policy – those developments which had a strong policy driver (from the national agenda) were more successfully implemented than those which originated from the “grass roots”.

Planning, implementation and evaluation factors

Leader dependence – several of the developments appeared to be dependent upon the leader for their continued implementation. This dependence and lack of

ownership by the practitioners involved was identified by some of the respondents as a significant factor. In some of the developments the dependence on the leader was so great that the development ceased when the change agent no longer took an active interest. The Site G developments illustrate the issue of leader dependence very clearly. In these developments there appears to be little sense of ownership amongst the operating theatre practitioners. As a result, unless the practice development facilitator drives the development there is little or no progress. However, there is a clear distinction in that only those developments which were originated by the practitioners or the facilitator were leader dependent. Others, for example, the development of a clinical governance infrastructure continued even after the leader departed.

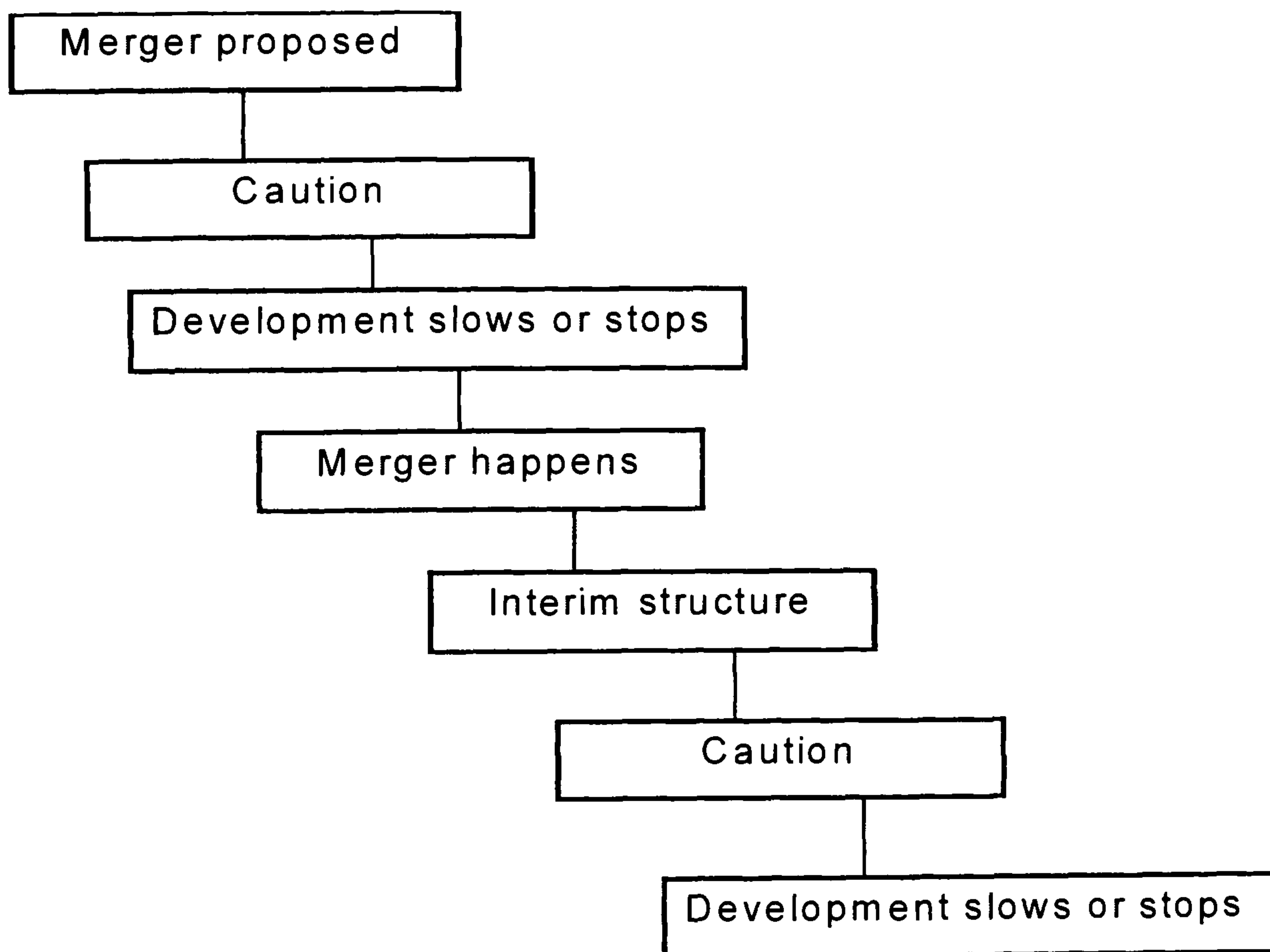
Pressure – many of the developments were adversely affected by pressure on individuals and the services in which they operated. In some cases, for example the development of clinical supervision in theatre (Site G – development ii), the development never really got started because of the pressures within the system. Other examples, such as the development of leg ulcer care (Site B – development i), suffered delays as a result of service pressures.

Merger and organisational transition – almost all of the developments were affected by merger or organisational transition at some time during their planning or implementation. Merger and transition had the greatest effect on the developments within Site F, with numerous changes in management resulting in caution and long periods of inactivity. Additionally, both the consultant and the practice development

facilitator became increasingly frustrated as they had continually to re-package and sell the development as various managers come and went.

Merger classically had one of two effects; either it caused delay because of interim management structures or it paused developments because of uncertainty. Figure 6.25 demonstrates the typical impact of merger and transition on practice development.

Figure 6.25 The typical impact of merger and organisational transition on practice development



□ Comparison between Delphi and causal network results

When comparing the Delphi results with those from the case studies, it is important to remember that these two approaches were designed to answer different research questions, and as such, were expected to yield differing but complementary results. For this reason comparison is used to provide a more comprehensive overview of the influence of organisations on practice development and not to provide confirmatory results. This issue is discussed in more depth in chapter 7.

Table 6.11 shows key positive antecedent and intervening factors identified through causal network analysis. These factors are compared with those identified from the Delphi survey and the subsequent principal component analysis of the data. The antecedent factors are a mixture of contextual (policy, patient focus and effectiveness) and individual (practitioner interest and education). There is less focus on structural and organisation factors, with the exception of the Director of Nursing and the champion. The reasons for this are discussed in more detail in Chapter 7.

Within the Delphi survey results factors such as organisation culture, empowerment of practitioners and multi-disciplinary structure were felt to be important antecedents by Directors of Nursing. While these are not directly identified in the case study findings, their importance cannot be underestimated.

As expected, more intervening factors were identified using a case study approach than using a Delphi survey. Intervening factors were more organisational and structural (approval for the proposed development, facilitation and support for the

Table 6.11 Comparison between Delphi survey and case study results (Positive factors)

Antecedent factors	Key case study factors	Corresponding Delphi factors	Principal Component Analysis – component label
	Identification of need / problem Practitioner interest Education Director of Nursing as champion of the development Policy Drive towards clinical effectiveness Creation of new post	Patient focus [ranked 1] Motivation [ranked 5] Education [ranked 7] National agenda [ranked 11]	Patient focus Anticipation of change
Intervening factors	Key case study factors Support from others Approval for the development Resources Risk assessment Facilitation of the development Awareness Ownership and involvement Education Identify solutions	Corresponding Delphi factors Risk taking [ranked 8] Education [ranked 7]	Principal Component Analysis – component label Culture and context

development). Additionally, individual factors (education, ownership and involvement) also figured prominently.

Table 6.12 shows key negative antecedent and intervening factors identified through causal network analysis. These factors are compared with those identified from the Delphi survey and the subsequent principal component analysis of the data. The table shows how almost all of the negative antecedent factors identified from the case study data are organisational and structural in nature. All of these factors are likely to cause considerable tensions for both the practitioner and the organisation and this is probably the trigger for the development of practice.

Again the case study data identifies a large number of intervening factors. These tend to be organisational, structural and contextual in nature with very few individual factors, with the exception of the influence of other professionals and leader dependence.

□ Conclusion

Throughout this chapter the results of the two phases of this longitudinal study have been presented. The chapter has set out the major antecedent and process factors which influence the development of nursing practice, together with the perceptions of a sample of Directors of Nursing from across the UK. While some attempts at comparison between the Delphi and case study data have been made, there is a need to articulate further and debate the similarities and differences. In the next chapter this comparison will be developed further. Additionally, the next chapter will also

Table 6.12 Comparison between Delphi survey and case study results (Negative factors)

Antecedent factors	Key case study factors	Corresponding Delphi factors	Principal Component Analysis – component label
	Lack of guidance Problem identification Poor quality services Threats to individuals or services Lack of uniformity in care Delays in treatment	Pressures [ranked 3]	Tensions Pressure
Intervening factors	Conflict between Directorates Not a priority Leader dependence Unclear approval process Influence of other professionals Merger / transitional structure Resources Caution Own agenda Manager's agenda Pressures Lack of support Control	Directorate structure [ranked 14] Transition [ranked 18] Resources [ranked 1] Pressures [ranked 3] Lack of support [ranked 11]	Interpersonal and structural Control Tensions Pressure

discuss the major findings from this study and identify how they compare to previous published work in the field.

○ Chapter 7: Discussion

□ Introduction

This chapter provides an in-depth discussion related to the findings of the research study. Initially the chapter will explore the appropriateness of the research approach used and seek to describe how the study has answered the research questions which were posed earlier in the thesis. Following this, the outcome of the analysis of the concept of practice development will be reviewed to identify how it might be useful to practitioners engaged in practice development activity and to NHS organisations. In addition, the results of the concept analysis will be compared and contrasted with other work which has sought to articulate what constitutes practice development.

In the previous chapter the results of the Delphi survey and case studies were compared. This comparison used the component titles developed during the principal component analysis to group findings from the different methods together. These component labels are used in this chapter as sub-headings, with the factors which link to them forming the basis for the discussion in each section. This chapter includes a discussion of the results as well as reflections on the possible reasons why certain factors influence development. The chapter concludes by reviewing the original contribution which this study makes to the body of knowledge about health care development and innovation, together with a review of the potential limitations of some of the methods and findings.

□ Appropriateness of the research approach

The research approach used in this study was developed to answer a range of specific research questions. The review of the literature outlined how existing studies were limited because of their focus on either antecedents to development or the process of implementation. Overall the previous literature provided several pointers to the selection of the research approach. The research approach and methods used do appear to have allowed the researcher to answer the research questions. The research questions in this study were: -

- What do Directors of Nursing perceive to be the optimal organisational structure to promote the development of nursing practice?

- What factors can facilitate or hinder the process of practice development?

- What influence do positive and negative factors have on the process of developing practice?

The question about the perceptions of the optimal organisational structure for practice development is answered using data from the Delphi survey. The results of the Delphi survey suggest that Directors of Nursing feel that several structural factors play a role in the development of practice. Amongst these are flat and multi-disciplinary management structures, management style including openness and supportive managers and a culture which encourages development and risk taking. The case studies have contributed to the view of what constitutes an optimal

organisational structure by identifying the importance of structural stability and champions during the process of practice development and the influence of Directorate structures and risk perception on certain cross organisational developments. The second question is addressed by both the Delphi survey and the case studies, although the Delphi survey results overemphasise the influence of factors such as antecedents to development. One possible reason for this is the choice of informant. Most Directors of Nursing are responsible for ensuring that practice is developed and rarely are they involved in the implementation of specific developments. The strategic overview which most Directors of Nursing will have could mean that there is a greater bias towards antecedent factors. Similarly, the third question is addressed by both parts of the research approach by providing details of the factors themselves and by discussing their influence on developments. It is important to remember that it was never the intention to identify generalisable factors but, as discussed in chapter 4, to provide results which may be transferable to developments occurring within similar contexts. Thus it is argued that the influential factors which have been identified must be studied in context. Therefore, throughout this chapter findings are discussed within the context in which they occurred.

When examined together there are similarities between the Delphi results and the findings of the case study analysis. Findings such as management style, resources and emphasis on finance have been identified as important by Directors of Nursing within the survey and the same factors were also highlighted in some of the subsequent case studies. While comparisons between the Delphi and case study results are possible, it must be remembered that the two methods examined different aspects of the same phenomenon. The Delphi survey, by its very nature, examined

the views of Directors of Nursing about what they felt were the significant factors which preceded the development of practice. While one of the survey's initial questions (round one survey Appendix 05) asked respondents to consider a development and identify which factors exerted a positive or negative influence during its development, the majority of questions sought to identify antecedents to development. The two principal parts of the research were chosen to be complementary and not confirmatory in nature. As such, the different methods were selected because they would hopefully provide a more comprehensive picture of factors which influence development. Inevitably, despite the intention being to identify a wide range of factors, some of the findings of the Delphi survey are confirmed by the later case studies. These are discussed in the following section together with a discussion of the importance and implications of the major findings of the study.

□ Conceptual analysis of practice development

As part of this study a review of the concept of practice development was undertaken. Details of this review have been described in chapter 2. The concept analysis represents a significant step forward towards identifying the contribution practice development makes towards nursing practice and patient care. The analysis identified that practice development, in its purest form, has led to new ways of working which in turn lead to a direct measurable improvement in the provision and quality of services to the client. In addition, it involves changes which were a direct response to a client problem or need and these changes led to the development of effective services which maintained or expanded the business of the professional or

organisation. It is contended that these four critical attributes should be present in all examples of practice development although other factors such as facilitation may be present in some cases. As a result, practitioners and organisations now have a clear set of criteria by which they can measure when practice development activity has occurred. However, such measurement must be tempered with a note of caution as the desire for rapid results and the measurement of outcomes may mean that incremental change over a long period of time may be sacrificed with corresponding negative effects on sustainability. These critical attributes when combined with the identified empirical referents of; a change in the way of working, a clear client focus and the development of clinically or cost effective services, can also be used during the planning stage of any development. Using these measures should go some way to ensuring that what is proposed is properly thought through in terms of its evidence base and its likely effect on patient care.

While the concept analysis provides a clear definition of what constitutes practice development, the author acknowledges that rarely does practice development exist in isolation from other related concepts such as professional development and that, within nursing, the development of practice is an eclectic mix of different activity. Despite the fact that practice development is often reliant upon other related concepts, the end result should still contain the identified critical attributes.

During the concept analysis the author also acknowledged the similarity between practice development and some of the definitions of innovation. Indeed the only attribute which was not consistently articulated in these definitions was that practice development occurred as a response to a specific client need or problem. This led to

the author contending and accepting that practice development was in fact a type of innovation which always had a clear client or patient focus inasmuch as it was a response to a specific client / patient need. This is another significant outcome from the concept analysis as it suggests that practice development utilises change theories and models of innovation to support the process of development. As articulated in chapter 3 there are similarities between the antecedents identified during the concept analysis and those described during the review of change theories. While the concept analysis identified that patient focus was a critical attribute it did not directly identify how patient involvement may be used to clarify what needs to change. The direct involvement of patients or service users in the planning and implementation of developments is starting to become more common. With the exception of Site B where user representatives are involved in the development of new patient information literature, continuous user involvement was not highlighted in the case studies. The development of Primary Care Trusts within England and similar commissioning arrangements in other parts of the UK have served to strengthen user involvement in local health care. Systems are needed to promote active user involvement in all stages of practice development. On reflection, within this study several of the case study sites might have benefited from additional user involvement. For example, Site E which was developing new documentation may have benefited from user involvement to ensure that the assessment processes identified were appropriate to the needs of patients and that the entire process of assessment was streamlined rather than each professional group undertaking their own assessment. In addition, Site A may have found that user involvement during the process of identifying unmet need might have added weight to the proposed change

and assisted the change agent to convince other professional groups of the importance of developing this aspect of care.

The literature review undertaken as part of the concept analysis also articulated that there were several schools of thought about practice development, with one school viewing it as an outcome of research activity and another viewing it as an outcome of change and innovation. In the review it is argued that both approaches have their merits and, indeed, that one approach may be more applicable than the other in certain circumstances. Essentially, where little is known about what needs to change or how the change should be operationalised, then models based around action research may be more appropriate than the use of models of change.

None of the case study sites articulated that they were using a specific model or theory to guide the implementation of their development. Analysis of the case study data suggests that several of the models discussed in chapter 3 may have been beneficial. For example, Site A's development would have benefited from a longer diagnostic phase and the identification of key stakeholders. The use of Lewin's (1959) force field theory within this development may have allowed for the prediction of the negative reaction to nurses ordering x-rays. Specific action could then have been put in place to prevent this problem through proactive consultation with Radiography staff from the neighbouring hospital. The development within Site B could have both been implemented using Rogers (1995) Diffusion theory. Indeed examination of the proposed changes using the 5 characteristics of successful change (Rogers and Shoemaker, 1971) would have assisted in overcoming resistance as the

change could have been presented as not too different to the current system of working.

The concept analysis presented in this study is significantly different to previous work undertaken in the field of practice development inasmuch as it uses different methods to identify the critical attributes. Previous work has been undertaken by the Royal College of Nursing Institute (RCNI) (McCormack and Garbett, 2000). This analysis utilises a concept development approach to analysis as described by Morse (1995). The analysis consisted of three stages; literature analysis, attribute verification and the identification of the manifestations of the concept within different settings. The RCNI used telephone interviews and focus groups as a means of exploring the meaning and dimensions of key ideas arising from the analysis. Prior to the literature review, a decision was made to examine only the use of the term 'practice development' within health care because it had a particular meaning within that context. While the decision to narrow the focus of the concept analysis is understandable, this decision resulted in a failure to examine the use of the term 'practice development' as it is used within General Practice and other professional business contexts. As such, the analysis does not examine how practice development is used as a basis to develop the business of a professional.

McCormack and Garbett (2000) describe how the purpose of practice development is to increase the effectiveness of patient centred care, despite the acknowledgement that some authors describe developments which are focused on the professionalisation of nursing or on the professional development of individual practitioners. It could be argued that this conflicting assertion owes much to a failure

on the part of McCormack and Garbett (2000) to delineate clearly the concept of practice development from other closely related concepts such as professional development. Another purpose identified by McCormack and Garbett (2000) was that practice development enabled health care teams to transform their care and the culture in which it takes place. This assumes that the developments introduced require a change in culture of the ward or team before they can be accepted and fully integrated into the day to day work of the staff. Most writers about innovation and culture (King and Anderson, 1995) suggest that any innovation impacts on a group's culture to some extent. Therefore, the assertion about practice development leading to a transformation of culture as well as care may be appropriate. Indeed the case study sites provide some indication of where the leaders of the developments were trying to transform the culture of the organisation or team within it. Site B development ii attempts to change the culture of Primary Health Care Teams by breaking down the barriers between professional nursing groups and promoting a more joined up approach to care delivery. In addition, Site E's attempts to develop uniform documentation across the organisation could also be viewed as trying to transform the culture of individual wards and Directorates. Both of these developments appear to be problematic as they are trying to introduce a change which involves individuals and teams adapting their values and working practices. In both cases, the teams decide to adapt the development so that it more closely matches their values and beliefs. This process is described by Rogers (1995) and is seen as a key component of diffusion theory. Where the proposed change does not match the five characteristics of a successful change (Rogers and Shoemaker, 1971) in particular the characteristic of how compatible the new approach is to the current

way of working, the team who are forced to adopt it will adapt it so that it meets their requirements.

McCormack and Garbett (2000) suggest that practice development has the attributes of being systematic and rigorous and is a continuous process founded on facilitation, although little information is provided about what constitutes a systematic or rigorous development. The notion that practice development is a continuous process is an interesting one because it assumes no end point. Again, this finding may have been related to the focus of the analysis around transforming care and ward / team culture. If the development is to improve care then it may be appropriate to assume that there is no end point. However, it is relatively easy to identify developments which have a clear end point. For example, the introduction of nurse prescribing can be judged as a practice development using the critical attributes identified within the concept analysis which forms part of this study and this development has an end point when all practitioners are able to prescribe. An alternative point of view is that no development should have an end point because change in practice requires continuous reinforcement and refinement to ensure that it continues to meet the requirements of the service user. Perhaps the fact that practice development is often not viewed as a continuous process has resulted in problems with the sustainability of some developments.

Another concern with the analysis by McCormack and Garbett (2000) is the idea that the process of practice development is founded on facilitation. It could be argued that the identification of the attribute of facilitation could be linked to the sources used as data to verify attributes and examine manifestations of the concept. Where practice

development facilitators are used as a data source, it is likely that they will describe developments that are facilitated as these are the types of developments in which they have involvement. Within this study, some developments were facilitated by groups, for example, the development of leg ulcer care within Site B. Leader dependence remained an issue within this Site as a single individual still had the role of facilitating the change within practice.

Overall, it is contended that the concept analysis presented as part of this study provides a clearer and more wide ranging definition of what constitutes practice development. While a number of developments may contain other attributes such as facilitation, this is not universal and, as such, it cannot be regarded as a feature of all developments in practice. In addition, the analysis presented in this thesis differs from previous work because it provides useful insight into how the development of practice may be evaluated during the process of implementation through the use of either the critical attributes or the empirical referents.

□ Antecedents to development

The study identified several positive and negative factors which were important in identifying the need to develop practice. Many of the case study sites suggested that a professional interest in the field led many of the change agents to embark upon a particular development. This finding is interesting, as it appears to be a neglected area within the current literature. One possible reason why professional interest is not highlighted in the literature could be that the majority of studies view development and innovation from an organisational perspective. This assumes that developments

are implemented by an organisation rather than by an individual practitioner. This study suggests that practitioner initiated practice development may be more common than the literature would have us believe.

Developments such as the adaptation and implementation of the SIGN guidelines (Site B) and the development of a nurse bronchoscopist's role (Site F) are examples of developments which originated from the change agent's interest within a particular field of practice. While individual interest plays a fundamental role in deciding what to develop, it can prove problematic in small teams of staff; for example, within small community nursing teams it may not be possible to identify a practitioner with a special interest in a particular field of practice and as a result, the services offered to the service users may be compromised. This is an important consideration for the way in which organisations plan the development of services. Individual interest is valid as an antecedent to development only in cases where individuals are in a position to select which areas of practice they wish to develop. However, in some cases an individual's personal interest may lead to a development which is not entirely congruent with the view of the organisation. For example, within Site G (development ii) where, despite the fact that clinical supervision was part of the Trusts nursing strategy, the organisation has a clear view of how the delivery of supervision should operate. In addition, individual Directorates within the organisation did not see the introduction of supervision as a priority given all of the other pressures related to service delivery. Both of these factors mean that the change agent, despite her interest in the topic, finds it very difficult to convince others of the need to change.

