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COMMENTARY

Overcoming synecdoche: why practice development and quality improvement approaches should be better integrated

Commentary on: Lavery, G. (2016) Quality improvement – rival or ally of practice development? *International Practice Development Journal*. Vol. 6. No. 1. Article 15.

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We are pleased to be provided with an opportunity to comment on the thoughtful article by Gavin Lavery about the relationship between practice development and quality improvement, published in 2016 in the *IPDJ*. We also respect and value the opportunity to bring different perspectives together – something alluded to in Lavery's article when discussing the relationship between service improvement and quality improvement.

We acknowledge Lavery's humility and openness to different perspectives as demonstrated by his willingness to participate in a foundation practice development school. We also accept that there are many different ways of achieving the same outcomes, by using a range of tools flexibly based on shared and common principles, as well as knowing the people you work with and being clear about purpose. At a time of scant resources in healthcare, it is vital that we avoid duplication and integrate approaches if service users are to experience the continuity and seamlessness of a person-centred approach to meeting the health and social care needs of individuals and communities.

Lavery makes reference to 'systems and processes'. It is important when discussing systems that we have a sense of shared meaning, as systems comprise structures, processes and patterns of behaviour. It is often the latter that are most challenging to address when trying to develop practice and improve quality (McCormack et al., 2008). Patterns of behaviours are an important focus when engaging staff in learning and reflection. Helping practitioners to become self-aware about the consequences of their actions on others (enlightenment), particularly in relation to being person-centred, has a strong history in practice development, linked to using the workplace as the main resource for active learning (Dewing, 2008). While these insights have relevance for both practice development and quality improvement, it is the former, through its theoretical development, that has attended to these concepts intentionally.

In practice development it has long been argued that structures and processes follow values and purposes and that these values also enable and guide decision making, not vice versa (Manley et al., 2011). Thus, liberating people from the bureaucracies of detailed processes and micromanagement may impact favourably on both practice development and quality improvement. This point enables us to emphasise that practice development is about co-creation of shared values and purposes, and it is these that guide direction and decision making linked to both the evidence base and the key principles

of collaboration, inclusion and participation, shaping whether a workplace culture enables or inhibits person-centred practice. Often this collaboration and participation takes the form of collective reconnaissance about context that marks the beginning of systematic action spirals in the practice development journey (McCormack, Manley and Titchen, 2013).

While there is some similarity between the practice development journey, with its connection to action research, and the Plan-Do-Study-Act cycle of quality improvement science (Reed and Card, 2016), this is only at a rudimentary level. Within the context of learning, we never return to the same place, but build on our learning going forward (hence a 'spiral' rather than a 'circle'). Also, the role of reflection in practice development means there is attention given to our assumptions, and the aspects of practice we take for granted, as these often constrain our thinking and actions when trying to make changes. In addition, reflection helps to identify the internal and external factors that may help or hinder us, for example, perceptions of power structures that impede practice change. Reflection is also the mechanism by which critical inquiry (an integral part of practice development) into practice is driven; such inquiry links reflection and learning in and from practice. Learning is also important to quality improvement and developing a safety culture, but in practice development learning is purposefully addressed through the processes of active learning and reflection. It is therefore these co-creation principles that guide the practice development journey, in which different tools and methods are used, rather than emphasising the tools and methods themselves. This is because a premium is put on involvement and engagement of stakeholders in order that ownership of change can be achieved.

The Health Foundation in the UK has more recently identified a link between tools, learning and other relationship skills through its Quality Improvement Pyramid, classifying them as technical, soft and learning skills (Gabbay et al., 2014). However, the primary challenge remains the engagement of staff, particularly when there is increasing demand for health and social care but reduced resources and little time for development and improvement work. There is a paucity of practice learning facilitators capable of enabling practitioners to reflect in, on and for practice as originally envisaged by Schön (1983). Part of the uniqueness of practice development activity is the emphasis on 'in' practice, but this needs to be facilitated and role modeled in practice if authentic learning is to take place; clinical leaders have an important role in enabling this engagement.

