

Title: Facilitation of an end-of-life care programme into practice within UK nursing care homes: a mixed-methods study

Short Title: Facilitation of end-of-life care into practice

Abstract

Background: The predicted demographic changes internationally have implications for the nature of care that older people receive and place of care as they age. Healthcare policy now promotes the implementation of end-of-life care interventions to improve care delivery within different settings. The Gold Standards Framework in Care Homes (GSFCH) programme is one end-of-life care initiative recommended by the English Department of Health. Only a small number of care homes that start the programme complete it, which raises questions about the implementation process.

Aim: To identify the type, role, impact and cost of facilitation when implementing the GSFCH programme into nursing care home practice.

Design: A mixed-methods study.

Setting: Nursing care homes in south-east England.

Participants: Staff from 38 nursing care homes undertaking the GSFCH programme. Staff in 24 nursing care homes received high facilitation. Of those, 12 also received action learning. The remaining 14 nursing care homes received usual local facilitation of the GSFCH programme.

Methods: Study data were collected from staff employed within nursing care homes (home managers and GSFCH coordinators) and external facilitators associated with the homes. Data collection included interviews, surveys and facilitator activity logs. Following separate quantitative (descriptive statistics) and qualitative (template) data analysis the data sets were integrated by 'following a thread'. This paper reports study data in relation to facilitation.

Results: Three facilitation approaches were provided to nursing home staff when implementing the GSFCH programme: 'fitting it in' facilitation; 'as requested' facilitation; and 'being present' facilitation. 'Being present' facilitation most effectively enabled the completion of the programme, through to accreditation. However, it was not sufficient to just be present. Without mastery and commitment, from all participants, including the external facilitator, learning and initiation of change failed to occur. Implementation of the programme required an external facilitator who could mediate multi-layered learning at an individual, organisational and appreciative system level. The cost savings in the study outweighed the cost of providing a 'being present' approach to facilitation.

Conclusions: Different types of facilitation are offered to support the implementation of end-of-life care initiatives. However, in this study 'being present' facilitation, when supported by multi-layered learning, was the only approach that initiated the change required.

Background

The predicted demographic changes internationally have implications for the nature of care that older people receive and place of care as they age. By 2050, 22% of the global population will be 60 years or over (Rutherford, 2012). With 80% of all deaths occurring in people aged 65 years or older, usually from serious chronic diseases, all countries should consider how they meet the increasing need for care in that population (Costantini and Lunder, 2012). Recently, the Organisation for Economic Co-operation and Development (OECD) stated: ‘Population ageing has increased the demand for long-term care, with spending increasing more than for any other type of health care’ (OECD, 2017:11). That statement highlights the importance of planning cost-effective care provision for future populations. Low levels of palliative care delivery in care homes has led to countries being encouraged to share examples of initiatives that improve palliative care delivery in long-term care settings (Froggatt and Reiting, 2013; Froggatt et al., 2017).

Using the UK as an example, annual deaths in England and Wales have been predicted to increase from 501,424 in 2014 to 635,814 in 2040 (Bone et al., 2017). It has also been predicted that by 2040 the most common place of death will be in a care home (Bone et al., 2017). It is, therefore, not surprising that English healthcare policy is promoting the implementation of end-of-life care interventions in the care home setting (Department of Health, 2008). That is of particular importance for a nursing care home where 56% of residents currently die within a year of admission (Kinley et al., 2014a).

Whilst end-of-life care delivery has been a feature of English and UK policy for the last 50 years (Fallon and Smyth, 2008), it was only formalised in England in 2008 with the publication of the *End of Life Care Strategy* (Department of Health, 2008). That resulted in the promotion of end-of-life care interventions at a national level. However, national policies provided little guidance about potential outcomes or how to translate recommendations into practice (Department of Health, 2008; National Palliative and End of Life Care Partnership, 2015). To date, the process by which high-quality end-of-life care is implemented has been variable and driven by local interpretation and commissioning criteria. Therefore, although end-of-life care in the UK has received international acclaim (The Economist Intelligence Unit, 2015), and continues to be nationally driven, policy implementation within care settings varies from one locality to another.

A number of programmes are available to support the delivery of end-of-life care in care homes (The End of Life Partnership, 2017; Kinley et al., 2017). However, the Gold Standards Framework in Care Homes (GSFCH) programme was the specific end-of-life care initiative recommended by the Department of Health (2008). It is a three-phased, system-based organisational approach to optimising the provision of end-of-life care (Gold Standards Framework (GSF) Centre CIC, 2011) (*Table 1*).

Table 1: Phases and core components of the Gold Standards Framework in Care Homes (GSFCH) programme

Phases of the GSFCH programme	Activities and purpose within each phase
Preliminary phase	<p><i>Activities:</i> The care home managers hold internal meetings for staff, family and residents to inform them about the GSFCH programme. Letters about the GSFCH programme are sent to residents, families and external healthcare professionals, including the general practitioner and specialist palliative care service.</p> <p><i>Purpose:</i> Awareness of the GSFCH programme is established both within the care home and between the care home and external professionals.</p>
Implementation phase	<p><i>Activities:</i> Four workshops are held to which nominated care home staff (known as the GSFCH coordinators) attend and who then take responsibility for implementing the programme back in their respective care homes.</p> <p><i>Purpose:</i> The GSFCH coordinators are encouraged to translate the information provided at the workshops into standard practice within their specific care home.</p>
Consolidation phase	<p><i>Activities:</i> A file of evidence is compiled pertaining to 20 specified standards to evidence the implementation of the GSFCH programme into daily practice. The portfolio is then submitted to the central GSF team to be assessed for GSFCH accreditation.</p> <p><i>Purpose:</i> To complete the programme and become an accredited GSFCH. As the care home staff work towards accreditation the principles of the GSFCH are embedded in the care home culture. The portfolio enables the NCHs to evidence that they are providing, ‘... <i>the right care, for the right person, in the right place, at the right time...everytime</i>’ (GSF Centre CIC, 2012a).</p>
Source: Gold Standards Framework Centre CIC (2011)	
Core component of the GSFCH programme	Activities and purpose of each core component
Coding meetings	<p><i>Activities:</i> Monthly review meetings are established, within the NCH, where all residents are discussed. Each resident is coded according to the time that staff feel they have to live (‘A’ = years, ‘B’ = Months, ‘C’ = weeks and ‘D’ = days).</p> <p><i>Purpose:</i> The code then shapes the care individual residents require. External healthcare professionals are encouraged to attend. It additionally provides time for teaching, learning and staff support.</p>
After Death Analysis	<p><i>Activities:</i> This involves reviewing deceased residents’ records, extracting specific details relating to their end-of-life care and reflecting on the death of the resident. It is undertaken at the start of the GSFCH programme, after the workshops and as they start accreditation.</p> <p><i>Purpose:</i> It acts as an audit tool to enable the NCH staff to review the end-of-life care they provided to a specific resident and learn from it.</p>
Significant Event Analysis	<p><i>Activities:</i> Reflection occurs on issues that cause concern, or after the death of a resident, with completion of specific documentation.</p> <p><i>Purpose:</i> It enables the NCH staff to review and learn from practice.</p>

