

HOW HEALTHCARE PROFESSIONALS IN SCOTLAND DEVELOP THEIR COMMUNICATION SKILLS, ATTITUDES AND BEHAVIOURS

An independent report for

NHS Education for Scotland

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1. INTRODUCTION

1.1 AIMS, OBJECTIVES AND SCOPE

The ability to communicate clearly and form effective, productive relationships is essential for the provision of high quality person-centred care and are therefore required skills and behaviours for practitioners in all areas of healthcare. Person-centred care involves placing the patient and their experiences at the heart of care (Coulter et al., 2009) and is one of the quality ambitions of the Healthcare Quality Strategy for NHS Scotland (Scottish Government, 2010).

Communication is a key component of most pre-registration education provided to healthcare practitioners. A wide range of educational initiatives or training courses are currently available which are promoted as ‘communication skills’ training. These initiatives have been developed for different professional groups across different aspects of care and are made available by various providers including hospice services, health boards and higher education institutions. Some are nationally available accredited courses and others are more ad hoc, locally developed programmes

Despite an increase in communication skills training and reported evidence that training programmes are effective in developing the skills of practitioners (Fellowes et al, 2003) concern remains that the quality of communication between healthcare staff and patients is inadequate (Fallowfield et al, 2002; Heaven et al, 2006).

It is recognised that a consistent approach to the development of communication and relationship skills within health is lacking in Scotland (West of Scotland Cancer Network, 2009). It is also recognised that the provision of education alone does not necessarily result in a change in practice i.e. the transfer and integration of new learning about communication and interpersonal relationship skills into daily practice (Heaven et al, 2006).

NHS Education for Scotland (NES) has been supporting learning and practice development opportunities which support the implementation of good practice in communication and relationships consistent with person-centred care.

As part of this programme of work, NES has commissioned this scoping exercise entitled “Supporting Person-Centred Care through Communication and Relationships”. The aim of the scoping exercise is to:

Explore how healthcare staff learn, continually develop and demonstrate communication and relationship skills, attitudes, values and behaviours/approaches.

The scoping exercise included:

- a top level review of the literature to explore learning from other reviews;
- qualitative interviews with national and local health professionals at all levels post-qualification and in various disciplines (medical, nursing, pharmacy and allied health professionals) including key informants who were considered to have high levels of knowledge and experience in the area of communication skills;
- exploratory work with patients from a variety of patient groups representing or supporting individuals with a range of a health conditions.

The specific methods and groups involved are discussed in Section 2 of this report.

1.2 WHAT IS MEANT BY 'COMMUNICATION SKILLS'?

It is important to understand the term 'communication' and what is meant by 'communication skills' in considering evidence and current practice in how healthcare practitioners develop their abilities in this area.

This can be complicated for a number of reasons. Firstly, the term 'communication' is sometimes used as a 'catch all' phrase which encompasses both the actual communication process and the values, behaviours and attitudes which underpin or impact on that process. Secondly, there is no universally agreed definition of the term 'communication' and most key review papers and grey literature documents do not include any common definition.

Interpersonal communication is concerned with what is said i.e. the language used, and how it is said e.g. the non-verbal messages sent, such as body language and facial expressions. The tone, pitch, stress and intonation that we attach to our use of language are also considered to be important aspects of interpersonal communication and our understanding of information.

Hargie (2006) develops this understanding further by introducing a notion of interpersonal communication and relations as a form of skilled activity. He suggests that this skilled activity consists of various key skill areas that include certain characteristics such as non-verbal communication, listening, explanation, questioning, negotiation, reinforcement, persuasion, reflecting, opening & closing and self-disclosure.

In practice, it is often impossible to separate the quality of the relationship between two people from the quality of the communication between them. It is helpful to think of communication and human relationships as intrinsically interlinked.

Effective communication and human relationships involve two or more individuals but are more than an exchange of information. They include a genuine desire to connect with and care for the other person and require the use of clusters of behaviours, values, traits, and attitudes as well as skills to exchange information, feelings and meaning verbally and non-verbally.

This description effectively captures the totality of communication and relationships capability that is explored in this scoping study.

Effective communication skills are acknowledged as an essential prerequisite for providing high quality healthcare and person-centred care (Lewin et al, 2009). This is reflected in the rights and healthcare principles enshrined in the Patient Rights (Scotland) Act, 2011 and in the quality ambitions of the Healthcare Quality Strategy for NHS Scotland (Scottish Government, 2010). The need for education associated with communication and human relationships has been highlighted in several NES workstreams including cancer, palliative care, long term conditions and mental health.

Statistics from the Scottish Public Services Ombudsman also highlight that communication issues continue to be identified in complaints about healthcare (issues around communication, staff attitude, dignity or confidentiality arising in approximately 10% of all cases from 2007-2009¹) and appears in the most recent reports from May 2011². Understanding what this means in terms of

¹ www.spsos.org.uk/statistics

² <http://www.spsos.org.uk/files/webfm/Commentaries/2011/2011.05.18%20SPSO%20Commentary%202011.pdf>

education provision can be complicated when what may be identified as unhelpful may be a reflection not just of poor communication skills, but of underlying attitudes, values or behaviours.

In summary, the focus of this scoping exercise is therefore not only concerned with how practitioners learn and develop their communication abilities, but how they learn and are supported to build effective relationships.

2. SUMMARY OF METHODS USED IN THE STUDY

This study consisted of a mixed method approach including a top level literature review, structured/semi-structured interviews and surveys. The approaches used were designed to capture as far as possible views from a cross section of multi-disciplinary health practitioners from across Scotland. In addition to key informants who had particular understanding of this topic, we sought to interview practitioners from five key areas of practice:

- Respiratory
- Mental Health
- Cancer
- Palliative Care
- Coronary Heart Disease

For each of these areas we sought to interview a manager of medical staff, of nursing staff and of allied health professionals (AHPs). Each of these managers were asked to identify 3 practitioners for interview at Stage 4. In addition we identified and interviewed a small number of nurses in other areas of practice and some general practitioners.

The patient survey, intended to collect examples from patients on how the communication skills of healthcare staff had impacted on their experience, was promoted through 5 patient organisations working in the key areas identified above. We were very flexible with the methods by which these stories could be collected, however most organisations opted to promote the online survey hosted by Survey Monkey. One organisation allowed us to visit a patient support group to conduct a focus group. A summary of some of the issues arising in the patient and practitioner's stories of positive and negative experiences of communication is included in Section 5 of this report.

The methods used are summarised in the following table and a broad outline of some of the questions discussed with key informants, managers and practitioners is included in Appendix A.

Table 1: Methods	Details	
Stage 1: Literature Review	<p><i>Review of reviews including:</i></p> <p>1a. Background and key papers suggested by NES and references included in these.</p> <p>1b. Extensive search using online portals using a wide range of relevant search terms for review papers.</p> <p>1c. Further papers suggested by Key Informants at Stage 2.</p>	
Stage 2: Key Informant Interviews	Semi-structured telephone interviews with key informants identified through discussions with NES.	n = 5
Stage 3: Manager Interviews	<p>Structured telephone interviews with managers.</p> <p><i>Respiratory = 1 Doctor, 1 Allied Health Professional (AHP), 1 Nurse</i></p> <p><i>Mental Health = 1 Doctor, 1 AHP, 1 Nurse</i></p> <p><i>Cancer Care = 1 Nurse</i></p> <p><i>Palliative Care = 1 Doctor, 1 Nurse</i></p> <p><i>CHD = 2 AHPs, 1 Nurse</i></p>	n = 13
Stage 4: Practitioner Interviews	<p>Structured telephone interviews with practitioners identified by managers in Stage 3.</p> <p><i>Respiratory = 2 Doctors, 2 AHPs, 3 Nurses</i></p> <p><i>Mental Health = 2 Doctors, 3 AHPs, 3 Nurses</i></p> <p><i>Cancer Care = 1 AHP, 3 Nurses</i></p> <p><i>Palliative Care = 3 Doctors, 3 AHPs, 2 Nurses</i></p> <p><i>CHD = 1 Nurse</i></p> <p><i>Other Nurses = 3</i></p> <p><i>Other Doctor = 1</i></p> <p><i>General Medical Practitioners = 2</i></p>	n=34
Stage 5: Patient Survey	Online survey with patients (n=10), promoted through patient organisation and completed by patients themselves. Additionally 1 focus group (n=9) was conducted with a patient support group.	n = 19

3. LITERATURE REVIEW

The aim of the literature review was to:

Collate findings from the evidence base on the effectiveness of communication courses, including evidence associated with their impact on practice or experience of healthcare.

The literature review was a top-level review of key background papers and previous published review articles, as outlined in Section 2 above.

The following key questions were considered:

1. **What review evidence is available on the effectiveness of interventions to improve communication skills?**
2. **What is the best way to provide education and development opportunities related to communication skills so that improvements are transferred to and have maximum impact on routine practice?**
3. **What are the relationships between communication, values and attitudes, and organisational culture? What helps and hinders the transfer and integration of learning into the everyday culture and practice of organisations?**
4. **What is the evidence on how communication, and the relationship between patients and practitioners, impacts on patient experiences or outcomes?**
5. **Is there any evidence relating to routine, day to day communication rather than advanced/difficult communication?**

3.1 SEARCH TERMS

The following search terms were used:

- Communication skills
- Communication + training
- Person centred care communication
- Communication + relationships
- Communication + organisation
- Communication + culture
- Communication + values
- Communication + attitudes
- GP Patient relationships
- Learning transfer
- Learning + communication
- Learning + relationships
- Communication + self management
- Supervision
- Supervision + staff
- Support + staff
- Integration
- Communication + learning transfer
- Communication + behaviours
- Communication + healthcare
- Communication + effectiveness
- Communication + patient outcomes
- Communication + transfer strategies
- Human relationship skills
- Values
- Attitudes
- Physician communication
- Knowledge skills framework
- Communication + skills knowledge
- NHS Knowledge and Skills Framework (KSF)
- KSF + Communication
- Integration
- Shared decision making

3.2 LITERATURE REVIEW FINDINGS

3.2.1 WHAT REVIEW EVIDENCE IS AVAILABLE ON THE EFFECTIVENESS OF INTERVENTIONS TO IMPROVE COMMUNICATION SKILLS?

We found 9 relevant review papers which are summarised in Appendix B. Overall, reviewers were in general agreement that communication skills training is effective in improving the communication behaviours of healthcare professionals but any more detailed conclusions were hindered by a significant absence of sound research studies. Uitterhoeve et al (2009), note particularly that of the 59 studies originally identified, only 7 met the criteria for inclusion. As this review focused particularly on the impact of communication training on patient outcomes, most of the studies were excluded because they did not report this but an additional 12 papers were excluded due to the lack of a control group. The results of Uitterhoeve et al do not shed any light on the components of training which might be important for effectiveness but they do comment on the need for programmes and accompanying evaluations in which:

- *The goals and content of the training programme are conceptually linked to outcomes that are important to patients and healthcare professionals.*
- *A primary outcome is chosen, preferably operationalised as a single measure.*
- *The training programme incorporates activities to promote the transfer of acquired skills into daily practice, preferably activities to strengthen the provision of supervisory support to participants of the programme.*

The latter point and the other findings of the Uitterhoeve et al., review in relation to the impact of training on patient outcomes are discussed further below.

Lewin et al (2009) reviewed interventions to promote a patient-centred approach in clinical consultations all of which included training with a communication skills element. They found that it was not possible to draw any conclusions with regard to what elements or intensity of interventions were important for positive outcomes commenting that:

'The intensity of the interventions varied across studies, both in terms of the teaching/training tactics (duration of training, didactic versus interactive approaches, additional materials, use of consultation tools) and patient centredness. Attempts to standardise assessments of the intensity of teaching and patient centredness for this review were unsuccessful.'

Some of the other reviews have attempted to comment on elements of training or interventions that appeared to be important for success, though these comments are based on the results from individual studies rather than the review as a whole. McGilton et al.'s 2009 review in residential care reports two studies (of 6 in total) that found that psychological components in the intervention helped to sustain the change in healthcare professionals' behaviour and one study which found that increased duration of the intervention improved its positive effects.

It is also clear from the range of studies included that the evidence base for communication skills courses and education has mainly focused upon the skills of medical, and to a lesser extent nursing staff and overlooks most other staff groups (Gremigni et al, 2008). However, Parry (2008) reviewed

5 studies in allied health professionals. Two of the studies suggested that targeted training for qualified AHPs could improve performance and patient outcomes. The other studies were in students (of physiotherapy and speech and language therapy), two of which showed small beneficial effects, though it is unclear whether this was in behavioural or patient outcomes.

Rao et al. (2007) again concluded that interventions can improve communication between patients and physicians and that most of the studies included in the final review (n=21) reported positive effects on one or more outcome variable. Practitioners who received 'high-intensity' interventions were more likely to elicit patient concerns and exhibit a patient-centred style. They were also more likely to express empathy although in one study the initial effect was not sustained after 12 months. In this case, interventions were classed as 'high intensity' if they were delivered more than once and involved clinic or research personnel in the delivery of the intervention (over and above distribution of information). High intensity interventions were also shown to significantly improve information giving and clinician's efforts to check that patients' understood the information given.

Merkaert et al. (2005) carried out a review of communication skills training in cancer care and conclude that learner-centred, skills-focused and practice-oriented communication skills training programmes organised in small groups of 6 participants maximum and lasting at least 20 hours were useful in improving skills, knowledge and confidence and in changing attitudes and beliefs. No change was observed in physician's ability to detect patient distress but 2 of 4 studies reported improvements in patient satisfaction and perceptions of the interview.

Chant et al. (2002) provides a useful summary of the research to that date in terms of what elements of training have been shown to be associated with a positive impact. In the absence of more robust or more recent data, this provides some guidance for trainers/educators and is included in the Table below. The West of Scotland Cancer Network guidance (2009, pp 9, 10 and 11) also provides a summary of practical guidance on the content of courses that they found to be important for success in enhancing skills.

The two older reviews included in the 9 identified also reported methodological flaws and found mixed results in relation to patient outcomes.

Elements/Features of Communication Skills Training (from Chant et al., 2002)

Positive outcomes in studies with sound methodology or verification in other studies

- Communication skill training in general (Evans et al, 1992; Reynolds, 1996; Salo-Chydenius, 1996; Cegala et al, 2000a,b; Greco et al, 1998).
- Audiovisual aids (Caris-Verhallen et al, 2000).
- Simulated patients (Ladyshewsky & Gotjamanos, 1997; Festa et al, 2000).
- Anti-discriminatory learning (Williams-Burgess et al, 1993).
- Training on professional support and coping (De Lucio et al, 2000).
- Interviewing skills development (Klein et al, 2000).
- Assessment through content analysis of essays (Reynolds, 1996).
- Relationship development skills (McCallion et al, 1999; Hordern, 2006; Shaw et al, 2000a,b).
- Experiential methods and skills, including role-play and empathy (Paxton et al, 1988; Burnard, 1995; Smoot & Gonzales, 1995; Yates et al, 1998; Keen, 1999; Razavi et al, 2000; Reynolds et al, 2000).

