An Evaluation of the SAGE & THYME

Communication Skills Training

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1. Introduction

a) Service Evaluation Context

This service evaluation project (SEP) was commissioned by Dr Gary Latchford, Consultant Clinical Psychologist at Leeds Teaching Hospitals NHS Trust (LTHT). The project was designed to evaluate the SAGE & THYME^{TM} communication skills training currently being delivered at LTHT. LTHT employs over 15,000 people across 7 hospitals, and treats approximately 1.5 million patients a year (NHS Employers, 2015). So far, sixteen LTHT members of staff have been trained to deliver the SAGE & THYME^{TM} Level 1 Communication Skills Training, and all members of LTHT staff have been encouraged to attend the training.

b) Literature Review

Impact of psychological distress on physical health

Psychological distress is common in individuals with physical illnesses (Mehnert, Brahler, Faller, Harter, Keller et al., 2015; Mitchell, Chan, Bhatti, Halton, Grassi et al., 2011; National Institute of Clinical Excellence, 2004; Rejinders, Ehrt, Weber, Aarsland & Leentjens, 2008), and has been associated with a number of poor outcomes such as experiencing a significantly higher number of physical symptoms (Katon, Lin & Kroenke, 2007), a reduced quality of life (Shih & Simon, 2008), and an increased risk of mortality (Rasul, Stansfeld, Hart, Gillis & Smith, 2004). Therefore, reducing psychological distress in individuals with physical illnesses has the potential to improve outcomes of treatment for physical illness.

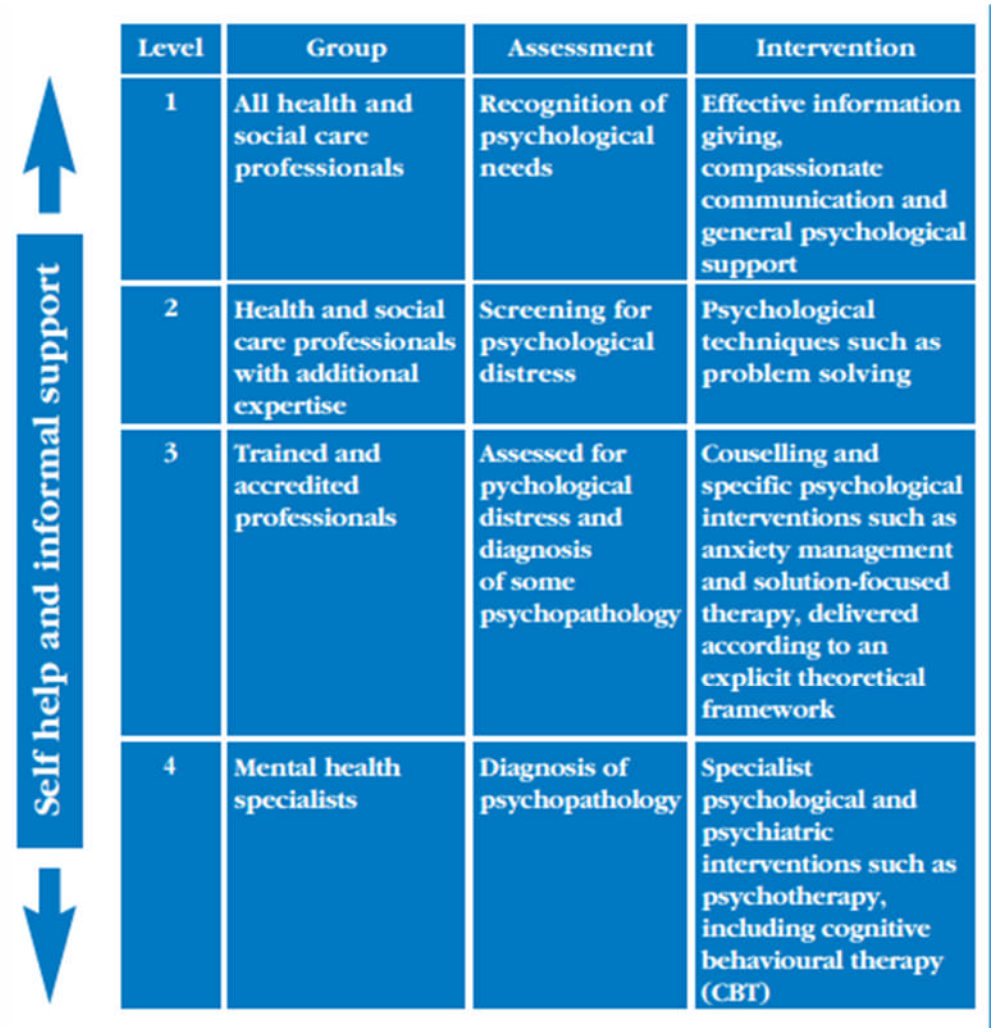
However, it has been suggested that healthcare professionals who provide much of the general psychological support to patients and carers lack appropriate psychological assessment skills, meaning that psychological distress is often not

recognised or dealt with (NICE, 2004). As a result of these observations, NICE (2004) developed a four-tiered model of psychological assessment and support (see Figure 1). This model stipulates that all healthcare staff are expected to be able to recognise psychological distress, communicate in a compassionate manner, and provide general psychological support (NICE, 2004).