Anecdotal evidence suggests that the majority of developments in nursing practice occur as a result of the individual's own interest in the area. If the government are to deliver the modernisation agenda, then nursing will need to change in order, to place strategic service development at the forefront of attempts to develop practice. Many developments are not as clear cut as to be categorised as top down and bottom up. In many cases developments in practice which originate from grassroots level are congruent with the aims of both the organisation and government policy. In addition, some developments initiated as a result of government policy are readily accepted and championed by practitioners. This is illustrated by case study Site D where an individual takes a lead role, because of her special interest in developing the organisation's clinical governance infrastructure. However, this individuals involvement is relatively short lived as the organisation subsequently retakes control by appointing a new manager. The change agent did not speculate on the reasons for this except to say that she felt that the Trust wanted someone who was from the more dominant acute side of the newly merged organisation. On reflection there could be several reasons why the organisation took control of the development. Firstly, the change agent's own interest in the topic meant that she had her own ideas about how the development should be taken forward. It is unclear whether the change agent's ideas were congruent with the organisations preferred approach. Secondly, the fact that the change agent was asked to rewrite the report so that it presented more clearly the future direction and what needed to be achieved suggests that the report at least did not match the expectations of the committee for which it was produced. Finally, it could simply be that the change agent was selected by her former manager to lead the development and once he decided to move on to another job outside of the organisation the way was clear for the development to be managed more centrally.

Although the change agent's interest in the topic area was a significant antecedent to many of the developments studied during this research some developments did not originate from personal interest. The Site B (development ii) project to develop integrated nursing teams was not initiated because of the change agent's personal interest. This development originated from the need to more effectively manage scarce resources so that a wider range of services could be provided using the same level of resources. Government policy is also a key antecedent within two of the case study sites. Policy drivers often ensure organisational commitment and this is clearly demonstrated in two of the case studies (Sites D and E). Within Site D, the organisation is required to undertake a review of its clinical governance infrastructure and produce a report for the Health Department. The need to meet report deadlines acts as a significant driver for the implementation of the development. Within Site E the development of nursing documentation is driven in part by the policy related to Information for Health (Department of Health, 1998b) although the more significant drivers are the identification of need and an awareness of a better approach to assessment.

In addition to the individual change agent's interest in a particular development, many developments are also reliant upon the generation of interest amongst practitioners who are being asked to participate in the proposed development. The development of interest within other staff is another new factor which has not previously been directly highlighted in the literature. However, the factor may be regarded as similar to the development of a sense of ownership amongst those individuals whom the change will affect. Occasionally, the change agent's interest

and the level of interest amongst participants may differ and, where this is the case, the implementation of change may prove very difficult. Site G's plan to implement clinical supervision into the operating theatre environment illustrates the difficulties when trying to implement a development where the participants are less enthusiastic than the change agent. Within Site G the change facilitator becomes increasingly frustrated by poor attendance at the meetings to plan the implementation of supervision. To what extent the organisations reluctance to support the development effect the practitioners subsequent adoption and sense of ownership is open to question. One can speculate that if this had been a development being driven by the organisation, attendance at meetings may have been less of a problem. Surprisingly, none of the sites studied appeared to use power to force the participants to change, although such techniques are frequently used to drive forward change where resistance is high (Lancaster, 1999a).

The planning of individual developments in practice can also be positively influenced by the identification of a champion. Championship was identified as an influential antecedent in several studies, although most of the studies provide little information about the role which these individuals may play during innovation. A champion is an individual within the organisation who takes an informal role to generate much needed support for the project from others within the organisation (Markham and Aiman-Smith, 2001). However, champions need more than enthusiasm for the proposed development; they need to understand the gritty tasks associated with actually introducing them (Frey, 1991). The use of champions within service development is becoming increasingly widespread within the NHS. Recently the government has acknowledged the benefit of having champions within various

levels of the organisation to guide the development of services in relation to the modernisation agenda. The National Service Framework (NSF) for Older People (Department of Health, 2001a) requires that the NHS and partner organisations appoint organisational, service and practice champions whose role is to consult with service users and guide the implementation of policies to assist the organisation to meet the NSF standards.

Within this study, champions played a role within five of the developments. In many cases the champion was the Director of Nursing, who provided support and legitimised the proposed development either directly or because of their general interest in the field, as in the case of clinical supervision (Site G). Site F and Site D differed in this respect because the champion in these cases was a Consultant Physician and a Medical Director respectively. Within the developments examined as part of this study the champions played differing roles but in the majority of the case study sites, the champion approved the proposed development and lent their support to it. This serves the purpose of providing the change facilitator with associative power to help him / her to drive forward the development. Lancaster (1999a) describes how associative power is based upon an individual's formal or informal connections or relationships with a powerful individual or group. The use of associative power in this way suggests that most change facilitators do not have direct organisational power to force through developments in practice and thus have to rely upon the support and power of others within the organisation.

These two different championship approaches are interesting as they represent different drivers. The projects supported by the Directors of Nursing in these case

studies receive general support which serves to legitimise the proposed developments. General support of this nature may be ineffective at driving through a development. For example, in case study Site B the Director of Nursing supports the development of leg ulcer guidelines but stops short of endorsing them. As a result some Practice Nurses are able to decide not to be involved in the initial pilots. The championship within the Site A and the Site F developments is more active as the Champions (Consultant Physicians) have a more direct involvement and have a vested interest in seeing the development become successful. Such active interest may also cause problems as the champion is likely to have his / her own agenda.

As highlighted, the role of the champions in this study suggests that there is another dimension to their traditional role of supporting, guiding and informing. In some cases the champion was able to use his / her role to manipulate the development to meet his / her own agenda. This is illustrated well within the Site F case study. In this example the champion (a Consultant Physician) blocks attempts by the change facilitator to identify funding for the development by tying the post into the plans for a new ambulatory care centre. This is blocked by the Consultant, despite the fact that it would achieve the desired outcome more quickly than by following the traditional funding route because he feels this would give him less control over the new post and would dilute his power within the wider service. Hidden agenda amongst champions have not been well articulated within the literature and such agenda are likely to be commonplace amongst those people identified to champion the modernisation agenda within the NHS. Markham and Aiman-Smith (2001) are one of the few groups of authors who suggest that champions come forward when the proposed development is likely to benefit their own department. This area requires further

research to identify the extent to which champions support development and if their own individual agenda influence the way in which they perform their role.

The identification of an appropriate champion is not as easy as it might at first appear. Often practitioners have little choice in who the champion for a particular development might be. Within several of the developments in this study the champions were self selected because of their positions within the organisation or because they were directly involved in the developments. For example, case study Site G the development of clinical supervision is championed by the Director of Nursing because it is part of the organisation's nursing strategy. The availability of other champions for this development from within the Directorate General Management structure is restricted as they feel the need to provide the surgical service is paramount and must take precedence over supervision for staff. As a result, the most appropriate person may not always become the champion. However, practitioners need to consider whether it may be appropriate to have more than one champion for their development. The use of multiple champions is commonplace in multi-agency developments where individuals from different agencies are used. Even with developments which concern only one organisation it may be beneficial to have multiple champions, as different individuals will bring different skills and be able to offer influence across a wide spectrum of potential stakeholders.

Another area around which there is a dearth of literature is the use of external champions. External champions would be individuals who are not part of the organisation but who are able to exert influence over members of the organisation and thus guide the introduction of a development. External champions are used

within some aspects of health care development, for example Department of Health funded demonstration sites for the expansion of the public health role of health visitors and school nurses and as part of some award schemes. External champions are likely to require greater levels of support from the team developing the aspect of practice, in order that they are aware of whom the opinion leaders within an organisation are. However, they do have advantages over internal champions. Firstly, they are not subject to the internal politics of an organisation, which may force a champion to conform. Also, they are not subject to changes within the organisation's structure in the same way as internal managers are and, as a result, support from an external champion is likely to continue even when organisations merge or are reorganised. In addition to the positive aspects of using external champions, there are a number of negatives which need to be considered. External champions are unlikely to be able to assist the development team with the nitty gritty of actually implementing the development because they are unlikely to have sufficient insight into the structure and workings of the organisation. The level of power the champion will have is dependent upon their background and the organisation they represent. Hence, Department of Health staff working as champions are likely to have more power to assist with the implementation of a development than those who represent a professional association which has given an award to allow practitioners to develop an aspect of practice.

For those developments where an external champion is not an option, it is possible to select certain types of champion which are "future proof" in terms of organisational transition and reorganisation. Changes in very senior management positions are rare and, therefore, the use of a Director of Nursing as a champion is likely to be

unaffected by reorganisation. Additionally, Non-Executive Directors would appear to be a good choice for a champion as they have significant influence within the organisation and represent a stable presence even during transition. However, neither of these types of champion will be totally unaffected by merger, although it is possible that Non-Executive Directors are more likely to continue to support a development during such transition, as their selection to a similar post in the newly merged organisation is made by people external to the organisation.

Within the Delphi survey and the case studies, education was identified as an antecedent to development. Several of the studies reviewed in chapter 3 suggest that education was a key antecedent to the adoption of innovation. However, the current literature does not articulate what role education plays as an antecedent to innovation. Within this study the concept analysis provides evidence that professional development through formal education or experience acts as an antecedent, as well as playing a role during the process of innovation. For example, attendance at a course may trigger the development of practice. This was the trigger for the development of clinical supervision (Site G, development ii). Alternatively, education may be used to support the implementation of a development as in Site B (development i) during the implementation of improved leg ulcer assessment.

Education and a clear patient focus for any change are important because they enable the practitioner or change facilitator to identify what areas of practice need to be changed. The identification of the need to change is the important first stage within any practice development. There are several things which may act as a trigger for the development of practice. These include: -

Awareness that the method of working is less than optimal – this may occur as a result of reflection on practice, following a complaint about a service or an aspect of care or as a result of research or audit. This trigger occurred in several of the case study sites. Within Site A, reflection on the care provided reveals that there are delays in commencing nutritional support and it is this delay and the desire to reduce it which drives forward the development. Similarly, within Site F the nurse expresses concern about how patient focused current care is and the desire to improve this acts as the catalyst for development.

Awareness of an alternative method of working – awareness of an alternative method of working usually occurs as a result of some professional development activity. This may be attendance at a course or study day which highlights deficits in practice and suggests how these may be improved, or as a result of visiting colleagues, or reading about the work of others in the field. This trigger forms the basis of the development within Site B (development ii) where the nature of integrated nursing teams comes to the attention of the change agent. One of the issues about using an awareness of an alternative method of working as the basis of developing nursing practice is that often people try to duplicate development without considering the original context in which the development was introduced. On reflection, the changes studied within Site B are introduced within different contexts for different reasons. One Practice takes a lead to implement integrated nursing with one of the General Practitioners driving through the development. Although the reasons for this were not articulated in the study it is possible to speculate that this development was driven by a desire to increase the flexibility of working patterns within the Practices nursing team. On the other hand, the other integrated nursing

team development was driven by workloads and staffing problems. While both individuals leading the change are aware of an alternative method of working they are hoping for slightly different outcomes because the needs of the practice settings are different.

A desire to reduce risks / litigation – this trigger usually occurs as a result of the identification of a particular problem, either through concerns about the quality of the service or because good practice is not uniform across the organisation. An example of this as a trigger is the development of standardised care for patients with leg ulceration within Site B (development i). This development utilises guidelines and protocols to reduce the risks associated with inconsistent and inappropriate care.

At the time of the study the internal market was still in place and this may be one reason why threats to services were identified as being antecedent to development in some cases. When the internal market existed, the purchasers of services played a role in triggering development of practice and services by setting enhanced performance measures. Purchasers had the power to take their business elsewhere (at least within the quasi-internal market) if these performance measures were not met within an agreed time scale. Many NHS Trusts perceived these performance measures as threats to relocate contracts if changes were not made within service delivery. Indeed, several organisations lost contracts to neighbouring providers during this time and many authors feel that the internal market had a significant influence on the development of practice (Ranade, 1997).

While the internal market has now disappeared, some of the same principles which supported development continue. NHS organisations now have new drivers to develop the services they provide and again these are tied into measures of performance and the allocation of additional resources. The Government has created a new organisation to oversee systems of clinical governance and to ensure that problem areas are addressed using systematic processes. The Commission for Health Improvement (CHI) undertakes inspections of NHS Trusts in England on a four year rolling programme. Similar arrangements are being developed for other UK health services, including the development of the Clinical Standards Board in Scotland. The Commission for Health Improvement is able to request changes and improvements and is able to revisit Trusts to ensure that these have occurred. As a result, the development of practice around specific unmet client need or following the identification of a specific problem is once again at the forefront of the work of all NHS Trusts. Similarly, the Government has recently tied the allocation of additional resources into performance against a number of measures. The NHS Plan (Department of Health, 2000) outlines how NHS Trusts in England will be assessed against specific performance criteria including standards for waiting times, hospital discharge, finances and health improvement. Following an assessment, the Trust is awarded a traffic light grading. Green Trusts receive “earned autonomy” (Department of Health, 2001b) and additional resources from the NHS Performance Fund to develop the services they provide. Amber Trusts will need to submit development plans to regional officers and red Trusts risk having a new management team appointed to take over the running of the organisation. This system of resource allocation creates an incentive to perform well and to meet the agenda for change and development in much the same way as contracting in the internal market did; for

example, better performance equals more rewards. Similar arrangements are being put in place for other UK health departments. For example, in Scotland a new Clinical Standards Board is being developed. This board will provide guidance on and incentives to encourage the development of services and patient care.

These contextual drivers are important to organisations as reports from the Commission for Health Improvement and Star Ratings can effect an organisation's standing. This in part explains why Site D decided to take control of the clinical governance planning, removing it from the hands of the change agent who until that point had taken the lead in developing the strategy. While the specific contextual influences mentioned here are new, the literature review did suggest that contextual factors, such as local competition between health care providers, might influence the likelihood of innovation adoption.

The contextual factors involving external assessment can function as triggers for the development of practice and services. However, more frequently they are used by practitioners and managers to support proactive development prior to inspection. Practitioners need to be aware of the importance of such contextual influences, as they provide a possible route of gaining approval, practical and financial support for any proposed development.

While the triggers of professional interest, education, awareness and contextual factors are presented separately within this discussion, most developments will contain elements of two or more of them as antecedents. Site B's development to implement the Scottish Intercollegiate Guideline Network (SIGN) guidelines

provides a clear illustration of how the above triggers are often inter-dependent. The change facilitator is aware that the way in which leg ulcer care is provided is less than optimal while, at the same time, she is aware that systematic assessment and guidelines could improve the situation. Once implemented, this will address the obvious risks associated with poor quality assessment and care.

□ Structural influences

It is suggested that organisational structures influence the development of practice in several ways. Organisations with flat structures were felt to facilitate development because they provided simple approval processes with typically only one manager needing to give approval before a development could be implemented. While such structures streamline the process of approval, they mean that there is less direct management support. Quite simply, streamlined organisations usually mean that there is one manager for a large service area and, as a result, they have a considerable number of staff and resources to manage. In addition, flat structures mean that nurses are managed by general managers and this can also result in problems because these people are focused on a wide range of employees and not simply concerned with the support of nursing practice. Perhaps the reduced support from line managers working in flat structures could be regarded as one reason for the establishment of practice development nurse and facilitator posts. It could be suggested that these posts are filling the gap which has been created as a result of the reduction in the number of service managers. In some ways, such facilitators are more acceptable to practitioners as they can approach them with concerns about their current practice, which they might not otherwise have raised with a manager. However, little work has

been undertaken to identify the impact of such flat structures on managers within the health care sector. Indeed, flat management structures, as a positive and negative influence, have not previously been identified within the literature. In addition to the effect that flat management structures have on practitioners, there is a suggestion that taking away positive aspects of the manager's role such as development work leaves them free to concentrate on other issues. However, there may be a danger that all that is left for the manager are the more negative aspects of the role, such as dealing with disciplinary action, employee problems and ensuring the service stays within budget.

While practitioners are not really able to alter the organisation's formal structure, they can do several things to take advantage of the opportunities presented by flat structures, while at the same time minimising the effect of any limitations. Firstly, practitioners could engage in professional development activity which may support them in identifying what aspects of practice might need to change. Such activity could include reflective practice, clinical supervision and quality monitoring. In addition, professional development activity which supports the practitioner in implementing change might be used to develop project management and change facilitation skills in individuals. Finally, groups of practitioners could work in a more collaborative way across ward / team boundaries to share skills and experience in developing practice. The studies by Wright and McCormack (2001) and Ward, et al (1998) suggest that such activity can be useful in the building of a sustainable capacity to develop practice.

The effect of management structures was highlighted in several of the case studies.

The flat structures within Site B allowed the change agent to introduce developments

within the minimum of formal approval. Those changes initiated by change agents who sit outside of an organisations formal structures (Site E) may appear more complex because of the need to seek approval from each Directorate. This finding suggests that those organisations which employ Practice Development Nurses who report to the Director of Nursing may experience difficulties when trying to implement developments within specific Directorates. However, the situation is further complicated in those organisations in which Practice Development Nurses are employed within particular Directorates as the implementation of cross organisation developments such as clinical supervision may be neglected as the nurses concentrate on Directorate priorities. The Site G developments illustrate how an individual Directorate's approach may conflict with the corporate nursing strategy on a particular issue. In this example the organisation has identified one approach to the implementation of clinical supervision which conflicts with the chosen approach within the Critical Care Directorate.

One of the main findings of this study has been the identification of the influence that organisational transition and the merger of NHS Trusts has on the development of practice. The results suggest that almost all of the developments have been influenced by management reorganisations or mergers at some time during their introduction. NHS mergers and restructuring have become more commonplace since the creation of NHS Trusts in the 1990s. The NHS and Community Care Act (Department of Health, 1990) describes how a merger involves the dissolution of one or more Trusts and the creation of a new merged Trust with a new management team and board. Both the dissolution of existing Trusts and the formation of a newly merged Trust require the approval of the Secretary of State for Health and follow a

minimum three month consultation period. As a result, NHS organisations and their employees are aware of proposed mergers for several months before they occur. This awareness creates both anxiety and uncertainty for practitioners and managers and appears to stifle creativity and developments within practice.

There are several reasons why NHS organisations merge and the overall drive towards mergers stems from the Government's policy to reduce bureaucracy, reduce management costs and drive forward an ambitious agenda for change. The Department of Health (1997; 50) White Paper "The New NHS: Modern, Dependable" states

"The Government certainly does not want to see reorganisation for the sake of it.... Mergers arising from local decisions will be considered on their merits, on the basis of demonstrable benefits in health and healthcare, and savings in administration"

However, Lilley and Richardson (1998) suggest that mergers have a more cynical role, providing a smokescreen to disguise underfunding within the NHS and that all too often mergers are proposed for the wrong reasons and that underlying problems are not tackled. Additionally, the British Medical Association (BMA, 1999) suggest that all mergers are, to some extent, takeovers where one party always dominates. This feeling is borne out in the case studies where one of the former organisations is seen as controlling the work of the others, for example Site A. This can influence the development of practice in several ways including the sharing of best practice between the former organisations. It can also have a negative effect as in case study Site A where the organisation is made up of two former Trusts, each of which was at

different stages in allowing nurses to order and interpret x-rays. In this case the dominant teaching hospital blocks the development by refusing permission for nurses to order x-rays despite the fact that a precedent for emergency nurse practitioners exists.

The case study results suggest that merger and transition have two principal effects on the process of developing practice. These effects are caution, as a result of the appointment of an interim management structure, or delay to the development because of uncertainty. This is borne out by the delay to the development of a nurse bronchoscopist (Site F), where none of the managers wanted to take the risk of developing the new role until the permanent management structure was implemented. However, the effects of merger and transition are not always negative. In certain cases the merger of services or organisations can create new opportunities for joint working and can make changes to the culture of the organisation so that it is better able to support development. For example, the development at Site B streamlines the process of GP involvement and makes gaining approval for developments simpler. Additionally, the creation of the Primary Care Trust allows GPs and others to influence the development of services, such as integrated nursing teams, in ways in which they had previously not been able to.

Another influence which merger can exert is the stalling effect it can have on a development almost as soon as the merger is proposed. Within Site E the development of new documentation is placed on hold as soon as news of a potential merger between neighbouring Trusts is proposed. What is not clear is to what extent the development is able to continue in the newly merged organisation and whether

the ground covered by the development prior to the merger is lost. One possible solution might be to incrementally build up a development over a period of time, using such an approach may protect previous work should organisational transition stall the development for any reason.

Merger and transition can affect individuals at all levels within the organisation.

McConnell (1998) describes how health care workers experience threats to their organisational culture including feelings of stress, uncertainty and loss. She goes on to describe how organisational transition, as a result of merger, consists of three stages, each with its own emotional characteristics. These are summarised in figure 7.1. These stages suggest that the effects of merger and the duration of its influence will differ depending upon the degree of change the new organisation represents.

Managers are well placed to lead staff through such transition and the process can be speeded up by providing comprehensive communication, meeting with staff, being honest about potential cuts to services or posts and dealing sensitively with individuals affected by this process (McConnell, 1998).

Figure 7.1: Stages of transition

Stage One: "The ending"	Characterised by high denial, followed by feelings of grief, loss and blame. This can sometimes be mistaken for poor morale
Stage Two "The neutral zone"	In this stage the organisation's new identity is being formed. This period can be a time of ambiguity, lack of focus and mixed messages. Staff may exhibit anger or apathy and resignation.
Stage Three "The new beginning"	Staff recognise new possibilities, learn new skills and embark on new initiatives.

Some of McConnell's (1998) stages of transition are apparent within the case studies. For example, Site A and Site F provide clear examples of stage two with characteristic lack of focus and high levels of ambiguity, with Site F moving on towards stage three before the end of data collection, when the new permanent manager takes an interest in the development and agrees to seek funding.

The finding that merger and organisational transition can have a profound effect on even small scale development in practice has important implications for health policy as well as health service managers. It could be argued that government policy is diametrically opposed inasmuch as it encourages mergers and organisational transition while at the same time it encourages large scale development and change as part of the drive to modernise health care. This study would suggest that, in some cases, the transition may slow or stop developments which are designed to improve patient care.

Health service managers are well placed to guard against the negative effect of transition by seeking to support development during the process of organisational change and by encouraging the appointment of "future proof" or external champions. In addition, the division of large scale developments into smaller chunks would allow developments to progress in stages. In this case, it might be possible to pause a development during transition without losing all of the previous groundwork and progress. While many of the developments studied in this research could be broken down into smaller actionable pieces it is unclear to what extent this would have assisted with sustainability following a merger or other organisational transition. For example, the change agent reports that the work to develop protocols (Site F) for

nurse bronchoscopy may need to be redone as the approval process has changed now the organisations have merged.

Another major structural influence was the differentiation of services into Directorates. As highlighted in the literature review, functional differentiation was found to have a positive effect on the adoption of innovation within hospitals in the USA. In the UK functional differentiation is achieved through Directorates, with each Directorate having its own management structure. Within most organisations only the Trust Executive Directors and specialist support services sit outside of the Directorate structure. Within the survey Directors of Nursing felt that Directorates both positively and negatively influenced the development of practice, although surprisingly, the Directorate structure was identified in the Delphi survey as a stronger negative influence (ranked 14), compared to a rank of 19 as a positive factor. One possible reason for this could be that the Directors of Nursing who completed the surveys are more likely to be concerned with cross organisational development, which could be construed as more difficult to implement where an organisation is divided into Directorates.