Positive outcomes but with inadequate research design or lack of supporting findings

- The use of transaction analysis for training (Bailey & Baillie, 1996).
- Flashcards (Banks, 1996).
- Drama workshops (Riseborough, 1993).
- Multidisciplinary learning (Freeth & Nicol, 1998).
- Problem-focused workshops (Parle et al, 1997).

Mixed or indeterminate outcomes

- Dealing with sensitive issues, including sexuality (O'Gorman et al, 1997).
- Team teaching strategies (Minardi & Riley, 1991).
- Mentorship (Wilson-Barnett et al, 1995).
- Meeting patients' needs and reducing blocking behaviours (Evans et al, 1992; Booth et al, 1996; 1999; Heaven, 1996; Heaven & Maguire, 1996; Baile et al, 1999).

3.2.2 WHAT IS THE BEST WAY TO PROVIDE EDUCATION AND DEVELOPMENT OPPORTUNITIES FOR COMMUNICATION SKILLS SO THAT IMPROVEMENTS ARE TRANSFERRED TO AND HAVE MAXIMUM IMPACT ON ROUTINE PRACTICE?

The transfer of new learning from the training room to the workplace is often described as the extent to which learners effectively apply the knowledge, understanding, behaviours, skills and attitudes acquired in a training context to their everyday practice with patients and members of the public (Baldwin & Ford, 1988).

Heaven et al (2005) suggest that training courses are often 'disconnected' on both a practical and managerial level from the work environment and that the challenge is often concerned with how to bridge the gap between learning and practice. The authors highlight two examples of transfer intervention ('goal setting' and 'self-management programmes') where the available literature in management training has demonstrated some effectiveness in bridging this gap.

The first of these, goal setting, is described as a process which involves establishing specific, measurable and time-targeted objectives for the application of new skills into practice. The second intervention, self-management programmes are described in this context as self-directed learning (NHS Connecting for Health) and are understood to consist of a number of key features that include:

- The creation of supporting conditions and environments for the learner;
- The creation of a forum that allows individuals to discuss experiences of attempting to assimilate skills into practice;
- Opportunities which support individuals to objectively reflect and review both positive and negative experiences through self-directed learning and understanding of problems and solutions.

This evidence suggests that these 'self-management programmes' are more effective than simple goal setting in the transfer of more complex behaviours like interpersonal communication skills. The strategies listed above as 'self-management programmes' are considered in many studies that are concerned with the effectiveness of the transfer of communication skills courses to healthcare practice and their impact on patient experiences and health outcomes.

Heaven et al. (2005) set out to explore the impact of supervision on the transfer of communication skills learning to the health workplace. The authors concluded that:

'Communication skills are not automatically transferred back into the workplace, and are not maintained or generalised in a clinically meaningful way unless some kind of intervention is offered.'

This conclusion is supported by the available evidence from other studies in this field (Fallowfield et al, 2002; Uitterhoeve et al, 2009). Clinical supervision in this study was found to be an effective process for the transfer and integration of newly acquired communication skills into the workplace. The authors suggested that without such supervisory support, clinical nurse specialists find the integration of new learning extremely problematic and that optimal support to patients would be significantly compromised.

Uitterhoeve et al. (2009) drew a similar conclusion in their systematic review of the literature on the effect of communication skills training on patient outcomes in cancer care. They found that there is

scarce evidence that communication training is 'uniformly' effective in improving patient centred relationships and outcomes where there is an absence of clear transfer strategies in training design. They also noted that the provision of supervisory support is considered to be a 'pivotal' element of packages of transfer interventions. The inclusion of strategies in the training design to augment or improve supervisory practice was also identified as a significant gap in many of the studies reviewed by Uitterhoeve et al (2009).

It is outwith the scope of this review to fully examine and comment upon the various strengths and weaknesses of effective supervisory arrangements and approaches in clinical settings. However, the study by Heaven et al (2005) provides some useful indicators as to what conditions and approaches are more likely to be effective for supporting the transfer and integration of communication skills into practice. The role of observation and direct feedback was highlighted as particularly important. The types of supervision provided and the techniques for feedback are known to effect supervisee anxiety and self-efficacy (Bernard & Goodyear, 1998; Norris, 1986). The technique of 'self-generated feedback' is highlighted as being more effective than simple verbal feedback as provided by a supervisor.

Self-generated feedback is described as a form of feedback that involves an individual observing their own behaviours as part of a self-directed learning process where the responsibility and ownership of feedback is led by the supervisee and supported by the supervisor (Maguire et al, 1978; Decker, 1983; Whittaker, 2004). This self-critique and learner centred approach is also advocated within the design of communication skills courses as an effective method to 'enhance continued improvements in skills' as well as changes in attitudes and beliefs (Fallowfield et al, 2003).

This particular approach to feedback is considered to be particularly useful for building up self-efficacy (Gist, 1987). Self-efficacy is recognised as being an important factor in the initiation and maintenance of communication behaviours and new skills, and for shifting the attitudes and beliefs of practitioners about the value of good communication (Jenkins & Fallowfield, 2002; Fallowfield et al, 2003; Parle et al, 1997).

3.2.3 WHAT ARE THE RELATIONSHIPS BETWEEN COMMUNICATION, VALUES AND ATTITUDES, AND ORGANISATIONAL CULTURE? WHAT HELPS AND HINDERS THE TRANSFER AND INTEGRATION OF LEARNING INTO THE EVERYDAY CULTURE AND PRACTICE OF ORGANISATIONS?

Attempts to describe and characterise what constitutes organisational culture have been described by many authors. Whilst a detailed analysis of culture as it applies to healthcare organisations and systems is outwith the scope of this review, it is helpful to consider what key features of an organisation's culture might support or impede the transfer and integration of new learning into practice. There is a lack of empirical evidence available from methodologically robust studies that demonstrate the effectiveness of the transfer and maintenance of communication skills training into routine healthcare practice (Baile et al, 1999; Libert et al, 2001; Fallowfield et al, 2003). It is therefore useful to consider the wider literature relating to learning transfer and organisational culture and to consider how this may be applicable to healthcare organisations and practice.

Organisational culture is often described as consisting of the values, beliefs, norms and customs that are shared by people within an organisation (Ogbonna, 1992; Sun, 2008) and is considered to have an influence upon employee satisfaction, motivation and morale and therefore has the potential to

enhance individual and organisational performance (Campbell et al, 1999; Hellriegel et al, 2001). Kirwan (2004) argues that although organisations don't necessarily exhibit overt resistance to learning transfer, the evidence would suggest that many organisations are indifferent to it. It is therefore necessary to ensure proper 'buy-in' at the appropriate levels within the organisation in order to shift values, attitudes and the culture of the organisation. 'Buy-in' is argued to be necessary at three levels, amongst participants, managers/supervisors and at a senior management level:

Participants- should be involved in the identification of learning needs and programme content where appropriate.

Managers/supervisors- require to be involved throughout the entire learning process, including the training needs analysis stage. They should engage with learners prior to training to explore required learning outcomes and develop a strategy/plan for transferring and applying learning into routine practice. Managers/supervisors should also support learners following training to start the process of implementing the action plan and providing support, coaching and feedback.

Senior managers- can have a valuable role with 'reinforcing the message that a particular learning intervention is trying to promote' as well as 'sending out strong messages (sometimes inadvertently) about what's seen as important'.

In the field of communication within a healthcare setting particularly, studies have previously shown that certain healthcare professionals remain unconvinced about the benefits of open communication with patients and that these negative beliefs can lead to blocking and/or distancing behaviour by practitioners when communicating with patients (Booth, 1996; Heaven, 1996; Bandura, 1988).

More recent literature reports indicate positive attitudes towards communication skills training among medical students (Anvik et al, 2008; Rees & Sheard, 2003). One study (Wittenberg-Lyles et al, 2010) of attitudes towards palliative care communication training reported that students: (a) prefer to learn nonverbal communication techniques, (b) believe that natural ability and experience outweigh communication curricula, (c) view the skill of breaking bad news as largely dependent on knowledge and expertise, and (d) prefer curricula on palliative and hospice care to consist of information (eg, advance directives) rather than communication skills.

Doctors and nurses report anxieties about asking certain questions or discussing certain subjects that may be emotionally charged or where there is a belief that these conversations may be unhelpful or too difficult for patients (Bandura, 1988; Wilkinson, 1991; Andersen & Adamsen, 2001; Uitterhoeve et al, 2009). This fear of the consequences of applying new communication skills is a key factor in transfer. Heaven et al (2005) analysis of the literature argues that

'Negative experiences, when attempting to implement new behaviours will influence whether a trainee continues or abandons new skills, irrespective of motivation to change or learning that has occurred.'

This is supported by Fallowfield et al.'s (2002) 12 month follow-up study of the impact of communication skills training, which found the converse was also true i.e. that as certain doctors discovered that the use of their new communication skills were beneficial to patients, this led to positive reinforcement of their beliefs in their ability to integrate communication behaviours successfully. Their conclusion was that

'Desirable communication behaviours were maintained because the outcome from using the new skills produced acceptable consequences' (2002:1448).

This finding provides further support for the argument for clear transfer strategies in training design and delivery, and would suggest that opportunities for supporting the effective transfer and integration of new skills should be planned for in advance of training in order to minimise the potential for negative experiences of applying new learning into practice. Furthermore, education and training that is able to challenge negative beliefs about, and reinforce the benefits of, good communication skills, attitudes, values and behaviours is considered desirable.

Few studies have directly examined the relationship between physicians' attitudes and beliefs and their actual approach to communication and patient care (Jenkins & Fallowfield, 2002). One such study that set out to examine this relationship was conducted by Levinson and Roter (1995) who identified a correlation between community primary care physicians' beliefs about the importance of psychosocial dimensions of patient care and their approach to routine healthcare practice and communication with patients.

The study concluded that patients of physicians with more positive attitudes were more likely to be engaged in psychosocial as well as biomedical aspects of their wellbeing. It also found that these more person centred communication facilitated more involvement of patients as partners in their healthcare as demonstrated by patients asking more questions and expressing more opinions during consultations.

A later study by Jenkins and Fallowfield (2002) examined this relationship further by exploring whether training on communication skills was able to alter beliefs and therefore communication behaviours in healthcare practice with patients. Results indicated that training interventions in communication skills that utilise cognitive, behavioural, and affective approaches to skills development are more likely to result in more effective communication behaviours. They were also more likely to modify attitudes and beliefs which in turn were more likely to be transferred into clinical practice and patient care. The authors suggest that an emphasis upon all three components (cognitive, behavioural and affective) in training may be required in order to produce the necessary change in beliefs and attitudes of practitioners.

An understanding of the concept and practice of 'cultural competence' as it applies to interpersonal healthcare is considered to be important when examining the impact of values and attitudes upon communication behaviours and patient experiences and outcomes. Culturally competent healthcare refers to the ability of organisations and individuals to provide appropriate and relevant care to people and communities with diverse values, beliefs and behaviours (Fortier & Bishop, 2003; Betancourt et al., 2002). Studies which examine the impact of cultural competence education and training on healthcare practice and patient outcomes are limited.

Available evidence does however indicate that culturally focused interventions that are designed to bridge barriers to communication and understanding between patients and health providers are able to positively impact upon improvements in communication skills and behaviours (Cross et al, 1999; Campinha-Bacote, 2002; Misra-Hebert, 2003).

These findings clearly have implications for those involved in the design and delivery of health professional education as well as health planners and professionals. They also highlight the

importance of values and attitudes in training design and in the ultimate delivery of patient-centred and culturally-sensitive care.

The transfer interventions or strategies so-far discussed are primarily concerned with the organisational environment and the processes and systems that are put in place to support an individual's ability and opportunity to transfer new learning skills into the workplace following training. The design and delivery of the training event itself is also recognised as critically important for creating the proper conditions and circumstances which facilitate and support the transfer and integration of learning from the training room to the workplace. Key considerations for design and delivery of training are summarised at the end of the literature review.

3.2.4 WHAT IS THE EVIDENCE ON HOW COMMUNICATION, AND THE RELATIONSHIP BETWEEN PATIENTS AND PRACTITIONERS, IMPACTS ON PATIENT EXPERIENCES OR OUTCOMES?

Very few studies have focused on the direct effect of communication skills training on patient outcomes. The recent review of Uitterhoeve et al. (2009) included 7 studies looking at the impact of communication training on patient outcomes in cancer care. These are summarised in Appendix B (along with additional studies of patient outcomes in other fields). Training effects on patient satisfaction were found in three of the seven studies and not in the other four. Both Ravazi et al. (2003) and Delvaux et al. (2004) reported statistically significant improvement on two of five patient satisfaction measures both after training and at six month follow-up. These were 'satisfaction with information and support' and 'satisfaction with assessment of concerns'. None of the four included studies that had patient distress or quality of life as an outcome measure reported significant training effects on any of these measures.

Although not a direct effect of communication skills training, one study of surgeon's tone of voice found an association with malpractice claims. Several variables were rated in routine visits that assessed warmth, hostility, dominance, and anxiety from 10-second voice clips with content and 10-second voice clips with just voice tone. Ratings of higher dominance and lower concern/anxiety in their voice tones significantly identified surgeons with previous claims compared with those who had no claims (Ambady et al, 2002).

The findings from the Uitterhoeve (2009) review usefully summarise some key approaches from the available evidence that should be of concern to those involved in the design and delivery of education and training as well as for those who have a role in supporting strategies and interventions that are concerned with the transfer and integration of new skills to the workplace setting. The authors suggest that the literature supports a 'combination' of approaches as the most effective way to establish transfer and that training design and transfer strategies and interventions should incorporate:

- An understanding of the 'contextual and organisational characteristics' of the workplace setting and environment where new knowledge and skills will be employed into routine practice.
- Organisational and management interventions, such as supervisory support, that encourage and aid practitioners to integrate new communication skills and behaviours into practice.
- Strategies in the design of training which augment and consolidate the provision of supervisory support.

- Training activities that focus upon attitudinal change in workplace culture and upon organisational and managerial priority of the benefits of person centred communication.
- Opportunities for managers and/or supervisors to participate in communication training to develop their understanding of what they are being asked to support the integration of within the workplace.
- Training goals and content that are 'conceptually linked to outcomes that are important to patients and healthcare professionals' (pp454).

This research builds on Stewart's older review of papers published between 1983 and 1993 which found 21 studies of relevance (Stewart, 1995). The authors in this case concluded that most of the studies demonstrated a correlation between effective physician-patient communication and improved patient health outcomes. The studies included do not appear to have been formally weighted according to their quality.

3.2.5 IS THERE ANY EVIDENCE RELATING TO ROUTINE, DAY TO DAY COMMUNICATION RATHER THAN ADVANCED/DIFFICULT COMMUNICATION?

Using the methods of this review of reviews, we were unable to identify any literature in which it was possible to distinguish between interventions focusing on enhancing day to day communication and interventions focusing on more complex communication. Studies of shared-decision making indicate that:

- Interventions to promote shared decision-making among people with mental health problems have been poorly researched and no firm conclusions can be drawn (Duncan et al, 2010).
- There is insufficient research to indicate which interventions are most effective in promoting shared decision-making among health professionals. However training may be important as may patient-mediated interventions such as decision aids (Légaré et al, 2010).
- Patient decision aids increase people's involvement and are more likely to lead to informed values-based decisions, however the size of the effects varies across studies. Decision aids have a variable effect on decisions but further research is necessary to explore their impact on patient-practitioner communication (O'Connor et al, 2003).

