‘Bridges in Paediatrics’

A co-design project to develop a fresh person-centred Self-Management approach and training programme

Heide Pöstges – February 2018

“Given the framework of Bridges, I feel that the targets that my team sets are much more practical, functional and patient-centred; and I can see it in the answers I’m getting from the parents and children.”

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1 Summary

Background
'Bridges in Paediatrics' at the Southern Health and Social Care Trust was co-developed with children, parents, Allied Healthcare Professionals (AHPs) and Bridges. The overall project aim was to jointly develop the first dedicated training programme for AHPs working in Children and Young People services that moves beyond a therapy-led approach, towards working in partnership with the young people and their families to share knowledge, make shared decisions and put building capability at the centre of rehabilitation.

Methodology
This quality improvement project was carried out between April and December 2017. It included engagement events and two-stage staff training to facilitate enhanced clinical practice by driving behavioural and cultural changes. The project design is grounded in a participative approach and uses a theory-oriented evaluation method. Bridges, a holistic and well-established self-management approach in Adult Services, served as an overarching theoretical approach that guided the development of new practical strategies and tools.

Results
Practitioner and patient stories reveal that Bridges has helped to enhance person-centeredness, effectiveness and efficiency.
Person-centeredness:

> *"Really promote child-centred approach and what matters to them by listening and asking what the child and family need now – timely intervention with the focus on the individual."*

Effectiveness:

> *"I think we provide more effective care now, which is of immediate benefit that families see quickly. Children are discharged, which is happening more regularly, or filtered through to other services. Parents and children leave with a sense of empowerment, they already help themselves and parents know what they can do to help their child or change things in their family."*

Efficiency:

> *"Going straight into working on the areas that matter most to child/family – so that we don't waste time by working on something that is not important to them."*

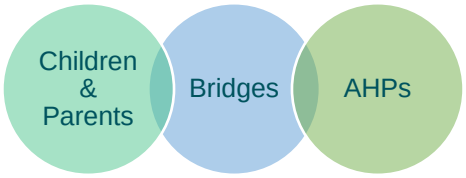
Key learning

- AHPs valued the Bridges approach as an overarching multi-disciplinary framework that made them feel liberated to work differently and get to the heart of what is important to children and their families quicker – achieving more meaningful therapy outcomes with existing resources.
- Engaging children and parents in co-developing new ways of working and engaging them in a more mutual relationship is feasible and was well received.
- Change can be best achieved by focusing on small changes that AHPs can easily combine with existing practice.
- Considering sustainability from the outset by focusing on integrating Bridges principles into team processes and documentation appeared critical.
- Changing underlying values to service delivery requires ongoing support and mechanisms to enable joined reflection and continuous re-adjustment of the chosen aims and actions beyond the timeframe of this project.

