NURSING THEORY AND CONCEPT DEVELOPMENT OR ANALYSIS

Getting evidence into practice: the role and function of facilitation

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Getting evidence into practice: the role and function of facilitation

Aim of paper. This paper presents the findings of a concept analysis of facilitation in relation to successful implementation of evidence into practice.

Background. In 1998, we presented a conceptual framework that represented the interplay and interdependence of the many factors influencing the uptake of evidence into practice. One of the three elements of the framework was facilitation, alongside the nature of evidence and context. It was proposed that facilitators had a key role in helping individuals and teams understand what they needed to change and how they needed to change it. As part of the on-going development and refinement of the framework, the elements within it have undergone a concept analysis in order to provide theoretical and conceptual clarity.

Methods. The concept analysis approach was used as a framework to review critically the research literature and seminal texts in order to establish the conceptual clarity and maturity of facilitation in relation to its role in the implementation of evidence-based practice.

Findings. The concept of facilitation is partially developed and in need of delineation and comparison. Here, the purpose, role and skills and attributes of facilitators are explored in order to try and make distinctions between this role and

other change agent roles such as educational outreach workers, academic detailers and opinion leaders.

Conclusions. We propose that facilitation can be represented as a set of continua, with the purpose of facilitation ranging from a discrete task-focused activity to a more holistic process of enabling individuals, teams and organizations to change. A number of defining characteristics of facilitation are proposed. However, further research to clarify and evaluate different models of facilitation is required.

Background

In 1998, a conceptual framework was presented which, it was proposed, represented the interplay and interdependence of the many factors influencing the uptake of evidence into practice (Kitson *et al.* 1998). Developed from a number of years' experience in practice development, quality improvement and research the multidimensional framework attempts to represent the complexity of the change process involved in implementing evidence-based practice also acknowledged by other authors (Dawson 1997, Dopson *et al.* 1999, Ferlie *et al.* 1999). Theoretical and retrospective analysis of four case studies, which had been undertaken by the RCN Institute led to the proposal that implementation is explained as a function of the relation between *evidence* (research evidence, clinical experience and patient preferences), *context* (culture, leadership and measurement) and *facilitation* (characteristics, role and style). The three elements – evidence, context and facilitation – are each positioned on a low to high continuum. We suggest that the most successful implementation occurs when evidence is scientifically robust ('high' evidence), the context receptive to change with sympathetic cultures, appropriate monitoring and feedback systems and strong leadership ('high' context), and when there is appropriate facilitation of change using the skills of external and internal facilitators ('high' facilitation). The framework considers these elements to have a dynamic, simultaneous relationship and that in order to maximize the uptake of evidence into practice the evidence, context and facilitation continua need to be located towards 'high' (Kitson *et al.* 1998).

Whilst the framework appears to resonate with people's practical experiences of trying to embed new knowledge into practice, the elements of evidence, context and facilitation had not been subjected to a systematic analysis derived from literature. As McKenna (1997) argues if a concept is unclear then any work on which it is based will also be unclear. Thus, as part of an on-going process of refinement and validation and in order to provide some theoretical rigour

and conceptual clarity to the constituent elements of the framework, a concept analysis of the dimensions evidence, context and facilitation has been undertaken to determine how each influences getting evidence into practice. This paper presents the findings of the concept analysis of *facilitation*.

Introduction

Kitson *et al.* (1998) proposed that facilitators had a key role in helping individuals and teams to understand what they needed to change and how they needed to change it, in order to translate evidence into practice. This involved facilitators using a range of interpersonal and group skills to achieve the desired change. From previous case study work three sub-elements of facilitation were identified as being particularly important in influencing the uptake of research into practice, namely the personal characteristics of the facilitator, a clearly defined role and appropriate styles of working. This paper provides an analysis of the research literature in order to achieve conceptual clarity about the concept of facilitation in relation to its role in implementing evidence-based practice.

Concept analysis method

This inquiry was conducted using Morse (1995) and Morse *et al.*'s (1996) approach to concept analysis. This method is particularly relevant to the concept analysis of facilitation because it is more interpretive than the staged methods described by, for example, Walker and Avant (1995) and Rogers (1994), whose methods are located in a positivist conception of objective truth (Morse 1995) and have been criticized for de-contextualizing concepts (Morse 1995, Paley 1996). In contrast, Morse (1995) and Morse *et al.* (1996) present a process of inquiry that establishes the developmental stage or maturity of the concept(s):

...as revealed by their internal structure, use, representativeness, and/ or relations to other concepts. (1996 p. 255)

For them, concept analysis entails an assessment process using various techniques to explore the description of a concept in the literature or from observation/interview data, as opposed to the completion of specific stages described by other concept analysis authors.

