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Balancing Rights and Responsibilities programme evaluation

October 2022





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- informing, influencing and inspiring the direction of future practice and policy.

Written by Rebekah Luff

Contact: Rebekah.Luff@scie.org.uk

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Social Care Institute for Excellence
Isosceles Head Office
One, High Street. Egham TW20 9HJ

www.scie.org.uk

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Executive summary

This report was commissioned by Social Care Wales and presents key findings from an evaluation of 'Balancing Rights and Responsibilities: Supporting a Cultural Shift Integrated Health and Social Care programme' (referred to as BRR). This programme aimed to develop new skills and capability to rebalance reliance on risk- and problem-based approaches, with a view to developing and delivering person-centred care.

The programme included:

- Leadership group: a two-day course to ground the vision and principles.
- Health and social care staff involved in discharge: a two-day course with follow-up workshop, completed by 50 participants.
- Mentors: a further two days' training plus a follow-up day for those who felt that they could champion the approach. Twelve mentors/champions were developed.
- Leadership and mentors: a one-day event with the leadership group and mentors.

Three strands of evidence are drawn on:

1. The findings from two surveys completed by programme participants
2. Key messages from a mentors and leadership event held on 25th March 2022
3. Case studies demonstrating the application of learning when working with patients and colleagues.

What could embedding BRR achieve?

Mentors with at least six months of experience of BRR thought it could achieve the following:

- shorter hospital stays
- some repeat patients would not return to hospital/services so much
- identifying strengths including family and community to support discharge
- having essential conversations with patients and families earlier
- aligning why staff do that job to the reality of the role and improving morale
- more multidisciplinary teams (MDTs) taking decisions together
- more helpful referrals that ensure that conversations have been had with the person.

Key messages

- Following the training, almost all survey participants reported an increase in confidence in undertaking 'what matters' conversations, in representing the views of their patients and in defending patients' views.
- Confidence was essential to staff enacting learning from BRR, enabling them to centre the patient's wishes and introduce or mentor colleagues in BRR concepts.

- Nearly all participants reported an increase in skills in “listening to understand”, “listening reflectively”, “helping people understand their strengths” and “summarising outcomes and actions”, as well as an increased understanding of duty of care.
- Undertaking and supporting/encouraging other colleagues to undertake collaborative discussions was a key outcome.
- There is evidence that the programme has supported positive patient outcomes at least some of the time, for most respondents. Staff felt positive patient outcomes would happen more often if more people had the opportunity, or were encouraged to undertake BRR.
- There was significant evidence that staff completing BRR, and especially the mentors, were teaching and supporting their colleagues in the ethos and techniques.
- The feedback on the programme itself was very positive, with 25 out of 25 strongly recommending it to colleagues:
 - Attendees and mentors emphasised how helpful it would be for more colleagues and a wider set of teams to have the opportunity to complete the programme.
- Enablers to embedding BRR were identified as:
 - more training opportunities, including opportunities for more job groups
 - awareness raising to wider staff
 - commitment from “top to bottom”, including Welsh Government and managers
 - permission for staff to take time to train and embed the approach
 - an ethos of team, not only individual, responsibility
 - the role of mentors
 - paperwork/forms aligning to the training.
- Barriers and challenges include:
 - the complexity of cases, including people who lack capacity
 - responding when colleagues do not wish to engage in BRR ethos
 - families tending to look to medics as the lead in the team or positioning their voice ‘above’ that of the patient
 - staff may be ‘firefighting’ and/or experiencing compassion fatigue
 - auditing is not aligned to what matters to people/families
 - a blame culture (between teams, individuals or social services vs hospital)
 - decisions coming from a place of risk and problems rather than strengths.

Introduction and background

This report was commissioned by Social Care Wales and presents key findings from an evaluation of ‘Balancing Rights and Responsibilities: Supporting a Cultural Shift Integrated Health and Social Care programme’.

Context of the programme

A key finding of the ‘Why not home? Why not today’ report which reviewed complex discharge across Wales, was that the hospital length of stay was often lengthened by professionals’ risk aversion. That is, there was evidence of a ‘cwch culture’ in Wales, which can place greater emphasis on the risk appetite of the multidisciplinary team (MDT) than on that of the individual. The report was launched at the NHS Delivery Unit’s 2018 conference, at which the concept of a joint programme emerged to address this culture.

The joint programme that was subsequently developed was a hybrid of the ‘Collaborative Communications Skills’ (social care) and the Care Aims (health) training. Lead consultants are Rhoda Emlyn-Jones and Kate Malcomess.

This programme aimed to develop new skills and capability to rebalance reliance on risk and problem-based approaches with a view to developing and delivering person centred care. The programme was called ‘Balancing Rights and Responsibilities: Supporting a Cultural Shift Integrated Health and Social care programme’. This is referred to as BRR throughout the report)

Funding to develop and test the programme came from Social Care Wales and a partnership was established with NHS Delivery Unit, Aneurin Bevan health board (ABUHB) and the local authorities of the Greater Gwent region. It was agreed that the target audience for delivery would be those involved in hospital discharge in the Gwent region.

Programme aims

The aim of the programme was to:

- Support a shift in the relationship between the public and state from ‘what is the matter with you?’ to ‘what matters to you?’
- Support a strengths-based rather than deficit-based model; supporting individuals and families to manage their own lives.
- Empower those involved in hospital discharge to:
 - reduce, rather than seek to eliminate, risk
 - listen and appreciate the views of the individual
 - avoid over-prescription of care
 - gain confidence in negotiating care decisions.

Programme structure and delivery

Overarching leadership group: a two-day course to ground the vision and principles of the strategic work. This included heads of adult services, heads of therapies, head of patient discharge, deputy medical director, and a consultant. Eighteen leaders attended in total.

Health and social care staff involved in discharge: a two-day course with chosen area teams, plus a follow-up workshop with each team. Fifty participants attended the team training. Participants included social workers, discharge assistants, therapists, community ward managers and a small number of nursing staff.

Mentors: A further two days' training, plus a follow-up day for those who attended the team training but felt that they would be in a position to champion the approach within their respective teams and services. Twelve mentors/champions were developed. This group continues to be supported as part of the programme, with the aim that this will lead to a joint health and social care self-facilitated group in the longer term.

Leadership and mentors: A one-day event with the leadership group and mentors.

Aims of the evaluation

SCIE were commissioned to undertake an independent evaluation of the programme. There are three areas that the evaluation looks at:

1. The extent to which trainees have been able to implement learning
2. Evidence of changes in the practice and culture of trainees
3. An understanding of the impact the mentor role has had (on mentors and more widely).

COVID-19 context

Delivery of the programme started in March 2020, just as the COVID-19 pandemic started within the UK. The final session with leadership and mentors was held in March 2022. It is therefore noted that this programme was significantly impacted by COVID in its delivery, and the implementation of learning.

The evaluation started in July 2021 and during the autumn to winter of 2021/22 hospitals were on red and black alert. The evaluation was paused and redesigned and it is highly likely that survey participation numbers were lower due to the pressures on the system and on staff, as has been the case across other projects involving front-line staff.

Evidence

Three strands of evidence are drawn on:

1. The findings from two surveys completed by programme participants.
2. Key messages from a mentors and leadership event held on 25 March 2022
3. Case studies demonstrating the application of learning when working with patients and colleagues.

Surveys

Everyone who had attended the Balancing Rights and Responsibilities (BRR) programme was asked to participate in both of the surveys. Invitations were sent via email with an embedded link to the online survey.

Table 1 explains how many people part in each survey. There were 28 survey responses included in the analysis for survey 1 and seven included for survey 2. For more information about the job roles and experience of those who took part, please see Appendix 1.

Table 1: Survey dates and participation numbers

Survey	Survey 1	Survey 2
Fielded	5 August – 2 November 2021	28 February – 27 April 2022
Total participants	31	8
Fully completed	18	6
Partial – included	10	1
Partial – excluded	3	1
Total included in analysis	28	7

Survey topics

All topics were included in survey 1, with those marked with an asterisk (*) included in survey 2.

- Confidence in undertaking ‘what matters’ conversations*
- Confidence in communicating the needs of patients to colleagues*
- Confidence in defending patient’s views and/or choices
- Skills development as a result of training
- Duty of care
- Collaborative discussions*
- Support to ‘do the right thing’ for patients*
- Contribution to positive outcomes
- Relationships with team and colleagues*

- Feedback on the training*
 - Collaborative working
 - Value of training across health and social care groups
 - Positive patient outcomes
 - Reflecting on practice and challenging views
- Suggestions to improve the training

Case studies

Three case studies were collected from mentors. The first is that of Mr A, a patient whose discharge home was supported by social workers who utilised learning from BRR, and were able to meet the wishes of Mr A despite concerns of the family and other colleagues.

