AN INDEPENDENT EVALUATION OF
THE PILOT PAEDIATRIC ADVANCED
COMMUNICATION SKILLS TRAINING
[CONNECTED© PROGRAMME]

Professor Jane Coad (Chief Investigator),
Professor in Children and Family Nursing,
Coventry University

Dr David Pontin
Director of the Graduate School/
Reader in Nursing & Professional Practice
UWE, Bristol.

Mrs Joanna Smith
Research Fellow,
Coventry University.

Professor Faith Gibson
Clinical Professor of Children and Young
People’s Cancer Care,
Please note
This project was commissioned by NHS West Midlands following funding to support local pilots around paediatric advanced communication skills training. The comments are those of the Coad and the evaluation team and do not represent those of Connected©. However, all the project work was agreed in full with Connected© and presented following collation of results.

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For further information, please contact:
Professor Jane Coad; Professor in Children and Family Nursing, Coventry University, Faculty of Health and Life Sciences, Richard Crossman Building
Coventry.
Tel: 02477 793802
Email jane.coad@coventry.ac.uk
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Executive summary

1. Introduction
2. Background
   2.1. Context
   2.2. Need for children and young peoples training
   2.3. Children and young peoples pilot
3. Aims
4. Ethics Review
5. Methods and methodology
   5.1. Recruitment of participants
   5.2. Data analysis
6. Findings
   6.1. Theme 1: Pre-course preparation, preconceptions and expectations
   6.2. Theme 2: Course delivery, teaching and learning strategies
   6.3. Theme 3: Post-course evaluation and ongoing development needs
7. Discussion
   7.1. Limitations
   7.2. Recommendations
8. Conclusion

References

Appendix 1: Sample of Connected© Programme (ACST)
Appendix 2: Interview schedule
Appendix 2: Development of categories and themes
Executive summary
This report outlines an independent evaluation of the pilot children and young people’s (CYP) advanced communication skills training known as the Connected© programme for health professionals working with CYP and their families.

Background
Effective communication is central to the quality of children, young people and families experiences of healthcare and has the potential to improve patient satisfaction and care outcomes. The value of effective patient-professional communication and the need for health professionals to undertake advanced communication skills training has been embedded within recent cancer care guidance and polices. However, there is a need to establish the tangible benefits of training programmes and ultimately their ability to impact on professional practice. The recent development of a specific training programme aimed at professionals working with children and young people training was timely but required an evaluation of the programme.

Aims
The overall purpose of this evaluation was to identify whether the current programme increased skills, knowledge, competence and confidence of the participants when communicating with children, young people and their families, and make recommendations in relation to the delivery of future programmes.

Methods
The evaluation design was based on Appreciative Inquiry (AI). Forty-five health professionals, primarily doctors and nurses, participated across six programmes. Data included individual interviews, pre and post course evaluations, e-mail survey results and reflective work records. The framework analysis approach was used to examine and explore the data.

Key findings. In short:
Findings were grouped into three themes pre-course preparation, preconceptions and expectations; course delivery, teaching and learning strategies; and post-course evaluation and ongoing development. Bullets summarise the main findings:

- Prior to undertaking the course delegates identified a lack of confidence when communicating with children, young people and their families, particularly when dealing with sensitive issues such as providing information about a child’s prognosis or discussing palliative and end of life care.
- Teaching strategies were highly rated in terms of personal and professional learning and organisation. Lead trainers were organised and welcoming. Trainers and delegates felt that the course enabled them to reflect on and develop their communication skills with children, young people and their families and it was important that trainers had the clinical experience to draw on. The range of examples highlighting ways that strategies learned were being used in the
clinical setting suggest the course does have a positive impact on individual practice. One health professional had implemented a dedicated ‘teenage clinic’ since the course. Peer and parental reporting also noted a positive impact on health professionals practice.

- In terms of post-course evaluation, the simulated role play and actors were highlighted as a particularly effective teaching and learning strategy. The role of trainers were key to reducing delegates’ anxieties in relation to multi-professional learning and maximising delegate’s contribution to and learning from the simulated role play.

There is much potential for including a blended learning approach. For example, the delivery of the course training could be reduced to two days by streamlining and reviewing the delivery of the theoretical content. Learning could be supplemented with some pre and post e-learning materials.

**Recommendations**

We have grouped our recommendations into three areas reflecting the three themes.

**In relation to marketing the course and pre-course we recommend:**

- A robust marketing strategy is developed in order to;
  
  - Raise awareness of health professionals working with children and young people in practice to the existence of the course;
  
  - Ensure that groups are mixed from different service areas and units are ‘blended’ to ensure that the different perspectives of the multi-disciplinary delegate audience (doctors, nurses, allied health professionals) and managers are included;

  - Ensure managers and commissioners have clear information about the tangible benefits of the course to care delivery

  - That health professionals are encouraged to reflect on the potential of the course prior to participating

- That given the current climate, pricing sensitivity will be vital for the continued development and promulgation of the advanced communication course and skills development in this client group. As professional/academic accreditation was highly valued it may be useful for the lead team and Connected to consider ways to facilitate this.

- Consideration should be given to expanding the course to health professionals working with children, young people and their families across care settings and specialities ;

- The rationale and mode of delivering of the pre-course preparation is re-evaluated; we suggest the development of an online self-assessment tool of current skills and a short virtual
e-learning package focussing on the theories and concepts relating to the skills health professionals require to effectively communicating with children and young people and their families. The knowledge gained from the e-learning package should be assessed and utilised in the course.

**In relation to teaching and learning strategies we recommend:**

- Retaining the use of simulated role play, and although this adds to the cost, this type of interactive teaching is the main strength of the course and a powerful learning tool;

- The programme is delivered by CYP health professionals for CYP health professionals in order to maximise benefits of the simulated role play and assist delegates when choosing and devolving scenarios.

- Facilitators adopt a flexible approach in order to ensure all delegates learning needs are met, particular delegates who have high levels of anxiety about undertaking simulated learning.

- Retaining the multi-disciplinary combination of delegates and build on the value placed on peer learning.

**In relation to the course structure we recommend:**

- Adjusting the course delivery to two days of face-to-face contact with the inclusion of either a follow-up day or a timely on-line meeting. The focus needs to be on interactive learning but not to compromise the highly valued role play. This may require consideration to be given to the timing and length of breaks;

- Ensuring that a user focus is maintained;

- Reviewing the trainer programme and developing ongoing support for trainers;

- The role play scenarios be retained in the course and that the lectures should be linked to the pre-course material. Consideration should be given to making the theory relevant in the structuring of the course and including a wider range e.g. learning disability; mental health.

- Consider a half day follow up workshop, and or develop an online support group and on-going peer-to-peer learning to meet delegates and trainers continued learning needs;

- The 360° reflective work records or similar reflection tool could be further developed and incorporated into the follow-up workshop.

Finally, we recommend further research be undertaken to assess the long term value of the CYP Connected© programme on the quality of health professionals communication in the clinical setting. The critical importance of communication throughout cancer diagnosis, treatment, and care is now a key benchmark issue for the delivery of high quality care (DH 2003). The emphasis, however remains
on *what* is communicated, and *when* rather than *how* and to *what effect*. We therefore recommend that there be a further study to specifically assess the impact of the Connected© programme on service delivery and organisation. This should include a significant degree of user involvement.
1. Introduction
This report outlines an independent evaluation undertaken during March and October 2010 by Professor Coad and partnership research team from Coventry University, University of the West of England, Bristol and London South Bank University (LSBU) of the Children and Young People’s (CYP) Advanced Communication Skills training for health professionals. Throughout we will refer to participants as delegates who attended the course and the trainers who train the delegates.

