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Implementation of new skills to support lifestyle changes - what helps and what hinders?

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Abstract

Effective communication is necessary for good relationships between healthcare practitioners and clients. This study examined barriers and facilitators to implementing new communication skills.

One hundred and one Sure Start Children's Centre staff attended one of 13 follow-up workshops to reflect on the use of new skills following a training course in communication, reflection and problem-solving. Barriers and facilitators were assessed with an adapted Problematic Experiences of Therapy scale (PETS). Staff reported frequency of skill use, and described what made it more difficult or easier to use the skills.

The PETS indicated that staff had confidence in using the skills, but felt there were practical barriers to using them, such as lack of time. Skills were used less often when staff perceived parents not to be engaging with them ($r_s = -0.42$, $p < .001$), when staff felt less confident to use the skills ($r_s = -0.37$, $p < .001$), and when there were more practical barriers ($r_s = -0.37$, $p < .001$). In support of findings from the PETS, content analysis of free text responses suggested that the main barrier was a perceived lack of time to implement new skills. Facilitators included seeing the benefits of using the skills, finding opportunities and having good relationships with parents.

Understanding the range of barriers and facilitators to implementation is essential when developing training to facilitate on-going support and sustain skill use. Special attention should be given to exploring trainees' perceptions of time, in order to be able to address this significant barrier to skill implementation. Staff training requires a multifaceted approach to address the range of perceived barriers.

Keywords

barriers; communication; epidemiology; Sure Start; training

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Introduction

Improving healthcare practitioners' communication skills to facilitate behaviour change in their clients was a key recommendation in public health guidance from the National Institute for health and Clinical Excellence (NICE, 2007). Government white papers describe a health care system where patients, as clients, are empowered to improve their own health with the support of a professional (DOH, 2004; 2010). The notion of 'client-centred' care places the client in control of their own health, working together with a healthcare practitioner. Client-centred care has been associated with a range of positive outcomes, such as increased self-efficacy, compliance with treatment, and better clinical outcomes (Keshishian, Colodny & Boone, 2008; Wagner, Lentz & Heslop, 2002; Zachariae et al. 2003). Clearly, effective communication is at the heart of 'client-centred' care, which enables clients to consider their current situation and identify appropriate strategies. This paper examines the uptake of enhanced communication and behaviour change skills by a range of healthcare practitioners working within Sure Start Children's Centres (SSCCs) in Southampton who have regular contact with women from disadvantaged communities. Recent observations at Southampton SSCCs had highlighted the positive relationships staff have with families, and therefore it seemed appropriate to train this group to support behaviour change in their clients (Lawrence et al. submitted).

Southampton is a coastal town in the affluent south of the UK. However, it is relatively deprived being in the bottom quarter of local authorities in England (IMD 2010). It has 14 SSCCs, with core centres located in the most disadvantaged parts of the city. SSCCs were set up in 2004-5, aiming to target the most vulnerable families in a community (Belsky et al. 2006; Belsky, Barnes & Melhuish, 2007; Melhuish et al. 2008).

Our research team have trained staff working in Southampton SSCCs in 'Healthy Conversations Skills', a training programme designed to enable more productive conversations with the parents attending Sure Start, based on a philosophy of empowerment and encompassing a problem-solving approach. The training consisted of three group sessions focusing on five core skills. A follow-up workshop then allowed trained staff to reflect on their experiences of using their new skills, and promoted further embedding of these in practice. A full description of the training has been published elsewhere (Barker et al. 2011). Box 1 describes the training in more detail.

Within their normal practice, healthcare practitioners may face a range of barriers to implementing new skills. A national survey of dieticians found that lack of time for client interviews was identified as a major barrier to skill implementation (Whitehead et al. 2009). Lack of support from colleagues and lack of confidence in using the skills were also identified as significant barriers (Whitehead et al. 2009). Within diabetes care, health professionals state a variety of barriers to client-centred care, such as lack of time, privacy, and support (Mosely, Aslam & Speight, 2009).

