The role and impact of facilitators in primary care: findings from the implementation of the Gold Standards Framework for palliative care

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Background. Facilitation is the process of providing support to individuals or groups to achieve beneficial change. It is intrinsic to the Gold Standards Framework (GSF) for palliative care, a programme introduced widely in UK general practices.

Objectives. To explore how GSF facilitators fulfil their role and the impact of the facilitators’ backgrounds and approach on practices’ uptake of the programme.

Setting. Primary care organizations and general practices in England and Northern Ireland.


Results. A total of 102 (59.6%) facilitators completed a questionnaire; interviews were performed with nine facilitators. A large variability was found in the facilitators’ professional backgrounds, role setup and activities. The impact of several facilitation characteristics on practice change was modelled for 63 (36.8%) facilitators and 266 practices (20.4%). No evidence was found of an association between practice change and facilitators’ specialist knowledge of palliative care, mean facilitation time per practice, mean number of visits, facilitator budget and incentives offered to practices. Facilitators with a GP background were associated with higher levels of GSF change than those with a clinical nurse specialist background ($P = 0.0078$ with Bonferroni correction, significance threshold for corrected $P = 0.008$). The interviews indicated that the differential implementation of the framework might have been strongly affected by internal and external practice-related factors that were not readily amenable to facilitation.

Conclusion. This study goes some way towards untangling aspects of facilitation associated with successful implementation of the GSF. Further prospective research and evaluation is needed to identify ways of improving its sustainability, effect on patient outcomes and cost-effectiveness.

Keywords. Facilitators, health personnel [MeSH], organizational innovation [MeSH], palliative care [MeSH], primary health care [MeSH], quality assurance, health care [MeSH].

Introduction

Facilitation is the process of providing support to individuals or groups to achieve beneficial change. It has been described as ‘the provision of opportunity, resources, encouragement and support for the group to succeed in achieving its own objectives and to do this through enabling the group to take control and responsibility for the way they proceed’.$^1$ A facilitator has been defined as a ‘catalyst for change’,$^2$ as someone who ‘helps forward’ and ‘gives direction, by drawing upon their own experience’.$^3$

The facilitators’ tools of trade consist primarily of knowledge, skills and techniques for structuring and driving a process of change and occasionally expertise in the clinical area addressed by the intervention.

Facilitation is an intrinsic component of the Gold Standards Framework (GSF), a programme promoting high quality primary palliative care that has been widely introduced in UK general practices. Its national rollout
in 2003–2005 involved 1305 practices and 171 facilitators. This paper uses data from the evaluation of the GSF to describe the variety of GSF facilitation models that emerged during the national rollout and to explore the relationship between characteristics of these models and the degree of change achieved by practices.

Facilitation in primary care and primary palliative care
In primary care, facilitated interventions have been used since the 1980s, predominantly to improve prevention and early detection of conditions like cardiovascular disease and cancer, and to support the design and implementation of self-selected quality improvement projects. Having been first described in 1984, this approach was in the ascendency in UK general practice in the late 1980s and early 1990s. In primary palliative care, a national network of GP facilitators was set up in the UK in the early 1990s by the charity Macmillan Cancer Relief (now Macmillan Cancer Support) with the Royal College of General Practitioners, aiming to enhance the continuity and quality of cancer and palliative care in the community. At present (2009), there are ~120 Macmillan GP facilitators in the UK.

The activities performed by primary care facilitators vary widely. Those recurring most often in reports on facilitated interventions in primary care are the following: auditing practice processes and feeding back the findings; facilitating discussions, consensus building, planning and responsibility allocation; providing training and sharing information and helping practices develop reminder systems, protocols and data collection forms. As far as the effectiveness of facilitated interventions is concerned, multi-faceted interventions employing trained individuals who meet with practitioners in their practices have been shown to be more effective in introducing changes in primary care than any other single intervention. There are doubts, however, as to the long-term and outcome-related effects of facilitated interventions as well as uncertainty as to which aspects of a facilitator’s role and approach are most effective in triggering practice change. The latter is unsurprising since most projects discussed in the literature involve only one or two facilitators, which precludes comparison between different approaches and facilitator profiles. The largest published study that we are aware of involved a total of 14 individuals.

Facilitation within the GSF
The GSF is a programme promoting high quality primary palliative care that has been introduced in a large number of UK general practices (Box 1). Its 2003–2005 national rollout (across England and Northern Ireland) involved 1305 practices supported by 171 facilitators. Evaluation of the national rollout demonstrated that the programme had fostered adoption of good palliative care-related processes.