2. Background
2.1. Context
Whatever the setting, effective patient communication, is a core professional and clinical skill (Baille et al. 1997; Baille et al. 1999; Beresford and Sloper, 2003; Aldiss et al. 2008). When this skill is undertaken inadequately it can have significant consequences leading to complaints by patients and their relatives (DH 2000; Healthcare Commission 2007). Conversely, good communication has been found to have a positive impact on patients’ emotional health, symptom resolution, function and physiological measures such as blood pressure as well as decrease reported pain and drug usage (Kruijver et al. 2000). There is also good evidence to show that insufficient training in communication is a major factor contributing to stress, job dissatisfaction and emotional burnout in healthcare professionals (Fallowfield et al. 2001; Fallowfield 2005).

Arguably, when a child is ill and parent(s) seek healthcare advice, the child may not be visible within the consultation, as health professionals interactions are often orientated towards the parent (Lambert et al. 2008; Ranmal et al. 2009). In addition, ensuring all members of the family are included and heard, irrespective of age or abilities, can be challenging for health professionals. Open communication about illness and treatment is regarded as the best policy for children, young people and parents as it leads to improved knowledge and understanding of the illness and its probable consequences and better engagement in decision making (Coad 2008; McDonagh 2009; Gibson et al, 2010). Despite the wealth of evidence regarding professional-patient/family communication, and more specifically communication with sick children and young people, effective communication is often perceived to be inadequate.

Understanding and responding to children and parents’ body language and verbal expression requires advanced communication skills. Undoubtedly, health professionals’ experiences are invaluable in the iterative process of understanding children, young people and family communication patterns but needs to be integrated with sound knowledge based on robust evidence. Interestingly, a recent Cochrane review in this area highlights that health professionals frequently use their subjective judgment rather than considering the most effective communication strategy during patient-professional interactions (Ranmal et al. 2009).
Consequently, improved training has been identified as a requirement to help support health professionals develop effective communication skills. A national programme for advanced communication skills training was developed in accordance with the National Institute for Health and Clinical Excellence [NICE] Supportive and Palliative Care Guidance since 2003 by the National Cancer Action Team (NCAT). This was subsequently developed into the Connected© programme in 2008. The aim of the Connected© programme is to provide skills based training focused on improving ‘advanced communication skills’ with senior health professionals working with patients in England and was developed with training approaches which were shown to produce actual behavioural change in participants (Connected© 2010). It also recognises and values the impact of good communication and with the intent of improving the cancer journey a commitment was made in the National Health Service [NHS] Cancer Plan (2000) that advanced communication skills would form part of continuing professional development for healthcare professionals. This commitment was reinforced in the NICE guidance on supportive and palliative care (2004), which although centred around adults, emphasised that healthcare commissioners should ensure accredited training courses were available for health and social care staff working with cancer patients. The continued success and demand for the Connected© programme is reflected in the way in which courses have evolved, from an initial pilot in several cancer networks into a national programme rolled out across all networks funded by the Department of Health (DH). The ‘Darzi’ report (DH 2008) and the ‘End of Life Care Strategy’ (DH 2008) both supported the value of ACST advocating its importance for healthcare professionals.

The programme is based on three-day experiential workshops, which are learner-centred and involve role play and feedback. At the outset there existed three models of communication training programmes (Maguire et al. 1996; Wilkinson et al. 1999; Fallowfield et al. 2001) which offered choice in relation to programme delivery but each had their own variants: for example one programme used professional actors to simulate patients and one used participants as actors. When evaluated all three programmes were found to have a positive influence on participants communication skills which led to a decision to amalgamate the courses into a single unified programme. It was felt that this would result in a more unified approach to advanced communication skills training. The implications of this were far reaching and meant that all existing trainers required additional training to deliver the new programme.

2.2. The need for children and young peoples (CYP) advanced communication training

Although the Connected© programme was primarily established to advance communication skills for professionals working with the adult population, health professionals working with Children and Young People (CYP) with malignant conditions, began requesting to attend the existing Connected© programme as far back as 2003. Professionals within the field of children and young people’s cancer care positively evaluated the course but felt that accessing courses for them was geographically haphazard, compounded by the lack of national CYP dedicated lead and budget to support CYP professionals training. Thus, delivering a dedicated programme around communicating with children
and young people with chronic illness such as cancer to health and social care professionals was an exciting and much needed development.

2.3. The CYP Pilot
An initial pilot of the adult programme for a CYP audience was undertaken in early 2007 and had been based on the Wilkinson variant of the ACST programme. The aim of the pilot was to evaluate the impact of a three-day communication skills course in improving levels of confidence in professionals when communicating with CYP and families. The pilot allowed participants to explore a wide range of communication issues. Common themes such as breaking bad news, managing aggression and communicating with young people were role played in a safe environment using professional actors as patients, carers and professionals. Nineteen participants undertook the course which included eight doctors and 11 nurses.

The pilot evaluated well demonstrating that the communication model used was feasible, acceptable and beneficial for healthcare professionals working with CYP with malignant conditions. Modifications to the model were recommended for example supporting video materials that were CYP appropriate, improved pre course material and it was also recommended that at least one facilitator should have a CYP background for programmes targeted at CYP groups. The availability of a robust equitable funding stream to support training was highlighted as a significant factor in the perceived success of a CYP programme. This pilot however had taken place over 2 years previously with the format of the new Connected unified training programme incorporating multiple changes. It felt necessary therefore to urgently review the changes to ensure the new format would be acceptable to a CYP audience whilst incorporating the changes to the national programme. Supported with funding from West Midlands SHA and the NCAT, six pilots incorporating the changes to the programme were undertaken in the West Midlands, Merseyside and Yorkshire.

It was felt to very important to have an independent evaluation of these programmes which could go beyond the questionnaire data in order to fully understand the real value of the three-day programme for CYP health professionals. This provided the back drop to the evaluation reported here.
3. Aims
The overall purpose of the evaluation was to answer the following questions:

- Does the current three-day programme increase skills, knowledge, competence and confidence of delegates in order to provide appropriate support to children, young people and their families as part of implementing the palliative care pathway?
- What changes to the programme are recommended in its current form and as part of a planned roll out via a train the trainer approach planned in future years?

4. Ethics Review
All supporting documentation including the proposal, letters of invitation, information sheets, consent and assent forms were submitted and approved for ethics review to the Faculty of Health and Life Sciences Ethics Committee at the University of the West of England (UWE), Bristol.

5. Methods and Methodology
Appreciative Inquiry (AI) was chosen as the most appropriate philosophy to underpin the study. Fundamental to this approach is the desire to discover ‘what works well’ and ‘why it works well’ (see for example, Cooperrider and Whitney 1999; Carter 2006). Appreciative Inquiry has been used effectively within a variety of complex, organisational structures including health and social care settings (Coad and Carter 2009). Appreciative Inquiry lends itself well to a pragmatic approach which was felt to have good fit within the current study.

5.1. Recruitment of Participants (Delegates and Trainers)
The study took place from March 2010 to October 2010 during and following delivery of six programmes. In line with the ethics committee request 63 potential participants (delegates and trainers) were approached through the West Midlands Deanery and invited to contact the research team directly in confidence.

The inclusion and exclusion criteria were set:

Inclusion criteria:
- All doctors, nurses and allied health professionals who had undertaken the pilot CYP Connected© communication skills programme across the West Midlands, Merseyside and Yorkshire.
- Members of Connected© training teams.
Exclusion criteria

- Actors involved in the course programme
- Senior leads based at the NHS West Midlands

Recruitment was generally very good (Tables 1 and 2; page 10) with 42 delegates and three trainers participating in interviews, email survey and 360 degree tool (Total n = 45; 75% response rate) and analysis of all pre and post-course questionnaires (Total n = 59).