Completion of the GSFCH programme occurs when the care home becomes accredited. At the time of the current study (2012), there were 17,808 care homes in England. Of those, 2,500 care homes had undertaken the programme. With 328 listed as accredited, the national average of care homes gaining accreditation, at that time, was no greater than 13% (GSF Centre CIC, 2012a,b). Accessing and implementing the GSFCH programme requires significant resources. In light of the current economic climate the low number of care homes completing the GSFCH programme through to accreditation raises questions about how the programme is facilitated.

Support from an external facilitator to care homes implementing the GSFCH programme is recommended by those who developed the programme (Thomas et al., 2005) and who have evaluated it (Clifford et al., 2007). However, it has never been a prerequisite to a care home starting the programme. As external facilitators are not employed by the GSF central team there is: no agreed model of best practice; little evidence about how facilitation of the programme should be provided; no knowledge of what such provision costs or how it could be funded; and limited evidence of outcomes that result from its provision. It is known that the level of facilitation required when implementing change into practice is influenced by both context and evidence (Kitson et al., 1998). Although previous research studies took that into account and identified that high facilitation in the care home setting was important, the specific format of facilitation was not identified (Hockley et al., 2010). As a consequence, where facilitation of the GSFCH programme is provided, different approaches exist.

In 2008, the GSF central team commissioned a regional training centre to provide a yearly GSFCH programme. A Care Home Project Team was established at the regional training centre specifically to provide facilitation for the GSFCH programme. With no evidence to guide the model of GSFCH facilitation, two studies (a cluster randomised controlled trial (CRCT) and a mixed-methods study) were undertaken to evaluate different levels of facilitation.

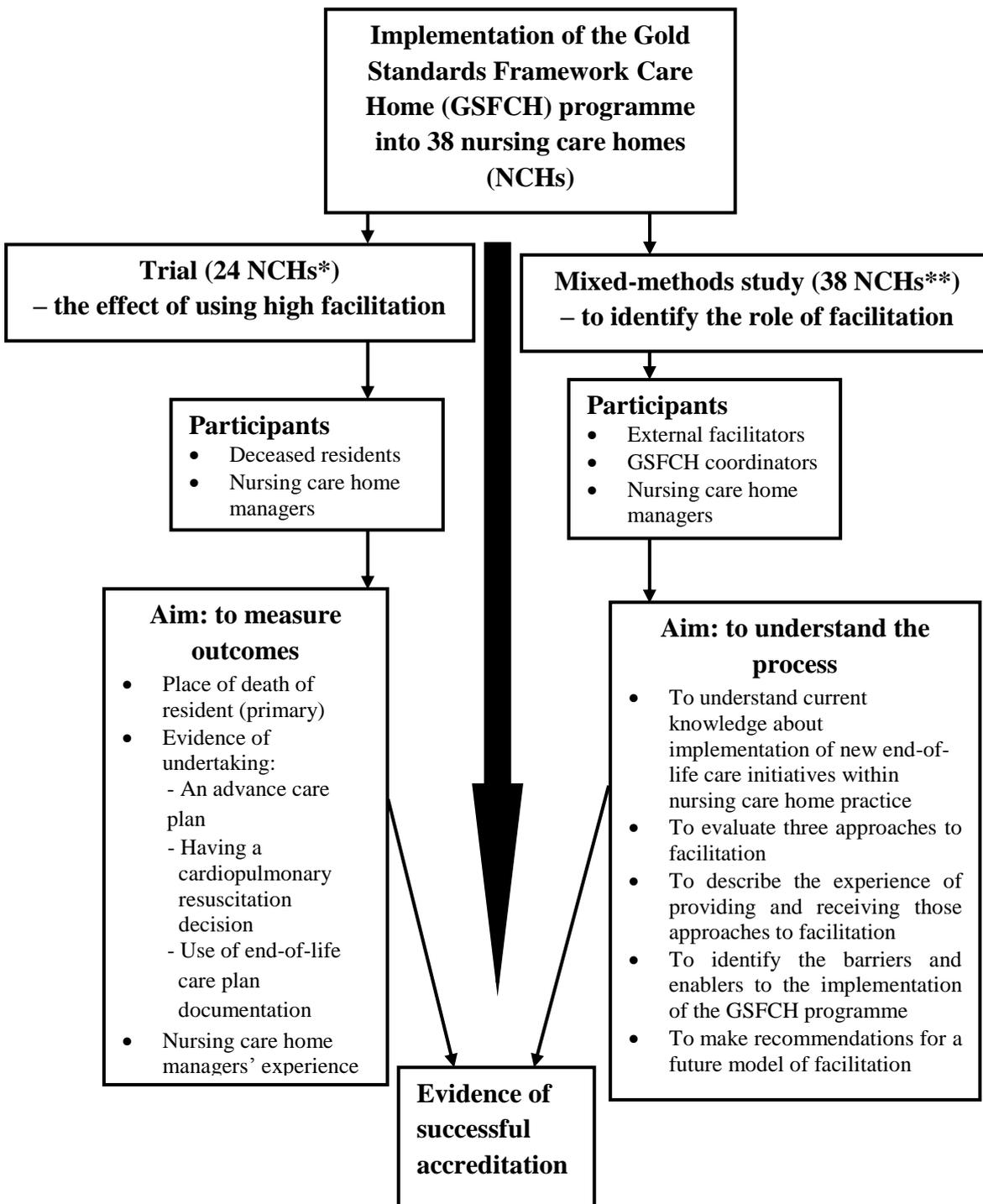
The results of the CRCT have been published elsewhere (Kinley et al., 2014b). That study examined the effect of using high facilitation. It compared two approaches: high facilitation (*HF*) and high facilitation and action learning (*HF+AL*). All 24 nursing care homes (NCHs) that took part in the trial were provided with structured *HF*, which included the appointment of at least two GSFCH coordinators in each home who attended a four-day training programme (Macmillan Cancer Relief, 2011). In addition, during the first year, an external facilitator visited the NCH two to three times a month and in the second year provided a local sustainability network (Kinley et al., 2014b).

