‘Me first’ Masterclass Evaluation Report January 2016

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Executive Summary

Aim:

The aim of the 'Me first' Masterclass series was to increase communication between young people and healthcare professionals by promoting a six-step communications model developed by Common Room Consulting Ltd. In addition, the Masterclass reviewed the core 'Me first' principles for prompting and developing an effective healthcare dialogue.

What we did

12 Masterclasses took place at Great Ormond Street Hospital (GOSH) between March 2015 and Dec 2015. In total over 200 healthcare professionals attended. The aim of the evaluation was to examine the impact of 'Me first' on healthcare professionals' attitudes and communication skills with young people, and to foster shared decision-making/person-centred care. The evaluation included questionnaires on healthcare professionals' perceptions of their skills and competencies prior to attending the Masterclass, straight after the Masterclass, and four-to-six weeks after completion of the Masterclass.

What we found

- Overall, healthcare professionals' attitudes towards collaborative practice significantly increased when scores were compared prior to the Masterclass and immediately after the Masterclass. Importantly, this increase was maintained at the four-to-six-week follow-up.
- When broken down by healthcare professional grouping, all groupings (medics, nursing staff, allied health staff, and other) experienced significant increases when scores were compared prior to the Masterclass and immediately after the Masterclass. For medics, this increase was maintained over the four-to-six-week follow-up period. For nursing staff, allied health staff, and the 'other' grouping, this did not appear to be maintained over the four-to-six-week period. However, all the professional grouping results should be treated with caution due to conservative estimates using the Bonferroni correction, as well as possibility of the study being underpowered due to small sample sizes of the professional groups.
- Overall, healthcare professionals' communication behaviours (exploratory listening, consensus-oriented listening, receptive listening, and action-oriented listening) significantly increased when scores were compared prior to the Masterclass and four–to-six weeks after the Masterclass.
- When broken down by healthcare professional grouping, all groupings (medics, nursing staff, allied health staff, and other) experienced significant increases in the four types of communication when scores were compared prior to the Masterclass and four–to-six weeks after the Masterclass. However, all the professional grouping results should be treated with caution because of the possibility of the study being underpowered due to small sample sizes of the professional groups.

- Goals set during the Masterclass could be divided into seven themes:: making the session more young person led, speaking to the young person more, listening to the young person more, giving options/exploring with the young person, checking the young person's understanding, explaining things to the young person, and trying new ideas to engage young people. Healthcare professionals who replied at the four–to-six-week follow-up responded positively in relation to progress made with these goals, with 55% saying that they had made 'a lot' or 'quite a bit' of progress across all areas. Areas where most progress was made was 'listening to the young person more' and 'explaining things to the young person more', with over 90% of respondents saying they had made 'a lot' or 'quite a bit' of progress in these areas.

Conclusions

Overall, results suggest that the 'Me first' Masterclass was successful in achieving its aims of increasing collaborative practice between young people and healthcare professionals. In particular, the Masterclass appears to have increased healthcare professionals' communication skills (exploratory listening, consensus-oriented listening, receptive listening, and action-oriented listening). Similarly, attitudes towards collaborative practice with young people also appear to have been positively affected by the Masterclass and maintained at four-to-six weeks after the Masterclass. It is less clear how behaviours and attitudes are affected by professional groupings due to small sample sizes and low completion rates for the questionnaires at four-to-six-weeks' follow-up. This means that some results should be treated with caution as those who did not complete may not have shown changes, skewing results.

‘Me first’ Masterclass Evaluation: Report Overview

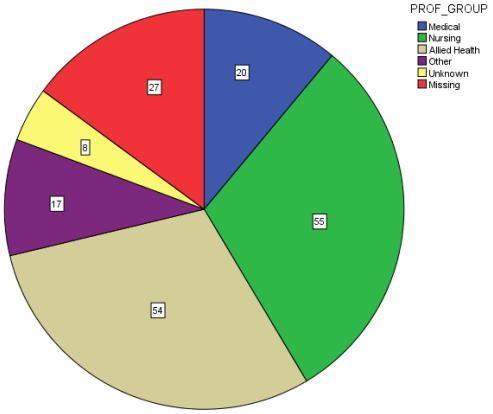
This report is divided into four sections:

- Section one focuses on demographic characteristics of the healthcare professionals that attended training and completed evaluation data.
- Section two focuses on whether the Masterclass affected healthcare professionals’ attitude towards working with young people.
- Section three focuses on whether the Masterclass affected healthcare professionals’ communication skills when working with young people.
- Section four covers goals that healthcare professionals set themselves during the Masterclass, and the extent to what they had achieved them at follow-up (4-6 weeks).

