Appendix L
Education and Training

1.1 Introduction

The Education and Training work stream is a major component of the UK Programme and incorporates four key elements:

-Development of master trainers
-Training trainers
-Training clinicians
-Provision of on-going coaching.

The UK training programme is very similar to the original programme developed by Ariadne Labs, but has been adapted for the UK setting. (See Figure 1)

1.2 Development of the Master Trainers

Due to the time constraints inherent to the Phase One pilot it was decided to train a Master Faculty who would be able to deliver training to clinicians across the three pilot sites and to provide on-going coaching. This differs from the US process of training local trainers to deliver the training and coaching but allowed the pilot to meet the set schedule.

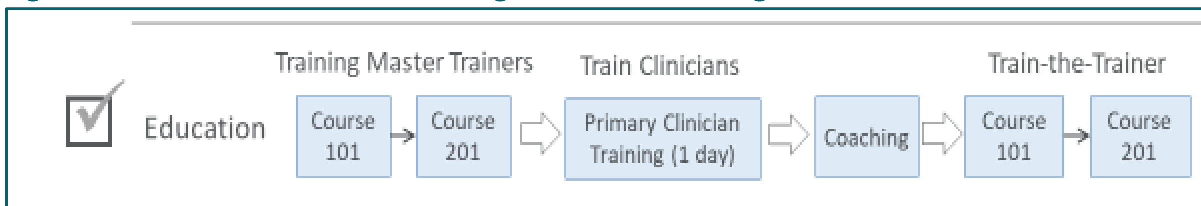
It was important to ensure high quality and effective training and teaching to realise good outcomes. Good clinical teaching requires clinical knowledge, context, and understanding of the general principles of teaching.[1] Effective teachers also need to be enthusiastic;[2,3] have leadership qualities;[4,5;]; and excellent communication skills.[6] These characteristics were all considered when developing the UK Master Faculty.

A team of four master trainers was established to lead the training programme in the UK with the support of the faculty from Ariadne Labs. The team comprised the Clinical Lead and Education and Training Work stream lead for the UK programme together with two experienced Palliative Medicine consultants. All members of the team were clinicians with extensive experience in palliative care, had undertaken advanced communication skills training, and were experienced in teaching palliative care and communication skills to a wide range of clinicians.

There were five steps to becoming a master trainer within the Serious Illness Care Programme UK:

1. Learning to use the Conversation Guide (Course 101).
2. Practising using the Conversation Guide with patients.
3. Learning to teach the clinician training day (Course 201).
4. Teaching the clinician training day.
5. Debrief and review of participant evaluations with the Ariadne Faculty.

Figure 1: The Serious Illness Care Programme UK Training Scheme



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In April 2016 during a visit to Ariadne Labs, the Clinical Lead and Education and Training Lead undertook Course 101 run by the Ariadne Faculty. This course provided the evidence-based rationale for a systematic approach to improving conversations about patient values and goals of care. It included an overview of the three components of the Serious Illness Care Programme and the benefits for patients and families. There was opportunity to understand the six domains of serious illness conversations and how the Conversation Guide can be used effectively. It also provided time to consider the challenges learners may have in mastering the Conversation Guide and the role of the Trainer in implementing the Programme.

On return to the UK, the Education and Training Lead ran this course for the remaining master trainers. All were then able to become familiar with using the Guide over the subsequent three months before undertaking Course 201.

Course 201 was run in the UK in July 2016 by the Ariadne Faculty. This course focused on general principles of teaching communication skills and teaching methods that motivate learning about communication. The keys steps of the clinician training day were identified and the master trainers given the opportunity to: practice leading a reflection; apply techniques to create safety during role play sessions; facilitate role play sessions on the use of the Serious Illness Conversation Guide; provide effective feedback to learners on their communication skills and responding to concerns of clinicians.

1.3 Clinician Training

1.3.1 Preparation for the Clinician Training

The clinician training was scheduled for September 2017, which gave the opportunity for the master trainers to adapt the training to meet the cultural and educational needs of clinicians in the UK, including adaptation of all course materials and case histories. Clinician training in the US programme consisted of a 2.5-hour session. For the UK Programme, a six hour study day was provided to ensure that clinicians had sufficient time to learn about the UK Programme, local arrangements and the evaluation process as well as the opportunity to learn about the Conversation Guide and practise in using it during role play.

We engaged a film production company to produce a 12-minute video which was used on the training day to promote discussion and demonstrate a level of clinician skill that would feel achievable to non-palliative care specialists. It provided an example of a doctor having a serious illness conversation with a patient who had Chronic Obstructive Pulmonary Disease. Further materials were developed: a facilitator guide, PowerPoint presentations and participant hand-outs which included the UK version of the Serious Illness Conversation Guide. Three case scenarios were adapted from those used in the US training and three further scenarios were developed. This resulted in three relevant case histories available for the GPs and three for the Oncologists.

1.3.2 The Clinician Training Day

There is evidence to show that education is likely to be effective in changing practice when it is interactive; includes discussion of evidence; local consensus and feedback on performance.[7] These elements were all included in the design of the training day. Accreditation for the training was applied for and approval given for six category 1 (external) CPD credits by the Federation of the Royal Colleges of Physicians of the United Kingdom.

The programme for the training day began with a large group reflection on the impact of communication on patient outcomes among the seriously ill, followed by an overview of the Serious Illness Care Programme, the current evidence base and the UK context. A demonstration video and discussion of the use of the Serious Illness Care Guide was followed by individualised practice by all participants, using role plays with actors trained as standardised patients and personalised feedback from the faculty.

