



Increasing person-centred care in paediatrics

Daniel Hayes¹ , Julian Edbrooke-Childs¹, Kate Martin², Joanna Reid³, Rob Brown³, Jessie McCulloch³ and Louise Morton⁴

¹Evidence Based Practice Unit, University College London and Anna Freud National Centre for Children and Families, London, UK

²Common Room Consulting, London, UK

³Great Ormond Street Hospital for Children, NHS Foundation Trust, London, UK

⁴Central and North West London NHS Foundation Trust, London, UK

SUMMARY

Background: Paediatric patients (PPs) often feel that they are not involved in care and treatment decisions. Although training clinicians may help, there is a lack of evaluated training programmes specifically for work with PPs. The aim of this article is to evaluate 'Me first', a training programme aimed at improving clinicians' attitudes and communication skills when working with PPs.

Methods: A total of 69 clinicians attended 'Me first' training and

completed questionnaires across three time points: (1) prior to attending the training; (2) at the end of the training; and (3) 4–6 weeks later. This included 14 medical staff, 29 nursing staff and 26 allied health staff. Attitude was measured using the Leeds Attitudes to Concordance II (LATCon II) scale, and communication skills were measured using the Effective Listening and Interactive Communication Scale (ELICS).

Results: Overall, clinicians reported that their attitude and communication skills improved

after attending 'Me first'. This was maintained 4–6 weeks later. Subgroup analysis showed that allied health staff did not maintain the improved attitude at the follow-up conducted 4–6 weeks later.

Conclusions: Findings suggest that 'Me first' may be helpful in improving clinician attitudes and communication skills with PPs. Further research should examine whether PPs report higher levels of communication and decision making with clinicians who have attended training.

... results demonstrate that clinicians' communication skills and their attitudes towards partnership with PPs improve after attending training

Subgroup analysis showed that allied health staff did not maintain the improved attitude at the follow-up conducted 4–6 weeks later

INTRODUCTION

It is increasingly recognised that paediatric patients (PPs)—individuals up to the age of 18 years, should be involved in care and treatment decisions. Despite this, PPs report that clinicians routinely fail to involve them.^{1,2} A perceived lack of capacity may be one barrier, as parents may be consulted as decision makers rather than the PPs.³ This leaves the PPs feeling marginalised and forgotten.⁴ Training clinicians around shared decision making (SDM) may increase involvement and reduce conflict between these stakeholders.⁵

A recent review of SDM training identified that the provision of training for clinicians has become more frequent over the last decade.⁶ Less than a quarter (24.4%) of courses had been evaluated, however, almost all of which focused on adult populations. The review concluded that it was not possible to determine

whether training helped with patient inclusion.

Most evaluated clinician training programmes for SDM with PPs tend to focus on outcomes such as compliance or satisfaction from service users.^{7,8} A study examining an educational intervention on clinician communication skills found significant increases after training that were maintained 2 weeks later;⁹ however, no studies have examined whether clinicians' attitude and behaviour changed because of the training. This is important as attitudinal change is needed prior to introducing other methods to change behaviour.¹⁰

There is a need for training and evaluations around communicating and involving PPs in health decisions, and particularly whether such programmes change attitudes and behaviour.^{1,4,6} 'Me first' is a programme designed to facilitate effective communication between clinicians and PPs. The aim of this study is to evaluate whether 'Me first' improves clinicians' attitudes

and communication skills when working with PPs.

METHODS

'Me first'

'Me first' is a 1-day masterclass focused on understanding and promoting effective communication through a six-step model as well as tackling barriers to effective communication. The model and the training were developed by Great Ormond Street Hospital, a specialist hospital for PPs, and Common Room Consulting, an organisation that connects young people with lived experience with researchers, clinicians and policymakers. The model provides six steps to guide clinicians in PP-centred care (Figure 1). The topics covered in the masterclass are outlined in Box 1.