However, Ong et al.'s 1995 review of doctor-patient communication describes and discusses three key purposes of communication and is referenced accordingly:

- 1) To create a good inter-personal relationship.
- 2) To exchange information.
- 3) To enable doctors and patients to make decisions about treatment.

Ong's (2009) review is useful in that it also discusses a range of relevant background information including a variety of different types of communication behaviours (including verbal and non-verbal) and the influence of communication on patient outcomes. Ong et al. (2009) presents a strong case for the development and establishment of a theoretical framework of doctor-patient communication. They argue that such a theory and framework would help to establish the relationship between variables such as those relating to background (such as cultural variations)

process and outcomes, and would help to establish a clear hypotheses for these relations which would provide the basis for the development of interventions that are concerned with improving the doctor patient relationship and patient outcomes.

3.3 CONCLUSIONS FROM LITERATURE REVIEW

- Communication skills training is effective in enhancing communication abilities of healthcare professionals although the evidence base is strongest for medical staff, followed by nurses.
- There is a lack of robust evidence indicating the impact of communication skills interventions on patient outcomes, although there is some evidence of an impact on patient satisfaction.
- There is a developing body of knowledge and understanding about the best ways to support the integration of new learning on communication into practice, for example, practitioners may improve their abilities, however may need support to use these improved abilities in practice. This body of knowledge is summarised in detail below and includes the importance of greater involvement of senior staff/managers, greater consideration of organisational culture and addressing attitudes and values. The latter is recognised as valuable for the ultimate delivery of patient-centred and culturally-sensitive care.
- Further quality research is needed to generate evidence relating to the effectiveness of training in enhancing communication among allied health professionals, the effectiveness of specific strategies in training, impact on patient outcomes and the role of values and attitudes in affecting the ability of staff to communicate effectively and deliver patient-centred care.

3.3.1 KEY CONCLUSIONS FROM LITERATURE FOR TRAINING DESIGN AND DELIVERY

Whilst the evidence is inconclusive with regard to what elements or intensity of teaching/learning interventions are important for positive outcomes, the available research provides some useful guidance on elements that may be important for optimising the integration of learning into practice. This is vital to maximise the likelihood that training will not only improve practitioners skills and capability but will also lead to a change in their day to day practice.

With this goal in mind, training design and delivery should:

- challenge negative beliefs about, and reinforce the benefits of, good communication skills, attitudes, values and behaviours (Fallowfield et al 2002),
- be ‘culturally competent’ and focused, ensuring that training responds to cultural diversity (Cross et al 1999, Campinha-Bacote 2002, Misra-Herbert 2003),
- include *buy-in* amongst- ‘participants’ (for identifying learning needs & programme content), ‘managers/supervisors’ (with being involved throughout the process from needs analysis to support with implementing learning) and ‘senior managers’ (for promoting and reinforcing messages that are seen as important) (Kirwan 2004),
- include opportunities for managers and/or supervisors to participate in communication training to develop their understanding and to better support the transfer and integration of practitioners learning into practice (Uitterhoeve et al 2009),

- have clear transfer strategies, including planning in advance of training for learning transfer with a particular focus upon strategies that minimise the potential for negative experiences of applying new learning into practice (Fallowfield et al 2002, Uitterhoeve et al 2009),
- ensure that training content and goals are conceptually linked to outcomes that are important for both patients and healthcare professionals (Uitterhoeve et al 2009),
- establish specific, measurable and time-targeted objectives for the application of new skills into practice (Heaven 2005),
- understand the contextual and organisational characteristics of the setting in which new knowledge and skills will be employed (Uitterhoeve et al 2009).
- have a focus upon 'self-directed' learning which includes- supporting conditions and environments for learning; forums that allow individuals to share experiences of learning transfer, and opportunities to support reflection of negative and positive experiences and understand problems and solutions (Heaven 2005),
- incorporate activities which promote the transfer of skills into practice, particularly those that augment or improve supervisory practice and support (Fallowfield et al 2002, Hecomovich & Volet 2009, Uitterhoeve et al 2009),
- utilise- cognitive, behavioural and affective approaches to skills development (McGilton et al 2009),
- be of an adequate duration and intensity which is likely to result in positive effects i.e. interventions which are delivered more than once and involve clinical or research personnel in the delivery (High-intensity interventions) (Rao et al. 2007, McGilton et al 2009), and
- be learner-centred, skills focused and practice orientated and be organised in small teaching/learning groups (Merkaert et al 2005).

4. INTERVIEW FINDINGS

4.1 HOW SKILLS ARE LEARNED: FORMALLY AND INFORMALLY

A major area of focus for this research was how practitioners develop their communication and human relationships capability and practice. The findings in relation to formal and informal learning are discussed in detail below. Overall, there was little sense of formality in decisions about who learns, what is learned, how learning takes place or how it is monitored in relation to communication capabilities.

“I think inevitably a lot of healthcare professionals learn some of this from their senior staff or more experienced staff and so sometimes I think it happens by chance in that respect too as opposed to being a planned and supported process.” (K1)

“I have to admit there isn’t really any kind of structured process in place you know for [reflection on practice]” (M5)

Just one participant described the use of a framework (other than KSF) that included assessment of competency in relation to communication.

“We do actually use a competency framework for communication, for different elements of the job but communication would be one of the competencies. It was devised for palliative care by the RCN so it is sort of specific but it wouldn’t be hugely different I think from KSF...[This framework] would involve the individual self-assessing and being prepared to provide evidence as to why they assessed themselves at a certain level. It’s got knowledge, skills and behaviour.” (M7)

Both senior and less experienced practitioners who were interviewed felt that the most common and most important way that healthcare practitioners learned to communicate with patients was by observing and modelling the practice of others. Communication training, through courses or undergraduate education were also felt to be important, though less universal, as were opportunities to discuss cases and issues with colleagues both informally and through more formal mechanisms such as case reviews. These are all discussed in greater detail in the sections below.

Some practitioners and managers felt that these skills are learned through life experience and that some people are naturally better than others at these skills.

“I think that an awful lot of the skills that you get when you come to this job are life skills that you’ve developed over the years. I don’t think you are necessarily given training.” (M2)

“Of course there are ways you can improve. There are people who are both ends of the spectrum who with or without courses are always going to be good communicators, be good listeners. And there are those who do well in taught situations and then there are those who it doesn’t matter how much teaching, you are never going to [get] it into them really.” (P13)

Managers also noted that time was a key barrier both to good communication in practice but also to learning communication skills as staff had less chance to work alongside each other and less time to debrief or discuss cases or practice.

4.2 INFORMAL LEARNING

4.2.1 OBSERVING AND MODELLING HOW OTHERS COMMUNICATE

Participants recognised the importance of observing and modelling the communication skills of others in helping them to learn.

“I think it’s something you develop when you work alongside colleagues, especially colleagues that have got a lot more experience. I think you learn a bit when you are working independently but it’s more learning by mistakes then. When you work alongside somebody who you respect as a professional and you respect the way that they communicate with people I think that’s the main way I’ve picked up different skills and been able to reflect on how you come across to people and how they do it differently and how you might try it differently in the future and I think that’s the only way really. I can’t see another way of doing it”. (P34)

This was reported to be more common the earlier a practitioner is in their career, where junior staff would have opportunities to and be expected to observe the skills of senior colleagues and to learn from them, whereas this was not expected of more senior staff in the same way.

Some staff reported that the learning from modelling the practice of others was ongoing throughout their careers, though this was not formally supported. On the other hand, most of those interviewed who had been qualified for a number of years, came across as confident and satisfied that they had reached a sufficient level of capability and were left to ‘get on with it’.

Opportunities to model the practice of others were not universal. Community based staff (GPs, community specialist nurses, pharmacists) in particular were reported as not having many opportunities to observe colleagues in action. Paired practice, co-therapy or joint assessments appeared more common in some areas and disciplines than others, for example in mental health and palliative care.

“You don’t get a lot of support, you get left. A GP don’t forget is a very lonely sort of life. You’re left in your room basically. You could stay in your room constantly for the next 20 years. Nobody can actually see what you do so there is a little bit of concern that you can get into very bad habits and unless you are actually self-critical you won’t see if you are consulting well or consulting badly.” (P26)

Some participants reported that senior staff such as consultants were less likely to have opportunities to observe their peers but this was variable. Others reported that joint ward rounds provided an opportunity for practitioners, including consultants, to observe each other’s practice.

Participants did not just model the communication of colleagues in their own specialty or profession; they also described and valued learning from the practice of different professionals and disciplines. A number of respondents particularly singled out nursing staff with whom they had worked whom they considered to be excellent communicators, while others described a single influential individual often whom they remembered from a long time ago.

“I would say almost entirely through experience of learning. And using the experience of supervisors, trainers, other health professionals, not necessarily medics, watching nurses,

watching other professionals, but predominantly I guess working with senior staff in what I suppose you would call a sort of apprenticeship type relationship.” (P29)

“I certainly remember that there was this ward sister when I first qualified [over 20 years ago]. She was phenomenal. She was really, really, good. She was calm, she used language the patient understood, she listened to them and I just remember her being really, really good.” (P6)

In some respects the language and level of detail used by participants in describing how they model the practice of others is indicative of how reflective the practitioner is. Some described in detail the process of modelling, as shown in the example given here:

“The real nitty-gritty of learning communication and relationship skills came after I qualified actually. The first staff nurse post I had was in a hospice and there was one or two really very skilled nurses that worked there and there was a very skilled doctor...So as a young staff nurse I would listen to these people, listen to how they communicated with patients.

I'd listen to things like phrases and words that seemed to be useful and would help them develop relationships and help them deal with difficult communication situations. I would try and listen for techniques that they were using that would help as well. A wee bit later on in my career I worked in the community as a district nurse for a while and there was a particular nurse that I used to listen to as well, so it was really sitting in with people that were more skilled and more experienced than I was and trying to use some of their script if you like and use some of their techniques and try and find my own style within that.” (P15)

4.2.2 CASE REVIEW AND DISCUSSION

Participants described various mechanisms for discussing communication issues with others as part of a wider discussion on individual patient cases.

These included opportunities for staff to make presentations of current patients to senior or other staff or as part of single or multidisciplinary team case reviews. These reviews took place every morning, a couple of times a week or weekly and were considered a good opportunity to discuss issues or difficulties with particular patient situations and to get ideas and advice from colleagues as to how care of the individual patient might be approached.

“On a Tuesday morning we have a team meeting where we discuss all new cases and we present our case basically we go through the whole assessment of the person, talk it back and make a formulation and plan there in a multidisciplinary way. So there will maybe be about, there's often eight to 12, maybe sometimes 15 people in that room who will all give you an idea on what thoughts they have or, you know, what you could have done differently or maybe they feel you didn't get enough information from something and they will be very open and say well actually you need to go back and meet with this person again and get a better personal history.” (P32)

In these reviews the focus was not necessarily on communication issues, but it would be discussed if there was a particular communication challenge, such as if a patient was very angry or experienced by staff as 'difficult'. Participants valued the feedback and suggestions they got from colleagues and seniors on how to deal with that situation in the future.

The opportunities to discuss individual patients varied in terms of how much they were structured and focused on helping an individual practitioner, or whether they were set up as joint reviews. Team meetings to discuss patients were joint reviews of how to progress a patient's care; presentations were led by a practitioner and focused on care progression as well as on the practitioner's own performance in caring for the patient. However the communication skills of an individual practitioner were not a specific focus of feedback or development.

"There was a lot of opportunities to present [patient cases] to your senior colleagues when I was training. But very little observation of you actually interviewing anybody. It was all a bit of bluff really." (P29)

However there were also a number of ways that case studies of individual patients were used to develop the practice of individual practitioners. Practitioners and managers from one discipline that described how they have monthly sessions with a psychologist to support them and managers also sometimes initiated the process of discussion themselves, picking out individual patients to discuss with staff. In the latter case it was easier for managers to focus on developing the specific skills, attitudes, and approaches of individual practitioners.

"I think case discussion is a good one and that's certainly something that I do with the Band 6s, picking out a case and just talking through the relationship they've built up with the client, how that might be difficult, how that might be improved, looking at different ways of being able to communicate." (M12)

In none of these examples were specific criteria or tools used to consider how good the communication had been between patients and practitioners and there would be no examples of where communication would be discussed as a standing item in case reviews. It seemed it would only come up if it had been identified as a particular problem or challenge. There was also no mention of patient, family or carer feedback as a valuable part of discussions of an individual patient's care.

4.2.3 INFORMAL SUPPORT FROM COLLEAGUES

Staff also make use of their colleagues informally in conversations over the course of everyday practice to 'bounce things' off each other and get informal support and advice. This kind of informal support mechanism would also be used for particular communication or relationship challenges.

Where staff were working in community settings, this kind of networking had to be actively supported by phone and by the manager encouraging communication between the team.

"There is a kind of informal support network." (M5)

4.2.4 REFLECTIVE PRACTICE

It was clear from discussions with many participants in this research that much of their own learning relied on them reflecting on and learning from their own practice, including positive and negative experiences. Some very clear examples were given describing this reflective practice and describing practitioners' commitment to reflective practice.

"For me, debriefing, reflective practice is huge, you know if there's been an incident or there's just been an episode that I think has been pretty significant I'll either take away and

work through it myself and just feel what maybe I could have done better and if I need help with that I would probably then speak to my supervisor.” (P21)

Managers agreed with this, noting that much of the learning relied on practitioners to reflect on their own skills as a result of the opportunities for informal learning that happen in everyday practice.

In reality, this depended on practitioners having time and there were few or no formal processes in place to support that kind of self-reflection.

“[There are] not really [any systems in place] since I’ve qualified as a pharmacist, because when I worked for X for example, I didn’t really have a mentor as such. I think when you are first qualified you do. Now my line manager doesn’t work here so it’s mainly through myself and CPD.” (P27)

“I also find a bit of reflective practice, which [is] self-reflecting more than anything. I can’t identify any way that it is monitored at all. Obviously I think that poor feedback always gets back to people but the positive never gets back to people.” (P6)

This sense of reflection was not universal, some more senior interviewees felt that a high level of communication capability was taken for granted whereas others came across as more open to the idea that they are learning and developing communication capabilities throughout their careers.

“I don’t think it is explicit now. I mean I think it’s expected but I think you get to the stage where you have been in the job for a certain amount of time that you’ll see that your managers just expect that you’ve got that skill and they don’t really question it.” (P34)

There was also a sense that senior staff were expected to have good communication skills as standard and that consultants would only get to that position by virtue of their communication (and other) skills. This was not always the view of others however who felt that some senior staff were poor communicators but that this was very hard to address.