Participants were then given the opportunity to see how conversations should be documented using the EHR, and there was discussion around local systems and clinical workflows. The day concluded with time to discuss the role of the website and the coaching arrangements.

Clinicians were trained in cohorts of nine or ten and the training was run twice at each of the three pilot sites: The Clatterbridge Cancer Centre, Airedale, Wharfdale and Craven CCG (AWC) and Southend-on-Sea CCG.

1.3.3 Evaluation of the Clinician Training Day

We trained 59 clinicians across the three sites:-

- 18 GPs and one Consultant in Palliative Medicine from AWC CCG
- 18 GPs and two Consultants in Palliative Medicine from Southend CCG
- 20 Consultant Oncologists from The Clatterbridge Cancer Centre

The day was evaluated using bespoke pre and post course self-assessment questionnaires, including a clinician acceptability questionnaire. Data from the evaluation of the training day is reported separately for the CCGs and The Clatterbridge Cancer Centre as slightly different versions of the forms were used for GPs and Oncologists.

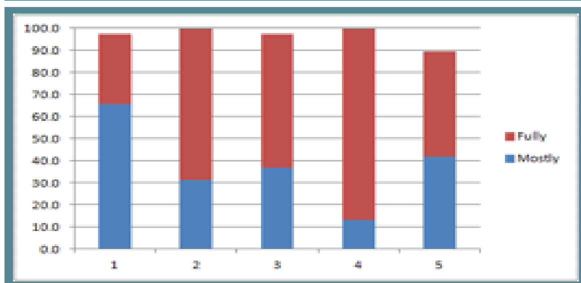
1.3.4 Evaluation of the Content

Participants felt that all the objectives for the day were met, apart from one participant who felt that one objective had not been met i.e. the ability to describe the UK Programme components (see Figure 2).

Figure 2: Meeting Objectives of Training Day for GPs and Oncologists

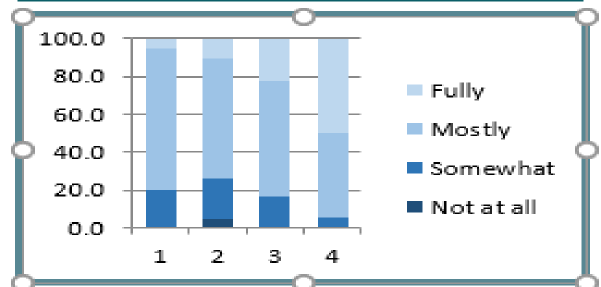
GPs

Key	Objective
1	Describe the benefits of serious illness conversations for patients and families
2	Describe my role in improving serious illness conversations
3	Describe the components of the serious illness conversation guide
4	Opportunity to practice using the serious illness conversation guide in role play
5	Describe local workflow and how it is organised to support the programme



Oncologists

Key	Objective
1	Describe the rationale for improving conversations about values and goals
2	Describe the components of the Serious Illness Care Programme
3	Identify 6 domains of the serious illness conversations
4	Willing to use the Guide in my clinical practice



1.3.5 Impact of Training on Skills and Confidence

The GP participants were asked to rate how they thought their level of skill had changed when they had completed the training compared to before the training on a 4-point scale: 1 = not at all confident, 2 = somewhat confident, 3 = mostly confident, 4= fully confident. Evaluation showed that overall the GPs felt their skill had increased for every element assessed. (see Figure 3)

Oncologist participants were asked to rate how they thought their confidence in their ability had changed after they had completed the training, compared to before the training on a 4-point scale: 1 = not at all confident, 2 = somewhat confident, 3 = mostly confident, 4= fully confident. Again the evaluation showed that overall, the oncologists' confidence increased on every element assessed. (see Figure 4)

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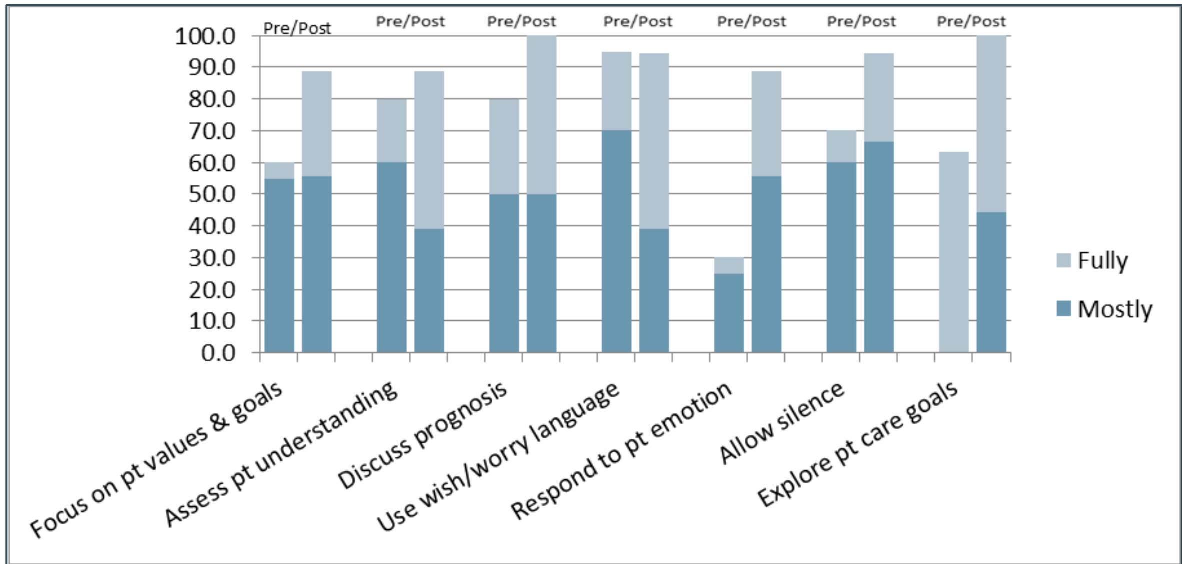
Figure 3: Skills Assessment (GPs)