In line with the original brief we:

1. **Analysed the completed pre- and post-course questionnaires** developed by Connected© using descriptive statistics. In total, we undertook a descriptive review of all the previously analysed questionnaires both pre and post course (n= 60 in total but only 59 pre-and post-course were included as one delegate withdrew after day 1). We also undertook a review of previous evaluation work [including Evaluation of the National Advanced Communication Skills Training (NASCT) 2008 Pilot Study; the Young Peoples pilot project of the NASCT, 2007; Children and Young People’s Connected© manual, 2009 and Connected© quantitative data evaluations]. Collectively, these data sets assisted the team to undertake a preliminary exploration of what was most and least useful in relation to communication skills training.

2. **We offered four focus groups using semi structured interviews** and in discussion with area lead contacts we undertook two open sessions, in recognition of professional’s commitments, thus allowing staff to attend in small groups or as individuals. The interview schedule was designed through a series of discussions between the research team, lead trainers, user input and experts in the field of communication skills training. Its purpose was to elicit a range of views and attitudes about the CYP communication skills training in general and the Connected© course more specifically. We used an Appreciative Inquiry (AI) enquiry approach to underpin the interviews in order to elicit what worked well and what could have been better. The interview schedule is shown in Appendix 2.

In the open sessions we included a *stop/start/continue exercise* to enable participants to reflect on the workshop and its impact on their clinical front-line work. We were mindful of being flexible in collating this data given health professionals work commitments, therefore we offered telephone interviews which lasted for no more that 45 minutes. We found whilst some delegates and trainers were very keen to be involved others felt that it was difficult to be interviewed due to work commitments. We therefore also offered an email approach using an open interview schedule for delegates and trainers to complete in order to maximise participation (Total interviews = 26).
3. We devised a succinct 360 degree reflective work record for all participants who were delegates on the programme. The 360 degree reflective work record was distributed via agreed email contacts to the previous delegates who then approached a peer and a user, such as a parent or child/young person, and asked them to complete the questions electronically. We received three completed records in total, this encompassed eight sets of rich data as each included a colleague and two included a parent.

4. We included a user perspective. We were aware that the brief called for a user perspective but there were ethical tensions in directly accessing children and young people who are health care users. Therefore, we incorporated user involvement by involving members of Professor Coad's email advisory group of young people living with chronic illness and their families. One mother and two young people reviewed the materials and as data were collated they were asked for their comments on two interview transcripts and the overall framework analysis.

5. We included added value through two members of the team writing 1st person journals in order to reflect on the process and inform the analysis.

5.2 Data Analysis
The principles of the framework analysis approach were used to examine and explore the data. We report data from participant narratives obtained from individual interviews, pre and post course evaluations and e-mail survey results, and reflective work records. Briefly, the framework analysis approach consists of three interlinked stages: data management (identifying codes from the data and grouping codes into broader categories); descriptive accounts (mapping the range and diversity of data to initial categories and constantly refining categories until the ‘whole picture’ emerges); and explaining the findings and in the context of this project brief included making recommendations in relation to the course structure and delivery (Spencer et al. 2003; Smith and Firth in press).

The analytical procedures involved:

1. The research team becoming familiar with the data through a process of reading and re-reading participants’ narratives. Participants were referred to as delegate or trainer as appropriate and assigned a confidential number. The narratives from the pre and post course questionnaires and two interviews (one recipient and one facilitator) were used to generate initial codes and preliminary categories. Categories were grouped together to form broad
themes. A coding index was developed from these preliminary categories and themes, which were used as a means of sorting and organising the whole data set. The coding index and an example of the coding matrix are presented in Appendix 3.

2. Descriptive data were extracted from the questionnaires and subjected to descriptive data analysis such as details of how the skills had been put into practice; preferred changes to the programme and any recommendations for any further adaptation of the programme.

3. Once all data sets were coded, preliminary categories and themes were refined to form the final themes (Figure 1). Researcher biases were reduced by ongoing e-mail correspondence and meetings in person between the research team members when developing the coding index and undertaking two data review sessions. These reflections were invaluable and enabled us to undertake a critical review of the processes associated with the analysis and reach an agreement about the final themes and categories.

Making sense of the themes and categories in terms of participants’ beliefs and experiences was achieved by exploring the relationship between the themes, project brief and literature relating to communicating with children and young people with life threatening illnesses and advanced communication skills training. This triangulation of the data from the reflective work records, questionnaires and interviews enabled us to explore the integration of competences and how practice is influenced within the participant’s scope of practice.
6. Findings

Findings from the analysis of participant narratives and the reflective work records have been grouped into three themes: pre-course preparation, preconceptions and expectations; course delivery, teaching and learning strategies; and post-course evaluation and ongoing development needs. Participant breakdown is included in Tables 1 and 2. The themes and related categories are presented in Figure 1. We have used direct extracts [as they were said or written] from the data in order to illustrate themes and bring the data to life, contextualise the findings and enable judgements to be made about their credibility. Individual identities have been protected by not referring to participants by name or identifying the course attended.

Table 1: Participants and Demographics

<table>
<thead>
<tr>
<th>Numbers of total approached</th>
<th>Questionnaires</th>
<th>One to one interviews</th>
<th>Telephone interviews</th>
<th>Email Survey</th>
<th>360 degree tool</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>60 delegates</td>
<td>59 pre-course</td>
<td>3</td>
<td>20</td>
<td>16</td>
<td>3 (8 items of data)</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>59 post-course</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 trainers</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Grand total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>162</td>
</tr>
</tbody>
</table>

Table 2: Breakdown of participant professional groups

<table>
<thead>
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<th>Professional Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>11</td>
</tr>
<tr>
<td>Nurses</td>
<td>23</td>
</tr>
<tr>
<td>AHPs</td>
<td>6</td>
</tr>
<tr>
<td>Not known</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
</tr>
</tbody>
</table>
Figure 1: Key findings: themes and categories

Pre-course preparation, preconceptions and expectations
- Accessing the course
- Perceptions about effective communication
- Expand knowledge and skills
- Develop personally and professionally

Course delivery, teaching and learning strategies
- Effectiveness of the learning and teaching strategies
- The learning environment

Post-course evaluation and ongoing development needs
- Evaluation of the course structure
- Evaluation of the course content
- Personal and professional development
6.1. Theme 1: Pre-course preparation, preconceptions and expectations

The theme pre-course preparation, preconceptions and expectations was associated with four interrelated categories that related to health professionals’ preparation in advance of attending the course, communicating with children and young people and their families and the anticipated benefits from attending the course. These categories are labelled: accessing the course; perceptions about effective communication; expanding knowledge and skills and developing personally and professionally. In keeping with an AI approach, in each we have drawn out perceptions of what works and what could work better.

6.1.2. Accessing the course

An important finding was that the majority of delegates applied to attend the course in direct response to a recommendation by their manager such as ‘I was recommended to undertake the course by the matron as I am new in post and all senior staff are to undertake the course, so timing was good for me’. Most delegates assumed training in relation to advanced communication skills was a requirement for all senior health professionals working with children and young people living with cancer but many had not personally sought information about current programmes or the availability of places. The following extracts summarise delegates’ accounts about accessing the course:

I thought with being new in post it would be appropriate as I had concerns with my own performance and want to check out how well I was doing and improve my own performance and skills’.

Participant15 Delegate (Interview)

‘I had heard of advanced communications course but did not see any information about the course, so not well advertised….Many are put off by the thought of role play. So I was given a place, I was not coerced and volunteered to take the place at short notice’.

Participant16 Delegate (Interview)

‘It is mandatory for TYP with cancer MDT members but I would have attended voluntarily’.

Participant10 Delegate (Interview)

Trainers felt that one aspect that could be better was that children and young people’s advanced communication training courses were promoted effectively within child health services. Having the course accredited and endorsed by professional bodies, such as Children’s Cancer and Leukaemia Group, Royal College of Paediatrics...
and Child Health, the Royal College of Nursing or a Higher Education Institute was considered to be one way of making the course more attractive to managers and potential delegates. Preference was a Higher Education Institute as post-graduate training.