These barriers could affect the sustainability of training interventions. It is therefore important to understand them and to provide adequate, on-going support. It is also important for intervention development to determine the facilitators that enhance skill implementation.

This paper examines barriers and facilitators to implementing new skills by SSCC staff following training in a specific form of communication and behaviour change – 'Healthy Conversation Skills'.

Methods

Participants

All SSCC staff, who completed the Healthy Conversations Skills course, were invited approximately three months post-training to attend one of thirteen follow-up workshops held at a SSCC between May 2009 and February 2011. See Box 1 for content of follow-up workshops.

Materials and Procedure

The Problematic Experiences of Therapy scale (PETS) (Yardley & Kirby, 2006) was originally developed to measure barriers to treatment adherence using twelve items divided into four subscales. To investigate barriers and facilitators to implementing Healthy Conversations Skills, the PETS scale was adapted, with authors' permission, to focus on three key areas: 1) Issues with parental engagement comprising three statements; e.g. "I couldn't use the skills I learnt because parents didn't like it", 2) Relevance of and difficulty with using the new skills comprising five statements; e.g. "I couldn't use the skills I learnt because I didn't know how to use them properly", 3) Practical issues comprising four statements; e.g. "I didn't have enough time to use the skills I learnt". "Skills" in this case were defined as using open discovery questions (see Box 1) in conversations with parents.

Similar to the original PETS, all items were scored on a scale of 1-5, where 1 = disagree strongly and 5 = agree strongly. A score for each subscale was generated, with a possible range of scores being 3-15 for "Issues with parental engagement"; 5-25 for "Relevance and difficulty of using skills"; and 4-20 for "Practical issues". The lower the score the fewer the perceived barriers. The adapted PETS was completed by trainees half-way through the follow-up workshop.

In addition, trainees were asked to rate how often they had used their new skills on a five point scale: never; rarely; sometimes; often; very often. They were also asked to describe the factors that made it more difficult (barriers) or easier (facilitators) to use Healthy Conversation Skills.

Analysis

Data were analysed using STATA version 11 (StataCorp, 2009). The associations between scores on each PETS subscale and the frequency of skill use were explored through Spearman's correlation coefficients. For each subscale, the data were summarised by obtaining the median score and then standardised medians were obtained by dividing the median score by the number of questions in each sub-scale.

Content analysis was used to analyse the free text descriptions regarding the factors that made it difficult or easier to use the new skills. The statements relating to barriers were coded into themes described by the three subscales of the adapted PETS: 1) issues with parental engagement; 2) relevance of and difficulty with using the skills; 3) practical issues. Statements relating to facilitators were also coded into three categories that broadly related to the three subscales of the adapted PETS but were positive in nature. This meant that subscale 2 was coded as "relevance of and ease of using the new skills". Statements were double-coded by two members of the team (WL and TT) and discrepancies were discussed until final codes were agreed.

Results

Data were available for 101 SSCC staff members who attended a follow-up workshop. Table 1 displays the participants' professions. Two-thirds of the 153 SSCC staff trained in Healthy Conversation Skills attended a follow-up workshop. There were a variety of reasons for non-attendance, including leaving employment with SSCCs and being on maternity leave.

Analysis of the adapted PETS scale

Table 2 displays the overall median score and inter quartile ranges for the items on each of the three subscales. Lower scores on each subscale indicate that staff perceived fewer barriers to implementing their new skills. The standardised medians were similar across the three sub-scales but suggest that trainees found practical issues to be marginally the greatest barrier to implementing new skills, with parental engagement and relevance and difficulty of skill use reported slightly less often.

Table 3 indicates that the new skills were implemented by more than 90% of the trained staff sometimes, often or very often; no one indicated they never used the skills.

All three PETS subscales were negatively correlated with frequency of skill use. Skills were used less often when staff perceived a lack of parental engagement ($r_s = -0.42$, $p < .001$), when staff felt less confident using the skills ($r_s = -0.37$, $p < .001$), and when there were more practical barriers ($r_s = -0.37$, $p < .001$). The negative correlations indicate that the fewer the barriers perceived, the more often the skills were used; conversely, the more barriers perceived, the less often the skills were used.

