NHS
Health Education England

Better Training Better Care (BTBC)
Inspire Improvement Project Evaluation Report

This report is designed to capture your project in your own words. Each section should be completed in full, with appendices attached where necessary.

When completing the report, please adhere to the points below:

- Ensure that you complete each field provided.
- Ensure your answers are concise. Although there is no specific word count for each section, we are looking only for the relevant information to support wider adoption of your project. This report is intended to capture the fundamentals and the key outcomes of your project and should be succinct and easy to read, using plain English.
- Any toolkits, 'how to' guides or other resources that you feel are key to support the delivery of your project should be attached as appendices.

Title

Please insert the title of your pilot and if applicable, a strapline to sum up the project in one sentence e.g. Enhanced education in handover with supporting e-solution
Improving trainee skills and patient safety

Move Eat Treat – How to Deliver Effective Lifestyle Advice *Empowering clinicians to work with patients to improve their lifestyle.*

Introduction

The introduction should summarise the background to the project intervention, what it set out to achieve and why.

1. Background

1.1 Rationale and drivers

- What was the rationale for choosing the project?
- What was the situation before the project was initiated?
- What were the local drivers / contextual factors?
- What problems were you trying to solve by implementing the project?

Rationale, situation and problems:
This project was developed in response to the crisis of obesity and lifestyle-related chronic disease that the NHS is facing. 800,000 UK adults are currently morbidly obese and over half of adults will be obese by 2050. Additionally, the prevalence of lifestyle-driven disease such as Type II diabetes is soaring, with 5 million people projected to have the disease by 2025. Diabetes already accounts for 10% (more than £10bn) of the NHS budget. Despite this, medical education poorly equips doctors to deliver effective lifestyle advice to patients, despite its proven efficacy.
Both the Royal College of Physicians and Academy of Medical Royal Colleges have recently called for much more lifestyle advice teaching in medical curricula. This deficit is reflected in doctor’s practice – over half of patients have never been given any lifestyle advice by their GP.

Local Drivers:
There was a nucleus of motivated clinicians who were passionate about lifestyle advice in Oxford. This produced a ready-made project team.

2. Approach and engagement

2.1 Project development

- How was the project developed?
- What was the approach taken for delivering the training intervention(s)?
- Who was involved in its development and implementation?
- What were the aims and objectives of the project?

Aims and Objectives
• To equip all Foundation Trainees in the Oxford Deanery with the ability to deliver effective lifestyle advice.
• To evaluate and measure impact, and to disseminate these findings.
• To ensure sustainability in the Oxford Deanery.
• To disseminate widely via presentation and publication, and to catalyse national adoption through the development of an open access toolkit of teaching resources.
• To contribute to a change in perception to the role of health professionals in the modern NHS.

Who was involved?
- Edward Maile (Project Manager)
- Helen MacMullen (Team Member)
- Il Do (Team Member)
- Dr Helen Salisbury (Hon. Senior Lecturer in Communication Skill at Oxford University, and Sponsor)
- Anne Edwards (Foundation School Manager and Deanery Sponsor)

Project Development
The project team initially met and developed plans for a flexible teaching session which covered the basics of a healthy lifestyle, and how to deliver this advice in a meaningful manner to patients, using both brief interventions and longer, motivational interviewing techniques.
We then consulted two experts to receive their advice; one communication skills expert and one behavioural medicine expert, both based at Oxford University. We implemented their changes to the teaching session.
We then piloted the teaching session by delivering it to medical students, junior doctors and allied health professionals in May 2013. We collected extensive qualitative and quantitative data based on the pilot session and used this to further refine the teaching session.

Delivery Approach
The sessions was delivered by 'peer-tutors', ranging in seniority from medical student to registrar. We trained the peer-tutors at a one-day "Teaching the Teachers" event in January 2014.

The peer-tutors then delivered a teaching session which was structured as follows:

1) Overview of the components of a healthy lifestyle. Lecture with videos. Focussing on nutrition, exercise and sleep. (1 hour).
2) Communication techniques for behaviour change. Lecture with videos. Focussing on very brief interventions and health coaching. (1 hour).
3) Practice with simulated patients. Interactive. This part of the session uses patient actors with lifestyle-based scenarios so that learners can practice the skills which they have acquired during the previous lectures. (1 hour).