Section1: Demographic information of healthcare professionals who took part in the evaluation

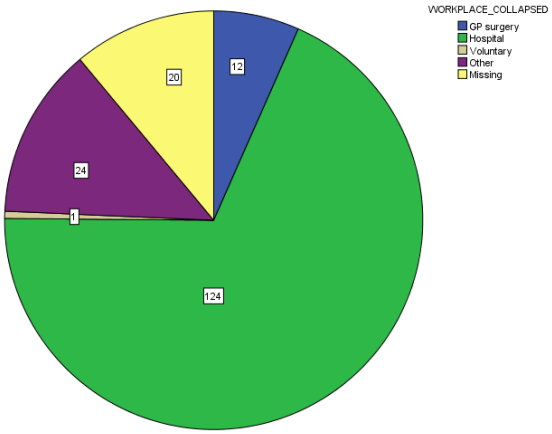
Professional Group

Nursing staff represented the largest number of respondents with 55 (30% of sample) completing questionnaires for at least one time point. The next largest number of respondents was allied healthcare professionals with 54 (30% of sample) completing at least one questionnaire. Medics comprised 11% of respondents and other professionals that attended the Masterclass made up 9% of respondents. Unclear responses and missing data made up 20% of responses.



Workplace

Hospital workers represented the largest number of responders with 124 (69%). This was then followed by the 'other' category accounting for 24 responses (13%); further analysis showed that many of these individuals worked in community settings (outside of GP services; e.g., schools). Responders working at GP settings made up 7% of the sample and 0.5% worked in the voluntary sector. Missing data accounted for 11% of the sample.

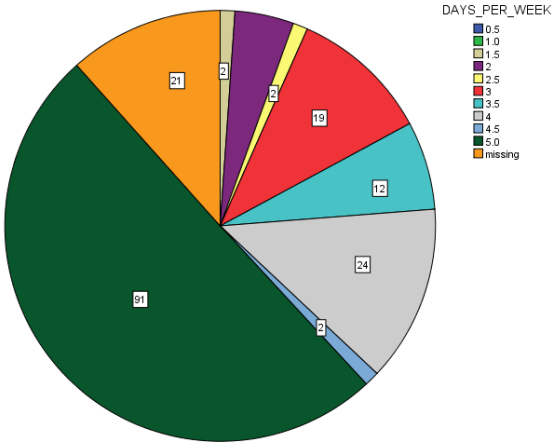


Gender

The majority of responders were female, which accounted for 80% (n=143), male responders made up 10% (n=18), whilst 11% (n=20) of responders' genders were unknown.

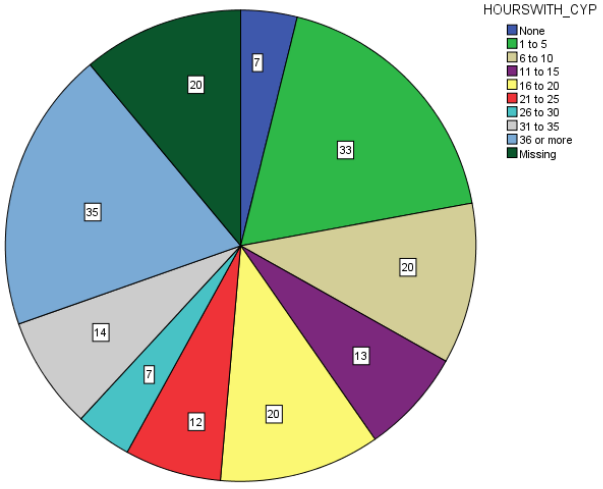
Days worked per week

The majority of responders worked full time, accounting for 50%. The next largest number of days per week worked was 0.8WTE, accounting for 13% of respondents.



Patient contact hours per week with young people

Thirty-six hours per week with a young person represented the largest proportion of responders at 20%. The next largest patient contact hours group was responders who worked with young people between one and five hours per week, accounting for 18%. This was followed jointly with 6-to-10 hours, 16-to-20 hours and missing data, each accounting for 11% (n=20). All other young person contact hour groups were less than 10% each.



