Title

Consult, negotiate and involve: evaluation of an advanced communication skills program for

healthcare professionals

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Abstract

Effective communication is central to children, young people and their families' experiences of healthcare. Most patient complaints in developed health care systems result from ineffective communication including: inadequate information provision; not feeling listened to; failure to value patients concerns; and patients not feeling involved in care decisions. Advanced communication skills training is now embedded within cancer care policy in the United Kingdom and now features prominently within cancer education in many countries. Here we share findings from a research evaluation of an Advanced Communication Skills Training program dedicated to health professionals caring for children and young people with cancer. We evaluated participants' (n = 59) perceptions of the program, impact on their skills, knowledge, competence and confidence. An Appreciative Inquiry design was adopted; data included interviews, pre-post course evaluations, e-mail blog survey and 360-degree reflective work records. The framework approach underpinned data analysis and triangulation of data sets. Key findings highlighted good and poor practice in health professionals' engagement with children, young people and their families; the purpose of communicating effectively was not always consistent with collaborative working. Attending a program helped participants expand their knowledge of communication theories and strategies. Participants valued using simulated scenarios to develop their skills, and were keen to use their new skills to enhance care delivery. Our emphasis within this evaluation, however remained on what was communicated, when and how, rather than to what effect. The impact of programs such as these must now be evaluated in terms of patient benefit.

Introduction

International and United Kingdom (UK) health policy advocates a model of participatory and collaborative care delivery (BMJ and NHS England 2014, Department of Health (DH), 2009; International Alliance of Patients' Organizations, 2007). Interactions between patients and health professionals is integral to the concept of patient collaboration (Drew et al. 2001) and person-centred care (Santana et al. 2017). The quality of patient-professional interactions and the way health professionals communicate with patients can impact on the effectiveness of information exchanged, the development of relationships and rapport building, as well as patient participation in care decisions (Ammentorp et al. 2009; Collins et al. 2005; Davies et al. 2016). Effective patient communication is a core professional value and essential clinical skill across health care settings (Baille et al. 1997; Baille et al. 1999; Fleischer et al. 2009): it has the potential to improve patient satisfaction and care outcomes (Kelley et al. 2014). Most patient complaints in developed health care systems result from ineffective communication (Levetown, 2008; Smith et al. 2015). Since 2008, cancer care delivery, guidance and polices, have stressed the value of effective patient-professional communication and for health professionals to undertake advanced communication skills training (CST) (Quail et al. 2016). Prudent healthcare requires evaluation of professional training so that practitioner needs and expectations are met, and the potential impact on care delivery identified. In this exploratory study, we aimed to identify whether health professionals attending a UK national advanced CST program self-reports increased skills, knowledge, competence and confidence when communicating with children, young people and their families. Based on our findings, we make recommendations about future programs, the need and focus for further evaluation.

Background

Communicating openly and compassionately with children, young people and families about illness and treatment options is essential for effective health care. It leads to improved knowledge and understanding of illness and probable consequences, and better engagement in decision-making (Levetown, 2008; Gibson et al. 2010; Coad et al. 2013; Henricks-Ferguson et al. 2015 a;b). In addition, effective communication, has a positive impact on patients' emotional health, symptom resolution, function and physiological measures such as blood pressure, reported pain and drug

usage (Kruijver et al. 2000; Stewart 1995). For many families, effective therapeutic relationships developed through creative, skilled and sensitive communication can be an essential lifeline, helping them to cope with their situation, and develop trust in those caring for their child (Levetown, 2008; Rodgers et al. 2016; Salmon and Young 2011; Street et al. 2009). Nurses in particular have described challenges building these relationships, often associated with not being able to respond effectively to questions, particularly around a negative prognosis and death, maintaining relationships with families who have rejected therapy, and managing conflicts that arise with the patient's families (Akgun Citak et al 2013; Newman 2016). Evidence suggests that although many health professionals focus on interactions with parents it can be challenging to ensure all family members are included and heard, irrespective of age or abilities (Lambert et al. 2008; Ranmal et al. 2009; Montgomery et al. 2016). Further challenges for health professionals working in cancer settings include initiating early and ongoing discussions around treatment choice and end of life care (Coad et al 2013; Hendricks-Ferguson et al. 2015 a,b). In addition, health professionals must be sensitive to and appreciate the unique needs of the adolescent population, where poor communication can lead to treatment refusal, non-adherence and abandonment of therapy (Essig et al. 2016). Communication difficulties have been identified as one of the three most common causes of conflict within healthcare, the others being disagreements about treatment and unrealistic expectations (Forbat et al 2016a).