4.3 FORMAL LEARNING

Basic Training/Pre-Qualification Training

Those interviewed for this scoping exercise varied enormously in profession, years qualified and where they trained and this is reflected in a variety of comments about the training they received prior to qualifying in their chosen profession.

Some practitioners felt their undergraduate or basic training had been useful in developing communication skills and one manager felt that that would be the only opportunity for training on communication skills for some staff.

“I predominantly manage nursing staff and AHPs so they will learn throughout their basic core training and from that I suppose through their clinical practice but...probably the only time they really get any training [on communication] would be around their basic training.” (M10)

Some older practitioners felt that their training did not have the same focus on communication skills that is there now, however some others felt that their training had offered better support to them in

developing their skills than what practitioners now go through. One manager felt that the introduction of degree courses for nursing had affected communication skills training by reducing the amount of ward time that practitioners are exposed to in training. It was also noted by her that there is so much to cover in undergraduate programmes it is possible that the “basics are being missed”.

“We were trained on the ward and we didn’t have degrees etc. Now we have a different core of staff coming out but a lot of them I don’t think are as fully prepared as they could be. There is so much to learn these days ...” (M2)

Another manager described an initiative for medical students at Aberdeen University where they spend time with clinical nurse specialists to observe the nurses communicating with patients and where they are asked to prepare in advance and write it up afterwards. She felt that this was very beneficial in how it formally supports learning and that it could be a useful model for supporting/developing junior or generalist staff on communication skills.

Courses for Managers

Managers reported few courses specifically on how to manage communication skills in others, but particularly in the cancer and palliative care disciplines, they had been on a number of communication skills courses themselves over the years which helped them to recognise the skills in others. For the most part however, courses for managers tended to be more about skills specific to managing staff rather than specifically focusing on supporting the development of communication skills in staff. These included:

- SCOTS courses – Supporting Clinicians on Training in Scotland.
- NES courses to do with education and training matters in terms of trainees.
- General manager training
- Appraisal training
- Advanced communication skills (various courses including doing, assessing and teaching) training necessary for a role as a nurse specialist in palliative care.
- A 9 month course on relationships with staff and dealing with people.
- “Leading an Empowered Organisation” training.

Apart from the one nurse specialist who had a lot of training on advanced communication skills, managers did not report having any particular training relating to giving feedback to staff on communication skills. Giving feedback on performance more generally was mentioned by some managers as having been part of generic courses on people management.

There was not generally a sense that managers felt specific training or support on how to develop staff communication skills was a gap for them. Those who had attended a lot of training on the topic themselves felt well-equipped to deal with it, though some recognised that the process for supporting this was not very well structured.

Courses for Practitioners

There was a sense that in 'sensitive' areas of practice such as cancer care, palliative care and mental health, communication skills were highly emphasised particularly for the staff who specialised in these areas. Of course the patients being treated, were also in contact with general nursing staff on wards or in the community, junior doctors and surgeons of different disciplines for example who would not be part of the particular specialism and might not therefore have had the emphasis placed on communication skills or might not be in post long enough to have attended training or learned the skills through observation.

Participants mentioned a whole range of short training courses that they had attended or that members of their team or department had attended that they felt were relevant. None of the specific courses emerged as being mentioned more frequently than others; most were mentioned by only one participant. The courses mentioned varied enormously in scope and relevance. A small number were specific courses on generic communication skills, others focused on specific techniques such as motivational interviewing or solution focused therapy. Other courses related to specific conditions or topics such as compassionate care or equality and diversity rather than focusing on communication techniques.

Again, there was little sense that practitioners or managers felt that they needed more training on communication skills, this was largely due to the fact that they felt that they were mostly experienced staff. They felt that they had learned their skills through experience and from time to time through some formal training courses.

One manager felt that he would be unlikely to send his staff on a course that was specifically on communication skills as he felt they would be picking it up from the variety of other courses available and '*communication is in-built in everything anyway*'.

Participants highlighted various training opportunities that they had found to be particularly helpful or useful and were asked what had made these so valuable. Most commonly they spoke about the value of videos for receiving feedback from others and seeing for themselves, their own communication with real, simulated or role-played patients.

"It was recorded. It was filmed and then once we played out our scenario we would look back at that episode of communication; one nurse would be the nurse and one nurse would be the patient and the whole class would look back at that and critique it. And that was incredibly useful." (P10)

Other aspects of training which were highlighted as particularly useful were:

- Tailoring of the course to the specific setting e.g. palliative care.
- The fact that training was spread out in multiple short sessions over a three month period that allowed participants to apply the theory to clinical practice between sessions and then report on the difficulties etc.
- The formalities of the different models of communication. The practitioner felt that it was valuable to have the different models in her head which she could draw on in difficult conversations.
- The trust in the group.

“Because it was over two days we actually developed quite a bit of trust within the group and obviously then as you feel more relaxed you are able to actually become more natural in what you’re doing and I find that particularly very beneficial.” (P18)

One manager was particularly reflective about how they choose who attends what courses and felt that different CHPs had ‘all gone at it in a different way’ and that the deployment of courses such as those above was done in a sporadic way.

“What I have favoured is making sure that everyone on the team is trained in the same approach because I don’t think it works when you are only training the odd person here and there on a scatter gun approach unless you are training someone to go back and champion it.” (M3)

The same manager felt that staff support in communication skills is not ‘robust’ enough.

“Three years ago when this all kicked off and we started having to develop our long term condition strategies locally, we went to the [health] board to say what can you do? There was never a clear and consistent plan for NHS X as to how we were going to support the whole agenda in terms of training and development of staff, there is nothing fundamentally built into care robustly to support this.” (M3)

4.4 WHAT INFLUENCES LEARNING?

There were many people mentioned as having a role to play in developing or influencing the learning of communication skills for staff. These include education co-ordinators, senior management and more senior staff who act as mentors for newly qualified staff. Meetings on a one to one with mentors or managers were felt to be very important in supporting new staff to develop .

One manager mentioned that the whole mindset of working with people with long-term conditions needed to change to one where the patient is recognised as the expert in their own condition from the outset. This was also alluded to by a few practitioners who worked with patients with long-term conditions. It was felt the communication and relationship development that happened with the patient had an influence over their ability to self-manage their condition.

Some practitioners also mentioned the changing expectations of patients in relation to what they are told about their condition and how it is being treated – most patients now expect greater information than they would have done years ago. Some mentioned the need to adapt and develop communication to respond to the changes with patients taking a greater interest and responsibility in their healthcare and demanding more information and openness. Related to this was the feeling that many practitioners, particularly doctors can over-professionalise language and ideas which act as a barrier to effective communication and understanding with patients.

A few people mentioned the importance of embedding a patient-centred attitude into the whole mindset or ethos of the organisation providing care. One described a recent initiative in community

teams where the letters sent to GPs following initial assessment were reviewed to highlight the attitudes and values demonstrated. This was felt to have been quite successful in getting people to think differently about how they communicated.

4.5 MANAGERS' ROLES

There was a strong feeling, amongst the majority of practitioners, that good communication and relationships skills are a fundamental and core part of what managers would expect of them and that this should be inherent in their work with patients. This was particularly true of palliative, cancer care and mental health settings where communication is understood to be the main tool of understanding and treating mental health conditions and of supporting patients' fears and concerns and relieving and preventing the suffering of patients in cancer and palliative care. This 'expectation' was also particularly true of 'older' more experienced and senior practitioners where they would be expected to have reached a particular level of competence in communication.

However, some practitioners felt that this expectation was often not explicitly stated and was merely implied as being so fundamental to patient care that it should almost be taken for granted. It was often assumed that good communication is important and that people should be competent in it:

"...there's probably a kind of unspoken expectation of where people will get to in order to be able to handle different situations in the clinical area..." (M7)

This was also described in terms of good communication amongst managers being expected but not necessarily made explicit:

"I don't think it is, I don't think it is explicit now. I mean I think it's expected but I think you get to the stage where you have been in the job for a certain amount of time that you'll see that your managers just expect that you've got that skill and they don't really question it" (P31)

Although practitioners were clear that good communication and relationships was expected of them by managers, many practitioners did not feel supported in this area and referred to it as not being explicitly raised and discussed either informally or via formal mechanisms such as supervision and personal development planning (PDP). A few practitioners also stated that discussions relating to communication tended to be more directive than supportive i.e. emphasising what should or should not be done but not necessarily in a supportive or role development way:

"Well they [management] don't discuss developments they just say you should be doing this. There is nothing about do you need to learn the skill, it's just about you must communicate more or make sure you communicate with so and so or do this or do that, it's nothing about developing. Just dictating or telling us what they expect." (P6)

Practitioners experience tended to be very variable and dependent upon individual managers and there were many suggestions that practice could be inconsistent and that the issue of communication was only raised when there was a problem or complaint by a patient. Patient complaints were often looked upon as a useful opportunity to bring focus to communication and address particular issues. However, it was also felt by a number of people that the way in which managers responded to it was variable and not always dealt with as an opportunity for improvement and positive change:

“It’s variable, most boards will have mechanisms in place to note when patients and families have been dissatisfied with the communication of NHS staff. The extent to where that loop gets closed in terms of feedback to the staff member, support to develop new skills or any redesign of a process or system I think again will be variable across the country” (K1)

The role of managers in supporting the development of communication and relationship skills among their staff was fulfilled through three main aspects: General support and supervision of staff; carrying out appraisals and PDP sessions with staff and directly observing staff in order to give them feedback. These are discussed in turn below.

One senior manager (who manages other managers) noted that his/her role was to ‘*set the tenor of where we are at and that might be around ensuring that we are embedding the values that we are espousing as a (health) board*’ (M3).

4.5.1 GENERAL SUPPORT AND SUPERVISION

Managers discussed their role as being about ensuring that staff have the necessary tools, skills, experience and knowledge to communicate effectively. In practical terms, that translates as being about encouraging and facilitating staff to attend courses about communication skills, giving feedback to staff and providing regular opportunities for staff to raise issues with managers if they need support. In support sessions, managers have a role in helping staff to recognise what the ‘difficulty’ might be and then asking them to practise modifying their behaviour to address the difficulty. However, as discussed above, in many cases managers were only proactively discussing communication when a specific problem arose or when it was raised by staff members themselves.

Many practitioners recognised the value of raising these issues directly themselves either with managers and/or within their teams. However, there was a feeling that the older more senior and experienced clinicians were not as likely to see themselves as needing the same level of support and supervision and ongoing professional development in communication as other staff members, and were therefore less likely to be proactively raising this as an issue with managers or clinical leads.

It was often assumed by managers and the more senior staff themselves that they would be adequately skilled and competent in communication and would therefore not require the same level of monitoring and support as younger newly qualified member of staff. However, whilst many practitioners would acknowledge and accept that many of these more senior and experienced practitioners would have a degree of experience and skills in patient communication it was also felt by some that this could not always be assumed. Some noted that the training received by more recently qualified staff was likely to have had a greater focus on communication than in the past.

It was felt that all practitioners should be encouraged and supported to improve and further develop their communication skills as part of their ongoing learning and professional development:

“I think people have got to want to engage in it and I think the higher up you go up the medical hierarchy the more resistance there will be. I think training also tends to be given or accepted by nursing and paramedical groups but it’s not accepted as easily by other medical groups” (P23).

Some managers and practitioners acknowledged the limitations of just having to rely upon patient complaints as the main or only mechanism for identifying and supporting communication issues, but a few felt that often this was the only way in which issues amongst individuals were likely to be picked up and addressed.

“Unless they notice themselves or someone complains it wouldn’t come up as an issue” (M5)

The exception to this was cancer and palliative care managers who came across as more proactive about trying to continually improve these skills in their whole staff group.

Some practitioners did however look upon complaints in terms of patient feedback as an opportunity to further develop skills and competence.

One practitioner (P26) discussed telephone communication skills and how a complaint (of her) resulted in some very valuable training taking place in the West of Scotland. It was encouraging to note that this individual was very open about this and clearly valued the work that resulted from this complaint and the opportunity that she then had to examine and develop her skills.

This issue of dealing with communication skills only when patients complain was mentioned in relation to both junior and senior staff, right up to consultant level. It was generally acknowledged that most complaints received could have been avoided or the patient experience improved greatly had better communication skills been employed, regardless of what actually clinically happened to the patient. In these cases, most managers would address the issue directly on a one to one with the member of staff involved, to get their side of the story and address any skills or attitudinal issues that the complaint had highlighted.

The importance of supporting clinical support workers e.g. Band 2s etc. was highlighted by one manager because they have a lot of patient contact and it may be that the patient will give them a piece of important information that they need to know to pass on to the clinical team. They also build up a relationship with patients and their families and so it may be important for them to be present for important conversations such as about bad news as they’re the ones with the relationship.

4.5.2 APPRAISAL AND PERSONAL DEVELOPMENT PLANNING (PDP)

Managers had a variety of roles in relation to appraisals and PDP sessions. Senior medical staff mentioned their role in formal assessment of junior doctors but felt that communication was not a big explicit focus of this.

Some nursing and AHP managers mentioned the use of KSF as part of annual appraisals (although some had to be prompted before discussing it). Communication as one of the core dimensions of KSF was discussed and the main kinds of evidence that staff would bring of their skills would include- reflective notes, diaries, evidence from training, compliment letters from patients or relatives, or

written communication such as leaflets for patients, letters they've written about complex issues etc. It was suggested that the emphasis on producing evidence was perhaps greater for those working within the community rather than in wards where you would be much more closely observed by peers.

There was a sense that this core dimension was so broad that it covered communication with other professionals and written communication as well as conversations with patients and much of the evidence discussed was in relation to this aspect. This was perhaps partly because communication with patients was considered 'so fundamental to what's expected' but what it meant in practice was that there was less of an expectation that practitioners would have to produce any evidence of their skills communicating with patients.

For some managers, discussion of communication skills as part of KSF was the only structured or active way in which this issue would be addressed with staff. In general, this process was led by staff so communication, as noted above, would only be a main focus if raised by the staff member themselves. If there had been a complaint this would have been discussed immediately with the member of staff but would then be followed up as part of PDP or appraisal processes.

There was also a sense that the issue of communication was more likely to be raised by staff who are more self-reflective and proactive with their own professional development and recognise and value the role that KSF (and other formal) mechanisms can provide to bring focus, structure, reflection and development to their skills. These staff may be the ones who are most likely to develop their own skills by observing others and informal means as well, due to their ongoing reflective practice as discussed above. The challenge in some ways is how communication capability is addressed in those practitioners whose ability is not awful (as this would likely be identified by managers or patient complaints) but who are also not particularly reflective (as they are unlikely to raise the issue themselves).

4.5.3 DIRECT OBSERVATION

Apart from the kind of informal modelling described above, managers made little use of more formal and planned direct observation of their staff for the purpose of giving them feedback on communication skills. Observations on the whole tended to take place on a more informal basis where team leaders or managers would interface and observe staff in the course of their everyday duties. There was some evidence of managers or team leaders proactively making time to be amongst staff in order to observe practice and provide feedback:

"...once every six weeks I try to spend a couple of hours in an area on rotation and climb into uniform for a couple of hours. So it's not necessarily about observing conversation between staff but it is being there, you know, I'll be there while they're, let's say, washing a patient or something so I am picking up on how they are communicating but I have not formally said that I want to sit in on a conversation you are having with a patient or relative" (M17).