GSF facilitators were recruited locally, with a small number of them having had previous experience as Macmillan GP facilitators. Most, however, had not worked in a similar role before, and many were from non-medical (mainly nursing) backgrounds. All facilitators received nationally coordinated training, which aimed to ensure that they started from a common facilitation platform. A national team supported

<table>
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<th>Box 1</th>
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<tr>
<td>Overview of the GSF</td>
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</table>

The GSF aims to facilitate primary health care teams to:

- achieve optimal control of patients’ symptoms
- enable patients to live and die well, in their preferred place of death
- reduce the number of crises and unplanned admissions to hospital or hospice
- improve their communication with patients and carers
- support, inform and empower patients and carers
- work more effectively as a team
- develop their confidence in the care they provide

Achieving these aims is seen as dependant on seven pillars, the so-called Seven Cs:

► Communication ► Coordination ► Control of symptoms ►Continuity ► Continued learning ► Carer support ► Care of the dying

The GSF operationalizes into specific actions and offers tools to support the processes of: identifying patients in need of palliative/supportive care; assessing patients’ needs, symptoms and preferences and planning care around these. The GSF places a strong emphasis on helping patients to live and die where they choose. Practices have a designated coordinator from within their team, are supported by an external facilitator and provided with tools, guidance documents and examples of good practice. They can also draw on resources available on a dedicated website (www.goldstandardsframework.nhs.uk).

Following initial piloting with 12 general practices in 2001, the rollout of the framework was sponsored by Macmillan Cancer Support in England and Northern Ireland and the New Opportunities Fund of the National Lottery in Scotland and more recently by the National Health Service End of Life Care Programme in England. As of October 2009, over 60% of general practices in the UK are using the GSF at a level above the basic one and 10–15% of practices have fully embedded the programme. This makes the implementation of the GSF one of the largest primary care facilitation projects to have ever been undertaken.
facilitators through workshops, an advice line, a newsletter and website resources. Facilitators were appointed at local level by primary care trusts and cancer networks under a variety of organizational arrangements, had varied levels of specialist knowledge of palliative care and were given a large degree of freedom in their choice of activities.

Aim and Objectives

This study had two main objectives: (i) to describe the variety of facilitation models that emerged in translating the common GSF platform into real life facilitation of more than 1300 practices and (ii) to explore, where data permitted, the impact of different facilitation characteristics on the degree of change achieved by practices. The overall aim of the study was to contribute to a template for the design and evaluation of facilitated interventions in primary care.

As the evaluation of the national rollout of the GSF was set up only after the programme was under way, there were substantial limitations to the type and amount of data that could be collected. On the positive side, the scope of the intervention, the wide range of local arrangements and the large degree of freedom given to facilitators allowed for a wide variety of facilitation models to emerge.

Methods

The study used quantitative (including ‘quasi-quantitative’, i.e. categorical) and qualitative data collected from facilitators, together with quantitative data collected from practices. Of these, the primary source of data was a self-completed facilitator questionnaire. It comprised 22 main questions and a number of sub-questions (closed and open). The questionnaire collected data about facilitators, the organizational setup of their roles, their activities and experiences and the local context in which they worked. The questionnaire was designed by DM and SA specifically for this study. It was based on the aims of facilitation for the GSF, a review of the literature and discussions within the evaluation team. After having been tested for face validity with clinical members of the Macmillan Research and Evaluation Collaborative, it was sent to all 192 GSF facilitators registered with Macmillan Cancer Support. Three weeks later a reminder questionnaire was sent to 129 facilitators who had not yet responded. After a further two weeks, the remaining non-responders were contacted either by telephone or email. It became clear in this process that 21 individuals had withdrawn from facilitating the programme and were no longer contactable. These were consequently excluded from the total number of GSF facilitators and a final reference population of 171 facilitators established.

Quantitative and quasi-quantitative (categorical) data

Closed questions from the facilitator questionnaire. The quantitative and categorical data used in the study came primarily from the facilitator questionnaire, as described above.

Practice change data. Wherever possible, we analysed facilitation characteristics relative to ‘practice change scores’, as obtained from another study within the wider GSF evaluation. Its methodology and findings have been reported elsewhere; a summary is given in Box 2. Briefly, an audit questionnaire was used to identify the extent to which, both prior to facilitation and after implementing the programme, practices had recommended palliative care processes in place. An aggregate practice change score was used as the primary outcome measure. In the present study, we used the practice change scores for the practices of those facilitators who had completed a facilitator questionnaire.

