Post impact and summary of findings following the evaluation of the RESPOND multi-agency mental health simulation training November 2016 – March 2017

Executive Summary

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1. Introduction

This report describes the findings from an evaluation of the RESPOND multi-agency mental health simulation training provided to professionals working in the mental health crisis care across the Northern England Strategic Clinical Network. It provides a summary of key findings and will provide recommendations to inform future training. The immediate and longer term impact of the training is summarised, based on the feedback from participants who attended five sessions over the period November 2016 to March 2017.

The RESPOND training programme was designed by Northumberland Tyne and Wear Foundation Trust, Northumbria Police, Tees Esk and Wear Valley Foundation Trust, Newcastle City Council, North East Ambulance Service & Fulfilling Lives based on priorities identified from local Mental Health Crisis Care Concordat events. The North East and North Cumbria Urgent and Emergency Care Network vanguard, through the Academic Health and Science Network, supported the development and delivery of the scheme after a successful pilot project funded by NHS England through the UEC Vanguard in collaboration with the Northern England Clinical Networks.

Respond is a unique multi-agency simulation training package for professionals involved in mental health crisis pathway, which creates hypothetical scenarios that the trainees respond to. By increasing collaboration and knowledge, it equips teams to improve crisis care responses through creating stronger relationships between agencies, including acute services, police, paramedics and mental health workers. Two methods of Respond simulation training are used: 'Desktop' and immersive using the 'Hydra method[1]'. Both approaches deliver exercises to develop decision makers to better manage critical incidents.

This report provides an independent evaluation of the impact of the two different methods of RESPOND simulation training undertaken between November 2016 and March 2017. The aim was to track the quality and impact of the training as the training programme was rolled out. To provide a suitable sample one training session out of the four training sessions held per month was selected. In total five sessions (25% of the total number of sessions), involving 53[2] participants, were evaluated. Participants included a range of professionals; Approved Mental Health Professionals (AMHP), crisis mental health practitioners, social workers, Police, Section

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[1] The Hydra method uses Northumbria Police Forces Hydra Suite. Hydra methodology is incident management software used to increase critical and strategic decision making skills. The group is split into three groups of 6 and placed in syndicate rooms. A team of directing staff comprised of learning experts and subject matter experts run the exercise from a central control room. A facilitator also observes the behaviors and requests from the micro world participants. The facilitators can see and hear teams at all times via CCTV and everything entered on the teams' computers is also displayed in the control room.

[2] Based on the information received by the evaluators, and excluding Experts by Experience

12 Doctors, psychiatrists and ambulance staff/paramedics. In addition Experts by Experience (EBE) attended the sessions.

The Simulation Training seeks to streamline and improve the efficiency of the care pathway to reduce wasted time and provide a better experience for the service user. The full Aims and Objectives are appended.

The evaluation process was administered by Quintessent Ltd, an independent company, on behalf of the Academic Health Science Network.

2. The evaluation process and methodology

The detail of the evaluation process and the uptake of the questionnaires and interviews are detailed in Appendix 2 and Tables 1 -2 below. The findings draw on the data collected from the pre and post training questionnaires, the Post impact interviews and Expert by Experience feedback.

The post programme evaluations measured immediate impact and were undertaken six to eight weeks after each session. The longer term impact was measured through the **post programme impact evaluation**, completed after the completion of the training programme between May and September 2017. The evaluation uses the Kirkpatrick Evaluation Framework[3] outlined in Appendix 1

Constraints: A number of known factors affected the number of completed questionnaires, uptake of interviews and comprehensiveness of the data and measures were undertaken to reduce the impact of these factors in conjunction with the organisers of the training.

Pre and post training evaluation findings

Reports, based on feedback from on-line questionnaires, were produced for each training session reflecting levels of confidence, skills and knowledge prior to the training and following the training. These reports have been submitted to RESPOND and Academic Health Science Network (AHSN).

Post impact findings

A semi structured interview process was used to provide insights as to the usefulness and impact of the training on a longer term basis. For this impact evaluation all participants (excluding EBE) were invited to participate in the post impact evaluation.

Tables 1 – 2 below summaries the evaluation and questionnaire methodology, process, and uptake.

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[3] Reference Kirkpatrick

Table 1: Summary of evaluation and questionnaire methodology, process, and uptake

Method	Kirkpatrick level(s)	Change measured	Questionnaire development	Uptake - % of completed questionnaires or interviews	
				By total number of participants attending the five sessions (excluding EBE) n= 53	By number of participants who completed both pre and post training questionnaire n=53
Pre-training self assessment questionnaire		Baseline	Questions mapped/aligned to training aims and anticipated outcomes	58% (31)	42% (22)
Post training self assessment questionnaire	1, 2, 3	Episodic change, developmental change	Questions specifically related to the individual event: - Relevance, content and delivery, - Overall acquisition of skills and knowledge and application into work practice -Confidence, knowledge and abilities compared to pre programme data	55% (29)	42% (22)
Impact evaluation **Semi structured telephone interviews**	2, 3, and 4	Episodic change, developmental change and transformational change	3 main lines of enquiry to assess longer term impact and sustainability: -Confidence and capability of participants in their role - -Application of learning from the programme with focus on the implementation of skills and knowledge acquired from the training -Impact on and benefits to patients and wider organisations	26% (14)	N/A