During the visits facilitation was provided to enable learning in a variety of formats, i.e. individually to GSFCH coordinators and organisationally in group format, such as at 'coding' meetings, where information about residents was discussed. In addition, 12 of the 24 NCH managers attended nine monthly three-hour action-learning sets. The facilitated action-learning sets provided an opportunity to learn across the care home system, from one home to another, to develop practice through '... a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done' (McGill and Beaty, 2001:11)

A third group ($n=14$) of NCHs had paid to undertake the GSFCH programme but were located out of the immediate regional training centre area. That group received the external facilitation available in their individual localities (local facilitation). They were not part of the

trial, but the same data were collected from them. The CRCT was completed and the results demonstrated a significant association between the type of facilitation provided and the NCHs' completion of the GSFCH programme through to accreditation (Kinley et al., 2014b).

Whilst the CRCT highlighted outcomes it did not show how they were achieved and the role that facilitation played. Undertaking a mixed-methods study alongside the CRCT enabled that aspect of the implementation of the intervention to be explored. It was commenced in 2010, independent from, but embedded within, the trial (*Figure 1*) and was undertaken to consider the role rather than the effect of facilitation when implementing the GSFCH programme. Ethical approval was granted (REC: 09/H0715/74).



*Of the 24 NCHs, 12 received high facilitation (HF) and 12 received high facilitation and action learning (HF+AL)

** As well as the 24 NCHs in * an additional 14 NCHs that received usual local facilitation took part. Some had a facilitator and so received local facilitation (LF). Others were unable to locate a facilitator and so received no local facilitation (NLF)

Figure 1: Relationship of the mixed-methods study to the cluster randomised controlled trial.

Aim

To identify the type, role, impact and cost of facilitation when implementing the GSFCH programme into NCH practice.

Design

A mixed-methods study was undertaken owing to the complex nature of the research focus (Farquhar et al., 2011, 2013), the need to ensure fidelity and enable complementarity (Denzin, 1970). Fidelity was assessed through the collection of quantitative data detailing how facilitation was actually delivered. As facilitation was provided over a two-year period, the only way to evidence exactly what facilitation a NCH received was to keep a record of that over time. The data collection also provided a more complete picture (complementarity) about the concept of facilitation, whereby the objective view of the world (from the quantitative data) would be complemented by the subjective view of the world (qualitative data). In addition, the use of O’Cathain’s (2010) framework helped ensure that the study took account of rigour and quality within eight domains: planning quality; design quality; data quality; interpretive rigour; inference transferability; reporting quality; synthesizability; and utility.

Setting

A total of 38 NCHs within south-east England took part in the study.

Participants

The participants were from 38 NCHs undertaking the GSFCH programme. They included:

1. Staff employed by and working within the NCH:
 - Home manager (M)
 - GSFCH coordinator/s (C)
2. Staff external to the core NCH staff and not employed by them:
 - External facilitator/s (F).

Methods

Qualitative and quantitative data were collected from staff employed within the NCH (home managers and GSFCH coordinators) and external facilitators working with them. Data-collection methods included surveys, interviews and completion of facilitator activity logs. The latter two specifically related to the facilitators. With regard to quantitative data, socio-demographic data were collected from the facilitators, including their role and band. They also completed a facilitator activity log, which was collated monthly, throughout the entire two-year study. It contained information of every contact the facilitator had with each NCH, including the type of contact (email/telephone/visit), duration, activity/activities, who was present and what occurred. In relation to qualitative data, a semi-structured interview was undertaken with the external facilitators at the end of the study. The interview related to the facilitation experience within each specific participating NCH.

The quantitative data were analysed through the use of descriptive statistics (Statistical Package for Social Science, version 18). Initial analysis of the facilitator activity logs took account of the components of the *HF* or the *HF+AL* role, as defined for the CRCT (Kinley et al., 2014b). Each activity was coded into a category, which was checked by a second reviewer. The time taken to undertake the activity and the mechanism of learning were also recorded. For example: role modelling the completion of an assessment tool with a specific staff member was recorded as individual learning; a reflective meeting with multiple staff in

the home after a death was recorded as organisational learning; and an educational meeting held for all the home managers in an external venue was recorded as systems learning.

Qualitative data were transcribed verbatim and entered into NVivo 9. Template analysis was then undertaken (Crabtree and Miller, 1999). Checkland's (1999) Soft Systems Methodology mnemonic CATWOE formed the framework of the coding templates for the initial exploration of the data (Crabtree and Miller, 1999). It took account of the NCH undergoing the change (**C**ustomer), the person (in this case the facilitator) implementing the change (**A**ctor), the process of change (**T**ransformation), any external worldwide influences (**W**orldview), management factors (**O**wner) and any environmental factors (**E**nvironmental constraints). That approach was chosen as Soft Systems Methodology enables mapping an understanding of what a complex organisational unit is doing and therefore is valuable before initiating change. Following population of the CATWOE templates, analysis and interpretation of the data collected occurred by immersion and crystallisation within each of the templates (Crabtree and Miller, 1999).

The quantitative data were analysed first, followed by the qualitative data. Integrating the total data set then occurred through 'following a thread' (Moran-Ellis et al., 2004). Any additional concepts emerging from the qualitative data were followed back within the quantitative data, the intention being to generate further knowledge by looking for evidence of resonance across findings (Moran-Ellis et al., 2004). The facilitator-specific data emerging from the initial data analysis is reported here.