Delivering communication training has become a high priority in cancer care, for all professional groups (Leonard 2017; Patenaude et al. 2015; Snaman et al. 2016; Stiefel et al. 2010). Insufficient communication training has contributed to health professional stress, job dissatisfaction and emotional burnout (Fallowfield et al. 2001; Fallowfield 2005). Evidence to date, however suggests that communication skills do not necessarily improve with experience, therefore, educational programs have been developed to improve health professionals' communication skills (Moore et al. 2013; Salmon and Young, 2016). Advanced CST programs have been required for senior cancer and palliative care health professionals working in England since 2003. The CST was initially delivered by the National Cancer Action Team, and superseded by the Connected© program in 2008 (Turner et al 2011): it used training approaches to produce participant behavioural change (Maguire et al. 1996; Wilkinson et al. 1999; Fallowfield et al. 2001). Similar to other programs (Kissane et al. 2012; Snaman et al. 2016; Wittenburg et al. 2017), the underpinning philosophy recognises and values good

communication in order to improve cancer patients' experiences. This also meets the UK National Health Service (NHS) Cancer Plan (2000) commitment that advanced communication skills should form part of health care professional continuing professional development. In the more recent cancer strategy (Independent Cancer Taskforce 2015), CST is described as 'mandatory' training for all new and existing staff (p52 https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf) and a number of courses have been made available following the withdrawal of central funding from the National Cancer Action Team (for example, http://www.christie.nhs.uk/media/3300/maguire_course_prospectus_2016.pdf).

The Connected© program was established to advance communication skills for professionals working with adult patients. However, over time increasing numbers of child health professionals accessed the training and a dedicated program pilot was developed. The dedicated program involved a three-day experiential learner-centred workshop. Didactic teaching was restricted to Day 1. Day 2 and 3 used interactive learning with professional actors to simulate clinical scenarios. This allowed participants to practice different approaches to communicating with 'patients', and receive individual performance feedback from specialist trainers.

Our commissioned research sought to explore health professional's self-reported communication skills and aimed to answer the following questions:

1. Does the training program increase skills, knowledge, competence and confidence of health professionals in order to provide appropriate support to children, young people with cancer and their families?
2. What changes are required to its current form as part of a planned roll out via a 'train-the-trainer' approach planned in future years to deliver the program more locally?

Methods and data collection

Our evaluation design followed Appreciative Inquiry (AI) principles, which seeks to discover 'what works well' and 'why it works well' (Cooperrider and Whitney 1999; Carter 2006; Carter and Coad, 2009). Appreciative Inquiry lends itself well to a pragmatic approach, which was a good fit with our study. We chose a multi-method approach to explore how the program as an intervention impacted on

health professional practice and our methods were chosen to encourage participants to interact, share and generate ideas with minimal direction from the research team.

Participants were drawn from a range of UK health settings using purposive sampling from six communication programs run over six months. Our sample therefore included health professionals who had participated in a CST program, primarily medical practitioners and nurses. In line with the commissioned brief we used three sources of data collection. This included: pre and post course questionnaires, individual interviews, an e-mail survey and a 360-degree reflective work record. Recruitment was good with all 59 out of the 60 courses delegates responding to our pre and post-course questionnaires, and three of the four trainers participated in individual interviews. We recorded 23 interviews, 11 participants contributing to an email open question survey and three completing a 360-degree feedback tool. To summarize:

1. We analysed the completed pre- and post-course questionnaires developed by education provided and included the qualitative data in our analysis. The questionnaire was developed with the funder and was used as a before and after assessment for all participants on the program, one week before and four weeks after, so not solely used by the respondents in our study. In total, all 59 participants on the program agreed to complete the questionnaires including 16 Doctors (10 male; 6 female); 32 Nurses (30 female; 2 male) and 16 Allied Health Professionals (14 female; 2 male). Questionnaire items focused on perceived skill set, confidence and current practice and helped the team to understand the program as an intervention and what was most and least useful in relation to communication skills training.