The influence of Directorates appears to take a number of forms. Firstly, Directorates allow staff and managers to work in a multi-disciplinary way as they include staff from a range of disciplines. This obviously promotes teamwork and supports the adoption of multi-disciplinary innovation. Directorates also allow staff to concentrate on those aspects of practice that they do well, developing practice which is peculiar to a particular specialism. Finally, another positive influence can be the spirit of competition which can exist between Directorates. This competition may spur

Directorates to follow an example set by others in the organisation to develop services or individual aspects of practice. However, this can also have a negative influence, as it can sometimes lead to undue pressure to conform to the model adopted by the first Directorate. This can be seen within the case study on the implementation of clinical supervision (Site G development ii). The change facilitator comes under pressure to adopt one to one supervision as this is the model used by the Surgical Directorate in the original pilot, despite the fact that such a model is unworkable amongst such a large team of staff. Additionally, on occasions, competition between Directorates may get out of hand and one Directorate may be seen to be taking over a particular development. This is illustrated in the development related to the implementation of new nursing documentation (Site E). Within this development both the Medical and Surgical Directorates are working closely together on developing new documentation. Conflict exists throughout the development with each side trying to move away from generic documentation to more service specific records. Just before the project is shelved because of the proposed merger, the Surgical Directorate takes a unilateral decision to amend the documentation to meet its own needs and order the reprinting of the forms.

Essentially, the results suggest that within the organisations studied, Directorate structures were beneficial when introducing single service developments in practice. For example, within Site F the development of nurse led bronchoscopy is a very Directorate specific development and to some extent it is unaffected by inter-Directorate relations. However, the change facilitator is concerned that the development may be unacceptable to the other hospitals within the newly merged organisation. Whether or not there is a precedent clearly plays a part in whether

individuals feel that a development is worth pursuing. However, while this factor is hinted at in some of the case study developments, for example, Site A related to nurses ordering x-rays, it is not a major factor in the majority of the other case study developments.

Problems can occur when trying to implement cross Directorate developments as this compounds the problems of selling the idea to staff and may lead to conflict between services. This raises the issue of whether organisations should attempt to introduce specific practice developments across the entire organisation. Clearly such developments are necessary, as they go some way towards reducing inconsistencies in treatment and risk. It is not the notion of cross organisational developments which is of concern here; instead the issue is whether there is in fact such a thing as a truly universal development which fits all practice situations in the same way. While such developments are unlikely to exist, it is possible to identify that there are universal principles which can be applied. For example, there is no single pressure sore risk assessment tool which fits every clinical area perfectly. Despite the lack of a single tool, no one would argue against the proposal that every area should have a tool which accurately predicts the risk of pressure damage. Most organisations have made efforts to ensure that all clinical areas are using such a tool. However, many have specified a single tool to be used and it is this universal application which leads to problems with implementation and acceptance. Rogers (1995) suggests that before accepting a change in practice which comes from the top down, the individual work group will make slight amendments to the way in which the change operates or is used. The preferred approach would be for the organisation to have a policy which states that all patients will have a risk assessment and then suggest which tools may

be used, thus allowing the individual groups of practitioners some degree of control over which tool is adopted. This is an example of how such centralised and decentralised decision making can be applied to nursing policy. Peters and Waterman (1982) suggest that this simultaneous centralisation and decentralisation of decision making is a key feature of an innovative organisation. If such an approach had been used within the clinical supervision development (Site G), then the outcome in terms of staff participation might have been different from that achieved. Although, support at two levels within the organisation would be required as the main issue in relation to this development was the lack of Directorate support, which enabled staff to opt out of attending the meetings about clinical supervision.

When considering universal developments it is worth noting that Kramer (1990) believes that within innovation “success comes from allowing each team to do its own thing, because each team is unique and works in unique circumstances”. This obviously makes the role of the organisation and the manager within it much more complex because, instead of measuring success on the outcome that all the wards have adopted a development, they are required to identify in which way the development was adopted on each ward. It could also make it easier for individual practitioners to opt out of developing their care with all the inherent legal and other risks.

The final major structural influence identified was that of decision making. As discussed earlier, the ability of an organisation to make decisions quickly is highly dependent upon both its structure and its culture. With flat management structures, the inference is that decisions can be made quickly with reference to one or perhaps

two people. Where such a structure exists, innovation is likely to be adopted quickly and staff are more likely to come forward with ideas for elements of practice they would like to develop. The strengths of a clear decision making process are illustrated by the development to introduce the passage of fine bore naso-gastric tubes by nurses (Site A). In this development the decision to proceed with the planning of the development is taken following a two stage approval process. Firstly, the Nutrition Support Team agree it is an important area and, secondly the Director of Nursing agrees that the development is worthwhile. In some organisations the decision making process is not as well established and this can slow down the introduction of developments or end the attempt in its early stages. The decision making process within an organisation is dependent upon strong leadership from the top and on the stability of the management structure. Those organisations in the case studies which had recently gone through merger had poor decision making processes and this caused frustration and delay for the change facilitators. The development in Site A, for example, was subject to delays when the original decision to allow nurses to order x-rays to check the position of the tubes was revoked by the larger department in the newly merged organisation. Similarly, the previously developed protocols from nurse bronchoscopy (Site F) required re-submission after the merger of the organisation with neighbouring Trusts. However, merger is not the only reason for problems with the decision making process. In some organisations decision making was left to groups whose specific remit was to deal with other issues and, as a result, the decision on the development was given low priority. This was seen within Site G when the change facilitator was trying to gain approval for theatre policies from the theatre users group. At each meeting the approvals process was

placed low down on the agenda and the meeting broke up before the policies could be discussed.

The decision making process also raises the issue of whether practice development activity should be largely “ad hoc” or more formalised in an organisational practice development plan. Both approaches have advantages and limitations. The “ad hoc” approach encourages individual practitioners to respond to local issues and to identify unmet need. However, such “ad hoc” development may lead to greater organisational risk, where poorly planned developments are introduced without regard for the legal and professional implications. The other approach, using an organisational practice development plan, would address organisational issues and would hopefully examine the implications of the proposed development. However, this approach is likely to have problems related to involvement and ownership as individuals react to imposed developments. Clearly, organisations need to develop a hybrid approach which encourages individual creativity and local responses to issues while, at the same time, tackling wider organisational concerns through a formalised practice development plan. Possible ways to develop such a hybrid approach can be identified by examining the nature of strategy development within an organisation.

None of the case study sites discussed developments which appeared to originate from an organisational practice development plan. However, several developments were part of other organisational strategies. For example, the Site A development was part of the organisations approach to reducing junior doctors hours. Whereas the Site D development of a clinical governance infra-structure was part of the Trusts business plan. Several other development were related to the Trusts nursing strategy

and on occasion this caused problems for the change agent because, as discussed earlier, in some cases this was incongruent with the priorities of the organisation's individual Directorates.

Johnson and Scholes (2002) describe how strategy development within organisations can take a number of forms. By far the most common approach within the UK National Health Service is the use of strategic planning systems. Such systems utilise step by step, chronological procedures designed to identify and analyse issues / problems and work up potential solutions. One criticism of this approach is that it is often detached from the operational delivery of the organisation's business, as a result problems can occur with the delivery of the strategic plan because of the lack of ownership by middle managers and employees. While strategic planning systems could be used to construct an organisation's practice development plan, the problems associated with a lack of ownership are likely to make implementation of the developments difficult.

Other approaches to strategy development include those associated with key individuals within the organisation. Within the NHS, this strategic leadership model could be used where the Director of Nursing or another senior manager responsible for nursing development could outline a practice development plan. However, reliance on an individual to develop the plan may compound the problems of leader dependence highlighted in this study. In addition, similar problems with ownership to those described for strategic planning systems are likely to occur as individual practitioners may view the plan as imposing developments on their practice.

Quinn (1980) describes a strategy development process known as logical incrementalism. Logical incrementalism involves the development of strategy through a process of “learning by doing”. Within practice development the formation of a strategy using an incrementalist approach would involve the introduction of trial developments and, following evaluation, the consideration of the development’s subsequent widespread adoption within the organisation. Within a logical incrementalist framework a senior manager or a practice development group would need to outline a broad view of where they saw the organisation or individual service going over the next few years and work towards this by encouraging both organisational and grass roots development. However, one of the limitations of this approach may be the absence of well developed procedures for organisational learning, and as a result many individual practitioners leading developments find it difficult to influence the overall strategic direction of nursing within their organisation.

Given the limitations of each approach to strategy development the most appropriate way forward may be to expound an eclectic approach to the practice development plan. Such an approach would involve the development of an organisational practice development plan based upon strategic planning systems that consider organisational imperatives and government policy combined with methods such as logical incrementalism. This would satisfy the organisation’s needs to structure development as well as encouraging individual practitioners to identify areas for development, try these out and subsequently share their experiences with the organisation to inform the practice development plan.

□ Factors which restrict and create organisational reaction

Organisational cultures can be restricted by financial and contractual constraints. In addition, some organisational cultures fail to be proactive in addressing potential risks, concentrating more on addressing actual problems highlighted by complaints / incidents. The Delphi survey of the Directors of Nursing identified that the emphasis on finance within the NHS was a significant negative influence on development.

While an emphasis on finances was not directly identified as a factor which can hinder innovation, it was suggested that the issue of resources was a possible barrier to the implementation of innovations and developments. One particular problem is that an over-emphasis on the financial benefits of a new system of working may result in organisations only taking forward developments which result in savings or new revenue. This was illustrated by the development of the role of the nurse bronchoscopist (Site F), where the change facilitator struggled to identify the financial benefits such a development may bring. Despite the fact that the development would free up Consultant Medical staff time, no savings would be made as the organisation would still continue to pay the Consultant his full time salary. The emphasis on finance in NHS organisations was counterbalanced by the introduction of a new corporate responsibility following the publication of the Government White Papers to reform the NHS structure. From 1998 NHS Trusts had the additional responsibility of reporting on standards of care and quality as well as being responsible for breaking even financially at the end of the year. While these changes may have altered the emphasis on finance, it is likely that most developments are still driven by their ability to attract resources or produce financial savings. Another example of organisational reaction from the case studies was the development of

integrated nursing teams (Site B development ii). Some of the General Practices involved in this development became involved because of a perception that they did not have sufficient resources to meet the demand for care. The view was that by getting primary care professionals to work in more integrated way the Practices and the Primary Care Trust would be more able to use existing resources effectively. This development suggests a reactionary response to a lack of nursing resources rather than seeking additional resources to assist with new service provision.

For practitioners, an inability to access resources can prove to be a barrier to implementing a development. The Directors of Nursing identified this as a significant negative influence in the Delphi survey, although it was not subsequently identified in most of the case studies. However, the development within Site F is unable to progress until resourcing issues are addressed. It could be argued that accessing resources within an organisation requires that the practitioner is politically aware of what resources may exist and how they should package and sell an idea so that they can access any potential funding. On reflection, one of the reasons why resources were not identified as a factor may have been that most of the case study sites used developments which were in progress and therefore the resourcing issues had already been resolved earlier in the planning phase.

Many of the respondents to the Delphi survey also identified that NHS organisations were too reactive to events and did not plan developments in a proactive way. This reactive culture is likely to stimulate the introduction of developments in response to significant events or incidents. The essence of the clinical governance agenda and complaints management is to reduce the likelihood of an event occurring again and

no one would suggest that development is not required in these situations. Essentially the problem with reactive development is that it is very haphazard and will lead to the development of services in an unsystematic manner. Organisations which simply react to complaints or events are unlikely to be regarded as leaders in their field. Moreover, they are likely to have problems meeting the Government's modernisation agenda because they are starting from a much lower baseline than those organisations which have been proactive in developing care and the services they provide. Within this study none of the case study sites was regarded as having reactive cultures. This finding could be attributed to the fact that the study participants were allowed to select the developments for the study. It could be argued that participants were more likely to select those developments which were leading edge than those which were simply the response to an incident or complaint. Practitioners, on the other hand, may use such incidents or events as the basis of identifying what needs to change, as described earlier during the discussion related to antecedents.

Both the Delphi survey and the case studies identified inter-professional tensions and the problem of lack of support from other professional groups. Surprisingly, the issue of inter-professional tensions and its influence on development and innovation has not previously been well articulated in the literature. The Delphi survey identified that such tensions were thought to be more prevalent between nurses and medical staff. However, within the case studies, tensions between groups of nurses and between nurses and other professional groups were identified, including tensions between district and practice nurses over the implementation of the SIGN guidelines on leg ulceration (Site B development i). Such tensions stemmed from the practice nurses'

ability to opt out of the development because they had different employers. Within Site A there were tensions between the change facilitator and staff from Radiography over nurses ordering x-rays and, finally, tensions surfaced between nurses working within different directorates over the development of new nursing documentation (Site E).

Such tensions between professional groups are complex and stem from the desire to maintain control over the bodies of knowledge and practice of each group of staff. In his seminal work Friedson (1971) outlines how medicine has dominated the division of labour within health care, deciding the range and focus of the various semi-professions. Given that medicine is predominantly a male profession and the semi-professions (nursing, physiotherapy etc.) are predominantly female, many regard the division of labour as being related to gender and power (Friedson, 1971). However, the situation is more complex than simply being related to gender and power as several of the case study sites are well supported by medical staff (Sites A, F and G development i) but some still experienced conflict from other professional groups which were largely female. In some cases this can be attributed to other factors combining to produce resistance. For example, the Site A development is affected by both the views of Radiographers and the recent merger of two organisations. On reflection, the resistance to nurses ordering x-rays come about as a result of merger rather than because of the view of another professional group. No precedent for nurses ordering x-rays exists at the other hospital and as a result the development is seen as widely different from existing practice. That apart, an awareness of the potential negative influence of inter-professional tensions should enable practitioners to develop strategies which are designed to prevent or overcome problems during the

process of planning the development. Such strategies may include encouraging multi-professional involvement early within the project or the selection of multi-professional champions for the development.

Tensions can also exist between NHS organisations, despite the fact that internal competition effectively ended following the dismantling of the internal market. Many organisations remain territorial about the services which they provide and are concerned when other organisations try to take over part of this work. Again this is illustrated within the development of leg ulcer care within Site B (development i).

The Consultant Dermatologist is unhappy with attempts to extend the range of services provided by district nurses, either because this could potentially reduce the number of referrals which are made to him or because he is not confident of the district nurses' ability to manage the patient.

Within the literature, service pressures were identified as a negative influence when introducing innovation and this is supported both by data from the Delphi survey and the findings from the case studies. Directors of Nursing identified pressures as the third most important negative influence. Pressure can come from several sources, including the pace of change, the need to deliver a service within tight monetary constraints and pressures on services caused by waiting lists and seasonal variation in demand. Within the case studies, pressure causes delays such as the delay within the leg ulcer project (Site B – development i), when the original facilitator leaves to go on maternity leave. Also, pressures are cited as a problem within Site G (development – ii) where staff cannot be released to attend supervision awareness sessions. The influence of pressures is particularly worrying in the current climate

because of high levels of nursing vacancies and problems with recruitment. Again, nursing appears to be faced with a major problem, as it struggles to modernise services against a background of major negative influences on the implementation of developments. An alternative view is that the development (Site G development ii) did not stall because of the pressures of work but because the proposed development was not congruent with the priorities of the Directorate. Also the Site B (development i) development stalls because the change agent has created a dependency upon her as the leader of the change. If these assumptions are correct it should be possible to undertake work during the planning and implementation phases of a development to prevent the project from stalling.

□ Individual factors

The literature review identified the importance of encouraging involvement and a sense of ownership in those individuals who will be working with the new development. Various methods were used to involve participants in the developments across the sites studied. The need to instil a sense of ownership for the development early in its introduction is vitally important to ensure the sustainability of the change after the change facilitator has moved on to another project. Achieving active involvement is not as easy as it sounds and it is dependent upon a number of factors. Firstly, as highlighted earlier, the process will be made easier in those cases where the participants are interested in the proposed development. However, the possibility of planning a development which is of interest to all practitioners is very unlikely. Even with the most interesting of developments, there will always be someone who is less motivated to change than their colleagues. Within the case studies,

consultation and information giving were the principal methods of gaining the practitioner's initial involvement in the proposed development. Site B (development i) used key opinion leaders in the form of link nurses to assist with the establishment of involvement and to provide feedback on issues of concern. Through this system the participants were able to inform the progress of the development, seeking more time during the initial pilot stage of the guidelines and documentation. Similarly, the link nurses were able to assist the change facilitator to identify the training needs of staff, acting as a link between the staff on the ground and those planning the development.

Participant involvement is made easier where the proposed development is similar to the system of working which is currently in operation. Where the proposed change represents a major shift in the way in which care is delivered, resistance is likely to be high amongst the participants (Lancaster, 1999b). Resistance of this type was seen during the implementation of the SIGN guidelines (Site B development i), where the practice nurses involved in treating leg ulcers refused to participate because of the considerable extra work the new guidelines would produce. The work of Eve et al (1997), outlined in the literature review, suggested that ownership may be strengthened through the early involvement of key individuals and opinion leaders.

Despite attempts to establish a sense of ownership of the development amongst the participants, most of the case study sites identified a dependence upon the leader for the continuation or progression of the development. Leader dependence is a common problem and past systematic attempts to develop practice, for example Practice Development Units, have been characterised by problems related to leader

dependence (Turner-Shaw and Bosanquet, 1993). Leader dependence can be an issue because of its effect on sustainability should the leader move on to another project or another role. Although none of the projects studied in this research suffered because the leader moved on, several change facilitators described their concern about how dependent the development was on their continued involvement. Within Site G, for example, the facilitator recognised that while people were willing to be involved in working groups, unless she attended all meetings the work did not move forward, despite the fact that she clearly mapped out what needed to be achieved and that she would attend only the first few meetings.

Each case study site had a different approach to encouraging involvement and reducing the likelihood of dependency on the leader. Within Site A the change agent led the development by planning the process of implementation including putting in place the necessary education for practitioners to undertake naso-gastric intubation. Although the change agent did not expressly indicate that she was using a particular change approach or model, the approach to development used could most be likened to project management. The process had a diagnostic phase which involved the identification of the problem and potential solutions and then moved into the planning phase. The development may have benefited from using an approach which allowed for the identification of driving and restraining forces such as that articulated by Lewin (1959). In terms of sustainability the change agent sought the approval of colleagues by presenting the problems associated with the current method of care delivery and then proposed the development as part of a whole system of patient care including identifying the benefits for practitioners as well as patients. It is likely that the sustainability of the development once the change agent moves on is assured

because it is driven by a Medical Consultant and the change presents benefits in terms of timing of care which will be valued by the practitioners implementing it. Similarly, the development within Site F involves just one small team who approached the change agent with the idea of developing the service, and as a result, their change agent does not need to undertake any work to increase the sense of ownership. This makes Site F the least leader dependent of all of the case study sites and the fact that the development continues even after the change agent leaves for another job is evidence of this.

Some of the developments have large working groups or steering groups which assist the change agent with implementation. However, in some cases (Site B development i and Site G development i) the developments remain leader dependent because the group never fully assumes ownership for the change. Other factors which may influence sustainability include where the development is part of a Trust strategy or business plan: in these cases, even if the leader moves on, the development is likely to be given to another person to manage as it is part of the organisation's plans.

To some extent, change facilitators can take steps to lessen leader dependence by encouraging involvement as early as possible in the planning of the development and by working throughout the implementation phase to develop a sense of ownership. In addition, the issue of leader dependence highlights the need for organisations to review how they organise practice development resources. In the earlier concept analysis (Chapter 2) studies by Wright and McCormack (2001) and Ward, et al (1998), projects were described which were designed to build a sustainable capacity amongst practitioners to develop practice. Both of these studies used facilitators who

worked with practitioners to guide and support them during the introduction of developments in practice. It could be argued that this approach to practice development is more likely to lead to sustainable development when compared with the use of practice development facilitators to lead specific developments. However, the approach is not without its problems as it could make the introduction of organisational wide development much more complex and time consuming.

The way in which this study was designed invariably meant that all of the case study sites involved developments which were facilitated by a change agent. Not surprisingly, facilitation was seen as a key factor in the successful progression of the development. The facilitator did not originate certain developments but the originator came to the facilitator for assistance. This is illustrated by the development of the nurse bronchoscopist (Site F), where the nurse seeks help from the facilitator to develop the initial idea. Similarly in Site D, a manager approaches the facilitator for assistance to develop a clinical governance policy plan for the Trust. In both cases the facilitator changes during the development and, despite this change, the development continues. The reasons for this could be that the development still has a person driving it forward, for example the originator. When the change of facilitator occurs, the originator simply seeks the assistance of another person to help facilitate and progress the development.

The role of the facilitator is very context dependent and therefore changes between developments and between case study sites. For example, within Site A the change facilitator is responsible for organising training, auditing progress and developing protocols. Whereas within Site E the change facilitator co-ordinates the working

group which is responsible for developing the new documentation as well as conducting audits and other data collection to gather practitioner's views on the new documentation.

□ Culture and Context

The literature review identified the importance of organisational culture, both as an antecedent to development and as a significant factor during the process of implementation. Organisational culture is a broad concept and, as such, encapsulates many of the findings discussed earlier in this chapter such as organisational emphasis on finance. The Delphi survey revealed how organisational culture could have both positive and negative influence on developments. The positive influences related to the organisation's willingness to encourage practitioners to take forward developments. This willingness is dependent upon a number of factors, including the organisation's view of risk taking, the degree of management control exerted over the workforce and to what extent the practitioners themselves are aware that they are able to take forward developments. Organisational culture has a number of effects on the developments studied during the second phase of the research. Some of the developments studied involved moving forward or developing traditional role boundaries. For example, within Site F, a practitioner was able to identify an area to develop and then seek assistance to take the development forward. The change facilitator identified that, prior to the very recent merger, the former Trust had had an organisational culture which encouraged innovation and risk taking in practice. This had placed them in a situation where some of their services were now far more developed, especially in relation to the role of the nurse, than the other Trusts

included in the merger. In other organisations there appeared to be a greater element of control exerted over the developments. For example, within Site E the development of new documentation was co-ordinated by the organisation. This is clearly an organisational risk management tactic, as the risk of problems and litigation would increase if each clinical area were allowed to develop their own documentation in a very ad hoc way.

By maintaining control, the organisation is able to ensure uniformity of documentation across the organisation and thereby reduce the risks associated with poor quality documentation. Risk taking in relation to practice development is obviously dependent upon the type of development proposed. In some cases, the development of practice is seen as a way of reducing the risks associated with inertia and, in these cases, development is viewed more positively. Without development practitioners would be open to litigation for not delivering the best possible care, given the available evidence. This would have certainly been the case within Site B, where the evidence related to comprehensive assessment and the use of compression with venous leg ulcers is compelling and not to develop practice, especially in light of clear national guidelines, could be regarded as negligent. Other developments in practice present lower risks (although no development is ever risk free), such as the introduction of open visiting on a ward.