Results

At the start of the study, 17 external facilitators provided facilitation of the GSFCH programme to 33 (87%) of the participating NCHs. Five (13%) NCHs had no local external facilitator. There were no missing data.

After reporting the facilitators' attributes, the results presented relate to the amount of time that facilitation was provided, the format of provision, the external facilitators' approach to the provision of their role and cost of providing facilitation. The study identified that some of the 14 NCHs in the *usual local facilitation* group had facilitation provided. That led to the division of the 14 NCHs into two groups: those either receiving *local facilitation* and those who had *no local facilitation*. Overall results are given and where possible in relation to the external facilitation provided to NCH staff, i.e. either *high facilitation and action learning (HF+AL)*, *high facilitation (HF)*, *local facilitation (LF)* or *no local facilitation (NLF)*. Other results are reported in Kinley (2014).

Facilitators' attributes

The external facilitators in each group had similar years of work experience. All trained within the UK as nurses and had been qualified for at least 18 years. The median time since qualification was 29.5 years in the *LF* group and 33 years in the combined *HF* group. In both *HF* groups, all facilitators had a specialist palliative care qualification. However, only two external facilitators within the *LF* group had specialist palliative care work experience. In total three facilitators had an education qualification (two in the *LF* group and one in the combined *HF* group). The majority of the *LF* external facilitators ($n=8/10$) worked full-time in their different roles, such as lecturer practitioner and regional head of operations, whilst the majority of those providing *HF* worked solely as external facilitators in part-time employment ($n=5/7$).

The external facilitators' familiarity with, and experience of, the GSFCH programme was similar. Six external facilitators (60%) in the *LF* group had previous experience as a GSFCH external facilitator. That was also the case for four (57%) of the seven external facilitators within the combined *HF* groups.

Facilitation time provided

It was intended that facilitation would be provided throughout the GSFCH programme. Two sources of facilitated support were available to the GSFCH coordinators implementing the programme in their NCH - at the regional training centre where workshop-based training was delivered and in the NCHs via the identified external facilitator. Across the four groups, the variation in facilitation time that was provided was considerable, ranging from 2–224 hours (*Table 2*). The *NLF* group only received facilitation via the regional training centre. For one of the NCHs in the *LF* group that had negotiated successfully the assistance of an external facilitator, the total facilitation time received was less than six hours. That was only slightly more assistance, over the two-year period, than one of the NCH in the *NLF* group.

Table 2: Total facilitation time provided to the nursing care homes

Facilitation group (<i>n</i> =number of homes)		Total facilitation time over the entire two-year GSFCH programme (hours)	
		Range	Median
Usual local facilitation* - facilitation was either absent or provided	<i>No local facilitation</i> (<i>n</i> =5)	2–4.30	3
	<i>Local facilitation</i> (<i>n</i> =9)	5.55–124.27	24.40
<i>High facilitation</i> (<i>n</i>=12)		41.35–163.25	120.18
<i>High facilitation and action learning</i> (<i>n</i>=12)		132.25–224.08	168.45

*This facilitation group was subdivided. In this group a facilitator, and therefore access to facilitation, was either provided or not; GSFCH = Gold Standards Framework in Care Home

Format of facilitation provision

The activities undertaken by the facilitators to support NCH staff to implement the GSFCH programme, as recorded in the activity logs, are provided in *Figure 2*. *Table 3* provides a key to the terms used in *Figure 2*. The activities were initially classified according to the format of facilitation provided and then collated under the format of learning provided, i.e. whether learning was provided to targeted professionals within the home (individual learning) or to groups of individuals either within the home (organisational learning) or external to the home (systems learning). Within each facilitation group the collective time of each facilitation activity across all homes is provided (see *Figure 2*).

Individual learning occurred with the GSFCH coordinators and the facilitators. NCH managers were encouraged to appoint at least two members of staff as GSFCH coordinators. They all achieved that. However, by the end of the two-year programme, only 11 of the 37 NCHs (30%) had retained their initial two GSFCH coordinators. One NCH closed in the study period. Six had no GSFCH coordinators in post that had attended the GSFCH workshops. When that occurred the role of the external facilitators extended beyond working alongside the GSFCH coordinators. They may then be the only individuals with clarity about what needed to be implemented within the participating NCH. It was therefore crucial that the facilitators themselves also undertook individual learning in order that they too had a

detailed understanding of the GSFCH programme and how to facilitate its implementation. Such learning was not evident within the *LF* group, where there was a sense that the external facilitators did not perceive themselves as providing a specific GSFCH external facilitator role:

'...we're none of us are specifically GSF but we're end-of-life facilitators.' [F7]

Such lack of engagement with the concept of being a GSFCH external facilitator may have arisen because the facilitators were uncertain about what they should be doing. A number of the external facilitators providing the *LF* approach reported that they were not sure of their role and responsibilities. For example, one stated:

'...some information of...what am I meant to be...facilitating them to do?...I wasn't even clear what Gold Standards were initially...it's not like I'd gone to a course for facilitators for Gold Standards and this...is what you should be doing.' [F10]

Organisational learning was supported through a number of activities, including coding meetings (*Table 1*). The facilitators in both *HF* groups encouraged the NCH to set up coding meetings (where facilitated support ranged from a mean of 11.5 hours in the *HF* group to 18 hours in the *HF+AL*). Those meetings provided the opportunity for residents to be discussed and their care planned and agreed upon by the entire team rather than by an individual. Interestingly, the 14 *LF* NCHs collectively received less facilitated support with that core element of the programme than the *HF* homes received individually. They had a mean of just 30 minutes across the entire two-year programme. The other main activity where organisational learning occurred was in relation to reflective practice (after death analysis and significant event analysis) (*Table 1*). Only NCHs in the *HF* groups received facilitation that supported that format of organisational learning (see *Figure 2*). Where facilitation was not provided proactively for that activity, its provision to enable organisational learning was minimal.