Importance of Communication Skills

Effective communication between healthcare professionals and patients is considered a key determinant of patient satisfaction, compliance with treatment and recovery (King & Morris, 2004). In 2015, the Department of Health in England updated the National Health Service constitution, which outlines values and principles that guide how the NHS should act. The constitution emphasises that "we respond with humanity and kindness to each person's pain, distress, anxiety or need…we find time for those we serve and work alongside. We do not wait to be asked, because we care" (DOH, 2015). Furthermore, the Patients' Association (2015) suggest that "patients want to be treated humanely, with compassion and listened to. Far too often this is not people's experience" (p.6). They also suggest that the needs of patients are frequently overlooked due to increasing demands and frequent reorganisations of NHS services (The Patients' Association, 2015). Indeed, the Francis report (2013) highlighted failures in healthcare professionals responding to the needs of patients in distress. Bramhall (2014) suggests that these failures may have been due to inadequate formal or structured communication skills training.

Figure 1. NICE (2004) model of psychological assessment and support



Level	Group	Assessment	Intervention
1	All health and social care professionals	Recognition of psychological needs	Effective information giving, compassionate communication and general psychological support
2	Health and social care professionals with additional expertise	Screening for psychological distress	Psychological techniques such as problem solving
3	Trained and accredited professionals	Assessed for pychological distress and diagnosis of some psychopathology	Couselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework
4	Mental health specialists	Diagnosis of psychopathology	Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy (CBT)

Communication Skills Training

Despite recommendations that healthcare staff should receive training in communication skills (e.g. Royal College of Physicians, 2014), research into communication skills training for general healthcare staff has been largely neglected (Connolly, Perryman, McKenna, Orford & Thomson et al., 2010). Connolly et al. (2010) note that in particular there is little evidence relating to the value of short, skills-based training in basic emotional support.

Promoting effective communication in healthcare setting is challenging, due to

the nature of the stressful and pressurised work environment, which provides little time for communication (Bramhall, 2014). In order to overcome the challenges of effective communication in healthcare settings, Bramhall (2014) suggests that healthcare professionals need to receive high-quality, evidence-based training.

The SAGE & THYME^{TM} model

The SAGE & THYME^{TM} model of communication skills was designed to train all staff grades to meet the NICE (2004) level 1 requirements set out in Figure 1. SAGE & THYME is a mnemonic (see Appendix 1) that guides staff into, and out of, a conversation with someone who is distressed. Central to the model is the belief that individuals with physical illnesses are able to understand and take some responsibility for their own wellbeing (Connolly et al., 2010). Thus, the model discourages staff from 'fixing', but instead encourages them to empower patients so that they feel more in control of their own situation (Connolly et al., 2010).

The model was developed by a patient and clinical staff at the University Hospital of South Manchester NHS Foundation Trust (UHSM) in 2006, and as previously mentioned, is currently being rolled out across LTHT. Each training session is run by three facilitators, lasts three hours and can train up to thirty members of staff. This training session incorporates facilitators teaching attendees about the model, small group work and role-play.

Evidence for the model so far

Across the UK, over twenty-six thousand healthcare professionals have been trained in SAGE & THYME (Griffiths, Wilson, Ewing, Connolly & Grande, 2015). An evaluation of the training in UHSM where the training was developed concluded that staff

members who had attended the training felt more competent, confident and willing to talk to individuals about ‘emotional troubles’ after the training (Connolly et al., 2010). However, as these conclusions are drawn from self-report measures following the training session and participants were not followed up after the training, this evaluation provides little insight into the impact of this training on their practice. Connolly, Thomas, Orford, Schofield, Whiteside et al. (2014) did follow up participants who had undergone the training 2-weeks and 2-months post training, and report “anecdotal evidence that patients seemed satisfied after having a conversation based on the S&T model” (p. 45). Despite this ‘anecdotal evidence’, participants in this study were not asked for specific examples of how the training had been used in practice.

A further study investigated the impact of the training on 31 district nurses working in palliative cancer home care through focus groups and interviews (Griffiths et al., 2015). At 2-month follow up, participants felt that their communication skills were improved, and all but two had used the model in their practice. All participants who had used the model described finding it beneficial (Griffiths et al., 2015).