Closely allied to the culture of the organisation is the type of management style adopted by line managers. Those managers who were open and who encouraged and supported development were felt to have a positive influence on the development of practice. Again, those who tried to maintain control and were authoritative and

unsupportive were felt to exert negative influence over the development of practice. Within the case studies there were varying degrees of support provided by managers. In some cases, for example Site F, this was little more than expressing support for the proposed development. In other cases, for example Site D, there was ongoing support for the development during the process. The case studies suggest that the amount of management support for a development is affected by the degree to which the manager is invested in the development. Those developments on which the manager's performance is judged, such as the establishment of a clinical governance infra-structure (Site D), are likely to receive more ongoing support than those which will have little impact on the manager themselves. This is similar to the notion of interest amongst practitioners, which was identified as a significant factor in deciding those areas of practice to develop. Like practitioners, managers are likely to be more involved in those developments which interest and affect them.

Practitioners can do little to influence the management style of the organisation or their line manager. However, it may still be possible for practitioners to initiate a development, even in situations where their line manager is less than supportive. This is one area where championship can assist groups of staff to gain managerial support for a development. The use of champions to assist with a development where the line manager is not directly supportive is not uncommon, although none of the case study sites provide an example of this. Such an approach is not without risks, as the potential for conflict between the practitioner and their line manager is considerable, especially if the line manager perceives that he / she is being forced to accept a development because his / her staff went to someone more senior. Again, political astuteness on the part of the practitioner and the champion is essential so

that the whole process of negotiating the acceptance of the proposed development can be done diplomatically.

Finally, both the Delphi survey and the case studies highlighted that the national priorities for the NHS and policy were major influences on the instigation and subsequent adoption of developments in practice. While the literature review did not directly highlight the part played by the national policy agenda, it did suggest that contextual influences were a possible positive influence on innovation adoption. It appears that those developments which are driven by national directives are more easily adopted than those which originate locally. This occurs for a number of reasons, mainly resource availability, including, in some cases, the employment of change facilitators to oversee their implementation. This results in a bypassing of the often lengthy stage of identifying resources or funding sources which is characteristic of local developments. Similarly, nationally initiated developments tend to have clear milestones and time scales on which managers and others are judged. Such developments usually involve an assessment of the current state of play, identification of an action plan and regular reporting to a performance management body, for example the NHS Executive Regional Office, and often it is a requirement that these systems are in place before any funding is released.

□ Originality within this study

In Chapter 3 the literature related to health care innovation and practice development was reviewed. The review revealed that there was little literature relating to innovation and development within the UK NHS. Most of the work which had been

undertaken related to innovation within the USA and the small studies which had been undertaken in the UK, usually examined innovation within small teams (West and Wallace, 1991). While some of the findings of this literature are transferable to the UK (for example functional differentiation within health care and its impact on technological innovation can be translated to the differentiation of NHS organisations into Directorates), other factors are less transferable. What is clear is that although the findings of the research in the USA can be related to the UK health system, it is not clear whether these factors really do influence practice development or innovation when applied to the UK context. This research aimed to ascertain to what extent the factors identified from the literature and others, identified through the research itself, influence the development of practice. Several of the factors identified in the literature were identified as having a positive or negative influence. In addition, some factors which had not previously been identified in the literature review were shown to influence developments, including the effect of merger and organisational transition. This had a significant negative influence on developments, resulting in the shelving of some developments and delays with others. The research adds significantly to the body of knowledge about practice development, not only through the definition of practice development as a concept but also in identifying antecedents and process variables which influence the introduction of developments within NHS Trusts.

In addition to the originality of the findings, the research has used original methods within both the concept analysis and the study design. Within the concept analysis, the construction of cases using vignettes represents a new approach to identifying how related and borderline concepts can go on to become model cases by changing

certain things within the case or adding components. Within the study design, the use of self report critical incidents to study the process of innovation and development is an original approach to organisational research. While Chell (1998) has previously used critical incidents to study entrepreneurship, her approach centres around post incident interviews. Such interviews usually take place some time after the incident and are, therefore, subject to changes in the respondent's perception of the incident. Self report critical incident technique enables the exploration of events as close as possible to the here and now and, thus, allows the researcher to gain insight into perceptions as the incident is occurring rather than later when the respondent may have resolved the issue.

□ Limitations of the study and implications for further research

This research provides a useful insight into the way in which organisations and the individuals who work within them can influence the development of practice. The literature review suggested that this study is one of a very small number which examine the process of practice development and innovation. Such process studies are better positioned to identify variables because they examine innovation or development within its real life context. However, like all research studies, this study has limitations. One of these is the way in which participants responded to the second round of the Delphi survey. Within the survey participants were asked to rank the categories using letters, for example A for the most important factors, B for the second most important, C for the third most important and so on. Participants were able to rank as many or as few categories as they wished. These instructions caused some confusion and some respondents (n = 7) ranked all categories A, B or C. Care

was taken in the analysis to minimise the effect of this misranking; however, the accuracy of the self reported importance of the factors by respondents may have been compromised. This may have had a bearing upon the subsequent results. With hindsight, it may have been more beneficial to restrict the number of categories the participants could rank to 10 and to provide a fully worked up example to avoid confusion.

The choice of methods and theoretical approach limited the type and range of data collected. Using a constructivist approach, allowed for the study of several research sites simultaneously thus providing a breadth of data about a wide range of developments across different types of Trusts. Having a number of case study sites naturally means there are limitations in the way in which data can be collected and this made the study dependent upon a key informant for the collection of data.

Attempts were made to minimise this limitation such as collecting data longitudinally over a period of one year and using dictation equipment to record critical incidents as and when they occur. Other approaches, such as ethnography, would have allowed for the collection of more in-depth data about developments using more than one key informant. Similarly, methods such as participatory research would have allowed for a more in-depth exploration of how factors influence development and how these could either be overcome or harnessed to produce the best outcome. However, these approaches would have limited the data collection to one site because of the time commitment required from the researcher. In addition, they would have probably required more regular contact and therefore would have needed to be more local to the researcher. The choice of methods was guided by the lack of a theoretical framework related to practice development. The dearth of literature meant it was

necessary to undertake some preliminary work within this study to explore perceptions of practice development and to attempt to delineate the concept from other related concepts. As described earlier this resulted in a conceptual analysis of practice development which presents tentative attributes of the concept. This concept analysis was started early in the study and has continued to evolve during the course of the research. Indeed, the evolutionary nature of the knowledge related to an immature concept such as practice development means that the concept analysis will constantly change as we learn more about the factors which influence the processes of planning and implementing a development.

The dearth of previous work on the subject of practice development and the need to identify what Directors of Nursing perceived as the optimal organisational structure to encourage practice development meant that there was a need to undertake some preliminary work to identify the perceptions of Directors of Nursing. In order to develop a consensus a Delphi survey design was utilised despite the fact that this conflicts to some extent with the constructivist approach used for the remainder of the study. One of the main limitations of the Delphi approach is that as a data collection technique it collects data that are devoid of context. However, the Delphi survey method was used to collect data to answer one of the study's research questions related to the optimal organisational structure to support development, and as stated earlier, the data from the Delphi were designed to be complimentary rather than confirmatory to the data collected during the case study phase of the research. Another issue related to the Delphi survey was the use of the results of this to select the case study sites. The Trusts which mirrored the top 5 positive and negative overall consensus were invited to participate in the second phase of the study. Using

these criteria it is possible to make value judgements about the participating organisations. For example, were the Trusts which mirrored the negative consensus selected because they were perceived as being less effective at introducing developments or were they selected because they were more aware of negative factors which can influence development. This issue highlights the problem with using data collection tools which are devoid of context as it is impossible to identify whether the Trusts were indeed less successful or simply more aware.

Another issue relates to the selection of the developments within the case studies.

Each of the original eight selected Trusts was allowed to select one large scale or two smaller scale developments to be examined longitudinally. While it would have been impossible for the researcher to identify and select developments without the input from the participants, allowing the participants to select raises several issues. Firstly, there is a potential for bias in relation to development selection as participants may be unlikely to select those developments which may prove to be problematic. There is some evidence to support this potential bias as one research site, which subsequently withdrew from the study, refused to talk about any work in progress but would only talk about developments which were almost completed. However, on the whole, the results from the case studies suggest that participants did not simply select non-contentious areas of practice to be included. The second concern about participant selection of the developments to be studied relates to the selection of developments which fall outside of the definition of practice development. In chapter 2 the concept of practice development is analysed and this leads to the identification of several critical attributes, which are present in all cases of practice development. While the concept analysis delineates practice development from related concepts,

such as professional development, it does acknowledge that in the real world practice development is rarely seen as a single entity and most developments involve professional development, change and innovation. Clearly, some of the case study developments fall outside of the definition of practice development, for example clinical supervision (Site G development ii), which is more closely related to professional development activity rather than practice development. However, given that practice development exists in the real world as an eclectic mix of education, training, professional development and change / innovation management, a decision was taken that developments which were considered to be practice development by participants should be included in the study. In addition to the reasons outlined above, this decision was taken for the simple and pragmatic reason that the researcher had no other way of identifying areas to be studied than to ask the participants.

A combined limitation and strength was the researcher's background in practice development. On reflection, this had a significant impact on the choice of research question and on the selection of key informants. Indeed the researchers own experience of working within a large organisation where some practice development facilitators were more effective than others led to the choice of research topic and the focus on factors which can influence developments. However, having struggled for several years to clearly define practice development the researcher was acutely aware of the dearth of literature and the need for conceptual clarity. In addition, the researcher's background also played a part in supporting some of the change agents during the process of data collection. During the interviews the research participants frequently described situations which they were finding complex and through a

process of shared learning the researcher was able to explore possible solutions.

Many of the research participants also commented on the event state networks which were developed between interviews and these helped the participants to clarify the next steps as well as to provide visual feedback on the progress they had made so far.

Finally, redundancy was achieved within all of the case studies, in that data were collected about each development up to the point where it was either implemented or it stalled with no further progress being made and no future date being set for a resumption of work. McCormack and Garbett (2000) identify how practice development has no end point and is a continuous process. This study assumed an end point and as a result data collection ended once implementation occurred. This prevented the study from really exploring in any depth the issue of sustainability and, in particular, the influence of leader dependence on the developments once the leader decided to move on.

With the benefit of hindsight, further data collection to examine how stalled developments might have progressed had they resumed would have been beneficial.

This suggests that there is a need for further research work, especially around the influence of merger and transition on developments. In particular, it would be interesting to know whether merger and organisational transition simply stall development for a period of time or whether these developments cease to exist.

Additionally, it would be useful to know whether certain types of development are more likely to be resurrected after merger than others. Further research in this area would require a longer period of data collection which covered the period before and after the merger. This may be difficult to achieve because mergers are often proposed

out of the blue or are created by changes in government policy. The merger of NHS Trusts does not appear to follow a particular pattern, apart from creating larger organisations in terms of budget and resources. Also, some mergers are planned well in advance, while others are achieved in the minimum time allowed for staff and public consultation.

□ Conclusion

The results of the current research suggest that several of the factors identified during the literature review do have a positive or negative influence on the development of practice. While some of these factors are outside the control of practitioners, many can be used by practitioners and managers to influence or guide development. In addition, it could be argued that awareness of influential factors will enable individuals to plan better the implementation of a development, not least because they will be aware of possible future problems and how these can be avoided.

The chapter suggests that the methods used in this current study were appropriate and that all the research questions were addressed satisfactorily. In addition, where limitations have been identified, these are accompanied by a discussion related to the implications for future research. Overall, the study represents a significant original contribution to the body of knowledge about nursing practice development.

○ Chapter 8: Conclusion and Recommendations

□ Introduction

This chapter explores the implications of the findings of the research for practitioners, management and NHS organisations while, at the same time, making a considered judgement about the contribution which the current study makes to the body of knowledge about practice development. The first section of the chapter examines the concept analysis and the findings of the study, using the sub headings identified through the principal component analysis. The chapter is structured in this way to ensure consistency between the results, discussion and conclusion chapters. Using some of the positive factors identified in this study a conceptual model has been constructed to explain how practice development can be facilitated. Finally, the chapter makes recommendations for practitioners, health service managers, organisations, health service policy and for future research in the field. Each recommendation is presented together with a rationale for its inclusion and a discussion about how the recommendation may be operationalised.

□ Concept analysis

The identification of the key attributes of practice development provides a clear and concise definition of what constitutes practice development. This represents a significant step forward because many practitioners and health service managers struggle to identify what practice development involves. In addition to the attributes, the concept analysis provides practitioners and managers with several empirical

referents through which practice development activity may be evaluated. Although this is tempered with a note of caution, because the assumption that a development is completed before it has become accepted into social system, and values of the practitioners adopting it, can affect the sustainability of the changes. The concept analysis also offers an explanation of how practice development is influenced by professional development. This is an important piece of work, as there is considerable confusion, especially amongst practice development facilitators, about whether their role is to offer training, education and professional development or whether they should be leading changes in practice. In this thesis it is contended and accepted that professional development may be an important component of practice development either as an antecedent to the development's introduction, as part of the process of introducing the change, or as an outcome of development activity. As a result, it would appear that the professional development activity carried out by some practice development facilitators is a legitimate part of their role.

The concept analysis also highlighted the differing schools of thought about how practice development activity should be approached. The author contended that each approach has its place and indeed, in certain circumstances, the use of a particular approach over any other may be appropriate. For example, in circumstances where there is little information of what aspect of practice needs to be changed and how this should be achieved, an action research approach is probably the most appropriate. Accepting that both schools of thought have a contribution to make widens the range of approaches which can be used by practitioners as frameworks for the organisation of practice development activity.

However, this study highlighted how many practice development facilitators do not use change theories or models to guide the process of implementation. Many of these models provide a framework which could be used to predict factors which may slow or impede the introduction of a development. Therefore, the use of change models may assist an organisation to adopt change and reduce resistance.

□ Influential antecedents to the development of practice

The study outlined how several factors play an important role as antecedents to the development of practice. Amongst these was the previously unidentified factor of professional interest as a trigger in deciding what to develop. The influence of this factor has a number of important implications for health care organisations. Firstly, some practitioners' individual professional interests may be in conflict with the organisational imperatives and, as a result, there is the potential for practice to be developed in a very ad hoc way with little regard to need. Additionally, allowing practitioners to initiate developments on the basis that they match with their personal interests is likely to result in unequitable service provision. This is especially a problem where staff are working alone or in small teams, as staff are unlikely to have a sufficiently large range of personal interests to ensure that a whole range of services is developed. Finally, the initiation of developments based upon personal interests suggests that all staff need to be equipped with the knowledge and skills to initiate and implement developments in practice.

Other influential antecedent factors identified in the study include education, involvement and championship. While these factors have a strong individual focus, they also suggest that organisations can promote the development of practice by having a focused educational and professional development programme. This would stimulate and assist with the development of specific aspects of practice which the organisation has identified as important.

Overall, the antecedent factors identified in this study were more focused around individuals than those highlighted in the literature review. The literature suggests that organisational and structural factors are better predictors of innovation than individual or contextual ones. However, both the Delphi survey results and the subsequent case studies highlight the important role played by individual factors, such as awareness of a specific problem, education and professional interest.

□ Structural factors

While the study did identify the influence of structural factors such as Directorates, there appeared to be fewer structural influences on the developments studied than the literature review had suggested. However, the studies did identify two significant new structural influences on the development of nursing practice.

The first of these is the effect which a flat management structure has on development. Two potential effects of a flat structure were highlighted, firstly, the freedom which this allowed and the ease with which practitioners could gain approval and, secondly, the fact that flat structures often meant that there was little

direct support and assistance for practitioners wanting to develop practice. To what extent practitioners are able to grasp the opportunities which such flat structures present is debatable and this could be one explanation for the proliferation of practice development facilitator posts since the NHS started to reduce management structures.

The second major new finding was the influence of organisational merger and transition on developments. Despite the fact that many of the developments studied within this research were small scale, they were still adversely affected by transition. The fact that organisations go through mergers and structural transitions is outwith the control of individual practitioners. However, practitioners can take steps to lessen the influence such changes have on their developments, including the breaking down of the development into smaller actionable pieces, allowing progress to be made with natural break points allowing for developments temporarily to be shelved during periods of transition. This would allow practitioners to pick up on their projects once structures had been agreed and things had settled, without losing the progress which had been made previously.

The majority of the structural factors identified have a stronger negative influence on developments. However, an awareness of factors such as the influence of organisational merger and transition can help practitioners to plan developments better so that they can withstand organisational change. In addition, the influence of merger and transition on developments needs to be considered by managers and health care providers as mergers are often proposed as a way of developing more effective services.

❑ Restricted and reactionary responses

Several restrictions and reactionary responses to events were identified as negative influences on the development of practice. One surprisingly previously unidentified factor was the effect which inter-professional tensions had on developments. These tensions involved a range of other professional groups, including doctors and allied health professionals. While the majority of tensions were diffused by the development facilitators, they did slow progress and added greatly to the work of the practitioners trying to implement the development. In the discussion it was suggested that an awareness of the potential for inter-professional conflict may allow practitioners planning a development to engage with other professional groups earlier in the process, thus avoiding conflict later.

In addition to the new factor, several factors which had previously been suggested within the literature review were also identified, including finances, resources, pressures and the reactive nature of some organisations. Overall, the factors identified had a negative influence and this suggests that organisations need to consider how practice development can best be supported within the tight constraints placed upon services by demand and financial pressures. In addition, it highlights how commissioners and other bodies need to have more transparent and open processes for applying for development resources and funding and health care providers need to ensure that staff are aware of these processes.

□ Individual factors

This study confirmed that the key individual influences of involvement, a sense of ownership and facilitation were indeed essential components of both successful implementation and the sustainability of the development. The outcome of the concept analysis and the fact that many developments continued to have a dependence on the leader suggested that organisations need to reappraise how they utilise practice development facilitators. It appears that using facilitators to lead individual developments may actually reinforce dependence upon the leader, and this in turn, seriously affects the sustainability of the development. It may be more appropriate to use facilitators to guide and supervise other practitioners in developing practice, as this should encourage ownership and involvement.

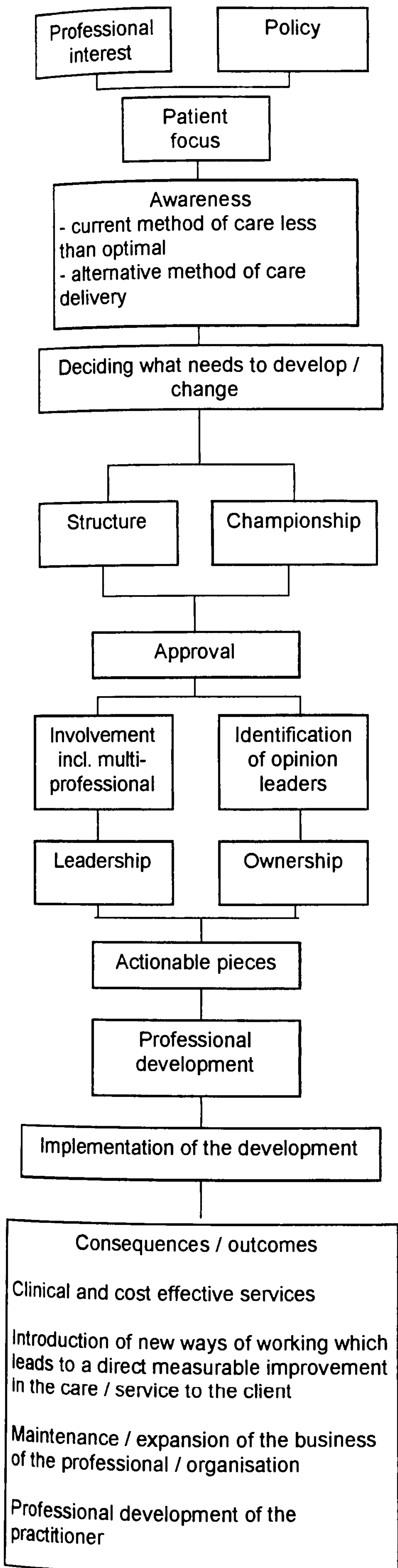
□ Culture and context

This study confirms that culture and context play an important role in both the initiation and subsequent implementation of developments. The main cultural factors appear to be the organisation's approach to risk, whether practitioners are allowed to take some risks when developing new methods of care delivery or services and the management style of the middle or line managers. Management style includes whether the manager is open, honest, credible and supportive of practitioners wishing to develop practice. The results of this study suggest that calculated risk taking and management style can be used to create a culture which encourages practice development. However, the earlier findings related to merger and transition suggest that management style may be affected by context and, during periods of transition,

some previously supportive managers may not be as willing to encourage risk taking as they would otherwise have been. As already highlighted in the last chapter, this is a reaction to the threat of being seen as too ready to take risks which could affect the manager's employment prospects.

The findings of this study are equally balanced between those factors which are the domain of individuals and those which relate to organisational and structural factors. This suggests that effective practice development requires action on more than one front and that an inability to develop practice cannot be attributed to a practitioners' reluctance to develop nor to a lack of organisational support. For practice development to flourish, individuals require stimulation and skill development and the organisation requires a culture which supports creativity.

Using the critical attributes from the concept analysis, and some of the positive factors identified in this study, it has been possible to construct a conceptual model of practice development. Figure 8.1 shows the model together with annotations to explain how each factor influences the process of practice development. The model presents antecedent factors such as professional interest and patient focus followed by those factors which assist in the planning and implementation of a development. Finally, the model presents the consequences and outcomes which result from a successfully implemented development.



Interest & Policy: Most practitioner initiated developments come about because of the interest of one or more professionals. In some cases government policy may act as the trigger for the practice development.

Patient focus: practice developments should have a clear patient focus based upon the identification of unmet need or more appropriate / different methods of care delivery. While patient focus is common, patient involvement in identifying what needs to change or in the process of developing practice is currently less common.

Awareness: The most common antecedent to practice development is awareness that either the current care is less than optimal or that there is a different (alternative) way of working. As an antecedent awareness may be triggered by evidence from research, a complaint, risk assessment, audit or professional development such as attendance at a course.

Deciding what needs to develop: This is reliant upon the identification of unmet need and an assessment of the effectiveness of the proposed development and deciding whether it is congruent with the needs of the organisation. In addition, a decision can be made at this stage about the framework for implementation and whether this will utilise change theories or action research.

Structure: Several structural and organisational factors may facilitate the initiation of a development, these include, a flat management structure where permission for the development may only be required from one or two managers. Differentiation into Directorates can also make the introduction of a development easier because of the availability of direct management support.

Championship: Championship exerts an important influence throughout the process. A champion can help to steer the development through an approval process, access resources and assist in the gaining of multi-professional approval.

Approval: Ideally approval should only be required from one person, although this is dependent upon the type of development and the systems for decision making in place within the organisation.

Involvement, ownership, leadership and identifying opinion leaders: These are a series of factors which are usually addressed simultaneously during the development process. Ownership and encouraging involvement involve selling the idea to others as well as allowing individuals to help plan the development. In addition, the identification of positive and negative opinion leaders will enable the individuals leading the change to target issues of concern while at the same time harnessing those who agree to help with the selling of the idea.