Systems learning was addressed by the provision of support for NCH staff (including the GSFCH coordinators and NCH managers), in groups with their peers across the NCHs (see *Figure 2*). However this varied in the different facilitation groups. Learning occurred, across care homes, by the GSFCH coordinators in the *HF* and *HF+AL* groups. In the preliminary phase of the programme system, they attended the Macmillan Foundations in Palliative Care for Care Homes training:

'They met with other co-ordinators who were in exactly the same situation as they were so...they were sort of able to have a support system for themselves...So the co-ordinators knew each other before they attended the first workshop and I think that really helped.' [F3].

Learning occurred side by side with action learning, for the NCH managers, in the *HF+AL* group:

'With the general feedback from the other managers at the session I was able to realise that some of the issues at my home were similar to other homes. So together we were able to solve some of them.' [M.HF+AL12.000]

In the implementation and consolidation phases of the GSFCH programme, learning occurred between all disciplines across the NCHs in local care home network forums:

'Training that has been put on by GSF programme, with the added benefit of meeting staff from other homes. It is interesting to hear and share ideas and challenging situations.' [C.HF+AL8.000]

In the *LF* group it was suggested that such links would be useful; however, no NCH had taken the initiative to forge such a relationship:

'It would have been useful for the GSF to arrange buddy system with another home, who you knew was willing to give advice.' [M.NLF9.000]

Systems learning was also identified as important to the external facilitators:

'I mean I've learnt quite a bit from F12 in terms of managing, organisation and things, you know, that whole thing of making six months of meetings and knowing why you're going in and what you're going for and all that.' [F16]

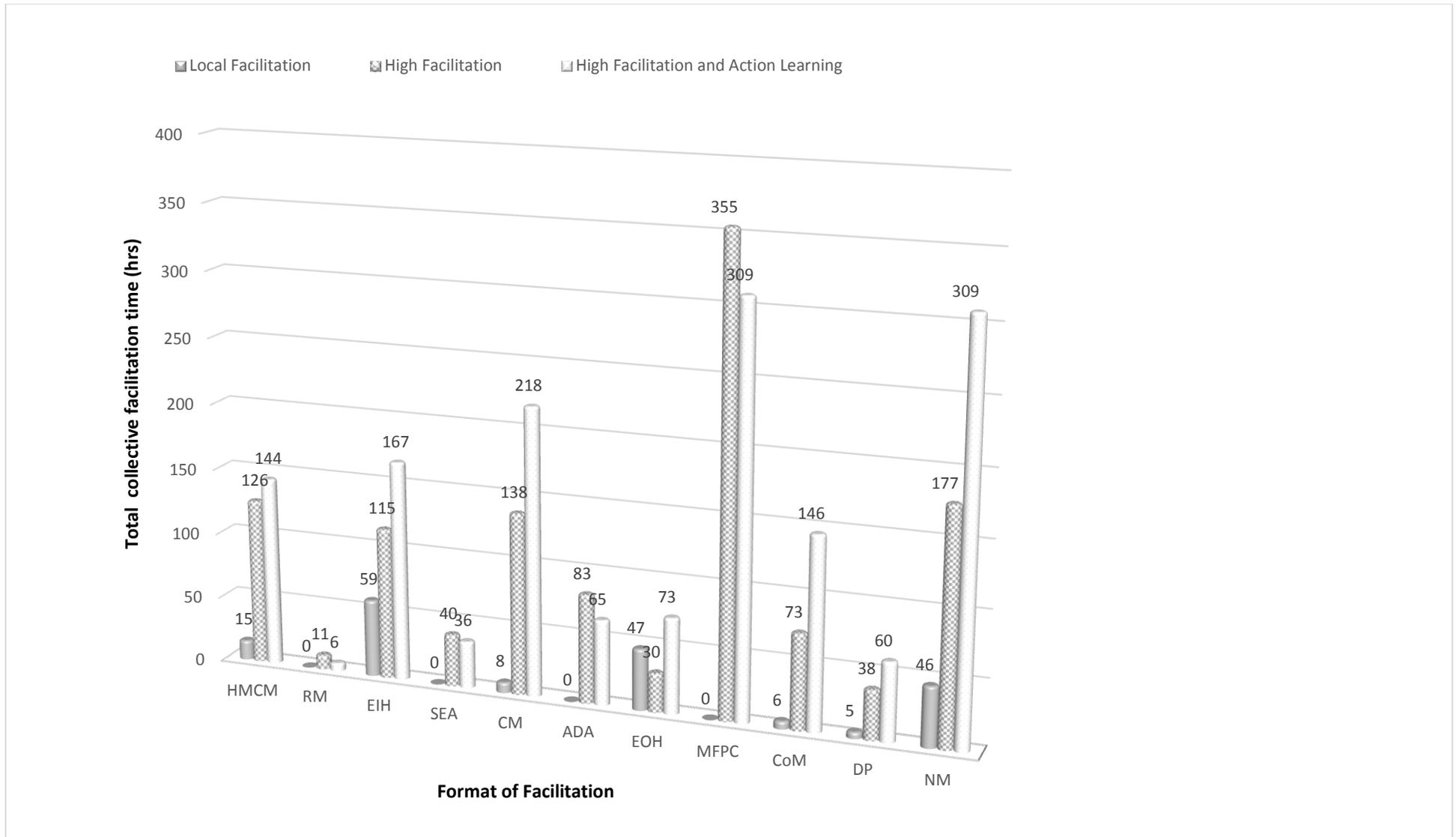


Figure 2: Format of external facilitation and total time provided (hours) to put systems into place within each facilitation group.

Table 3. Key to Figure 2

Format of learning	Format of facilitation	Key
Individual learning	Nursing care home manager and Gold Standards Framework in Care Homes (GSFCH) coordinator meeting	HMCM
	Role modelling	RM
Organisational learning	Education within the nursing care home	EIH
	Significant event analysis	SEA
	Coding meeting	CM
	After death analysis	ADA
Systems learning	Education outside the nursing care home	EOH
	Macmillan Foundations in Palliative Care training	MFPC
	GSFCH coordinator meeting	CoM
	Developing partnerships with other professionals	DP
	GSFCH network meeting	NM

Approach to the provision of facilitation by an external facilitator

The experience of facilitation, by a nominated external facilitator, was only applicable in three groups (*LF*, *HF* and *HF+AL*). However, in addition, the NCH manager in one of the *NLF* groups acted as an internal facilitator. External facilitators recognised that the ultimate outcome of their role was the NCH taking on responsibility for the GSFCH programme, in a way that suited them. There was agreement among external facilitators around the core elements of facilitation: provision of support, advice, guidance and helping others to avoid problems; active work; and inspiring a vision for change. However, there was greater disparity in how the role was undertaken in practice. Three approaches to facilitation were identified when implementing the GSFCH programme into practice: ‘being present’ facilitation; ‘fitting it in’ facilitation; and ‘as requested’ facilitation.