2. We offered semi structured interviews both in a focus group style and one to one interviews in recognition of professional's commitments, thus allowing staff to attend in small groups or as individuals on the telephone, providing choice to maximise participation. The interview guide was designed to elicit a range of views about the communication program and was developed through a series of discussions between the research team, lead trainers, user input and experts in the field of communication skills training. The interview guide included open questions about the program, group size and dynamics, perceived content, self-report of confidence and competence skills and

implications for health professionals individual practice. We included a stop/start/continue exercise to enable participants to reflect on the program and its impact on their clinical front-line work. Of the total 59 participants, 26 agreed to interview (4 doctors including 2 females; 2 males; 19 nurses all female and 3 allied health professionals 2 female and 1 male). Telephone interviews lasted approximately 45 minutes. No focus groups were undertaken as all health professional and trainers opted for individual interviews. As a follow up, we also offered an email open question survey if any reflections came to mind as they interacted in normal clinical practice (n = 11 gender and professional group unknown).

3. We devised a succinct 360-degree reflective work record for all participants who were participants on the program (Table 1). This was based on the programs learning outcomes and used a 5-point Likert scale with invitations for free text comments. This record was distributed via agreed email contacts to the participants 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 completed records from only three doctors but this encompassed eight sets of rich data as each included a peer report and two included a parent perspective. Although the detailed findings from this data set will be published elsewhere, an exemplar is included in the findings section.

Ethics approval was granted by the [INSERT NAME] University Health and Life Sciences Research Ethics committee. Direct extracts from the data have been used to illustrate themes and bring the data to life, and enable judgments to be made about the credibility of findings. Identities were protected by not referring to participants by name or identifying which course they attended. Participants were referred to as their appropriate title/role in the study with an assigned a confidential number and data collection tool source.

Data Analysis

The principles of the framework approach underpinned our triangulation of data analysis (Spencer et al. 2003; Ritchie et al. 2014; Smith and Firth 2011). The framework approach consists of three interlinked stages: familiarization and identifying codes; indexing and charting data to develop a thematic framework; and explaining findings, which for this study brief, included making recommendations about course structure. Analytical processes involved:

1. Building the research teams' familiarity with each data set through each member of the team analysing a sample of 10 pre and post questionnaires, six email blog surveys and reading/re-reading two of participants' interview narratives. Two members reviewed all the completed 360-degree tools (JC, DP). One member of the team then brought all the initial data sets together (JS). We then agreed the collective initial codes and preliminary categories and discussed these between the team to develop a shared understanding of the data and analytical processes. A coding frame was developed from the preliminary categories, which was used to sort and organise the whole data set.

2. Once all data sets were coded, preliminary categories were grouped together to form broad themes and refined to form the final themes.

3. Data triangulation using 360-degree reflective work records, questionnaires and interviews enabled us to explore competence integration and how practice is influenced within the participant's scope of practice. This iterative process reduced researcher bias such as checking meaning through a data analysis workshop and refining themes through email communication.

Findings

Findings from the qualitative analysis have been grouped into three themes, broadly pre-course, intra-course and post-course (INSERT See Figure 1). Overall, health professionals participating in this evaluation study reported on the importance of developing effective communication skills. They specifically valued the role-play and simulations and despite some initial anxiety enjoyed the scenarios and actors as an effective learning and teaching strategy. The complexity of the triadic nature of communication was mostly reflected in the 360-degree work record, for example it was noted that parents and children are rarely invited to discussions on their own: the value of reflecting on practice after the program for some was clearly helpful. We detail these findings further drawing on illustrative quotes from both participants and trainers where relevant.