The second is from the physiotherapy team, three of whom had attended BRR. Faced with barriers in facilitating wider learning in their team, they created and ran a half day training session based on the full programme, focussing on reflective listening, 'what matters' conversations and strengths-based discussions. This has now been run twice for physiotherapy colleagues. 'What matters' conversations refer to a targeted conversation relating to any assessment process. It refers to a skilled way of working with individuals to establish the situation, their current well-being, what can be done to support them and what can be done to promote their well-being and resilience for the better.

The third is an example of how physiotherapists who had attended the half-day training applied this learning to a difficult conversation, using reflective listening.

Each case study is set out in full in the appendix, and excerpts and summaries of the case studies are drawn on throughout the report.

Leaders and mentors' event held on 25 March 2022

As part of the programme a final one-day event was held in Cardiff to facilitate dialogue and learning between the programme mentors and senior leaders in relation to BRR. This event was preceded by a half-day online workshop for mentors held earlier in the month, in which mentors discussed case studies and considered key messages to share with leaders.

The day included presentations, group discussion and activities, and wider discussion on:

- what leadership had noticed in terms of messages and all system change
- key findings from the first survey
- learning from the workforce in terms of their hopes, what they are pleased about, barriers and enablers to applying their learning and what would make a difference going forward
- how to sustain and enhance the change in culture
- co-producing ways to embed, influence, change systems, ensure 'line of sight' and a clear mandate to proceed.

Notes were taken from the mentors; workshop and the main event, including presentations and table discussions. Summaries and key messages are used throughout this evaluation.

Findings

This section starts by outlining what mentors highlighted the programme could, and to some extent already had, achieved. The following sections then draw on the surveys, case studies and event/workshop to describe the impact of the programme in two areas:

- **the impact of the programme on attendees** – this includes the change in confidence, skills development and collaborative discussions
- **the impact on services** – this includes the impact on patient outcomes and on teams/colleagues

The team and organisational environment is then considered, focusing on how supported staff feel to act in the best interests of their patients.

Feedback on the programme itself is then provided, including how helpful attendees thought it would be for more of their colleagues to complete the programme in future.

The findings end with a summary as to how embedding BRR could be supported, as well as some of the barriers, including those experienced during the pandemic.

What could embedding BRR achieve?

Mentors that had completed the programme, and with at least six months to embed the learning, set out some of the key changes they thought could be achieved using BRR:

- shorter hospital stays
- some patients would not return to hospital/services as much – reducing, for example ambulance use
- identifying strengths, including family and community, to support discharge
- having essential conversations with patients and families earlier
- aligning why staff do that job to the reality of the role
- improve morale by celebrating success
- more MDTs taking decisions together
- more helpful referrals that ensure that conversations have been had with the person (and family) by the referrer, and that important information is passed on to the right team.

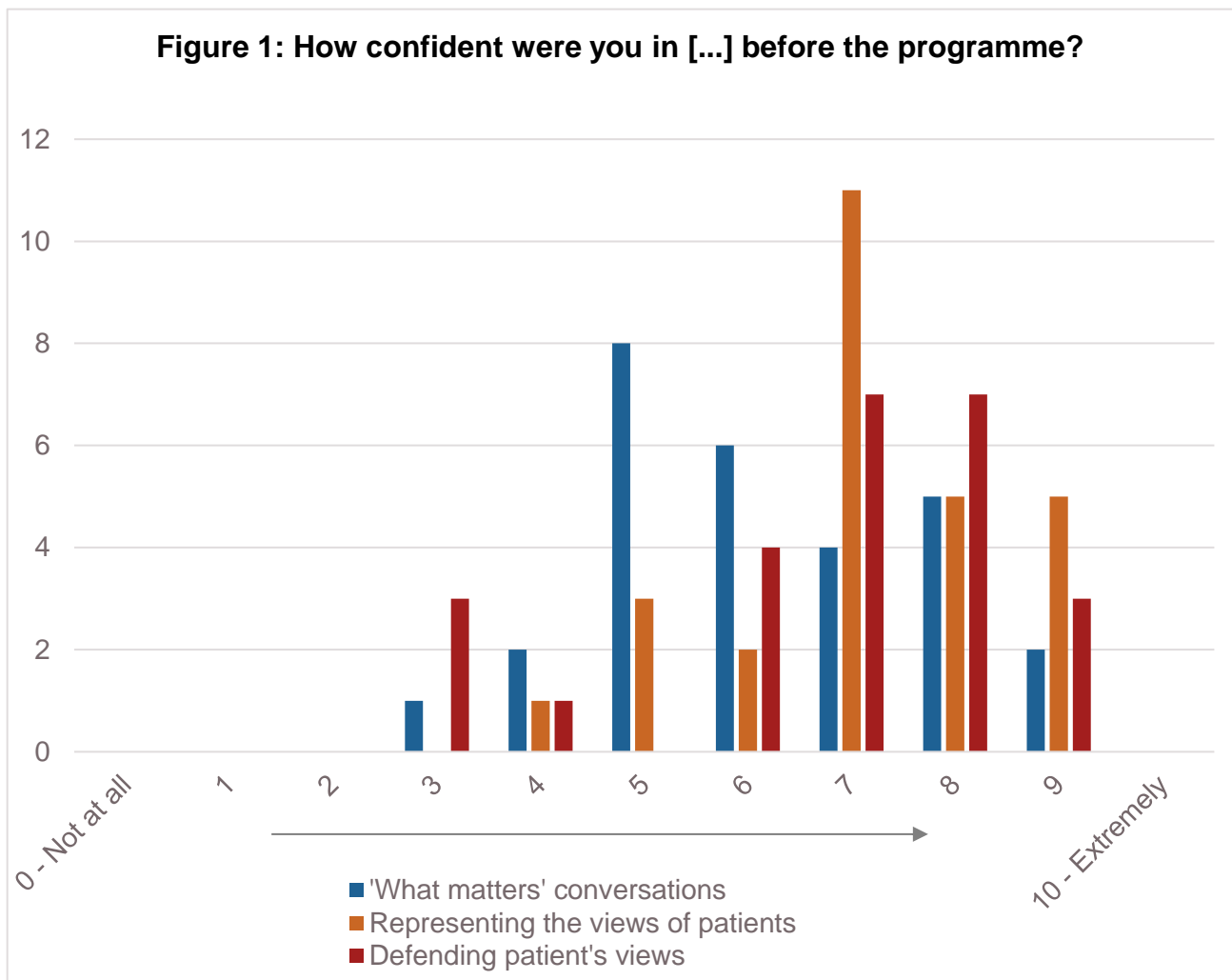
Mentors described examples of these changes that have already been happening since the programme. However, the relatively small number of staff that had completed the programme were not in a position to make it happen consistently, across all services.

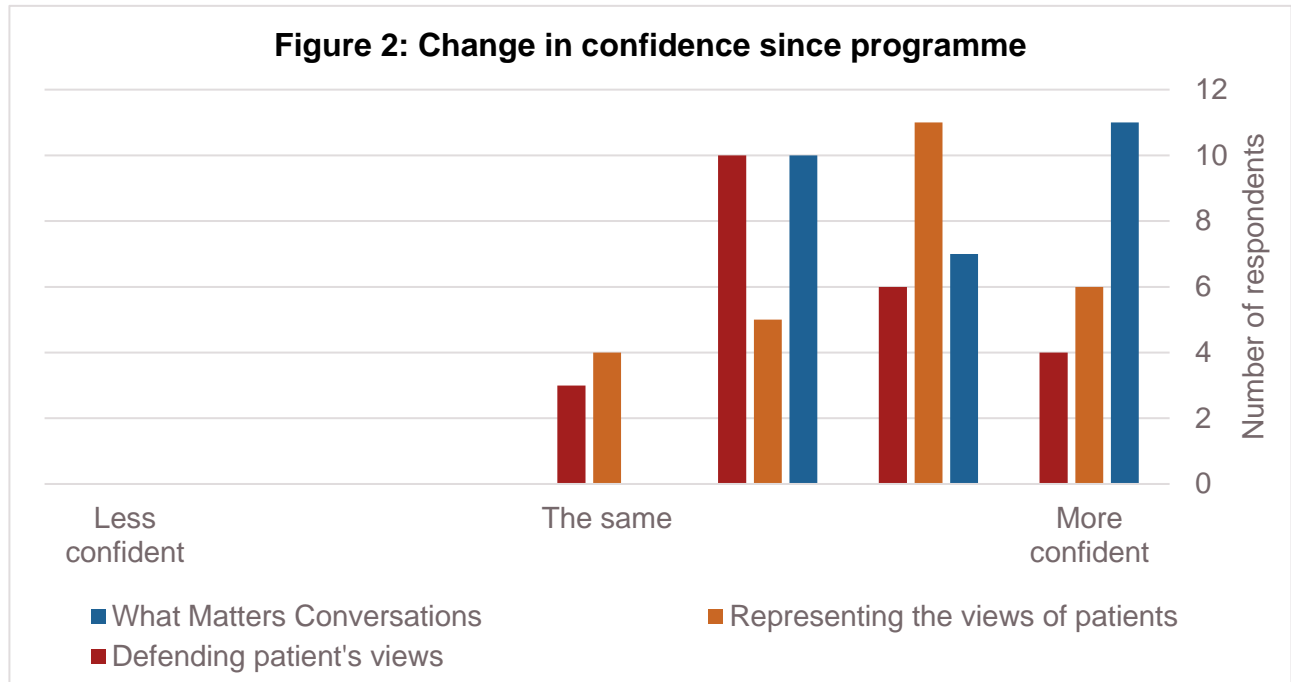
Impact of the programme on attendees

Increased confidence

Increased confidence was one of the most important outcomes of the programme. In this section, the survey and qualitative data outlining both the increase in confidence and what impact that confidence makes to staff and patients is set out.