At a systems level, the use of social media has much potential to contribute to achieving engagement through capturing consensus at scale as well as enabling contributions, expertise and innovations from multiple stakeholders – another key focus of practice development. Even social movement theory and also appreciative inquiry – both dependent on engagement – do not make sufficiently explicit the strategies that enable this engagement. Staff engagement is therefore an area that would benefit both practice development and quality improvement as well as other interrelated areas. An example of such a movement can be found at the HARTS of the possible (hartsofthepossible.wordpress.com), a collaboration between Cochrane UK, the WhyWeDoResearch campaign, National Institute for Health Research, experts by experience and the England Centre for Practice Development, working with social media leaders.

The human elements of social change challenge the link Lavery makes to industrial processes, which aside from addressing efficiency, are no longer really helpful as personal systems always follow different principles. This is seen in the growing focus on human factors linked to safety culture and the consequent need for skills in challenge and support, developing self-awareness (enlightenment) and empowering staff to speak up and act in relation to patient safety and patient advocacy. Practice development has paid much attention to building such open cultures and ways of working that embrace holistic safety and effectiveness and that also enable people to flourish.

It is often argued that practice development enables flourishing – but flourishing goes beyond joy in work; it is also about growing the potential so necessary for innovation and creativity. While we endorse Lavery's view that most healthcare staff possess a strong desire to do their best, flourishing

is also about pushing the boundaries, not just of the service but also of staff through using creativity to inform innovation and new ways of working. The expectation in practice development is that the context continually changes so one core value of an effective culture is adaptability – being able to embrace change through pushing the boundaries forward. Nurturing creativity therefore has an important role in practice development.

Other than staff engagement there is another challenge that confronts both quality improvement and practice development – the recognition by health organisations that those with the greatest insight into what can be changed and improved are the practitioners and clinical leaders working directly with service users. This focus in practice development is seen through the concept of micro culture. It is at the micro-culture level that most care is provided and experienced; at this level service providers and service users interact and the business of healthcare happens. The challenge then is influencing those in positions of power to provide the support required for bottom-up development and improvement. While organisational readiness and other enablers are recognised as important for supporting frontline teams, little research exists about which strategies are effective in engaging and enabling frontline teams other than the concept of facilitation and the role of clinical leadership (Akhtar et al., 2016). Both facilitators and clinical leaders need to possess the skillsets of practice development and quality improvement, not just to support frontline teams but also clinical systems leadership across the whole health economy (Damschroder et al., 2009; Dixon-Woods et al., 2012). When these principles underpin the development of clinical leaders across all disciplines then influence and engagement is embellished (Bradd, 2016) and outcomes improve, particularly around workplace cultures (Akhtar et al., 2016). Within practice development, effective workplace cultures are proposed as a proxy for the achievement of health outcomes (Manley et al., 2011). This is also stressed in reviews on implementation strategies and experiences (Damschroder et al., 2009; Dixon-Woods et al., 2012)

Practice development and quality improvement are not necessarily two sides of the same coin. We would instead suggest that they are complementary in their principles and purpose. Practice development has a more general focus and is not limited to a particular area of care. It emphasises person-centredness, workplace cultures and flourishing staff, and integrates a strong focus on learning, reflection and knowledge translation, as well as promoting innovation through creativity and the need to embrace different tools. Quality improvement emphasises the tools but recognises the role of learning and other softer skills. It focuses on defined areas of practice where problems have been identified and on achieving a high degree of attainment of predefined goals. But in doing so without regard to the broader social, cultural, intrapersonal and structural facets of an organisation or workplace, it is in danger of creating synecdoche – whereby progress in the areas of focus is assumed to imply progress for the whole organisation. Bevan and Hood (2006) highlight the problems caused when health organisations focus on performance measurement as a quality improvement strategy – for example, highlighting the importance of collecting data on falls but not acting on the causes or taking into account the impact a fall might have on the patient's fear of falling again. The problems highlighted in the report of the Mid Staffordshire NHS Foundation Trust public inquiry (Francis, 2013) are a well-known illustration of this. Seeley and Goldberg (1999) argue the ethical case for looking at the whole as well as the parts in order to achieve the best clinical outcomes.

Yet greater integration between practice development and quality improvement approaches would benefit healthcare organisations by making a case for collaborative learning and development, research and innovation. The relationships between these activities have begun to be well described by McCance (2012) – a move towards working in a 'joined-up' way is a change that does not have resource implications. What a fantastic opportunity such integration would offer to model the way to overcome synecdoche and contribute complementary insights for engagement and action towards person-centred, safe and effective health and social care.

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