2.2 Engagement

- Who did you need to engage in the project – for example: trainees, trainers, consultants, patients, executive Board members?
- What was the level of lay and patient involvement?
- Did you get support from an academic partner to develop the evaluation and outcome measures?

Who did we need to engage?
The Deanery – successfully engaged Dr Anne Edwards, Foundation School Director.
Our home trust (Oxford University Hospitals) – Successfully engaged Dr Peter Sullivan, Director of Medical Education and Dr Andrew Woodhouse, Foundation Training Programme Director with responsibility for the Foundation Programme teaching curriculum.
Other Trusts in the Deanery – Successfully engaged the Foundation Training Programme Directors and administrative staff at these trusts.
Trainees – Successfully recruited junior doctors as tutors.

Lay and patient involvement
The simulated patients (who were both lay people and patients) were involved in developing some of the teaching scenarios and fed back on their experience of the teaching.
Overall, we will strive to formalise the role of lay and patient representatives in future work, as we believe that this is an essential to delivering projects which have a positive impact on patient care.

Support from an academic partner to develop the evaluation and outcome measures
We were supported by two academics at Oxford University. One of whom was a communication skills expert and one was an expert in behavioural medicine.

2.3 Project management and governance

- How was the project managed and implemented? i.e. what governance, project management structures and processes were put in place?

The project was led by Edward Maile. He worked with a small core project team composed of Helen MacMullen and William Do. Roles were delegated and together, the core team

worked to deliver the teaching.

Processes and Governance
We had a monthly meeting with Sonia Panchal from Health Education England. This meeting was supported by a monthly progress report which outlined progress, opportunities and threats. This report formed the basis of the discussion. We also formed a monthly action plan and submitted monthly financial statements to document the use of funds.

1. Resources

3.1 Funding

- What funding did you bid for as part of your application and how much were you awarded?
- What were the overall financial resources required to deliver your project? Please include the amount of trust funding required in addition to the BTBC funding if applicable
- What was the final budget amount at the end of your project? (Please include the detailed funding schedule as an appendix.)

Funding

- We bid for, and were awarded, £5,000.
- During our initial application we felt that we required £5,000. There was no Trustt funding.
- The final budget amount was a surplus of £3219. Please see funding schedule attached as an appendix. The principal reason for the under-spend was the realisation that teaching with simulated patients was difficult to include in the sessions at a number of Trusts because of time and space limitations (multiple additional rooms required to accommodate simulated patient scenarios). Therefore for a significant proportion of the teaching sessions we were unable to include simulated patients which reduced our costs dramatically.

3.2 Staffing

- What were the human resources required to deliver your project?

- Significant time was contributed by the core team members (Edward Maile, Helen MacMullen and William Do). This was unpaid. It is difficult to quantify this in hours but it probably amounted to 1-10 hours per week each over the life of the project.

3.3 Other key resources

- Did you require any IT equipment or other types of equipment / specialist input?
- Did you require any specialist medical devices or materials?

- No.

2. Achievements and outcomes

4.1 Overall achievements and critical success factors

- What have been your greatest achievements and why?
- What have been the critical success factors for enabling these achievements?

Greatest achievements:

- Training 20 medical students and doctors to be peer-tutors who delivered the teaching sessions.
- Delivering teaching to FY1's and FY2's at 4 of 5 Trusts in the Oxford Deanery.
- Achieving statistically significant improvements in knowledge and confidence about lifestyle advice delivery among the learners.
- Received excellent qualitative feedback about the teaching session from the participants.
- Disseminating these results at two national and one local conference, as well as via printed media.

Why?

These results demonstrated that our project had real impact, as follows:

- We gave 20 junior medics teacher training and concrete teaching experience, as well as a deep understanding of the subject.
- We significantly improved the knowledge and confidence of learners about lifestyle advice, which we hope will translate into positive changes in patient care.

