

SUPPORTING COMMUNICATION SKILLS AND BEHAVIOURS IN HEALTHCARE STAFF

EVALUATION OF TWO PILOTS: THE CARE APPROACH & PRACTICE BASED SMALL GROUP LEARNING

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The ability to communicate effectively and to form productive human relationships is integral to the provision of effective, high quality, person-centred care. This evaluation of 10 pilot sites across Scotland builds on previous work undertaken by NHS Education for Scotland (NES) and focuses on two approaches that aim to support the communication and human relationship skills of health practitioners and the integration of those skills into routine interactions with patients. The two approaches used were 'The CARE Approach' (CARE) and Practice-Based Small Group Learning (PBSGL).

THE CARE APPROACH

The CARE Approach learning tool aims to enhance person-centred communication and is based on a manual and online film scenarios covering four interactive components: of **C**onnection, **A**ssessing, **R**esponding and **E**mpowering. Practitioners work through the materials in small groups led by a facilitator.

It is based on, but not to be confused with, the CARE *Measure* (Consultation and Relational Empathy) developed by Stewart Mercer and colleagues at The Departments of General Practice within Glasgow University and Edinburgh Universities. The measure consists of patient scores of 10 statements related to health professional's consultation style and patient's experience.

PRACTICE-BASED SMALL GROUP LEARNING (PBSGL)

Practice-Based Small Group Learning (PBSGL) is a form of peer facilitated small group learning for health practitioners based on written modules that focuses on implementation of learning into changes in practice. PBSGL involves small groups of practitioners meeting with a trained peer-facilitator to work through topic specific modules consisting of an introduction, cases, additional information and case commentaries. Evaluation and planning change to practice is built into the PBSGL process by the use of module logsheets.

The PBSGL module piloted in this evaluation was rewritten specifically for use in secondary care and focused specifically on developing abilities in sensitive conversations at the end of life.

EVALUATION AIM & AREAS OF INTEREST

The aim of this evaluation was to:

Evaluate the impact of two approaches (the CARE Approach and Practice Based Small Group Learning) to supporting learning on communication and human relationships in a healthcare context in 10 pilot sites.

Specific areas of interest included:

1. Participants' and facilitators' experiences
2. The acquisition of knowledge and skills,
3. Changes in professional practice,
4. Barriers and facilitators to the application of new learning
5. Learning in relation to the spread and sustainability of the two approaches.

METHODS

The evaluation adopted a mixed method approach across 10 pilot sites (5 sites for the CARE Approach and 5 sites for PBSGL) comprising the following elements. Further details are available in the full evaluation report.

- **A review of quantitative records (attendance etc.) and PBSGL learning logsheets.**
- **Questionnaires with facilitators and participants** specific to each approach administered pre and post delivery.
- **Qualitative interviews with facilitators and participants.**

KEY FINDINGS - PROCESS

CARE APPROACH

Facilitators and participants were generally satisfied with their involvement in the project, and with the materials and group discussion, however there were a number of areas which were highlighted as having worked well and important for future rollout. These included:

- Using protected practice time or negotiating protected time for delivery as the time required to complete all six modules is significant.
- Adapting the materials to suit each group (many facilitators did this in their own time).

There were also some areas for development including:

- Providing clearer information to participants to support staff recruitment and to ensure staff know what to expect if they become involved in the initiative including the nature and value of the approach and the benefits of participation.
- Supporting the video clips with clearer information and discussion points and ensuring that all participants have access to the manual.
- Exploring possible accreditation routes or links to the formal CPD framework.

PRACTICE-BASED SMALL GROUP LEARNING (PBSGL)

Effective **facilitation** was also essential to the successful delivery of PBSGL and there were a number of aspects that worked well:

- A trained facilitator, preferably with previous experience in group facilitation.
- Modelling the PBSGL approach on the facilitator's training day. Co-facilitation also helped.
- Staff were hand-picked and encouraged or invited to attend.
- The case studies were essential to learning and positive experiences of the approach.

There were also a number of aspects which made the approach challenging to deliver including:

- Lack of information prior to facilitator training and prior to attending sessions for participants.
- A need for greater support for facilitators on the content and issues being discussed in the modules, not just training in facilitation skills.
- A significant administrative burden for facilitators in recruiting staff and setting up groups.
- The time required to allow groups to settle and become comfortable with open discussion beyond case studies and into real-life practice experience.
- Practitioners' knowledge about and comfort with the style of learning involved in PBSGL (i.e. not didactic).

For both CARE and PBSGL, the multidisciplinary make-up of the groups was found to be beneficial. As well as improving communication and relationships between staff it also offered participants;

- The opportunity to learn from staff in other disciplines and with varying levels of experience
- A better understanding of other staff roles and pressures
- A chance to see things from different angles and perspectives

KEY FINDINGS - IMPACT

CARE

The CARE Approach had a **clear impact** on the development of **knowledge and skills** of the majority of participants. This included an increase in knowledge of best practice in relation to communication and consultation skills, and also a sense of increased confidence and improved person centred consultation/communication skills.

Even participants who reported no new learning felt that participation in the CARE Approach had refreshed or reconfirmed skills which they had previously held. Linking the approach with use of the CARE Measure may provide useful information in terms of impact evaluation in the future.