Quantitative data analysis. Descriptive statistics were obtained for the closed questions from the facilitator questionnaire, using the statistical package SPSS 15.0.

Box 2
Overview of findings from the quantitative evaluation of the national rollout of the GSF (2003–2005)

- The quantitative evaluation was based on an audit questionnaire completed by 1305 practices at baseline and 955 practices at baseline and follow-up. Thirty-five questions were used to compute a ‘palliative care process score’ at baseline and ~1 year later and the degree of change that occurred. Degree of change could be computed for 505 practices that responded to all process questions at both baseline and final.
- Significant change in the implementation of ‘good palliative care processes’ was observed, with an average of nine new processes introduced by practices at follow-up (increase from an average of 16 to an average of 25 good processes at 12 months). Degree of change was associated with practices’ rating of their quality of palliative care at follow-up and their rating of support to carers at baseline.
- The most commonly introduced changes were: establishing a register for patients in need of palliative care (23.4% practices at baseline–90.2% at final), discussing palliative cancer patients at team meetings (27.0–78.9%), recording advanced care planning with the primary health care team (23.4–70.6%) and recording palliative care patients’ preferred place of death (25.4–72.8%).
- The low quality of numerical data prevented exploring the relationship between the introduction of processes recommended by the framework and patient outcomes, such as dying at preferred place and reduced number of crises.
In addition to that, linear regression models were used to assess the facilitator effect, with the practice change score as the response variable. The facilitator effect was then incorporated into random effects models. These were used to explore a possible relationship between practice change scores and the following variables: professional background of the facilitator; specialist knowledge of palliative care or palliative care services; mean facilitation time per practice (total employment hours as facilitator per month divided by number of practices); mean number of visits to facilitated practices (per year); budget available to facilitator and financial incentives to practices. The statistical software package SAS 9.13 was used. The PROGLM was used to fit the linear regression model and PROC MIXED to fit the random effects model. No practice-specific values were available for the variables on facilitation time and number of visits; it was only possible to use mean values derived from the facilitator questionnaire. Although such an approximation has serious limitations, it was deemed acceptable as the dispersion on the relevant variables was substantial, which might signal greater inter-facilitator than intra-facilitator variability in a large number of cases (Time per practice per month: range 0.36–50 hours; mean = 7.2 hours; SD = 8.5 hours. Visits per year: range 1–12; mean = 3; SD = 2.9).

Qualitative data

Data on activities from the facilitator questionnaire. An open question in the facilitator questionnaire produced rich and complex data on the activities in which GSF facilitators engaged. One researcher (SA) did the initial categorization of these activities; a second researcher (MP) built on it to develop a final set of categories of facilitation activities.

Semi-structured interviews with a subsample of facilitators. The interview schedule included questions about the facilitator role and activities as well as questions eliciting data for the wider GSF evaluation. Nine semi-structured interviews were carried out; seven via telephone and two in person. The sample of interviewees was chosen from those who had indicated a willingness to be interviewed when they returned the facilitator questionnaire and were selected to represent a mix of backgrounds and organizational arrangements (Table 1). New topics and considerations stopped emerging early in the interview process, most likely because the questionnaire contained a number of open questions overlapping in content with questions from the interview schedule. This served to triangulate data, providing evidence of their reliability. The interviews were transcribed and then coded by two researchers. Thematic analysis was used. Main themes and unusual/deviant observations were coded for. Relationships were sought between approach to facilitation and characteristics such as professional background, organizational setup of the role and personal philosophies of effective support expressed by the interviewees. One of the researchers used the data analysis package NVivo 7; the other did the coding unaided by specialized software. Both contributed to establishing a final coding scheme.

Results

Of the 171 GSF facilitators, 102 (59.6%) returned a completed questionnaire. Of these, practice change scores were available for the practices of 63 facilitators (36.8%), for a total of 266 practices. Data on these practices and facilitators were used to model the potential impact on practice change of a set of characteristics of the facilitators and the organizational setup of their work (Fig. 1).