Within LTHT, an evaluation of the questionnaires given to attendees immediately post-training revealed that staff felt more confident and willing to talk individuals about their ‘emotional troubles’ following completion of the workshop (Lamb, Youngs, Bennett & Miler, 2014). This evaluation also revealed that staff strongly believed that the training would influence their practice (Lamb et al., 2014), but to date no follow up studies have investigated the actual impact that this training has on LTHT staff who undergo the training.

c) Aims

The aim of the SEP is to evaluate the foundation level SAGE & THYME communication skills training programme currently being delivered within LTHT, with a particular focus on whether attendees go on to use any of the training in their day-to-day professional roles. Based on the findings of the SEP, recommendations will be made on possible improvements to the training.

2. Method

a) Design

The project used semi-structured interviews over two time points to capture expectations of how participants might use the training in their professional roles, and whether they do go on to use the training. Using online questionnaires would have allowed for the possibility of reaching a larger numbers of participants, and may have made it easier for participants to express negative views about the training and model as responses could have remained anonymous. However, online questionnaires were not used as they would not have allowed for such in-depth information about participants' experience of the training to be captured.

b) Participants

89 members of LTHT staff who were registered to attend the SAGE & THYME^{TM} training between June and September 2015 were invited to take part in the project. 11 members of staff expressed an interested in taking part in the evaluation, and 10 of these consented to take part. One member of staff expressed an interest in the evaluation but was unable to do so as their training was cancelled, and they were unable to book onto another training course within the evaluation recruitment period. One participant who consented to take part in the evaluation dropped out of the project prior to the second interview due to time constraints. The profession of each of the participants is illustrated in Table 1.

c) Measures

Each participant underwent two semi-structured interviews; just after the training and again at a later date (see Table 1 for interview timescales). Semi-structured interviews

are considered the best way of researching the motivations behind people's behaviour, and impact of events on their lives (Raworth, Narayan, Sweetman, Rowlands & Hopkins, 2012). Schedules for both interviews were developed following discussions with one facilitator of the training and the project's commissioner (see Appendix 2). These included a number of open-ended and closed questions. The questions asked in the first interview aimed to capture participants' experiences of the training and expectations of how they might use the training in their role. Questions asked in the second interview aimed to capture participants' views on the training, whether they had utilised any of the training in their roles, and if so, how.

d) Procedure

Invitation emails were sent to LTHT staff members who were registered to undergo the training (see Appendix 3) with an attached information sheet documenting why the project was being done and what participation in the project would involve was attached to this email (see Appendix 4). Interested participants were asked to respond to the email declaring their interest. Interested participants then met with the researcher as soon after the training as possible, where they were given a hard copy of the information sheet and the opportunity to ask any questions about the project. Participants who wished to take part in the project at this point were asked to sign a consent form (Appendix 5) documenting this and were then interviewed. Participants were then contacted again a couple of weeks after the first interview to arrange the follow up interview as close to a month after the training as possible. Due to busy schedules, participants were not always able to be interviewed immediately after the training and then a month later. For 2 participants, the second interview was conducted over the telephone due to difficulties with arranging a time to meet.

Table 1. The profession and timescale of interviews for each of the participants

Participant	Profession	Number of weeks after training that first interview took place	Number of weeks after training that second interview took place
1	Medical Secretary	0	4
2	Senior Clinical Support Worker	2	15
3	Specialist Nurse	0	Withdrew from project
4	Medical Secretary	0	10
5	Research Nurse	0	7
6	Child Occupational Therapist	1	6
7	Pharmacy Technician Specialist	2	5
8	Dietician	2	6
9	Nurse	0	4
10	Research Nurse	1	3

e) Data analysis

The responses from the semi-structured interviews were analysed using thematic analysis; “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p.79). This method of analysis was chosen due to its flexibility and suitability to a range of research questions (Braun & Clarke, 2006), and its usefulness in exploring the actual behaviour and attitudes of interviewees

(Vaismoradi, Turunen & Bondas, 2013). An inductive approach was employed for the analysis, meaning that the themes were generated from the data rather than based on pre-existing ideas. The analysis was guided by the six phases of thematic analysis as set out by Braun & Clarke (2006, see Appendix 6). Responses from participants were grouped together, and data from the two sets of interviews were analysed separately.

f) Ethical considerations

This evaluation did not require ethical approval having been deemed a service evaluation under the NHS Health Research Authority's guidance on what constitutes research (2013). This was agreed through discussions with the Research and Innovation department and Quality Assurance team at LTHT.

All data remained confidential and was stored in line with the BPS Code of Human Research Ethics policy document (2014).

g) Credibility

A number of steps were taken to ensure credibility and enhance quality of the project. Firstly, identified themes and subthemes were discussed with the commissioner, resulting in a number of these themes being refined and re-defined. Secondly, data extracts to provide evidence for each theme are included within the results section of this report.

3. Results

This section will explore the results of the two sets of interviews. For each of the two time points, a thematic map illustrating an overview of the themes is presented. Each of the themes will be discussed, alongside extracts from the interviews to provide evidence for the themes.

a) Results from Interview 1

Figure 2 illustrates a thematic map of the responses given at the first set of interviews. Each theme is described in further detail.