A few managers stated that observation was something that they had done in the past and a few stated that they would do so if a problem arose but not something that was routinely done. There was some indication from the data that planned observation was perhaps more common practice within certain disciplines such as mental health where communication was considered to be the primary therapeutic tool for supporting patients.

Some managers also referred to having received feedback about staff from other colleagues about communication issues that they had observed between staff and patients. It was suggested that observing was more likely to involve junior staff observing or sitting in on more senior & experienced staff in which to observe and learn from their practice. However, it would appear that this was not always formally de-briefed in any kind of planned and structured way following observation (role modeling as discussed above).

There was no indication that where observations had been utilised that any tools or checklists had been used to support this approach.

A few people highlighted concerns about the lack of formal monitoring systems in which to pick up on issues and bad practice and that on the whole nobody would necessarily be aware of poor communication skills amongst staff and patients unless it came up as a problem such as a complaint. Community based staff were flagged up more than once as working on their own in people's homes and therefore not being observed by other practitioners:

“Yes, I have some concerns about this, not so much about communication skills as about how we continue to monitor communication skills. I think if nurses are part of hospital teams then I think that there are others within the team who are observing how these individuals work... Whilst I don't manage community ...nurse specialists, sometimes I do have concerns about that because you could actually have a nurse who spends a lot of time communicating, providing psychological support to patients on his or her own, in a patients home and there's no way of assessing that” (M5)

This was a concern to the managers (in cancer care and in mental health) who raised it as an issue and felt it was a gap. There were also many hospital-based staff who would not be directly supervised in interacting with patients, but some managers described making a specific effort to do that from time to time.

Only a minority of the managers interviewed mentioned actively using direct observation of their staff as a developmental initiative. Although, a few managers did mention that although they personally did not observe staff with patients, this was something that team leads would do or be expected to do.

For those who did mention it, time was felt to be a major barrier to managers being more involved in directly observing their staff and providing them with developmental feedback on their communication skills as a result of such observations.

4.6 FEEDBACK SYSTEMS

This section discusses the variety of ways in which feedback on communication skills is gathered in practice (other than direct feedback from managers to the staff for whom they are responsible), which is discussed above. These include: systems and approaches for gathering patient feedback, systems and mechanisms for peers to give feedback on communication skills and other formal systems such as 360 degree feedback techniques. These are discussed in turn below.

4.6.1 PATIENT FEEDBACK

Patient feedback was not collected specifically in relation to communication skills but would often be mentioned by patients when feedback was collected about their general experiences or if they made complaints. Other than formal complaint mechanisms, a variety of approaches were in use for gathering feedback from patients:

- Meetings/face to face consultation with patients and carers/patient groups
- Informal discussions with patients to check how things are going
- Annual questionnaire (used for every patient on a particular day)
- Qualitative discussion with patients on their experiences from start to finish of treatment (funded by Government)
- Informal feedback from patients as part of a collaborative approach to treatment
- 'CARE Measure'- structured patient feedback assessment questionnaire
- Gathering testimonials from patients
- As part of the 360 degree appraisal system (within psychiatric services)

Again as noted above, there was a sense in many cases that patient's experiences may not be proactively or routinely gathered so they will only be taken account of if the patients complain or also if they write a thank you note or a letter. However, there was strong indication of the importance of patient feedback and a number of people did state that they and their colleagues would seek patients' views on their care experience in general (via the above mentioned methods).

A few people also referred to continually reflecting on their relationship with individual patients in the course of giving care. Whilst not using a formal feedback mechanism, staff would be looking out for non-verbal signs and cues and would be reflecting on the way the relationship and treatment plan was going in general as an indication of whether communication was positive or not. This also related to staff referring to the need to be flexible and adaptable and gauging each patient as individuals to judge how best to communicate and adapt communication with them as required. There was little mention of checking out their perceptions of how well they were doing directly with the patient. Practitioners reported making their own (subjective) judgement of this based on the quality of the therapeutic relationship.

A similar situation was described in mental health services where it was suggested that the relationship is the treatment and therefore good communication is central to building the therapeutic intervention and to a patient's treatment plan. In this respect it was felt that mental health practitioners would very quickly be aware if their communication with a patient was not particularly effective even without a patient verbally providing feedback on any poor communication as a particular issue. However, again, there was no mention of practitioners actively checking out patient's views.

There were a few examples cited where patient feedback had directly resulted in individual staff development where a communication deficit had been identified and a staff member was encouraged and supported to access training and development opportunities.

There was an acknowledgement of the challenges involved in getting patients to properly critique their experience i.e. feedback tends to be couched in general terms and is often focused and expressed as being really good or bad without detailed descriptions about what exactly made the experience a positive or negative one:

"...I think it's always good to get patient feedback. And yes, not just the thank you cards, you know, 'thanks you were a great support', you know, what was it about my support?" (P32).

There was also a suggestion that it would 'unnecessarily burden' patients to be asking for feedback and that it is often not too difficult to pick up when there may be problems with communication with patients.

Another practitioner discussed the challenge of obtaining honest and open feedback when you are asking the patient to comment on your own practice and that it may be more effective when a third party can ask the question, then patients are more likely to be open and candid. A few people did feel that asking patients directly would not be productive as they would unlikely to be entirely open with you (these practitioners did not appear to be aware of systems or tools that would allow for anonymous patient feedback).

It was also suggested that it would be useful to have a system where patient feedback could be collated as part of the ongoing therapeutic relationship rather than at the end of the process when it would be too late to respond to in terms of adapting the patient's treatment plan. There were some specific initiatives relating to patient feedback mentioned by interviewees as noted above but little mention of actually using mechanisms for getting regular feedback from patients specifically on communication skills. There was a general sense that this would be valuable, however a lack of awareness of how it could be done left people feeling that it was difficult or ineffective.

4.6.2 PEER REVIEW

There were no examples of structured peer review for the purposes of developing communication skills such as practitioners sitting in on consultations led by their colleagues with the specific intention of debriefing afterwards in order to support skills development. Participants understood peer review in a number of different ways, the most common being

- Professional Peer Groups, Forums, Team meetings with a focus on Case reviews & Joint Assessment - for shared learning and problem solving either as a group (multi-disciplinary) or with a colleague- frequency variable i.e. daily (start of day), 2/3 times a week, weekly, twice a month.

Other descriptions of peer review included:

- The use of video where consultations were recorded and feedback provided by peers or colleagues either as a group review or where a video was sent away to an external peer reviewer who would provide you with written feedback (see 3.3 below also).
- Internal & External Peer Review of Services
- Informal Peer Support
- Peer Modelling & Mentorship- sometimes with an individual and sometimes as a group

Some of these appeared to be similar to 360 degree feedback but were not necessarily described in this way.

More common was peer modelling and mentorship which is discussed above.

“I’m not sure that people will then get enough feedback on their own communication skills because I think modelling and mentorship is all very well...but...not all the people that would be your mentor are necessarily good communicators themselves.” (M1)

There was a general (though not universal) sense that it was a good idea but that there was little time for it. However, there was strong evidence that staff made time for it in terms of case reviews as a process of peer review where particularly challenging cases would be discussed and where communication was sometimes an issue.

There was an acknowledgement that peer review requires a certain degree of confidence and skills which would require training and support. Some people reported not having a problem with providing colleagues with feedback; others reported this as being difficult, particularly when it related to negative feedback:

“I find giving negative feedback incredibly hard. I really do. I don’t think anybody finds it pleasant but I usually try and take them aside...” (P39)

4.6.3 OTHER FORMAL SYSTEMS

Other systems that were mentioned by a variety of disciplines were the use of the 360 degree feedback process (commonly referred to as 360 degree appraisal and appeared to be closely linked to annual appraisal systems) whereby an individual would receive specific feedback from a range of colleagues including peers, seniors and juniors. In one case, the views of patients were also included in the 360 degree programme. It was felt to be more effective when the feedback was anonymous but this was not always the way it was used. One interesting model referred to was as part of appraisal where someone would choose peers/colleagues above and below them to fill in an anonymous questionnaire asking for feedback on their performance.

360 degree feedback was generally felt to be quite useful in that if more than one colleague was highlighting communication skills as an area of concern for an individual then it was easier for a manager to address that and difficult for the member of staff to ignore. This was perhaps a

mechanism that would be particularly useful in addressing any issues with the communication skills of senior staff.

The use of video recording, whilst not universally used, was highlighted by a number of practitioners as being a valuable tool for self-reflection and supporting 360 degree feedback and peer review. It would appear to be more common amongst community GPs, GP registrars and mental health and possibly less common now than in the past:

“In my career the most useful thing I’ve done, and I’ve done a lot of different things, has been the video review” (P26)

The use of video as a tool did however appear to be reliant upon the interest and enthusiasm of individuals; one person referred to it no longer being done because the person who set it up had left the service. The interest of another individual (GP) led to a small consortium of local GPs coming together to set up a video peer review group. It was also acknowledged by a few practitioners that whilst the use of video was extremely valuable it did pose a number of challenges which mainly related to the practicalities of accessing and setting up equipment and obtaining patient consent, as well as some practitioners lacking the confidence to scrutinise their practice in this sort of way.

Psychometric testing was not discussed much but was generally felt to be useful but resource-intensive to do (time and money).

A strength of many of these approaches were said to relate to the multi-disciplinary aspect of the process where learning and sharing of information took place across disciplines.

4.7 CHALLENGES AND TENSIONS

Three main areas of challenge were discussed: time, sensitivities on the part of staff and the subjective nature of ‘good communication’.

4.7.1 TIME PRESSURES

In general staff noted that the pressure on them in terms of seeing more patients in less time mitigates against any of the more formal ways of addressing and improving communication skills such as peer review and direct observation discussed above. There was also a general sense that this time pressure was likely to get worse as the health boards come under greater pressure to achieve more for less in view of the constraints on public finances.

“Are staff too busy? Some of the stuff that’s coming out from patient experiences work is that nurses are too busy so patients actually don’t even get the opportunity to communicate with nurses because they don’t initiate anything because nurses are too busy doing other things.” (M5)

It was also noted that the pressures of the job ‘in the current climate’ militate against people having time for ‘added extras’ such as communication skills courses.

One manager particularly noted the size of the challenge, for example if all staff who were to come in contact with cancer patients were trained in communication skills, it would require training for thousands of nurses.

One person suggested that it is an issue of 'time-management' and that guidance and tools in this area would be helpful, the suggestion being that this would have a positive knock-on effect in freeing up time to focus more on areas such as communication.

4.7.2 STAFF SENSITIVITY

Managers generally felt that it was part of their role to address these kinds of issues with staff but one noted that it is one of the most daunting things to learn as a manager. Practitioners also reported that 'getting people to realise that there is a problem' is a big challenge, many practitioners were thought of as not being particularly self-reflective. A few people also highlighted the difficulty in providing negative feedback and challenging colleagues or peers, and that confidence and skills are required to be able to do this in a helpful and constructive way.

A few people suggested having a third party or 'facilitator' is what's required to better support feedback and to enable people to be more forthcoming and to give people the confidence in which to be open and honest. This was also felt to be useful when dealing with team and group attitudes that perhaps needed to be challenged and discussed.

There was a feeling amongst some practitioners that resistance to focusing on communication was more prominent the higher up the 'medical hierarchy' one goes, and that nursing and 'paramedical' groups were perhaps more open than certain medical groups. Those who commented on this did not refer to allied health professionals.

4.7.3 OTHER ISSUES

A number of managers raised the issue of 'who decides what good communication skills are?' This was also felt to make giving feedback to staff more difficult.

"You're trying to put some structure and some definites to something that is really inherent in the job...there is no right way to communicate so it would be wrong to suggest one method or one approach that works." (M6)

It was felt that senior managers were influential in shaping the culture of an organisation and if managers did not identify communication as being important then this was likely to filter throughout the organisation and be important for staff. Managers and senior staff were therefore identified by a number of people as being the key to ensuring that communication was a priority of organisations and services.

Cultural Diversity & Language

A few people highlighted the challenges of communicating with patients from different backgrounds and cultures and where language may be a barrier. Relating to this was the need to challenge staff attitudes. It was however felt that there has been a greater emphasis placed upon this in recent years and a lot of good work in terms of guidance and training has been taking place.

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The main focus of modern day challenges related to the use of telephone and electronic information and communication technologies (ICT) such as telephone communication with patients and telemedicine where patients are increasingly accessing information remotely and from a distance. It was felt by a number of people that there was a gap and lack of guidance and training relating to communication in this area and that it poses particular communication challenges:

“Our first communication with a patient might be via a phone call and they won’t have met us so it won’t be face to face so we will have received a referral from another service in another hospital which will basically only tell us about the patient’s heart condition and what treatment they’ve had for that so there is almost an element of cold calling where we are phoning people up and explaining who we are, what our service can offer them and I think that can be quite challenging because it’s not face to face so you are missing out on a lot on the nonverbal behaviours and things” (M14)

4.8 SUGGESTIONS FOR IMPROVEMENT

4.8.1 ADDRESSING ATTITUDES

Addressing attitudes also related to cultural diversity as briefly discussed above. It was felt that challenging people’s attitudes towards other cultures was important in terms of promoting good communication with patients-

“In recent years there has been good work done in relation to valuing people and diversity. This has been valuable for people who are maybe not coming from multi-cultural backgrounds and where attitudes need to be looked at and challenged” (P36)

Although managers and practitioners did not always explicitly use the terms ‘attitudes and values’ it was often clear that when they were talking about the approach taken to supporting and communicating with patients that they were referring to the general attitudes and beliefs of the practitioner and the importance of how that shapes the way in which they work with patients-

“...I do absolutely think if you see an illness rather than a patient you are never going to communicate with an illness so it’s that drive to see that person and their needs that will help communication enormously” (M7)

The attitudes of people towards professional development were highlighted by a number of people. This mainly related to practitioners who had been practicing for a number of years or who operated at a more senior level. It was felt that attitudes such as *“I’ve been here 20 years why do I need to go*

on a communication skills course” were a significant barrier to change both at the individual and organisational level.

The notion of attitudes was also expressed by some individuals in terms of the culture of the service, where attitudes were concerned with the collective attitude of the organisation in terms of the priority and status it placed on communication and whether it was supported and driven by senior managers from within. This also related to the need for a whole system approach to improving patient communication across the NHS.

4.8.2 TOOLS & RESOURCES

Various practical tools, resources and approaches were suggested for improving communication with patients. These included:

- Checklists & scales for managers to support more junior and newly qualified staff
- Patient and staff stories / case studies- highlighting good practice
- DVDs and support materials – highlighting good & bad communication, dealing with difficult situations
- Laminated prompt cards - that can be referred to when difficult situations arise
- Training, particularly learning that utilises role-play scenarios to practice and reflect on skills development
- E-learning communication module
- Guidance on time management to create opportunities for focusing on communication
- Self-review & reflection frameworks which highlights core-skills (check-list format)
- More emphasis upon models of behaviour change and links to communication
- A commitment to ongoing professional development throughout the career path
- Developing the evidence base by utilising evaluation to more effectively determine patient experience and views
- Not just voluntary guidance, but more compulsory measures which insist that certain tools such as video evidence are employed on a regular basis

It was also felt by a few people that the emphasis should be on making better use of existing resources and tools.