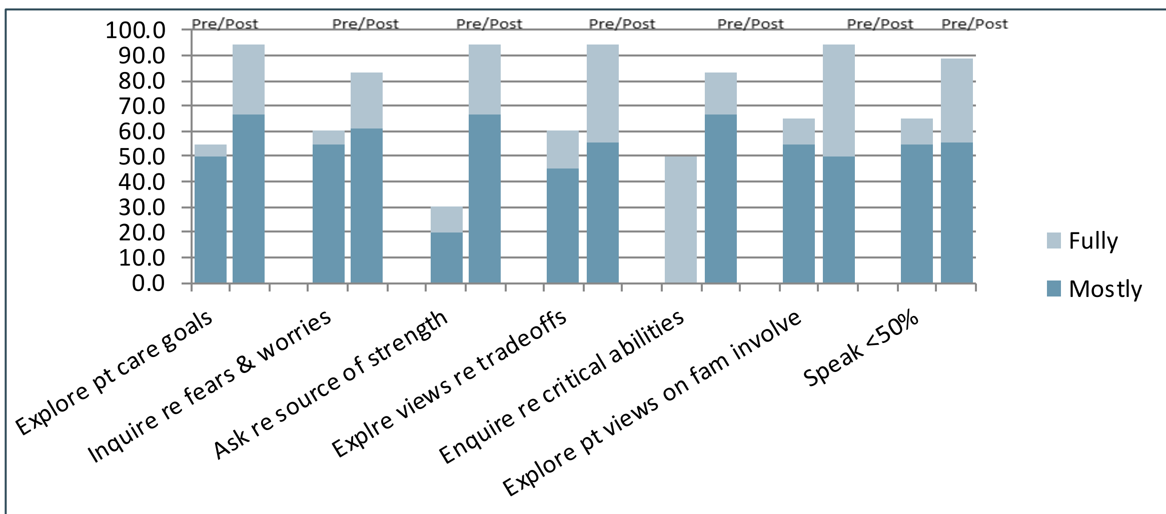
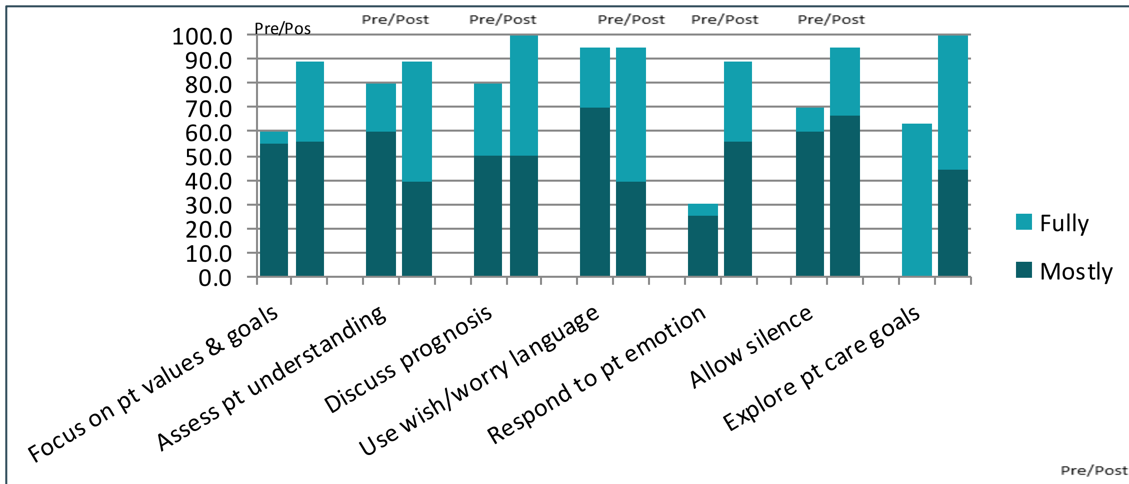


Figure 4: Skills Assessment (Oncologists)



1.3.6 Faculty Evaluation

Participants were asked to evaluate how well the faculty: presented and paced the training; respected participants; gave feedback; demonstrated mastery of the content and expertise as educators. The participants indicated that all elements had been achieved with most of them rating these as being fully achieved. Figure 5 shows feedback from GPs and Figure 6 shows feedback from oncologists