Theme 1: It provides a structure

Participants reported that the training had been helpful in enabling them to structure conversations with individuals who are distressed. Identified subthemes suggest that the training provided a framework, gave pointers to use and was able to be adapted to fit individual needs.

Subtheme 1a: A framework you can work through

"It was a framework that you can work through" (P1)

Subtheme 1b: Pointers to use

"It gives you pointers to use" (P5)

Subtheme 1c: Adapting it for practice

"I won't use the 'setting' part as not relevant to role. Almost all my patient contact is via the telephone, so I have no control over the setting" (P4)

Figure 2. Thematic map from the first set of interviews

Theme 2: What I learnt

Participants talked about a number of things they had learnt from the training, including the importance of empathy, paying attention to the patient's perspective and feeling as though they did not need to act as an expert. Furthermore, participants felt the training would increase their confidence in talking to individuals who are distressed, and that the training had enabled them to reflect on their own clinical practice.

Subtheme 2a: The importance of empathy

"Nurses can assume what patients might be thinking so it helps to discuss with patients what else might be on their minds" (P5)

Subtheme 2b: The patient's perspective

"I would find out what patient's expectations are as sometimes they just want you to listen" (P8)

Subtheme 2c: Not being an expert

"It also taught me that I do not always need to give an answer or come up with a solution. That sometimes it's okay to not have to give answers" (P1)

Subtheme 2d: Confidence

"I feel a bit more confident than before I went on it" (the training) (P2)

Subtheme 2e: Reflection on practice

"It made me reflect on myself" (P2)

Theme 3: I would recommend it

Overall, participants spoke highly of the training, and felt that the training should be undertaken by all members of staff. Participants also talked about how using the model would help them to solve problems they face.

Subtheme 3a: Everyone should do it

"I would recommend it to everyone. It is useful in lots of situations, even outside of the hospital" (P4)

Subtheme 3b: Solving problems

"It solves problems before they happen" (P2)

Theme 4: Expectations

A number of expectations of how and when participants might use the model were discussed. Participants spoke about when they expected they would use the model, what situations they expected it to be useful for, and where they thought it might help. There were also expectations about using the model to empower patients.

Subtheme 4a: When I'll use it

"I find myself in situations regularly where I could use it weekly, mostly with other members of staff, although I work with patients a lot too and they can sometimes complain to you- I could use the structure of SAGE & THYME in those situations" (P7)

Subtheme 4b: What it will be good for

"I sometimes get caught up in going over and over things with patients, so that the conversation is making no progress; this model will allow me to process through a conversation and allow me to get to the end." (P1)

Subtheme 4c: Where it might help

"This might allow us to go through telling people the processes of the service, such as that they are on a waiting list, differently" (P1)

Subtheme 4d: Empowering patients

"it will be useful in getting patients to come up with their self-management strategies, my goal would be to get them to come up with their own solutions" (P8)

Theme 5: Barriers

A number of barriers to using the model were also raised. These included a potential lack of opportunity to use the model, difficulties with remembering parts of the model, and feeling that more practice was necessary. Other barriers included participants feeling that they were already using many of the skills taught in the training, and feeling uncertain about the model.

Subtheme 5a: Opportunity

"Where I work at the moment people are only in for short periods of time" (P2)

Subtheme 5b: Remembering

"It will be difficult initially as I try to remember the acronym but once I can remember it, it will be easier to use" (P3)

Subtheme 5c: Need practice

"I think it's quite difficult to do without practice" (P10)

Subtheme 5d: Already doing it

"I feel as though I already do much of what the training taught me, like listening without interjecting- a lot of this is what I would do instinctively" (P1)

Subtheme 5e: Uncertainty about the model

"They used nice neat problems in the role play- in the real world problems may not be so tidy" (P6)

b) Results from Interview 2

Figure 3 illustrates a thematic map of the responses given at the second set of interviews. Each theme is described in further detail.

Theme 1: It has influenced my practice

All participants felt the training had influenced their clinical practice in some way, through listening more to patients, stopping and thinking before interacting with patients, and empowering patients to help themselves. All but one participant reported feeling confident in using the model in their practice, and the majority of participants talked about taking parts of the model rather than using the model as a whole.