Content analysis of free text responses

Staff were asked to describe 'things that made it more difficult to use the new skills' (barriers). Seventy staff responded, some with more than one response such that there were 77 statements. These responses were coded into the three subscales of the adapted PETS. Fifty-one percent (39) related to practical barriers, 30% (23) related to parental engagement, and 19% (15) related to relevance and difficulty of use. The findings were similar to those from the adapted PETS scale in that practical issues were predominant. However, in the PETS scale all three types of barrier were rated fairly similarly, whereas more than half the barriers identified in the free text were practical in nature, indicating these provide a more frequent barrier than might have been anticipated from the PETS responses.

Staff were also asked to describe 'things that made it easier to use the new skills' (facilitators). Sixty-four individuals provided responses, some with more than one response such that there were 84 statements. Forty-nine percent (41) related to relevance and ease of use, followed by 31% (26) relating to practical issues and 20% (17) relating to parental engagement.

The next section presents examples of responses given by staff to illustrate the types of barriers and facilitators they experienced in using their new skills.

Parental engagement

A barrier for some staff was their feeling that parents would react negatively to the use of the skills (specifically asking open discovery questions) and consequently would not engage. Reasons for this ranged from staff believing that parents were preoccupied, eg supervising their children, to feeling that parents needed to have built relationships with staff before being ready to have healthy conversations.

“Some people do not want to speak, I don’t know why. They seem to be very busy doing other things.” Participant IDno.44

“Parents who don’t want to engage with anyone no matter how hard you try.” Participant IDno.93

“When you see a new parent there is no relationship with them.” Participant IDno. 89

There appeared to be some general anxiety about alienating parents or talking to them at the wrong moment. Some staff also found it difficult to use the skills with parents new to the Centres.

Language issues were also stated as a barrier preventing the implementation of the new skills.

“I speak Punjabi, Urdu and English but some parents don’t understand these languages at all.” Participant IDno.90

“Parents that find it hard to talk to me. There’s a language barrier.” Participant IDno.128

On the other hand, a facilitator to implementing the skills was when staff perceived parents to be receptive to them using healthy conversation skills, and when they knew they had gained the parent’s trust.

“I was able to help one parent, who herself worked out what the problems were with her child.” Participant IDno.52

“Having a relationship with the parent already. Having their trust.” *Participant IDno.15*

“*Knowing the parents/carers.*” *Participant IDno.33*

Thus, when staff felt they might compromise parental engagement, for example when parents were new users at the Centre or where there were language difficulties, they were less likely to use their new skills. If they had built a relationship with a parent and felt they would be receptive to this style of communication, they were more willing to practise their healthy conversation skills.

Relevance and difficulty/ease

Finding it difficult to use the skills, or feeling they were not relevant to the particular conversations they were having with parents, were other barriers to using the skills.

“I have conversations with families every day and know I could use this technique. It’s just knowing how to and having the confidence to do so.” Participant IDno.37

“It’s trying to find the right open discovery questions” Participant IDno.120

Conversely, a good understanding of the new skills and their effectiveness facilitated implementation.

“Learning how effective ‘open’ questions can be and that by using them it is not always necessary to use lots of questions if we ask the right open questions.” Participant IDno.10

“Doing this course made me more aware of how to communicate with parents and ask open ended questions.” Participant IDno.32

“Using them on people you know well. Using self-reflection. Seeing the benefits it had on others.” Participant IDno.111

These contrasting experiences appear to indicate the level of confidence in using the new skills. Those who commented on their effectiveness in conversations with parents, and reported positive experiences in using reflective techniques, were demonstrating evidence of their assimilation of the new skills.

Practical issues

Over half of the barriers described were practical in nature. Many of these related to the staff members’ perception that they lacked time to hold healthy conversations.