Trainers and delegates also felt that the course was value for money. Despite this, some participants indicated they would not pay for themselves to attend the course, others indicated they would be prepared to self-fund if costs were kept to a minimum (less than £250). Although not representative, a few delegates considered self-funding up to £500. Delegates and trainers suggested that the course should not be exclusive to professionals working in cancer and palliative care services, and that it would be of value to all professionals working with children and young people and their families. There was a perception that participation in the course could be widened to include health and social care professionals from different backgrounds. It was felt that this may facilitate more effective collaboration across child health services as experiences and challenges of working with children and young people and their families could be shared. Examples of participants’ perceptions of course marketing and costs include the following:

‘I think the adult one is well marketed and there are communication courses popping up all over, but for paediatrics not the same…. We need to broaden this to non-malignant groups…I think everyone’.
Participant 8 Trainer (Interview)

‘(On marketing) the course could be promoted by our professional bodies and professional acknowledgement for example (continued professional development) points’
Delegate 8 (E-mail survey)

‘I know it cost about £500 and I would pay that and as an employer I would budget for that… but we need to get the message out there that it is value for’.
Participant 2 Trainer (Interview)

‘The course is value for money but then don’t know how much it cost’. [Researcher Would you pay £250?] ‘Definitely, yes.’ When asked if he would pay £500 there was more hesitance in responding; ‘this would be about my limit’
Participant 18 Delegate (Interview)

Delegates preparing for the course were influenced by the time available to commit to the pre-course reading which was in fact three articles although some delegates perceived these as a ‘workbook’. This one aspect received the most comments. For some delegates securing a place on the course at short notice ‘meant I only glanced at the pre-reading but this was not a hindrance’. Others said that due to time ‘they did not use the
pre-reading’. Alternatively, a few delegates valued the pre-course reading, explaining that the content was useful to ensure all participants had a similar knowledge base and undertaking the pre-course reading generated enthusiasm in advance of undertaking the course. Interestingly delegates who did not undertake the pre-course reading did not feel that this put them at a disadvantage ‘I did not do the pre-reading. It was long and pretty boring if I am honest’. Furthermore, those who had undertaken the pre-reading mentioned that it was either not well utilised during day 1 or knowledge gained was not assessed. For example:

‘More use could have been made of the pre-course reading materials. They were very useful yet some on the course had not received them and some not read them! Just a brief feedback would have been helpful’.
Delegate₁ (E-mail survey)

6.1.3. Perceptions about effective communication

One important finding related to the variability in health professionals’ engaging with children and young people and their families; participants reported observing both good and poor practice. Participants described observing health professionals taking time to listen to children or young people and family member’s viewpoints and a willingness to consider ways to develop an effective rapport in advance of the interaction. In contrast, examples of ineffective communication strategies included hurried and poorly planned interactions, which failed to take into account the child, young person and parents’ perspectives. A lack of a consistent approach to communicating with children, young people and family members across the inter-disciplinary team was highlighted as a barrier to developing effective relationships and included:

‘Professionals care very much, they are scared of getting it wrong … and …concerned about making things worse’.
Participant₂ Delegate (Interview)

‘My experiences of health professional’s communicating, well its variable, never had the confidence to challenge them, especially doctors, frustrated about that’.
Participant₃ Delegate (Interview)
‘Would like children and parents to let us carry out treatment plans sometimes and truly just trust us as professionals’.
Participant 6 Recipient (Pre-course Questionnaire)

Rather worryingly, some delegates’ accounts about the purpose of communicating effectively were also not always consistent with a collaborative approach to working with children, young people and their families; for example a belief that the aim of effective communication was to ensure consent and adherence with healthcare treatments was evident. This was particularly striking in the pre-course questionnaires. For example:

‘Parents that have their own treatment agenda and have strong own ideas about what they want and have difficulties in allowing me and the doctors and nurses to carry out a plan of care they need’.  
Participant 8 Recipient (Pre-course Questionnaire)

‘Parent and child do not comply, lots just do their own thing and this is difficult to talk through calmly and professionally’.  
Participant 9 Recipient (Pre-course Questionnaire)

6.1.4. Expand knowledge and skills, and to develop personally and professionally

A range of outcomes were anticipated as a result of undertaking the course. These are grouped into two key areas: to expand knowledge and skills of communicating with children and young people and their families, and to develop personally and professionally (Table 3).

<table>
<thead>
<tr>
<th>Professional Skills</th>
<th>Personal Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critically reflective</td>
<td>Critically reflective</td>
</tr>
<tr>
<td>Concerns identified</td>
<td>Communication with colleagues/peers</td>
</tr>
<tr>
<td>Treatment choice</td>
<td>Handling family emotion better</td>
</tr>
<tr>
<td>Health advice given</td>
<td>Listening skills improved</td>
</tr>
<tr>
<td>Children having choice to talk alone</td>
<td>Being more flexible</td>
</tr>
<tr>
<td>Inviting questions in the consultation</td>
<td>Being more open and receptive</td>
</tr>
</tbody>
</table>

Table 3: Breakdown of perceived personal and professional skills (Drawn from the 360 degree tool as most skills undertaken following the course)
In relation to personal and professional development, trainers and delegates anticipated and expected delegates to reflect on and critically evaluate their own clinical practice in relation to communicating with children and young people and their families. We noted however that some delegates experienced that they had wanted to go on the course for a long time whilst for others this was more a hurried decision such as the course place was available and they obtained the place at short notice. We also noted some delegates actively prepared themselves and had a positive attitude in terms of their readiness for learning. Conversely, for a minority, the opposite was true.

Both delegates and trainers also expected the course would enable delegates to expand their knowledge of communication theories and strategies. Ultimately, it was perceived that the skills developed would improve child and parent-professional communication and collaboration, which would have the potential to enhance care delivery. Delegates also identified specific knowledge deficits in relation to effectively communicating with parents from diverse ethnic groups, with children and young people who have communication difficulties, and when confronted with sensitive topics such as discussing sexual health issues with young people and end of life care. Examples of participants’ accounts relating to their expectations about knowledge and skills development included ‘Learn different communication strategies in difficult situations’; to ensure imparting the ‘most effective information/ advice/ support using most appropriate skills; developing improved ‘cultural based practice knowledge’ and ‘asking about sexual activity’.

Delegates welcomed the opportunity to develop their communication skills and practise the skills learned in a controlled environment. They also enjoyed that learning built one day upon another and seemed logical. A key finding was that delegates, from all professional groups, described a lack of confidence in their ability to communicate effectively with children and young people and their families when faced with difficult topics such as providing information about the child’s prognosis or discussing palliative and end of life care. Delegates described frustrations when they observed colleagues not communicating effectively with children and young people and many did not consider themselves to have the skills to challenge behaviours hindering effective child and parent-professional communication and collaboration. Thus they hoped the course would enable them to develop skills to communicate more effective with colleagues and ‘have lots of experience but often work solo, you need to be challenged by self and also to challenge others’. Others stated:

‘To gain more insight of my own communication skills and learn more about effective communication for the benefit me children, families and my colleagues’.

Participant 5 Delegate (Pre-course Questionnaire)
‘To gain more confidence in difficult situations especially when child moves or to a palliative care situation or opts out of treatment’.

*Participant₉ Delegate (Pre-course Questionnaire)*

‘Different skills which will enhance my ability of dealing with others in the multi disciplinary team. I am hoping it will improve my ward environment’.

*Participant₁₆ Delegate (Pre-course Questionnaire)*

Becoming a trainer was perceived as very challenging because of the intensity of the training, personal commitment and developing the skills and confidence to support delegates with diverse experiences and from a range of professional backgrounds. Novice trainers described that at times they felt a mentoring system could be more supportive as highlighted:

‘Taken me a long time to become a trainer. It’s hard to be a trainer. Feel that there is a tiered approach and it needs to be made a more positive for new trainers. We also need some kind of mentoring of training and trainers’.