Pre-course preparation, preconceptions and expectations

Four interrelated categories were associated with this theme related to health professionals'

preparation before attending the course, communicating with children and young people with cancer

and their families and the anticipated benefits from attending the course. These categories were

labelled: accessing the course; perceptions about effective communication; expanding knowledge and

skills and developing personally and professionally.

The majority of participants were recommended to attend by their manager for example, 'I was

recommended to undertake the course by the matron as I am new in post and all senior staff are to

undertake the cour*se, so timing was good for me'* Participant 4 (e-mail correspondence). Few course

delegates had sought information about current programs or available places. Participants who

actively sought a place on the course perceived the skills gained would enhance their clinical skills

repertoire:

 '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' Participant 15 (Interview).

Trainers reported that children and young people's advanced CST programs could be promoted more

effectively within child health services. Having the course accredited and endorsed by national

professional bodies, such as the Children's Cancer and Leukaemia Group (http://www.cclg.org.uk);

Royal College of Paediatrics and Child Health (http://www.rcpch.ac.uk); Royal College of Nursing

(https://www.rcn.org.uk) or preferably embedded in a Higher Education Institute/Organisation

curriculum were highlighted as possible solutions for making the course more attractive to managers

and potential delegates. Preparing for the course was influenced by the time available to commit to

the pre-course reading.

An important finding was the variability of health professionals' engagement with children and young

people living with cancer and their families; participants reported observing both good and poor

practice. They described observing health professionals taking time to listen to children/ young people

and family members' viewpoints, and a willingness to consider ways to develop effective rapport in

advance of interaction. In contrast, examples of ineffective communication strategies included hurried

and poorly planned interactions ignoring children/young people and parent's perspectives. An inconsistent approach by inter-disciplinary teams to communicating with children, young people and family members was described as preventing effective relationship development:

'Professionals care very much… they are scared of getting it wrong … and …concerned about making things worse' Participant 20 (Interview).

'My experiences of health professional's communicating, well its variable, never had the confidence to challenge them, especially doctors, *frustrated about that' Participant* 3 (Interview).

Some participants' accounts about the purpose of communicating effectively were not always consistent with a collaborative approach to working with this population; 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 (Pre-course Questionnaire).

*'Parent and child do not comply, lots just do their own thing and this is difficult to talk thr*ough *calmly and professionally'* Participant 9 Pre-course Questionnaire).

A range of outcomes were anticipated as a result of undertaking an advanced CST program. Drawn from the 360-degree tool, 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. From this data, it was interesting to find that participants also expected the program would enable participants 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. Participants 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. For example:

'*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'* Participant 22 (Pre-course Questionnaire).

Participants welcomed the opportunity to develop their communication skills and practise in a safe controlled environment. They also enjoyed building on Day 1's learning in Day 2, and Day 3 and found the incremental learning structure to be logical. A key finding was that participants from all professional groups lacked confidence in their ability to communicate effectively with children, young people and their families when providing information about prognosis or discussing palliative and end of life care. Participants described frustrations when observing colleagues not communicating effectively with children and young people. Many did not consider themselves sufficiently skilled to challenge behaviours hindering effective child and parent-professional communication and collaboration.

Course delivery, teaching and learning strategies

The CST program was highly rated in terms of skill development (Table 2) and participants valued the role of health professionals from their field of practice as trainers. Participants and trainers suggested that the course would be of value to all professionals working with children, young people and their families, and should not be restricted to cancer and palliative care: a wider range of issues could be included to address those challenged by mental health and/or learning disability.

This was the first experience of shared learning with colleagues from different professional backgrounds for many participants. Some were anxious about senior doctors' receptiveness to the course being delivered by other professional groups. However, participants indicated that trainers were key to reducing their anxieties about multi-professional learning because trainers made sure the learning environment was a safe place to share personal concerns and difficulties when communicating with this population. Participants valued the trainers' knowledge and experience, particularly when they drew on their own clinical practice.

In contrast, a few participants described the learning environment as intimidating and perceived their contribution was not always valued. Some novice participants experienced variable support from more experienced colleagues and consequently their confidence waivered when support was absent, which reduced their ability to work effectively with all participants. Participants identified peer support had a positive effect on the learning achieved:

>*'Thoroughly we*ll 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).