Evaluation

Ethical approval was obtained by the University College London Research Ethics Committee (6328/002). To examine whether 'Me first' was effective in improving the attitudes and communication



Figure 1. Outline of the 'Me first' training programme.

skills of clinicians, two self-report questionnaires were administered: the Leeds Attitude to Concordance (LATCon II) questionnaire and the Effective Listening and Interactive Communication Skills (ELICS).^{11,12} The following demographic information was also collected: age, gender, ethnicity, days per week worked, hours per week with PPs and role.

LATCon II

A measure for clinicians and student clinicians, LATCon II¹¹ consists of 20 items scoring between zero (strongly disagree) and three (strongly agree). It is scored out of 60, with higher scores indicating a more positive attitude towards working with PPs. Responses were measured before (time point 1), immediately after

(time point 2) and 4–6 weeks after (time point 3) the masterclass. This measure has not been validated with paediatric clinicians.

ELICS

A measure for paediatric clinicians, the ELICS¹² consists of 24 items with four listening subscales. Definitions are provided in Table 1. Each item is scored

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Box 1. An outline of the topics covered in masterclass

- An exploration of the barriers and challenges to paediatric patient-centred communication
- Listening to the impact of person-centred communication on paediatric patients (PPs)
- Exploring scenarios to apply principles of PP-centred communication
- Simulated scenarios to develop confidence and skills
- Sharing new ideas, tools and resources for communicating with PPs

Table 1. Effective Listening and Interactive Communication Scale (ELICS) subscales and definitions¹²

Action-oriented listening

Listening focused around the implementation or outcome-oriented aspects of practice. This can include engaging paediatric patients (PPs) in what they want the next steps to be and letting them steer the direction and pace of treatment

Exploratory listening

Listening focused around the exchange of information between the clinician and PPs. This can include the clinician addressing issues important to the PPs and supporting them to ask questions

Consensus-oriented listening

Listening focused around developing a joint understanding of the difficulty and treatment plan. This can include goal setting, shared decision making and mind mapping

Receptive listening

Listening focused around paying attention to the PPs' unique identity and circumstances. This includes understanding their values, beliefs, personal circumstances and expectations. This also involves the clinician ascertaining information from what is not said

Table 2. Characteristics of all participants (total sample) compared with final questionnaire respondents (included sample)

Variable	Total sample 290	Included sample (%) 69 (23.79%)
Gender (male) ^a	35	10 (29.00%)
Age ^{*b}	25–34 years	34–44 years
Days worked per week ^{*b}	5 days per week	5 days per week
Hours worked with PPs per week ^{*b}	1–5 hours	6–10 hours
Medical staff*	33	14 (42.42%)
Nursing staff	117	29 (24.78%)
Allied health staff	80	20 (25.00%)

^aThree individuals did not disclose gender status.

^bModal frequency category.

*p < 0.05.

Clinicians scored moderately high on their attitudinal views towards PPs, suggesting that they are not opposed to partnership

1 (not at all) to 7 (to a very great extent). Scoring higher on each subscale indicates that the participant is engaging with each behaviour to the greatest extent. This was measured before the masterclass (time point 1) and at 4–6 weeks after the masterclass (time point 3). It has been validated with paediatric clinicians.¹²

Analysis

Data were analysed using non-parametric testing to account for assumptions of normality being violated. The Wilcoxon signed-rank test was used to compare changes in communication skills. The Friedman test was used to examine changes in attitude across the three time points. Significant

results on the Friedman test resulted in post-hoc testing.