Actionable pieces: The breaking down of the development into small actionable pieces allows the change leader to present it as an evolutionary process. The phased introduction of the development may also protect it from organisational changes such as merger.

Professional development: The professional development of practitioners may form an important part of the process of implementation as the development may require individuals to undergo further training.

Implementation of the development: implementation may be guided by a framework such as a change theory or an action research methodology.

Consequences / outcomes: Once implemented the development should have improved the effectiveness of the service offered to the client. There should also be a discernable improvement in the quality of care / service. This in turn should ensure the maintenance or the expansion of the business of either the professional or the organisation. Finally, the whole process of practice development should result in the professional development of the practitioners involved.

Figure 8.1: A conceptual model of practice development

□ **Recommendations for nurses engaged in practice development**

This research study makes the following recommendations for individual practitioners engaged in practice development:

- **Practitioners should use change frameworks to assist in the identification of actual and potential driving and restraining forces which may influence the implementation of a development**
- **Practice development facilitators need to consider the most effective method of supporting development activity ensuring that a sense of ownership amongst the practitioners adopting the development is fostered**
- **The planning of all developments should include the identification of opinion leaders at varying levels within an organisation and these individuals should be used where possible to sell the idea to others**
- **The planning and implementation phases of all practice developments should centre around developing a sense of ownership**

The review of the literature in chapter 3 highlighted how there are a large number of change theories and models each of which has its strengths and limitations. While it is not possible to highlight one particular model which could be used to guide the development of nursing practice, several models are particularly strong at identifying the driving and restraining forces. Field theory (Lewin, 1951) and the model developed by Pettigrew et al (1992) both provide a framework for considering how the development may be received by both the organisations and the professionals working within it. In addition, Rogers' (1995) Diffusion theory allows the change agent to judge the potential for resistance amongst the workforce expected to

introduce a development by examining how the proposed development fits against the five essential characteristics for an ideal change (Rogers and Shoemaker, 1971).

The study highlights how leader dependence is encouraged in situations where practice development facilitators are used to lead individual developments. The study and the literature review suggested that a more appropriate approach may be to use facilitators as a supportive resource for practitioners leading projects. Further research work is required to evaluate the models of practice development facilitation which have been developed since the early 1990s. However, other techniques can be used to increase a sense of ownership amongst the practitioners who are expected to adopt the new way of working. Firstly, the breaking of the development down into smaller actionable pieces would allow for the sharing of workload between the facilitator and other individuals who make up to steering group etc. Secondly, where the developments were championed by the organisation or by Consultant Physicians from the clinical area they appeared to have reduced dependency on the leader and if the leader did move to another area the development was largely unaffected and continued. Finally, larger developments by their very nature require a more active steering group or implementation team. Developments of this nature are rarely dependent upon a single individual for their continued success.

The successful implementation of any development is also dependent upon the leader identifying the opinion leaders within the clinical setting. The routine identification of positive and negative opinion leaders within the practice setting needs to become a pre-requisite to the implementation of all developments. This should enable the practitioner to harness those individuals who support the development and use them

to convince others, while at the same time aiming to change the views of those opinion leaders who are less supportive.

Finally, nurses need to work to develop a sense of ownership amongst colleagues through shared decision making, joint planning and the leadership of developments. These approaches, combined with work to transform the ward / team culture and gain support from opinion leaders, should serve to make implementation smoother and to strengthen long term sustainability. In some cases, a sense of ownership may also extend to sections within an organisation and as a result Directorates and teams may need targeting so that they are supportive of the change. Where a service or Directorate is not fully behind a development the individuals within those areas may find it easier to opt out and not become involved.

□ Recommendations for health care organisations and policy

Given the wider ranging implications of the findings of this study for both the NHS and individual organisations, it is important to consider a number of recommendations for organisations and health policy.

- **Managers need to be aware of the potential effect of merger and transition on practice development activity and use different management strategies to lessen any potential adverse effects**
- **The effects of merger and transition may be reduced by the appointment of a senior manager to support developments during the period of transition and through the establishment of the new structure in the shortest possible timescale**

- **Organisations need to ensure that practitioner initiated developments do not lead to the development of inequitable service provision; this may be achieved through the development of an organisational practice development plan**
- **Organisations should consider the appointment of a senior manager to take responsibility for practice development, the support of practice development facilitators and the guiding of champions**
- **Organisations should develop a practice development plan / strategy which takes into account the organisation's and individual Directorate's priorities together with practitioner initiated developments**
- **Managers should make explicit the procedures by which practitioners or teams can bid for resources to support development**
- **Organisations should ensure that their approval processes are streamlined so that typically permission from one or two people is all that is required to commence a development**

In an ideal world the number of mergers and management re-organisations would be reduced, although this is unlikely to happen in the short term, given the recent proposals to shift the balance of power in England (Department of Health, 2001c) and drives to unify Health Boards in Scotland. Research is required to examine whether NHS mergers and re-organisations actually do lead to the benefits, whether financial or structural, which they purport to. In the meantime, the negative influence of merger and transition can possibly be lessened using a number of steps. Firstly, the appointment of a senior manager, both during merger negotiations and immediately after merger, to assist developments to continue may significantly assist

practitioners to sustain developments during the period of transition. The breaking down of developments into smaller actionable pieces may also assist with maintaining a development during a period of transition. If a large development can be broken down to allow pieces to be implemented over shorter timescales, then at least, if a development has to be shelved because of transition, some of the work has been completed and implemented. In theory it should then be possible to continue the development from where the implementation programme left off rather than starting from scratch again.

The effect of merger on practice development could also be reduced if the new organisational structure was implemented as soon as possible after the merger occurred. In some cases this can take more than one year and the uncertainty which it can create results in caution on the part of managers placed in temporary or acting roles. An alternative to this would be to appoint a manager with specific responsibility for developing practice and ensuring that developments which commenced prior to the merger were quickly picked up and continued. Given that this manager would be judged on how effective he / she was at doing this the person would be less cautious than other managers who feared continuing with potentially high risk developments.

One concern is that, because practitioners appear to utilise personal interest when deciding what aspects of practice to develop, there is a risk that services are allowed to develop in an ad hoc and inequitable way. Organisations need to ensure that the availability of service provision is not affected by concentration on individual practitioner initiated practice developments. This can be achieved through the

development of teams to ensure a comprehensive spread of expertise throughout the organisation and the sharing of skills and experience amongst primary care teams. Additionally, the development of an organisational practice development plan will ensure the systematic development of care and services. Once developed, practice development facilitators and other organisational support systems can be organised around the delivery of the plan rather than concentrating on developments which are the priority for a group of practitioners or managers. However, it is essential that the plan is developed by individuals and teams across the organisation if problems of incongruent developments are to be avoided. Ideally, the plan should include organisational and Directorate priorities as well as those developments which practitioners themselves would like to initiate.

As highlighted earlier, organisations should identify a senior manager who can take specific responsibility for practice development. This senior manager could take responsibility for supporting the practice development staff, as well as identifying and guiding champions. This senior manager should undertake to identify appropriate sources of funding and could co-ordinate bids to outside agencies or commissioners. The development of clear systems through which practitioners can seek funding for their proposed practice developments would be a significant improvement when compared to the current system which exists within organisations, where practitioners and managers are unsure of funding sources for small scale developments.

□ **Recommendations for the education of professionals**

The study identifies a number of previously unidentified issues within practice development and, as such, it is important that recommendations are made as to how professional education may be altered to reflect this new knowledge. It is suggested that professional education should:

- **Include information about identifying what may need to change in educational programmes**
- **Ensure that educational programmes designed for staff who will play a role in practice development equip them with the skills and political awareness to be able to manage change in complex environments**
- **Educational programmes should provide more information about how to manage resistance to change, the use of champions and how to promote involvement and ownership**

While many educational programmes for health professionals now include modules on change or practice development, such programmes have traditionally addressed the introduction of change using change theories. Tiffany and Lutjens (1998) suggest that one of the major criticisms of such theories is that they often present change and innovation as being rather linear. This does little to address the complexity of introducing changes into large organisations like NHS Trusts. Therefore, it is not surprising that practitioners and facilitators experience problems when their attempts to develop practice meet the challenges presented by organisational, individual or contextual factors. The results of this research suggest that the content of educational programmes needs to be amended so that nurses and others are better placed to meet

the challenges associated with introducing developments in complex environments. In particular, it is recommended that future educational programmes include information on deciding what needs to change and the methods which may be used to identify when care is less than optimal or to identify better ways of delivering care. Nurses also need to be aware of funding sources, as well as how to sell their proposed development and how to write bids for funding. Any programme for nurses who will be leading developments must empower participants and equip them with both skills and political awareness. This is essential if nurses are going to be able to manage developments during periods of organisational transition and if they are successfully to implement developments which affect more than one clinical area or speciality. Additionally, nurses need to become politically aware in order to be able to select a champion for their development. Most educational programmes do not address the idea of championship and this, together with details of how a champion may be able to assist with implementation, needs to be incorporated into future programmes.

Finally, programmes should provide more information about how to cope with resistance to change, including how this can be overcome through cultural assessment and the identification of opinion leaders. Any programme needs to be mindful of how continuous support and advice can be offered to practitioners leading practice development. Given the numerous factors which can influence a development, practitioners need to be able to seek advice about how a problem can be overcome. This could be provided either internally within the organisation or through external facilitators from higher education or professional associations.

□ Recommendations for future research

The study highlights the need for further research in a number of different areas.

Many of the findings of this study are tentative and require further study to identify the full influence which some factors have. With this in mind the recommendation is that future research should:

- **Explore the role and function of champions in encouraging innovation and development**
- **Explore more specifically the impact of merger on practice development and innovation within health care organisations**
- **Identify and evaluate a range of approaches for encouraging the ownership of innovations and developments amongst practitioners**
- **Explore in greater depth the factors which influence the sustainability of a development within health care**

The championing of service developments is becoming increasingly commonplace and as a concept championship is being embraced within the UK NHS. However, there is a dearth of empirical work about the role and function of champions and as a result there are problems defining the role. It is also not possible to identify who the best champions are for a particular development and while this study has suggested that external champions may be useful in some circumstances this remains an untested area. The widespread availability of champions as a result of their inclusion in major policies such as the National Service Frameworks makes this an ideal time to explore their roles and how they influence the development of practice and services.

This study suggests that there is a need for further study to determine whether merger stalls or slows development or whether some developments cease to exist following a merger. Such a study would utilise a pre and post merger longitudinal methodology because organisational transition can last in excess of one year after the merger is completed. Given that most organisations have a substantial period of consultation prior to merger it should be possible to identify organisations at the outset of the period of transition. What may be more problematic is the need to identify a particular development to study as the research is likely to commence at the outset of merger negotiations and this may have already had a negative influence on developments in practice.

The issue of encouraging ownership is important in both practitioner and policy originated development. Little is known about the best approach of developing a sense of ownership and further work is needed to identify the range of approaches used and to evaluate the effectiveness of each. Such a study would need to examine different approaches to facilitation and different types of development including those which are organisation initiated and practitioner initiated. Additionally, further work is needed to study what factors positively and negatively influence longer term sustainability of developments. Such a study would need to be longitudinal and would need to explore the fate of development once the change facilitator moved on to another role or to lead another development.

This chapter has explored why the findings of the research are considered of importance, detailing how factors influence practice development and how they can either be avoided through careful planning or harnessed to assist practitioners and the

organisation. The research presented has made a significant contribution to the body of knowledge about practice development by providing a clear indication of what actually constitutes practice development. In addition, it has detailed how such developments rarely exist in isolation and are often combined with other activities such as education and training. Finally, the study has suggested how positive and negative factors may influence a development and how these can be addressed by either practitioners or organisations to ensure that nursing practice is advanced for the benefit of patients.

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Appendix 01: Letter distributed with first Delphi survey

Northumbria Healthcare NHS Trust
Wallsend Health Centre
The Green
Wallsend
NE28 7PD

Telephone (0191) ### ####
Fax (0191) ### ####

4th January 1999

«Title» «FirstName» «LastName»
«JobTitle»
«Company»

Dear «Title» «LastName»,

Research Project: Organisational influences on the development of nursing practice.

The first phase of the above project is a Delphi survey of Directors of Nursing (or equivalents) from NHS Trusts in the UK. Delphi technique consists of a series of surveys which are designed to develop a consensus amongst relevant experts. The first round of the survey involves you providing written answers to open questions. Later rounds will involve you ranking responses and providing feedback.

Your organisation has been selected as part of the sample for this project because it has a track record of developing nursing practice.

Some organisations have Assistant Directors who are responsible for the development of nursing practice. Should you wish to pass this survey onto another person please feel free to do so. If the survey is passed on please ask the person to complete the address panel on the back of the return envelope. This will allow the administrative staff to update our database to ensure they receive information directly in future rounds.

Any responses you provide will remain confidential.

Further information can be found in the enclosed information leaflet and I would be delighted to answer any queries you may have.

Thank you in anticipation of your reply.

Yours sincerely,

John Unsworth

Appendix 02: Letter to Directors of Nursing regarding case study research

Northumbria Healthcare NHS Trust
Wallsend Health Centre
The Green
Wallsend
NE28 7PD

Telephone (0191) ### ####
Fax (0191) ### ####
E-mail

31 August 1999

Dear

Research Study: Organisational Influences on the Development of Nursing Practice

Earlier this year you contributed to the above research study. I have pleasure in enclosing the first phase results in the form of a short report. Analysis of the data from this phase of the research revealed that your responses mirrored the overall consensus. As a result your organisation has been selected as a potential second phase site.

The second phase involves an examination of the process of practice development to ascertain how the factors identified influence development and how such influence can be harnessed or reduced. It is anticipated that data will be collected from a Practice Development Nurse/Facilitator using both semi-structured interviews and critical incident recording. All data collection will take place on site within the Trust and no expense will be incurred by your organisation. Additionally, all data collected will remain confidential.

I have written to ***** who has been identified as a Practice Development Nurse/Facilitator within your Trust. These details were obtained via the Practice Development Nurses' Forum Database and I hope that they are still relevant. If these details are not correct please distribute the enclosed to the relevant member of your staff. I would also be grateful if you could indicate to this person that you are happy for them to be involved.

Finally, I can assure you that I will share any finding with you and the participants once these are available. In the meantime should you require any further information please do not hesitate to contact me.

Thank you once again for your assistance with this project

Yours sincerely,

JOHN UNSWORTH

Appendix 03: Letter to Practice Development Facilitators regarding case study research

Northumbria Healthcare NHS Trust
Wallsend Health Centre
The Green
Wallsend
NE28 7PD

Telephone (0191) ### ####
Fax (0191) ### ####
E-mail

31 August 1999

«FirstName» «LastName»
«JobTitle»
«Company»

Dear «FirstName» «LastName»,

Research Study: Organisational Influences on the Development of Nursing Practice

I am writing to enquire whether you would be willing to be involved in the second phase of the above study. The research aims to identify individual, organisational and contextual factors which may positively or negatively influence the development of nursing practice. The first phase of the study involved a UK wide Delphi Survey of UK Directors of Nursing. Analysis of the data from this phase revealed that your organisation mirrored the overall consensus. A short report detailing all of the results of this phase is enclosed for your information.

The second phase involves an examination of the process of practice development to ascertain how the factors identified influence development and how such influence can be harnessed or reduced. Data collection will involve three semi-structured interviews which will be conducted at a mutually convenient time onsite in your Trust. Additionally, it is hoped that critical incidents (both positive and negative) can be recorded between interviews either using a Dictaphone (supplied by the researcher) or during a short telephone interview.

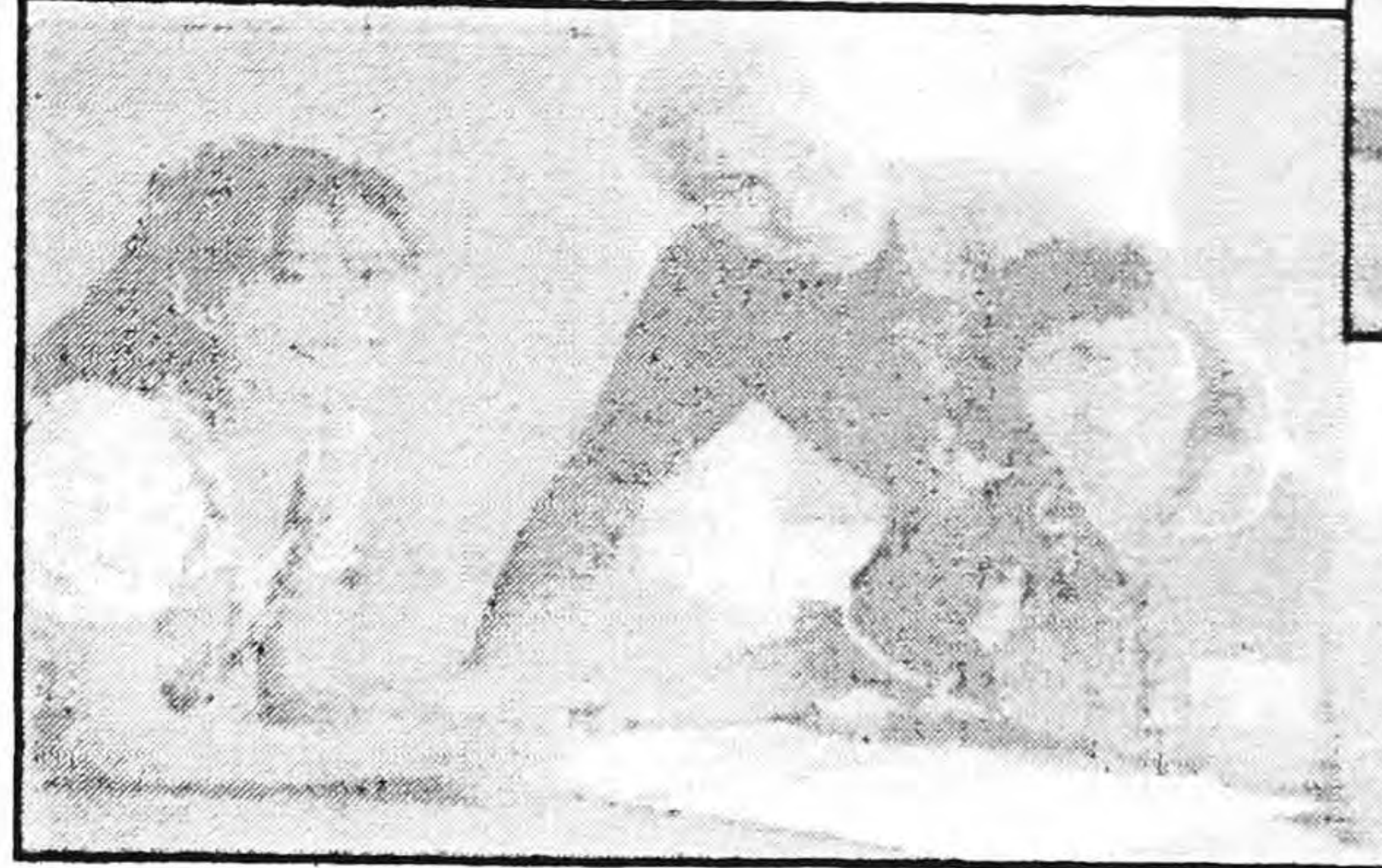
All data collected will remain confidential and neither the organisation nor you will be identified in any report related to the findings.

Further details of the research can be found in the enclosed information leaflet. Additionally, I would be delighted to answer any questions you may have and you can contact me on any other numbers listed.

If you are willing to be involved then please return the attached stamped addressed post card and I will contact you shortly to discuss a date and time for the first interview.

Yours sincerely,

JOHN UNSWORTH



Organisational influences on the development of
nursing practice

Pilot Delphi Survey

Organisational Factors

This first section will explore, how the organisation in which you work, influences the development of nursing practice. Remember that such influence may be positive or negative in nature.

Please answer each question as fully as you can.

1. How is your organisation structured?

You may wish to draw the structure as an organisational chart

2. How does the structure of your organisation impact on the development of nursing practice?

3. How does your organisation identify potential areas for development?

4. What strategies are used to operationalise such developments?

5. What are the actual and potential barriers to the operationalisation of developments using the strategies identified above?

Individual Factors

This final section will explore how individuals as members of organisations influence the development of nursing practice. Remember that such influence may be positive or negative in nature.

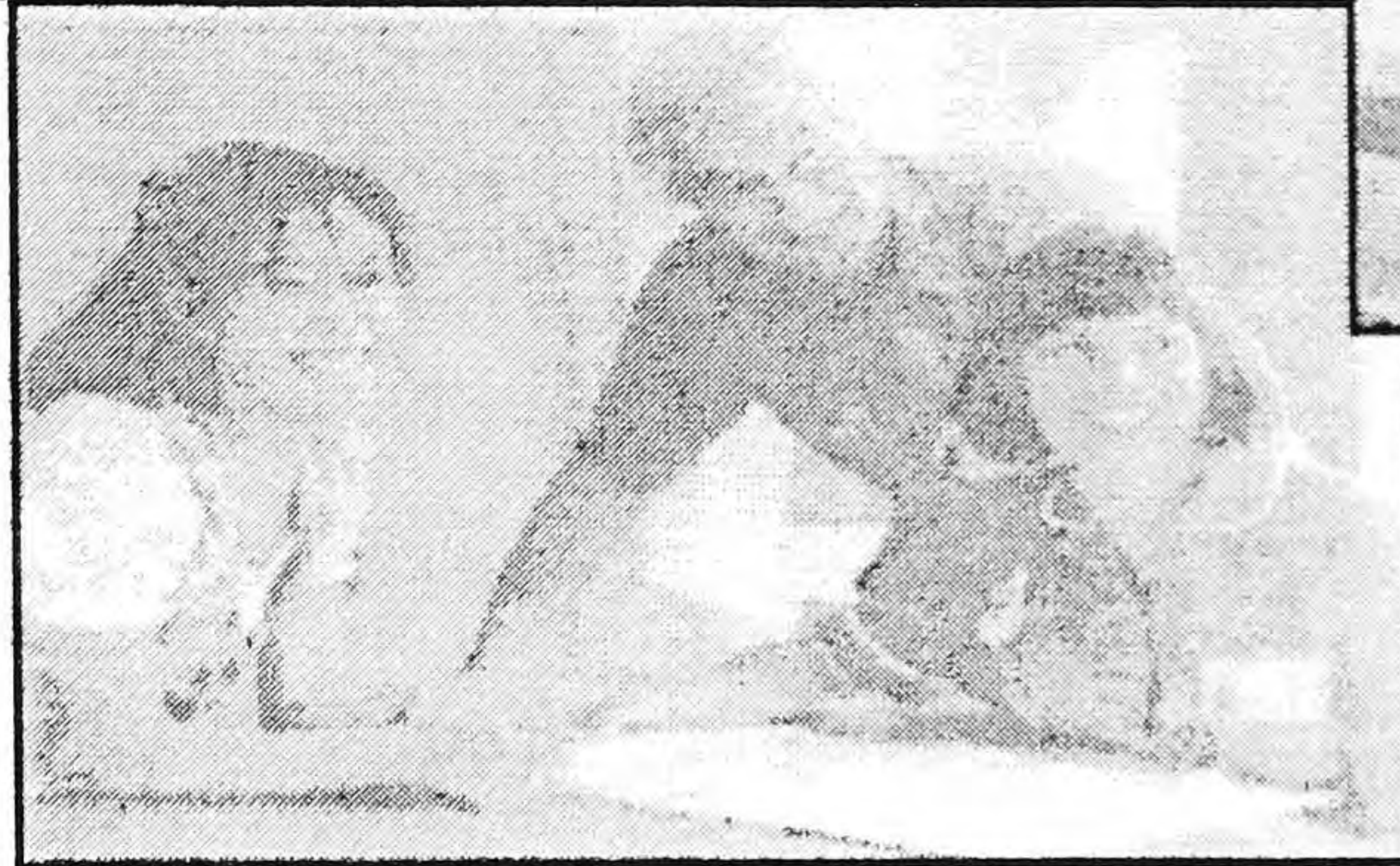
Please answer each question as fully as you can.