Formal characteristics of the different GSF facilitation models

Tables 2 and 3 summarize data on the background of respondents, the range of organizational setups for...
their roles and the availability of financial incentives for their local practices. The data demonstrate a large variability of models, particularly in terms of hours dedicated to GSF facilitation (ranging from no formally dedicated time to full working week, mean = 10.0 hours, SD = 10.4 hours) and number of facilitated practices (ranging from 1 to 78 practices, mean = 7.5, SD = 6.5).

Facilitation activities
The facilitators had two primary tasks: recruiting practices and supporting their implementation of the programme. A number of facilitators also engaged in ‘meta-support’ activities: they worked more broadly on developing local palliative care services and/or developing palliative care-related tools and resources.

Recruitment of practices. Most (85%) facilitators targeted every practice in their designated areas for participation in the programme, either all at once or sequentially, starting with practices that they perceived as enthusiastic or easy to work with. Facilitators introduced the programme and themselves to

The sub-group of 63 facilitators was very similar to the wider group of 102 facilitators who returned a facilitator questionnaire (comparison tables available from the authors). The 266 practices were also very similar to the wider group of practices (505) for which a change score was available from the audit study: their mean change score was 9.39 (SD = 6.20), with the respective statistics for the 505 practices being 9.60 (mean) and 6.63 (SD).

For the 63 facilitators, data on practice change were available as follows:

<table>
<thead>
<tr>
<th>Number of practices</th>
<th>Number of facilitators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>26 (41.2%)</td>
</tr>
<tr>
<td>3-5</td>
<td>24 (38.1%)</td>
</tr>
<tr>
<td>6-10</td>
<td>10 (15.9%)</td>
</tr>
<tr>
<td>&gt;10</td>
<td>3 (4.8%)</td>
</tr>
</tbody>
</table>

**Figure 1** Arriving at the sub-sample of facilitators and practices used in the modelling of impact on facilitation characteristics on practice change.

102 (59.6%) facilitators who completed a facilitator questionnaire

- For 21 facilitators no practice data were available from the audit questionnaire
- 81 facilitators
  - For 10 facilitators no change data for their practices could be computed (i.e. only one audit questionnaire completed by practices)
- 71 facilitators
  - In 7 cases practice data were available from shared facilitation practices, while the questionnaire was filled in by one facilitator only
- 64 facilitators
  - In 1 case the questionnaire was filled in by two facilitators, while practice data were available for one of the two facilitators only
- 63 (36.8%) facilitators who supported 266 practices for which full audit data were available.
practices individually and/or used a group approach. The group approach targeted practices through talks and presentations at local meetings, training events and road shows and publications in local bulletins. Facilitators differed in how active they were in their promotional efforts and in their perseverance in cases of non-response. No data were available on the success of facilitators in their recruitment efforts.

**Group support to practices.** Facilitators supported groups of practices by organizing and leading meetings, including training events and workshops. The regularity of meetings ranged from monthly to twice yearly. Attendance varied from restricted to practice coordinators to broader inclusion of other members of the practice team and representatives of the services involved in local palliative care delivery, such as out-of-hours, ambulance and social services, hospices, older person teams and community pharmacies. The principle used to generate the thematic focus of the meetings also varied. Some facilitators allowed the focus of a meeting to emerge from participants’ concerns on the day, while others structured meetings around a particular topic from the framework, such as registers for palliative care cancer patients or a more general palliative care topic, such as bereavement. Less typical approaches were to have each meeting dedicated to a different practice, whose coordinator presented a case study, or to invite guest speakers—palliative care consultants, patients and carers.

**Support to individual practices.** While a few facilitators provided support only when requested by practices, most were more proactive and initiated contact themselves. Facilitators delivered support through different media—telephone, email or personal visits. The number of visits made to practices over a year ranged from none to 20, with most facilitators visiting their practices two to three times per year (Table 3).

Practical support consisted of providing advice, sharing knowledge and information and occasionally hands-on help. Facilitators with a background in palliative care were likely to complement this with specialist advice and training on aspects of palliative care. Facilitators differed in the degree to which they provided hands-on support, for instance in setting up the register, completing audit questionnaires or ‘tweaking the paperwork’.

**Meta-support for implementation of the framework—creating a more favourable local context.** Many facilitators worked to make their local context more favourable to the GSF and primary palliative care. Facilitators who perceived this as part of their mandate were involved in activities aiming to create a facilitative infrastructure, such as through the development of new policies or the restructuring of local services; to obtain the support of key individuals and to create networks of similarly minded people.