Morse (1995) and Morse *et al.* (1996) suggest that ideally concepts in a discipline should be 'mature' meaning that a concept is relatively stable, clearly defined, with well described characteristics, demarcated boundaries, specified preconditions and outcomes. In contrast, if a concept is 'immature' it will be poorly understood, poorly developed and poorly explained. The aim of concept analysis is to move the concept towards maturity. In terms of our work, the concept analysis is being undertaken by an examination of the literature. Therefore, the first stage in analysis is determining the concept's level of maturity (1996). This paper presents the findings of an in-depth analysis of the concept of facilitation by describing its meaning, exploring its key features and characteristics, and reviewing research into the effectiveness of facilitation in relation to changing clinical practice.

Search strategy

This review necessarily included an analysis of a broad subject range of health care literature, as the literature relating specifically to the role of facilitation in the implementation of evidence-based practice is limited. Consequently, it focused on the use of facilitation within health care, where an explicit facilitator role was adopted to promote changes in clinical practice. Four databases were searched (Medline, Cinahl, Pyschlit and Sociofile) for papers published in English between 1985 and 1998. Key words used were: facilita, education, audit and clinical audit, quality improvement, quality assurance, change, change management, behaviour, teamwork, group work and leadership. In total 95 articles and books were included in the review. These covered the role of facilitators in: primary care, health care education, quality management and quality improvement, audit, nursing management and teamwork. Educational materials for training facilitators in standard setting and audit, concept analyses, overviews of the facilitator role and books on the theory of facilitation were also reviewed.

Characteristics of facilitation

The review indicated that for facilitation to exist as a discrete concept, certain key elements need to be in place; including a clear understanding of the facilitation process, an appropriate role (the facilitator) to enable the process, with the right set of skills to achieve effective facilitation. There are also questions about the role of facilitation in relation to alternative strategies or methods for implementation, as highlighted above, in terms of how it compares to and is both conceptually and practically distinct from other change agent strategies.

The findings of the concept analysis are structured around the following key questions about facilitation:

- What facilitation is (meaning)?
- What it is attempting to achieve (purpose)?
- Through what sort of roles and in what ways (roles, skills and attributes)?
- How does it relate to other change agent strategies?
- What evidence there is of its effectiveness?

Origins and meaning of facilitation

Facilitation has been applied in different fields and disciplines, both within and outside health care, including education, counselling, management, practice development, health promotion, action research, clinical supervision, quality improvement and audit. Kitson *et al.* (1998, p. 152) described facilitation as 'a technique by which one person makes things easier for others'. This notion of 'making easier' is also reflected in the following dictionary definition (*Oxford English Dictionary* 1989):

…to make easier, to promote, to help forward; to lessen the labour of…

Within the field of evidence-based practice, there are other strategies thought to be effective in terms of promoting individual and organizational change. These include a mixture of change agent roles and change management techniques, for example, academic detailing, educational outreach visits, audit and feedback, social influence and marketing approaches. The research evidence suggests that some of these approaches are effective in some situations and that the most effective implementation strategies are those that adopt a multifaceted approach, combining a number of the most effective roles and techniques (Oxman 1994, Bero *et al.* 1998).

In the context of this paper, facilitation refers to the process of enabling (making easier) the implementation of evidence into practice. The definitions suggest that facilitation is achieved by an individual carrying out a specific role (a facilitator), which aims to help others. This suggests that facilitators are individuals with the appropriate roles, skills and knowledge to help individuals, teams and organizations apply evidence into practice.

Purpose of facilitation

The concept of facilitation appears to have emerged from the fields of counselling and student-centred learning, influenced largely by humanistic psychology and, in particular, Rogers' (1951, 1969, 1983) seminal work on therapeutic client-centred approaches to counselling. In Roger's work and subsequent developments (see, e.g. Heron 1977, 1989, Reason & Rowan 1981, Reason 1988), facilitation refers to a process of enabling individuals and groups to understand the processes they have to go through to change aspects of their behaviour or attitudes to themselves, their work or other individuals (Marshall & McLean 1988). Hence, the focus is on facilitating experiential learning through critical reflection, dealing with psychological defensiveness and challenging cultural norms.