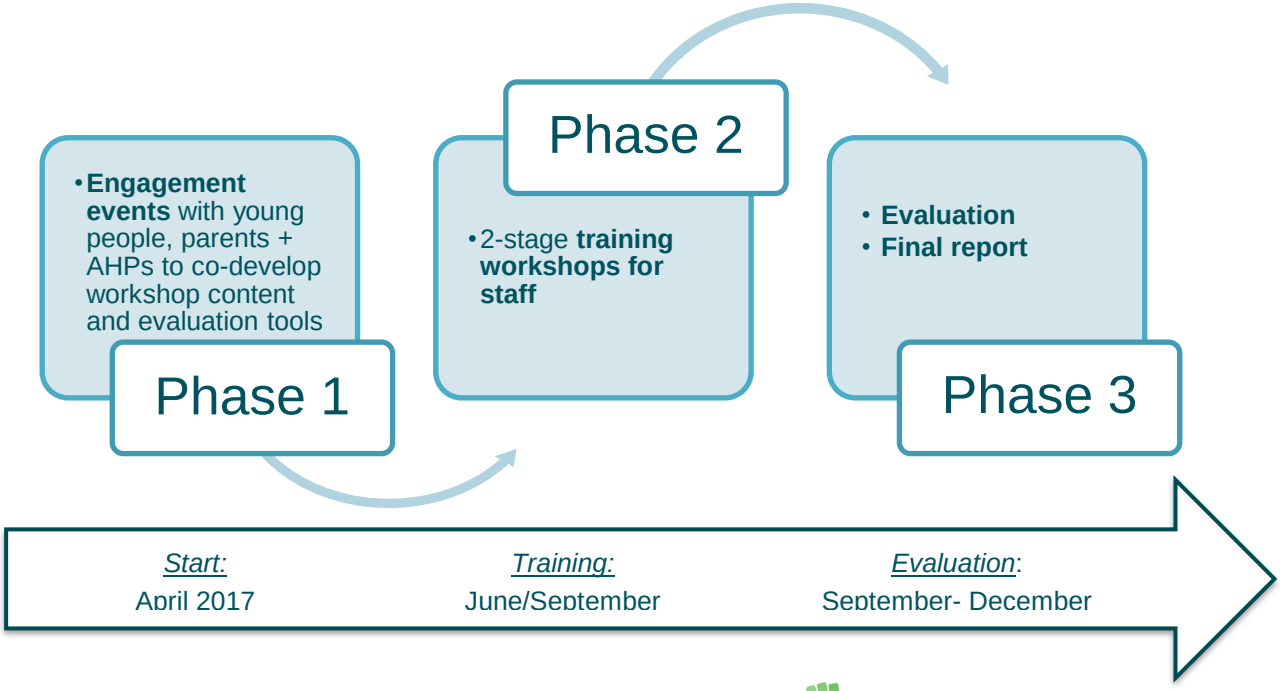
2 Project overview

Children with lifelong conditions have to continuously weigh up their clinical against their social needs as they move through different life stages[1]. While building capacity to adjust to ever-changing life situations is critical for these children and their families, the medical notion of fixing problems still restricts the scope of paediatric rehabilitation to date[2].

'Bridges in Paediatrics' at the Southern Health and Social Care Trust was co-developed with:



The overall project aim was to jointly develop the **first dedicated training programme for paediatric Allied Healthcare Practitioners (AHPs)** that supports a cultural shift from a therapy-led towards a **collaborative, strength-based approach** in Children and Young People Services at the Southern Health and Social Care Trust in Northern Ireland.



Funded by

Southern Health and Social Care Trust
Quality Care - for you, with you

Bridges
SELF-MANAGEMENT

[1] Sattoe, J.N.T.; Bal, M.; Roelofs, P.D.D.M., Bal, R.; van Staa, A.; and Miedema, H.S. (2015). Self-management interventions for young people with chronic conditions: A systematic overview. *Patient Education and Counselling*, 98 (6): 704-715.
[2] King, G.; Imms, C.; Stewart, D.; Freeman, M.; and Nguyen, T. (2017). A transactional framework for pediatric rehabilitation: Shifting the focus to situated contexts, transactional processes and adaptive developmental outcomes. *Disability and Rehabilitation*. 23 (3-4): 1-13.

3 Methods

The project design is grounded in a participative and theory-oriented approach. Evidence-base principles guided service users and healthcare professionals to jointly identify needs and make change happen.

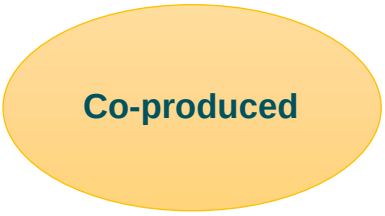
3.1 Bridges: A fresh person-centred approach to Self-Management

Bridges, a holistic and well-established self-management approach in Adult Services, has served as an overarching theoretical approach that guided the development of new practical strategies and tools to achieve the jointly agreed aims. Bridges facilitators worked alongside AHPs to support them to embed Bridges into their everyday clinical practice.