“Not having enough time to be able to spend on individual parents during sessions.” Participant IDno.27

“Time constraints (e.g. in a busy clinic I sometimes lapse back into old ways of giving solutions instead of asking more open questions towards help parents find their solutions).” Participant IDno.144

Several staff members also found it difficult to identify and create opportunities to have healthy conversations:

“I just find that the opportunity does not always present itself to use the techniques learnt.” Participant IDno.18

“The role I have with parents, means I do not go into homes, so I see them on a daily basis, but usually only fleetingly.” Participant IDno.112

Conversely, where staff were able to identify and create opportunities, this facilitated their implementation of the skills.

“Opportunities that make it easy to bring up healthy conversation skills i.e. if parents mention that they would like to lose weight or learn to cook.” Participant IDno.14

“Snack time gives a good opportunity to discuss healthy eating.” Participant IDno.22

“If play sessions are quiet, there are more opportunities to have longer conversations.” Participant IDno.28

Many of the staff trained in Healthy Conversation Skills work in the same Centres, facilitating similar sessions. Therefore, the difference in their perceptions of time and the opportunities available to use the skills is interesting and may reflect their level of confidence and competence in using these new skills.

Discussion

The majority of trained staff reported using Healthy Conversation Skills at least some of the time during their conversations with parents. However, the more barriers were perceived, the less they felt able to use the skills. Results from the adapted PETS indicated that practical issues relating to using the new skills, such as lack of time, were the most frequently reported barriers. Barriers relating to parental engagement and relevance of and difficulty with using new skills were reported less often.

Content analysis of the free text responses supported the findings from the adapted PETS, suggesting that the main barriers to skill implementation were practical in nature. These included difficulty in finding the time to have healthy conversations, and difficulty in

creating opportunities to hold them. Some trainees perceived parents as not ready to engage in healthy conversations. The least cited reason in free text responses for not implementing the skills was that they were not relevant or were too difficult to use. Conversely, the main facilitator to using the new skills was relevance and ease of using them.

Strengths and Limitations

This training focused on staff working at SSCCs, and therefore results may not be generalisable outside this group. Nonetheless, trained staff represented a wide variety of professional roles, and all have regular contact with the community. As further groups of healthcare practitioners are trained, we will discover whether they perceive the same barriers and facilitators to skill implementation.

The reliance on self-report is also a limitation. Self-report, however, provides valuable insight into trainee perceptions. It is also a practical and efficient way of exploring their world unlike other methods such as shadowing or direct observation of staff practice that are more resource-intensive. The combination of quantitative and qualitative data used in this evaluation maximises the insights gained.

Other measures of barriers to training, such as the Barriers to Change Questionnaire (BARCQ) could have been used (Corrigan, Kwartarini, & Pramanan, 1992). The BARCQ, however, was developed to look at barriers to training within an institutional setting and so places more emphasis on job-setting than is appropriate to our own training. The adapted PETS scale was used to evaluate the use of skills and explored three different types of barriers. Qualitative responses were found to map well onto the subscales and the adapted PETS and the free text responses both identified practical issues as the most common barrier. This suggests that both assessments were measuring the same thing. Using a deductive approach to the data analysis allowed an examination of the relevance of the three subscales in capturing the essence of the free-text responses, and demonstrated the usefulness of the adapted PETS with this population. Given the relatively small amount of data derived from the brief comments made by the staff who took the time to respond to the open-ended questions, a deductive approach was regarded as the most appropriate method of data analysis. This paper highlights the benefits of collecting both quantitative and qualitative data when exploring training outcomes in order to fully appreciate the nuances of an individual's experience.

What this study adds

Barriers to implementing new skills are well described in the health research literature. A lack of time with a client is a problem often perceived with a client-centred approach (MacLellan & Berenbaum, 2007; Mosely et al. 2009; Whitehead et al. 2009). Primary care mental health workers, who attended a short course to deliver self-help cognitive behaviour therapy, reported that the main barriers to skill implementation were institutional, such as too many clients and too few staff, resulting in too little time for effective discussions (Ekers, Lovell & Playle, 2006).