Critical Success Factors

- Funding from HEE.
- Credibility through endorsement by HEE.
- Fantastic support, advice and opportunities from HEE relationship manager (Sonia Panchal and Renee Knopp).
- A great team in Oxford.
- Support from the Trusts, Deanery and Oxford University.
- Clear goals which we were all passionate about.

4.2 Delivered outcomes

What outcomes has the project delivered for the following:

- For trainees
- For trainers
- For patients
- Across the wider multidisciplinary team
- That provide value for money

Please provide headline key findings.

For trainees
- We gave 20 junior medics teacher training and concrete teaching experience, as well

as a deep understanding of the subject.
- Delivered teaching to FY1's and FY2's at 4 of 5 Trusts in the Oxford Deanery.
- Achieved statistically significant improvements in knowledge and confidence about lifestyle advice delivery among the learners, therefore equipping them with new skills which will improve the quality of care they can deliver to patients.

For trainers

- We delivered part of the Foundation Programme teaching curriculum which reduced the workload for the Foundation Training Programme Directors in those Trusts.
- I hope that our teaching was more innovative and interactive that normal foundation programme teaching, and therefore added additional value to the Foundation Programme teaching programme.
- In our capacity as trainers, the project team developed valuable time management, financial management and personnel management skills.

For patients

- Lifestyle-driven chronic disease is a huge source of suffering for patients and we hope that the trainees we taught will be more effective at working with patients to improve their lifestyles (stopping smoking, reducing ETOH, exercising etc.), which will significantly improve patient health and hopefully alleviate suffering.

Across the wider MDT

- Some members of the wider MDT attended the initial pilot sessions and received teaching.

That provide value for money

- Lifestyle-driven chronic disease has been described as healthcare's equivalent of climate change by the Department of Health's Director for Long Term Conditions.
- Diabetes already accounts for 10% (more than £10bn) of the NHS budget and this is set to worsen.
- Therefore, we believe that interventions such as ours, which have the potential to reduce the burden of chronic disease, are vital to the future financial viability of the NHS and therefore provide significant value for money.

3. Experienced challenges

List the challenges you experienced, why you experienced them and what steps you took to overcome them, or if not, why not? It is important to capture any challenges or issues that made an impact on progress - irrelevant of how small.

1) Effective engagement with the Foundation Training Programme Directors (FTPD) responsible for the Foundation Programme Teaching Programme at each trust.
This was problematic on a number of occasions during the project. The FTPD responsible for the overall delivery of the foundation programme teaching in the deanery was very supportive but was not reliable in terms of answering email. This made it difficult to achieve time-critical objectives. Additionally, I was unable to secure a teaching slot at one of the trusts in the deanery due to the FTPD in that trust not answering emails. To overcome this, I persevered by sending a number of emails, but after receiving no response I felt that it was not worth persevering.

2) **Unanticipated problems with room capacity and time availability for simulated patient teaching.**
It transpired that time and room capacity issues would make it difficult to include the simulated patient aspect of the teaching in every session. This was because additional rooms were required to run the simulation, which were not always available, and because the length of time available as part of the formal teaching programme was not always long enough.
We overcame this by being flexible and thinking creatively about how we could maximise the amount of information we could deliver with the time and space available.
This issue was not anticipated at the start of the project. In future, we will think through every possible scenario for the project at the beginning and make a contingency plan to deal with each possible issue.

4. Lessons learnt and recommendations

6.1 Lessons learnt

- Other than the above challenges, what have you learnt through your experience of designing and implementing the project?
- Were there additional benefits realised that were not originally identified at the start of the project? E.g. knock-on impacts to other members of staff who were originally not targeted; greater collaboration across teams; and/or a financial gain which was not originally in the plan.
- If you were to undertake a similar project, what would you do differently?

Lessons Learned

- Try to obtain support of the key enablers (in this case the FTPD's), in as meaningful a way as possible. During this project, I received verbal assurance from several key enablers that they fully supported the project, but when it came to requesting concrete actions from these enablers, they did not deliver.
  Thing to do differently: In future, I will therefore endeavour to be as clear and specific as possible about the support the project will require from key enablers, and obtain specific assurances that they will be able to deliver on each requirement. I also think that building a 'coalition' of key enablers is important, so that I have a "plan B" to go to in case I face difficulties with obtaining help and/or support from one person.