4.8.3 LEARNING & DEVELOPMENT/TRAINING

Various views concerning training were expressed by a number of managers and practitioners. These included:

- In general training was valued and identified as very important in terms of promoting and developing good communication, particularly in relation to skills development
- In general it was felt that any local and national training courses that focused on communication would be welcomed.

- The need for blended and multi-faceted learning approaches was highlighted that moved away from the traditional ‘chalk and talk’ and ‘one size fits all’ approaches of the past
- The need for training to bridge the gap between classroom and practice was highlighted by a few people-

“I think there needs to be some means of following that [training] through because it’s about changing practice quite fundamentally so there needs to be some type of support/supervision/follow through, both in terms of being able to speak to someone, whether that’s just on the phone or having probably peer supported groups that come together maybe with someone who is more experienced to talk through difficult scenarios and make sure that people are actually deploying the skills, new skills effectively” (M3)

- Training that utilises scenario work and role-play was consistently rated highly by a number of people
- The need to tap into local expertise and services more effectively. There was some evidence that local psychiatric services were often approached to provide in-house training in areas such as communication
- The need for an attitudinal change that promotes the opportunities and value of ongoing learning and training and re-fresher courses in communication amongst groups of practitioners and managers that have been practicing for many years and not just newly qualified staff.
- A few people highlighted opportunities for learning about the different parts of the system or care pathway and how different people’s roles relate to your own particular role in supporting patients. An interesting suggestion was provided by someone who worked for British Airways where they would undertake ‘job-swaps’ across different departments to promote a better understanding of different peoples roles and the system as a whole.

4.8.4 OTHER SUGGESTIONS

A number of other general and a few specific suggestions were made on how to improve communication skills in healthcare staff. These included:

- Observing each other’s practice (but very little time to do this)
- Focus on the development of generalist nurses rather than specialist nurses
- Focus on more multidisciplinary understanding
- Further training for experienced professionals rather than trainees (as hard to address in senior staff)
- Support for staff in writing patient information materials
- More opportunities to come together as staff groups to discuss difficult cases
- Nothing needed.
- Focus on written communication with patients e.g. letter-writing, not just verbal
- Guidance on how to manage time to make room for addressing these issues
- Checklists or scales for supporting KSF communication skills dimension (for new/less experienced managers)

- Some kind of line management resource that included training on 360 degree feedback, psychometric testing etc.
- Improving systems for generating regular, honest feedback to staff
- Training all staff to change how they consult to incorporate shared decision-making
- Streamlining treatment pathways to remove barriers to effective communication by making them simpler and smoother.
- A phone number that you can ring to find support on developing communication skills so you could ask someone for a tool or whatever rather than having to search online for it.
- More opportunities for staff to be trained using video feedback (as is done for CBT etc.)
- Doubling up with colleagues where more instant feedback could be provided to each other
- Improved access to information in general, resources, tools and information on available training. Including improved access for remote and rural services via technologies such as web-cams and video links.

5. PATIENT AND PRACTITIONER STORIES

Patients were asked to recall examples of conversations or interactions with health professionals which they felt had an impact on their experience of care. The situations described varied but there were a number of recurring themes. A number of patients reported their positive experiences which included instances when the health professional involved had time to listen to the patients concerns, answered patient questions and explained things in a way that the patient was able to understand. Patients reported experiences of interactions which showed empathy and compassion. The impact this had on patients was described as an establishment of trust and a sense of being supported and cared for.

“His tone of voice and general manner was very gentle, and he seemed to be showing a genuine interest in what might be wrong. The whole consultation felt friendly. He sat next to me rather than behind his desk. I thought he showed great listening skills because he picked up on what was a fleeting comment. It made me feel that in future if anything was wrong I had a doctor who I’d be able to talk to. For once, I didn't feel like I was being seen as quickly as possible. I felt like he had all day to speak to me if I needed it, even though I know that’s not true.” (PS7)

Negative patient experiences were most commonly those when the patient felt that they were being rushed, that their concerns or fears were not heard or accepted, or a lack of empathy was shown by the professional. Often this was manifest through lack of eye contact, or a patronizing, dismissive or brusque tone of voice. Many patients felt that they were not given the information that they needed, and for some, information and bad news was given in a blunt and uncaring manner. The consequences of these experiences varied but included a distrust of the healthcare system and reluctance to access services or treatment in future. Patients were left feeling patronized, angry and let down.

“The tone of voice that they used was very patronising and dismissive. The GP completely ignored the fact that I know my own body and when I am ill. I was in too weak a state to point out that I didn't need patronising.” (PS2)

Very few of the negative experiences described by patients were reported. Patients described feeling that they did not have grounds for a complaint, a belief that they would not be listened to or believed and a fear of repercussions.

In the interviews, practitioners were also asked to reflect on their experiences of situations where they felt their communication skills had played a part in patient experience. They described struggling with difficult conversations, or dealing with angry or aggressive patients. They described patients who were left feeling worried or stressed and without the proper information to calm these fears.

“You just get stuck sometimes. With this particular woman, there are issues with her personality, her attitudes, all these things, and I’m stuck and struggling to know how to help her. Sometimes it’s not as clear as that. Sometimes it’s a chemistry thing, whatever that means, the chemistry is not there. You and that person are not making that connection and so sometimes you just need to handover to someone else.” (PRS3)

Positive experiences of communication for practitioners included taking time to share information with patients, being open, honest and truthful and confronting the difficult issues. Practitioners described positive patient-practitioner relationships and rapport being built by creating safe environments, respecting confidentiality and boundaries and ensuring the patient felt valued and an active part of the decision making process. They described the skills used by them as including listening, eye contact, empathy, appropriate physical touch and a friendly tone of voice. There was a belief that these skills helped patients to feel supported and more relaxed.

“I work in an area that tends to run quite slow because the doctors spend a lot of time with the patients. I communicate with the patients from the minute they come in. After introducing myself, I give a full explanation of what’s about to happen to them. I invite them to ask me any questions and also let them know that if there is anything they can think of in the future they can come back and ask me. I make sure they know my name and I do tend to find that often people come back to me and say thank you so much for your time...” (PRS8)

It is clear that both practitioners and patients describe very similar aspects of positive communication and indeed in describing negative experiences, both refer to a lack of information as being a key underpinning issue.

All of the stories provided have been submitted to NHS Education for Scotland separately.

6. DISCUSSION

This study explored how health professionals in Scotland learn their communication and relationships capability. It also explored how communication skills, approaches, attitudes, values and behaviours are developed and supported in staff throughout their careers. A wide range of experiences and initiatives were described by both frontline staff and supervisors/managers, and by patients but there was an overall sense of a lack of consistent, formalised, planned or structured systems and processes to support learning and best practice in this area. This lack of structure and focus means it would be very difficult to get an objective sense of how well practitioners are communicating in any given team at any given time, even from the manager or senior staff in that team.

Informal Learning in Everyday Practice

A key finding was that most practitioners reported learning their communication and relationship skills through everyday practice, either through emulating the skills and behaviours modelled by others or through reflecting on their own practice. Both of these processes relied largely on the awareness and commitment of individual practitioners, rather than being triggered or supported by processes or structures in their team or organisation. Both were also largely solo activities.

Practitioners reported that having the skills and approaches modelled by colleagues and senior staff was an important mechanism for learning, though there were more opportunities and emphasis on this earlier in their careers. This relied largely on practitioners reflecting on what they observed, rather than having been an overt focus or expectation that practitioners would identify their own learning needs and actively address them as a result. It was also noted that not all senior staff would have good communication skills themselves and so an over-reliance on role modelling, without an objective insight into what good communication capability means, could reinforce less effective behaviours and approaches.

Some practitioners appeared to be naturally more reflective about their own practice than others. There was a sense that senior practitioners were generally happy and confident about their communication and so were less likely to continually reflect on how it could be improved.

Interestingly, self-directed learning is highlighted in the literature as an important part of integrating new skills, approaches and values into practice (Heaven et al 2005) particularly when accompanied by effective support and supervision by supervisors and managers (Fallowfield et al 2002, Heaven et al 2005, Uitterhoeve et al 2009). Self-generated feedback is highlighted as useful for self-directed learning as part of the supervision process (Whittaker 2004). The self-critique approach would involve individuals observing or reflecting on their own practice, thus taking ownership and responsibility for what action should be taken to address any issues arising, with the support of a supervisor. Research indicates that this reflective feedback technique is more effective than simple verbal feedback provided by a supervisor (Whittaker 2004, Heaven et al 2005).

In this study, the role of supervisors and managers in actively supporting effective communication and relationships with patients was found to be variable and inconsistent. It was reported by many respondents that communication capability was only discussed by a supervisor with a practitioner if there was an obvious problem or a complaint by patients. Everyday support and supervision processes were rarely used to discuss communication capability and even then were more likely to focus on inter-professional rather than professional-to-patient communication. No managers described using specific checklists or objective criteria to review practitioner communication with patients.

The research literature argues for organisational and cultural 'buy-in' for communications amongst a broad range of staff at all levels. This should include practitioners, managers/supervisors and senior managers who have a key role in promoting key messages and shaping the culture of the organisation (Kirwan 2004). The importance of managers in shaping organisational values and culture around communications was mentioned by a few respondents in this study.

Although practitioners were clear that good communication was expected of them it was often felt that this was an unspoken expectation and that there was little emphasis on it unless a specific problem with communication was identified. Only in some palliative care and cancer care settings, was there a sense of a continuous focus on communication skills and supporting staff to build their confidence and capability in dealing with complex or difficult issues. Such continual focus was not evident in relation to everyday communication or elsewhere.

Formal Learning

While informal learning was most commonly mentioned, practitioners and managers also highlighted the role of formal training courses in developing communication and relationships capability. Those who had been on specific courses about communication were generally very positive about their value and in particular highlighted the usefulness of demonstration videos to highlight good and bad practice and the use of video-taping of participant's consultations as a tool to support self-reflection and critique. This was valued by those who had been on such courses, who tended to be working in cancer or palliative care. Those who had not been on courses specific to communication themselves tended to report that it was covered by a range of other more generic courses, however these would not have had the specific video elements described above. Many of this group of respondents felt that further training on communication was not necessary.

Training can provide a relatively uninterrupted opportunity for staff to think, learn and reflect on their communication. There is clearly a challenge for practitioners and managers in making such training a priority, at least partly because there are so many competing training agendas available to NHS practitioners and resources for releasing staff to attend are extremely tight.

Moreover, there is a challenge in overcoming the perception that communication is something staff are already doing well, that does not need any development or attention. We feel that this may be a case of 'you don't know what you don't know', and that describing courses as developing communication skills may put some more experienced practitioners off attending. Most staff feel they communicate well, but projects or courses focusing on advanced skills or with specific and clearly advanced goals may attract practitioners interested in more in-depth learning. It would be

even better if managers can be encouraged to assess or review the needs of their staff in relation to communication skills using an objective framework or tool, before considering what training they may or may not need.

There are indications from previous research that training can sometimes be described as being 'disconnected' from the work environment with the challenge being about how to bridge the gap between learning and practice (Heaven et al 2005). Lessons highlighted from literature (summarised in the box below) will be useful in guiding the design and delivery of training and can ensure that training is more strongly linked to the transfer and integration of learning into everyday practice. This summary could take the form of a good practice 'checklist' for those involved in the planning and design of training as well as to support managers and practitioners considering commissioning or signing up for training courses. This could be linked to informal learning opportunities, which appear to be a more important mechanism for ongoing development of communication and relationships skills,

Good Practice in Formal Training Design and Delivery (see Page 13 for full details).

- Challenge negative beliefs about, and reinforce the benefits of, good communication.
- Be 'culturally competent' and focused, ensuring that training responds to cultural diversity.
- Include *buy-in* amongst participants, managers/supervisors and senior managers.
- Include opportunities for managers and/or supervisors to participate.
- Have clear transfer strategies, including planning in advance of training.
- Ensure that training content and goals are conceptually linked to outcomes that are important for both patients and healthcare professionals.
- Establish specific, measurable and time-targeted objectives for the application of new skills.
- Understand the contextual and organisational characteristics of the setting for implementation.
- Have a focus upon 'self-directed' learning, including peer support for individuals post-training to discuss implementation experiences.
- Incorporate activities which promote the transfer of skills into practice, particularly those that augment or improve supervisory practice and support.
- Utilise cognitive, behavioural and affective approaches to skills development.
- Be of an adequate duration and intensity.
- Be learner-centred, skills focused and practice orientated and be organised in small teaching/learning groups.

Feedback on Communication from Patients and Colleagues

A range of sources of feedback to practitioners on their practice and performance are in use, some of which could be utilised better to support the development of communication and relationships capability. In addition to self-reflection, respondents reported various approaches for gathering patient feedback, some systems and mechanisms for peers to give feedback and other systems such as 360 degree feedback techniques.

Patient feedback was not routinely or proactively gathered and it was rarely collected specifically in relation to communication skills. It was however considered to be important and a number of interviewees did state that they and colleagues would often seek patients' views on their care experience in general. There was also evidence of direct feedback from patients in the form of a complaint resulting in individual staff development. There was a sense from respondents that patient feedback could be a powerful motivator for stimulating action to support good communication, but that it was not currently being maximised for this purpose. The research review found some evidence of patient feedback (via surveys) being effective in stimulating quality improvements but the evidence also highlights the need for additional organisational support to implement changes following such feedback (Crawford et al 2002).

Practitioners did not report any mechanisms for them to get direct feedback on their communication from colleagues. There was no evidence of peer review involving a peer or colleague observing consultations with patients with the specific intention of debriefing in order to enhance communication skills. Although there was a vague sense that this was a good idea, some practitioners reported that there was little time for it in practice. In addition, some respondents felt that providing such feedback to colleagues would be difficult and that they would not feel particularly comfortable or confident in doing that. It is unclear whether practitioners welcomed the idea of being reviewed by peers and just need some support with it, or whether they were actually fundamentally unsure of the value or feasibility of this approach.

The one mechanism for getting support from colleagues was where difficult issues with patients were discussed as part of 'case reviews' or clinical supervision sessions and sometimes communication arose as an issue in these scenarios. This allowed for colleagues to make suggestions as to communication strategies that might be used with a particular patient/carer/family member. These opportunities for input from colleagues were felt to be very helpful but did not allow for a practitioner's communication skills to be directly reviewed.

Differences Between Settings

A key finding of this study, is that there appears to be huge variation in practice across different care settings. Those settings which have come to perceive communication as being important because the staff are regularly dealing with serious or difficult emotional situations (e.g. cancer and palliative care) appear to have made progress in embedding a culture of good practice on this topic. This is often due to the necessity of supporting staff to deal with such situations and to prevent emotional burnout. These settings often take the lead in developing or delivering training to others.