Section 2: Impact of the Masterclass on attitudes towards working with young people

Healthcare professionals' attitudes towards partnership and medication taking were measured using the Leeds Attitude to Concordance (LATCon II) questionnaire[1] (Knapp, Raynor, Thistlethwaite, & Jones, 2009), which defines concordance as 'partnership in medicine-taking'. This questionnaire consists of 20 items with each item scoring between zero (strongly disagree) and three (strongly agree), giving a possible range of 0–60. Higher scores indicate a more positive attitude to concordance with young people.

Effects of the Masterclass on attitudes to partnership in medicine-taking[2]

	Mean	Median	Interquartile range
Immediate effects (straight after workshop)[3]			
Prior to the Masterclass	42.12	42	37-46
Straight after the Masterclass	48.53	49	46-52
Effects over time (after 4-6 weeks)[3]			
Prior to the Masterclass	42.57	43	37-49
Straight after the Masterclass	49.00	49	46-52
4-6 weeks after the Masterclass	47.11	48	42-53

Immediate effects.

In total, 97 participants completed questionnaires. Professionals' attitudes towards partnership significantly increased ($Z = -7.84$, $p < .001$) from before the Masterclass to straight after.

By Professional Grouping

Medics

	Mean	Median	Interquartile range
Immediate effects (straight after workshop)			
Prior to the Masterclass	40.56	40	37-43
Straight after the Masterclass	49.81	49	46-53

Nursing staff

[1] The wording was changed from 'patient' to 'young person' to make it relevant for healthcare professionals who may work across a wide age range

[2] Nonparametric tests were used because assumptions about the normality were not met. In particular, the Wilcoxon signed-rank test was used to compare 'immediate effects' as there were two time points and the Friedman test was used for 'effects over time' as there were three time points.

[3]Different sample sizes for those that completed questionnaires straight after the Masterclass (n=97) and those that completed questionnaires at the four-to-six-week follow up (n=34).

	Mean	Median	Interquartile range
Immediate effects (straight after workshop)			
Prior to the Masterclass	42.78	43	38-47
Straight after the Masterclass	48.27	49	46-52

Allied Health

	Mean	Median	Interquartile range
Immediate effects (straight after workshop)			
Prior to the Masterclass	42.12	42	37-46
Straight after the Masterclass	48.53	49	46-52

Other

	Mean	Median	Interquartile range
Immediate effects (straight after workshop)			
Prior to the Masterclass	41.69	42	36-46
Straight after the Masterclass	47.73	51	40-53

Differences were still present when broken down by professional groupings for medics (n=16), ($Z = -3.52$, $p < .001$), nursing staff (n=33), ($Z = -4.60$, $p < .001$), allied health staff (n=34) ($Z = -4.66$, $p < .001$), and those that were classified as other (n=14), ($Z = -2.51$, $p < .12$).

Effects over time

In total, 34 participants completed questionnaires asking about attitudes to partnership across the three time points. There was a statistically significant difference between attendees' attitudes towards partnership between the three time points ($\chi2(2) = 40.41$, $p < 0.001$).

Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < 0.017$. When applied, there was a significant difference between attitudes prior to the Masterclass and straight after the Masterclass ($Z = -5.02$, $p < 0.001$). There was also a significant difference between attitudes prior to the Masterclass and at four-to-six-weeks' follow-up ($Z = -4.05$, $p < 0.001$). There was no significant difference between attitudes straight after the Masterclass and four-to-six weeks later ($Z = -1.76$, $p = 0.079$).

By Professional Grouping

Medics

	Mean	Median	Interquartile range
Effects over time (after 4-6 weeks)[3]			
Prior to the Masterclass	38.75	37.5	37-41.5
Straight after the Masterclass	48.25	47.5	44.25-52.75
4-6 weeks after the Masterclass	46.38	47	39.75-52

When broken down by professional grouping, there was a statistically significant difference between medics' (n=8) attitudes towards partnership between the three time points ($\chi2(2) = 12.45$, $p < 0.01$). Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < 0.017$. When applied, there was a significant difference between attitudes prior to the Masterclass and straight after the Masterclass ($Z = -2.52$, $p = 0.012$). There was also a significant difference between attitudes prior to the Masterclass and at four-to-six-weeks' follow-up ($Z = -2.52$, $p = 0.012$). There was no significant difference between attitudes straight after the Masterclass and four-to-six weeks later ($Z = -0.68$, $p = 0.497$).