Table 2. Breakdown of participants

Date of session	Participants attending each session[4]	Participants who completed the pre training questionnaire (%[5] of all attendees at session n= 53)[6]	Participants who completed the post training questionnaire (%[7] of all attendees at session n= 53)[8]	Participants who completed both the pre and post training questionnaires (%[9] of all attendees at session n= 53)	Participants who participated in the post impact interviews (% of all attendees at session n= 53)
Nov 2016	11	7	5	3 (27%)	3
Dec 2016	8	6	7	6 (75%)	3
January 2017	14	5	6	5 (36%)	2
February 2017	14	8	8	6 (43%)	5
March 2017	6	5	3	2 (33%)	1
Totals	**53**	**31(58%)**	**29(55%)**	**22 (42%)**	**14 (26%)**
Type of approach					
Hydra		14	15	12	8
Desktop		17	14	10	6

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[4] As notified to the evaluators. Excluding EBE

[5] Rounded up

[6] Does not include Experts by Experience or Participants who completed the pre training questionnaire but did not subsequently attend the training session

[7] Rounded up

[8] Includes all participants who completed the post training questionnaire regardless of whether they had also completed the pre training questionnaire

[9] Rounded up

3. Summary of the findings and Conclusions

1.   Overall the results from the evaluation indicate that for the majority of the participants involved in the evaluation, the training has been highly successful in improving the understanding of and collaboration and communication between different professions and agencies working together to care for people experiencing a mental health crisis. It has led to changes in behaviour, approach and work practice for all those involved in the post impact interviews.

2.   Relevance and expectations: There has been a strong positive reaction to the programme from participants. All but one participant reported that the training had been highly to extremely relevant to their current role and for the majority of respondents the training met or exceeded their expectations.

3.   Acquisition of new knowledge and skills: The training has made an impact on a range of key skills and knowledge important for the timely and effective delivery of the crisis care pathway. Overall participants have acquired both knowledge and skills as result of the training. They have more knowledge with regard to the assessment and management of people experiencing a mental health crisis and the majority report their knowledge with regard to legalisation requirements had increased 'a little bit'. In particular they now report good to high levels of knowledge around Place of Safety legislation and Criteria for Detention under the Mental Health Act, and reasonable to high levels of knowledge around Criteria and Responsibilities under Section 136 and the Assessment of Mental Capacity under the Mental Capacity Act 2005, and attribute the training to their greater understanding. Knowledge around the use of restraint remained low for around a third of participants.

4.   Understanding of roles and responsibilities: There is an improvement in participants understanding of their role and responsibilities in the care of service users experiencing a mental health crisis, attributed to a reasonable/ significant degree to the training by three quarters of participants. There is also an improvement in the understanding of their own role by other staff groups and professionals.

5.   Participants also reported a positive change in the understanding of the specific roles of agencies and health and social care professionals involved in the care of people experiencing a mental health crisis, across all staff groups following the training. The largest shift in their understanding was around the roles of ambulance staff /paramedics and the police. Participants indicated an increased understanding of the roles of the police, ambulance/ paramedic staff and AMHP staff was as a result of the training.

6.   Ability to work effectively with other professionals and agencies: Post training, participants reported an improvement in their ability to work effectively with professionals involved in the mental health crisis / emergency care pathway. Self reported levels of ability at the beginning of the training were already good, but these have improved across the agencies and professionals with nearly all participants reporting their ability as good to high. Whilst a direct correlation cannot be made between the training and these improved scores, they

strongly suggest that following the training these participants feel better able to work with other professionals when dealing with people with a mental health crisis.

7.   However, they report only a modest improvement in their ability to undertake a range of key tasks and responsibilities, which they had assessed as 'good' to 'highly able' prior to the training. And, whilst the feedback showed a positive impact on participant's ability to make decisions in partnership with other professionals and agencies and to contact and involve other agencies and professionals, around 30 – 40% of participants reported the training had made little impact on their ability overall.

8.   Confidence: Participants are overall more confident following the training and results show report an improvement in their confidence to communicate, collaborate and work in partnership with other colleagues and other agencies and professionals as well as with service users and their families. In particular overall confidence has improved with regard to offering advice and expert knowledge, supporting staff, communicating with the appropriate agencies decisions made and follow up and for working in collaboration with other agencies and professionals.

9.   Impact of the training on behaviour, approach and work practice: Post training around **two thirds** of participants reported they were applying or starting to apply skills and knowledge from the training. Examples highlighted the impact of the training on the increased and improved understanding of other people's roles and responsibilities, how to work more effectively with other agencies and partners in the pathway and specifically during the Section 136 process, and crucially how to interact more effectively and with greater understanding and empathy with clients.

10.   In the post impact interviews, five to six months later, the application and implementation of skills and knowledge has been sustained with nearly all participants doing something different as a result of the training.