A similar interpretation of facilitation is apparent in some approaches to practice-based learning in health care. For example, facilitative learning approaches (including student-centred, problem based and experiential learning) have been applied within frameworks of reflective practice and clinical supervision (Barrows & Tamblyn 1980, Titchen 1987, Johns & Butcher 1993, Palmer *et al.* 1994), the aim being to challenge existing practice and support the development of new ways of working. An emphasis on experiential learning, critical reflection and changing practice cultures is also apparent in much of the literature on practice development and action research (Ward *et al.* 1998, Binnie & Titchen 1999, Jackson *et al.* 1999, McCormack *et al.* 1999). For example, in Titchen's model of facilitation described as critical companionship (Titchen 2000), clinical and facilitation expertise are developed through experiential learning. Here, the emphasis is on facilitating learning from practice and, co-creation of new knowledge through critical reflection, and dialogue between the practitioner (or learner) and an experienced facilitator (the critical companion). The role of the companion is to help individuals and groups of practitioners to use the new theoretical insights to transform self and social systems that hinder improvements in practice.

In other fields such as quality management and in some health promotion activities, the purpose of facilitation appears to be more concerned with the achievement of specific goals. This is evident, for example, in the use of facilitation methods in quality circles and total quality management (Leventhal 1984, Moore & Kovach 1988, Harvey 1993, Smith & Hukill 1994), or in some models of health promotion such as the so-called 'Oxford Model' (Fullard 1994). Here, although the emphasis of facilitation remains that of a helping process, this is more specifically focused on the achievement of tasks or goals, as opposed to exploring relationships at team and individual levels. For example, the 'Oxford Model' of facilitation was established in the early 1980s to introduce more systematic approaches to coronary heart disease prevention and was applied as a practical technique to support the establishment of systems such as health checks and screening for high-risk patients.

Other approaches have adapted the 'Oxford Model' of facilitation to support the implementation of clinical audit, with perhaps a more explicit focus on teamwork than the original approach (Hearnshaw *et al.* 1994). In a similar way to the 'Oxford Model', audit support staff have been trained to act as facilitators, applying a structured, collaborative approach to enable the completion of the audit cycle (Carroll 1994). Indeed, as the original initiatives focusing on health promotion activities have developed and expanded, there is evidence of a widening interpretation of the facilitation concept to address issues such as team-building (Baker *et al.* 1995, Loftus-Hills & Harvey 2000).

Many of the descriptions of facilitation in the literature seem to suggest the existence of 'hybrid' models of facilitation, which aim to balance the achievement of goals with the development of individuals and group processes. For example, in the Dynamic Standard Setting System (DySSSy) (RCN 1990) facilitation is identified as one of the key building blocks of a method that aims to promote the local implementation of standards and audit. The facilitation approach is adapted from Heron's model of co-counselling and aims to translate the core principles underpinning the DySSSy method (teamwork, devolved responsibility, consensus decision making and local ownership of quality improvement) into practice. Facilitation is consequently focused on two key aims, namely the achievement of specific goals (the implementation of standards and audit in practice) and the development of processes to enable effective teamwork (Morrell & Harvey 1999). Additionally, in practice development and action research there is evidence that facilitation can encompass different modes, providing a range of technical, practical and emancipatory support during the change process (Jackson *et al.* 1999, Titchen 2000, McCormack & Garbett 2001).

Overall our analysis suggests that the purpose of facilitation can vary from providing help and support to achieve a specific goal to enabling individuals and teams to analyse, reflect and change their own attitudes, behaviour and ways of working. These are not mutually exclusive and may be best represented as extreme points on a continuum of facilitation (see Figure 1). Descriptions of applying the concept indicate a combination of approaches in use, often addressing different needs at the same time. Here, examples of different approaches outlined above have been located on the continuum, in terms of where they focus particular attention (see Figure 1). As the approach
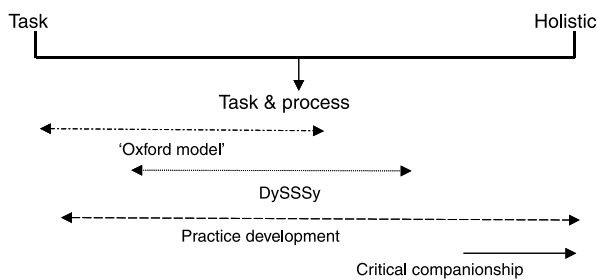
Figure 1 Characteristics of facilitation.

moves to the right, facilitation is increasingly concerned with addressing the whole situation and the whole person.