*Participant₂ Trainer (Interview)*

In summary, delegates’ advance preparation for the course was variable, particularly their commitment to pre-course reading. Trainers and delegates expected attendees to improve their communication skills as a direct result of the skills training, and gain confidence to use the skills to communicate more effectively with children and young people and their families within the multi-disciplinary team.

### 6.2. Theme 2:

**Course delivery, teaching and learning strategies**

The second theme concerned the effectiveness of the teaching and learning strategies that were used to deliver the course. Two interlinked categories were identified: effectiveness of the learning and teaching strategies; and the learning environment.

#### 6.2.1. Effectiveness of teaching and learning strategies

Overall, the course was highly rated. Trainers were organised and welcoming. A range of teaching and learning strategies were employed as part of the delivery of the training including pre-course information, key lecturers and
simulation in the form of role play. Delegates highly valued having trainers who they knew were CYP health professionals. We explored further in the data sets to identify if any comments were made about how many CYP trained health professionals were actually required but could find none. Several comments were made that the balance of trainers to students was ‘about right’.

Delegates and trainers suggested that the course should not be exclusive to professionals working in cancer and palliative care services, and it would be of value to all professionals working with children and young people and their families. A wider range of issues such children and young people with learning disability and mental health needs could be included.

Accounts about the delivery of the theoretical content, primarily key lectures on day 1, was variable in that some felt to be the bedrock of feeling comfortable for the role play of Days 2 and 3, whilst others felt it was laboured and far too long. Similarly, whilst the majority of delegates’ considered the pre-course workbook to be informative, both delegates and trainers noted that the content was not subsequently used to structure the teaching delivery and subsequent learning on day 1. Many said that this resulted in repetition, which was highlighted through the different data sources as a less productive use of time as reflected in the following comments:

‘The level and amount of theory is justified [but not mode of current delivery]’.
Participant20 Delegate (Interview)

‘The theory on the first day, We had introductions then coffee then theory and then an hour lunch and then more evidence... it went on a bit long’.
Participant2 Delegate (E-mail survey)

‘(In related to user and carer input) …. It would find it difficult having parents and young people present in scenarios- too threatening. But parents could deliver a session raising issues that are pertinent to them- may reduce mismatch between parents’ and health professionals’ perspectives’.
Participant15 Delegate (Pre-course Questionnaire)

In contrast, the use of simulated role play and the actors were highly valued by all participants. For example:

‘Best aspects of the course: role play was very educational, very surprising and insightful’.
Participant21 Delegate (Post-course Questionnaire)

‘Role play - increases confidence and challenges each individual’.
Participant23 Delegate (Post-course Questionnaire)
‘Effective use of professional actors / actresses. They really made the role playing real and to be able to practice or test our ways in a safe environment. It was certainly the closest thing I could get to have a feedback from a real-life situation’.
Delegate₁ (E-mail survey)

6.2.2. The learning environment

Trainers’ and delegates’ accounts indicated that for many this was their first experience of shared learning with colleagues from different professional backgrounds. This created some initial apprehension, for example some trainers were anxious about senior doctors receptiveness to the course being delivered by non-medical professionals or allied to medicine such as nurses. However, no doctors reported this in any data sets.

Delegates were apprehensive about how their underpinning knowledge base and skills would compare to other professionals: in particular there was an assumption that doctors would have advanced skills and knowledge. The majority of delegates had not experienced simulation as a teaching strategy and were anxious about participating in the role play scenarios. Despite these initial worries delegates described the learning environment and use of simulation as an extremely effective teaching strategy. For example:

‘The opportunity to learn from and with others was very useful indeed, especially having such a mix of skills and professions - I have never studied alongside consultants before and it was invaluable experience’.
Delegate₂ (E-mail survey)

The role of facilitators was highlighted as key to reducing delegates’ anxieties in relation to multi-professional learning and maximising delegate’s contribution to and learning from the simulated role play. Delegates described the effectiveness of trainers in ensuring the learning environment was a safe place to share personal concerns and difficulties when communicating with children and young people and their families. Delegates valued the knowledge and experience of the trainers, particularly when they drew on their own clinical practice of working with children, young people and their families. The majority of delegates’ accounts described facilitators as being responsive and supportive in meeting their individual needs, which enhanced their learning.
Alternatively, a few participants described the learning environment as intimidating and perceived their contribution was not always valued. Some novice trainers described the support they received as variable and when this was not provided they felt that confidence waivered which impacted on their ability to work effectively with the group. Delegates identified peer support had a positive effect on the learning achieved as highlighted in the following extracts:

‘Thoroughly well facilitated course. As a co-facilitator, I felt very supported and encouraged by both facilitators. By taking the lead, I felt have learned a lot about this course and it helped my confidence’. 
*Participant* 18  *Trainer (Post-course Questionnaire)*

‘I think the approach is good but could be bit more flexible and go with the flow more. It seemed at times that x had to be done by coffee and y be done by lunch’. 
*Delegate* 8  *(E-mail survey)*

‘Facilitation is a powerful place to be, they (delegates) are in your hands........ We are there to develop them. These are skilled professionals’. 
*Participant* 8  *Trainer (interview)*

In summary, multi-professional learning and simulated role play were powerful and effective teaching and learning strategies employed. The role of trainers in terms of their ability to influence learning cannot be underestimated.

**6.3. Theme 3:**

**Post-course evaluation and ongoing development needs**

The final theme has three interlinked categories that related to the evaluation of the course, its continued development and the ongoing needs of both trainers and delegates. The three categories are labelled: evaluation of the course structure; evaluation of the course content; and personal and professional development.

**6.3.1. Evaluation of course structure**

Feedback from trainers and delegates about timetabling and the length of the course was variable. The majority of delegates felt that the course could be *reduced to two days*, streamlining the introduction and theoretical content on day 1 or providing a more dynamic mode of delivery such as using information technology or an e-learning format. A minority felt that the length of the course was described as appropriate, with three days identified as necessary to reflect on practice. Some delegates valued the length of breaks which gave them opportunity to network and provided valuable *thinking time* whilst others found the length of breaks *frustrating* and *not a good*
use of time. However, both trainers and delegates acknowledged, it would pose difficulties to reduce break times as they used the time to set up the next session and were available to support both delegates and actors:

'Liked three days - not rushed, enough time to put skills into practice. Breaks were good to be honest, like one hour lunch, it was about networking so needed it'.
Participant, Delegate (Interview)

'It …[the course] could be two days… and a follow up day later, may be cut down day one… and speed up the introduction a bit'.
Participant2, Trainer (Interview)

'Change- day one. Could you not send out pre-reading than go over it all then - test us - a bit basic day one … make it more fun!'.
Participant10, Delegate (Post-course Questionnaire)

6.3.2. Evaluation of course content
Feedback from trainers and delegates suggest the content was appropriate to meet the course aims. Across data sets it was evident that delegates were very positive and highly satisfied with the training received. The outcomes with regards to improving knowledge and skills when communicating with children, young people and their families were achieved. As highlighted previously some trainers and delegates suggested that the theoretical content on day 1 need re-evaluation. However, the practical skills taught and practised were highly valued:

'Have a structure to impart news… I learned cues, empathy, silences, less is more, summarising, check understanding … I just need to put into practise'.
Participant16, Delegate (Post-course Questionnaire)

'I have learned to gather information first than give out information on that basis'.
Participant18, Delegate (Post-course Questionnaire)

'Useful to do silences and will practise them'.
Participant9, Delegate (Post-course Questionnaire)

'It was fun, informative and has helped me to develop and improve my practice'.
Delegate14, (E-mail survey)
6.3.3. Personal and professional development