Interestingly, in the pre-questionnaire, role play had been a concern for participants but it was the use of simulated role play and working with the actors that were most highly valued by all participants. For example:

>*'Best aspects of the course: role play was very educational, very surprising and insightful'.* Participant 21 (Post-course Questionnaire).

>*'Role play - increases confidence and challenges each individual'* Participant23 (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'* Participant 1 (E-mail survey).

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

Post-course evaluation and ongoing development needs

Across data sets it was evident that participants were very positive and highly satisfied with the training received. The feedback from trainers and participants about timetabling and program length was variable. For many participants two days would be sufficient by streamlining the introduction and theoretical content on Day 1 or using a more dynamic delivery mode such as an e-learning format.

Participants considered the content appropriate to meet communication with children and young people with cancer and their families. Notably, practical skills teaching and practise 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'. P*articipant16 (Post-course questionnaire)

*'Useful to do silences and will practise them' Participant9 (Post-*course questionnaire).

'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'* Participant 16 (E-mail survey).

All data sets indicated that participants considered the program had helped them reflect on and develop their communication skills with this population. The 360-degree work record provided useful insights into how participants contextualised the training to fit the needs of their clinical areas following the course e.g. children's intensive care or community clinics. In addition, the reflective accounts suggested change in the way participants interacted with young people as highlighted by participant 2, and a colleague and parent reflecting on their practice:

*'Actually, am meeting more of youn*g *peoples'* needs now since the course but I realise I do not see parents alone unless it*'*s really bad news. Guess I need to work on this one*'* Participant 22 (360-degree tool).

*'*Since the course, I have noticed *'she'* always invites them (young people) in an open way so they can*'*t just say no*' Colleague of Participant 22* (360-degree tool).

'(Providing information) yes and she checks it with my son each time and never rushes us*' Parent* of Participant 22 (360-degree tool).

Participants felt their skills were developed and they had been able to put into practice strategies learned from the course, for example: new ways of working with a medical consultant; being prepared to listen more; and establishing heath professional roles prior to a consultation. One health professional had implemented a dedicated 'teenage clinic' since the course. Some elements however remained difficult, indicating to participants and trainer's areas for ongoing development, such as meeting the emotional needs of parents, helping children to discuss psychological problems or issues regarding

romantic relationships. Peer and parental reporting in the 360-degree work record noted positive impact on the way health professionals' interacted in every-day practice such as:

*'I think I will alwa*ys 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 (Post-course questionnaire).

*'I've noticed the difference in p*atient 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!' Participant* 16 (e-mail survey).

Discussion

Key findings emerged which merit further consideration as they have implications for practice, and reinforce the requirement for communication training for all health professionals. First, reports of poor collaboration between health professionals and children, young people and families, and between professionals were reported. Second, participants provided examples of the variability in some health professionals' communications with this population, reporting good and poor practice. The program was highly rated in terms of personal and professional learning; as a way of developing participants practice. There was general consensus that this must focus on children, young people and their families' specific communication needs, and be delivered by expert trainers with experience of child health.

Our research focussed on the program, and how this was perceived by learners and by trainers. It is possible that some participants were highly skilled communicators prior to the course, and their experience could be incorporated into the course delivery. The extent of potential attendees' level of communication skills would be difficult to assess, and given some of the attitudes implied in the pre-course questionnaire, it appears that undertaking the course was very important to participants' confidence in communicating in difficult situations.

Clearly there are challenges in delivering a standardised program as experience varies immensely. Peer performance was challenging but overall enjoyable. However, pre-course preparation raises particular concerns. Whilst for some participants, attendance was a well-planned and prepared for

event, for others it was a hurried decision at short notice. This impacted on readiness for learning, an important antecedent in the process of learning to communicate with this group (Ranmal et al. 2009; Gibson et al. 2010; Montgomery et al. 2016; Newman, 2016). Trainers perceived the work as very challenging because of the intensity of the program, personal commitment required, skill development and confidence needed to support participants with diverse experiences and professional backgrounds. Participants and trainers both expressed some anxiety about working with actors and simulation. This has been highlighted previously, coming to the same conclusion that despite initial anxiety, the benefits outweigh the challenges once it is experienced (Kenny et al. 2016, Quail et al. 2016).