The facilitator role

Just as the purpose of facilitation appears to vary within the literature, there are also multiple interpretations of the facilitator role in practice. These range from a practical 'hands-on' role of assisting change to a more complex, multifaceted role.

In the models of health promotion which explicitly employ a facilitator, the emphasis is on external facilitators using an 'outreach' model to work with several primary health care practices, providing advice, networking, and support to help them establish the required health prevention activities (Fullard *et al*. 1984). By contrast, approaches to facilitation that are rooted in the fields of counselling and experiential learning are strongly influenced by underlying theories of humanistic psychology and human inquiry. Consequently, the facilitator's role is concerned with enabling the development of reflective learning by helping to identify learner needs, guide group processes, encourage critical thinking, and assess the achievement of learning goals. For example, in some of the reported practice development initiatives, the facilitator role is concerned with enabling cultural change in organizations, through facilitating individuals and teams to analyse and challenge current ways of working through methods of reflection using action learning and mentoring (McCormack & Garbett 2001). This often involves models of external–internal facilitation, where facilitators from outside the change setting work with identified internal facilitators, using a range of support and supervisory methods to enable the development of the internal facilitator's own skills and knowledge in managing change (Johns & Kingston 1990, Binnie & Titchen 1999, McCormack & Wright 2000).

Heron's (1989) model of facilitation incorporates facets evident in both the outreach and practice development model of facilitation. Whilst Heron emphasizes the facilitator's role in addressing issues of feelings within the group, confronting

resistance and giving meaning to group discussions, he also acknowledges their role in planning and structuring the task. In performing the role, Heron suggests that facilitators operate in different ways at different stages, according to the group's needs and stage of development. This may require the facilitator working in either a directive, co-operative or nondirective way in any given change process.

It appears, therefore, that the operationalization of the facilitator role depends upon the underlying purpose and interpretation of the facilitation concept. Where the primary purpose of facilitation is to achieve set tasks or goals, the role is largely concerned with providing practical help and support. However, where facilitation is focused more broadly on developing and empowering individuals and teams, there is at least an equal emphasis on the development of a helping (enabling) process or relationship.

The central focus of the facilitator role has a corresponding influence on the level and amount of support provided by the facilitator. It also determines the number of sites or organizations (coverage) they can work with and the level of operation (individual, team or organizational). For example, facilitators operating in an 'outreach' model typically work across a large number of organizations, whereas facilitators supporting a practice development initiative may be appointed to work full-time within a specific setting (for example an organization, unit or ward) for a set period of time (Binnie & Titchen 1999, McCormack & Wright 2000). It also follows that facilitators who are attempting to improve group processes and change existing cultures require a longer, more intensive period to achieve their purpose.

In summarizing the literature of facilitator roles, it appears that a broad distinction can be made between a facilitator role that is concerned with 'doing for others' and a role whose primary emphasis is on 'enabling others' (Loftus-Hills & Harvey 2000). The 'doing' role is likely to be practical and task-driven, with a focus on administrating, supporting and taking on specific tasks where necessary. In contrast an 'enabling' facilitator role is more likely to be developmental in nature, seeking to explore and release the inherent potential of individuals. In reality, many approaches contain elements of both these characteristics. Again, the range of apparent roles can be presented along a continuum as illustrated in Figure 2.

Facilitator skills and attributes

A diverse range of skills and personal attributes are reportedly required to perform an effective facilitator role (RCN 1990). This hardly seems surprising given the possible
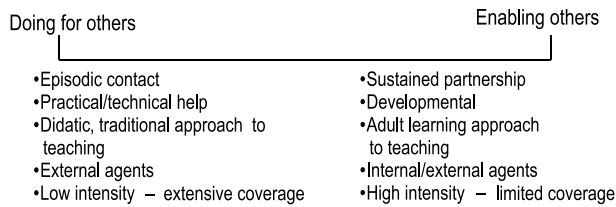
Doing for others ——————————— Enabling others

- Episodic contact
- Practical/technical help
- Didatic, traditional approach to teaching
- External agents
- Low intensity – extensive coverage

- Sustained partnership
- Developmental
- Adult learning approach to teaching
- Internal/external agents
- High intensity – limited coverage

Figure 2 Role of facilitators.