RESULTS

A total of 28 training sessions of 'Me first' took place between March 2015 and May 2017. Data were collected from all 290 participants for time points

Table 3. Comparison between time points of attitude, as well as listening and communication skills, overall and by professional grouping

	Time Point 1 (prior to the masterclass) Median and CI ^b	Time point 2 (immediately after masterclass) ^a Median and CI	Time point 3 (4–6 weeks after masterclass) Median and CI	Test statistic
Overall attitudinal score (out of 60)				χ^2
	43.00 (38.00–48.00)	49.00 (45.00–53.00)	47.00 (38.00–52.00)	48.88***
Medical staff (<i>n</i> = 14)	41.00 (37.00–44.50)	51.50 (45.75–54.25)	51.50 (41.25–54.00)	21.71***
Nursing staff (<i>n</i> = 29)	41.00 (37.50–44.50)	47.00 (41.50–52.00)	46.00 (37.50–50.00)	15.29***
Allied health staff (<i>n</i> = 26)	47.50 (38.00–50.00)	50.00 (45.00–53.00)	46.00 (37.00–52.25)	21.00***
Overall communication score (out of 7)				Z score
Action-oriented listening (<i>n</i> = 69)	5.25 (4.50–6.00)	–	6.25 (5.75–6.75)	–6.03***
Medical staff (<i>n</i> = 14)	4.62 (3.69–5.25)	–	6.00 (5.19–6.81)	–3.15**
Nursing staff (<i>n</i> = 29)	5.50 (4.75–6.00)	–	6.25 (5.75–6.50)	–3.79***
Allied health staff (<i>n</i> = 26)	5.38 (4.88–6.25)	–	6.38 (5.63–7.00)	–3.59**
Exploratory listening (<i>n</i> = 69)	5.14 (4.57–5.86)	–	6.14 (5.86–6.71)	–6.48***
Medical staff (<i>n</i> = 14)	4.50 (3.89–5.14)	–	5.79 (5.29–6.75)	–3.18**
Nursing staff (<i>n</i> = 29)	5.43 (4.79–5.86)	–	6.14 (5.86–6.71)	–4.09***
Allied health staff (<i>n</i> = 6)	5.43 (4.82–6.14)	–	6.36 (5.86–7.00)	–3.96***
Consensus-oriented listening (<i>n</i> = 69)	5.43 (4.71–6.00)	–	6.29 (5.71–6.86)	–6.46***
Medical staff (<i>n</i> = 14)	4.71 (3.96–5.57)	–	6.07 (5.29–6.75)	–3.05**
Nursing staff (<i>n</i> = 29)	5.43 (4.79–6.00)	–	6.00 (5.79–6.71)	–4.04***
Allied health staff (<i>n</i> = 26)	5.64 (5.07–6.04)	–	6.50 (5.82–6.86)	–3.96***
Receptive listening (<i>n</i> = 69)	5.50 (4.75–6.33)	–	6.33 (5.92–7.00)	–6.04***
Medical staff (<i>n</i> = 14)	4.83 (4.17–5.42)	–	6.25 (5.79–7.00)	–3.18**
Nursing staff (<i>n</i> = 29)	5.67 (5.00–6.33)	–	6.33 (6.00–6.83)	–3.51***
Allied health staff (<i>n</i> = 26)	5.75 (4.83–6.50)	–	6.67 (5.79–7.00)	–3.75***

^aThere are no scores for listening and communication at Time Point 2, as these are taken at the end of the masterclass and this is a behavioural measure asking on previous practice.

p* < 0.01, *p* < 0.001.

^bConfidence interval.

1 and 2. At time point 3, 69 participants returned surveys. This represents a response rate of 23.79% from which baseline data were collected. Table 2 outlines demographic information in the total and included sample. Compared with the overall data set, the included sample were older [$\chi^2(6) = 256.73$, $p < 0.05$], spent more time with PPs [$\chi^2(8) = 92.19$, $p < 0.05$] and differed in terms of professional role [$\chi^2(3) = 28.89$, $p < 0.05$].

Attitude towards partnership with PPs

The Friedman test showed a statistically significant improvement in participants' attitudes towards partnership working with PPs across the three time points [$\chi^2(2) = 48.88$, $p < 0.001$]. The scoring across the three time points, both overall and by professional role, is outlined in Table 3.

Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level at $p < 0.017$. When applied, there was a significant increase between the scores before the masterclass (Median = 43.00) and the scores at 4–6 weeks later (Median = 47.00) ($z = -4.00$, $p < 0.001$).

For medical staff ($n = 14$), there was a statistically significant difference between attendees' attitudes towards partnership working across the three time points [$\chi^2(2) = 21.71$, $p < 0.001$]. Post-hoc analysis showed a significant improvement in attitude from before the masterclass (Median = 41.00) to 4–6 weeks later (Median = 51.50) ($z = -3.30$, $p < 0.001$).

Nursing staff ($n = 29$) followed a similar pattern to medical staff. There was a statistically significant difference between attendees' attitudes towards partnership working across the three time points

[$\chi^2(2) = 15.29$, $p < 0.001$], and post-hoc analysis showed a significant improvement in attitude from before the workshop (Median = 41.00) to 4–6 weeks later (Median = 46.00) ($z = -2.42$, $p < 0.015$).

For allied health staff ($n = 26$), there was also a statistically significant difference between attendees' attitudes towards partnership working across the three time points [$\chi^2(2) = 21.00$, $p < 0.001$]. Post-hoc analysis showed a significant improvement in attitude before the masterclass (Median = 47.50) and immediately afterwards (Median = 50.00) ($z = -3.60$, $p < 0.001$); however, there was no significant difference between attitude scores from before the masterclass (Median = 47.50) and at 4–6 weeks later (Median = 46.00) ($z = -0.37$, $p = 0.72$).

Communication skills

Overall, there were statistically significant increases in all four communication domains when comparing scores at time point 1 (prior to the masterclass) with scores at time point 3 (4–6 weeks later), detailed in Table 3. The significant differences across all four communication domains were also found when results were broken down by professional role.

DISCUSSION

The aim of this study was to evaluate the impact of PP-centred care training with clinicians. Overall, the results demonstrate that clinicians' communication skills and their attitudes towards partnership with PPs improve after attending training.

This increase in communication skills is congruent with previous research that employed an educational intervention in paediatric rehabilitation settings.⁹ Baseline and follow-up scores across this study and the previous study were similar, which suggests that clinicians

already believed that they involved PPs but also benefited from the intervention. As interventions differed in content and structure, this suggests that there may be multiple ways to change behaviour to facilitate PP-centred care.

An overall improvement in clinician attitude was demonstrated in this study. Prior to the intervention, clinicians scored moderately high on their attitudinal views towards PPs, suggesting that they are not opposed to partnership. This contradicts reports outlining that PPs often feel excluded,^{1,2} and suggests that clinicians do not see capacity as a barrier to involvement.³ This initial improvement shows that attitudes can be changed with training. Scores had decreased at follow-up, however, suggesting that the impact was time limited, possibly as these changes were not internalised before clinicians returned to practicing in the 'real world'.

Limitations should be considered. Attrition at follow-up indicates that findings should be treated cautiously. It may be that clinicians who were already committed to collaboration with PPs were those who completed the last survey. It should be noted that this study relies on self-reports from clinicians and could be subject to social desirability bias or do not translate into what PPs experience during care. Lastly, statistical testing assumes a completely random sample. Given that this sample was not chosen completely at random, findings and inferences should be treated cautiously.

CONCLUSIONS

Future research should focus on whether 'Me first' training results in changes to shared decision making and satisfaction with care. Longer term follow-up should also be considered to

Overall, there were statistically significant increases in all four communication domains

Scores had decreased at follow-up, suggesting that the impact was time limited

examine whether improvements in attitude and behaviour are maintained for certain groups. Finally, intervention developers may wish to examine which behaviour-change techniques may be contributing to change.

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Corresponding author's contact details: Daniel Hayes, Anna Freud National Centre for Children and Families, 4-8 Rodney Street, London, N1 9JH, UK. E-mail: daniel.hayes@annafreud.org

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