Figure 5 - Feedback to Faculty from GPs

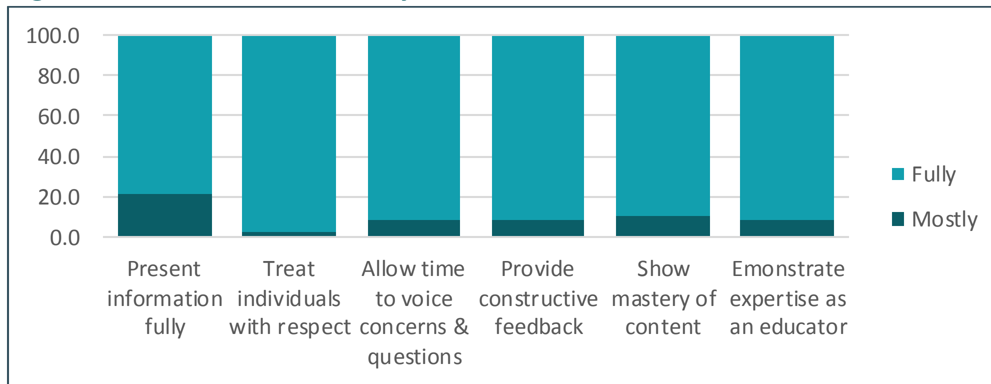
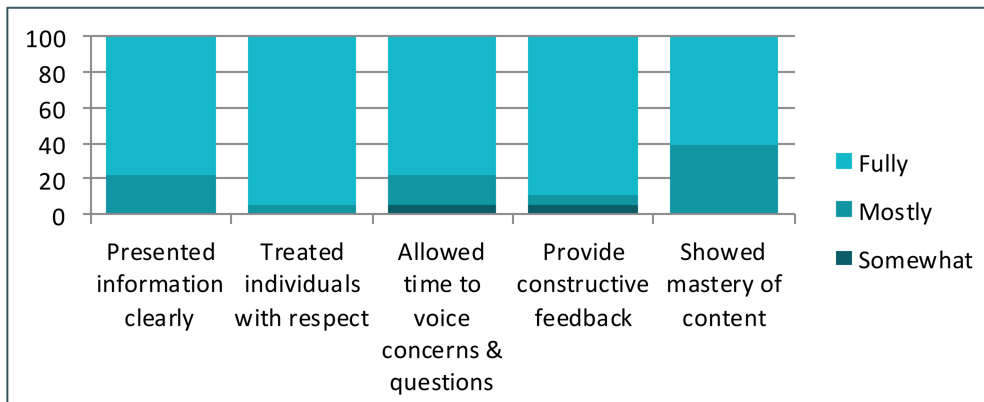


Figure 6 - Feedback to Faculty from Oncologists



The participants evaluated the training very positively. They felt that they understood the association between effective communication and improved care and that they would be able to have better conversations with patients who had a serious illness. They highlighted that they had learned skills to help in this, specifically identifying the use of silence and listening as being important.

Most participants recognised the value of the structure of the Guide and the specific questions and an even greater number felt it was essential that they use the Guide in their practice. Participants recognised that establishing the patients' understanding of the illness was also an important part of the conversation, as was discussing prognosis.

Participants mentioned several aspects from the training that had surprised, inspired, or helped them. They thought that the training had enabled them to change the way they cared for patients and gain confidence in having difficult conversations. There were also comments relating to how patient could benefit from this initiative in that it may reduce anxiety, depression and unnecessary admissions. They also stated that they would have a better understanding of the goals, abilities and strengths that patients value most. Some commented that even though the conversation was tough, the knowledge that it will help patients will help them to keep going.

Another aspect that was mentioned was the importance of knowing how to ask patients questions about their preferences using the Guide and asking the questions as they appeared on the Guide as otherwise the meaning could be lost. They also noted how useful silence was and valued learning different ways of discussing prognosis but still retaining hope.

The participants valued learning from each other during the training. They found the shared learning and personal stories inspiring and helpful. Watching the video and having the opportunity to role play had helped them to make sense of the Guide – even though some found the role play a bit scary! Participants found the role play was valuable not only in that it allowed them to practise using the Guide, but also to appreciate that using a script wasn't as awkward as they had imagined. They also valued watching other participants use the Guide well and to see that it worked well with participants who struggled to do it at all.

Participants found the inspiring – in particular the group work and the training structure. They were very encouraged by the enthusiasm of the trainers and what they saw as the very high level of dedication and expertise. They also commented that the actors were excellent.

When asked what could be done to improve the training, only one participant commented that it could be made shorter but many participants asked for more time in role play. Other suggestions included being more directive at the start of the role play, providing more detail on the organisational aspects of the training, extending the training to more GPs, nurses and health care professionals and sending out pre-course reading. Many participants commented that nothing

needed to be changed. Some of the key lessons learned during the training and potential solutions are summarised in Figure 7.

1.3.7. Serious Illness Conversations Following Training

Following the training, 77% (n=43) of the participants (excluding three Consultants in Palliative Medicine) went on to have 207 conversations during the pilot phase of the project (end June 2017). This gives a mean score of 3.6 (median = 3) conversations per trained clinician. Thirteen of the trained doctors had no conversations. Of these 13, three were unable to participate in the project due to long term illness or workload. Therefore, the doctors who were active following the training, had a mean score of 4.8 conversations (median=4).