Task/doing for others ——————————— Holistic/enabling

- Project management skills
- Technical skills
- Marketing skills
- Subject/technical/clinical credibility

- Co-counselling
- Critical reflection
- Giving meaning
- Flexibility of role
- Realness/authenticity

Figure 3 Skills and attributes of facilitation.

myriad of purposes and roles the concept of facilitation might encompass. However, there appears to be little concrete evidence in the literature as to the mix and relative importance of the different skills needed for the successful performance of the facilitator role. Generally, it seems that a mixture of personal attributes and personal, interpersonal and group management skills contribute to the development of effective facilitation. Table 1 illustrates this point by summarizing the skills and attributes that have been identified from studies applying facilitation in three different activity areas.

Just as there is little evidence to indicate the relative importance of the different skills and attributes needed for effective facilitation, there is also little clarity about how facilitation skills are developed and refined. From the work reported to date, it appears that most facilitators develop their skills and styles of working through an experiential process (Harvey 1993, Loftus-Hills & Harvey 2000). These experiential processes can be either informal (for example, a process of trial and error), or more formal and structured (for
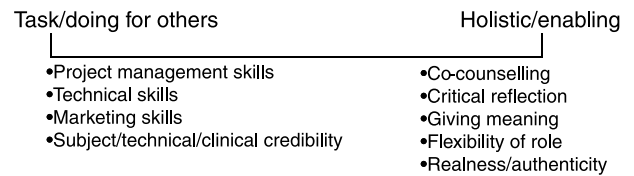
example, through models of critical companionship or external-internal facilitation (Titchen 2000). There is also some evidence that facilitators move from a more direct support role towards a more enabling one as their skills and confidence develop (Harvey 1993).

Whilst there are core skills, such as interpersonal and communication skills that are believed to be a prerequisite requirement of any facilitator role, it appears that to be effective, facilitators require a tool kit of skills and personal attributes that they can use depending on the context and purpose. In cases where the purpose of facilitation is to achieve a specific, task-driven goal, the skills and qualities used would be different from those required to achieve longer term developmental goals, as illustrated by the proposed continuum (see Figure 3). Arguably however, the expertise could be in having the flexibility to be able to recognize the requirements of an individual situation. This may mean drawing on a combination of skills and qualities in the course of any change process.

Table 1 Skills and attributes required to be an effective facilitator

'Oxford' prevention model	Quality improvement – DySSSy	Practice development
Allsop (1990)	Morrell *et al.* (1995)	McCormack and Garbett (2001)
Supplying technical or clinical advice	Empowering clinicians	Being pragmatic
Networking	Recognition of other's skills and abilities	Risk taker
Offer suggestions	Local credibility	Belief in the worth and value of people
Formulate solutions	Highly developed communication skills	Patience
Help shift attitudes		Commitment
Political skills	Harvey (1993)	Having vision
Vision	Knowledgeable and up- to-date	Being motivated
Energy	Innovators	Being empathetic
Fullard (1994)	Help with group dynamics	Experiential
Catalyst for change	Understanding the system	Titchen (2000)
Resource agent	Lateral thinking	Attending to whole person through use of self
Helping hand	Sensitive	Facilitating:
Teambuilding	Good communicator	– cognition, meta-cognition, intuition and their interplay
	Allowing people to learn by their own processes	– use of different kinds of evidence
		– particularization of research findings
		Ability to create an environment of high support and high challenge

Clarity between facilitation and other change agent roles and strategies

Recent research has highlighted that human sources of information are seen as influential because they provide relevant, prescriptive, clinically focused messages for practice, tailored to the context of individual decision situation and presented in a language that clinicians can understand (Thompson *et al.* 2001a, 2001b). Similarly our concept analysis has found that facilitation is a process that depends upon a person carrying out the role of the facilitator, with the appropriate skills and knowledge to enable changes in practice. However, there are a number of other change strategies that similarly depend on a person-led intervention to support the change process. Those commonly reported in the literature include educational outreach visits (sometimes referred to as academic detailers) and local opinion leaders.