Subtheme 1a: More listening

"I've used it to find out why they might feel a particular way. Letting them do more of the talking, and doing more of the listening" (P8)

Subtheme 1b: Stop and think

"It has made me think about things a bit more, like how to deal with it in a more sensitive way, it has made me stop and think a bit more." (P7)

Subtheme 1c: Empowering patients

"The important thing is facilitating their capabilities….acknowledging their ability to help themselves." (P9)

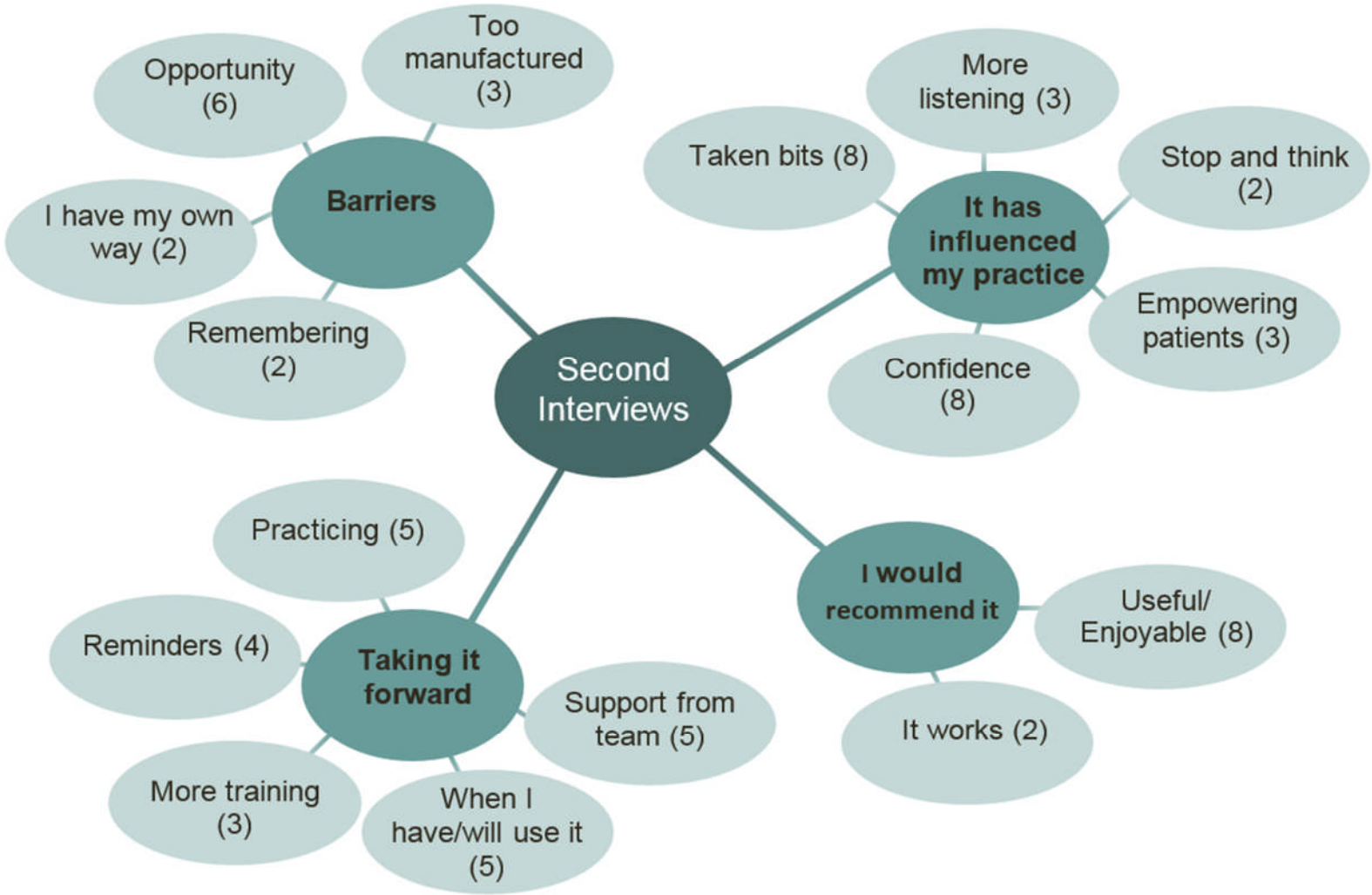
Subtheme 1d: Confidence

"I would be more confident if the patient was very distressed." (P5)

Subtheme 1e: Taken bits

"I have been thinking more about gathering information, so in normal interactions it has raised my awareness of gathering info. But I haven't used all of it." (P1)

Figure 3. Thematic map from the second set of interviews



Theme 2: I would recommend it

Once again, participants reported that they would recommend the training to other staff. Almost all participants described the experience as useful or enjoyable, and two participants described experiences of using the model successfully.

Subtheme 2a: Useful/enjoyable

"It was the most useful bit of training I've done for a long time. It's so applicable." (P6)

Subtheme 2b: It works

"The times I've gone through it the best as I can it has worked." (P1)

Theme 3: Barriers

Participants described a number of barriers to putting the model into practice, which included having a lack of opportunity to use the model, difficulties with remembering parts of the model, feeling that they already have their own way of talking to distressed individuals, and concerns about the model being too artificial to use in its entirety.