Nursing Staff

	Mean	Median	Interquartile range
Effects over time (after 4-6 weeks)[3]			
Prior to the Masterclass	42.29	43	37.25-49.75
Straight after the Masterclass	47.83	47.5	44.5-51.5
4-6 weeks after the Masterclass	47.08	47.5	42.75-59.75

When broken down by professional grouping, there was a statistically significant difference between nursing staff (n=12) attitudes towards partnership between the three time points ($\chi2(2) = 13.83$, $p < 0.01$). Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < 0.017$. When applied, there was a significant difference between attitudes prior to the Masterclass and straight after the Masterclass ($Z = -3.06$, $p = 0.002$). There was no significant difference between attitudes prior to the Masterclass and at four–to-six-weeks' follow-up ($Z = -2.52$, $p = p = 0.025$). There was no significant difference between attitudes straight after the Masterclass and four-to-six weeks later ($Z = -0.54$, $p = 0.59$).

Allied health staff

	Mean	Median	Interquartile range
Effects over time (after 4-6 weeks)[3]			
Prior to the Masterclass	45.08	49	37.5-50.5
Straight after the Masterclass	50.38	52	48-52.5

4-6 weeks after the Masterclass	46.92	51	38-53

When broken down by professional grouping, there was a statistically significant difference between allied health staff (n=13) attitudes towards partnership between the three time points ($\chi2(2) = 14.74$, $p < 0.01$). Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < 0.017$. When applied, there was a significant difference between attitudes prior to the Masterclass and straight after the Masterclass ($Z = -3.06$, $p = 0.002$). There was no significant difference between attitudes prior to the Masterclass and at four-to-six-weeks' follow-up ($Z = -2.15$, $p = p = 0.32$). There was no significant difference between attitudes straight after the Masterclass and four-to-six weeks later ($Z = -2.25$, $p = 0.24$).

Other

	Mean	**Median**	**Interquartile range**
Effects over time (after 4-6 weeks)[3]			
Prior to the Masterclass	41.69	42	36-46
Straight after the Masterclass	50.38	52	51-53
4-6 weeks after the Masterclass	44.62	48	39-51

When broken down by professional grouping, there was a statistically significant difference between the other staff (n=13) attitudes towards partnership between the three time points ($\chi2(2) = 23.80$, $p < 0.01$). Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < 0.017$. When applied, there was a significant difference between attitudes prior to the Masterclass and straight after the Masterclass ($Z = -2.15$, $p = 0.012$). There was no significant difference between attitudes prior to the Masterclass and at four-to-six-weeks' follow up ($Z = -3.19$, $p = 0.34$). There was no significant difference between attitudes straight after the Masterclass and four-to-six weeks later ($Z = -.39$, $p = 0.13$).

Section3: Impact of the Masterclass on communication skills with young people, and perceived barriers to collaborative practice

Listening and communication skills were measured using the Effective Listening and Interactive Communication Skills (ELICS) questionnaire (King, Servais, Bolack, Shepherd, & Willoughby, 2012). This questionnaire consists of 24 items with four subscales (action-oriented listening, exploratory listening, consensus-oriented listening, and receptive listening). Each item is scored from 'one' (Not at all) to 'seven' (to a very great extent). Higher scores on each of the four subscales indicate they are engaging with each subscale behaviour to a greater extent.

As this is a behavioural measure asking professionals to reflect on their practice with young people, data was only analysed at two time points: prior to taking the Masterclass and four–to-six weeks after the Masterclass. Thirty-eight [4]healthcare professionals completed questionnaires prior to the Masterclass and four-to-six weeks after the Masterclass.

	Mean	Median	Interquartile range
Action-Oriented Listening			
Prior to the Masterclass	5.11	5.25	4.25-6.00
4-6 weeks after the Masterclass	6.09	6.25	5.75-6.81
Exploratory Listening			
Prior to the Masterclass	5.17	5.14	4.53-6.00
4-6 weeks after the Masterclass	6.16	6.21	5.86-7.00
Consensus-Oriented Listening			
Prior to the Masterclass	5.28	5.42	4.71-6.00
4-6 weeks after the Masterclass	6.22	6.36	6.00-7.00
Receptive Listening			
Prior to the Masterclass	5.47	5.67	4.79-6.33
4-6 weeks after the Masterclass	6.37	6.58	6.00-7.00

Action-Oriented Listening

Action-oriented listening is defined as listening directed towards implementation or outcome-oriented aspects of practice. This type of listening moves the intervention process along by engaging the client in prioritising issues and determining next steps, thereby facilitating the client's sense of control regarding the nature, direction and pace of the intervention.