Where such 'difficult' interactions are less common, or perceived to be less common, communication is less likely to be a priority and staff seemed less likely to have attended courses. There is a challenge in embedding the 'person-centred' culture expected by national initiatives (such as the Patient Rights Act), in such settings, where communication does not create obvious problems for staff. One potential solution can be to make better use of patient feedback mechanisms to provide specific feedback on communication (as discussed above).

In mental health settings, good communication and relationships were perceived to be essential to the therapeutic process, and training in this setting tended to focus on specific communication techniques e.g. cognitive behavioural therapy and so on. There was a possibility of complacency here however, as staff seemed to assume that they would know if there was a communication problem, but did not report checking out their perceptions with patients.

Those interviewed for this study were generally positive about the importance of communication and relationships. This is encouraging, but also as would be expected from the self-selected sample chosen and a focus on settings where communication has traditionally been a high priority (cancer, palliative care, mental health). It is of more concern that it was considerably more difficult to recruit interviewees in the field of coronary heart disease and that those interviewees who were not from the first three areas were generally less likely to report having accessed formal training on communication.

The literature highlights the importance of values, beliefs and norms in the shaping of organisational culture and influencing employee motivation and enhancing individual and organisational performance (Campbell et al 1999, Hellriegel et al 2001). Thus the varying emphasis that appears to be given to this issue across different care settings may also reflect differing values and cultural norms that pervade those teams/departments. Such values and cultural aspects may be more difficult to pin down and address than gaps in practitioner skills or capability.

Patient Views

Patients were able to describe a number of positive and negative experiences of communication by health professionals and their stories are powerful testament to the impact that such experiences have on them. Although the stories they describe date from both recent experiences and from a long time ago (e.g. 10 years), it is of concern that few of them reported their negative experiences in any way. Much progress has been made in establishing infrastructure for patient feedback recently through the Patient Rights Act and Patient Experience programme in Scotland. This report highlights the importance of continued effort to help patients to give feedback in ways that are open, supportive and positive for them

Other Issues

Some respondents mentioned how healthcare has changed in recent years in particular greater use of telephone contact and electronic communications with patients/carers/families. In addition, a few respondents mentioned the changing expectations and role of patients in terms of increased knowledge and responsibility for their own care.

7. CONCLUSION AND RECOMMENDATIONS

It is widely accepted that the ability to communicate effectively and appropriately is essential for the provision of high quality care that meets individual patient's needs. Effective communication requires a cluster of particular skills, behaviours and approaches, and underpinned by appropriate attitudes and values. Although more recent graduates may have had support to develop their communication skills as part of their formal training, it appears that there is no comprehensive system for ensuring continuous professional development in this area.

This study has highlighted that training can be effective in enhancing skills although there is a lack of robust evidence that this can have an impact on patient outcomes. Anecdotal evidence gathered from patients nonetheless provides a powerful indication of the impact on patient emotions and attitudes to healthcare. Helpful criteria have been identified that will ensure that communication skills training can be as effective as possible in improving practice. In addition, key factors to support the adoption of new learning in relation to communication have been highlighted, including opportunities for providing learning opportunities as part of everyday practice.

Tackling attitudes will be fundamental to setting up a culture of improvement with individuals and across organisations. Differences between settings must be acknowledged and the way forward must be flexible enough to support and respond to new ways of working and changing patient expectations in the years to come. Although there are challenges to improvement in the light of diminishing resources and increased pressures on time, there are many opportunities for development in this field which are highlighted in this report, which could be availed of more widely. This would benefit patients, staff and the NHS more widely.

Recommendations

1. Future efforts to improve communication should include a significant focus on supporting practitioners to reflect on and critique their skills, attitudes, behaviours and approaches with support from managers/supervisors. Both self-review and feedback from managers/supervisors/seniors have a role to play in developing communication capability.
2. Managers and practitioners need support - both resources and development - to build their understanding of what good communication and relationships means in a person-centred health service. Simple tools or checklists for reflecting on the quality of interactions with patients would be of benefit.
3. Encouragement and support is needed for managers/supervisors to identify where communication could be improved, even if there is not a serious or obvious problem in that area. Managers/supervisors should be encouraged and supported to regularly review the communication capability of their staff, for example, by having it as a standard item on support and supervision agendas.
4. Managers need specific support on how to set up and carry out practice observation and how to give feedback to practitioners.
5. Practitioners need help to better enable them to develop their communication capability by observing practice modelled by others. This support should include guidance to enable

practitioners to identify the nuances of good and poor communication, so that emulating how others communicate does not reinforce negative approaches or behaviours.

6. There is a need to highlight to senior staff, their importance as role models in influencing what more junior staff learn about how to communicate and develop relationships. Continued focus on reviewing and developing the capabilities of senior staff is needed at a strategic level.
7. Projects, guidance and training on communications may need to be clear on their likely benefits and cleverly designed in order to attract more experienced participants who would not necessarily consider themselves to be in need of support with 'communication skills'.
8. There is a need to raise awareness generally of the value of direct feedback in developing communication and relationships skills, including the value of video reviews in formal training.
9. Formal training on this issue should take account of the best practice criteria identified in the literature review (see page 13) and summarised in the discussion above. These criteria address the issue that training alone, without organisational and cultural support, will often be insufficient to change practice.
10. There is a need to explore, develop, offer and evaluate flexible and creative training solutions such as practice based coaching, distance learning including the use of video review and online/live demonstrations, and peer-supported learning.
11. There is a need for particular effort in supporting patients to report their experiences of communication in healthcare settings. This should include consideration of how current initiatives on patient feedback including the NHS Scotland Patient Experience programme can be used as vehicle for improvement in the field of communication and relationship skills. It may be that there is a need for a more specific focus on this issue in the questions that patients are asked both nationally and locally as well as facilitating direct feedback from patients.
12. NES should consider how whether there is a synergy between this agenda and other strategic initiatives which have an indirect focus on communication skills, such as the HEAT H4 target on alcohol brief interventions, with a view to maximising any opportunities to reach wider audiences through partnership work.
13. It would be useful to investigate further if/how case review and clinical supervision sessions could be utilised to support effective communication capability in a more structured way and to actively seek out examples of good practice.
14. There is a need for more robust evidence demonstrating that good communication and relationships lead to improvements in patient outcomes, in order to actually influence values and culture across the NHS to actively focus on continually improving practice in this area.
15. The practitioners most likely to access formal training are those from disciplines where there is already a high priority attached to good communication. It is important that future initiatives and funding focus on other mechanisms of improving communication, especially informal learning in everyday practice as described above, and specifically target areas of health care that have not traditionally highlighted this as an important issue.
16. People generally did not feel that confident about giving feedback to peers or even juniors about their communication skills, but where there was confidence it appeared to be where the culture was open and supportive across the team. The issue of giving feedback therefore needs attention in education and development initiatives.
17. Training and support needs to be reflective of changes in modern practice to cover telephone communication and use of ICT and also to respond to greater awareness, expectations and involvement of patients in relation to health and the healthcare that they should receive.

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APPENDICES

KSF Key Informant Questions

1. Who does KSF apply to from our target groups? What is its jurisdiction?
2. Can you talk us through examples of how the different levels in the core dimension of communication would apply to different posts and professions of relevance to this work:
 - a. Nursing staff
 - b. AHPs – Physios, OTs, Dieticians etc.
 - c. Pharmacists
 - d. Does it apply to medical staff at all?
3. What kind of evidence would you expect to be presented at the different levels?
4. How well do you feel the current dimension of communication incorporates values, attitudes and behaviours as well as communication skills?
5. If the KSF process, development review etc. is what is *meant* to happen, what is your view on what actually happens in practice? Is there any general research/intelligence that has looked at the fidelity with which people have approached the process?
6. Are you able to highlight an example/examples of good practice that you have observed of managers giving good ‘feedback’ to staff as part of KSF? What was it about this feedback that made it particularly helpful (TEASE OUT- approach, communication skills, techniques, mechanisms)?
7. Do you feel that enough importance/emphasis is placed upon ‘feedback’ as part of the KSF process? Have/do staff receive particular guidance/support/training in this area?
8. What are your thoughts on how communication and relationships skills, values and behaviours could be better developed, supported, assessed, monitored and evidenced?

Questions for Other Key Informants as Relevant

1. Can you tell me what you know about how GPs/medics/nurses/AHPs learn their communication skills, attitudes, values and behaviours?
2. Where in their training/careers would these areas be learned, if anywhere? How formal/informal is this? Can you describe?
3. For GPs/medics:
 - a. How are GPs/medics appraised/assessed? Is there a system for appraisal and development planning similar to that of KSF? Would these skills etc. fall into this system?
 - b. When, if anytime, would GPs/medics be expected to evidence or demonstrate that they have these skills/attitudes/values/behaviours? What would this depend on?
4. For nurses/AHPs:
 - a. Can you describe how KSF contributes to the appraisal (assessment, monitoring etc.) and development planning of these attitudes, values, skills and behaviours?
 - b. If you are familiar with it, can you describe how well you feel the current dimension of communication incorporates values, attitudes and behaviours as well as communication skills?
5. To what extent would any deficiencies be picked up on through normal practice (or through KSF where relevant)? By whom/how? How would they be addressed?
6. Are you able to highlight an example/examples of good practice that you have observed of managers giving good ‘feedback’ to staff as part of KSF? What was it about this feedback that

made it particularly helpful (TEASE OUT- approach, communication skills, techniques, mechanisms)?

7. Do you feel that enough importance/emphasis is placed upon 'feedback' as part of the KSF process? Have/do staff receive particular guidance/support/training in this area?
8. What are your thoughts on how communication and relationships skills, values and behaviours could be better developed, supported, assessed, monitored and evidenced among GPs/medics/nurses/AHPs?

Manager Interview Questions

- 1) Explanation of what is meant by communication and relationship skills and the purpose of the scoping exercise (esp to emphasise including values/attitudes/behaviours).
- 2) How do you feel your staff learn and continually develop these skills in practice?
- 3) What/who influences their development of these skills?
 - a. What do you see as your role in supporting and developing the communication and relationship skills of your staff?
- 4) How do you know what (different standards?) to expect in terms of the communication/relationship skills from different staff members?
- 5) What systems are you aware of for assessing, monitoring and evidencing such skills, strengths and weaknesses in staff that you manage or to whom you provide clinical leadership?

What use do you (or your colleagues) make of mechanisms such as the following for this purpose?

- a. PDP or appraisals (linked to KSF/other system).
- b. Patient experience measures?
- c. Peer review?
- d. Psychometric instruments?
- 6) Do you ever observe or sit in on conversations your staff have with patients/families? When/why/why not?
- 7) What tensions or challenges are you aware of associated with focusing on developing communication and relationships?
- 8) What training do you have for your role in supporting/assessing/monitoring/evidencing such skills? Including training on using observation/giving feedback to staff etc.?
 - a. What might help you to develop further? Resources/support?
- 9) What are your thoughts on how communication and relationship skills could be better developed, supported and evidenced (for your profession/discipline)?
 - a. What is needed to ensure that these skills are actually applied in practice?
- 10) How do you continually develop your own communication/relationships skills? Does this have an impact on staff skills?

Practitioner Interview Questions

- 1) Explanation of what is meant by communication and relationship skills and the purpose of the scoping exercise – *patient communication only*.
- 2) Can you describe what has helped you to develop these skills in your career so far? Prompt about the influence of...
 - a. Undergraduate training?
 - b. Post-qualification professional training?
 - c. Short training courses?
 - d. On the job learning?
- 3) Where you have learned on the job, can you describe how this has happened in practice?

- a. What, if anything, do your seniors or managers do to *actively* support you in developing your skills? When and why is it discussed? What is the role of PDP/appraisal?
- b. Other than PDP/appraisal, what systems are you aware of for assessing, monitoring and evidencing such skills?
 - i. Peer review?
 - ii. To what extent was patient experiences/feedback used to support your development of these skills?
 - iii. 'What are your thoughts about asking patients or peers for feedback about your communication? What about giving feedback to your colleagues?

[Q3 may also cover modelling of peers/seniors, collaborative working, case reviews and discussions]

- 4) What are the tensions or challenges that exist or existed in relation to you developing excellent communication skills with patients? *[resources, time, manager's own skills/priorities, sensitivities etc.]*
- 5) What are your thoughts on how your communication and relationship skills could be better developed and supported? *[can prompt about someone with great skills if nec]*
 - a. What could be done strategically, e.g. by NES/the NHS in general to improve practitioners' skills in communicating with patients?
- 6) Can you describe a situation when your communication skills have had a particularly positive or negative influence on patient experience? (if not covered already).

If you would prefer time to think about this question we can send you a template to fill in and email back as we are particularly interested in collating examples of practice for case studies.

Reference	Studies Included	Results of the Review
<p>Uitterhoeve RJ, Bensing JM, Grol RP, Demulder PHM, Van Achterberg (2009)</p> <p>The effect of communication skills training on patient outcomes in cancer care: a systematic review of the literature.</p> <p>European Journal of Cancer Care, Volume 19, 442-447</p>	<p>7 studies were included encompassing 10 papers and involving 5 randomised controlled trials. 59 were originally assessed.</p>	<ul style="list-style-type: none"> • Training effects on patient satisfaction were found in three of the seven studies and not in the other four. • Both Ravazi et al., (2003) and Delvaux et al., (2004) reported statistically significant improvement on two of five patient satisfaction measures both after training and at six month follow-up. These were 'satisfaction with information and support' and 'satisfaction with assessment of concerns'. • None of the four included studies that had patient distress or quality of life as an outcome measure reported significant training effects on any of these measures.
<p>Lewin S., Skea., Entwistle VA., Zwarenstein M. and Dick J. (2009).</p> <p>Interventions for providers to promote a patient-centred approach in clinical consultations (Review).</p> <p>The Cochrane Collaboration. John Wiley & Sons, Ltd.</p>	<p>17 studies were included. 10 studies evaluated training for providers; the remainder were multi-component interventions which included training for providers. The practitioners were mainly primary care physicians, though 2 studies also included nurses.</p>	<ul style="list-style-type: none"> • There is fairly strong evidence to suggest that some interventions to promote patient-centred care in clinical consultations may lead to significant increases in the patient centredness of the consultation process. • 12 of the 14 studies that assessed consultation processes showed improvements in some of these outcomes. • There is also some evidence that training healthcare providers in patient-centre approaches may impact positively on patients' satisfaction with care. Of the 11 studies that assessed patient satisfaction, 6 demonstrated significant differences in favour of the intervention group in one or more measures. Few studies examined healthcare behaviour or health status outcomes. • Overall, there is limited or mixed evidence on the impact of interventions to promote patient-centred care on patient healthcare behaviours or health status.