It was evident across all data sets that trainers and delegates considered the course to have enabled them to reflect on and develop their communication skills with children, young people and their families. The 360 degree work record provided useful insights into how delegates contextualised the training to fit the needs of their clinical areas e.g. children’s intensive care or community clinics following the course. Delegates felt that skills were developed and they had put strategies learned from the course into practice such as new ways of working with the consultant, being prepared to listen more and setting out health professional roles prior to a consultation. One health professional had implemented a dedicated ‘teenage clinic’ since the course. Peer and parental reporting also noted this as having had a positive impact on the health professionals practice:

‘I think I will always find communicating in palliative care situations difficult, however the course has helped me learn new skills to take forward and make communication easier / more effective’.
Participant_{10} Delegate (Post-course Questionnaire)

‘Actually am meeting more of young people’s needs now since the course but I realise I do not see parents alone unless its really bad news. Guess I need to work on this one’.
Participant_{9} Delegate (360 degree)

[Since the course] ‘…yes – [doctor x] has seen my girl on their own once for first time and I sat outside .. it was good for them and me’
Participant_{9} Parent (360 degree)

‘I have questioned one of the doctors I work with since the course and he was a bit shocked….I did it discretely after family left consultation but I did it …never would have done it before’.
Participant_{3} Delegate (Interview)

‘I thought I was fine at communicating prior to the course but have found that the skills that I learnt invaluable. They’ve made the difference in a wide range of situations and I think have made the biggest improvement in my medical practice of any course’.
Delegate_{16} (E-mail survey)

‘It’s done a lot for my confidence, and I hope it improves. Funnily enough I have had more parents crying on the phone recently, but I feel I have improved… I am more open now and they talk to me more. Maybe I was cutting myself off before because I couldn’t deal with them’
Although the positive impact of undertaking advanced communication skills training on individuals’ practice was evident throughout the data sets, participants also identified the need for ongoing support. Delegates identified that they experienced continued uncertainty in managing sensitive topic areas, for example the 360 degree record highlighted the ongoing difficulties in challenging parents about over protectiveness. Delegates suggested they would value a follow-up session or on-line discussion group in order to continue developing the skills in relation to communication with children, young people and their families and as a mechanism for ongoing support. Support for the actors, that encompassed a de-brief session was highlighted positively. Trainers identified the need for ongoing trainer support and mentoring:

‘We do need to make it ... positive for new trainers. We also need some kind of mentoring for training and trainers’.

Participant2 Trainer (Interview)

‘I would really like to have some way of meeting/linking to my group again. I know it would be hard to meet again but some kind of link through the website would be good where we could share information’.

Delegate6 (E-mail survey)

‘I've noticed the difference in patient satisfaction through skills I learnt on the course. I've have been able to help people express longstanding concerns or problems’. ‘It's even useful in everyday life!’

Delegate16 (E-mail survey)

In summary, the course evaluations were very positive; with delegates able to identify the ways in which the skills they learned are already influencing their practice. There is the potential to review the delivery of the course, for example the training could be reduced to two days. This could be achieved by streamlining and reviewing the delivery of the theoretical content so that it was carried out and related to the face-to-face delivery. A follow up workshop, either in person or using IT systems, could be developed with the aim of delegates sharing experiences of implementing the skills learned, facilitating ongoing development and offering a support system.
8. Discussion

A number of key findings emerged which merit further consideration. Of great significance, was the fact that overall the course was highly rated in terms of personal and professional learning. Organisation by the national CYP lead for the Connected© programme was rated as excellent. The health professionals who participated in this project reported on the importance of developing effective communication skills in order to engage effectively with the child, young person and family. They specifically enjoyed the role play, scenarios and actors despite initial anxiety. Rather worryingly, we found that delegates and trainers reports of collaborative practice and skills of health professionals when communicating with children, young people and the family was very variable. Therefore, a key finding was that participants valued the importance of the advanced communication skills training as a way of developing their practice and that this must be specifically focussed on children, young people and their families specific communication needs and delivered by expert trainers with experience of child health. In short, the current Connected© programme is delivering what it set out to do.

In terms of content there could be a number of areas developed. From all the data sets, day 1 was the most contentious day and needs a re-think. Whilst each day did build one upon another which was valued, many health professionals also felt that the Connected© programme was too long in terms of days and some were reluctant to take three days out of clinical practice. A frequent suggestion for improvement included a one day e.learning introduction followed by a two day teaching programme where supportive literature was more interactive and actually ‘tested’ or utilized in some way during the programme. Suggestions also included a long term follow up half day, again using information technology systems. Some also mentioned that breaks were too long and longer days such as 8.30am to 5pm could be considered whilst others said these were balanced. Many mentioned that the pre-reading material was dull, not interactive and not drawn upon or tested during the training. Most worryingly some delegates said that they did not do the pre-reading but it made no difference. However, what was encouraging was that there appeared to be no resistance to the training, and everyone mentioned how much they had gained overall.

It also emerged that the course needed improved recognition and accreditation in order to ensure sustainability. Whilst preferences were a Higher Education Institute (e.g. university) other suggestions included professional bodies, such as Children’s Cancer and Leukaemia Group, Royal College of Paediatrics and Child Health and the Royal College of Nursing. The course may also be useful to senior under graduate nursing, medical and allied health and social care professionals but we have no collated data to substantiate this.

It is possible that some delegates were highly skilled communicators prior to the course and their experience could be utilised or acknowledged more but this would be difficult to assess and given some of the attitudes
implied in the pre-course questionnaire it would seem that undertaking the course was very important and to all start in the same place. Clearly, there are challenges in delivering a programme with a *one size fits all* as experience varies immensely. Peer performance it was agreed can be challenging but enjoyable. However, one of most worrying findings surrounded preparation. Whilst some delegates reported excitement and anticipation of wanting to go on the course for a long time, for others this was more a hurried decision and some obtained the place at short notice. This impacted on readiness for learning, an important antecedent in the process of learning to communicate with this group (McDonagh 2009; Ranmal et al, 2009; Gibson et al, 2010).

Interestingly, delegates and trainers suggested that the course should not be exclusive to professionals working in cancer and palliative care services, and it would be of value to all professionals working with children and young people and their families. A wider range of issues such children and young people with learning disability and mental health needs could be included. There has also been some debate in the literature about the best way to train health professional especially doctors, and whether this should be as individual groups. However, whilst this study did not seek to specifically explore inter-professional training findings here infer that shared learning across professional groups was effective and the shared learning with colleagues from different professional backgrounds was unique and valued despite some initial apprehensions.

In terms of the trainers there are also some points which merit further discussion. Whilst in the main it was reported that there was a conducive learning environment and that well trained reflexive facilitators are crucial for the success of the course some participants suggested a need for more flexibility. This was also echoed in the training of the trainers and a request by them for follow up mentoring for novice trainers. Support for the actors, that encompassed a de-brief session was highlighted positively and trainers identified the need for ongoing trainer support and mentoring for themselves and as a group.

Finally, there is a lack of objective evidence that the course makes any difference to an individual’s communication skills in the long term. Some of the comments made by participants in this study indicate that whilst delegates and trainers are enthusiastic about the training, and felt that undertaking the course enabled them to improve their skills for the benefit of patients it is still not known whether or not their skills do indeed improve and whether any improvement is sustained in the long term.

**8.1. Limitations of the study**

There are a number of limitations to this study that should be acknowledged. First, it was conducted across only six CYP courses and so the findings cannot be generalised. The research also relied on self-reporting from participants, and so we cannot comment on actual communication skills.
Improving response rate without coercion was challenging and required flexibility in terms of data collection methods offered. Although the comments from the 360 degree appraisal indicate that insight into skills is enhanced on return to clinical practice, our study lacks follow-up longitudinal data. It was also not possible to match the number assigned to each participant across questionnaire data sets because participants were not identified by name within the course evaluations.