‘Being present’ facilitation

The ‘being present’ approach was evident in both *HF* groups. That format of facilitation provided proactive rather than reactive facilitation:

‘...every time I left the NCH I would set the next date...giving them time to do what we’d planned for them to do...and I would try and say to them, “How long do you think it’ll take you to do this? And I’ll come back then”’. [F1]

‘Being present’ enabled the external facilitators to identify where a NCH needed help. Holding monthly coding meetings within the NCHs is a core element of the GSFCH programme. ‘Being present’ meant one external facilitator noticed that a home was struggling to start the process. Working with staff, the facilitator set up a template on the home’s computer that produced the required documentation. Coding meetings were then started. Providing that type of facilitation role took time, commitment and energy. However, ‘being present’ enabled facilitators to give attention to detail and follow things through.

In one *NLF* NCH the manager recognised the need for the entire NCH to adopt the principles of the GSFCH programme. She saw the importance of providing face-to-face education sessions for all staff members and acted as the ultimate ‘being present’ facilitator. Her passion and drive empowered her to run internal education sessions and motivate all her staff:

‘She and three members of her staff have taught all the other staff the Macmillan Foundations in Palliative Care. She learnt loads about her staff doing this, e.g.

multicultural beliefs re death and dying as she has totally multicultural workforce. ...this really helped her develop a relationship with the staff. She hosts as many training events as she can for the community matron, e.g. verification of death. That way her staff go for free.' [Researcher]

In that home 'being present' facilitation was still required but it was provided internally rather than externally. The home manager's position and GSFCH coordinator role enabled the process to occur. The manager used the opportunity to increase understanding between herself and her team and between the team members. Achieving that involved spending time with her staff and them spending time with each other.

'Fitting it in' facilitation

In the *LF* group, where a facilitation plan was not imposed, other factors acted to shape the format and, therefore, the experience of the facilitation that was provided. One such approach identified was 'fitting it in' facilitation.

The external facilitators providing *LF* had multi-faceted roles, and facilitation was not their major concern/priority. They had often been asked to take the role on, leading to conflict in time management between that and their other roles:

'...It was something I was asked to do as a part of my job.' [F8]

In such cases facilitation was often seen as the least important aspect of the job. When undertaking external facilitation in the NCHs, they tended to focus their activity on the key elements of their main role, which were their areas of strength and easier components to fulfil. For example, the main role of one of the external facilitators was in education; therefore, the main focus of her GSFCH facilitation was education. A second example was where an external facilitator's role was linked to a clinical role:

'I think because I was...doing, a busy day job, the facilitation was very much an add-on to my then role, and, you know, there was a lot of conflicts with priorities and things. And although the GSF was a priority, you know, if you've got a home in crisis, then that's clearly a priority.' [F13]

The lack of clarity around the GSFCH external facilitator role led to local interpretation. However, that did not always occur in relation to an identified need within the nursing home. It was also affected by the other role and responsibilities of the external facilitator:

'...although facilitator doesn't mean this, for me it's involved a change of policies, writing manuals...' [F9]

The lack of clarity in how to provide facilitation, alongside the need to juggle time for it alongside other roles, meant that the facilitation offered was what time permitted. Some of the external facilitators in the *LF* group reported that they had linked their local NCHs together. However, unlike with the *HF* nursing home network forums, where homes were encouraged to meet as a way of supporting and sustaining change, the approach had been developed as a result of time pressures:

'...the only way I could do it was to get all the homes together and just see where they are...I can't facilitate 10 of them...I connect in with them and sort of have a catch up

session on how they are, but that's just purely for my reporting.' [F4]

'As requested' facilitation

'As requested' facilitation was also identified in the *LF* group, where a facilitation plan had not been imposed. As with 'fitting it in facilitation', various factors acted to shape the format and therefore the experience of the facilitation that was provided.

In the *LF* approach, rather than building a relationship, the external facilitators tended to rely on the NCHs to approach them for assistance. However, when the onus was left to the home to contact the external facilitator, it did not happen:

'It's very ad hoc...it's just whatever they want and whatever they need really... 'Cos that's the thing, I mean, you can't, you can't force yourself on people, can you?...I've got to rely on you to get in touch with me and...consequently they haven't actually...'
[F17]

The lack of contact referred to in the above quotation is also illustrated by comments received from a GSFCH coordinator in the *LF* group:

'Had I of known the route I would not have commenced not having a facilitator.'
[C.LF10.00]

However, that NCH did have an external facilitator. Over time, as the onus for facilitation here was one of 'as requested' by the NCH staff, and requests did not occur, the GSFCH coordinators in the NCH became unaware of their facilitator's existence.

Cost of facilitation

In this study the median cost for providing facilitation of the GSFCH programme is estimated only in relation to the total time provided by the facilitator, not additional costs such as staff time in attending facilitated activities. *Table 4* shows that cost varied according to the facilitation approach taken. It also identifies the cost for the then mid-band 7 salary, with an hourly pay of £18.54 (Royal College of Nursing, 2016).