Many facilitators actively liaised with services, groups and people affected by or affecting the implementation of the programme, such as out-of-hours and specialist

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**Table 2 Facilitator profiles and administrative arrangements for their role**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of facilitators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>41 (40.2%)</td>
</tr>
<tr>
<td>District nurse</td>
<td>27 (26.5%)</td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td>18 (17.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>14 (13.7%)</td>
</tr>
<tr>
<td>No response</td>
<td>2 (2.0%)</td>
</tr>
<tr>
<td>Specialist knowledgea</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35 (34.3%)</td>
</tr>
<tr>
<td>No</td>
<td>45 (44.1%)</td>
</tr>
<tr>
<td>No response</td>
<td>22 (21.6%)</td>
</tr>
<tr>
<td>Involvement in direct clinical work</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>75 (73.5%)</td>
</tr>
<tr>
<td>No</td>
<td>24 (23.5%)</td>
</tr>
<tr>
<td>No response</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td>Employment organization</td>
<td></td>
</tr>
<tr>
<td>Primary Care Trust</td>
<td>77 (75.5%)</td>
</tr>
<tr>
<td>Macmillan Cancer Support</td>
<td>10 (9.8%)</td>
</tr>
<tr>
<td>Cancer Network</td>
<td>6 (5.9%)</td>
</tr>
<tr>
<td>Local hospice</td>
<td>2 (2.0%)</td>
</tr>
<tr>
<td>Other (including hospital)</td>
<td>5 (4.9%)</td>
</tr>
<tr>
<td>No response</td>
<td>2 (2.0%)</td>
</tr>
</tbody>
</table>

*A yes/no response for specialist knowledge of palliative care was coded on the basis of ‘other roles’ (apart from facilitator) reported by respondents.

**Table 3 Formal characteristics of facilitator interaction with practices**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of facilitators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of practices per facilitator</td>
<td>1–78</td>
</tr>
<tr>
<td>Range</td>
<td>7.5 (6.5)</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>13 (12.7%)</td>
</tr>
<tr>
<td>Hours employed as a facilitator per week</td>
<td>0.0–37.5</td>
</tr>
<tr>
<td>Range</td>
<td>10.0 (10.4)</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>25 (24.5%)</td>
</tr>
<tr>
<td>Number of visits per practice, per year</td>
<td>0–20</td>
</tr>
<tr>
<td>Range</td>
<td>3.3 (3.4)</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>16 (15.7%)</td>
</tr>
<tr>
<td>Budget for facilitator</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30 (29.4%)</td>
</tr>
<tr>
<td>No</td>
<td>66 (64.7%)</td>
</tr>
<tr>
<td>No response</td>
<td>6 (5.9%)</td>
</tr>
<tr>
<td>Minimum to maximum</td>
<td>£200–£32 000</td>
</tr>
<tr>
<td>Financial incentives for practices</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25 (24.5%)</td>
</tr>
<tr>
<td>No</td>
<td>70 (68.6%)</td>
</tr>
<tr>
<td>No response</td>
<td>7 (6.9%)</td>
</tr>
<tr>
<td>If yes—range (per practice)</td>
<td>£100–£2000</td>
</tr>
<tr>
<td>If yes—mean</td>
<td>£493</td>
</tr>
</tbody>
</table>

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Box 3
Facilitator types in terms of the intensity of their interaction with individual practices

**Driver of practice change.** Such facilitators invested much time, energy, enthusiasm and conviction in recruiting, supporting and motivating practices and in overcoming resistances or lack of sufficient interest. They also provided much hands-on and step-by-step support to practices and/or ‘nagged’, ‘chivied’ or ‘harassed’ them to perform certain tasks (e.g. complete the audit questionnaires used in the GSF evaluation).

‘If they don’t do it, I’ll come and nag them, yeah. Why haven’t you filled your questionnaire in? Why aren’t you meeting? Why aren’t you communicating with out-of-hours? (Fac 3, GP, up to 1 day per week)’. 

‘[W]e were like on a PR exercise. At every meeting we went to, we talked about GSF. Anything to do with palliative care, we talked about GSF [Fac 9, clinical nurse specialist (CNS), up to 1 day per week]’.

**Partner in practice change.** Such facilitators worked from the assumption that engaging with the GSF and the extent to which this was done was primarily the choice and responsibility of practices. Their proactive efforts at engaging and motivating practices were more sensitive to signs of limited interest. Such facilitators had individual contact with practices but were less likely that the previous type to provide hands-on, step-by-step support and/or ‘harasses’ practices with reminders of what was expected of them.