8.2. Recommendations

We have grouped our recommendations into three areas reflecting the three themes presented in Figure 1 (page 11).

In relation to marketing the course and pre-course we recommend:

- A robust marketing strategy is developed in order to;
  - Raise awareness of health professionals working with children and young people in practice to the existence of the course;
  - Ensure that groups are mixed from different service areas and units are 'blended' to ensure that the different perspectives of the multi-disciplinary delegate audience (doctors, nurses, allied health professionals) and managers are included;
  - Ensure managers and funders have clear information about the tangible benefits of the course to care delivery
  - That health professionals are encouraged to reflect on the potential of the course prior to participating

- That given the current climate, pricing sensitivity will be vital for the continued development and promulgation of the advanced communication course and skills development in this client group. As accreditation was highly valued it may be useful for the lead team and Connected to consider ways to facilitate this.

- That the course be accredited and endorsed by professional bodies, such as Children's Cancer and Leukaemia Group, Royal College of Paediatrics and Child Health, the Royal College of Nursing or a
Higher Education Institute in order to make the course more attractive to managers and potential
delegates.

- Consideration should be given to expanding the course to health and social care professionals working
  with children, young people and their families across care settings and specialities;

- The rationale and mode of delivering of the pre-course preparation is re-evaluated; we suggest the
development of an online self-assessment tool of current skills and a short virtual e-learning package
focussing on the theories and concepts relating to the skills health professionals require to effectively
communicating with children and young people and their families. The knowledge gained from the e-
learning package should be assessed and utilised in the course.

In relation to teaching and learning strategies we recommend:

- Retaining the use of simulated role play, and although this adds to the cost, this type of interactive
teaching is the main strength of the course and a powerful learning tool;

- The programme is delivered by CYP health professionals for CYP
  health professionals in order to maximise benefits of the simulated role
  play and assist delegates when choosing and devolving scenarios.

- Facilitators adopt a flexible approach in order to ensure all delegates
  learning needs are met, particular delegates who have high levels of
  anxiety about undertaking simulated learning.

- Retaining the multi-disciplinary combination of delegates and build on
  the value placed on peer learning.

In relation to the course structure we recommend:

- Adjusting the course delivery to two days of face-to-face contact with the inclusion of either a follow-up
day or a timely on-line meeting. The focus needs to be on interactive learning but not to compromise the
highly valued role play. This may require consideration to be given to extending the timing and length of
breaks;

- Ensuring that a user focus is maintained;

- Reviewing the trainer programme and developing ongoing support for trainers;
• The role play scenarios be retained in the course and that the lectures should be linked to the pre-course material. Consideration should be given to making the theory relevant in the structuring of the course and including a wider range such as learning disability and mental health needs;

• Consider a half day follow up workshop, and or develop an online support group and on-going peer-to-peer learning to meet delegates and trainers continued learning needs;

• The 360° reflective work records or similar reflection tool could be further developed and incorporated into the follow-up workshop.

Finally, we recommend further research be undertaken to assess the long term value of the CYP Connected® programme on the quality of health professionals communication in the clinical setting. The critical importance of communication throughout cancer diagnosis, treatment, and care is now a key benchmark issue for the delivery of high quality care (DH 2003). The emphasis, however remains on what is communicated, and when rather than how and to what effect. We therefore recommend that there be a further study to specifically assess the impact of the Advanced Communications course on service delivery and organisation. This should include a significant degree of user involvement.
9. Conclusion

Current health policy advocates a model of care delivery that is participatory and collaborative in nature (DH/DfES 2004; DH 2007; 2009). Integral to the concept of patient collaboration are the interactions that occur between patients, or as in the context of this project the child or young person and their family, and health professional (Drew et al. 2001). This report has outlined an independent evaluation of the Children and Young People’s (CYP) Connected® programme for health professionals working with children, young people and their families. The background literature of the report highlighted that the quality of these interactions can influence the effectiveness of information exchange, the development of patient-professional relationships, rapport building and the way care is negotiated at each stage of the care pathway (Gordon et al. 2009; Bailing and McCubbin 2001; Dickinson et al. 2006). We can conclude from the study that delivering a dedicated programme around communicating with children and young people with chronic illness such as cancer to health professionals is an exciting and much needed development. The evaluation found that the Children and Young People’s (CYP) Connected® programme was highly rated but we have suggested a number of improvements for consideration. We hope that the evaluation at this early stage of its development will be useful and that the recommendations will make the course more responsive to clinical and health professionals needs.
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NICE. (2004) Improving Supportive and Palliative Care for Adults with Cancer.


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Appendix

Appendix 1: Sample of CYP National Advanced Communication Skills Training Programme (ACST)

With permission from Nicki Fitzmaurice CYP lead for use

National Cancer Action Team

COURSE PROGRAMME

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00-9.15</td>
<td>ARRIVAL AND COFFEE</td>
</tr>
<tr>
<td></td>
<td>Pre-course questionnaires – to be completed and handed in</td>
</tr>
<tr>
<td>9.15-10.30</td>
<td>INTRODUCTION AND ORIENTATION TO COURSE</td>
</tr>
<tr>
<td></td>
<td>AGREEMENT OF GROUND RULES</td>
</tr>
<tr>
<td>10.30-11.15</td>
<td>AGENDA SETTING 1</td>
</tr>
<tr>
<td>11.15-11.45</td>
<td>COFFEE</td>
</tr>
<tr>
<td>11.45-12.15</td>
<td>THE EVIDENCE BASE FOR ACST (PRESENTATION)</td>
</tr>
<tr>
<td>12.15-13.00</td>
<td>SKILLS AND STRUCTURE (PRESENTATION)</td>
</tr>
<tr>
<td>13.00-14.00</td>
<td>LUNCH</td>
</tr>
<tr>
<td>14.00-15.30</td>
<td>INTERACTIVE EXERCISE</td>
</tr>
</tbody>
</table>
### Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>15:30-16:00</td>
<td>TEA</td>
</tr>
<tr>
<td>16:00-17:00</td>
<td>ROLE PLAY REGULATIONS, AGENDA SETTING II</td>
</tr>
<tr>
<td>17:00</td>
<td>CLOSE FOR THE DAY</td>
</tr>
</tbody>
</table>

### Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>ARRIVAL AND COFFEE</td>
</tr>
<tr>
<td>9:15-9:30</td>
<td>MINI-PLENARY - As large group</td>
</tr>
<tr>
<td>9:30-11:00</td>
<td>ROLE PLAY SESSION 1</td>
</tr>
<tr>
<td>11:00-11:30</td>
<td>COFFEE</td>
</tr>
<tr>
<td>11:30-13:00</td>
<td>ROLE PLAY SESSION 2</td>
</tr>
<tr>
<td>13:00-13:45</td>
<td>LUNCH</td>
</tr>
<tr>
<td>13:45-14:15</td>
<td>ROLE PLAY SESSION 3</td>
</tr>
<tr>
<td>14:15-15:30</td>
<td>TEA</td>
</tr>
<tr>
<td>15:30-16:30</td>
<td>FLEXIBLE SESSION</td>
</tr>
</tbody>
</table>
Appendix 2: Interview schedule

Paediatric Advanced Communication Course

Which group did you attend?
Where?
Did you stay overnight?
How many were in your group?

Questions about the course

1. Why did you go on the course at this time (mandatory or opportunistic)?
2. What would be your overall rating be of the course out of 10?
   (0 being poor and 10 being excellent)
3. What did you think about the length of the course? Is it too long/just right/too short and why
4. What did you think about the length of days?
5. What did you think about breaks? – too many/not enough?
6. How did the trainers facilitate your learning? What strategies were used?
7. Was using actors beneficial to the training? How?
8. Can you tell us three good aspects [relative merits] of being on the course – what was your favourite bit? What do you remember the most?
9. Can you tell us three aspects that could be covered better – worst bits?
10. What can remember about Day 1?
11. What did you think about the role play? Did you like choosing your own role play? Are you happy to tell us what case you choose and why?
12. How did working through your scenario and others help increase your skills, knowledge, competence and confidence of the participants?
13. If YOU had to pay £250 would you If you had to pay £500 would you
14. Can you think of an example since you did the course how you have changed in your practice of communication?
15. What ways were users involved enough in the planning and/or delivery course?