Survey 1 participants were asked about their confidence in undertaking 'what matters' conversations, in representing the views of their patients and in defending patients' views before and following the training. Confidence before the programme was mixed (Figure 1), but nearly all 28 of the participants reported increased confidence in all three areas (Figure 2). Increased confidence in 'what matters' conversations was particularly high.





In the second survey, participants were asked about change of confidence in ‘what matters’ conversations and in representing the view of patients. Though the numbers are small, four out of seven reported being much more confident in ‘what matters’ conversations and three out of five were much more confident in representing the views of patients.

Why did attendees feel more confident?

In the first survey, respondents were prompted to describe in what way they felt more confident.

‘What matters’ conversations

Attendees felt better prepared when undertaking conversations with patients and in having a more holistic approach. Some respondents expressed they benefited from knowing how to “ask the right questions to guide conversations and utilise reflective listening”, making conversations “more about the patient”, whilst giving opportunities for staff to reflect on their own practices.

One respondent commented that the “discussion about conversation traps and how we sometimes default to interview mode resonated with me hugely”.

Some respondents highlighted that patients are not always receptive to the conversations and some found communication difficulties or lack of interest to be a barrier:

Representing the views of patients/clients to colleagues

The group felt more confident following the programme, highlighting different ‘tools’ they found particularly helpful. For example, one found “reflection in our groups to view patients/colleagues wishes and respect opinions and beliefs” useful and another benefited from “the personal statement summary”.

For some, the programme confirmed what they felt they already knew:

“...The training confirmed why we do this and the importance of advocating for the patient. The training also confirmed...that wider MDT colleagues do not have the same approach.”

This concern around others not having the same approach was echoed by other participants, including one feeling “more confident that if this training is more widely adopted then there should be other staff who are more open to listening to this information.”

A number of participants were concerned that hospital systems were the main barrier to enabling training to be put into practice at work:

“I feel that the patients’ wishes will not be always considered due to the nature of the hospital setting and the push for discharge.”

“...There is such a blame culture that often installs fear in different professions in health and social care that we want to simply pass things on, but shared responsibility and being confident to say when we are not the right professional for what is required saves wasted time and duplication for the individuals at the heart of the conversations.”

Defending patients’ views and/or choices

Each of the four people who reported they previously lacked confidence, reported increased confidence after the programme. Participants reported that the programme helped them to understand the patient, focus on the patient and/or understand the patient’s feelings.

It was felt to be particularly helpful that professionals from health and social care were together on the programme. Participants appreciated the opportunity to discuss different situations and talk about risk with colleagues from different job groups.

“I feel as an experienced nurse, I have always been able to advocate for my patients, however, I feel nursing as a body of professionals can be very risk averse. The training days were very helpful... it gave me the opportunity to meet and discuss issues with our social services colleagues and I learnt that social services are far less risk averse, and are used to dealing with very challenging problems and supporting clients through challenges, and allowing them to remain as independent as possible whilst keeping them in their own homes.”

Some participants still felt that there would still be barriers to fulfilling patients’ wishes due to the system and pressures of discharge:

“While I feel confident and able to clearly write up and discuss the views/wishes of the patient, enabling the MDT to understand what the patient has identified is important to them, I feel that the patients’ wishes will not be always considered due to the nature of the hospital setting and the push for discharge.”

What could further increase confidence?

In the second survey, attendees were asked if there was anything in relation to the training or their workplace that would further increase their confidence in undertaking ‘what matters’

conversations. Having more time and opportunity to practice “so it becomes the norm” was highlighted, as well as the impact of the pandemic which limited opportunities for some staff.

Things which were already helping included “trying things out with health colleagues who are less familiar with the approach”, indicating that an openness from other colleagues who have not had the training helps; having the opportunity to try the approaches out further built confidence.

In addition, participants felt able to raise expectations more widely, by “[challenging] practitioners to ensure they have had and evidenced the ‘what matters’ question and to support staff to work in this way”. In this way, participants helped align discharge and/or referral paperwork with the importance of ‘what matters’ conversations, placing them at the centre of decisions made about individuals.

Attendees were asked if there was anything in relation to the training or their workplace that would further increase their confidence in clearly representing the views of your patients/clients. Again, time was highlighted as a barrier.

The main enabler was other colleagues, especially managers and MDTs, also embracing the approach and supporting these conversations.

Why is confidence important and what wider impact does that have?

Confidence was not only something that attendees felt, but central to them enacting on their training in their everyday work. Attendees described:

- **confidence to make suggestions and put forward a BRR approach with colleagues and patients.** As highlighted in the survey findings, barriers to undertaking ‘what matters’ conversations can include public perceptions, or the patient not being interested. Barriers to advocating for patients were mainly about other staff or teams not consistently working in a BRR way.
- **confidence to keep going with the approach when that is hard or feels more time consuming** at the start.
- **confidence to introduce and ‘mentor’ junior colleagues and newer staff** in BRR concepts as well as the training and materials to do so.
- **confidence to centre the patient’s wishes when others disagree.** A theme at the Mentors and Leaders’ event was that in order for staff to effect change, confidence and the self-belief that this is the correct approach is essential. Without it, they cannot hold firm when colleagues or ‘the system’ takes an approach that does not centre the patient.

Focusing on the final point, several comments were made that the programme gave them the confidence to explain different approaches to colleagues and to stand more firmly with what they felt was right for that person. Teams with more staff that had completed the programme were able to support each other, but others stood alone and so had to draw on their own resources.

The case study of Mr A (Appendix 2) is an example of this. Staff presented the case study at the event and reflected that undertaking the programme provided the confidence to stay firm in following the wishes of Mr A, despite disagreement from family and some colleagues.

Example from case study 1: Mr A – centring the patient’s wishes

While in hospital, Mr A repeatedly said that the only thing that mattered to him was going to back home to his recliner armchair and was aware of the risks. He was discharged home, though his family and an occupational therapist (OT) were unhappy with the decision. The first few days of discharge caused concern as he did not move from his chair. The worker advocated that it was Mr A’s decision, and with further conversation he did then accept a package of care.

“I have been a social worker for about 12 years and whilst working with Mr A was not difficult, managing the anxieties of those around him certainly was. When I first saw him at home looking so frail, I was initially worried that I’d completely misjudged the whole situation. But as soon as Mr A spoke to me I was completely satisfied that I had done the right thing. Being shouted at in the kitchen [by family] that morning wasn’t pleasant but at no point did I find myself moving away from what Mr A wanted from us all. I am sometimes asked what gave me the strength and confidence to keep going with Mr A’s plan and I always answer that it was Mr A himself. Mr A was so specific with his wishes that advocating for him was the easy bit. We simply had to go at his pace and only step in when he told us we could.”

Skills development

The development of skills enabled staff to use BRR in their work with patients and colleagues and the development of these skills increased their confidence.

In survey 1, the majority confirmed that the programme did help them to develop in all four skill areas and there was a 100% positive response for ‘helping people understand their strengths’ and ‘listening reflectively’.