Educational outreach visits are defined as the use of a trained person who meets with providers of care in the practice setting to give information with the intent of changing the provider's practice (Oxman 1994). This may include the use of a range of educational and social marketing approaches. In contrast, local opinion leaders are individuals who are viewed by their colleagues as 'influential' (either positively or negatively) in relation to the proposed change and who are able to exert influence on their colleagues to change by setting an example, providing education and creating new norms (Oxman 1994, Locock *et al.* 2001). Examples of using both approaches are reported in the literature on implementing research into practice (Avorn & Soumerai 1983, Lomas *et al.* 1991, Soumerai *et al.* 1993, Davis *et al.* 1995). Systematic reviews of the effectiveness of different intervention strategies suggest that educational outreach visits can be effective, although there is insufficient evidence to assess the impact of local opinion leaders (Bero *et al.* 1998).

The question arises, however, as to how and whether facilitation is conceptually discrete from the change agent strategies described as educational outreach and local opinion leaders. Certainly, elements of the educational outreach visit approach are evident in some of the facilitation models studied in the concept analysis, for example, Fullard *et al.* (1987) and Cockburn *et al.* (1992). In their review, Bero *et al.* (1998) comment specifically on the lack of a common approach across different studies to of how particular interventions are categorized, which makes the process of reviewing the effectiveness of roles across a number of studies highly complex.

One distinction between the different roles may be whether the change agent is working internally or externally to the environment in which the change is being implemented. For example, facilitators can be external or internal to the organization, whereas opinion leaders are often internal and educational outreach workers (or academic detailers) tend to be external. There are also other aspects 'peculiar' to a role, for example, academic detailers tend to use marketing principles, techniques and materials to reinforce their message, an approach not explicitly acknowledged as part of a facilitator role. Additionally, some facilitators explicitly focus on the need to address and develop organizational systems and culture, whereas this is not a primary concern of the role of an educational outreach worker, academic detailer or opinion leader. Overall, however, the distinction between the facilitator role and that of other change agents, in particular educational outreach workers, is far from clear.

Effectiveness of facilitator intervention

Just as studies are reported that address the impact of intervention strategies such as educational outreach visits and academic detailing, a number of studies also attempt to evaluate the application of facilitation in health care, although the majority of these do not focus specifically on the implementation of evidence into practice. These include feasibility studies to assess the extension of a particular facilitation approach, intervention studies to test the effectiveness of a facilitation method or role and qualitative studies to explore the facilitation process and facilitator roles. Studies also vary as to whether they study patient or practice outcomes. Again, findings reflect the diverse way in which facilitation has been conceptualized and applied, making it difficult to draw meaningful conclusions about the efficacy of a facilitator intervention.

A number of feasibility studies have been reported which evaluate the wider applicability of the 'Oxford Model', both to other health care settings and other countries than the United Kingdom (UK) (Alexander & Harrison 1990, Crotty *et al.* 1993, McBride & Moorwood 1994, Schol & Goelen 1996). Although each of these studies conclude that the role of the facilitator was useful, and some that it should be extended, there is little overlap across the studies in terms of the specific application of the facilitator role. For example, facilitation is interpreted in a number of different ways and the level and intensity of facilitator support varies widely. As a result, it is not possible to isolate which, if any, dimensions of the concept are effective in promoting and supporting change.