The lessons learned during clinician training are summarised in Figure 6

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Figure 6 Lessons Learned - Clinician Training

	Area of Concern	Possible Solutions
1.	More information is needed pre-course particularly relating to an overview of the programme and what it entails	• Develop specific pre-course packs for all participants (clinical and non-clinical)
	Support staff did not know much about the programme or what their role was in supporting it	• Include support staff in training that is relevant to them
2.	Other members of the care team (e.g. CNS; StR) could be involved in having Serious Illness Conversations which may help to reduce workload concerns	• Include other disciplines in the training day
3.	More time needed on Training Day	• Reduce time allocated to overview of programme and evidence base by including this information in pre-course materials • Provide more time for Role Play • Provide more time for practicalities (e.g. screening process, using EHR templates etc)
4.	Need to find ways to maximise clinician engagement in having conversations	• Consider issuing the Certificate of Training after a clinician has had a minimum number (?5) of conversations • Ensure all systems are in place prior to the Training day so that the clinicians can start having conversations as quickly as possible
5.	Some clinicians continue to lack confidence in having the conversations after the training	• Consider offering remedial sessions if required • Consider offering opportunities for further practice as part of the Coaching Programme • Consider other opportunities such as observation, peer review etc. • Use Webinars to provide information and support post training.
6.	Clinicians need access to peer support	• Consider ways to develop local or national community of practice

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2. Coaching
2.1 Overview
All clinicians were offered coaching following the training. The coaching programme was intended to reinforce best practice in having serious illness conversations and to support clinicians who were having any difficulties. It also provided an opportunity to celebrate the successes they were having and to maintain motivation to participate in the UK Programme.

The coaching programme was led by two of the master trainers- the Clinical Lead and Education and Training Lead. They conducted all sessions together and following each meeting, the discussion was documented on a Coaching Summary Form. A copy of the summary was sent to the clinician. The coaching framework and the template for the summary form can be viewed in Appendix E

Sessions were either by telephone, email or face to face, depending on the preference/availability of the clinician and each session lasted approximately 30 minutes. A workshop was planned for December 2016 but due to the workload and effects of winter pressures, the clinicians preferred telephone sessions.

2.2. Coaching Results
Fifty-six participants were invited to participate in the coaching programme (Consultants in Palliative Medicine were not included).

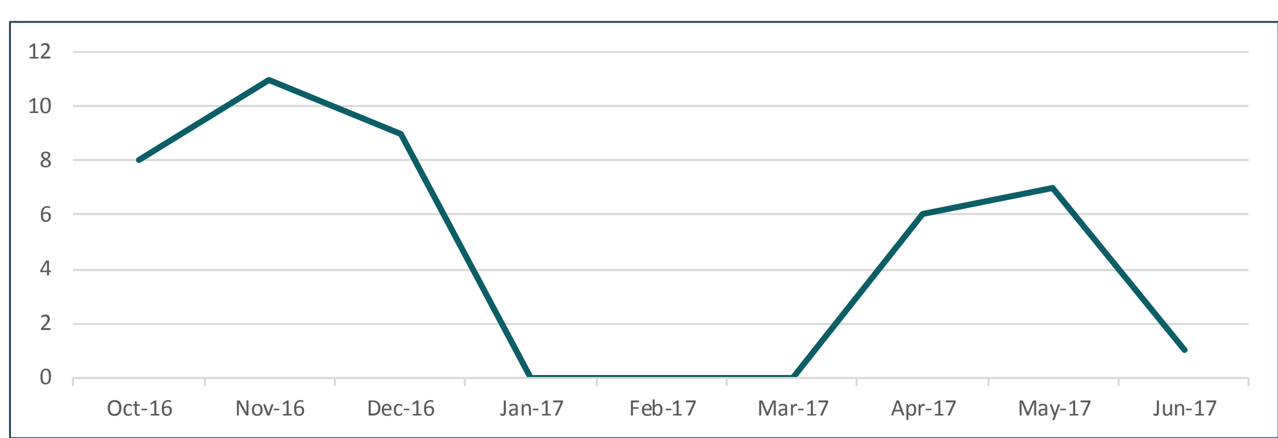
- 18 from AWC
- 18 from Southend-on- Sea
- 20 from The Clatterbridge Cancer Centre

Of these clinicians, 57% (n=32) took part in the coaching programme.

- 13 out of 18 GPs from AWC (72%)
- 11 out of 18 GPs from Southend (61%)
- 8 out of 20 Oncologists from CCC (40%)

Thirty nine percent (n=22) had one coaching session and 18% (n=10) had two sessions. The coaching programme began after the last training day and ran from October 2016 - June 2017. As expected the greatest demand was at the beginning of the Programme. No sessions were held in January due to Christmas holidays, or in February and March due to staff absence (Figure 7)

Figure 7: Number of Coaching Sessions by Month



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Clinicians who were engaged with the coaching programme had a higher number of conversations compared with those not involved in the coaching programme. This finding was the same in all three sites (Figure 8).

Figure 8: Number of Conversations in relation to Coaching Involvement

Site	Involved in coaching			Not involved in coaching		
	N° Clinicians	N° Conversations	Conversation per clinician (Mean)	N° Clinicians	N° Conversations	Conversation per clinician (Mean)
AWC	13	75	**5.8**	5	27	**5.4**
Southend	11	47	**4.3**	7	4	**0.6**
CCC	8	34	**4.2**	12	20	**1.7**

The coaching programme was very time consuming for the two master trainers. They spent a total of approximately 63 hours in holding the coaching sessions and documenting the summary. In addition, time was needed to send out frequent reminders to the clinicians that coaching was available, arrange the sessions and send out copies of the summaries.

It is interesting to note that clinicians involved in the coaching programme had more conversations than those not involved. It is not possible to say whether the coaching led to increased engagement by clinicians and a greater number of conversations with patients. However, coaching participation appears to be a good barometer of the level of clinician engagement.

The coaching sessions proved to be a rich source of information about the clinician experience of having serious illness conversations. Feedback from the coaching sessions is summarised below.

2.3 General Observations from Coaching Programme

Coaching sessions enabled clinicians to identify things that helped them to have the conversations and importantly, to find ways to address the difficulties they encountered. The clinicians undoubtedly found that having serious illness conversations with patients was important and very helpful even though they could be tiring and emotional.