- Think through every possible scenario for the project at the beginning and make a contingency plan to deal with each. In this case, it transpired that time and room capacity issues would make it difficult to include the simulated patient aspect of the teaching in every session. This was not anticipated at the start of the project.
  Thing to do differently: Think through every possible scenario for the project at the beginning and make a contingency plan to deal with each.

Additional Benefits

1) Development of the project team's time management, financial management and personnel management skills.
2) Made new connections with other people interested in lifestyle advice teaching in the trust, which will hopefully result in long-term networks. For example, we started working with the Sports Medicine department at the Trust, who will now deliver the teaching project going forwards. In addition, we liaised with the clinical director of endocrinology and diabetes about delivering similar teaching to the Consultant and trainee body in that department.

6.2 Recommendations – project enablers

What recommendations can you provide to other NHS trusts who may want to adopt your project? Please think about the critical 'enablers' that need to be in place to ensure the success of the project.

Requirements for successful adoption:
1) Effective personnel. You must have a) a senior clinician who is willing to support the

teaching and who has influence over the teaching programme to ensure that time is made available for the teaching programme, and b) someone who is passionate, knowledgeable and driven to actually deliver the teaching themselves.

2) Money. A small amount of money would be beneficial for transport, printed hand-outs for the learners, refreshments and payment of the simulated patients where applicable.

3) Intellectual Resources. You must have the correct resources to be able to deliver the teaching. i.e. you require slides, hand-outs etc. We will make our slides and resources available via the Move Eat Treat website (www.moveeattreat.org), which anyone wishing to deliver similar teaching will be able to access for free.

7. Sustainability and adoptability

You should be able to use the information provided in your project closure report as a basis for completing this section.

- What plans are in place to continue the project within your trust – please include details of wider trust roll-out and/or spread to other specialties?
- How is the project being managed and by who?
- What are the governance arrangements in place?

• All three of the key drivers of the project (Dr Edward Maile, Dr Helen MacMullen and Dr William Do) have now left the Thames Valley, two of whom are abroad.
• We have recruited the **Sports Medicine Department at Oxford University Hospitals NHS Trust**, which is led by Dr Natasha Jones, to continue delivering the teaching in the Deanery and at Oxford University Hospitals.
• We have faced some difficulty in securing agreement to continue the teaching in Trusts in the Thames Valley. This is because the relevant people have not replied to email regarding the teaching.
• However, we have **agreement to continue the teaching at Oxford University Hospitals and Milton Keynes NHS Trust**. I am still waiting to hear from the remaining three Trusts.
• The project is currently being managed remotely by Edward, and he is liaising with Dr Natasha Jones to organise the teaching sessions for the 2014-5 academic year.
• Edward is still in touch and working with the other two key members of the project team, therefore project knowledge is not at risk.
• Now that the Better Training Better Care Inspire Improvement project has ended, we do not envisage there being formal governance arrangements in place with Health Education England going forwards.

8. Feedback and testimonials

- Please use this section to capture the feedback and testimonials you have received throughout the project (where consent is given). This will be used for the final case study to support the engagement with and adoption by other trusts. You may include this as an appendix, weave the comments throughout the report or insert them in this section. Please state the title of the person concerned.

- Please aim to include a good selection of quotes from trainers, trainees, other members of the MDT, the Medical or Education Director and CEO if possible.

I do not have access to the qualitative data we collected currently. However, I will have access to this over the next few days and can provide it as soon as I receive it. Thank you

Appendices

If you have developed any toolkits, 'how to' guides or other resources that you would like to share, please include these as an appendices to the report.

We are currently in the process of developing an education library for clinicians and patients which we will make freely available via www.moveeattreat.org. This will include the slides we used to deliver the teaching. This resource is still under development but I attach a copy of the plan (Appendix A).

I also attach a copy of the provisional evaluation data (Appendix B).