Table 4: Median cost of facilitator time per nursing home

Facilitation approach	Year 1 median time (hours)	Year 1 median cost*	Year 2 median time (hours)	Year 2 median cost**	Total 2009 2-year cost	Total 2016/17 2-year cost
No local facilitation	2	£33.08	1	£16.94	£50	£56
Local facilitation	17.10	£282.83	7.3	£123.66	£407	£457
High facilitation	72.58	£1,200.47	50.29	£851.91	£2,052	£2,290
High facilitation and action learning	105.48	£1,744.64	68.10	£1,153.61	£2,898	£3,226

*Cost estimated from the then mid-band 7 salary (minus all other costs)

** Cost estimated from the then mid-band 7 salary (minus all other costs)

Discussion

Facilitation of the GSFCH programme has previously been identified as important (Thomas et al., 2005; Clifford et al., 2007; Hockley et al., 2010; Hockley and Kinley, 2016). The CRCT undertaken alongside this study highlighted the value of *HF*, notably when supported by action learning (Kinley et al., 2014b). This study details how facilitation of the programme was provided within the 38 NCHs in the CRCT, to enable understanding of the outcomes resulting from its provision. What became apparent was that translation of the GSFCH programme into practice required more than the action learning for home managers and a ‘being present’ approach by a facilitator that the CRCT had highlighted (Kinley et al, 2014b). The facilitation provided within the 38 NCHs was directed at individual, organisational or systems level learning (see *Figure 2*). It was the provision, or absence, of that multi-layered approach to facilitation (enabling learning at individual, organisational and systems level) that impacted on implementation.

Multi-layered learning

Senge et al (1994) identified five elements that were essential to a learning organisation: personal mastery; mental models; shared vision; team learning; and systems thinking. Those elements support the multi-layered approach to learning that emerged from this study’s findings.

Personal mastery: this relates to the individual learning of both the external facilitator and GSFCH coordinators. The facilitator needed to know the GSFCH programme and be able to share the vision of how to implement it into practice within the context of each specific NCH. That may explain why a ‘being present’ approach to facilitation resulted in more NCHs completing the GSFCH programme.

In relation to individual learning, the initial focus of the GSFCH programme is the individual education of GSFCH coordinators in workshops. However, the intended outcome of the programme is one of cultural organisational change (GSF Centre CIC, 2011). Implementation of the GSFCH programme required the associated knowledge and skills to become part of everyone’s practice, not just the practice of individuals. For that, organisational learning as

well as individual learning needed to occur. Senge et al (1994) referred to organisations undergoing such change as *learning organisations*. Such learning is only possible when attention is provided to Senge et al's (1994) remaining four elements — mental models, shared vision, team learning and systems thinking.

Mental models: these are individuals' personal pictures and understanding of the world that shape their actions and decisions. They are not static. Senge et al (1994:267) described an organisation's culture as, 'its members' collective mental models, which is why you cannot change an organisation without investigating its cultural assumptions'. Changing those can only occur with conversations and/or reflection within the system, where individual mental models are discussed or challenged. A strength of the GSFCH programme is that its completion requires putting time aside to reflect on practice. That process can help identify individuals' mental models. However, it is only a strength of the GSFCH programme if it is translated into practice within the NCH. In this study, without *HF* and the associated 'being present' approach to facilitation, reflective practice failed to occur (see *Figure 2*). The view of learning from practice and recognition of its importance is not a new. It was described by Wenger (1998:95): '...one reason they do not think of their job as learning is that what they learn is their practice...what they learn is not a static matter but the very process of being engaged in, and particularly in developing, an ongoing practice.'

Shared vision: to become a *learning organisation*, individual GSFCH coordinators needed to transfer the information they learnt at the workshops to the organisation as a whole. To achieve that there needed to be what Hendy and Barlow (2012:351) described as, 'a significant shift in the ownership of the work'. That shift of ownership can only occur if the organisation is able to grasp a shared vision of the future. In the programme the generation of such a vision was enabled through reflective practice and the coding meetings.

Team learning: a team that learns together will have a greater ability and intelligence than the sum of the individual members' parts (Senge et al., 1994). To become a learning organisation, the team needs to move forward collectively. The establishment of the coding meetings, the significant event analysis 'reflective practice' meetings and the creation of the portfolio of evidence (see *Table 1*) enabled all members of the internal system of the participating NCHs to learn together. Such activities also ensured the sharing of personal mental models and the creation of a shared vision. Those three elements built on one another. The only NCHs to undertake consistently those activities with their staff were those provided with *HF*. Where reflective practice had not formed part of structured facilitation of the GSFCH programme (i.e. in the *NLF* and *LF* NCHs) there was no mention of it occurring in any of the formats listed above.

Systems thinking: this means the relationship between the systems of which each NCH is a part. It includes both intra- and inter-connections. Challenges to the NCH becoming a learning organisation occurred when the GSFCH coordinators failed to engage the rest of their organisation and their external community with the programme. The NCHs were not able to implement the programme without their internal systems (e.g. manager/nursing/care staff, relatives and residents) and external systems (e.g. GP) all understanding the programme and wanting to engage with it. In both *HF* groups, the external facilitator was instrumental in developing such systems thinking. Time was spent helping the NCHs develop partnership working both within the NCH and externally (see *Figure 2*). If there was no external facilitator, such change usually failed to occur.

Whilst this study highlighted the importance of systems thinking (the joining together of a NCH and its internal and external systems) for organisational learning to occur, it showed that that was not enough. Collaboration between such learning organisations created an additional opportunity to learn (i.e. the joining together of a NCH and its internal and external systems with another NCH and its internal and external systems). Blackmore (2005:338) described the term ‘learning systems’ as follows:

‘By learning system I mean inter-connected subsystems, made up of elements and processes that combine for the purposes of learning. The placement of a boundary around this system depends on both perspective and detailed purpose.’

Vickers (1983) conceived the concept of inter-organisational learning, i.e. learning from systems that are in a similar situation. He wrote: ‘...the more uniform the experience of members of a society, the more fully they are likely to share their common language and the more rich it is likely to be’ (Vickers, 1983:42). The establishment and use of learning systems are dependent upon the users’ perception of them, whilst the goal of a learning system is to share joint experiences and create joint learning (Holmqvist, 2003). The joining together of NCHs by the external facilitator created learning systems and in so doing increased the learning potential of those NCHs. That occurred in both *HF* groups and some of the *LF* groups. Effort would only be made to maintain links within learning systems that were perceived as worthwhile. Learning within an appreciative learning system is therefore important.

The creation of such appreciative learning systems between the NCHs in the *HF* groups resulted in learning. The action learning, reported in the CRCT, was one example of an appreciative learning system (NCH managers learning from other NCH managers) but others existed. Learning through such appreciative learning systems required work by the external facilitator to initiate and then maintain them. However, work was also required by the staff in the NCHs in order to attend, participate in, and learn from them. It was their attendance, not their creation that led to the learning.