8. As a Nurse Leader how do you feel you can influence the development of nursing practice?

9. What particular aspects of your own and your colleagues' management style do you feel facilitate or hinder the development of nursing practice?

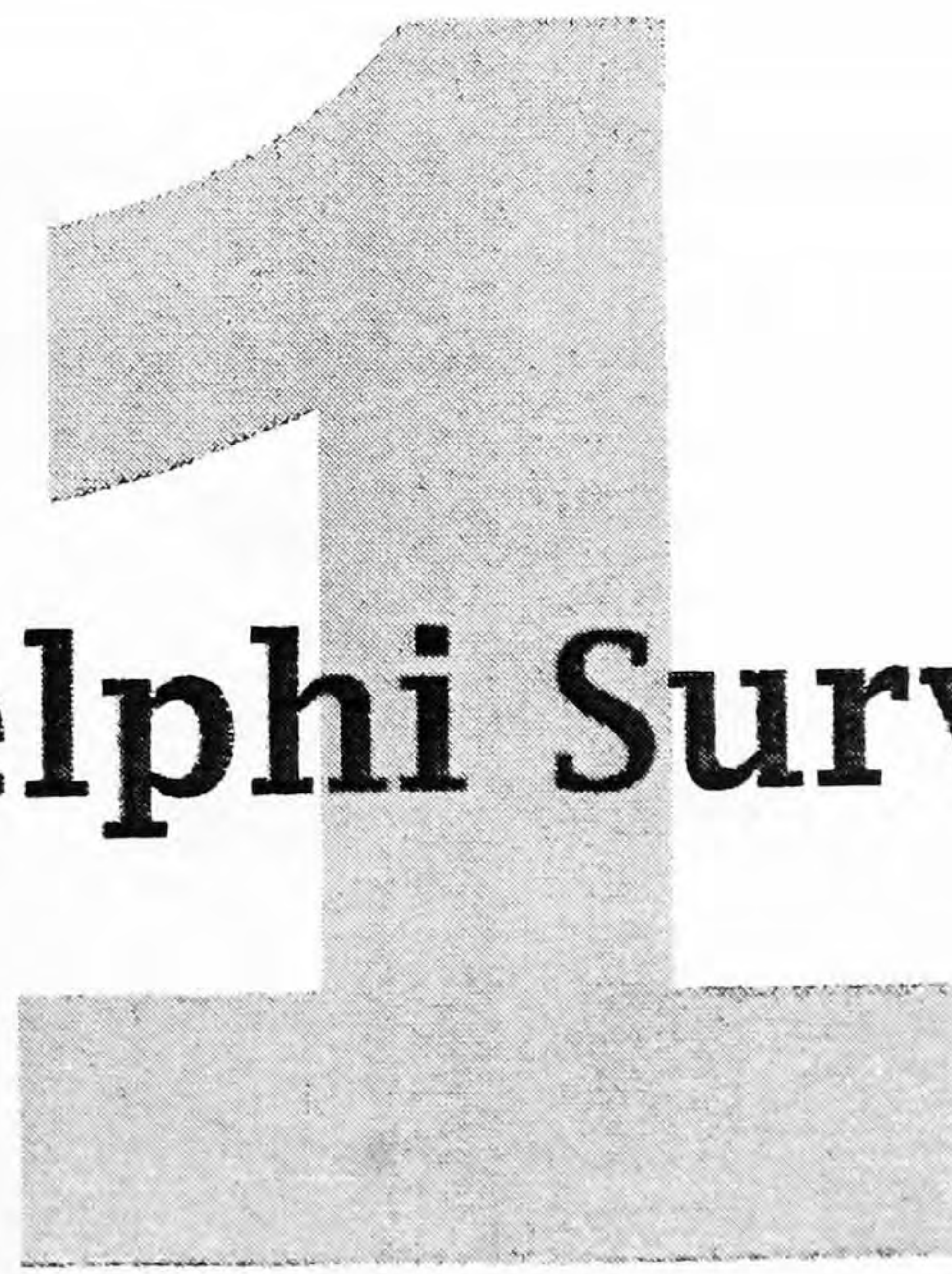
**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS
QUESTIONNAIRE**

Please add any additional information over the page



Organisational influences on the development of nursing practice

Delphi Survey



Please read these notes before completing the survey

This survey is one of a series of surveys designed to develop a consensus amongst Nursing Leaders about how NHS Trusts can influence the development of nursing practice.

The survey is the first phase of a larger study the aims of which are:-

- To examine the factors which influence the introduction of nursing innovations
- To ascertain what Nurse Executives perceive to be the optimal organisational structure to promote nursing innovation
- To explore how organisational factors facilitate and hinder the process of innovation

Definition

For the purpose of this study nursing practice development is defined as:

a conscious process by which new practices, work systems and roles are introduced and evaluated. Such developments may or may not be regarded as innovative by the practitioners involved.

Instructions for completing the survey

- Please answer all of the questions
- The survey should be completed by the Executive Director of Nursing or equivalent.
- The survey may be passed to another Senior Manager where he/she has specific responsibility for the development of nursing practice.
- When you have completed the survey please return it in the stamped addressed envelope provided

The information you provide will be treated in the strictest confidence.

Further information can be obtained by contacting:

John Unsworth

Tel (0191) ### ####

Fax (0191) ### ####



Thank you

This number is used to monitor replies for the purpose of sending reminders and will **not** be used to identify respondents

Organisational Factors

This first section will explore, how the organisation in which you work, influences the development of nursing practice. Remember that such influence may be positive or negative in nature.

Please answer each question as fully as you can.

1. Identify five or more words which describe the structure of your organisation

-
-
-
-
-

2. How do the aspects of organisational structure identified in Question 1 impact on the development of nursing practice?

Are there any other factors which you feel could influence the development of nursing practice?

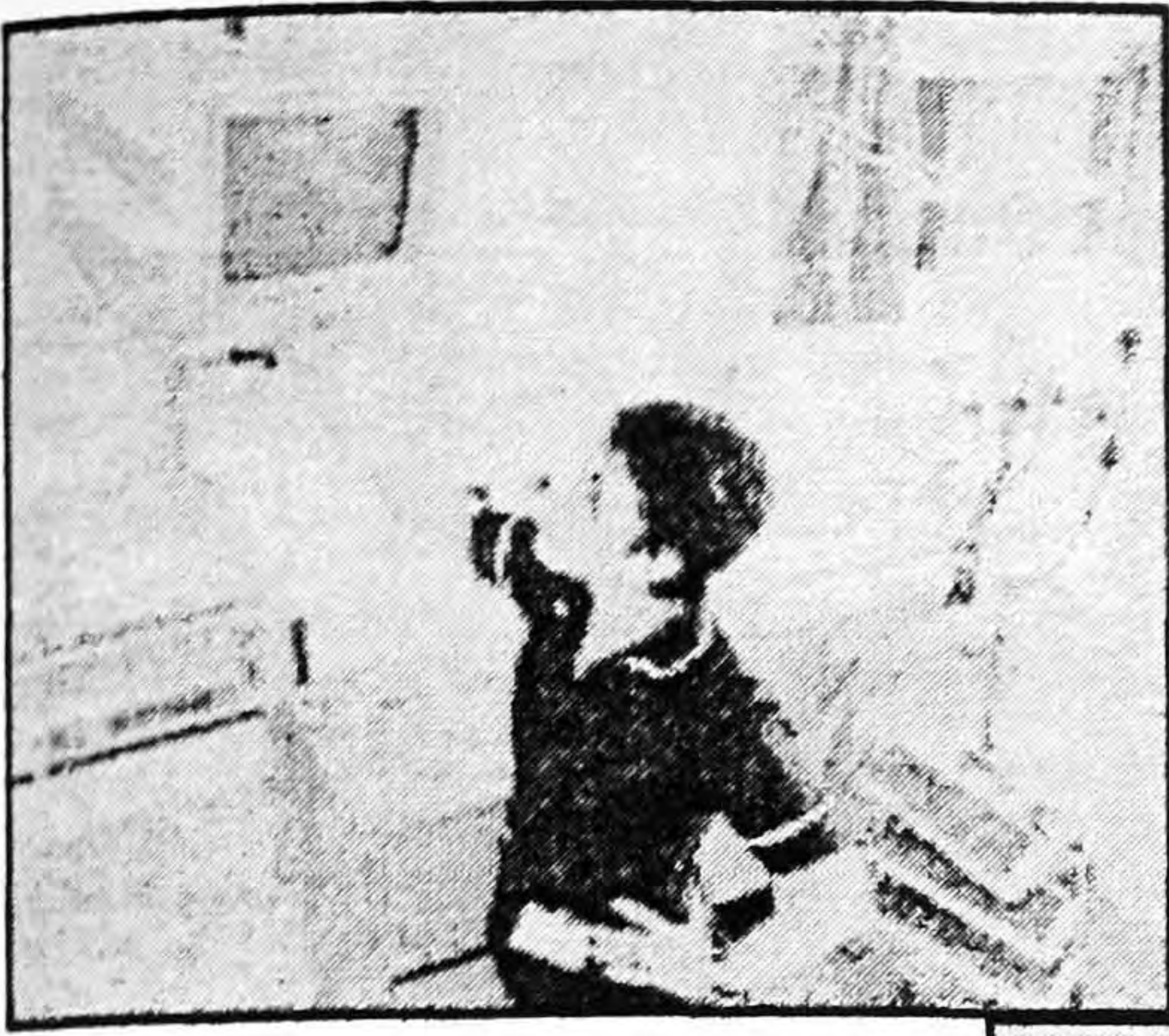
Contextual Factors

This second section will explore issues around the contexts in which your organisation operates and how these influence the development of nursing practice. Remember that such influence may be positive or negative in nature.

Please answer each question as fully as you can.

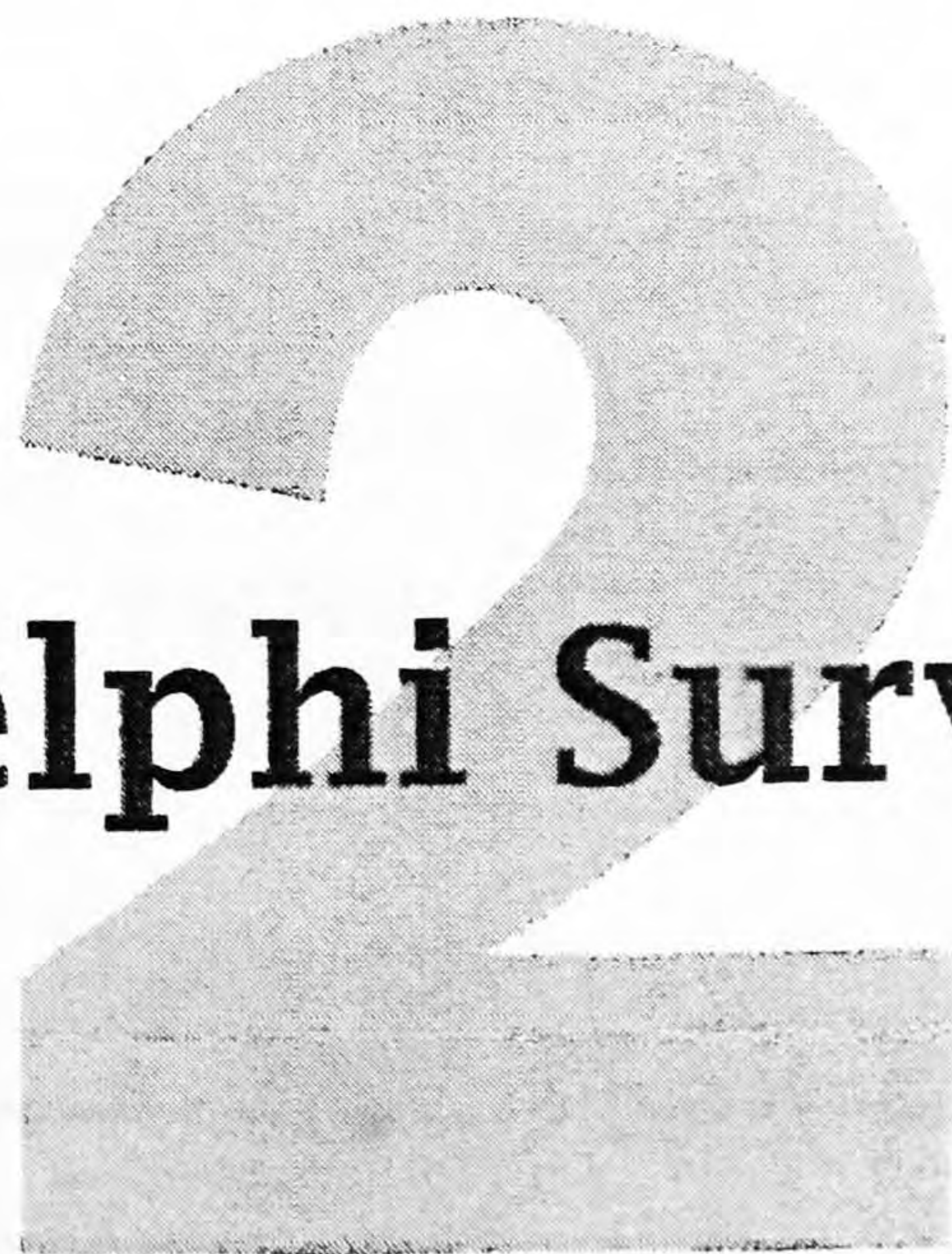
5. How does your organisation's role as a **local health care provider** facilitate or hinder the development of nursing practice?

6. How does your organisation's role as part of the **wider NHS** facilitate or hinder the development of nursing practice?



Organisational influences on the development of nursing practice

Delphi Survey



Please read these notes before completing the survey

Listed on the enclosed pages are the responses from the first Delphi Survey which was designed to identify factors which can influence the development of nursing practice. The original responses have been aggregated together to form categories. The categories are divided into **Positive Influences** and **Negative Influences** although some categories appear in both sections.

Instructions for completing the survey

- Please examine each category and its illustrative quotes from the first survey.
- Rank the categories in order of priority **A = most important, B = second most important and so on** for the Positive Influences section. Do the same for the section related to Negative Influences.
- **You can rank as many or as few categories as you wish.**
- When ranking the categories you should use your experience in the NHS rather than simply relating your responses to your current organisation.
- Write your justification for the ranking or add any comments which you feel would help to clarify a category.
- Add and rank any influences which you feel are important which are not covered in the sections.
- When you have completed the survey please return it in the stamped addressed envelope provided

The information you provide will be treated in the strictest confidence.

Further information can be obtained by contacting:

John Unsworth

Tel (0191) ### #####

Fax (0191) ### #####



Thank you

This number is used to monitor replies for the purpose of sending reminders and will **not** be used to identify respondents

POSITIVE INFLUENCES

Ranking – A = most influential, B = second most influential and so on

Category	Illustration	Rank	Comments
Flat management structure	<p>“prevents hierarchical interference”</p> <p>“makes management more accessible”</p> <p>“assists two way communication and facilitates bottom up development”</p>	<input type="checkbox"/>	
Multi disciplinary structure	<p>“breaks down barriers between professions for the benefit of patients”</p> <p>“emphasis on not pushing the nursing agenda but keeping focused on clinical development”</p>	<input type="checkbox"/>	
Hierarchical structure	<p>“allows for strong leadership”</p>	<input type="checkbox"/>	
Devolved management responsibilities	<p>“can be beneficial in getting bottom up commitment which is responsive to local need”</p> <p>“devolved management enables local development thus maximising staff involvement”</p>	<input type="checkbox"/>	
Directorate structure	<p>“can be advantageous because it can allow for local identification of areas for development”</p> <p>“breaks down professional boundaries”</p> <p>“assists in the focusing of developments”</p> <p>“enables nurses to develop in partnership with Doctors encouraging collaboration rather than competition”</p>	<input type="checkbox"/>	
Stability of the structure	<p>“working in an environment which is well structured and established facilitates development”</p>	<input type="checkbox"/>	
Patient focused	<p>“great commitment to the care of patients where nursing is recognised as important”</p> <p>“proof that the development would have net benefits to both patients and the organisation”</p> <p>“the organisation considers the potential impact of the development on patient care”</p>	<input type="checkbox"/>	

Category	Illustration	Rank	Comments
Centralised	“a Corporate drive towards development ensures uniformity and links strategic development with service provision”	<input type="checkbox"/>	
Medical support	“support from medical colleagues is essential”	<input type="checkbox"/>	
Risk taking	“a supportive environment which encourages risk taking” “blame free culture which allows nurses to take risks and develop”	<input type="checkbox"/>	
Culture	“organisations need to develop a forward thinking and motivated culture which supports innovation and development” “move away from autocratic system to one which fosters innovation”	<input type="checkbox"/>	
Motivation	“a desire amongst nursing staff to develop their roles” “enthusiasm”	<input type="checkbox"/>	
Education	“the need for a Professional Development Strategy” “links with University”	<input type="checkbox"/>	
Combined Acute & Community Trust	“enables development across care settings and organisational boundaries” “enhances continuity”	<input type="checkbox"/>	
Public expectations	“local people value the service and wish to see it develop”	<input type="checkbox"/>	
National Agenda	“compliance with National and Professional directives which can then be included in the local agenda” “Clinical Governance initiatives will facilitate the development of nursing practice” “drive towards quality from the centre”	<input type="checkbox"/>	

Category	Illustration	Rank	Comments
Local Agenda	<p>“responsiveness to local needs”</p> <p>“knowledge of service requirements of local populations”</p>	<input type="checkbox"/>	
Other Providers	<p>“reduction in competition and more sharing between Trusts”</p>	<input type="checkbox"/>	
Relationships with	<p>“good relationships with Voluntary sector and Community Health Council”</p>	<input type="checkbox"/>	
Managers Political Awareness	<p>“awareness of political and professional contexts”</p> <p>“practical and political leadership”</p> <p>“recognising realities”</p> <p>“power and influence”</p> <p>“securing resources from Trust Board”</p>	<input type="checkbox"/>	
Managers Openness	<p>“listening to staff”</p> <p>“good communicator”</p> <p>“accessible”</p>	<input type="checkbox"/>	
Empowerment	<p>“avoiding becoming ‘bogged down’ in operational issues”</p> <p>“empowerment of staff to take a lead role”</p> <p>“identification of potential leaders and innovators”</p> <p>“devolving responsibilities and developing ‘stars’</p>	<input type="checkbox"/>	
Management Style	<p>“nurturing staff with ideas while firmly managing them to ensure that any development is in keeping with organisational need”</p> <p>“proactive and not afraid to be positive or novel”</p>	<input type="checkbox"/>	
Credibility	<p>“wide view of nursing”</p> <p>“credibility in the eye’s of clinical staff”</p> <p>“positive role model ‘viewing change as a challenge’”</p> <p>“developments much more credible when backed by medical colleagues, national guidance or the Health Authority”</p>	<input type="checkbox"/>	

NEGATIVE INFLUENCES

Ranking – A = most influential, B = second most influential and so on

Category	Illustration	Rank	Comments
Flat Management structure	<p>“reduces the ability of managers to network and share developments”</p> <p>“hard work to introduce and sustain developments”</p> <p>“provides minimal human resources for practice development”</p>	<input type="checkbox"/>	
Hierarchical structure	<p>“makes communication across specialities/ward/depts difficult”</p> <p>“can make it harder for nurses who deliver care to influence practice development”</p>	<input type="checkbox"/>	
Devolved Management Responsibilities	<p>“can make a Corporate view more difficult to maintain”</p>	<input type="checkbox"/>	
Directorate Structure	<p>“makes it difficult to attain any uniformity, coherence or shared strategic vision for nursing”</p> <p>“creates Directorate based boundaries”</p> <p>“leads to reinventing the wheel”</p> <p>“competitiveness between Directorates encourages development but also leads to a reluctance to share good practice”</p>	<input type="checkbox"/>	
Geographical Spread	<p>“difficult to co-ordinate while allowing for local decision making”</p> <p>“multiple sites makes implementation slow”</p> <p>“complexity of services over a wide area can lead to difficulties in sharing best practice”</p>	<input type="checkbox"/>	
Transitional Structure	<p>“the evolving nature of the organisation and it’s management is detrimental to the continuity and quality of clinical leadership”</p>	<input type="checkbox"/>	

Category	Illustration	Rank	Comments
Reactive	<p>“development is often the response to an event or incident”</p> <p>“developments are often the result of a complaint, government initiative or media/CHC interest”</p>	<input type="checkbox"/>	
Emphasis on Finance	<p>“business orientation means that Practice Development is secondary to finance at times”</p> <p>“managers wishes to improve quality are often overtaken by cost pressures”</p>	<input type="checkbox"/>	
Resources	<p>“lack of funds and difficulty in gaining long term funding to sustain developments”</p> <p>“not enough staff in development areas with the energy and motivation to take projects onboard”</p> <p>“need the resources to work up workable initiatives from initial idea to policy”</p> <p>“devolving resources to local services can inhibit flexibility and the development of Trust wide initiatives”</p> <p>“lack of administrative support”</p>	<input type="checkbox"/>	
Legal Aspects	<p>“anxiety about increased litigation”</p>	<input type="checkbox"/>	
Multiple Management Responsibilities	<p>“managers often find that nursing has to compete for time and attention with other professional groups”</p> <p>“the demands of the job mean that it is difficult to focus exclusively on nursing”</p> <p>“the development of nursing practice is often not one of the primary objectives of a manager and managers are rarely judged on this criteria”</p>	<input type="checkbox"/>	
Lack of Support from other Professional Groups	<p>“some professionals perceive change as a loss of power”</p> <p>“resistance from professions outside medicine”</p> <p>“the medical voice can limit development as many Doctors have a traditional view of what a nurse is and what a nurse does”</p>	<input type="checkbox"/>	

Category	Illustration	Rank	Comments
Recruitment and Retention	“continuity of staff is important if development is to happen or be sustained”	<input type="checkbox"/>	
Education	<p>“some practitioners lack certain skills in critical appraisal and change management”</p> <p>“it is difficult to educate a large number of staff both within or outside the Trust”</p> <p>“training strategies can be a bit of a hit and miss affair”</p>	<input type="checkbox"/>	
Attitudes of Staff	<p>“resistance to change from staff ‘stuck in their ways’”</p> <p>“reluctance to try something different”</p> <p>“need to get rid of ‘dead wood’”</p>	<input type="checkbox"/>	
Commissioners & Contracts	<p>“little support from Commissioners/ Primary Care Groups”</p> <p>“contracts can hinder development because they allow little room for manoeuvre”</p> <p>“changing demands from Commissioners”</p>	<input type="checkbox"/>	
National Agenda	<p>“the National Agenda is diverse”</p> <p>“been part of the NHS bureaucracy which can be deemed to hold things up”</p> <p>“having to implement changes which do not necessarily fit the local picture”</p>	<input type="checkbox"/>	
Pace of Change	<p>“sometimes it can feel like you have not had time to implement one thing before you are expected to do something else”</p> <p>“the pace of change within the NHS is such that it is becoming more and more difficult to keep up-to-date”</p> <p>“it is easy to get bogged down in what is happening today rather than looking towards the future”</p>	<input type="checkbox"/>	
Pressures	<p>“pressure particularly in terms of bed occupancy”</p> <p>“pressure to do more and more”</p> <p>“conflict between the ‘must do’ from policy and the ‘like to do’s’ from nurses”</p>	<input type="checkbox"/>	

Category	Illustration	Rank	Comments
Other Providers	<p>“tensions between Primary and Secondary care”</p> <p>“certain aspects of work seen as the remit of other providers”</p> <p>“the split between Acute and Community Trusts restricts development across the Primary/Secondary care interface”</p> <p>“historical concept of Acute Hospital Trust been that of cure rather than focusing on prevention”</p> <p>“frustration because other organisations develop services which bypass existing provision”</p>	<input type="checkbox"/>	
Need for Rapid Visible Change	<p>“the desire to get things done quickly to be able to tick the box, the long term sustainability of the development is often sacrificed as a result”</p> <p>“development very outcome focused”</p>	<input type="checkbox"/>	
Disempowerment	<p>“the managers need to command rather than empower”</p> <p>“managers reluctance to devolve decision making”</p> <p>“wanting to control and direct the project”</p> <p>“glory taking and a focus on self achievement rather than team working”</p> <p>“disempowerment as a result of territorialism”</p>	<input type="checkbox"/>	
Management Style	<p>“democratic style can lead to lengthy debate and little action”</p> <p>“macho management”</p> <p>“authoritarian style favouring top down rather than bottom up”</p> <p>“too traditional and insular”</p>	<input type="checkbox"/>	

ADDITIONAL INFLUENCES

Please note any additional influences you feel are important which are not covered in the sections. These influences such be ranked as part of your deliberations on the Positive or Negative Influences.