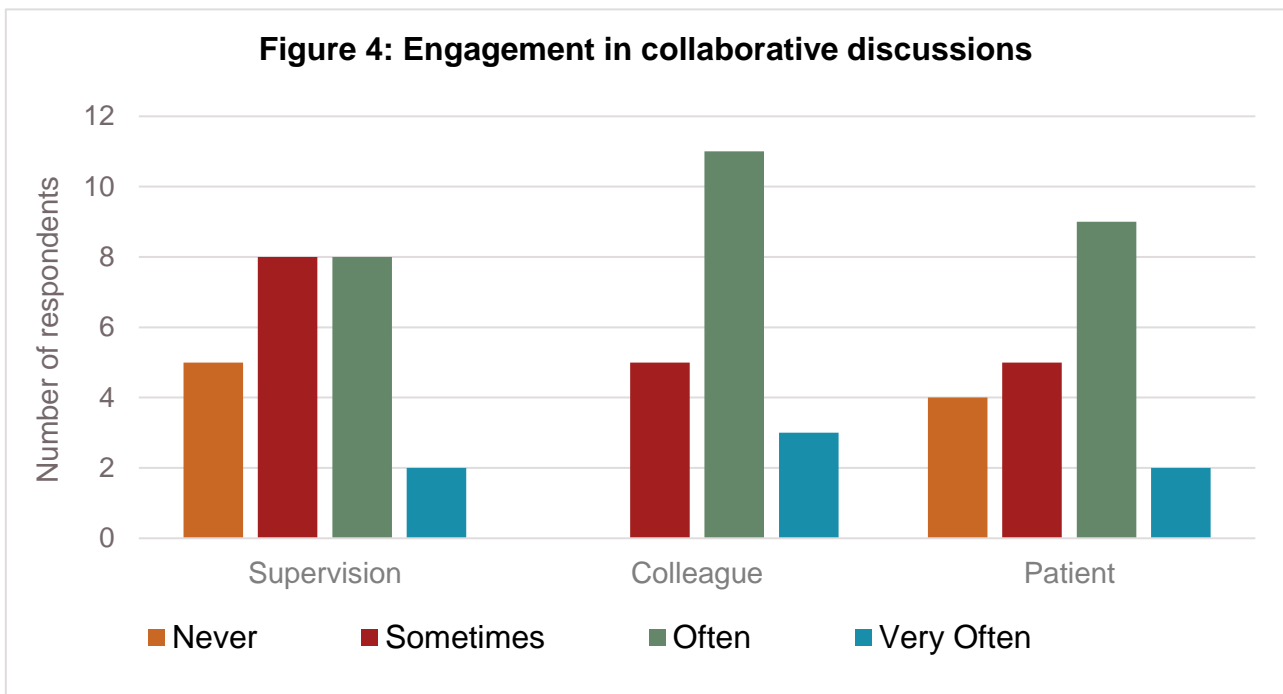


Duty of care

When asked if the “training had improved your understanding of how Duty of Care supports your approach in using these skills”, 25 respondents indicated that it had, with two not responding and one respondent indicating the training hadn’t improved their understanding.

Collaborative discussions

In survey 1, participants were asked how often they engage in collaborative discussions during supervision, with colleagues, and with patients. 26 people responded in total; 23 responses were recorded as having collaborative discussions with supervisors, 19 with colleagues, and 20 with patients (see Figure 4). It is noticeable that collaborative discussions took place with colleagues more often than with patients or during supervision.



Respondents were asked to type in if there was anyone else they had collaborative discussions with. Their responses included: ward staff, support staff, hospital discharge assistants, other LA and health colleagues, senior managers, student social worker(s), families of clients and occupational therapists.

What would help support staff in having collaborative discussions?

In survey 2, participants were asked what would help support them in having more collaborative conversations. All three responses to this question referred to wider embedding and culture change across the organisation.

“Understanding from all about the approach as I feel the nurses and newly qualified staff members should be more familiar with the approach to **help instil the culture change** across health.”

“We are embedding these conversations into every part of our internal system – the buy-in from other parts of the whole system would be great – **it is difficult being a**

lone voice in a large arena. It is when we have successes individuals notice, but culturally there is a massive shift required.”

Importance and impact of collaborative discussions

At the event, the usefulness of collaborative discussions was highlighted, particularly as a way that mentors/managers, teams and MDTs could discuss and work together on complex cases.

Case study 3 is an example of where the programme supported the use of collaborative discussions. The person had undertaken the half-day training led by mentors in the physiotherapy team (see case study 2 for information about the half-day training) and was additionally supported by a mentor to respond to a distressed family member. The family member was upset that the patient’s physiotherapy assessment had included climbing stairs. Taking time and using a reflective approach to the discussion helped reassure the family, enabled the family and the physiotherapy team to work in the same direction, and very likely prevented a complaint.

This example further demonstrates the important role of mentors in embedding BRR and supporting colleagues to translate the learning into practice.

Example from case study 3: The importance of reflective listening

The therapist listened and provided reflective feedback including "it sounds like you've had a tough couple of years" and "I can hear from what you're telling me that you care deeply about your Mum", "I can understand that you see being in hospital as a risk to mum" and "it sounds like you are very frustrated by the situation today and worried about Mum". She then asked if it would help to understand how and why the therapists undertook the stair assessment to which the family agree.

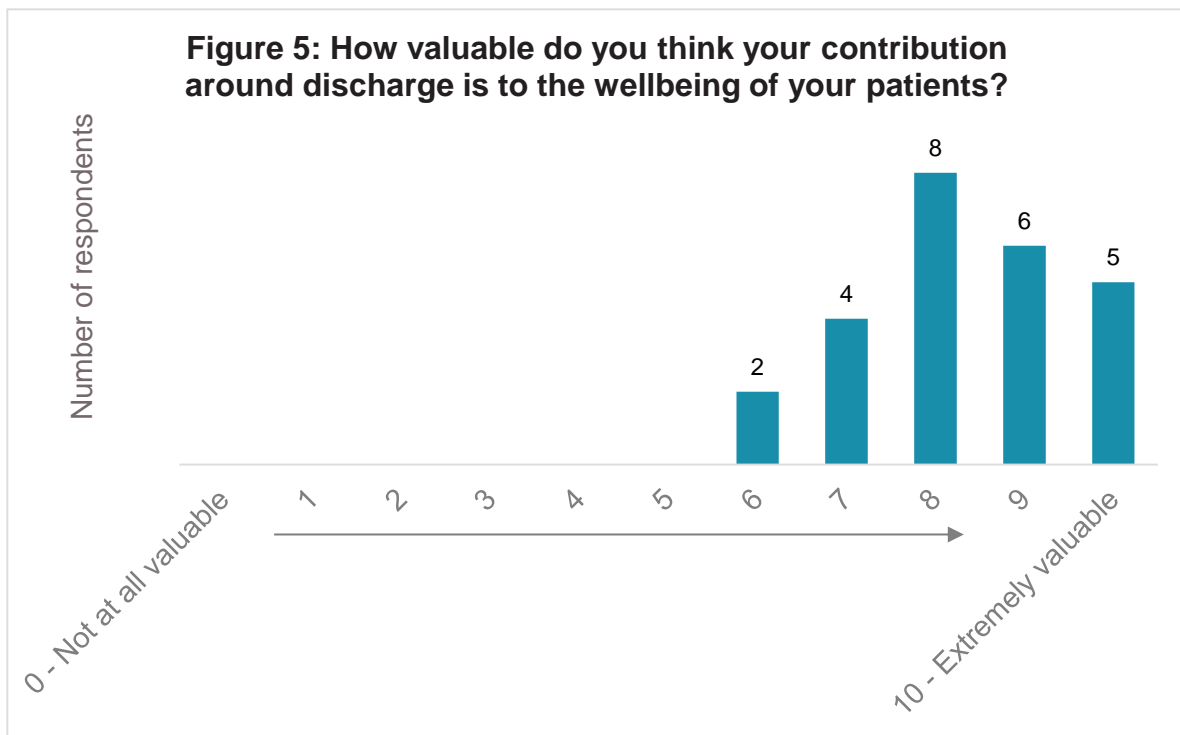
...The family understood the rationale and calmed, the therapist asked what they would like to be the outcome of this discussion and if they would like information regarding how to make a complaint. The family reported feeling much less angry about the situation and feeling that they had been listened to and reassured, they did not want 'putting things right' information.

Impact on services

Two important areas of impact were considered: impact on patient outcomes and impact on colleagues.

Contribution to patient outcomes

In survey 1, participants were asked, “How valuable do you think that your contribution around discharge is to the wellbeing of your patients?” with 25 participants responding. All felt their contribution was valuable, with an average response score of 8 (see Figure 5).



Impact of training on contribution to patient outcomes

A similar question was asked in survey 2, but focusing more on how the programme supported this positive impact: “Do you think your way of working since the training has had a positive impact on discharge outcomes for patients/clients?” Of the seven responses, three felt it was about the same, two felt it was a more positive outcome some of the time, and two that it was more positive most of the time.