Having the Serious Illness Conversation Guide to hand was very helpful and was not problematic to the patients. Clinicians found that it was best to start having conversations with patients that they already knew and that it was beneficial to have a family member present. Both GPs and oncologists found that the clinic/surgery environment was not always ideal for these conversations. For the GPs, it was easier to see patients at home or in the nursing home. One clinician had arranged for the nursing home staff to identify suitable patients and then had seen them on routine visits

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to the home. The oncologists determined the best way to schedule the appointments depending on their individual circumstances. The clinicians valued having a Data Manager in place and commented on how helpful this role had been.

Clinicians were very enthusiastic about the UK Programme with some having the conversations in their own time. They also found that they were using the structure of the Guide in different situations, for example one clinician had used the Guide when telling a patient that he was dying.

2.4 Benefits of the Serious Illness Conversation for Clinicians

Many of the clinicians said that having this conversation with patients had given them a real opportunity to gain helpful information that they hadn't previously been aware of. The conversation provided a more whole, cohesive approach, helping them to re-align goals with the patient if they were unrealistic and helping them to avoid just talking about treatment options. In particular, it helped the clinicians to get a good understanding of the patients' level of insight and their issues and concerns. They found that they developed a real understanding of what was important to the patient. One of the real benefits was that the conversation brought everything together. They also felt that the conversation improved the rapport they had with the patient.

The clinicians said that it was helpful having relatives present during the conversation and that using the Guide helped to keep the patient focused. Some of the clinicians noted that when they had had the conversation with a patient in a Nursing Home, it also helped the staff to gain a better understanding of the patient and even improved their relationship with the patient.

2.5. Benefits of the Serious Illness Conversation for the Patient

The clinicians felt that patients were very keen to talk. Having the conversation makes the patients feel that they are being listened to and supported ('someone at the practice is looking out for me, is concerned about me and is supporting me') and that it shows that the doctor is interested in finding out more about them. They thought that patients found that the conversation provided a good opportunity to clarify their wishes and concerns and that it was important in helping to make their family aware of their wishes and priorities. It gave patients time and space to talk about how they were feeling and clinicians felt that some patients were definitely calmer following the conversation. One GP reported that it had been very useful for a patient who had not understood an earlier conversation with the oncologist.

Clinicians reported that having the conversation also had practical benefits in that it was a good point to share supporting leaflets but also that the conversation had prompted patients to address practical issues. This included having a flu jab, joining a choir, and even changing the furniture around so they had a better view from their bed for when they became bed bound. It also prompted more serious decisions such as completing a DNACPR form.

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2.6. Challenges when Having a Serious Illness Conversation

One of the clinicians found that occasionally, patients and their families could be a bit suspicious at first. The clinicians identified some situations that made having the conversation feel more difficult, such as when a patient thought they were cured and the doctor had to highlight uncertainty. The conversation also seemed to be more difficult if the patient seemed to be quite well, did not appear to have any specific problems, was very pragmatic or went a bit off track. Some of the clinicians felt it was difficult talking about prognosis. This was especially the case if there was no clear diagnosis (e.g. old age). Others found it harder talking about trade-offs. One oncologist felt it was difficult to ask the patients 'What would you want to go through?' when there were not many treatment options available. One clinician felt that the affirmation statement at the end of the Guide didn't always feel natural.

The clinicians also identified some practical challenges in having the conversations. For some, time management was an issue and others found it hard to concentrate on the computer and the Guide at the same time although they did find that this improved over time. Initially, there were a few challenges with documenting the conversations. These included knowing exactly what to document on the EHR, not being able to access the system or difficulty in saving and editing information on the system.

2.7. Barriers

The main concern reported by the clinicians was that although they really wanted to have the conversations, finding sufficient time and opportunity was difficult. For some, their Job Plan made it difficult to access appropriate patients. One GP struggled to identify appropriate patients as the population served by the practice were generally young. Workload was frequently cited as being a major problem, particularly with the severe winter pressures that occurred over the last year. The oncologists found that it was difficult to allocate appointments as clinics are routinely overbooked. Some clinicians were having personal problems that impacted on their ability to engage with patients at this level.

Another problematic area was the screening process. GPs found that there were limited numbers of patients being identified via the screening process. It was felt that this was due to wider problems with how patients were being coded. It was also apparent that the screening was not being run each month as planned. Some of the clinicians found it difficult to identify suitable patients if they did not know the patients on the screening list.

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2.8 Lessons Learned from the Coaching Progamme

	Area of Concern	Possible Solutions
1.	Need to motivate clinicians to engage with coaching programme	• Make appointments for the first coaching session on the Training Day • Develop the website to support the coaching programme
2.	Master Trainers were geographically remote from some implementation sites	• Develop local coaches
3.	Need to improve and maintain confidence in having conversations following the training	• Consider developing local peer observation as part of the coaching programme
4.	Coaching is very time consuming and requires on-going commitment	• Factor time demand of coaching into the business case/project budget