The evaluation did not involve longer term follow-up of staff but some participants were able to describe examples of putting aspects of the CARE Approach into **practice** during patient consultations. Findings suggest an increased belief that participation in the CARE Approach will have a long term benefit for patients, partly resulting from improved working relationships between staff. The most positive results were seen in sites which appeared to have fostered a relatively high level of staff buy in for the CARE Approach.

Barriers raised by participants included the constraints of **current models or ways of working**. Key to this is the limitations placed on practitioners by short and rigid consultation times. While module 1 of the CARE Approach addresses the tension between task and patient focused encounters, it still remains a considerable challenge. It may be beneficial for the training to include more discussion of how the CARE Approach can be used while continuing to address the clinical needs of patients. This could be backed up by a more strategic approach to tackling this issue.

There is a perception that a **facilitator to changes** in practice would be a change in the **organisational culture** and whole team approach. This includes high priority being given to communication skills and needs to be backed up by supportive managers and supervisors.

PBSGL

Participation in PBSGL had a **positive impact on knowledge and skill levels** among participants and facilitators. Learning came from the information and tools included in the module materials as well as through the process of sharing with other professionals. Additionally, the comparison of pre and post pilot questionnaire results shows a significant increase in confidence in all but one of the measures of palliative and end of life care.

Practice change was identified in several areas. One key change reported by a majority of participants was improvement in team work and relationships, which appears to be a clear by-product of the small group learning approach. The timescales of this evaluation have meant that many interviews and questionnaires were completed very quickly following final group sessions, or in a small number of cases prior to final session. Even if they were unable to identify changes already made, many of the participants identified potential areas for change or signalled intention to change in the future.

In terms of **facilitators to change**, several participants suggested that it would be useful to have follow up or refresher sessions following completion of the module. The conditions of the pilot meant that groups were asked to meet at least twice. However, it is clear that enthusiasm for both the topic and the PBSGL learning approach led many to feel that continued meetings would enhance their knowledge and provide an opportunity for further reflection on the impact the process has had on their practice.

In addition, it was identified that **support from above** demonstrating the value placed on communication by the organisation would be helpful in the application of learning to practice. In addition, simple changes to the working environment which were conducive to more meaningful communication with patients were highlighted. A level of importance needs to be placed on communication skills at **organisational and even governmental level** in order for practice change to be possible.

4: CONCLUSIONS AND RECOMMENDATIONS

Following the pilots of the CARE Approach in primary care settings and Practice Based Small Group Learning in acute care/secondary care settings there were increases in self rated knowledge, confidence and skills backed up by positive reports from the qualitative data. A wealth of learning was attributed to the multi-disciplinary small group work method present in both approaches, which allowed a level of sharing and discussion among colleagues and across professional groups.

Changes in professional practice were reported or predicted from participants of both approaches as a result of the new learning. This could be explored further in future with longer-term research. An additional by-product reported by staff across all pilot sites was improved team and staff working relationships and an increased understanding of individual roles and responsibilities. The opportunity to meet with other members of staff to focus on communication, either to refresh skills and learning or to review and reflect on practice change was highly valued.

This evaluation has found a high level of satisfaction with both approaches from facilitators and participants. Despite some initial uncertainties and organisational difficulties the majority of participants reported positively on both the delivery methods and content of both approaches. The important role of skilled and experienced facilitators has been highlighted across both approaches. In addition, the findings demonstrate the need for adequate resources to support implementation of the learning opportunities.

Participants identified that application of learning from the approaches is best supported by an organisational culture where good communication with patients is valued and rewarded. This requires support from management and changes to the working environment as well as national emphasis on the value and importance of good communication skills.

KEY STRATEGIC RECOMMENDATIONS

A range of recommendations relating to improving the materials, processes and management of each approach in any future roll-out are outlined in detail in the full evaluation report. Only key strategic recommendations are provided here.

1. The CARE Approach and PBSGL should be rolled out as part of a broader strategy to improve communication skills based on the wider recommendations of other initiatives and research.
2. Consideration should be given to the need for specific funding to support roll out of the learning approaches. This would demonstrate the value placed on patient-centred communication skills at a national level and help to tackle the challenge of managing competing agendas and the limited ability of teams to release staff for training.
3. Support should be provided for groups and teams to evaluate the impact of any future roll out on skills and practice of staff and impact on patient care over a longer period of time in order to produce further evidence of effectiveness. This may have a positive effect on wider team and organisational buy in. In addition, it may be beneficial to coordinate evaluation to enable collation and sharing of learning.
4. Further investigation of ways of aligning the two approaches with formal accreditation frameworks may be beneficial for recruitment.
5. Managers and clinical leaders have a key role in supporting practitioners to make changes to practice following their involvement in either of these two initiatives by:

- Developing processes for supporting individual staff and team members to make changes to practice
 - Undertaking regular review of communication skills and practice of their staff and providing support for continuous reflection and peer-to-peer informal feedback on communication.
6. Continued emphasis on and promotion of the benefits of improved communication and relationship skills should be coordinated at a national level, supporting managers and practitioners to prioritise this within their team planning, individual workloads and personal professional development. One way to build a supportive culture would be to include emphasis on the importance of these skills in leadership programmes for senior NHS staff.