Participants went on to say more about their own and/or their team’s impact since the training. This included:

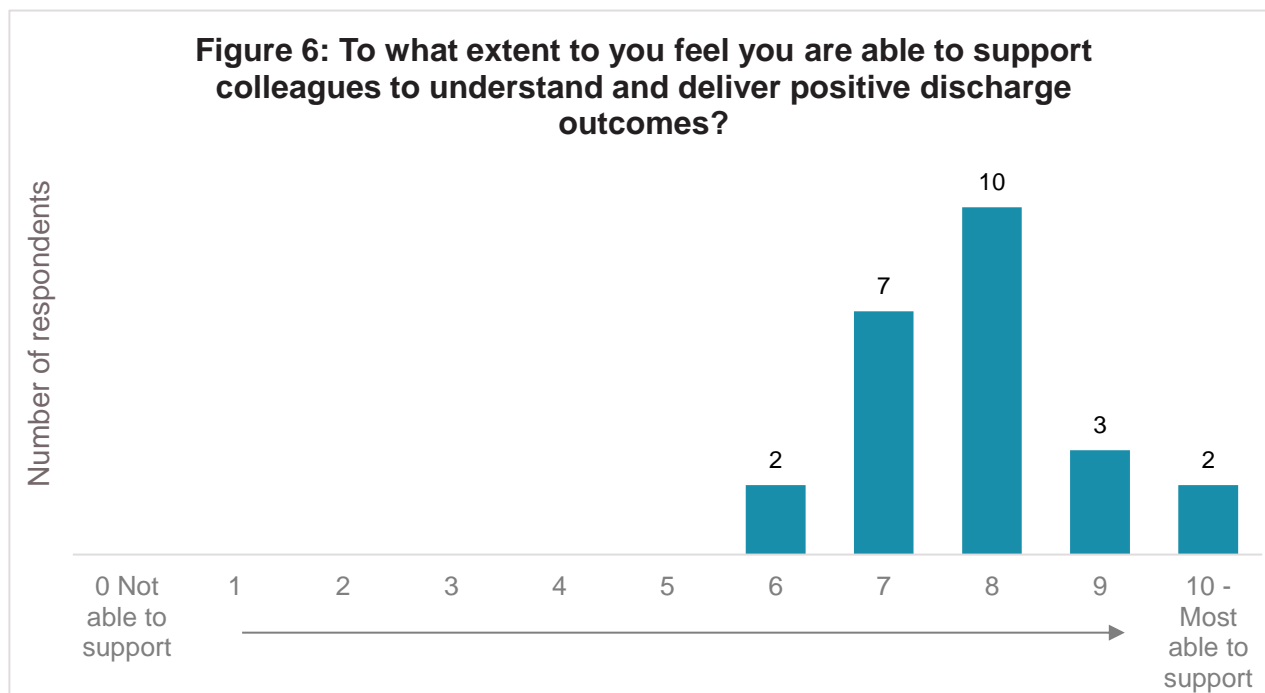
- more members of the team undertaking the training (in later sessions); by more members of the team completing training, the team as a whole took a more consistently BRR approach to discharge
- conversations and questions being ‘less deficit-led’
- the programme reinforcing positive practice by teams and keeping momentum going to continue to improve
- some feeling they could readily apply the training in their day-to-day practice.

One participant captured the change in approach to patients:

“I am totally convinced patients are being listened to; very often they are able to find their own solutions and with support they have their outcomes achieved, which is usually to go home to their own homes. We are concentrating on getting people home (if that is what they want) and then looking at risks and what we need to put in place to ensure [being at] home can be safely achieved.”

Supporting colleagues with changes to their practice

In survey 1, participants were asked, 'To what extent to you feel you are able to support colleagues to understand and deliver positive discharge outcomes?' with 24 responses. All responded that they were able to support colleagues, though this was to a lesser extent for nine participants (7 or lower). (See Figure 6.)



Examples of positive outcomes and of sharing learning with other staff

A strong outcome across all data types was that of staff who had completed the programme feeling empowered and more confident to share that learning and different ways of approaching decision making and discharge with colleagues. Specifically, part of the role and value of mentors was considered to be:

- sharing learning/training
- prompting and supporting junior staff – for example to have a reflective conversation or to ask for more information.

An example from the event was a mentor overhearing a more junior member of staff on the phone, potentially accepting a referral when it was not clear that an appropriate conversation (ideally a 'what matters' conversation) had occurred with the patient, and so the referral may not be appropriate. The mentor was able to support their colleague in ensuring this information was available. The mentor was undertaking wider work on ensuring team documentation aligned with BRR so a requirement for a 'what matters' conversation would be inbuilt as a part of the referral process.

An exceptional example is detailed in case study 2, which outlines the work of mentors in a physiotherapy team who have led half a day of training on key aspects of BRR for their colleagues. This has been run twice.

Example from case study 2: Cascading BRR within the physiotherapy service

Following the BRR training two managers had tried to facilitate team sessions focused on reflective listening by discussing patient case studies. They found staff struggled without having more of the wider BRR context though.

“Determined to share the BRR philosophy within their service, the team agreed an objective during the mentoring training to look at and develop a means of cascading the programme to a wider group within physiotherapy... It was decided that the physiotherapy training session would therefore provide an overview and aim to stimulate discussion and reflection.

The skills used and honed as part of the training are not just relevant to clinical practice. It is noteworthy that reflective listening, ‘what matters’ conversations and strengths-based discussions are important with staff or service users and have been effectively used.”

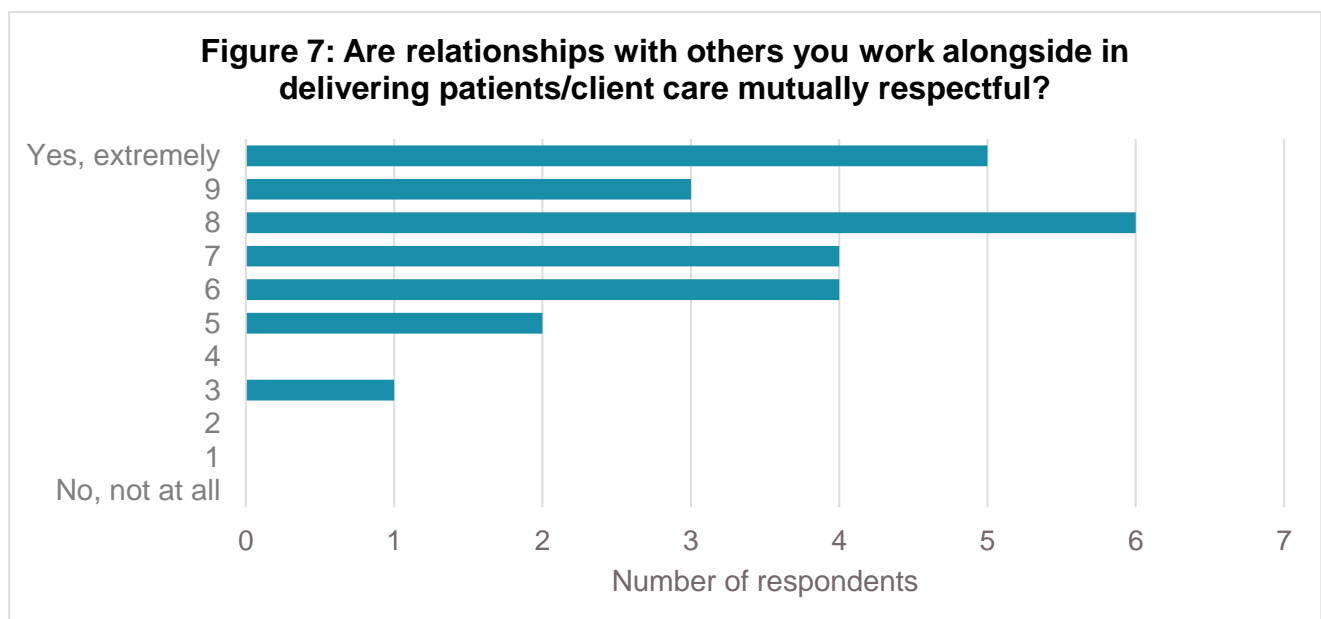
Team and organisational environment

It is recognised that organisational structures and relationships with colleagues play a significant role in how people who participate in the BRR programme can apply their knowledge and skills. This section looks at the relationships between staff and how well they feel supported to do what is right for their patients.

Relationships with team and colleagues

In survey 1, participants were asked to think about their professional relationship with those they work alongside as part of delivering patient/client care and support. In doing so, they had to rate to what extent they would describe these relationships as mutually respectful. In total 25 people responded to this question.