Subtheme 3a: Opportunity

"I haven't had the opportunity to use it yet." (P5)

Subtheme 3b: Remembering

"I can't remember much about the model. It was quite a while back" (P2)

Subtheme 3c: I have my own way

"Maybe if I was new to the role I would have found it more useful. But I have my own way of dealing with difficulties." (P7)

Subtheme 3d: Too manufactured

"It feels too manufactured. It's not natural to think in acronyms" (P1)

Theme 4: Taking it forward

A number of participants discussed ways that they planned to use what they had learnt from the training in the future, which included discussions about when they will use the model in the future. Participants also discussed a number of things that they would find helpful in continuing to put the model into practice, which included practising using the model more, being reminded of the model, having more training on interacting with individuals who are distressed, and for whole teams to undergo the training so that they can be supported by others in their team.

Subtheme 4a: When I have/will use it

"A lot of time I go with my gut instinct. When it looks like it will be a harder conversation, then I will look at the card." (P1)

Subtheme 4b: Practising

"But it still feels early, I think it will get better when I'm not having to go through the script, when I become more practiced at it" (P1)

Subtheme 4c: Reminders

"Repetition is a good way (of learning)…it could be a screensaver." (P8)

Subtheme 4d: More training

"I would like more training on how to recognise psychological needs. Sometimes I don't pick up on them. Sometimes I don't realize. A foundation course or something. Something more on picking up people's…signs of people being distressed. Some people keep it all in, so we need to know about the more subtle signs." (P2)

Subtheme 4e: Support from team

"You need to work in a supportive environment. It's a culture thing as well" (P10)

4. Discussion and Conclusions

a) Summary of Findings

Participants were initially interviewed before they had had the opportunity to use the training in their roles, in order to investigate their experiences of training and expectations of how they might use the training in their day-to-day job. Overall, at this stage participants discussed a number of things that they had gained from the training. They talked about what they had learnt from the training, including ideas central to the model such as an emphasis on the patient's perspective, the importance of empathy and not feeling that they have to do the 'fixing'. Participants also talked about how the model provided structure to interactions with distressed individuals, expectations of when and how they might use the model to empower patients, and their enthusiasm for the model. However, there was also some uncertainty about how the model would work in practice. More specifically, participants talked about perceived potential difficulties in being able to remember the model, feeling that they need more practice using the model before using it with patients, and concerns about not having opportunities to use it.

Participants were then interviewed once more after they had had a number of weeks to put the model into practice. Analysis of data from these interviews revealed that participants still felt that there were some barriers to putting the model into practice. These included difficulties with remembering parts of the acronym, and having had a lack of opportunity to put the model into practice. Interestingly, Griffiths et al (2015) report that although two participants from their study similarly described having had a lack of opportunity to put the model into practice 2 months after the training, following the focus groups both these participants reported that in retrospect they were able to think of situations in which using the model would have been appropriate. This

highlights the benefit of having the opportunity to discuss experiences of using the model with others. Participants also described concerns that the model is too artificial to use in its entirety, a concern that has been acknowledged by the model's developers (Connolly et al., 2010).

Despite these barriers, all but one participant described feeling confident in being able to use the model to guide interactions with distressed individuals, a finding that is consistent with previous research (Connolly et al., 2010; Lamb et al., 2014). Moreover, two participants described experiences of using the model successfully which contributes to Connolly et al.'s (2014) existing 'anecdotal evidence' that the model can be used successfully in practice. All participants described the training as having influenced their practice in some way, which is consistent with Lamb et al.'s (2014) finding of attendee's expectations that the training will influence their practice. Encouragingly, all participants reported that they would recommend the training to colleagues.

Participants also highlighted a number of things they felt would be helpful in increasing their confidence in interacting with distressed individuals. These included being sent reminders of the model, having further communication skills training and working in a supportive environment where the ideas behind the SAGE & THYME model are central to the culture. The importance of a supportive environment has been noted by Reynolds, Scott & Austin (2000), who conclude that even if people are effectively trained in certain skills, the environment and structures around those individuals need to be supportive in order for them to be able to put their new skills into practice and continue to do so.

b) Recommendations

Based on the findings of this SEP, the following recommendations have been made:

1. **Display reminders about the model through the Trust.**

   A number of participants described difficulties with remembering various aspects of the model. Displaying reminders could help staff to remember the specific parts of the model, and would serve as a reminder of the model more generally. Suggestions from participants about reminders included displaying the model as a screensaver on LTHT computers, and sending occasional reminder emails about the model to staff who have undergone the training.

2. **Encourage participants to practice using the model.**

   A number of participants described feeling that they needed more practice using the model before using it with patients. This could either be encouraged within the training session itself or with peers outside of the training. Increased familiarity with the model is likely to increase both confidence in, and likelihood of, using the model.

3. **Provide further, more advanced communication skills training.**

   A number of participants also reported that they felt they would benefit from further, more advanced training in communication skills. In particular, one participant felt that they would benefit from further training on noticing more subtle signs of distress

4. **Set up a forum for staff to share ideas and experiences of using the model**

   Participants expressed the potential value in being able to share experiences of using the model with others, and learning from others' experiences of using the model. This is also likely to increase awareness of situations the model could be used in, as discussed above.