Reference	Studies Included	Results of the Review
<p>McGilton KS, Boscart V, Fox M, Sidani S, Rochon E, Sorin-Peters R. (2009).</p> <p>A systematic review of the effectiveness of communication interventions for health care providers caring for patients in residential care settings.</p> <p>Worldviews on Evidence-Based Nursing, 6(3):149-159.</p>	<p>6 controlled trials (n=825; 399 residents, 426 health providers) were included in the review. Three studies were randomised and three were non-randomised controlled trials. Studies met six to 10 quality criteria.</p>	<ul style="list-style-type: none"> • All studies found an improvement in the health care providers' communication behaviour, skills and knowledge after completion of the intervention. • Negative communication and interactions decreased. • Patients had increased responsiveness and eye contact with the health care provider and a decrease in verbal disapproval, anger and agitation. • Psychological components in the intervention helped to sustain the change to health care providers' behaviour (two studies, n=226). • One study (n=194) found that increased duration of the intervention improved the positive effects of the intervention.
<p>Parry R. (2008).</p> <p>Are interventions to enhance communication performance in allied health professionals effective, and how should they be delivered? Direct and indirect evidence.</p> <p>Patient Education and Counseling, 73(2):186-195.</p>	<p>5 studies (n=152) were included in the review: one controlled pre-post intervention study; one controlled post-intervention only study; two uncontrolled pre-post intervention studies; and one cohort post-only intervention study.</p>	<ul style="list-style-type: none"> • All five studies reported positive effects of interventions. • Evidence from two studies (n=13) suggested that targeted training for qualified clinicians could improve performance and patient outcomes. • Two studies in students (physiotherapy and speech and language therapy) reported small statistically significant benefits of interventions that consisted of additional teaching aimed at communication. • A third study in physiotherapy students showed some beneficial effects, but the statistical significance was unclear.

Reference	Studies Included	Results of the Review
<p>Rao J K, Anderson L A, Inui T S, Frankel R M., (2007).</p> <p>Communication interventions make a difference in conversations between physicians and patients: a systematic review of the evidence.</p> <p>Medical Care, 45(4):340-349.</p>	<p>36 studies were included.</p> <p>Total number of participants: 1,352 (594 practising physicians, 758 residents/registrars).</p> <p>Also included studies of interventions directed at patients.</p>	<ul style="list-style-type: none"> • 21 studies reported on various communication behaviours of medical staff. Most reported significant effects on one or more outcomes. • Participants who received high-intensity interventions were more likely to elicit patient concerns and exhibit a patient-centred style. They were also more likely to express empathy, although in one study the initial effect was not sustained after 12 months. • High intensity interventions were also shown to significantly improve information giving. There was also a significant effect on physician behaviour to verify patient understanding of the information given. • This review also reported on the impact of interventions directed at patients – findings were mixed.
<p>Merckaert I, Libert Y, Razavi D., (2005).</p> <p>Communication skills training in cancer care: where are we and where are we going?</p> <p>Current Opinion in Oncology, Vol 17(4), 319-330</p>	<p>13 studies (described in 22 papers), of which four were randomised trials, were included. The bulk of the analysis focused on the randomised trials.</p>	<ul style="list-style-type: none"> • Training skills programmes were associated with reported improvements in communication skills, increased knowledge and confidence, changes in attitudes, and satisfaction among health care professionals. • There was no change in the physicians' detection of patient distress. • Findings about the effects of training on participant stress and 'burnout' were inconsistent. • Two of the four studies that focused on patient outcomes reported improved patient satisfaction and perception of interviews.

Reference	Studies Included	Results of the Review
<p>Chant S, Jenkinson T, Randle J, Russell G, Webb C, (2002).</p> <p>Communication skills training in healthcare: a review of the literature.</p> <p>Nursing Education Today, 22, 189-202</p>	<p>65 evaluations of communication skills training in pre and post registration nurse education and in other disciplines were found.</p>	<ul style="list-style-type: none"> • Of the 65 studies, 24 were considered methodologically sound (37%). Those with sound research designs were less likely to find the communication skills training to be effective (66%) than those flawed designs. • In total 16 of the 65 studies indicated positive effects of training. • The findings of the studies are shown in the table in the main body of text. • The authors recommend more rigour in research, a greater variety of research methods, the use of observational methods and combinations of methods, greater awareness or acknowledgement of limitations of studies, establishment of an electronic network of good practice, longitudinal work especially on the transition from education to practice, more work on patient outcomes, and encouragement of participatory action research at practice levels.
<p>Kruijver I P, Kerkstra A, Francke A L, Bensing J M, van de Wiel H B., (2000).</p> <p>Evaluation of communication training programs in nursing care: a review of the literature.</p> <p>Patient Education and Counseling, 39(1):129-145.</p>	<p>14 studies were included (involving 1001 nurses or health care workers), comprising 3 randomised controlled trials (RCTs) with randomisation at the level of the individual; 1 RCT with randomisation at ward level; 4 studies with pre-test post-test non randomised design; and 6 studies with a single group pre-test post-test.</p>	<ul style="list-style-type: none"> • Methodological flaws included: experimental design used in relatively few studies; training did not include non verbal communication; and studies used measuring scales without reporting their validity or reliability. • One study reported the importance of giving participants feedback on their performance. • 9 studies looked at impact on skills, attitudes and knowledge of practitioners. Results were inconsistent - 4 studies reported no benefit and 5 reported a positive effect of training. • Results on impact on behaviour changes in nursing practice (reported by 5 studies) also found inconsistent results, with 3 studies reporting no effect and 2 studies reporting a positive effect of training. • 4 studies reported on patient outcomes, with 2 studies reporting no effect and 2 studies reporting a positive effect of training.

Reference	Studies Included	Results of the Review
<p>Stewart M A., (1995). Effective physician-patient communication and health outcomes: a review. Canadian Medical Association Journal, 152(9):1423-1433.</p>	<p>Twenty-one studies were included, of which 11 were RCTs and 10 were analytical (observational) studies. The total number of participants (patients) was 3,753. In addition, a total of at least 312 physicians participated in the review, as specified in 15 studies.</p>	<ul style="list-style-type: none"> • In studies of history-taking (4 RCTs involving 1,349 patients and 4 analytical studies involving 614 patients), education of both the patient and physician was found to improve patient health outcomes. Of the 8 studies, 7 showed significant positive findings, and 1 (an analytical study) a non significant result. • In studies of the discussion of the management plan (7 RCTs involving 1,251 patients and 8 analytical studies involving 1,025 patients): patient education was found to influence both emotional and physiological status, whilst physician education was found to influence emotional status. All of the RCTs and 6 of the analytical studies found significant correlations between communication interventions or variables and patient health outcomes. • Studies of other aspects of communication and patient health outcome (3 RCTs with 600 patients and 1 analytic study with 242 patients) were inconclusive.

Studies including Patient Outcome Measures in Uitterhoeve et al.

Title	Intervention	Results
<p>Brown R.F., Butow P.N., Boyle F. & Tattersall M.H. (2007) <i>Seeking informed consent to cancer clinical trials; evaluating the efficacy of doctor communication skills training.</i> Psychosocial Oncology 16, 507–516.</p>	<p>Training Group (<i>n</i> = 10): oncologists received a 1-day workshop, incorporating presentation of different specific doctor behaviours, a video model of ideal behaviour, feedback in role-playing exercises and provision of individualized feedback on two audiotaped real patient informed consent consultations.</p> <p>Group size: four to six participants.</p> <p>No control group</p>	<p>Healthcare professionals communicative behavior: 1 of 4 categories showed significant increase, i.e. <i>shared decision-making category.</i></p> <p>Patient satisfaction: No training effects</p> <p>Patient Distress/quality of life: No training effects</p>
<p>Delvaux N., Razavi D., Marchal S., Bredart A., Farvacques C. & Slachmuylder J.L. (2004) <i>Effects of a 105 h psychological training program on attitudes, communication skills and occupational stress in oncology: a randomised study.</i> British Journal of Cancer 90, 106–114.</p>	<p>Training Group (<i>n</i> = 57): nurses received 105 h (30 h theoretical information + 75 h of role-playing exercises) training to decrease professional stress levels, to improve attitudes and communication skills. Training was given during three consecutive months. Each month five consecutive days. Topics were approached according to increased complexity. Groups consisted of max. 10 participants.</p> <p>Control Group (<i>n</i> = 58): no training.</p>	<p>Healthcare professionals communicative behaviour: 1 of 15 measured behaviours showed significant increase, i.e. <i>educated guesses, alerting to reality and confronting.</i></p> <p>Patient Satisfaction: 2 of 5 dimensions of the Patient Satisfaction with the Interview Assessment Questionnaire showed significant improvements, i.e. <i>clarification of the preoccupations and information and support.</i></p> <p>Patient Distress/quality of life: N/A</p>

Studies including Patient Outcome Measures in Uitterhoeve et al.

Delvaux N., Merckaert I., Marchal S., Libert Y., Conradt S., Boniver J., Etienne A.M., Fontaine O., Janne P., Klastersky J., Melot C., Reynaert C., Scalliet P., Slachmuylder J.L. & Razavi D. (2005) **Physicians' communication with a cancer patient and a relative: a randomized study assessing the efficacy of consolidation workshops**. *Cancer* **103**, 2397–2411.

Lienard A., Merckaert I., Libert Y., Delvaux N., Marchal S., Boniver J., Etienne A.M., Klastersky J., Reynaert C., Scalliet P., Slachmuylder J.L. & Razavi D. (2008) **Factors that influence cancer patients' and relatives' anxiety following a three-person medical consultation: impact of a communication skills training program for physicians**. *Psychosocial Oncology* **17**, 488–496

Training Group ($n = 29$): basic training and Consolidation workshop. The 19-h basic programme consisting of two 8-h sessions and one 3-h session. It included a 2-h plenary session focussing on theoretical information and 17 h of small-group session (max six participants) practising skills in role-play with immediate feedback. The consolidation programme consisted of six 3-h workshops during 3 months.

Control Group ($n = 33$): basic training without Consolidation workshop.

Healthcare professionals communicative behaviour: 11 of 16 measured patient-directed behaviours showed significant improvement, i.e. *statement and responses; open, open directive and screening questions; directive, leading and multiple questions; eliciting and clarifying psychological information; eliciting and clarifying general information; checking; acknowledging; appropriate information giving; feelings stated explicitly, hints at feelings, facts only.*

Patient Satisfaction: 1 of 9 dimensions on the Patient Perception of the Interview Questionnaire showed significant improvement, i.e. *assessment of concerns*. No effects on the mean Patient and Relative Perception of the Interview Questionnaire score for both patient and relative. Overall satisfaction with interview (one item) improved significantly.

Patient Distress/quality of life: No training effects

Studies including Patient Outcome Measures in Uitterhoeve et al.

<p>Hulsman R.L., Ros W.J., Winnubst J.A. & Bensing J.M. (2002) <i>The effectiveness of a computer-assisted instruction programme on communication skills of medical specialists in oncology</i>. Medical Education 36, 125–134.</p>	<p>Training Group ($n = 21$): a computer-assisted instruction programme consisting of four modules: basic communication skills; breaking bad news; effectively providing information and how to deal with patient’s emotions. Communication theory is also presented, as are multiple-choice practice questions about the video, with immediate feedback. Each module can be completed within an hour.</p> <p>No Control Group</p>	<p>Healthcare professionals communicative behaviour: Training effects on judgements ratings, i.e. general rating, average quality rating and average quantity rating improved for the combined post-course ratings compared with the combined pre-course rating.</p> <p>Patient Satisfaction: No training effects</p> <p>Patient Distress/quality of life: N/A</p>
<p>Kruijver I.P.M., Kerssens J.J., Bensing J.M., van de Wiel H.B., Wind R.M., de Kruijf J.C.M. & Marres H.A.M. (2001b) <i>Communication Between Nurses and Admitted Cancer Patients: The Impact of a Communication Training Program on Nurse and Patient Outcomes</i>. National Institute for Health Services Research, Utrecht, The Netherlands.</p>	<p>Training Group ($n = 28$): nurses received 18 h of training. Training focused on learning facilitating skills and consisted of theoretical education, discussion of homework assignment, instruction regarding skill, demonstration of the skills and feedback in role-playing sessions. Training was given for 6 days in periods of 3 h and a follow-up meeting after 2 months. Group size: 10–15 participants..</p> <p>Control Group ($n = 23$): no training.</p>	<p>Healthcare professionals communicative behaviour: No training effects</p> <p>Patient Satisfaction: No training effects</p> <p>Patient Distress/quality of life: No training effects</p>

Studies including Patient Outcome Measures in Uitterhoeve et al.

Razavi D., Merckaert I., Marchal S., Libert Y., Conradt S., Boniver J., Etienne A.M., Fontaine O., Janne P., Klastersky J., Reynaert C., Scalliet P., Slachmuylder J.L. & Delvaux N. (2003) **How to optimize physicians' communication skills in cancer care: results of a randomized study assessing the usefulness of posttraining consolidation workshops.** *Journal of Clinical Oncology* **21**, 3141–3149.

Liénard A., Merckaert I., Libert Y., Delvaux N., Marchal S., Boniver J., Etienne A.M., Klastersky J., Reynaert C., Scalliet P., Slachmuylder J.L. & Razavi D. (2006) **Factors that influence cancer patients' anxiety following a medical consultation: impact of a communication skills training programme for physicians.** *Annals of Oncology* **17**, 1450–1458.

Training Group ($n = 29$): basic training and consolidation workshop. The 19 h basic programme consisting of two 8-h sessions and one 3-h session. It included a 2-h plenary session focussing on theoretical information and 17 h of small-group session practising skills in role-play with immediate feedback.

The consolidation programme consisted of six 3-h workshops during 3 months.

Control Group ($n = 30$): basic training and no Consolidation workshop.

Healthcare professionals communicative behaviour: 4 of 22 measured behaviours were significant, i.e. *acknowledgement; empathic statement; educated guesses; negotiation.*

Patient Satisfaction: 1 of 9 dimensions on the Patient Perception of the Interview Questionnaire showed significant improvements, i.e. *assessment of the patient's understanding of the disease.* No effect on the mean Patient Perception of the Interview Questionnaire score nor overall patient satisfaction with interview (one item).

Patient Distress/quality of life: No training effects

Studies including Patient Outcome Measures in Uitterhoeve et al.

<p>Jenkins V. & Fallowfield L. (2002) <i>Can communication skills training alter physicians' beliefs and behavior in clinics?</i> Journal of Clinical Oncology 20, 765–769.</p> <p>Shilling V., Jenkins V. & Fallowfield L. (2003) <i>Factors affecting patient and clinician satisfaction with the clinical consultation: can communication skills training for clinicians improve satisfaction?</i> Psychosocial Oncology 12, 599–611.</p>	<p>Training Group (<i>n</i> = 48): oncologists received a 3-day course, which was learner centred, incorporating cognitive, experiential and behavioural components. Small groups (three to five). Role-playing with patient simulators, followed by video review and group discussion</p> <p>Control Group (<i>n</i> = 45): no training</p>	<p>Healthcare professionals communicative behaviour: Significant improvement for: <i>empathy; appropriate responses to patient cues; psychosocial probing; use of open questions</i></p> <p>Patient Satisfaction: No significant training effects</p> <p>Patient Distress/quality of life: N/A</p>
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