What was clear is that inter-organisational learning requires a knowledgeable, skilled external facilitator to ensure that a ‘safe’ environment for learning is generated (Van Winkelen, 2010). The external facilitators in the *HF* group all had a specialist palliative care background and facilitation was the sole role and, therefore, the priority of their job. As facilitation was not the dedicated main role for any of the external facilitators providing a *LF* approach, the lack of clarity and focus may have meant they did not have to accept responsibility or accountability for the role. External facilitators in the *LF* group had other responsibilities. Consequently, their performance would probably have been judged with regard to the core aspects of their role and not their facilitation of the GSFCH programme. That may have led to the ‘as requested’ and ‘fitting it in’ approach, described above.

For change to occur, external, not internal, facilitators are required. However, those external facilitators need to be local to the NCH so know their local external support systems. There was recognition amongst the external facilitators in the *HF* group that they might not know all the answers. As with the external facilitators in the *LF* group, some were new into post. However, unlike the external facilitators providing *LF* they had joined a GSFCH external facilitator team and thus learnt from those experienced at providing the role. They needed to be part of an appreciative learning system. That should be considered when setting up a service that is facilitating such initiatives.

The one exception to the model was the *NLF* home manager who was able to provide the five elements that Senge et al (1994) identified as essential for organisational learning. She was not only knowledgeable and skilled in relation to the GSFCH programme but also connected to and part of her external specialist palliative care service. That was the only *NLF* NCH to complete the programme through to accreditation. It may be that, over time, if care home managers gain knowledge and skills and establish connections with their external healthcare providers, they will begin to take on more of the facilitation role. However, literature relating to change suggests that the presence of a facilitator who is external to the specific organisation implementing change is valuable (Schwarz, 2002). For example, Hendy and Barlow (2012) found that their process of health system change was enabled when there was a champion who, like the GSFCH external facilitators, was not an internal member of staff. Ross and Roberts (1999) supported such a model of facilitation but had an additional recommendation. They suggested that group learning is improved and change implemented when external facilitators are supported by internal facilitators, who are familiar with the organisation's culture. The GSFCH coordinators were those internal facilitators.

Given the current economic climate, sourcing funding for such facilitation could be problematic. However, the generalisability of this study's findings is enhanced when savings in the care system are plotted against the cost of providing facilitation. The CRCT (Kinley et al., 2014b) demonstrated a greater proportional reduction in the number of hospital deaths when *HF* (10% reduction), or *HF+AL* (13% reduction) were provided. An admission to hospital of a frail older person that ends in death costs between £2,352 and £3,779 (National End of Life Care Programme, 2012). Ennis et al (2015) demonstrated that it costs £4,223 more if the death of a resident occurs in the hospital rather than in the NCH.

If cost savings are accounted for purely in relation to hospital admission at the end of life, then the cost of providing facilitation within NCHs for the GSFCH programme could be justified. What is crucial is that cost savings are mapped across the system — in this example, the cost of providing facilitation in NCHs can result in cost savings to the acute sector. The national drive to encourage collaborative working across care settings through, for example, in England the Sustainability and Transformation Plans, could enable innovative partnerships to work (NHS England, 2017). Looking beyond cost-effectiveness the CRCT also highlighted additional benefits in relation to implementing the GSFCH programme, e.g. the increased frequency in completion of advance care plan documents (Kinley et al., 2014b).

There were a number of limitations to the study. Data collected related to that which was reported, not observed, to have occurred. Its accuracy relied on the recollection, recording and honesty of the participants. It is also recognised that factors, other than the provision of usual local facilitation, may have played a part in NCHs' implementation of the GSFCH programme. NCHs, for example, may have sought assistance for end-of-life care training provided via another system (e-learning) or from another professional.

Implementation of change into practice is challenging. Hockley and Kinley (2016) highlighted that achieving change in care homes requires understanding both practice development (Manley and McCormack, 2003) and implementation science (Kitson et al., 1998; Rycroft-Malone, 2004). The PARIHS (Promoting Action on Research Implementation in Health Services) model (Rycroft-Malone, 2004; Kitson et al., 2008) proposes that implementation of change occurs in response to the interplay of context, evidence and facilitation. It is, therefore, more likely when those are taken into account. Marshall et al (2017) also highlighted the importance of context when evaluating the limited uptake of a

safety improvement initiative they were implementing into care homes. They stressed that taking time to understand the context for change is essential. In the current study, Soft Systems Methodology was used to provide that analytical lens. Implementation of change in NCHs required the facilitator to learn about each individual NCH's context. 'Being present' facilitation was essential for that to be achieved. However, 'being present' was not enough. It was the facilitator's individual learning from 'being present' that enabled them to provide an appropriate multi-layered approach to learning, specifically tailored to an individual NCH. That ensured that the facilitation provided resulted in change, as it was appropriate to the specific setting of the individual NCH and utilised what was already in place. Further evidence supporting multi-layered learning approaches in care homes in relation to implementing and sustaining the GSFCH and other end-of-life care programmes is now emerging (Hockley and Kinley, 2016; Kinley et al., 2017).

Whilst the study reported here relates to the implementation of the GSFCH programme within the UK, its applicability is being explored on a wider scale. The approach has been adapted and incorporated into a subsequent European Union's Seventh Framework Programme funded study (Van den Block et al., 2016). However, when implementing initiatives other than those relating to end-of-life care, the value of paying attention to learning at all three levels of learning requires further investigation. The NHS England's (2016) publication on new models for care homes may begin that process. It highlights the importance of health and social care commissioners, care home staff and owners and service users working together (organisational learning) and care homes engaging in a forum (appreciative systems learning). For now, multi-layered learning should be considered when implementing new initiatives into care homes.

Conclusion

The GSFCH programme is promoted as enabling participating NCHs to provide, '*... the right care, for the right person, in the right place, at the right time...everytime*' (GSF Centre CIC, 2012a). The current study shows that to achieve implementation of the programme, NCHs also need access to and support from the right external facilitator, for the right member/s of the NCH staff, in the right format, at the right time throughout the process. As care homes play a vital role in meeting the needs of the population, it is important to ensure that end-of-life provision is delivered in this care setting. The study findings offer one cost-effective way to achieve that.

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