Table 2 Included studies of effectiveness of facilitator intervention

Study	Study method	Intervention	Results	Type of facilitation
Cockburn *et al.* (1992) Australia	RCT	Short personal presentation by an educational facilitator with a follow-up visit 6 weeks later. Aimed to improve the use of a smoking cessation kit by GP's	Intervention group were significantly more likely to believe that the kit was less complicated and reported more knowledge on how to use it. Yet the intervention failed to produce sufficient benefit to justify the cost	Task focused External facilitation Two visits Education and follow-up
Fullard *et al.* (1987) UK	RCT	Facilitators introduced a screening package, provided training to the staff, and offered continuing support and advice	The intervention group had significantly more documented recordings of blood pressure, smoking habit and weight	Task focused External facilitation Educational visit and support to set up systems Ongoing support and advice
Dietrich *et al.* (1992) USA	RCT	Physician education and a facilitator assisted office system intervention to improve the early detection of cancer. Each practice was visited three times over 3 months	The office assisted facilitator groups showed an increase in a whole range of screening and advice giving activities while the education was only associated with an increase in mammography	Task focused External facilitation Three visits over 3 months Support to establish routines for specific services
Szczepura *et al.* (1994) UK	RCT	Three forms of information feedback: tabular, graphical (management awareness profiles) and graphical plus an educational visit from a medical facilitator	The three forms of feedback did not differ in intelligibility or usefulness but feedback plus a medical facilitator was significantly less acceptable to practitioners	Task focused External facilitation Single visit Feedback and discussion of audit results
Hearnshaw *et al.* (1994) UK	Small RCT	Facilitated structured teamwork of primary health care teams to enable them to conduct multidisciplinary audit	The intervention had a positive effect on the introduction of effective, multidisciplinary audit	Mostly task focused using a structured facilitation approach; some focus on team functioning External facilitation Repeated visits over a 5-month period Range of methods, e.g. didactic presentation, small group and individual work
Hulscher *et al.* (1997) Netherlands	Non randomized control trial	Intensive outreach visits by a trained nurse facilitator to improve the organization of services to prevent cardiovascular disease. Included offering support, repeating messages, involving the practice team, conducting audits and providing feedback	Found a significant increase in the number of practices in the intervention groups adhering to established guidelines	Task and holistic focus External facilitation Repeated visits over a period of time Multiple methods in use, including audit and feedback, education and teambuilding

Table 2 (Continued)

Study	Study method	Intervention	Results	Type of facilitation
McCormack and Wright (2000), UK	Before and after study	Evaluated the impact of the utilization of an external facilitator who worked with the ward managers and staff using a range of approaches including action plans, support of an internal facilitator, action learning circles and role modelling	The pre/post evaluation revealed that the ward had moved from providing ritualized and routinized 'poor' practice to more patient-centred, responsive care e.g. action learning, role (compared to the control)	Holistic focus External/internal facilitator model Continuous presence over a prolonged period of time Enabling methods in use, modelling, action planning

The studies in this table have all been subject to critical appraisal and included based on the results of this process.

A similar picture emerges when studies of the effectiveness of facilitator intervention are examined (see Table 2).

Again these evaluative studies vary considerably in their interpretation of *facilitation*, leading to marked differences in the intervention and the type of facilitator roles being evaluated. For example, in the study reported by Hulscher *et al.* (1997), facilitation is interpreted as a multifaceted, intensive approach, with the facilitator using a range of interventions such as audit and feedback, education, support, advice and team building. By comparison, in the study undertaken by Cockburn *et al.* (1992), facilitation is largely interpreted as an exercise in education and persuasion, with the facilitator intervention comprising a personal presentation and follow-up visit to the general practitioner to encourage them to make use of smoking cessation kits. In these two studies, the intensity of the facilitator intervention varied considerably, ranging from an average of 25 visits over an 18-month period in the former to an initial visit lasting an average of 12·8 minutes in the latter.

Other studies have examined the facilitator role using qualitative research methods often as part of a wider study (Harvey 1993, Binnie & Titchen 1999, Loftus-Hills & Harvey 2000). Binnie and Titchen (1999) report on practice outcomes whereby distinctive facilitator roles and strategies worked effectively in achieving structural, cultural and practice changes necessary to create a patient-centred service. Titchen (2000) research suggests that an external critical companion enabled nurses to become more patient-centred, more critical thinkers and to use different types of evidence in their practice.

In summary, the findings of the evaluative studies suggest that the presence of a facilitator who provides face-to-face communication and uses a range of enabling techniques has some impact on changing clinical and organizational prac- tice, although the effect size is variable and associated with differing costs (Loftus-Hills & Harvey 2000). However, it is difficult to isolate which aspects of the facilitation process or the facilitator role are more or less effective in influencing change.

Discussion and conclusions

The body of literature about the role of change agents is considerable. Despite this, there are few explicit descriptions or rigorous evaluations of the concept of *facilitation*. What exists are multiple perspectives and interpretations and therefore according to Morse *et al.*'s criteria the concept is partially developed but in need of delineation and compar- ison which necessarily involves more research. Currently this is difficult because of the various ways facilitation has been described and studied, often encompassing elements of other change agent strategies, in particular educational outreach. Such differences need to be made explicit in study methods and subsequent reporting.