Within the questionnaire, there were four questions related to exploratory listening: To what extent to you: (a) encourage people to lead the direction and pace of intervention? (b) engage in action planning to establish the next step? (c) prioritise issues with people? (d) work to create a shared vision of the desired end outcome?" There was a significant increase in healthcare professionals' reports of action-oriented listening between prior to

[4] There were four more competed questionnaires for the ELICS than the LATCON 11

the Masterclass (M =5.11, SD = 1.11) and four-to-six weeks after the Masterclass (M =6.09, SD = 0.94); t(37)=-6.86, p <0.001).

By Professional Grouping

Differences for action-oriented listening were significant across all professional groupings. For medics there were significant increases when comparing scores prior to the Masterclass (M =4.48, SD = 1.35) and scores four-to-six weeks after the Masterclass (M =5.78, SD = 0.97); t(8)=-3.14, p <0.05). There were also significant increases for nursing staff when comparing scores prior to the Masterclass (M =4.73, SD = 1.17) and scores four-to-six weeks after the Masterclass (M =5.92, SD = 0.90); t(12)=-4.51, p <0.001), as there were for allied health staff when comparing scores prior to the Masterclass (M =5.58, SD = 0.78) and scores four–to-six weeks after the Masterclass (M =6.36, SD = 0.74); t(14)=-3.62, p <0.05).

Exploratory Listening

Exploratory listening is defined as a more active form of listening. It involves information sharing, dialogue, questioning, encouraging, and challenging of clients. In exploratory listening, the professional shares information related to the young person's worries and concerns, and encourages the client to ask questions.

Within the questionnaire, there were seven questions related to exploratory listening: To what extent to you: (a) try to keep people talking about their issues, even when you are having a busy day? (b) encourage people to ask questions? (c) provide information, education, and instruction? (d) challenge people who seem stuck on an issue, to encourage them? (e) explore people's worries and concerns? (f) feel you are able to identify a person's greatest worry or concern about an issue, and the reason why? (g) challenge people when you think this will be helpful in assisting them to take a next step? There was a significant increase in healthcare professionals reports of exploratory listening, prior to the Masterclass (M =5.17, SD = 1.06) and four-to-six weeks after the Masterclass (M =6.16, SD = 0.86); t(37) = -7.87, p<0.001).

By Professional Grouping

Differences for exploratory listening were significant across all professional groupings. For medics there were significant increases when comparing scores prior to the Masterclass (M =4.65, SD = 1.20) and scores four-to-six weeks after the Masterclass (M =5.81, SD = 0.96); t(8)=-3.55, p <0.05). There were also significant increases for nursing staff when comparing scores prior to the Masterclass (M =5.11, SD = 1.15) and scores four-to-six weeks after the Masterclass (M =6.04, SD = 0.93); t(12)=-4.87, p <0.001), and for allied health staff when comparing scores prior to the Masterclass (M =5.54, SD = 0.83) and scores four-to-six weeks after the Masterclass (M =6.43, SD = 0.71); t(14)=-3.88, p <0.05).

Consensus-Oriented Listening

Consensus-oriented listening is defined at the ability to establish a shared perspective or understanding regarding decisions and jointly determined goals. These include practices such as brainstorming with the client about how to proceed and explaining reasons and rationales for what is proposed.

Within the questionnaire, there were seven questions related to consensus-oriented listening: To what extent to you: (a) pay particular attention to non-verbal cues when you first meet people? (b) explain reasons or rationales for the things you propose? (c) clarify agreed-upon goals? (d) try to ensure that the person understands what has been achieved or agreed upon in the encounter? (e) check that the other person has understood what you have said? (f) brainstorm ideas with people? (g) try to reach a shared perspective or jointly agreed-upon decision? There was a significant increase in healthcare professionals' reports of consensus-oriented listening between the two time points: prior to the Masterclass (M =5.28, SD = 0.96) and four–to-six weeks after the Masterclass (M =6.22, SD = 0.82); $t(37)= -7.06$, $p<0.001$).