5. Continue to raise awareness of the training

A number of participants discussed the importance of the ideas that they had learnt from the training being integral to their working environments. This could be facilitated by continuing to increase awareness of the model and encouraging all staff to undertake the training.

6. Conduct further evaluations

A number of participants interviewed for this SEP felt that they had not yet had a chance to put the model into practice as they had not encountered individuals who were distressed. Conducting another evaluation with a longer follow up period would allow for more participants to have had the opportunity to try out using the model. Furthermore, another evaluation interviewing patients on the care they receive from staff before and after they have undergone the training would provide insights into the direct impact this training has on patient care.

c) Strengths and Limitations

This project provided insights into the impact of communication skills training on the clinical practice of a number of healthcare staff. There are a number of strengths associated with the methodology used for this project. Firstly, a strength of the project lies in the range of professionals who participated in the evaluation, meaning that the findings of the project are more generalisable than they would have been with participants from fewer differing professions. Secondly, although the busy schedules of participants meant that participants were not always interviewed immediately after the training and a month later, the more dispersed timescales mean that the project offered insights into the impact of the training at differing lengths of time following the training. Finally, as the project was conducted by a researcher external to the

developers or facilitators to the SAGE & THYME training, participants may have felt more able to give candid responses.

There were also a number of limitations related to the design of this project, including the reliance on participants volunteering to take part in the project meaning that the sample may be biased towards the most motivated members of staff. However, as participants volunteered to take part in the evaluation prior to going on the training, this meant that it was not biased towards participants who most enjoyed the training. Another limitation to the project lies in only interviewing members of staff, which did not allow for an exploration of how this training impacts patients directly. The reliance on self-report measures also means that it cannot be presumed that these findings are reflective of behaviour change. As Chant, Jenkinson, Randle & Russell (2002) highlight, a number of evaluative studies using both students' self-ratings and patient satisfaction as outcome measures have revealed that whereas students often report an improvement in skills, patients do not. Thus, by only interviewing staff perceptions of the training in the current study, it is possible that the results may not reflect an improvement in patient satisfaction. Finally, as mentioned above, due to the timescale of interviews not all participants had had an opportunity to use the model in their practice, and therefore an extended timescale may have been beneficial.

d) Dissemination

The findings have been discussed with the commissioner, Dr Gary Latchford. Findings were presented at the annual Leeds Doctorate in Clinical Psychology SEP poster conference in October 2015, and there are plans for the poster to be displayed within LTHT. A copy of the poster has been sent to LTHT SAGE & THYME steering group members, and discussions with these steering group members about further

dissemination of the findings are on-going. All participants opted in to receiving a summary of the findings, which shall be emailed to participants in November.

e) Conclusions

The foundation level SAGE & THYME communication skills training currently being delivered to LTHT staff was generally highly regarded, and influenced the clinical practice of staff who attended the training. However, a number of barriers to putting the model into practice also exist. Recommendations for how to reduce these barriers have been made.

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6. Appendices

Appendix 1: Components of the SAGE & THYME model

The SAGE & THYME model

SETTING	If you notice concern - think first of the setting, create some privacy - sit down.
ASK	"Can I ask what you are concerned about?"
GATHER	Gather all of the concerns - not just the first few - "Is there something else?"
EMPATHY	Respond sensitively - "You have a lot on your mind."
TALK	"Who do you have to talk to or support you?"
HELP	"How do they help?"
YOU	"What do YOU think would help?"
ME	"Is there something you would like ME to do?"
END	Summarize and close - "Can we leave it there?"

Appendix 2: Interview Schedules

Evaluating the SAGE & THYME Model of Communication Skills Training: Interview Schedule

Interview at Time 1 (Straight after the training)

1. Which staff group do you belong to?
2. What can you remember about the model?
3. Do you think that you will use the model in your role?
    a. If so, in what way?
        i. Can you give any examples of how you think you might use this/these?
        ii. Are they any parts of the training that you do not think you will use?
        iii. How confident do you feel in trying out some of the training in your job? (prompt: How confident do you feel in being able to implement the model/parts of the model into your work?)
    b. If not; why not?
        i. How confident would you feel in trying out some of the training in your job if you wanted to? (prompt: How confident do you feel in being able to implement the model/parts of the model into your work?)
4. Would you recommend the training to the colleague?
    a. If so, why?
    b. If not, why not?