Interestingly, participants and trainers suggested that the course would be of value to all professionals working with children and young people and their families, and should not be restricted to those working in cancer and palliative care services. There has also been some debate in the literature about the best way to train health professionals especially doctors, and whether this should be as uni-professional groups (Wilkinson et al; 2003; Henricks Ferguson, 2015 a;b). This study did not seek to specifically explore inter-professional training per se. However, our findings suggest that shared learning across professional groups was effective, and valued despite some initial reservations.

Additional issues merit further discussion with respect to educators of communication theory and the nursing/medical curriculum. Participants reported that there was a conducive learning environment, and that well trained reflexive trainers or educators are crucial for course success. However, some participants suggested a need for more flexibility in structuring the program and responding to the group needs. This was also echoed by the trainers, and their request for follow up mentoring for novice trainers through specific mentorship arrangements was one of our recommendations. Support for the actors using a de-brief session was highlighted positively, and trainers identified the need for ongoing trainer support and mentoring for themselves as individuals and as a group.

Finally, this dedicated program meets many of the consensus recommendations reported by Stiefel et al. (2009) i.e. program length, learner centred and multi-professional, simulation using actors or videos, delivered by credible experienced cancer health professionals. Assessment of long term

impact is however needed to evaluate skill maintenance, uni-disciplinary skills as well as collaborative communication skills e.g. diagnosis and prognosis communication (Newman 2016), communication about clinical trials (Pearce et al. 2016), palliative and end of life communication (Hendricks-Ferguson et al 2015 a;b), communicating with parents (Drew et al 2001) and child decision-making (Coyne et al 2016).

Limitations

Our emphasis within this evaluation, was on what was communicated, when and how, rather than to what effect. We focussed mainly on self-report, a lack of an objective measure means that we cannot comment on whether the course makes any difference to an individual's communication skills in the long-term. Nonetheless, comments made by participants indicated enthusiasm for the training, and highlight their perception that the course improved their skills for patient benefit. Our funder did not commission us to explore patient or families' perspectives. However, this would be important to include in future evaluation studies as the quality of patient interactions with health professionals can influence the effectiveness of information exchange. The inclusion of a period of observation, would be a further important addition to data collection. We were commissioned to undertake this evaluation, we were not involved in the development or delivery of the course, our brief was to provide an assessment of the CST program at that time. Through team analysis we mitigated against personal views influencing our analysis of the data collected.

Implications for practice and research

Cancer communication is a complex problem and effective solutions require multifaceted approaches, of which communication training is one important element. We conclude that delivering a dedicated advanced CST program around communicating with this population to health professionals is a much-needed development, and should be sustained. Training is not however a one-off exercise, maintaining excellent communication skills must be finely tuned and improved constantly. We agree with Salmon and Young (2016) that communication training that remains only at the level of skills training does not go far enough. Bringing judgements about communication goals to the foreground of communication training offers a potentially more realistic way to influence communication (Salmon and Young 2016). Communication programs must also find ways to harness the experience of

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participants, to involve family members in simulated sessions, and find ways to bring creativity and holism into the classroom (Salmon and Young 2011, Gorniewicz et al 2017). In addition, the use of case studies, script role plays with 'genuine' content are additional approaches to content that educators should consider as essential: we show here the individual benefit of such approaches that now need to be evaluated in terms of patients' satisfaction, well-being, and managing conflict (Forbat et al 2016b). Although participants were initially cynical about the value of role-play as an educational tool, they subsequently describe the value of role-play methods as a means of critically reflecting on their own communication skills in a safe environments .