Issue	Comments	Rank	Positive/Negative
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**Thank you for taking the time to complete this survey
- please return it in the stamped addressed envelope -**

Appendix 07: Letter distributed with second Delphi survey

Northumbria Healthcare NHS Trust
Wallsend Health Centre
The Green
Wallsend
NE28 7PD

Telephone (0191) ### ####
Fax (0191) ### ####

Dear

Research Project: Organisational influence on the development of nursing practice.

Thank you for responding to the first round survey. The results of this have now been analysed and are summarised in the enclosed second round survey. The next stage of the research involves the ranking of the first round results to identify which of the categories you consider to be most influential in terms of their positive or negative effect on the development of practice.

I would be grateful if you could rank the enclosed survey categories using the letter A for the most influential, B for the second most influential and so on using as many or as few letters as you wish.

Once completed please dispatch the survey in the enclosed stamped addressed envelope.

Should you require any further information please do not hesitate to contact me.

Yours sincerely,

JOHN UNSWORTH

Phase Two: Initial Semi-Structured Interview Schedule

Area	Questions/Issues	Rationale
Background to organisation	<p>How would you describe the organisation in which you work?</p> <ul style="list-style-type: none"> ▪ How is the organisation structured? ▪ How large [size in relation to number of sites, staffing] is the organisation? ▪ What services does it provide? ▪ How does the service support the development of practice and clinical services? 	<p>This question is designed to provide information on the structure of the organisation as perceived by the respondent.</p> <p>Questions about the size and diversity of the organisation may raise issues about the problems of implementing developments across large and complex organisations. However, this is dependent upon the nature of the development highlighted during the interview. Finally, perceptions about the culture of the organisation are explored.</p>
Background to current development(s)	<p>Can you tell me about a development that you are currently involved in implementing?</p> <ul style="list-style-type: none"> ▪ Who is involved? ▪ Who initiated the development? ▪ Why was this development decided upon? ▪ Does the development cross departmental/directorate boundaries? ▪ Does this cause any problems? 	<p>This question aims to identify the development which will be tracked during the second stage. If the development is small scale then more than one example may be obtained from each organisation.</p> <p>The probes explore whether the development was generated by practitioners or managers. The scope of the development in relation to whether it crosses professional or departmental barriers will be examined and any issues around these areas</p>

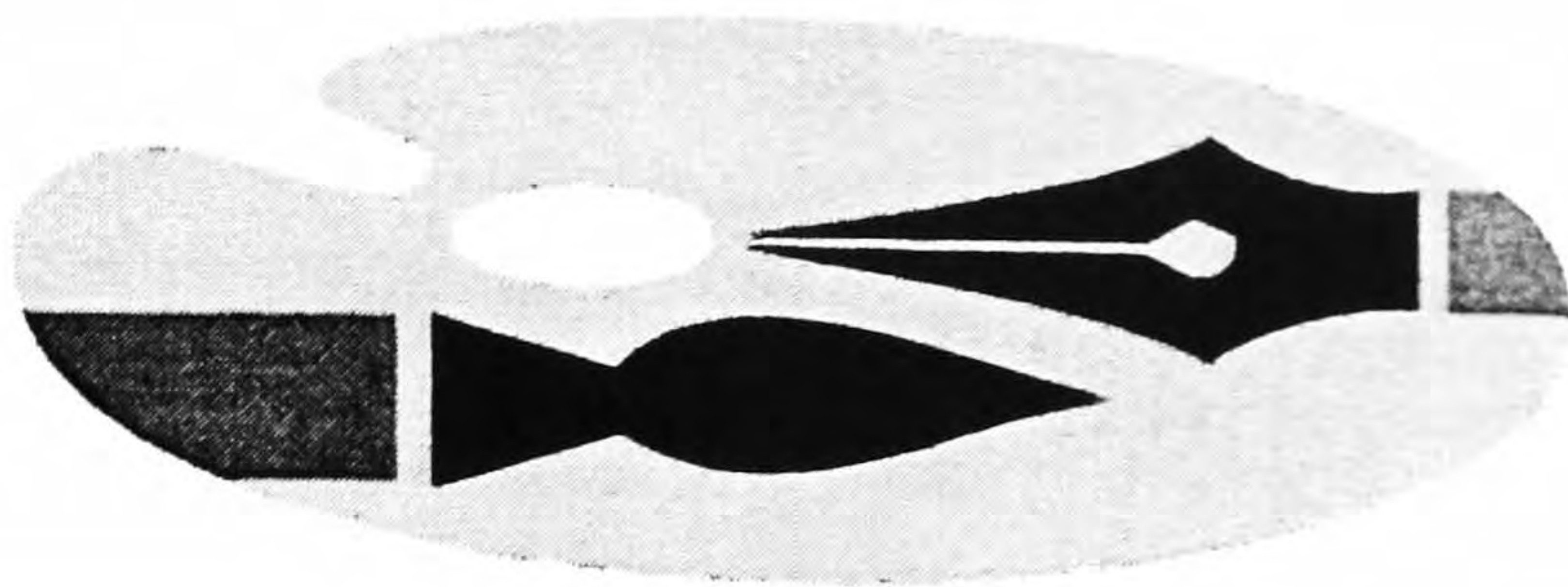
	<ul style="list-style-type: none"> ▪ Is the development multi or uni disciplinary? ▪ How has the development effected multi-disciplinary working? ▪ Does the development have the support or backing of other professional groups? ▪ How is the development being perceived by staff, line managers and other managers? ▪ What do you anticipate the benefits will be from this development? 	<p>explored.</p> <p>This examines whether the development has the support of medical and other professionals.</p> <p>This identifies if staff are resistant/supportive of the development, and whether line managers support the development.</p>
<p>Planning</p>	<p>What are the short, medium and long term goals of the development?</p> <p>What is the timescale for the implementation of the development?</p> <p>How do you plan to evaluate the development</p>	<p>These questions are designed to explore the planning stages of the development.</p>

<p>Context</p>	<p>What are the factors which are driving forward the development?</p> <ul style="list-style-type: none"> ▪ These may be local or national <p>Who did you consult before you decided to implement the development?</p> <ul style="list-style-type: none"> ▪ How did you do this? ▪ What did this consultation tell you? ▪ Did the development change as a result of this consultation? ▪ How is the development resourced or financed? 	<p>This section looks at driving forces i.e. is the development patient focused, is it reactive to a specific problem, a response to pressure from the commissioners or as a result of government policy.</p> <p>Are patients, staff, managers and other stakeholders consulted about the proposed development?</p> <p>Finally, is the development supported by financial and/or other resources</p>
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Phase Two: Second and Final Semi-Structured Interview Schedule (6 months & 1 year)

Area	Questions	Rationale
Progress Check	<p>Can you tell me how the development we discussed the last time we met is progressing?</p> <ul style="list-style-type: none"> ▪ What success have you had? ▪ What do you attribute this success to? ▪ What issues or problems have you encountered? ▪ How have you overcome/tried to overcome these issues/problems? ▪ How has the organisation assisted you with this process? 	<p>This question is designed to identify factors which have influenced the development (either positively or negatively).</p> <p>The probes explore the impact these factors have had.</p> <p>How the respondents or the organisation have tried to overcome the negative influences</p>
Alteration to original plan	<p>Has your original plan for the implementation of the development changed?</p> <ul style="list-style-type: none"> ▪ What changes have you made? ▪ Have these enhanced or weakened the original intended development? ▪ If you were planning the 	<p>This explores whether the factors identified by the previous question have resulted in changed to the originally proposed development or implementation plan.</p>

Critical incidents	development again would you do anything differently	
	<p>You have sent me/We have discussed several critical incidents since we last met (describe the incidents)</p> <ul style="list-style-type: none"> ▪ How did these effect the project? ▪ Did they alter the implementation plan? ▪ How did you alter the implementation plan in response to these incidents? ▪ What role did you play in relation to overcoming any problems these incidents caused? 	This explores the impact critical incidents have had (this may be irrelevant depending upon the quality of the self-recorded incidents).



Organisational Influences on the development of nursing practice

Guidelines for the recording of

Critical Incidents

Between the scheduled research interviews respondents are asked to record any incidents which effect the implementation of the previously discussed development(s). The recording of such incidents will allow for an examination of how organisational, contextual and individual factors impact on the development and what the organisation or you do to promote or lessen this impact.

In this study a Critical Incident is any significant occurrence (event, incident, process or issue) which effects the implementation of a nursing practice development. Such an incident may have a positive or negative impact.

Recording of incidents should be done as soon as possible after the event to ensure the accurate recall of events. Incidents can either be dictated into the dictation recorder provided or you should contact John Unsworth on the number below so that a short telephone interview can be carried out.

What to record:

Background to the incident

- what was the source of the incident i.e. a particular individual, a group of people?
- were these internal to the organisation or from an external source?
- what do you think triggered the incident? i.e. was it following a meeting with stakeholders etc.

What do you think the incident was about?

What effect (if any) has the incident had on the development? remember this may be positive or negative

What steps have you taken to strengthen or lessen the incidents effects?

What steps have others in the organisation taken to strengthen or lessen the incidents effects?

For interview recording page John Unsworth by telephoning
Leave your name and telephone number and you will be called back

Organisational Influences on the development of nursing practice

Once you have recorded your incident:

Write the date on the tape

Place the tape in the padded stamped addressed envelope provided and dispatch it to John Unsworth

You will be sent a further supply of envelopes and tapes as you return your recordings

Further Information:

Contact

John Unsworth

☎ (0191) ### ####

Fax (0191) ### ####

email

Appendix 10: Variable labels

Positive

FLAT_STR	Flat Management Structure
MD_STR	Multi-disciplinary Structure
HIER_STR	Hierarchical Structure
DEVMANR	Devolved Management Responsibilities
DIR_STR	Directorate Structure
STAB_STR	Stability of the Structure
PT_FOCUS	Patient Focus
CENTRAL	Centralisation of Decision Making
MED_SUPP	Medical Support
RISK_TAK	Risk Taking by Managers and Practitioners
CULTURE	Culture of the Organisation
MOTIVAT	Motivation of the Practitioner to develop
EDUCATE	Education
COMBINED	Combined Acute and Community NHS Trust
PUBLIC_E	Expectations of the Public
NAT_AGEN	National Agenda
LOCAL_A	Local Agenda
OTHER_P	Other Providers
REL_STAK	Relationships with Stakeholders
MAN_POL	Managers Political Awareness
MAN_OPEN	Managers Openness
EMPOWER	Empowerment of the Practitioner
MAN_STYL	Management Style
CREDAB	Managers and the Practitioners Credibility

Appendix 10: Variable labels

Negatives

FLAT_STR	Flat Management Structure
HIER_STR	Hierarchical Management Structure
DEV_MAN	Devolved Management Responsibilities
DIR_STR	Directorate Structure
GEO_SP	Geographical Spread of the Organisation
TRAN_STR	Transitional Structure
REACTIVE	Reactive Organisation
EMP_FIN	Emphasis on Finance
RESOURCE	Resources for the development
LEGAL	Legal Implications of the Development
MULT_MAN	Multiple Management Responsibilities
LACK_SUP	Lack of Support from other professional groups
RECRUIT	Recruitment and Retention of staff
EDUCAT	Education
ATTITUDE	Attitudes of staff
COM_CONT	Commissioners and Contracts
N_AGENDA	National Agenda
PACE_CH	Pace of change
PRESSURE	Pressures
OTH_PROV	Other providers
RAP_VIS	The need for rapid visible change
DISEMP	Disempowerment of practitioners
MAN_STYL	Management style

Practice development: a concept analysis

J. UNSWORTH MSc, BSc (HONS), BA, RGN, PGCE

Research Student, *The Robert Gordon University, Aberdeen* and Practice Development Nurse, *Northumbria Healthcare NHS Trust, Wallsend, Northumbria, UK*

Correspondence

J. Unsworth

Northumbria Healthcare NHS Trust

Wallsend Health Centre

The Green

Wallsend

NE28 7PD

UK

UNSWORTH J. (2000) *Journal of Nursing Management* 8, 317–326

Practice development: a concept analysis

Aims This analysis sets out to explore the nature and scope of the concept of practice development.

Background The last 10 years has seen a growing interest in the development of health care practice. However, the exact nature of practice development remains poorly articulated and nebulous. Literature from nursing, medical, accountancy, social work and counselling is used to identify the critical attributes of the concept.

Data analysis The analysis uses the techniques developed by Walker & Avant (1995) to collect information on the use of the concept from the literature and to construct cases.

Key issues Many of the attributes of practice development are shared by other related concepts such as innovation. However, four critical attributes of practice development were identified and illustrated through case construction.

Conclusions An understanding of the nature and scope of practice development is essential if the role of the Practice Development Nurse is to be evaluated. The critical attributes and empirical referents identified in this analysis provide a framework for both role development and evaluation.

Accepted for publication: 14 April 2000

Introduction

In the last 10 years the term practice development has become widely used both by the nursing profession and other health care practitioners/managers. The desire on the part of practitioners and managers to develop clinical services and aspects of practice has resulted in the development of an infrastructure to support such endeavours. As a result, many NHS Trusts have Practice Development Nurses or Facilitators, while other organizations have embraced the establishment of Practice Development Units as test beds for new nursing practices. While the term practice development has been widely used, the concept of practice development remains nebulous and poorly articulated. Page (1998) describes how 'the focus on action in practice development results in it being less tangible than other more easily categorisable activities such as audit and research'. In essence there is a

concentration on the description of specific developments rather than discussing the process of or the conceptual framework which supports practice development.

The importance of practice development activity to an organization should not be underestimated. Practice development is already widely used as part of the health commissioning process. Indeed, it could be argued that the proliferation of practice development owes its origins to the creation of the internal market in the NHS. It is likely that practice development will become more central to the work of NHS organizations with the introduction of corporate and clinical governance (Royal College of Nursing 1998). If manager and practitioners are to lead the development of practice it is essential that the nature and scope of practice development activity is clearly articulated. This can be achieved through the systematic analysis of practice development as a concept.

Creating conceptual meaning

Concept analysis is part of ideological concept development, and as a stage it involves the definition of existing concepts (Rodgers & Knafl 1993). Concept analysis is therefore useful not only in the development of theory but also to define the focus of a piece of research. The philosophical foundations of concept analysis lie in what is known as the classical approach to analysis. Aristotle (McKeon 1973) suggests that the purpose of scientific enquiry was to identify 'essences' or in other words the attributes which set a thing apart from other things. Rodgers & Knafl (1993) describe how the classical approach to analysis is typical of entity theory. Such methods of concept analysis are not without their critics. Rodgers (1989) expressed concern about the use of such methods because of their focus upon reduction and a failure to examine the context in which the concept exists. This view is supported by Morse (1995) who describes how 'the attributes identified are devoid of context so that the practical application is lost'. Furthermore, the approach has also been criticised because of a reliance upon the unrealistic rule that all examples of the concept are equally as good because they possess all of the requisite defining features. This insistence on uniformity does not allow for either exception or ambiguity (Medin & Smith 1984).

This concept analysis utilizes the framework described by Walker & Avant (1995). The approach used is illustrated diagrammatically as Fig. 1. Each of the stages of analysis involves the progressive focusing of the concept so that the critical attributes can be identified. The early stages of concept analysis involve the selection of the concept. In certain situations this can be problematic and even when there is a common language the concept may still be poorly articulated. Once the concept to be analysed has been isolated it is important to clarify the purpose of the analysis. Concept analysis may be undertaken for several reasons, for example it may be used to define a term for subsequent research or to examine how a concept is used within current literature or in actual clinical practice (Chinn & Kramer 1995). This concept analysis is part of a larger research study examining organizational influences on the development of nursing practice. During the early part of the research study it became apparent that in the NHS practice development is often combined with other closely related activity, i.e. professional development and practitioner education. In order to identify the organizational factors which impact on practice development it was necessary to define the nature and scope of practice development as a concept.

Despite the limitations outlined earlier the framework developed by Walker & Avant (1995) was used for this

analysis for several reasons. Firstly, the close interrelationship between practice development and other concepts means that a reductionist approach to analysis should allow for the isolation of a single concept. Thus areas of overlap should be separated out. Secondly, the approach allows for the identification of antecedents and consequences which are both essential components of the wider research study. In order to overcome some of the limitations highlighted earlier the author decided to utilize practitioner experience in the construction of cases and the subsequent identification of the critical attributes. This was achieved through the use of a group of practitioners who's principal role was practice development ($n=9$). The practitioners constructed and tested cases working in small groups. Chin & Kramer (1995) advocate the use of practitioners as a source of evidence. It is felt that such an approach can strengthen the validity and reliability of the analysis and allow for the exploration of the concept within different contexts (Chin & Kramer 1995).

This concept analysis aims to examine the notion of practice development and its use both within health care and in other professional contexts. The aims of this analysis are:

- Explore the use of the term practice development, both within health care and by other professional groups.
- Identify the critical attributes of practice development as both a process and a product.
- Distinguish whether practice development differs from the concept of innovation.

Existing definitions of practice development

Once the concept has been selected the process of creating conceptual meaning can begin. This stage uses multiple sources of evidence to generate and refine criteria which can be used to identify the concept. Walker & Avant (1995) refer to these criteria as defining or critical attributes of the concept. While a concept may contain several attributes, some of these will be shared by other related concepts. However, it is the critical attributes which set the concept being analysed apart from other similar concepts.

Walker & Avant (1995) describe how one of the sources of evidence is definitions. While such definitions do not give a complete sense of meaning for the concept, they can help to clarify common usage which is useful in identifying the scope of subsequent work. There is little literature which defines the term practice development. One definition of the term is that offered by Kitson (1994) who describes how practice development is

'a system whereby identified or appointed change agents work with staff to help them introduce a new

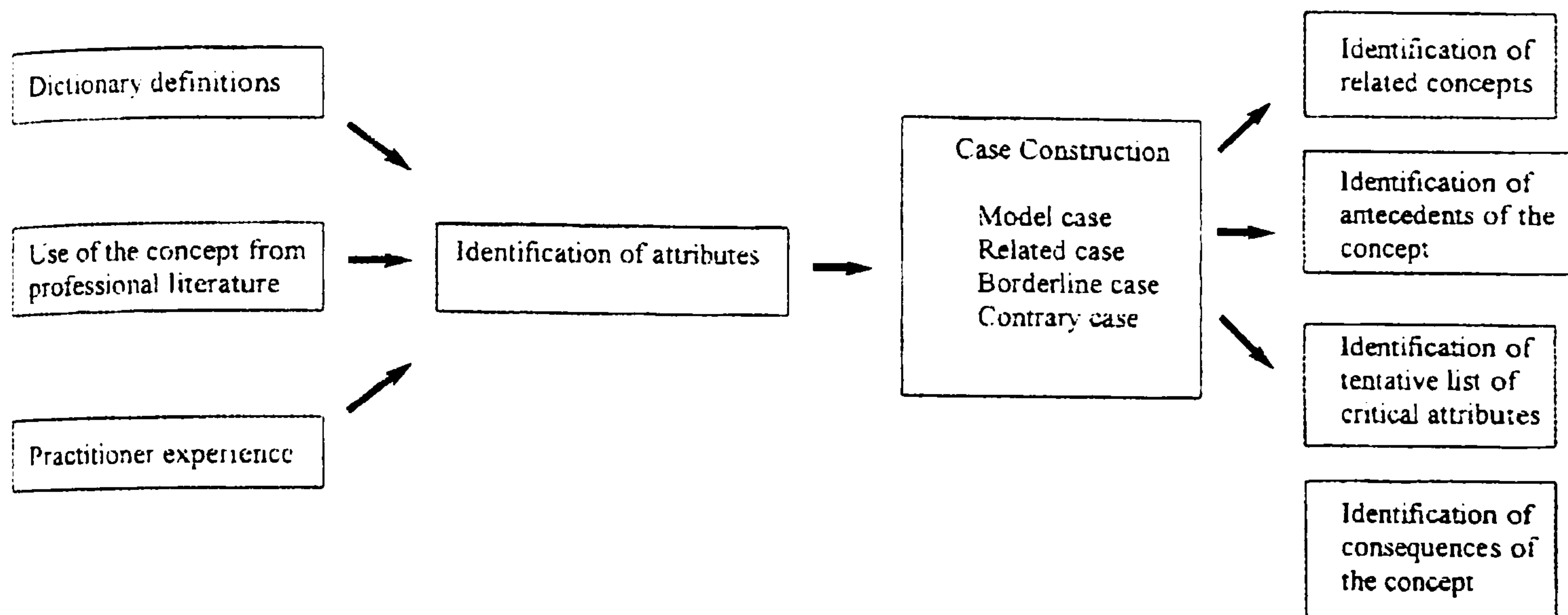


Figure 1
Stages in the creation of conceptual meaning.

activity or practice. The new practice 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 be carefully evaluated to ensure that the new practice has achieved the improvements intended'

This definition highlights several possible themes, some of which concur with the earlier definition. The notion of meeting identified need is not articulated in this definition. The emphasis is instead, upon the professional with the definition promoting the identification or appointment of a change agent. There is clearly the idea that practice development involves planned systematic change and that the professionals need someone to lead or facilitate this process. Finally, there is a strong emphasis on the use of evidence related to the proposed development. This evidence is presented almost as a continuum from empirically based research through to the testing out of a good idea.