3. Training the Trainer

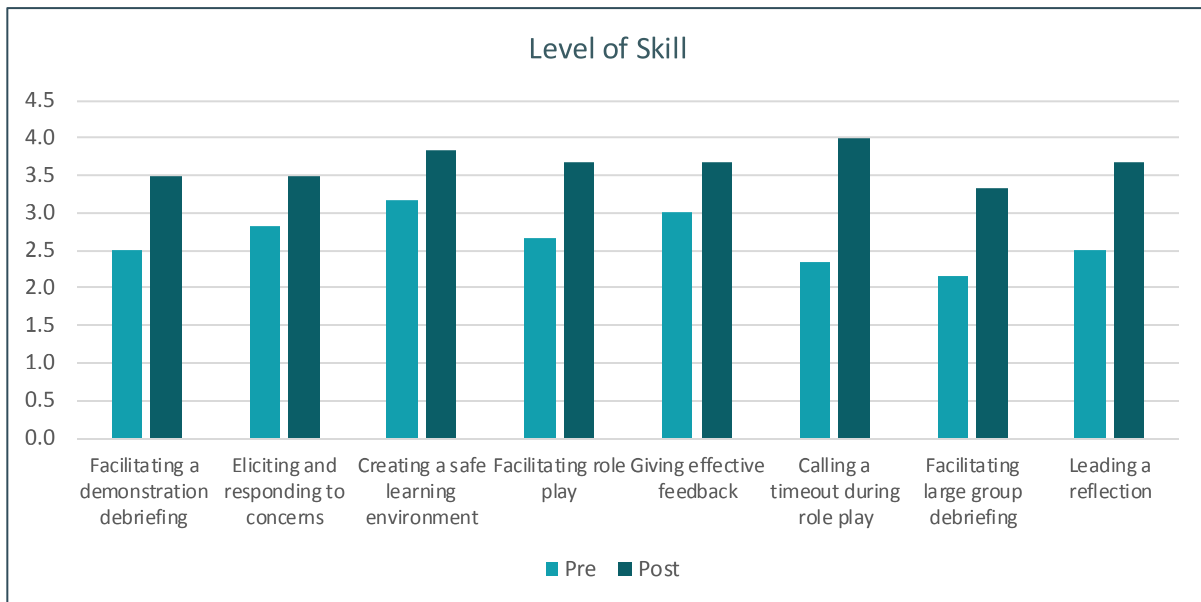
It was agreed as part of the Phase One pilot, that selected clinicians from each of the three sites would be trained as trainers for the UK Programme. A specification was developed to ensure that potential trainers had the requisite skills and attributes (see Appendix F).

Six clinicians attended the study day which was led by two UK Master Trainers. The participants comprised of two Consultants in Palliative Medicine; two GPs and two Oncologists. Three participants were from Airedale, two from Clatterbridge and one from Southend. All had undertaken the initial clinician training in autumn 2016 and all had used the Serious Illness Conversation Guide in their clinical practice.

3.1. Skills Assessment for Trainers

Participants were asked to assess their level of skill in key areas of facilitating clinician training, both before and after the training. Participants were asked to rate their level of skill on a five point scale: 1 = not at all skilled, 2 = somewhat skilled, 3 = skilled, 4 = very skilled, 5 = extremely skilled. Participants' self-assessed level of skill increased for every question asked. The mean pre and post course scores for each element are shown below.

Figure 9. Self-assessment of skills pre and post training



3.2. Evaluation of Study day for Train the Trainers

Participants were asked how to what extent the study day met the set learning objectives. (Figure 10) They were asked to use a four-point scale: 1 = not at all, 2 = somewhat, 3 = very much, 4 = completely.

The evaluation showed that all of the learning objectives were met either "very much" or "completely." The mean scores for each objective are displayed in Figure 11.

Figure 10: Meeting Objectives of the Training for Trainers Study Day

participants, gave feedback to

Key	Learning Objectives
1	Describe 4 teaching methods that motivate learning about communication
2	List general principles of teaching communication skills
3	Identify the steps of the clinician training on the use of the Serious Illness Conversation Guide
4	Lead a reflection on the impact of communication on patient care
5	Apply techniques to create safety during skills practice
6	Facilitate a skills practice session on the use of the Serious Illness Conversation Guide
7	Provide effective feedback to learners on their communication skills
8	Respond to learners concerns and barriers during large group debriefing

Participants were asked to evaluate to what extent they felt the faculty presented, how well they respected participants, and showed mastery of the content. The mean scores for each element are shown below. (Figure 12)