We would encourage educators and trainers to go one step further and draw upon the 'arts' much more to bring practice into the classroom and focus more on the 'person' in communication encounters, and what is the shared goal of these encounters. For example the 'skills compass' (http://www.kingshealthpartners.org/assets/000/000/588/Circle_of_Care_original.pdf) is one way to get us to think about the way we teach communication skills as one part of compassionate healthcare by placing it in a broad social and interpersonal context, describing a multi-directional flow of care between healthcare professionals and their colleagues, patients and carers (INSERT **See Figure 2**). Development of the skills on the compass draws on methods from simulation, Human Factors skills training and techniques and ways of thinking that come from the arts (Clod Ensemble and Guy's and St Thomas' NHS Foundation Trust, 2016): offering ways that emphasise health professional's creativity as they craft original solutions to unique communication needs (Salmon and Young 2011).

Conclusion

Participants reported an expansion of their knowledge of communication theories and strategies. Participants valued using simulated scenarios to develop skills, and were keen to use their new skills to enhance care delivery. We offer here some suggestions, based on our evaluation, for future programs to consider. Similar to Bylund (2017), we have emphasised that communication training is not a discrete event, we should aim to build on the communication skills that professionals already have and in future programs engage more with them using reflection, experiential and self-directed learning. The tangible benefits of CST programs, their impact on professional practice, and patient outcome have yet to be established: further evaluation of these outcomes would be welcomed.

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Table 1: Range of data collected and participant numbers

Questionnaires	Face-to-face interviews	Telephone interview	e-mail survey	360 degree tool
pre-course 59	3	23	11	8 items
post-course 59				

Table 2: Perceived skills as a result of the program

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

Figure 1: Key findings: themes and categories

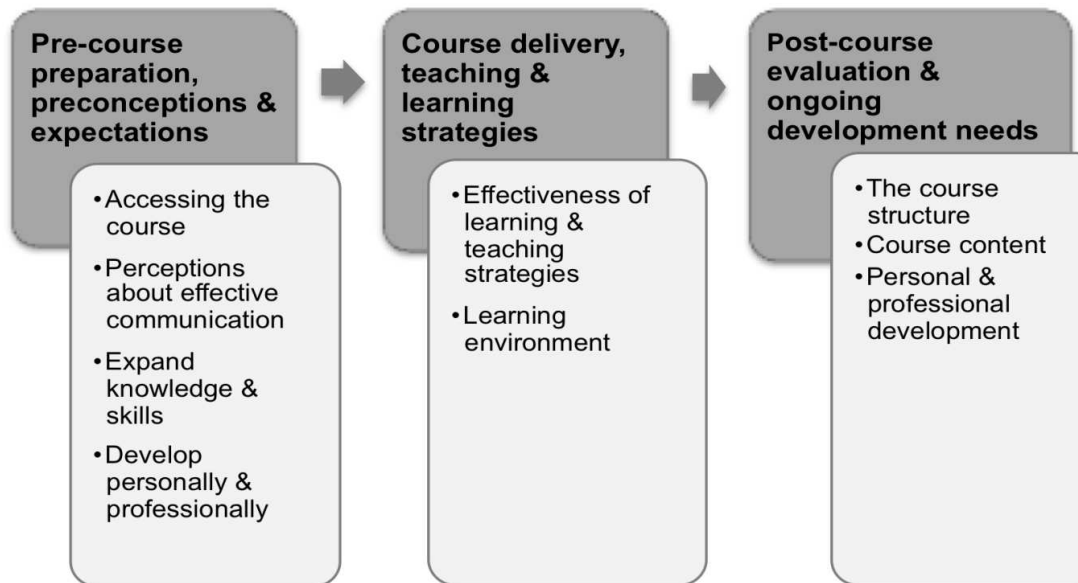| Pre-course preparation, preconceptions & expectations	Course delivery, teaching & learning strategies	Post-course evaluation & ongoing development needs
• Accessing the course • Perceptions about effective communication • Expand knowledge & skills • Develop personally & professionally	• Effectiveness of learning & teaching strategies • Learning environment	• The course structure • Course content • Personal & professional development

Figure 2 Circle of care

Clod Ensemble and Guy's and St Thomas' NHS Foundation Trust, (2016) Circle of care
http://www.kingshealthpartners.org/assets/000/000/588/Circle_of_Care_original.pdf accessed February 10th 2016

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