Dictionary definitions are useful because they convey accepted ways in which words are used. This in turn can be useful in defining the scope of any subsequent analysis of the literature. The Oxford English Dictionary (1992) was used to define the word practice. The definition suggested that practice is about the performance of work or action. For example, in nursing the word practice is used in relation to the delivery of patient care or patient services. The term is also used to describe the business of a professional, i.e. General Practice, Law Practice, etc. The term development involves the notion of gradual advancement (The Oxford English Dictionary 1992). This could be

likened to the systematic development described earlier by Kitson (1994). The idea of growth from within also suggests ownership by the person or group which is developing. In addition to examining definitions of practice development it is useful to review the use of the concept within the professional literature. When undertaking this literature review it is important to examine the how the concept is used by other professional groups and within other contexts.

The literature reveals several uses of the concept. Firstly, the concept was used to describe a change in clinical practice and service delivery. Secondly, the concept was used to describe the utilization of research evidence into practice. Finally, the concept was used to describe the development of business practice with the professions of medicine and accountancy.

Use of the concept in clinical practice

Mallet *et al.* (1997) describe how practice development can be regarded as both a process and an outcome. They go on to outline how practice development is the advancement of patient focused care, which may be achieved by professional development or progress by other means. The link between continuing education and professional development as a catalyst for the development of practice is a common thread in the literature from the nursing profession. Indeed the National Board for Scotland (NBS 1997) clearly articulated the relationship between a Continuing Professional Development strategy, its implementation and the impact on practice development. While there may be a link it does not always follow that because a practitioner has attended a course or updated their skills

and knowledge that improvements in practice will follow. However, the literature related to Practice Development Nursing roles clearly identifies a link between the development of both clinical work and the professional development and growth of the practitioners engaged in this work (Weir 1995). Therefore it is unclear from the literature to what extent professional development is an antecedent, attribute or a consequence of practice development.

Clarke (1998) describes how

'The development of practice is integral to professional care; both care for the individual patient and the systematic enhancement of services and the professional role to meet patient need'

This suggests that practice development may be related to introducing change which is a response to clearly identified patient need. Clarke (1998) also appears to suggest that practice development contains the notion of improvement in clinical services. Additionally, the notion of practice development being integral to professional care is interesting, in so much as the development of practice is sometimes seen as an add on to the delivery of patient care. Clarke (1998) states 'rather than being built into day-to-day work, practice development is relegated to something a few keen people do for an hour after their shift has finished'.

As highlighted earlier an examination of the use of the concept within different contexts is useful in both the development of critical attributes and in identifying previously unconsidered meanings. Outside of nursing and health care, the term practice development is used in relation to the practice of both Social Worker and Counselling. In Social Work, the term has been used in relation to improving aspects of work, i.e. the production of social inquiry reports in line with national guidance and recommendations (Bottoms & Stelman 1988). While in counselling, the term is used to describe the process of examining and improving certain key areas of work (Dryden & Feltham 1994). Within both of these contexts it is possible to identify a notion of improvement in client care and services. The Social Work example also suggests that practice development may occur as a response to national guidance and recommendations.

Use of the concept in the Professions of Medicine and Accountancy

In medicine the term practice development is frequently used to describe the implementation of new work systems or services which are designed to improve the business of a general practice. An example of this is the Practice Development Toolkit developed by the National Health

Service Training Authority (1994) to assist General Practices to assess, plan, implement and evaluate the introduction of new information technology systems. Again this example suggests a notion of improvement. However, this example also suggests that a new attribute may be present here. The development of information technology could be regarded as important in improving or maintaining the business of the organization because such technology is important in managing the work and accounts of the practice. This attribute is further illustrated by the use of the concept of practice development in the accountancy profession. Within this context it is used to describe the advancement of business through marketing. Cowley & Mountford (1985) describe how practice development is the 'management process responsible for identifying, anticipating and satisfying client requirements profitably'. This definition suggests that the attributes of practice development in marketing are responding to client needs and improving the business of the accountancy practice. Furthermore there is a suggestion from the idea of 'satisfying client requirements profitably' of cost effective service provision. Finally, the notion of market diversity is also raised in relation to a business expanding and developing its range of services to clients. As a result the business would not be reliant upon one or two areas of work.

Brody (1989) describes how practice development in business terms is 'a strategic process involving the identification of opportunities for practice growth, determining which of these offer the greatest potential in the long term and preparing to capitalize on them'. Central to practice development whether this is related to marketing, business development or clinical care is the notion of improvement, the meeting of unmet need and effectiveness.

Use of the concept in relation to research

Within the NHS the terms Research and Development are closely aligned. The practice development phase usually refers to the implementation of research findings into clinical practice. The exception to this is the use of research methods such as Action Research where the emphasis is on the implementation of change while at the same time gathering data about a social situation. Thus practice development can occur as a result of the use of participative research methods such as Action Research (Waterman *et al.* 1995). It appears that such methods are used as a framework for practice development once the professional has decided upon the aspect of practice which requires development. Indeed, Clarke (1998) suggests that

'practitioners engage in practice development for the purpose of changing that practice, research methods which emphasize participation and action are particularly appropriate'. Despite the use of such methods the Department of Health (1994) identify that 'the gap between dissemination and implementation is huge and we do not know how to bridge it'. Kitson & Currie (1996) conducted a survey to identify clinical practice development and research activities in four District Health Authorities. They suggest that generally nurses did not think about practice development in a structured way. That is development was often not based upon scientific evidence but resulted in a good idea or hunch. Kitson & Currie (1996) found that very few respondents quoted research evidence as a rationale for change. They went on to argue that the approach used by nurses is consistent with an attitude more sympathetic to experimental knowledge than scientific method. This supports the view of Kitson (1994) that the development of practice can be based upon a variety of types of evidence. These can vary from empirical research to trying out what is considered a good idea in practice.

Within the NHS there has traditionally been more emphasis on research although work is in progress to ensure that development has equal status and resources. One of the driving forces encouraging a greater focus on development has been the clinical effectiveness agenda (DoH 1996). Within this agenda, the production of evidence based guidelines has formed part of the drive towards the utilization of research into practice. Such guidelines are one way of developing practice and this can be driven either locally or nationally (Clarke 1998). If we consider practice development within the context of research we are able to identify that the notions of improvement and effectiveness are central to the development of practice either following research or during the research process.

Using the definitions and the use of the concept of practice development from the literature it was possible to identify a number of attributes (Table 1). Some of these attributes are common to a number of different concepts. For example, the use of facilitation can be found in innovation as well as practice development. The next stage of the concept analysis involved the examination of closely related concepts and the construction of cases so that the defining or critical attributes of practice development could be identified. Defining or critical attributes are those attributes which are present in all examples of practice development. Therefore, attributes such as facilitation are not regarded as critical because not all practice development would require an identified facilitator.

Table 1

Attributes of practice development identified from definitions and use of the term in the literature

Practice development involves:
Facilitation through an identified or an appointed source
Planned systematic change
Utilization of evidence
Responding to identified client need
Improving services to the client
Improving the professional's role or skills
Improving the business or the professional or the organization
Improving the effectiveness of the service

Related concepts

It is important to consider whether practice development is simply another way of describing innovation. One of the most widely used definitions of innovation is that provided by West & Farr (1990)

'the intentional introduction and application within a role, group or organization of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, organization or society'.

West & Farr (1990) describe how innovation has the intentionality of benefit. While the definition above describes a broad range of people or groups who may benefit from the innovation in practice development the emphasis is on improvement. While these words are similar, benefit is defined as 'advantage' while improvement implies 'making better' (Oxford English Dictionary 1992). Therefore, practice development does not necessarily make the delivery of care or services more advantageous for the practitioner, but it should always be perceived as an improvement by the patient/client. An innovation on the other hand might be advantageous to both the practitioner and the patient/client. This is illustrated through King's (King 1989) definition of innovation within a health care setting.

'Innovation is the sequence of activities by which a new element is introduced into a social unit, with the intention of benefiting the unit, some part of it or the wider society. The element need not be entirely novel or unfamiliar to members of the unit, but it must involve some discernable change or challenge to the status quo'.

These definitions suggest that innovation differs from practice development in several respects. Innovation is not necessarily a response to an identified patient/client need. Nor is it directly related to the development of effective services, although it could be argued that an innovation which is of benefit to the group or organization should relate to effectiveness. Despite these subtle differences there are several similarities. These include the fact that

both innovation and practice development are planned processes which have a clear social and applied component which means that they impact directly upon others.

The development of cases

Another source of evidence is the use of experience to construct cases. This involves the construction of a scenario which illustrates the concept. Through this process, attributes which define the concept, can be identified and tested. Case construction was undertaken by a group of practitioners ($n=9$) involved in practice development within the NHS. The cases were constructed during a workshop which involved the practitioners working in two small groups. Walker & Avant (1995) describe several types of cases; these include model, contrary, related borderline, imaginary and illegitimate cases, although they acknowledge that not every concept analysis will utilize every case type.

Model cases

A model case is used to represent the author's best understanding of the concept at the time. Model cases must contain all of the critical attributes of the concept. It is generally regarded that the author should be able to construct a model case which allows him/her to state 'If this is not X, then nothing is'. Figure 2 describes a model case.

The case illustrates the development of practice in both clinical as well as business terms. The example demonstrates how the development was a clear response to an identified patient need, i.e. the need for more information. This need was partially met through the provision of written information which subsequently led to an improvement in the uptake of services. Such an increased uptake suggests that patients had become more aware of the range of services provided by the practice. Finally, the development can be regarded as maintaining the business of the practice and ensuring a more effective use of resources because Practice staff will now spend time running clinics where only half of the appointments are taken.

Related case

A related case is similar to a concept being studied, but it does not have the critical attributes of the concept. Figure 3 is an example of the concept of change. Though similar to practice development, change does not necessarily lead to a direct measurable improvement in client care/services and is not necessarily a response to an identified need or client problem. From the case we are

A GP Practice decides to fund a piece of research to examine how users perceive the range of services the Practice provides. The research highlights a number of areas, but one of the principle concerns is that patients often don't know about the full range of services provided. The Practice meet to discuss the findings and decide to produce a practice information booklet. This booklet is distributed directly to all patients who make up the practice population. An audit is undertaken six months later and this shows that there as been an increased uptake of several services including Citizen's Advice Bureau sessions, Counselling and Well Man and Well Woman Clinics. A total of 57% of patients attending these sessions state that they did not know that the services existed.

Figure 2
Model case.

also able to identify that the change has not been effective in reducing car crime. Additionally, it is unlikely that such a change would increase the business of the organization, as some people will use alternative methods of transport or park outside of the Hospital grounds.

Borderline cases

A borderline case contains some of the critical attributes of the concept being examined but not all of them. Figure 4 illustrates such a case.

This case is an example of the concept of professional development. While the nurse may have developed new skills in response to a specific patient problem, there is no evidence that she uses these skills following completion of the course. As a result, this case does not contain the defining attributes of a direct measurable improvement in client care/service. Nor does the case indicate how the development leads to more effective services or improves or maintains the business of the organization. In this case the professional development undertaken by the nurse could go on to become an antecedent to the development of her clinical practice.

Contrary cases

A contrary case provides the best example of what the concept is not. Such cases contain none of the defining attributes of the concept. Figure 5 illustrates a contrary case.

This case has none of the attributes of practice development. Firstly, the scenario does not indicate any development to overcome the actual patient problem, or identified unmet need. The lack of development also means that there is no direct measurable improvement in the service to patients/clients and that there is no improvement

The hospital is concerned about the amount of car crime which is occurring in the staff and visitor car parks. The General Manager decides to introduce car parking charges for both staff and visitors. The justification for these charges is that it will pay for additional security to monitor the car parks. The new charges are planned and introduced, but six months later there has been no reduction in car related crime.

Figure 3
Related case.

in the effectiveness of the service offered. Finally, the scenario suggests that it is unlikely that the outcome will have any influence on the business of the Practice.

Following the development of the above case examples, it became clear that a contrary case could easily have become a borderline or related case if certain antecedents were present. A decision was made to develop vignettes which would illustrate contrary, borderline, related and model cases using the same scenario. These vignettes serve to illustrate the conditions necessary to facilitate the development of practice.

Case A

Case A (Fig. 6) highlights an organizational development. The vignette starts by identifying how the organization was slow to respond to developments in neighbouring organizations. This both led to the identification of a better method of service delivery as well as placing in jeopardy the contract. The tendering of the contract is a borderline case of practice development which is initiated by the Primary Care Group. The case is borderline because it is a response to an unmet need identified by service users. In this scenario the organization produces an action plan which requires approval by the Trust Board. This approval could be regarded as an administrative change and thus, it can be regarded as part of the related concept of change. Finally, all of the stages build to produce the final outcome, which is an example of the model case. In this case the attributes of improvement, response to a specific need, effective service delivery and the maintenance or expansion of business are all present.

Case B

Case B (Fig. 7) demonstrates how an individual can develop practice. The vignette starts by describing how the nurse continues treatment even though there has been little improvement. Information from colleagues and subsequent training both increase the nurse's awareness of other

A ward nurse is interested in finding out more about wound assessment and she is concerned that the current wound care assessment is not considering all of the potential underlying pathologies. She seeks sponsorship from her manager, to attend a wound care course which she completes several months later.

Figure 4
Borderline case.

treatment modalities. This is a response to the patients need and could be regarded as the related concept of Professional Development. Despite this increased knowledge at this stage, the care of the patient remains unchanged. The nurse is able to convince her manager to seek funding for a Laser machine and eventually the machine is purchased. This represents an administrative change (a related case) as it involves the relocation of finances within the budget. Finally the practice development occurs as a result of all of the above stages and Mr Jones commences treatment and his leg ulcer subsequently improves. Again this case has the attributes of improvement, response to need and effectiveness. Additionally, the fact that the nurse is able to continue treating the patient without needing to refer him on to another professional means that the business of the organization is maintained.

Critical attributes of the concept

Following case construction it was possible to identify the following tentative list of critical attributes. Therefore, practice development involves:

- New ways of working which lead to a direct measurable improvement in the care or service to the client.
- Changes which occur as a response to a specific client need or problem.
- Changes which lead to the development of effective services.
- The maintenance or expansion of business/work.

These attributes should be present in all examples of practice development and can be used to define or measure when practice development has occurred. One of the key critical attributes identified in this analysis is the implementation of new ways of working which lead to a direct measurable improvement in the service to the patient or client. As highlighted earlier this attribute is important as it differentiates practice development from other related concepts such as innovation. The attribute together with the fact that development should be based upon an identified patient/client need provides a clear patient focus for practice development. McCormack *et al.*

At a Partners meeting the General Practitioners from a large GP Practice discuss the problems related to the Medical Centre's telephone system. The large number of incoming calls means that lines are often not available for staff to telephone out. One particular concern is the possibility that someone who requires urgent medical attention would not be able to get through to the Medical Centre. The Practice Manager informs the partners that a new telephone system would cost a minimum of £4,000 as the existing system was already working to its maximum capacity. The Practice feel that they are unable to finance such a development at this time, but they agree to explore other funding sources.

Figure 5
Contrary case.

(1999) state that the majority of developments in nursing practice in the 1980s centred around the development of the profession and attempts to measure the impact on patients were fraught with methodological problems. They go on to state that the 1990s have seen the re-emergence of humanistic caring and thus a move toward more patient focused practice development with greater emphasis on clinical effectiveness and patient outcomes. This concept analysis suggests that the outcome of practice development activity should always be patient related. It is acknowledged that there may be other related 'spin off's' from such activity such as professional

development. However, in the past people have been guilty of confusing what is essentially professional development with the direct development of patient care and this has resulted in practice development activity being difficult to quantify. Joyce (1999) states that 'practice and professional development are two different concepts, yet in the literature and in job titles they are often used interchangeably'.

Antecedents and consequences

The identification of antecedents and consequences is an important, although sometimes ignored step in the analysis of a concept. Walker & Avant (1995) define how 'an antecedent is an event or incident which occurs prior to the occurrence of the concept'. Several antecedents to practice development were identified during case construction. Firstly, all practice development activity appears to commence with an awareness of either a better method of service/care delivery or an awareness of a specific client need. Similarly, many developments in practice occur as a result of professional development activity. Professional development as an antecedent may take several forms for example reflective practice or clinical supervision may prove to be the catalyst of the proposed development. Alternatively attendance at an educational event or course may raise the practitioner's

Antecedent	Vignette	Case Type	Consequences
Awareness of a better method of service/care delivery	Anytown NHS Trusts Continence Service currently centre's around District Nursing staff assessing patients, instigating interventions and providing incontinence products. Patients or their relatives collect products from clinics or the nurse delivers them. A neighbouring NHS Trust has developed its service and offers both community-based treatment services and home delivery of all incontinence products.	Contrary	
Awareness of a specific client need/unmet need	Following several complaints for patient's a Primary Care Group decides to review its contract for continence services. It invites tenders from both the current provider (Anytown) and neighbouring NHS Trusts	Borderline	
	Anytown Trust reviews its service and identifies the need to improve treatment services and the need to reexamine the clinic issue system for incontinence products		
	The Trust Board approves the service development plan	Related (administrative change)	
	The service development plan is operationalised and the first Primary Care based continence treatment service commences. A home delivery service is established. The contract is retained and an additional contract from a neighbouring Health Authority is obtained.	Model	Improvement and expansion of the organisations business

Figure 6
Case A.

Antecedents	Vignette	Case type	Consequences
Awareness of a specific client need/unmet need	Mr. Jones a patient with a long standing arterial leg ulcer has been visited regularly by his District Nurse. Despite her best efforts the ulcer refuses to heal. A Vascular Surgeon has seen Mr. Jones but surgery is not indicated at the present time. The District Nurse continues to visit twice weekly to change his dressings.	Contrary	
Awareness of a better method of care delivery	The District Nurse is concerned about the ulcer not healing, she discusses this with her colleagues when she attends her course at the local University. One of her colleagues mentions an article she had been reading about Low Level Laser Therapy. The nurse locates this and contacts the company for further information. The company offer her a free place on their next Laser training course. The nurse attends the course and feels that Laser may benefit a number of her patients including Mr. Jones.	Borderline	Professional Development of the nurse
	Following the course the nurse collects together relevant literature about the effectiveness of Laser therapy and approaches her manager about the purchase of the equipment. The manager subsequently presents a case to the Trust Board. The Board agree that a small pay underspend can be moved and used as capital to fund the purchase of this equipment.	Related	
	The Laser is purchased and the nurse commences the treatment of Mr. Jones leg ulcer which over the next 6 weeks improves by granulating and reducing in size.	Model	Direct improvement in the care/service to a client

Figure 7
Case B.

awareness of a better method of service delivery or care provision. Finally, any practitioner intending to introduce a development into practice must make sure that the proposed development is congruent with the aims of the organization. Unless this antecedent is present the development is likely to be blocked by managers within the organization.

A consequence is an event or incident which occurs as a result of the occurrence of the concept (Walker & Avant 1995). Some of the consequences of practice development are highlighted in the critical attributes of the concept. For example, the development of effective services and the introduction of a new way of working which leads to a direct measurable improvement in the care or service to the client. Similarly practice development would also be expected to maintain or expand the organization's business. Finally, professional development can also be seen as a consequence of practice development activity because the professional would have enhanced their own knowledge and skills as a result of the implementation of the new way of working.

Empirical referents

Empirical referents are categories of actual phenomena which demonstrate the occurrence of the concept itself

(Walker & Avant 1995). The categories relate to the critical attributes of the concept and in some cases the empirical referents are the same as the critical attributes identified. The empirical referents for practice development are similar to the critical attributes but these have been reworded to facilitate the measurement of the concept. The empirical referents are identified as:

- A change in the way of working
- A clear client focus for the development
- Cost or clinically effective service delivery.

Each of these referents can be measured within the practice setting to identify a development in practice. Firstly, there should have been a change in the way of working. This could be anything from an alteration in ward routine to the development of a new service. The practitioners implementing the development should be able to articulate why they felt the need to change, giving an example from practice of how a client related incident raised their awareness of the issue. Even nationally driven developments such as Nurse Prescribing have their origins in the identification of client need, i.e. the need for more timely treatment. Finally, it is possible to identify whether the development is either cost or clinically effective through either financial assessment or the identification of the evidence base for the treatment/development.

Discussion

Many NHS Trusts have considerable resources invested in practice development. Many of these organizations have introduced Practice Development Nurse or Facilitator posts to assist with the development of practice. There is wide variation in the way in which these posts operate (Mallet *et al.* 1997) with some post holders concentrating on education and professional development while others work on specific clinical developments. There is a dearth of empirical work related to the role of the Practice Development Nurse (PDN) and as a result the individuals themselves and their managers have problems identifying the best way to develop such posts. In addition the setting of objectives for post holders can also be problematic because of the difficulties in defining just what is practice development activity. Hopefully the tentative list of critical attributes and their associated empirical referents will assist both PDNs and their managers to define the scope of and measure the outcomes from the PDN's work.

The critical attributes suggest that practice development is a complex issue which requires a considerable array of skills amongst the practitioners implementing any development within practice. For example, the practitioner needs to be able to identify the potential impact of the proposed development on the business of the organization. This raises the issue of how organizations can ensure that their staff have the necessary skills. Further research is needed to examine the process of developing practice and how staff interact with this process so that the skills necessary can be identified. It is likely that the need for research of this kind will become increasingly pressing because practice development is a key part of clinical governance. The Royal College of Nursing (1998) describes how clinical governance makes explicit the need for a systematic approach to the development of practice within organizations. In order to achieve this organizations need information on the nature, scope and process of practice development.

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