The working definition of facilitation which has emerged from this concept analysis builds on that reported in 1998 (Kitson *et al.* 1998). The analysis reinforces the view that the facilitator role is about supporting people to change their practice. It also helps to clarify further some defining characteristics of facilitation that could help to distinguish it from other change agent strategies. Namely,

- it is an appointed role as opposed to that of, for example, an opinion leader who through their own personal repu- tation and influence acts as a change agent;
- this role may be internal or external (or encompass a combined internal/external approach) to the organization in which the change is being implemented;
- the role is about helping and enabling rather than telling or persuading;

- within the concept of helping/enabling, the focus of facilitation can encompass a broad spectrum, ranging from the provision of help to achieve a specific task to using methods which enable individuals and teams to review their attitudes, habits, skills, ways of thinking and working;
- given the broad focus of the facilitation concept, a wide range of facilitator roles are possible, with corresponding skills and attributes needed to fulfil the role effectively.

However, questions could still be raised about the extent to which facilitation is different from strategies such as educational outreach visits, which also depend on an appointed role to help and support the change process. One possible distinction might be that the role and methods employed in the educational outreach model do not cover as broad a spectrum of interventions as those described within the concept of facilitation. Indeed, it could be argued that the facilitation model described at the left-hand side of the proposed continua, where facilitation is a task-focused activity that uses a distinct set of structured methods to provide support and advice, is conceptually the same as the educational outreach model.

This in turn may raise questions about whether the entire proposed continuum represents the concept of facilitation or whether facilitation as represented by the right-hand side of the continua presents something conceptually different from other change agent strategies. In other words, facilitation is an intervention with a holistic purpose, which employs a range of enabling roles and skills. Alternatively, it could be suggested that to function effectively, facilitators need to be able to move along the whole range of the continua, depending on the needs of the situation and the change to be implemented. This implies that effective facilitators need to be flexible and possess a range of both task-focused and enabling skills, which are employed according to the needs of the context or environment in which they are working. In relation to the conceptual framework (Kitson *et al.* 1998) therefore 'high' facilitation would be where a specific facilitation intervention is employed that is appropriate to the needs of the particular change situation (see Figure 4).

These are obviously complex issues and the lack of clarity evident shown by the concept analysis does not allow us to draw definitive conclusions at this stage. Questions also remain about how and in what situations change can be sustained. Clearly the research agenda is large. In relation to facilitation generally, there is a need to evaluate the effectiveness of different models in order to inform our understanding of how they impact on getting evidence into practice. It is still unclear, for example, whether a 'task, doing for others' approach is as effective as a 'holistic, enabling' approach and in what contexts. Given that there is
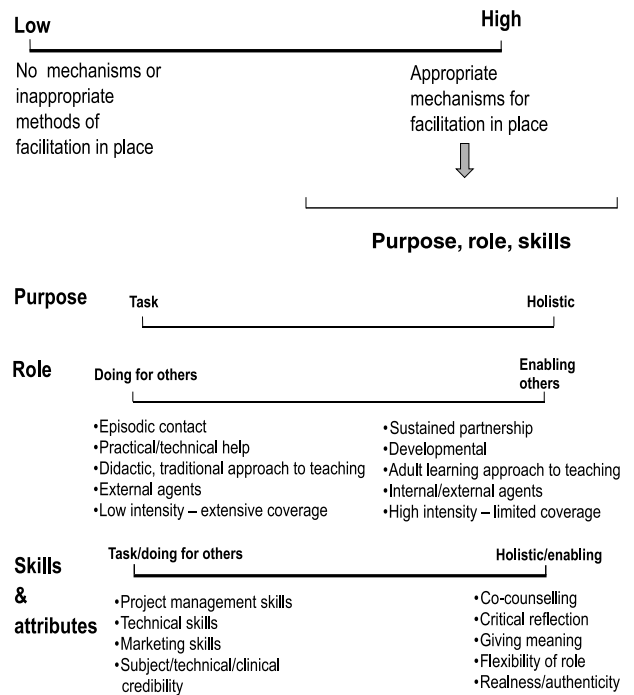

Figure 4 Characteristics of facilitation.

research to suggest that practitioners do not apply research findings via a simple deductive process, but need time to think, translate and particularize research findings (Dawson 1997, Dopson *et al.* 1999, Titchen 2000), an approach that enables these to occur may have a greater impact than one which does not. Equally, however, there is evidence (Deitrich 1994) that in certain circumstances, such as in an overstretched service, the task orientated, practical approach is effective. These complexities and issues highlight the importance of and need for further research and will continue to be explored in the on-going development and testing of the conceptual framework.

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