Figure 11. Meeting the Learning Objectives

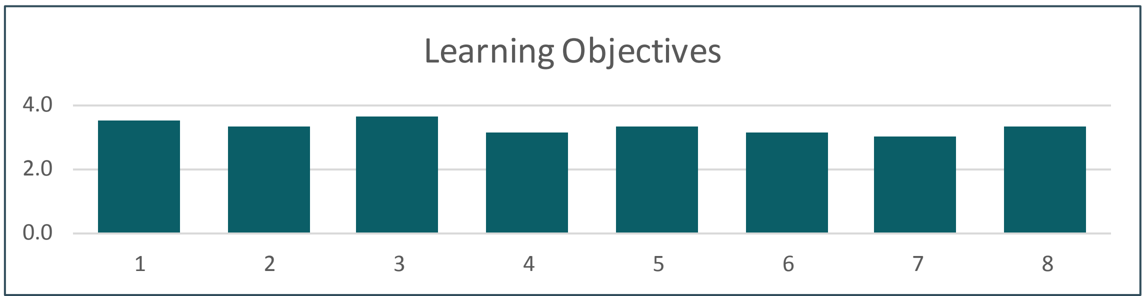
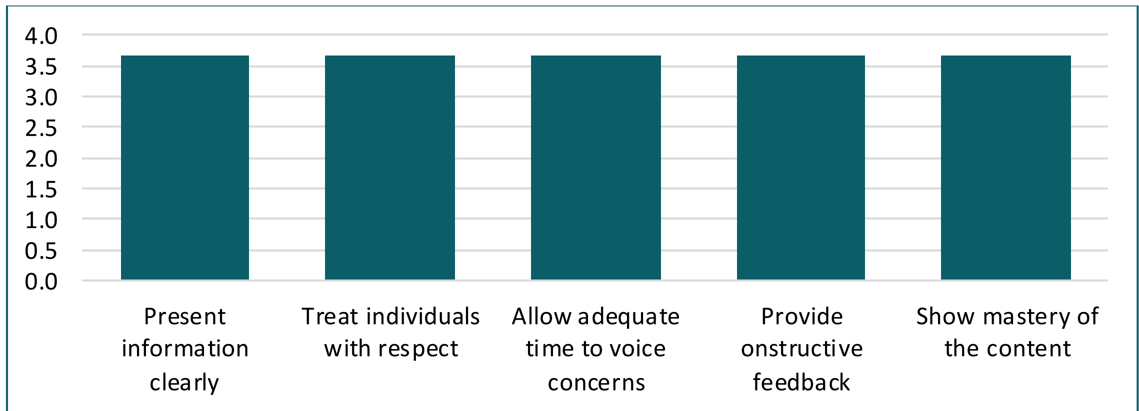
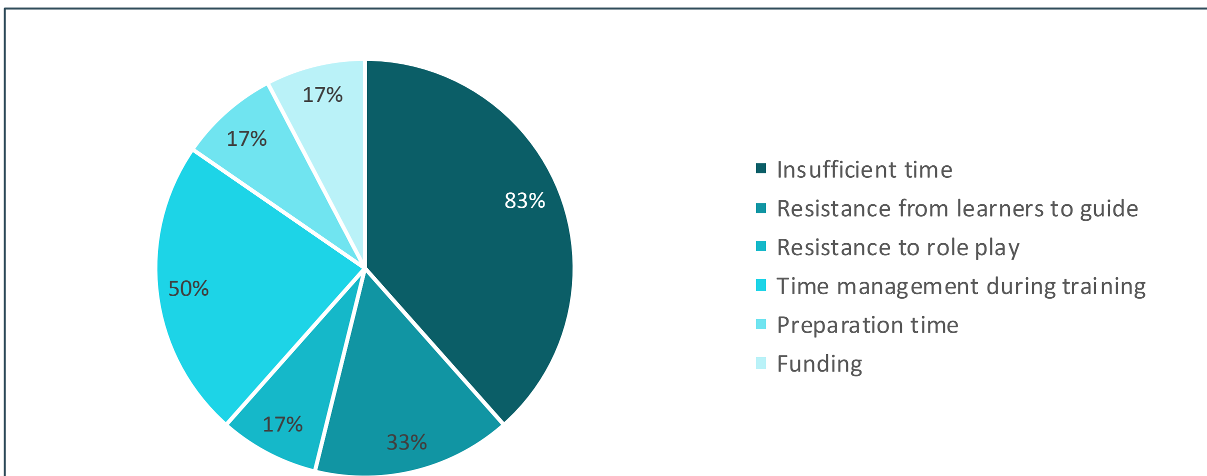


Figure 12. Assessment of Faculty



Participants were asked Identify what the major barriers would be for them to teach the Clinician Training Day. The most frequently mentioned barrier was insufficient time. (n=5)

Figure 12 Barriers to Teaching



Participants were asked to rate how effective the training was in improving their skills in leading a Serious Illness Clinician Training Day using a 4-point scale: 1 = not at all effective, 2 = somewhat effective, 3 = mostly effective, 4 = extremely effective.

All participants felt that the day had been effective, with 50% rating it as mostly effective and 50% rating it as extremely effective.

The clinicians clearly found the training day valuable and were all enthusiastic about continuing with the UK Programme supported by the Master Trainers. It is important that any new skills are utilised and consolidated as quickly as possible following the training so that they are not lost. It had been hoped that when the clinicians attended the Train the Trainers study day they would have already have plans in place to train more clinicians in their own localities. However due to on-going funding issues, this had not been possible in AWC or Southend.

Further training is planned at The Clatterbridge Cancer Centre in the winter of 2017. This will enable the oncologist trainers to use the skills from the training, supported by the Master Trainers. To support the GP Trainers, they have been given the opportunity to join with facilitating this training. The lessons learned from our experience of training the trainers are summarised in Figure 13

6. References

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Figure 13. Training the Trainers - Lessons Learned

	Area of Concern	Possible Solutions
1.	Need to ensure the quality of the training programme is maintained	• Timing of the Training the Trainers Study Day should be linked to Clinician Training Days to ensure new trainers are running training as soon as possible • Ensure that all trainers attend an annual Trainers Meeting
2.	Training local trainers can be problematic - if the local implementation is limited (e.g. no ongoing funding/ support) - greater risk of dilution of knowledge and skill impacting on quality of the training/programme	• Consider a different model of training: It may be more effective and cost efficient to develop a central cohort of trainers rather than isolated local trainers
3.	It is helpful for trainers to have local knowledge and relationships	• If central trainers are used, local champions could be developed to be part of the training team for a specific location. This would provide local intelligence and support. • If local Trainers are used, they should be trained at the beginning of the role out and should co-train local clinicians with Master Trainers until they are competent and confident in the role
4.	Coaching is very time consuming and requires on-going commitment	• Factor time demand of coaching into the business case/project budget