By Professional Grouping

Differences for consensus-oriented listening were significant across all professional groupings. For medics there were significant increases when comparing scores prior to the Masterclass (M =4.95, SD = 1.09) and scores four-to-six weeks after the Masterclass (M =5.87, SD = 1.09); $t(8)=-2.78$, $p <0.05$). There were also significant increases for nursing staff when comparing scores prior to the Masterclass (M =4.98, SD = 1.07) and scores four-to-six weeks after the Masterclass (M =6.08, SD = 0.78); $t(12)=-4.75$, $p <0.001$), and for allied health staff when comparing scores prior to the Masterclass (M =5.71, SD = 0.66) and scores four-to-six weeks after the Masterclass (M =6.51, SD = 0.58); $t(14)=-4.07$, $p <0.001$).

Receptive listening

Receptive listening is defined as being open to the client's input, experiences, beliefs, and life situations; and also paying attention to what is not being said. The intent of receptive listening is to gain a full understanding of the client's situation, concerns, and expectations regarding intervention, and to acknowledge the legitimacy of their concerns.

Within the questionnaire, there were six questions related to receptive listening: To what extent to you: (a) acknowledge that people's concerns are legitimate, to make them feel heard? (b) try to be open to what people are saying to you? (c) listen to what is not being said? (d) try to fully understand the person's perspective? (e) try to be present in the moment with the person?, and (f) try to be aware of when people want to be engaged and when they do not? There was a significant increase in healthcare professionals' reports of receptive listening, prior to the Masterclass (M =5.47, SD = 1.00) and four-to-six weeks after the Masterclass (M =6.38, SD = 0.75); $t(37)= -7.73$, $p<0.001$).