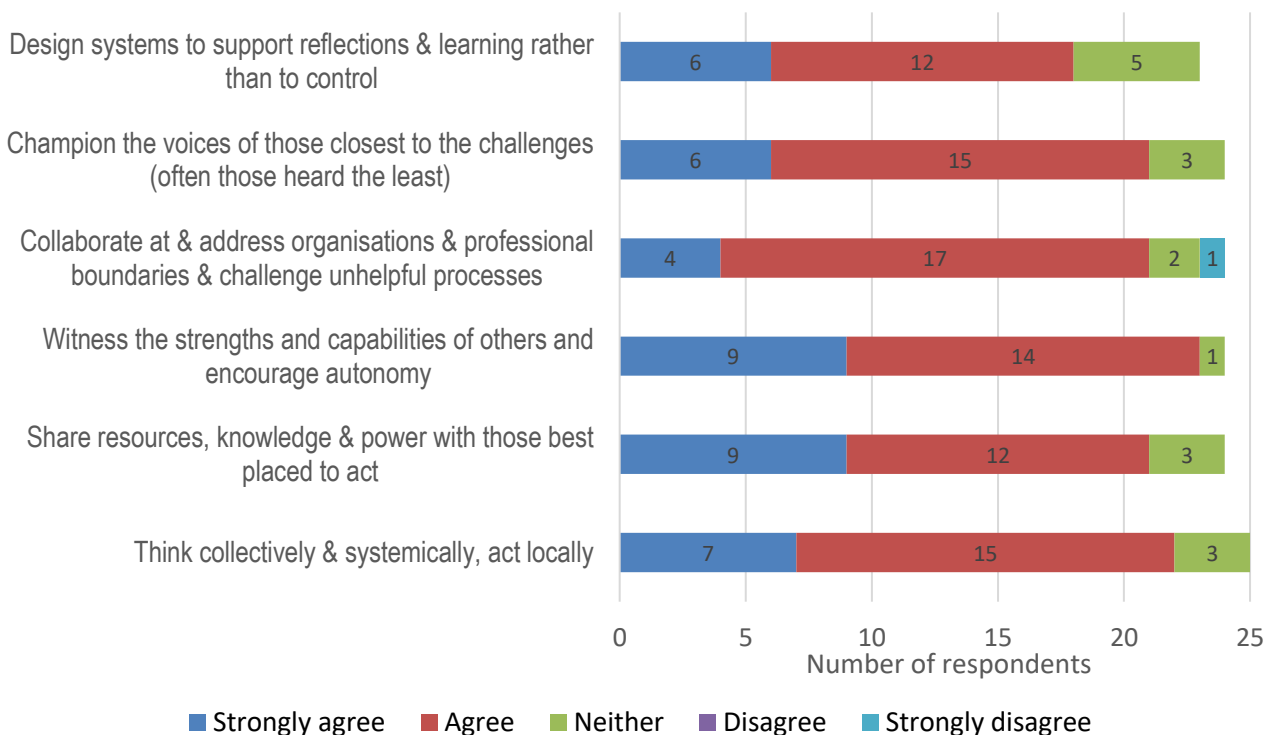
The findings are quite variable, with one participant not finding relationships mutually respectful and two others selecting the middle point of the scale. See Figure 7.



At the leadership and mentors' event it was highlighted that team relationships were essential in order to hold meaningful collaborative conversations and to work together to positively enact BRR and increase patient outcomes. Collaborative conversations cannot be entirely one-sided. At the same time, the components of BRR were seen as helpful tools to improving some relationships – providing a structure for difficult conversations and the confidence to engage colleagues in a different way of approaching an issue.

Looking in further detail at how teams worked together, again there is variation as described in Figure 8. While much of it was positive, some teams do not currently work in a way that aligns with BRR, or that would be more likely to embed BRR principles. The event highlighted that there was not a 'one size fits all' approach to improving team communication and decision making, but that the programme had been helpful in being able to find out about other teams, and the different approaches and priorities.

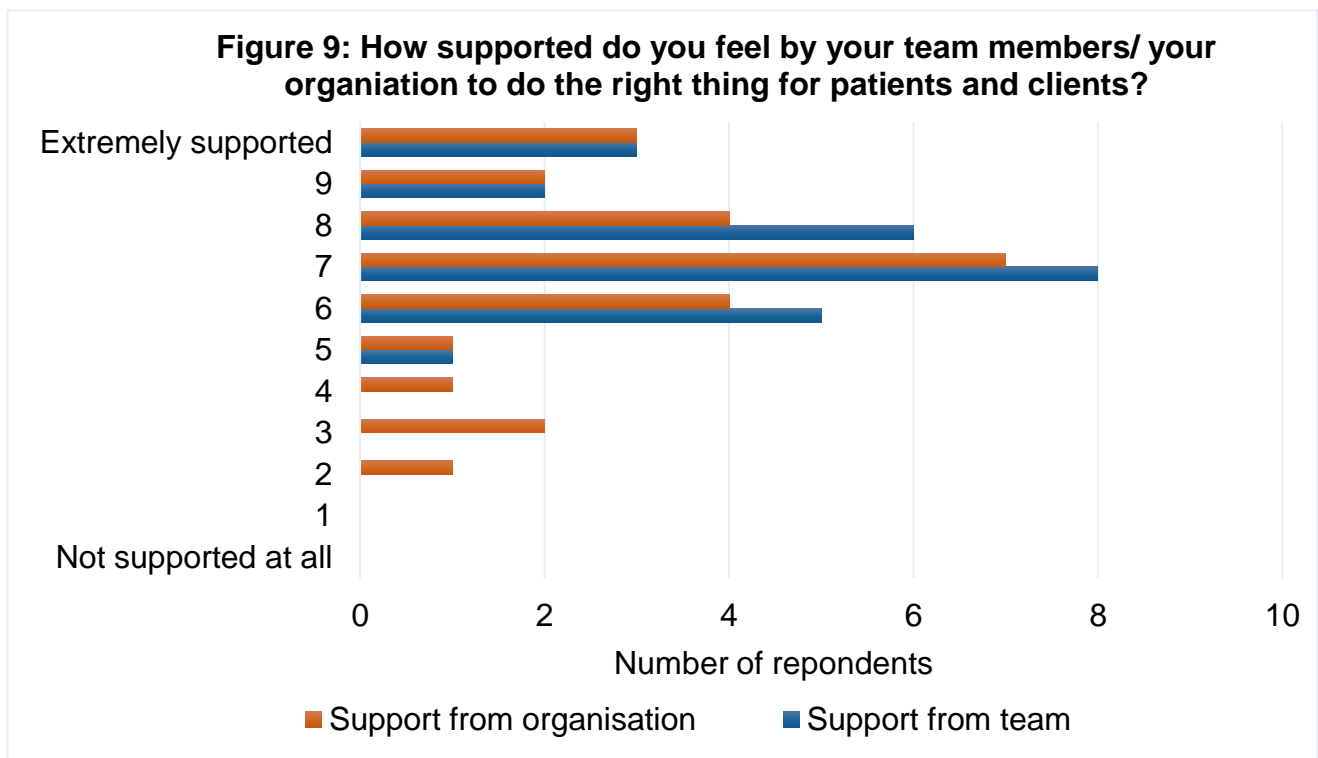
Figure 8: To what extent do you agree or disagree with the following statements: "In my team we..."



Support to 'do the right thing' for patients

Respondents were asked 'How supported do you feel by your **team members** to do the right things for patients and clients?' (Figure 9). Twenty-five participants responded, 24 of whom felt support, and 11 of those a high level of support (8 or higher).

Participants were then asked, 'How supported do you feel by your **organisation** to do the right thing for patients and clients?', with 25 participants responding. Responses were more mixed, although the majority (20 out of 24) did feel supported.



Feedback on the training

Survey 2 participants gave some feedback on the training itself. When asked how helpful they thought the training would be in their day-to-day job, 25 responded, with 20 scoring towards 'extremely valuable' (8 or above). Three felt it was a little valuable, and two that it was either not very valuable or neither (scores of 4 and 5).

When asked if they would recommend the training to a "colleague in your team", of the 25 people that responded, 23 would strongly recommend the training (8 or above) with only one indicating they would neither recommend or not recommend it.

The value of the programme to colleagues

Many mentors as well as other survey participants argued that BRR would be of value to colleagues, both within their own teams and across other teams and roles.

"I feel strongly that this training needs to be rolled out to other MDT members, especially medical staff/doctors who have a medical model approach. Our nursing colleagues would greatly benefit from this training, as therapists I feel like we already apply this." Survey 2 participant

At the leadership and mentors' event, several staff groups that were felt to be missing from the training were:

- nurses – they have a key role in having conversations and in sharing information
- care assistants/nursing assistants

- ward/nursing managers
- clinicians – though there were questions as to how to get them on board.

Embedding BRR

The leadership and mentor event in particular considered how BRR could be embedded organisation-wide. It was highlighted that this wasn't a 'simple intervention' but a process of changing the culture or ethos of the organisation.

Enablers to embedding BRR were identified as:

- **More training opportunities**, including opportunities for more job groups
 - teams having several staff that have attended BRR – this helps with back-up, support and bringing the wider team on board
 - setting realistic expectations - it takes time to get used to difficult conversations with patients and with other staff
 - the opportunity for learning and collaboration between health and social care
 - start at undergraduate level/induction
 - receive BRR training/mentorship during induction.
- **Awareness raising** to wider staff – mentors have already taken on part of this role
 - the value of informal 'corridor conversations', questioning people in a compassionate way
 - organisational messages that packages of care are not the only approach
 - emphasise that the ethos of BRR aligns with the values of many staff
 - build on staff keenness to work in a different way and to work better across teams
- **Commitment from 'top to bottom'**, including Welsh Government and managers at every level being on board
 - support from all levels of management to enable positive risk-taking.
 - supervision reflecting the BRR ethos.
- **Permission for staff to take time**
 - for meaningful conversations with patients and colleagues
 - to reflect on decisions or difficult situations
 - considering whether it is 'more' staff time, or using that time differently
 - being aware of who gives that permission and do they know they need to do so
 - giving time to attend training and wider BRR activities.