‘I think it’s taken up to the level at which the practice is happy with it and… I’ve been quite relaxed about what level they took it up to really (Fac 3, GP, up to 1 day per week)’. 

‘[T]here was also an element of ‘they had signed up to it, they had to take responsibility for what they were doing and if I continue to hand-hold them all the way, they weren’t gonna do that (Fac 2, CNS, full time)’.

**‘Available if requested’ support for practice change.** The level and type of support provided by such facilitators was constrained by the minimal amount of time they could spend in their facilitator role (e.g. about an hour per week). This made feasible only a group approach to facilitation and being available for limited help and advice if individual practices requested it.

‘I kept the monthly meetings going, but didn’t have time really to do individual liaison with practices. And so the ones who didn’t turn up to those meetings, slightly fell by the wayside (Fac 8, GP, ~1 hour per week)’.

palliative care nursing services, hospices, the local care agencies, social services and community pharmacies.

A smaller number of facilitators contributed to the draughting of policies, strategies and frameworks on a local or national level, or were involved in strategic decision making in their locality, by belonging to or regularly participating in meetings of local palliative care bodies, such as palliative care strategy groups. Other approaches to modifying the local context included lobbying for support for the GSF, such as securing funding to sustain its functioning, providing regular updates on its implementation by means of a dedicated bulletin or news items in local publications and bringing together the threads of a supportive network by establishing palliative care interest groups or databases of individuals involved in palliative care.

**Meta-support for implementation of the framework—developing and improving the tools, resources and know how.** Many facilitators worked on adapting and improving the paperwork and extending the range of tools and resources available to support implementation of the framework. They developed, for instance, out-of-hours handover forms, medication charts with advice on prescribing, audit tools, IT systems to support computer-based palliative care registers, district nurse care plans, palliative care pathways and bereavement leaflets.

**Style and strategy of interaction with practices**

Two salient messages, underpinning the facilitators’ interaction with practices, pervaded all interviews and seemed to define a ‘GSF style and strategy’. The first message was about the GSF being non-prescriptive—a framework that is there for practices to adapt to their own needs and resources, including the extent of its implementation. The second message was about making small steps: practices were advised to implement the programme piecemeal, gradually adding new components to what they have already developed. Beyond these main GSF-style messages, facilitators appeared to have been given the freedom to follow their own personal style and preferred strategies.

With regard to the intensity of interaction, three types of facilitator role emerged: driver of change, partner in change and ‘available if requested’ support for change (Box 3). With regard to the facilitators’ preferred route into gaining practices’ commitment, in terms of members of the practice team whose support they tried to gain first and foremost, facilitators tended to approach their peers (e.g. GPs approached GPs and district nurses approached district nurses). Both the GPs and district nurses saw their route as the privileged one, as placing them in a better position to make the GSF work in the practices they were supporting. With regard to the inclusiveness of their interaction with team members, there seemed to be two types of facilitator—those who preferred to focus on their
interaction with key GSF individuals and those who aimed to involve as many members of the primary care team as feasible.

**Impact of facilitation characteristics on practices’ change scores**

Using linear regression models, we found no evidence of a difference between individual facilitators in terms of their ability to stimulate practice change. Random effects models, controlling for the facilitator effect, found no evidence of an association between the extent to which practices adopted palliative care processes and the following characteristics: facilitators’ specialist knowledge of palliative care, the mean facilitation time per practice, the mean number of visits to practices, the availability of budget for facilitation activities and the availability of financial incentives to practices. Statistical significance was reached for the association between facilitators’ professional background and the extent of practice change (P = 0.03). Pairwise comparison showed that practices facilitated by a GP achieved higher levels of change than practices facilitated by a clinical nurse specialist. The respective adjusted means for practice change were 10.67 and 6.69, P = 0.0078 with a Bonferroni correction, significance threshold for corrected P = 0.008.

**Discussion**

**Summary of main findings**

This study found considerable variation in the approach taken by GSF facilitators. GSF facilitators varied in their background, organizational arrangements for their roles and style of interaction with practices and employed a wide range of facilitation activities. Limitations of the evaluation design precluded in-depth exploration of which models were the most effective in inducing practice change. From the characteristics that we were able to test, specialist knowledge of the facilitator, the mean time available for each practice, the mean number of visits made, the budget available and financial incentives to encourage practice involvement in the programme were not found to be related to practice change. The exception to this general tendency of undetected impact was that practices supported by a facilitator with a GP background achieved a higher level of change than practices facilitated by a nurse with specialist knowledge in palliative care (clinical nurse specialist).