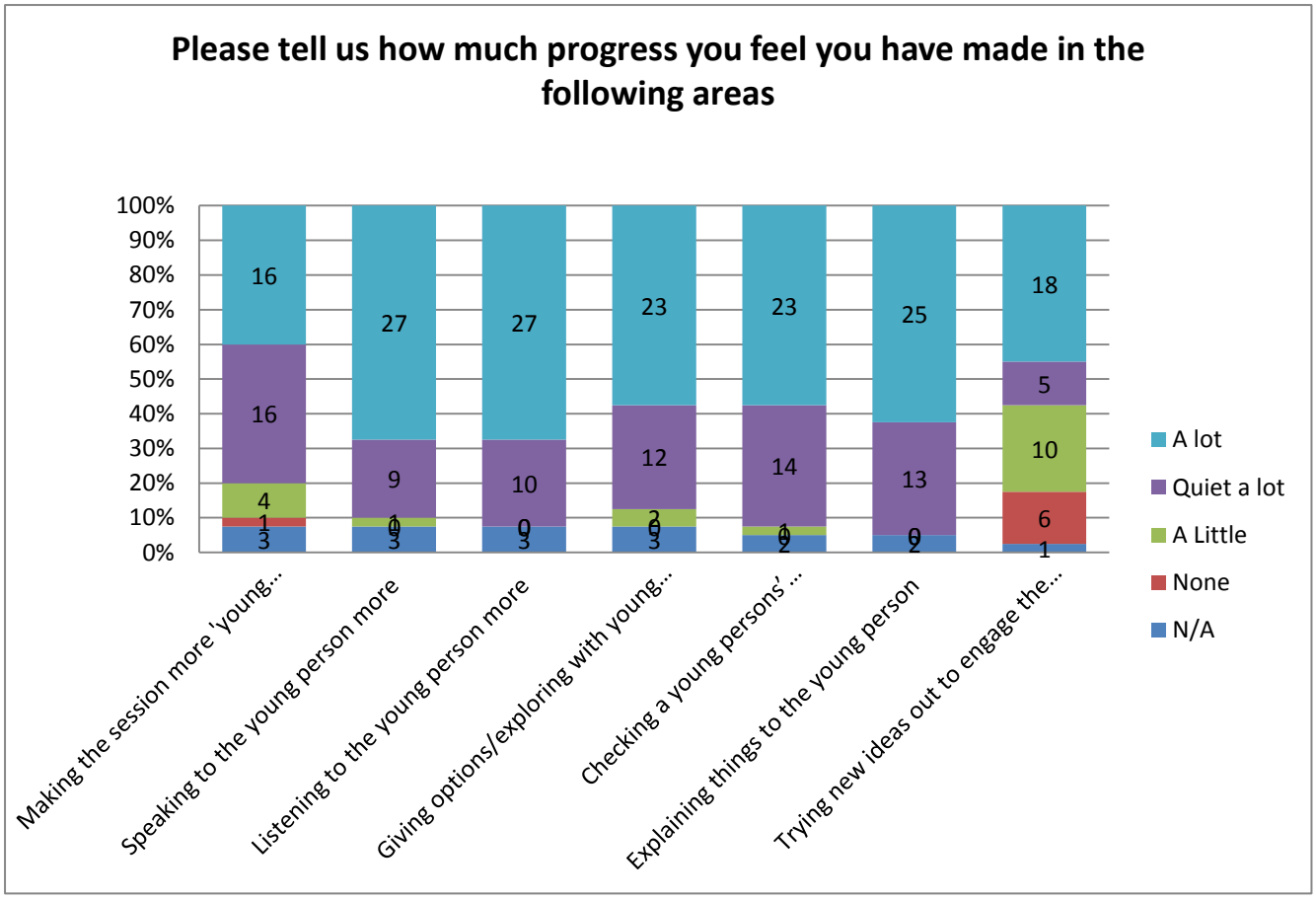
By Professional Grouping

Differences for receptive listening were significant across all professional groupings. For medics there were significant increases when comparing scores prior to the Masterclass (M =5.13, SD = 1.06) and scores four–to-six weeks after the Masterclass (M =6.11, SD = 0.83); $t(8)=-3.56$, $p <0.01$). There were also significant increases for nursing staff when comparing scores prior to the Masterclass (M =5.33, SD = 1.14) and scores four–to-six weeks after the Masterclass (M =6.21, SD = 0.81); $t(12)=-4.31$, $p <0.001$), as there were for allied health staff

when comparing scores prior to the Masterclass ($M = 5.79$, $SD = 0.82$) and scores four-to-six weeks after the Masterclass ($M = 6.64$, $SD = 0.57$); $t(14) = -4.67$, $p < 0.001$).

Section 4: Healthcare professionals' goals set after the Masterclass and to what extent these were achieved

At the end of Masterclass, healthcare professionals were asked to set goals they wanted to focus on in future. Thematic analysis was conducted and seven themes emerged. These were: making the session more 'young person'-led, speaking to the young person more, listening to the young person more, giving options/exploring with the young person, checking a young person's understanding, explaining things to the young person, and trying new ideas out to engage young people (i.e. storyboard/visual aids). At four-to-six weeks' follow up, professionals were then asked how much progress they had made with achieving their goals. Forty healthcare professionals responded:



Feedback related to progress in different goals healthcare professionals could have set themselves was positive, with over 55% of total responses being either 'A lot' or 'Quite a bit'. The area that healthcare professionals reported themselves as having made the most progress in was 'explaining things to the young person', with 95% reporting that they had made 'A lot' or 'Quite a bit' of progress. This was closely followed by 'listening to the young person more', with 93% reporting that they had made 'A lot' or 'Quite a bit' of progress.

Conclusion

The aim of 'Me first' was to increase collaborative practice between young people and healthcare professionals. To achieve this, healthcare professionals were presented with a six-step communications model developed by Common Room Consulting Ltd., took part in collaborative practice activities, and reviewed core principles for prompting and developing effective healthcare dialogue. Twelve Masterclasses took place at Great Ormond Street Hospital (GOSH) between March 2015 and December 2015.

Overall, it appears that 'Me first' was successful in significantly increasing healthcare professional-reported collaborative practice skills (exploratory listening, consensus-oriented listening, receptive listening, and action-oriented listening). Similarly, attitudes towards partnership with young people also appear to have been positively affected by the Masterclass and maintained at four-to-six weeks after the Masterclass. It is less clear how behaviours and attitudes are affected by professional groupings due to small sample sizes and low completion rates for the questionnaires at four-to-six weeks' follow up.

A thematic analysis of goals set during the Masterclass revealed seven themes: making the session more young person led, speaking to the young person more, listening to the young person more, giving options/exploring with the young person, checking the young person's understanding, explaining things to the young person, and trying new ideas to engage young people.

Low completion rates for the questionnaires at the four–to-six-week follow-up have resulted in smaller sample sizes than hoped for (n=34). This means that some results should be treated with caution as those who did not complete may have not shown changes, skewing results.

References

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