- **Considering how to better include families** so they understand the approach.
- **An ethos of team responsibility** not only individual responsibility
 - sharing responsibilities by having best-interest and other MDT meetings.
- **Mentors**
 - mentors demonstrated capability and confidence, took responsibility for BRR in their teams and helped 'cascade' learning
 - mentors had a specific role in raising awareness of BRR and could do so in a manner that was tailored to their team.
- **Paperwork/forms aligning to the training**
 - for example 'outcome paragraphs'
 - change complex needs profile to more positive strengths.

Barriers and challenges were also identified:

- **complexity of cases** including people who lack capacity.
- **responding when colleagues do not wish to engage** in BRR ethos
- **managers need support to overcome barriers** – identify where power and responsibility lies
- **people do not understand the existing legislation that supports risk**, especially the Mental Capacity Act
- **families may not agree with an approach or decision** as demonstrated in the case study concerning Mr A, or may position their voice 'above' that of the patient
- **families tend to look to medics as the lead** in the team which is hard to challenge
- **staff may be 'firefighting'** and/or experience compassion fatigue
- **auditing is not aligned to what matters** to people/families
- **blame culture** (between teams, individuals or social services vs health)
- **decisions coming from a place of risk** and problems rather than strengths
- **lack of time** for effective communication with patients and professionals; competing pressures do not always allow the right person to have the right conversation at the right time.

As mentioned in the introduction, this programme and the evaluation were undertaken in the context of COVID-19. In survey 2, participants were asked whether there was anything that would be helpful for us to know, in relation to the pandemic, that had an impact on how they applied their learning. Feedback included:

- PPE impacting on communication and especially 'what matters' conversations

- the movement of patients round the hospital system made it hard to build relationships and be outcomes led rather than services led
- high levels of demand and lack of time
- being unable to attend programme meetings due to lack of time or being unable to commit as much as they would have liked due to competing priorities.

Key messages

- Almost all survey participants reported an increase in confidence in undertaking 'what matters conversations, in representing the views of their patients and in defending patient's views following the training.
- Confidence was essential to staff enacting learning from BRR, enabling them to:
 - make suggestions and put forward a BRR approach with colleagues
 - keep going with the approach when that is hard or feels more time-consuming
 - introduce and 'mentor' junior colleagues and newer staff in BRR concepts
 - centre the patient's wishes when others disagree.
- Nearly all participants reported an increase in skills in 'listening to understand', 'listening reflectively', 'helping people understand their strengths' and 'summarising outcomes and actions' as well as an increased understanding of duty of care.
- Undertaking and supporting/encouraging other colleagues to undertake collaborative discussions was a key outcome:
 - staff gave examples that demonstrate the use of this technique and positive outcomes from doing so
 - a barrier to these conversations was other staff who were unfamiliar with the approach not being so willing to engage in them.

There is evidence that the programme has supported positive patient outcomes at least some of the time, for most respondents. The case studies and mentors' presentations at the event support this. Staff felt positive patient outcomes would happen more often if more people had the opportunity, or were encouraged to undertake BRR.

- There was significant evidence that staff completing BRR and especially the mentors were teaching and supporting their colleagues in the ethos and techniques:
 - a great example of this is the training led by mentors in the physiotherapy department
 - it is likely this would happen to a greater extent in a non-pandemic context.
- Staff do in general feel supported to do the right thing for their patients by their team and organisation, but more so by their team. This suggests there are organisational barriers in enacting BRR.

- The feedback on the programme itself was very positive with 25 out of 25 strongly recommending it to colleagues
 - Attendees and mentors emphasised how helpful it would be for more colleagues and a wider set of teams to have the opportunity to complete the programme. It was the most commonly reported enabler that would help them embed BRR in their everyday work.
- Enablers to embedding BRR were identified as:
 - more training opportunities, including opportunities for more job groups
 - awareness raising to wider staff
 - commitment from ‘top to bottom’, including the Welsh Government and managers at every level being on board
 - permission for staff to take time to train in and embed the approach
 - an ethos of team responsibility not only individual responsibility
 - the role of mentors and their continued support
 - paperwork/forms aligning to the training.
- Barriers and challenges include:
 - complexity of cases including people who lack capacity
 - responding when colleagues do not wish to engage in BRR ethos
 - families tending to look to medics as the lead in the team or positioning their voice ‘above’ that of the patient
 - staff may be ‘firefighting’ and/or experiencing compassion fatigue
 - auditing is not aligned to what matters to people/families
 - a blame culture (between teams, individuals or social services vs hospital)
 - decisions coming from a place of risk and problems rather than strengths
 - competing pressures do not always allow the right person to have the right conversation at the right time.

Appendix 1: Survey participants

Table A1 provides an overview of the background and experience of the survey participants.

Table A1: Survey participant profession background

Organisational background	Survey 1	Survey 2
NHS	17	4
Local Authority (LA)	8	2
Unknown	3	1
Job role in NHS	Survey 1	Survey 2
Discharge liaison nurse	3	0
Hospital discharge assistant	5	0
Occupational therapist	3	0
Ward sister/ stroke rehabilitation	2	0
Nurse – other	1	1
Operational manager for physiotherapy	1	1
Community resource team manager	1	0
Unknown	1	0
Job role in LA	Survey 1	Survey 2
Senior practitioner	3	0
Service manager	3	2
Team manager	2	1
Unknown	0	1
Previous training	Survey 1	Survey 2
Care aims	4	N/A
Collaborative communication skills	4	N/A

Appendix 2: Case studies

The three case studies below were all written by BRR mentors to demonstrate how the programme has impacted on patient outcomes and teams.

1. Mr A – centring the patient’s wishes

This case study was written by the hospital discharge social work team.

Mr A is gent in his 90s who lives alone in the house he was born in. He was well known to services for being a man who “did things his way” and refused to accept any help. In January this year, Mr A was admitted into hospital with an infection. During three separate conversations with our hospital hub, he said that the only thing that mattered to him was going to back home to his recliner armchair. He refused the offer of help at home, despite the fact that the ward was assisting him with his personal care, continence and that the occupational therapist (OT) has some concerns with his fluctuating mobility.

Mr A was referred to my team for a follow-up assessment once he was home. The allocated worker was immediately uncomfortable that Mr A was going home with no care package and decided to visit him in hospital. On her return to the office, she said, “Well, he’s accepted everything!” On further exploration of “everything”, the worker said that Mr A had said he would accept anything as long as he could get home. The worker suggested four calls per day. I asked if Mr A realised that this would mean he’d need to stay in hospital while this was organised, the worker said that he didn’t. When Mr A was informed of this later that day, he said that he was not prepared to wait in hospital for a minute longer and that he wanted to go home. Mr A had the mental capacity to make this decision.

With the training in mind, I asked the worker who the worried person was in this scenario. Mr A had been told several times about the potential risks at home but he was determined that he would be able to manage by himself.

His outcome paragraph:

“I want to return home to the house I was born in to and return to my recliner armchair. I do not want to be in hospital any longer and do not want people in and out of my house all day.”

The worried people in this scenario were the Information, Advice and Assistance (IAA) worker, the family and the hospital OT. Keeping Mr A’s views and wishes at the focus, together we identified the following:

Strengths	Priority risks	Good enough outcomes
Mr A is able to make his own decisions independently.	Family are concerned that dad will be unable to manage without a care package at home. He is experiencing incontinence and his mobility fluctuates.	Mr A would like to return home to his 'recliner chair' (even if this means he might struggle with certain tasks).
Mr A wishes to return home to live in the home he was born in.	Mr A does not want people in and out of his home all day. He has always been fiercely independent all his life and is worried that this independence will be taken away from him.	Mr A was accepting of some support upon discharge in order to return home – Age Cymru and meals on wheels.
Mr A has a supportive family around him.	There are barriers from other agencies/professionals who do not feel comfortable with Mr A returning home without a 'POC' (package of care)	Whilst unhappy with the decision, the family said they'd still support Dad at home.

Mr A's family were very unhappy with this decision (as were the OT and the worker in my team). But with Mr A's consent, the worker arranged three daily check calls with Age Cymru and community meals each day. District nurses would also call each morning to administer eye drops. My team's assessment would continue as Mr A returned home.

Mr A came home on the Tuesday evening of that week. On Wednesday, the district nurse called my team expressing concerns of a 'failed discharge.' Mr A was barely able to stand and was sitting in a urine-soaked pad. DNs reported a pressure sore on his bottom too (we were unaware of this at the time of his discharge) and Mr A couldn't stand for them to treat it. Shortly after, Age Cymru also rang the team to report the same concerns.