These findings need to be interpreted with caution. Practices participating in the national rollout (2003–2005) were early adopters. As such, they are likely to have had greater interests in palliative care and motivation to improve the quality of care than non-participating practices. The data on time input and number of visits made by facilitators represented means rather than practice-specific data, and there may have been substantial local variation that the data failed to recognize. Amongst the GPs, there were a number of Macmillan GP facilitators, which means that ‘GP background’ may have masked experience rather than reflected background-specific effects.

**Comparison with existing literature**

Papers on facilitated interventions rarely focus on the facilitation component of the intervention and generally involve a small number of facilitators. This study is unique in reporting such a wide range of naturally occurring variations from a general facilitation platform. Exploration of the effect of formal parameters of different models of facilitation (such as facilitator background, number of visits, etc.) is also scarce. We have found only a few studies exploring such relationships, as reported below.

Similarly to this study, Kinsinger et al. found no association between number of visits and a practice’s improvement in office system indicators of breast cancer screening and/or actual performance of breast cancer screening. As far as professional background is concerned, a study by Watkins et al. of an intervention to support evidence-based prescribing found no evidence that a background in pharmacy was ‘the sole key to acceptable facilitation’. Participants in their intervention considered professional background less important than group facilitation skills. In contrast, most GPs interviewed by Shipman et al. for the evaluation of the Macmillan GP facilitator programme preferred a GP facilitator to a specialist palliative care facilitator. Our findings concur with the latter study. It is plausible that GSF facilitators with a general practice background were more successful in soliciting the support of their peers, which in turn influenced the commitment to implementing the framework within the practice. Doctors’ involvement has been found to be ‘crucial and symbolic’ for a practice’s commitment to change. Further exploration of this issue is particularly pertinent in view of the current drive in the UK to recruit nurse facilitators, for instance to support research adopted by the newly established Primary Care Research Networks.

**Strengths and limitations of the study**

Evaluation of the GSF provided the context for a large-scale natural experiment in which to explore the nature and impact of different approaches to primary care facilitation. The programme rollout itself was uniquely large in terms of the numbers of practices and facilitators that participated, yet analysis of the facilitation effect was only possible for a much smaller number of facilitators and practices for whom full data were available. Nevertheless, this still remains, to our knowledge, the largest reported study on a facilitated intervention.
in primary care and the one that explores the largest number of predictor variables.

This study shares the weaknesses of most other evaluations of facilitated interventions in primary care. As the evaluation of the programme rollout was set up after the latter was under way, we were constrained in our data collection, particularly in terms of quantitative data on facilitation activities.

Another major limitation is that all participating practices were given facilitator support. Such a decision was fully justified in terms of the aims of the GSF rollout but prevented quantifying the facilitator contribution to the programme’s effect. Consequently, it was not possible to explore to what extent the differential uptake of the GSF was determined by the nature of facilitation given to practices; by contextual factors or by internal practice-related factors, including capacity for change, practice culture and commitment by members of the primary care team to engage with such a framework.4,5

Implications for future research

Research on facilitation and the evaluation of facilitated interventions need to move towards deliberate exploration of the mechanisms of effective facilitation. In light of the findings of this study and the general context of the literature on facilitation, the following research directions seem particularly important:

- quantifying the relative impact and cost of facilitation models that differ in their resource-intensiveness, e.g. individual support versus group support models or face-to-face versus indirect contact models;
- developing and evaluating tools and techniques of facilitation that, in addition to achieving the intended change, promote organizational learning; and
- placing facilitated interventions and facilitation research more firmly into the context of change management theory and research. Both the design of facilitated interventions and the theories of change management will benefit if facilitated interventions are rooted in explicit change management models, which are faithfully applied. Change management theory and research may also help articulate what aims lend themselves to being achieved through facilitator support and what dimensions of a primary care organization are most susceptible to being influenced by external change agents.

Conclusions

This study goes some way towards untangling the threads of facilitation success associated with implementation of the GSF. Further prospective research and evaluation is needed to identify ways of improving its sustainability, effect on patient outcomes and cost-effectiveness and help support facilitators in a challenging role that demands not only management and clinical knowledge and skills but also a certain ‘dash of diplomacy and pioneering spirit’.27

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