11.   All the participants interviewed, highlighted the impact of the training on their understanding of the roles and responsibilities of other professionals and agencies in the crisis care pathway, which for most of most of those interviewed have led to changes in their approach and interaction with other professionals in the crisis care pathways.

12.   The majority of interviewees said a greater understanding of roles had made a positive impact on their confidence, even when this was 'already good'.

13.   Whilst around of third of the participants are no longer in roles which require them to respond to an immediate mental health crisis, they reported that they are using or will use the learning from the training as and when required and they are using their experience to inform and train their teams and colleagues.

14.   The training has improved patient experience and safety. Nearly all the interviewees related how they had changed their behaviour and /or practice with regard to patients/clients/ users and nearly all of them specifically mentioned the presence of an Expert by Experience,

which for some had had a profound impact on their way of working with patients and people experiencing a mental health crisis.

15.   Cascading the learning: Nearly all participants have passed on the learning from the training in some way. A few have done these formally through specific sessions with their teams and / or individuals in their organisations, but for most it has been done informally through feedback and review of cases. A number of them have encouraged or arranged for colleagues and staff to attend the RESPOND training and all the interviewees recommended the training.

16.   Added value and unexpected benefits of the training: The format of the training, the presence of EBE and the multi disciplinary nature of the training were cited as having added value to the training and given unexpected benefits.

17.   Difference between the Desktop and Hydra Approach: In the majority of the areas evaluated, there was no discernible difference between the two different approaches. There were, however, some interesting differences in some specific areas. However, it should be noted that due to the small numbers involved it is not possible to assess whether these differences are statistically significant.

18.   More of the Hydra respondents scored the training as 'extremely relevant' and reported that training had met or exceeded their expectations compared to those who completed the Desktop training. They also reported a greater shift in confidence levels both overall, and for specific areas of communication and collaboration, and higher levels of understanding of their role and responsibilities, though it was less clear whether this had been as result of the training compared to the Desktop approach.

19.   The training approach also may have made a differential impact on participants with regard to improving ability for key tasks, for example, those attending the Hydra session reporting a significantly improved ability overall.

4. Recommendations

1. Develop clearer guidance as to who should attend and will benefit the most from the training

2. Strengthen course content with regard to skills acquisition, ability to work effectively with professionals involved in the mental health crisis / emergency care pathway, and the use of restraint

3. Retain the format and inclusion of EBE as key elements of the training

4. Consider adapting the training format to reflect other crisis situations

5. Consider facilitating and /or developing opportunities for participants to follow up the training and continue joint working with a range of agencies and professions, this might include participation in training offering different scenarios such as case review meetings and shadowing opportunities.

Appendix 1. Aims and objectives of the training

The delivery of the Simulation Training seeks to streamline and improve the efficiency of the care pathway to reduce wasted time and provide a better experience for the service user, and aims to:

- Improve conveyance by supporting the organisations to develop a better understanding of each other's roles, responsibilities and how they can work together to ensure care is coordinated.

- Ensure service users will receive the right care and are taken to the most appropriate facilities in a timely manner. A more timely response to crisis will impact positively on outcomes.

- Improve patient experience, which will reduce the stress of a crisis and improve outcomes.

- Improve the knowledge and understanding of mental health of all of the participants. As a result it can be assumed that they will be more confident in recognising mental health problems and will know what to do when they do come across a person with a mental health problem. This should mean that mental health problems are identified and treated more quickly.

- Improve staff knowledge of legislation and what the different agencies can and can't do. For example, it will improve staff knowledge of when the mental health act can be used and when restraint can and can't be used.

- Improve patient experience and safety by increasing confidence, communication and collaboration of all staff involved.

- Enable each agency to understand the role of the other agencies in the pathway.

- Identify more effective ways of working together.

- Improve staff confidence and competence in their specific roles in the pathway.

- Save time both for service users and professionals and thereby save money.

- Better equip professions involved in the wider mental health crisis/emergency care pathway to respond quickly and appropriately and improve individual outcomes.

Appendix 2: Kirkpatrick Evaluation Framework

Evaluation framework		Level	Evaluation type (what is measured)	Evaluation description and characteristics	Examples of evaluation tools and methods
Episodic Change	The acquisition, use and impact of new knowledge and tools	1	**Reaction**	**Reaction evaluation** is **how the delegates felt** about **the training or learning experience.**	'Happy sheets', feedback forms. Verbal reaction, post-training surveys or questionnaires.
		2	**Learning**	**Learning evaluation** is the measurement of the **increase in knowledge** - before and after.	Typically assessments or tests before and after the training. Interview or observation can also be used.
Developmental change	Sustainable change an individual behaviour and/or approach to the implementation of a complex programme	3	**Behaviour**	**Behaviour evaluation** is the extent of **applied learning** back on the job - implementation.	Observation and interview over time are required to assess change, relevance of change, and sustainability of change.
Transformational change **Quality and service improvement**	Fundamental shifts in behaviour and performance Impact on the organisation by the individual as a result of the learning from the programme	4	**Results**	**Results evaluation** is the **effect on the business or environment** by the trainee.	Measures are already in place via normal management systems and reporting - the challenge is to relate to the participant.