Myself and the allocated worker visited Mr A. It was clear that Mr A was sitting in his own urine and he had apparently not moved since coming home the day before. I asked Mr A if he was able to stand and he said "Yes." I asked if he would be happy to show me how and he said, "I am not dancing around my living room for no reason. I can stand and walk – I am fine." Running through my mind were the questions "Who is bothered/worried concerned? What are Mr A's good enough outcomes?" I told Mr A that I was worried about him – how uncomfortable he must be and that he had a pressure sore that would likely get worse. Mr A ushered me away with his hand. I made Mr A a cup of tea and a sandwich, and left at his request.

I went back to see Mr A the following morning. He was in the same position. In the kitchen was a district nurse, two members of staff from Age Cymru (plus their line manager on speaker phone), the allocated worker and Mr A's family. Each of them express serious concerns for Mr A's welfare and said, "I can't believe he's been sent home with no package of care! He needs to be back in hospital! Or emergency respite!" Amongst the noise, I advocated that this was still Mr A's decision and that he would take the lead in what happens next – even if this made us all feel uncomfortable. It was his right to refuse help, even if the priority risks were increasing.

While everyone continued to talk in the kitchen, I went into the living room to speak with Mr A. I asked, "Are you ok?" And he said, "Oh yes, it's so good to be home... In my chair at last." We talked about how long he had lived in his house and the some of the memories he had

as a child. I asked Mr A if he was wet and he said yes. He admitted that he was really uncomfortable and that his bottom was sore. I again encouraged him to accept help – explaining that if he wanted to stay at home, then he needed to work with us. At this point, Mr A said, “As long as you promise it’ll only be what is absolutely necessary. I do not want people back and fore in my house for no reason.” **This was the good enough outcome.**

With Mr A giving us the green light, my team were able to request an urgent home visit from an OT, and our emergency care team provided three calls each day to assist with hygiene and pressure relief. The support of the district nursing team and community meals would continue.

By the end of the assessment, Mr A required (and accepted) three domiciliary care calls per day. During conversations with the allocated worker afterwards, she commented that this should have been done prior to Mr A’s return home. But in my view, Mr A had made his decision clear – he’d rather be at home, sitting in his urine for two days than sitting in a hospital bed clean and comfortable, waiting for a care package.

Personal reflection

I have been a social worker for about 12 years and whilst working with Mr A was not difficult, managing the anxieties of those around him certainly was. When I first saw him at home, looking so frail, I was initially worried that I’d completely misjudged the whole situation. But as soon as Mr A spoke to me I was completely satisfied that I had done the right thing. Being shouted at in the kitchen that morning wasn’t pleasant, but at no point did I find myself moving away from what Mr A wanted from us all. I am sometimes asked what gave me the strength and confidence to keep going with Mr A’s plan and I always answer that it was Mr A himself. Mr A was so specific with his wishes that advocating for him was the easy bit. We simply had to go at his pace and only step in when he told us we could.

The biggest lesson I think we can all take from this is that this could and should have been done sooner. Mr A spent far too long in that hospital bed when he could have been sitting in his armchair in his own home, eating his favourite apricot sandwiches.

2. Cascading BRR within the physiotherapy service

This case study was written by the mentors from the physiotherapy department.

Three staff from physiotherapy attended the initial training and mentoring training sessions held in 2021. One works as a senior clinician within front door and acute services at the Grange University Hospital and two are operational managers, supporting and managing all physiotherapy inpatients teams across seven of the eight acute and community sites in ABUHB.

Following the training, both managers had tried to facilitate within their areas a session with staff, focussing on a patient case study where the reflective listening style could be explored. The sessions proved very challenging, in that changing the emphasis and discussion amongst clinicians from problem identification as the basis of goals and treatment planning to that of strengths-based outcomes was tough. Supervision and mentoring sessions ordinarily discuss objective findings and clinical reasoning for solutions. It was felt that staff needed to have greater understanding and context of the concept to appreciate this

approach, for the sense of reframing patient management and valuing the quality of the interaction in itself.

For the clinician who works within a MDT concentrating on admission avoidance, the programme ethos echoed clinical practice and the mentoring and clinical reasoning used within her team. Her focus was considering how the BRRR messages could be communicated and integrated into practice more widely, and also how documentation could better support this.

Determined to share the BRRR philosophy within their service, the team agreed an objective during the mentoring training to look at and develop a means of cascading the programme to a wider group within physiotherapy. Follow up-meetings were arranged.

It was acknowledged that summarising the three-day programme into essential key messages in a couple of hours would be challenging. It was important to provide enough detail and be able to inspire staff to consider change in their practice. The time to support development of skills during the training was valued, as well as the opportunity to listen to discussions facilitated by Rhoda and Kate, the trainers; it was recognised this could not be easily replicated. It was decided that the physiotherapy training session would therefore provide an overview and aim to stimulate discussion and reflection.

The content of the session would focus on the themes of patient wellbeing, conversation (and practice) traps, reflective listening, engaging families, the perspective of risk, and outcome paragraphs, consolidated through presentation of a case study. Breakout groups would then consider their own patient story/case, and present back as a summary and outcome paragraph.

It was decided that the initial target group would be senior physiotherapists representing all sites (both acute and community) and specialties. These staff are static within sites, have established links within their MDT and are role models, influencing service development, leading mentoring, and clinical reasoning sessions within their teams. It is worth noting that some staff within the group had previous experience of other training including Care Aims, Bridges Self-management and Shared Decision-making.

To date, two training sessions have taken place, delivered to ten staff members. The feedback was encouraging and there is appetite to take this further in a small steps approach. The groups reflected the value of being led by 'what matters' conversations and would consider how this may be utilised in their clinical practice.

It is recognised that the large rotational physiotherapy workforce is a hugely valuable resource, who can share and spread good practice as they move between sites and departments. As part of the training and support programme for Band 5 clinicians, a core skills training programme is delivered across specialties by clinical staff. It was identified that including Balancing Risks, Roles and Responsibilities training within this rolling programme would be an effective and efficient means of how to spread and scale across the service. The session will be delivered to Band 5 physiotherapists whilst they are working within front door, medicine and rehabilitation rotations and was due to commence in June 2022. These rotations align with locations where the senior staff have already attended training and it is anticipated they can provide peer support and supervision.

The skills used and honed as part of the training are not just relevant to clinical practice. It is noteworthy that reflective listening, 'what matters' conversations and strengths-based discussions are important with staff or service users and have been effectively used.

3. The importance of reflective listening

This case study was written by the mentors from the physiotherapy department.

A member of staff received a call from a relative who was very angry following the assessment of her mother by a physiotherapist that morning. This member of staff explained that it was not herself who had completed the assessment and suggested she ask the senior physio on site to call the relative back.

This message was relayed to the senior physio who had attended the half-day BRR training run by the mentors from the physio department (see case study 2). This staff member thought that the reflective listening techniques that we had discussed may be useful as well as understanding the families identified risks. She investigated the situation prior to calling the relative back but opened the discussion with an open question of 'tell me what's concerning you and what I can do to help'.

The relative was very emotional and described her mother (the patient) being "dragged" up a flight of stairs by physiotherapists despite not having climbed stairs for a year due to her cardiac failure. She described how the patient then had a "cardiac collapse" and now had to remain in the hospital over the weekend for further monitoring instead of coming home today. She went on to explain that the patient (and her husband) had isolated for nearly two years due to the patient being deemed 'vulnerable' and wanting to avoid COVID, and that they were really worried about her being in hospital and catching it.

The therapist listened and provided reflective feedback including "it sounds like you've had a tough couple of years" and "I can hear from what you're telling me that you care deeply about your Mum", "I can understand that you see being in hospital as a risk to mum" and "it sounds like you are very frustrated by the situation today and worried about Mum".

She then asked if it would help to understand how and why the therapists undertook the stair assessment, and the family agreed that it would. She explained that they had only completed three steps as this was what the patient said she had at home to access the property and explained that physiotherapists would do this to ensure patients can manage on discharge and would not go home to find themselves unable to manage, and trigger outcomes such as the patient had today in the community where medical attention would be less readily available. She explained to the family that the assessment was undertaken in the hospital as it was deemed by the hospital staff that the risk of not being able to complete the steps on discharge would be greater than the risks of today's outcome; she apologised that this was not the same as the risk the family identified.

The family understood the rationale and were calmed. The therapist asked what they would like to be the outcome of this discussion and if they would like information regarding how to make a complaint. The family reported feeling much less angry about the situation and feeling that they had been listened to and reassured, they did not want 'putting things right' information. The therapist reflected that the techniques had helped to diffuse the potentially confrontational situation and had helped the family to feel listened to and to understand the balance of risks in this situation.



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Social Care Institute for Excellence
Isosceles Head Office, One High Street
Egham TW20 9HJ



www.scie.org.uk