The perception of time is an important concept because it is so often perceived as a barrier. Time scarcity, or time famine, is the perception of not having enough time to do all one wants within the day (Godbey, Lifset & Robinson, 1998). This feeling of time scarcity has been associated with, amongst other things, a feeling of needing to speed up in the work place (Godbey et al. 1998). However, observations of staff practice in the SSCCs before the training showed that staff members have frequent contact with parents, either in a group setting or on a one-to-one basis, and as such there appear on the face of it to be many

opportunities to hold healthy conversations which need only last a few minutes (Lawrence et al. submitted).

Staff indicated that the most common practical barrier was a perceived lack of time, whilst the most common facilitator related to ease of using the skills. Psychological theory suggests two explanations for these findings. First, it may be that individuals tend to attribute their failures externally and their successes internally. Self-attribution theory suggests that individuals attribute negative outcomes externally, in order to protect the self, and attribute positive experiences to internal, dispositional sources, i.e. the self (Weiner, 1986). In this case, when asked to both report (adapted PETS) and describe (free-text responses) things that made skill implementation difficult, the main barrier was an external, practical issue, i.e. there being no time to use the new skills. Blaming practical issues externalises any difficulty with implementing the skills. This therefore protects the self by reducing the sense that not using the new skills is a failing on their part, and so is not such a threat to the ego. Furthermore, when asked to describe things that made skill implementation easier, the main facilitators given were relevance and ease of using the new skills. Here, staff were attributing their ability to use the new skills internally, enhancing their sense of self as a success, which may in turn promote further use of the skills. Indeed, the more the skills were used, the less often barriers were reported.

A second, but related explanation of these findings lies within Social Cognitive Theory (SCT) (Bandura, 1997). SCT states that barriers to action are multifaceted and combine cognitive, situational and structural aspects. Staff in this study reported a range of barriers to using Healthy Conversation Skills. In the context of this training, lack of belief in one's own ability might represent a cognitive barrier, lack of time a structural barrier, and lack of response from parents a situational barrier. Perceiving structural barriers, those that are practical in nature such as lack of time, may reflect a sense that using the skills requires effort in a situation where staff feel stretched and lack resources. Staff highlighted these structural barriers, which are external to the individual, and therefore create less damage to their self-image as a competent practitioner.

Exploration of the free text responses overall suggested that staff felt that some situations lent themselves to having healthy conversations, for example snack time during a group activity session. This contrasts with those who found it difficult to identify opportunities to initiate healthy conversations, and suggests that staff in similar jobs may view their roles differently – thus we could speculate that some prioritise working with families to support change whereas others see this as the responsibility of others. Furthermore, when staff perceived parents to be more receptive and relaxed, they felt more confident in having such conversations.

The issue of language barriers was raised by several staff members. Indeed, language barriers have been reported by other health professionals when communicating with clients (Gill, Beavan, Calvert, & Freemantle, 2011; Parker, Steyn, Levitt, & Lombard, 2011). This perception of not being able to hold a fluent conversation appears to prevent the implementation of new skills, and may reflect a lack of confidence in their abilities. On-going support could address this issue, and it may be a factor requiring attention when developing training. For example, newly-trained doctors reported using a range of strategies to compensate for a language barrier such as repeating information and changing their style of speaking (Jain & Krieger, 2011). That being said, parental engagement was not reported as the primary barrier either in the adapted PETS or in free text response. In other words, the parents are not perceived as the main barrier to implementing Healthy Conversation Skills.

Some staff had already seen the benefits of using Healthy Conversations Skills, which suggests that their implementation can provide immediate reinforcement of their effectiveness. This again is related to Bandura's (1997) notion that having a belief that one can use skills facilitates their use. Having staff who communicate better may therefore not only benefit the parent, but also the staff members themselves by providing them with positive reinforcement and enhanced self-efficacy (Wagner et al. 2002).