Is there anything else you would like to tell that we have not asked you?
Appendix 3: Development of categories and themes

### 1. Example of coding matrix:

<table>
<thead>
<tr>
<th>Description (in-vivo codes)</th>
<th>Preliminary thoughts</th>
<th>Preliminary categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data: Interview 3 (JC) Recipient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to improve talking to families, particularly breaking bad news to families</td>
<td>improve talking to families</td>
<td>Being effective when engaging with families</td>
</tr>
<tr>
<td>Thought would help parents talk to children, affected one and brothers/sisters</td>
<td>wasn’t sure how I was doing</td>
<td>Assess performance</td>
</tr>
<tr>
<td>wasn’t sure if I was doing it very well. Lots of experience but often work solo</td>
<td></td>
<td>Challenge own practice</td>
</tr>
<tr>
<td>My experiences of HP’s communicating, variable</td>
<td>communicating, variable</td>
<td>Develop confidence to challenge poor practice</td>
</tr>
<tr>
<td>never had the confidence to challenge them, especially doctors, frustrated about that now</td>
<td>never had the confidence to challenge</td>
<td>Perceptions about communicating effectively</td>
</tr>
<tr>
<td>Too long. I did not do the pre-reading long and pretty boring - it did not matter. No-one checked me and actually there was little referral to it. It should be used more.</td>
<td>did not do the pre-reading… was little referral to it</td>
<td>Value of pre reading</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review purpose of pre-reading</td>
</tr>
<tr>
<td>I also thought the lunches were a bit long. An hour is too long for someone who is used to 10 minutes, like me</td>
<td>lunches were a bit long. An hour is too long</td>
<td>Review timings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Course structure</td>
</tr>
<tr>
<td>Some are more flexible you know especially children’s nurses</td>
<td>Flexibility especially children’s nurses</td>
<td>Inflexibility of facilitators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitudes of facilitators</td>
</tr>
</tbody>
</table>
## 2. Coding index

### Pre-course perceptions

<table>
<thead>
<tr>
<th>Preliminary themes</th>
<th>Preliminary categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and skills deficits</td>
<td>Communication strategies</td>
</tr>
<tr>
<td></td>
<td>Cultural differences in relation to communication</td>
</tr>
<tr>
<td></td>
<td>Discussing difficult topics</td>
</tr>
<tr>
<td></td>
<td>Ensuring interactions are focused</td>
</tr>
<tr>
<td></td>
<td>Communicating with children</td>
</tr>
<tr>
<td></td>
<td>Communicating with children with special needs</td>
</tr>
<tr>
<td>Managing conflicts</td>
<td>Parents and child conflicts</td>
</tr>
<tr>
<td></td>
<td>Inter-professional conflicts</td>
</tr>
<tr>
<td></td>
<td>Family and professionals conflicts</td>
</tr>
<tr>
<td>Building confidence</td>
<td>Responding to emotions</td>
</tr>
<tr>
<td></td>
<td>Handling difficult topics</td>
</tr>
<tr>
<td>Constraints to developing communication skills</td>
<td>Handling difficult situations</td>
</tr>
<tr>
<td>Desired outcomes of effective engagement</td>
<td>Workload pressures</td>
</tr>
<tr>
<td></td>
<td>Time pressures</td>
</tr>
<tr>
<td></td>
<td>Being effective when engaging with families</td>
</tr>
<tr>
<td></td>
<td>Developing effective parent-professional collaboration</td>
</tr>
<tr>
<td></td>
<td>Ensuring family compliance</td>
</tr>
</tbody>
</table>

### The course

<table>
<thead>
<tr>
<th>Preliminary themes</th>
<th>Preliminary categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective learning environment and teaching strategies</td>
<td>Role play</td>
</tr>
<tr>
<td></td>
<td>Simulation</td>
</tr>
<tr>
<td></td>
<td>Child and family input</td>
</tr>
<tr>
<td></td>
<td>Attitudes of facilitators</td>
</tr>
<tr>
<td></td>
<td>Critical analysis of own practice</td>
</tr>
<tr>
<td></td>
<td>Learning from other participants</td>
</tr>
<tr>
<td>Improvements to course</td>
<td>Adapt scenarios to participants concerns</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Greater focus on situations encountered in oncology &amp; specific delivery</td>
</tr>
<tr>
<td></td>
<td>Review purpose of pre-reading</td>
</tr>
<tr>
<td></td>
<td>Review length and use of time</td>
</tr>
</tbody>
</table>

### Post-course evaluations

<table>
<thead>
<tr>
<th>Preliminary themes</th>
<th>Preliminary categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal development - accomplishments</strong></td>
<td>Improved knowledge</td>
</tr>
<tr>
<td></td>
<td>Implemented strategies learned</td>
</tr>
<tr>
<td></td>
<td>Manage conflicts</td>
</tr>
<tr>
<td></td>
<td>Deal with colleagues and families</td>
</tr>
<tr>
<td></td>
<td>Accepting challenges as part of work</td>
</tr>
<tr>
<td></td>
<td>Better equipped to deals with challenging situations</td>
</tr>
<tr>
<td></td>
<td>Challenge own practice</td>
</tr>
<tr>
<td><strong>Personal development- ongoing needs</strong></td>
<td>Handling difficult situations</td>
</tr>
<tr>
<td></td>
<td>Handling difficult topics</td>
</tr>
<tr>
<td></td>
<td>Managing inter-professional conflicts</td>
</tr>
<tr>
<td></td>
<td>Ability to implement strategies effectively</td>
</tr>
<tr>
<td></td>
<td>Ensuring family compliance-</td>
</tr>
<tr>
<td><strong>Effective learning environment and teaching strategies</strong></td>
<td>Role play</td>
</tr>
<tr>
<td></td>
<td>Simulation</td>
</tr>
<tr>
<td></td>
<td>Child and family input</td>
</tr>
<tr>
<td></td>
<td>Supportive facilitators</td>
</tr>
<tr>
<td></td>
<td>Critical analysis of own practice</td>
</tr>
<tr>
<td></td>
<td>Learning from other participants</td>
</tr>
<tr>
<td><strong>Improvements to course</strong></td>
<td>Adapt scenarios to participants concerns</td>
</tr>
<tr>
<td></td>
<td>Greater focus on situations encountered in oncology</td>
</tr>
<tr>
<td></td>
<td>Review purpose of pre-reading</td>
</tr>
<tr>
<td></td>
<td>Review length and use of time</td>
</tr>
</tbody>
</table>
### 3. Final themes and categories

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-course preparation,</td>
<td>1. Accessing the course</td>
</tr>
<tr>
<td>preconceptions and expectiations</td>
<td>2. Perceptions about communicating effectively</td>
</tr>
<tr>
<td></td>
<td>3. Expand knowledge and skills</td>
</tr>
<tr>
<td></td>
<td>4. To develop personally and professionally</td>
</tr>
<tr>
<td>Course delivery, teaching and learning</td>
<td>1. Effectiveness of learning and teaching strategies</td>
</tr>
<tr>
<td>and learning strategies</td>
<td>2. The learning environment</td>
</tr>
<tr>
<td>Post-course evaluation and ongoing</td>
<td>1. Evaluation of course structure</td>
</tr>
<tr>
<td>development needs</td>
<td>2. Evaluation of course content</td>
</tr>
<tr>
<td></td>
<td>3. Personal and professional development</td>
</tr>
</tbody>
</table>