

Facilitation (1, 2)

AH-TRIP stands for Allied Health Translating Research into Practice. In this session we hope to give you an overview of facilitation which can be an important implementation strategy.

In its most basic form facilitation is the act of making something easier.

‘Facilitate (*verb*): To make easier’

In the case of the implementation project, it is a process which relies on a designated role that encourages others to reflect upon current practice, introduce the idea of change, and enable knowledge sharing to work towards a shared goal of improving outcomes or service provision

Facilitation is needed because having a good idea or strong evidence alone is not enough to influence and bring about change; especially when the change is complex. The iPARIHS framework lists facilitation as the active ingredient or active agent in implementation to actively facilitate the innovation with the recipients in the inner and outer contexts.

$$\text{Successful Implementation} = \text{Fac}^n (I + R + C)$$

Implementing a complex intervention requires time to reflect on the problem or current practice for people to know that change is required and identify potential solutions however as clinicians we often don't get time to step back from their everyday practice and reflect



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In complex systems such as health care settings, there are often challenges with communication between multiple departments, wards or disciplines – and this is needed to solve complex problems. There can be marginalized groups e.g. patients, assistants/operational staff, nurses, who can find it challenging to have input into implementation projects, often end up getting told what they are doing or having done to them,

It is not uncommon for there to be different priorities and goals between or grouped involved in or affected by an intervention, and if these aren't agreed on early on in the piece, this can affect progress.

Facilitation aims to enable people and groups to develop and implement changes to behaviors, systems and routines; by ensuring that everyone is able to participate in this process, have open communication and to help the group work together as a team;

Facilitation is NOT doing. It is often easier to get in there and started doing. The change might occur quicker but this makes the intervention rely upon the facilitator and not owned or implemented by the team, which is likely to impact on sustainability. Instead, facilitators enable the group to develop and trial their own changes to practice, even when we think or know they won't work; The goal is for the group to work that out and for the facilitator to then help them to reflect on why it did or didn't work and to explore alternative strategies.

Facilitation is NOT telling. It is not about coming to a group with a set intervention or toolkit and telling them what they will be doing and how to do it.

Facilitation is NOT coercing, persuading, deciding. Sometimes there needs to be some influencing skills to help people to see alternatives, but as I said earlier, the facilitator doesn't decide the strategies to trial, the facilitator helps the team decide what strategies to try, so there is shared decision making.

And finally, facilitation is NOT directing or managing. Facilitators don't set the goals and manage the project to meet the KPIs or targets; a facilitator supports the group with the process of setting goals. Project management skills are needed, to keep things on track, make sure groups meet, data is collected etc. But this is not at the expense of the process.

Here is scenario to demonstrate what a facilitator is and does, compared with other roles that might be seen in a project: typical project manager, a champion, and a do-er. It sounds simple in practice but let's explore a facilitator role in more detail using the example used earlier about a new extended scope of practice role. Local data has confirmed that there is a substantial delay in a specific patient group accessing treatment from medical officers, and a new allied health extended scope role has been identified as the intervention to overcome this problem.

A project manager would approach this situation by convening a meeting with key stakeholders, presenting the group with a draft role description and pathway for referral and assessment to the new extended scope role, and seeking feedback on these from the team. They would educate all staff on the new role and pathway and set a launch date. They'd schedule regular audits and report back to the group on progress, and continue to meet with the team for updates and feedback until project completion.



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Does this scenario sound typical of how projects are conducted in your workplace? From what I've already said about facilitation can you see how a facilitator might approach this slightly differently?

Here is what a facilitator might do, you can see some of the "soft skills" of facilitation come through here. A facilitator might identify and engage the people involved in the change in the first instance, spending time working out exactly who needs to be in a workgroup, and finding out what they think about the extended scope role in individual conversations before the meeting so they have an understanding of their individual goals, priorities, viewpoint etc

Instead of the first meeting being about presenting the solution, it is focused on reflecting on the problem and local practice (so unpicking why there are long wait times, what does this mean for patients and staff), with the goal of enabling the group to come to a shared vision of what success might look like, and start conversations about how they might start working towards that.

Rather than the audits being compliance or outcome focused, they would be an opportunity to reflect on progress and identify whether additional strategies should be trialled to get the intervention in place. So for example, if administrative data shows issues with patients declining their allied health appointment in favour of waiting for a specialist medical officer, it might be important to talk to patients to understand why this is occurring and what could be trialled to overcome this.

There would still be regular meetings with the workgroup, but these would be again be focused on reflecting on the progress of implementation of the intervention.

And finally, a key difference between a facilitator and other roles is centred around reflection on their own progress and role, debriefing with others about what is and isn't working, and changing their approach based on the context and the people involved.

A do-er might emerge where the facilitator is also a clinician within the unit, and progress isn't being made despite their best efforts. They are having trouble engaging people in change and the project deadline is looming. In response to this, they might start taking on new roles themselves to ensure that appropriate care is delivered. For example, if there are issues with staff appropriately referring patients into the new clinic, the do-er might take on this triaging role to ensure this part of the process happens,) so that project outcomes are achieved. The problem with this is that the implementation relies on the do-er, which is risky for the longer-term sustainability of the role.

Finally, champions are those individuals, those few gems, that make the facilitators life easier. They are the enthusiastic individuals from within the unit who voluntarily take a special interest in the project. So perhaps there is a medical officer who can see real potential in the new allied health role. These are the people that the facilitator needs to keep their eyes and ears open for, to be-friend, and empower.

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Champions are different to facilitators – they may only have influence over their own patch; they don't have dedicated time for the project so can't do all that is needed to get a project off the ground. Champions are your cheerleaders, so engage them, build their confidence, give them the info that you want spread throughout the team, but take care that they don't become do-ers, otherwise you risk the intervention becoming them which is only sustainable as long as they are around.

Based on what I've said about facilitators, have a think about what skills or attributes might be needed for this. If you like, take some time now to write these down, and reflect on someone you know who is a good or not so good facilitator and why.

Here are some of the attributes and skills of a good facilitator. When you think about the key functions of a facilitator being enablement, participation and communication, shared power and decision making about shared goals, you can see why some of these attributes and skills are important. Being a good listener, being reciprocal, having credibility and being a good networker are important attributes. For me, genuine curiosity is key, wanting to really understand why and how things work, and being able to keenly observe and keep asking questions to get to the bottom of an issue is important. Patience and resilience cannot be understated; change takes time and it is hard, and it is important to be able to accept this is part of the process and keep chipping away at things, or getting back up when things have not gone well.

There are resources available to help those working in facilitator roles. We particularly like the book called *Implementing Evidence-Based Practice in Healthcare: A Facilitation Guide* by Harvey and Kitson. However, there is only so much you can do by reading. Facilitation is a learned skill, and can only be done by doing, reflecting and learning. It's unlikely that you can do facilitation on your own– a new facilitator needs support from other more experienced or expert facilitators, this can help to develop reflective skills to improve the facilitation process and learn from the journey.



References

1. Harvey G, Kitson A. Implementing Evidence-Based Practice in Healthcare: A facilitation Guide. New York Routledge; 2015.
2. Harvey G, Lynch E. Enabling continuous quality improvement in practice: the role and contribution of facilitation. *Frontiers in public health*. 2017;5:27.