Interview at Time 2 (A month after the training)

1. What can you remember about the model?
    a. What helped you to remember these parts?
    b. Would any additional support be helpful in remembering the model?
2. Do you use any parts of the model in your role currently?
    a. If so, in what way?
        i. Can you give any examples of how you've used this/these?
        ii. Are there any parts of the training that you have not used?
        ii. How confident do you feel in trying out some of the training in your job? (prompt: How confident do you feel in being able to implement the model/parts of the model into your work?)
    b. If not; why not?
        i. How confident would you feel in trying out some of the training in your job if you wanted to? (prompt: How confident do you feel in being able to implement the model/parts of the model into your work?)
3. Would any additional support be helpful in putting the model into practice?
    a. If so, what?
4. Would any additional support be useful in helping you to recognise the psychological needs of the client?
5. Would any additional support be useful in helping you to provide general psychological support?

Appendix 3: Invitation to Project Email

Dear colleagues,

You are receiving this email as you are due to attend the SAGE & THYME Communication Skills Training on XXXX. As you will be aware, this training programme is currently being implemented across LTHT. **I am emailing you to invite you to take part in an evaluation project of the SAGE & THYME training.** This would involve meeting with me on two occasions at a place convenient to you to discuss the aspects of the training that you found helpful and less helpful. Further information about the project can be found in the Participant Information Sheet attached. Most importantly, tea/coffee and biscuits will be provided!

I would really appreciate any volunteers! **If you are interested in taking part in this evaluation project, I would be very grateful if you could respond to this email letting me know of your interest**. I will then contact you to again to arrange a time to meet.

Best wishes,

Emma Waters
Psychologist in Clinical Training

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Leeds Institute of Health Sciences
Doctorate in Clinical Psychology
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Appendix 4: Information Sheet

The Leeds Teaching Hospitals NHS
NHS Trust

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Evaluating the SAGE & THYME Model of Communication Skills Training:
Participant Information Sheet

I would like to invite you to take part in a service evaluation project. Before you decide whether you would like to take part I would like you to understand why the project is being done and what it would involve for you.

This information sheet explains the purpose of the study and what will happen if you take part. Please ask if anything is not clear. You may also talk to others about the project if you wish.

What is the purpose of the project?
The project aims to evaluate the SAGE & THYME model of communication skills training that is currently being implemented across the Leeds Teaching Hospitals NHS Trust. In particular, I am interested in talking to staff members who have undergone the training to find out which parts of the training they found useful and less useful, and whether they use it in their clinical practice afterwards.

Why have I been invited?
You have been invited to take part because you are registered to attend the SAGE & THYME communication skills training.

Do I have to take part?
It is up to you to decide whether to take part. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
You will be contacted to arrange a time to meet face to face following the training.

At this point you can ask any questions you might have about the project. If you are happy to take part I will ask a number of questions relating to the SAGE & THYME training that you have recently undertaken.

One month later, I will contact you again to arrange another meeting to ask you a further set of questions about the SAGE & THYME training.

What will happen to information about me collected during the study?
All information will be stored securely and in strict confidence. Only I will have access to identifiable information so that I am able to see whether participants' opinions about the training have changed over time.
All data collected in the project will be archived for a period of 3 years following completion of the project. After 3 years all data will be destroyed.

What will happen to the results of the study?
When the project is completed, the results will be written up into a report, and the project's findings will be disseminated (e.g. through poster presentations). Your identity and personal details will be kept confidential and no identifiable information about you will be published in any reports.

What are the possible benefits of taking part?
There is no direct benefit of taking part. However, your input will be useful in helping both the Trust and Sage & Thyme trainers to think about which parts of the training are most useful, and how it could be improved. You will also have a chance to have your views about the training heard.

What are the possible disadvantages and risks of taking part?
It is not anticipated that there will be any disadvantages or risks from taking part in the audit. Taking part will require a short time commitment in order to be interviewed on two occasions. You can withdraw from the project at any time without giving a reason why.

What if there is a problem?
If you have any concerns about this project then you can contact myself (Emma Waters) or the commissioner of the project (Dr Gary Latchford) using the details below, and we will do our best to answer any questions.

Thank you for taking time to read this information sheet
Emma Waters (Psychologist in Clinical Training, js06ew@leeds.ac.uk)

The University of Leeds
Leeds Institute of Health Sciences
Doctorate in Clinical Psychology
Charles Thackrah Building, Room G.04
101 Clarendon Road
Leeds, LS2 9LJ

Commissioner: Dr Gary Latchford, Department of Clinical and Health Psychology, St James's' Hospital

g.latchford@nhs.net

Appendix 5: Consent Form

The Leeds Teaching Hospitals NHS
NHS Trust

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Evaluating the SAGE & THYME Model of Communication Skills Training: Consent Form for Participants

Please tick all boxes

☐ I have read the Participant Information Sheet provided.

☐ I have had the opportunity to ask questions about the audit and have received satisfactory answers to any questions.

☐ I understand that participation is voluntary.

☐ I understand that I am free to withdraw from the audit at any time without giving a reason for doing so.

☐ I consent to participating in this audit.

Signature: _____

Printed Name: _____

Date: _____

Appendix 6: Phases of Thematic Analysis from Braun & Clarke, 2006)

Table 1: Phases of Thematic Analysis

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.