Conclusion

The main barrier to trainees using newly acquired communication skills seems to be a perception that they lack time. However, the main facilitator for staff using these skills was not that they perceived they had more time, as might be expected, but that they felt the skills were relevant to their work and easy to use. Our observations show that staff actually have both time and opportunity to use these skills (Lawrence et al, submitted). Therefore, ongoing support of staff needs to address their perceptions of time scarcity, so that they can begin to use the skills and hence increase their sense of self-efficacy. An increase in self-efficacy will, in turn, increase staff use of their new skills and reduce their perception of barriers. It is therefore essential to provide opportunities for staff in training to practise using new communication skills. Improving the communication skills of healthcare practitioners was a key recommendation of NICE public health guidance in supporting behaviour change (NICE, 2007). Our research suggests that practitioners need on-going support and opportunities to practise new skills if training in communication skills is not to be wasted effort. In our work, we will be providing on-going support by way of focus groups and interviews with staff. Using an inductive approach to analysing these data will further increase our understanding of the barriers and facilitators to embedding their new skills into everyday practice. With this understanding, we will be better placed to support staff in their efforts to have more effective conversations with families and ultimately enhance those families' ability to make important health behaviour changes.

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BOX 1**Healthy Conversations Skills Training Intervention**

Communication is enhanced through staff developing the skill of asking open-ended, or “open discovery”, questions: those that generally begin with “how” and “what”. Such healthy conversations allow an individual to explore an issue, identify barriers, and generate solutions that can be reviewed with staff at their next encounter. Training aims to increase self-efficacy and sense of control of both staff and their clients.

The five core skills focus on:

- identifying and creating opportunities to hold “healthy conversations”;
- the use of open-ended (open discovery) questions;
- reflecting on practice;
- listening rather than providing information;
- supporting goal setting through SMARTER planning (Specific, Measurable, Action-oriented, Realistic, Timed, Evaluated, Reviewed).

Healthy Conversations Skills training consists of three 3 hour group sessions over three to five weeks to allow time for practicing and reflecting on skills. Training is delivered by a team of researchers experienced in group work and behaviour change. This is followed by a period of on-going support, including a three hour follow-up workshop approximately three months after training. This workshop allows trainees to reflect on the training, how they have implemented their new skills and the barriers that got in the way of implementation.

What is known about this topic

- Improved communication skills of health and social care practitioners are associated with a range of positive outcomes.
- Communication skills can be improved through training.
- Trainees face a range of barriers and facilitators to implementing new skills.

What this paper adds

- The more a skill is used, the more confident trainees feel in its use.
- Qualitative data substantiated the quantitative data that trainees face a range of barriers to implementing their new skills, the most significant being a perceived lack of time.
- Barriers to using new skills are attributed externally to reduce threat to the ego, whereas facilitators tend to be attributed internally, to the trainee's level of skill for example.

Table 1
Job roles of staff who attended the Healthy Conversation Skills training

Job role	Number of staff trained	Follow-up workshop completed
Community development workers	19	12
Community health nurses	16	7
Play supervisors/play workers	68	59
Health promotion/oral health	11	9
Family support workers	24	9
Project workers/Admin	15	9
Total	153	105*

* Missing data on 4 individuals resulted in 101 being eligible to be used in the analysis

Table 2
The median score (with IQR) and standardised medians for each subscale of the adapted PETS (N = 101)

PETS Subscale (score range)	Median	IQR	Standardised median^I
Parental engagement (3-15)	6	(6, 7)	2
Relevance & difficulty (5-25)	10	(9, 12)	2
Practical issues (4-20)	9	(8, 11)	2.25

^I Standardised median takes account of the different ranges of scores per subscale so that each median is divided by the number of questions per subscale to provide a method of comparison.

Table 3
The frequency of Healthy Conversation Skills use (N=101)

Frequency of skill use	N	Percentage
Very often	12	11.9
Often	30	29.7
Sometimes	51	50.5
Rarely	8	7.9
Never	0	0