The Bridges approach

- moves the focus from treatment to creating meaningful relationships between children, parents and health care staff
- reduces dependency on services, isolation and feelings of helplessness
- easily combines with existing practice – quickly becoming a routine part of what health care staff do every day

Bridges is firmly rooted in over 10 years of research and used to support people with a range of long-term conditions using Adult Services[3] [4]. **'Bridges in Paediatrics' is the first project that aims to extend this work into Children and Young People Services.**



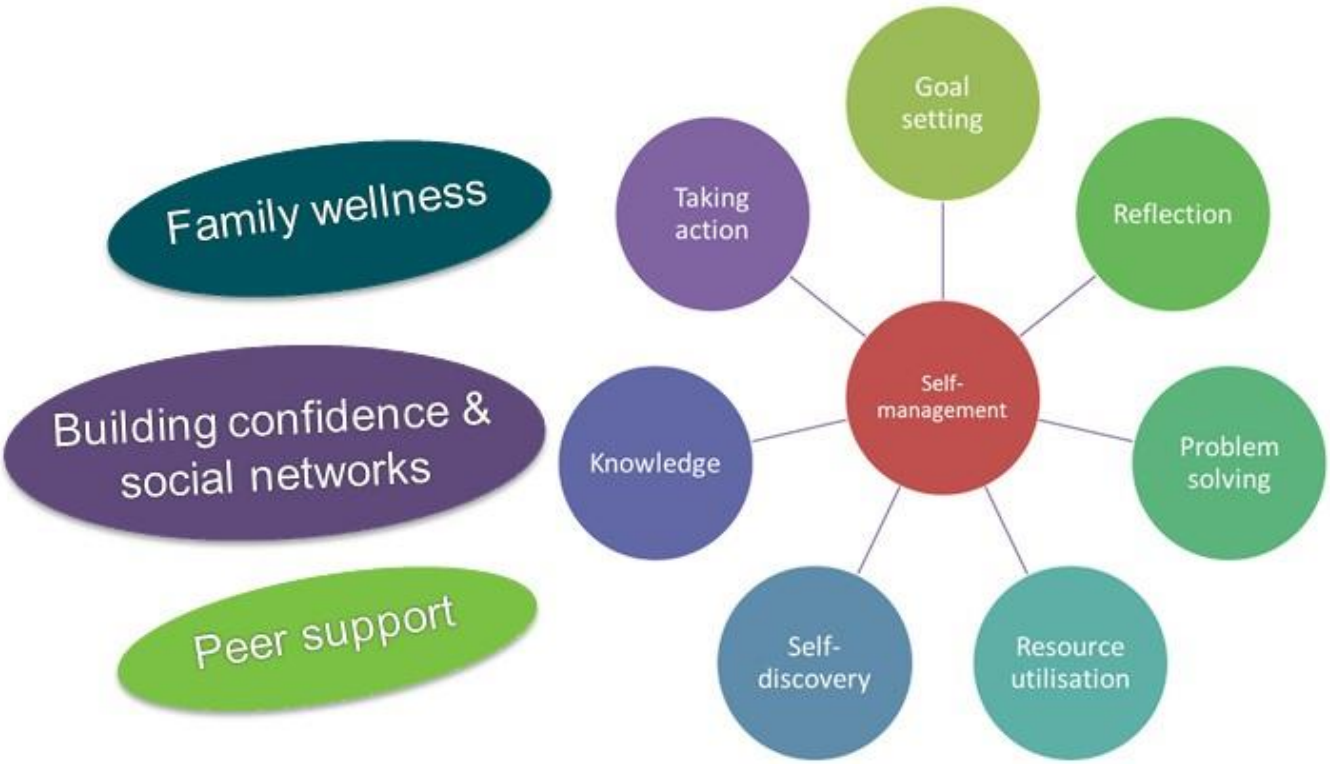
Bridges teams up with people including their friends and family.

Their vast experience and insight shapes the content of the workshops and is shared in books, featuring their stories, tips and advice to help other people live well.

[3] McKenna, S., Jones, F., Glenfield, P. and Lennon, S. (2013). Bridges self-management programme for people in the community: A feasibility randomised controlled trial. *International Journal of Stroke*, 21, DOI: 10.1111/ijs.12195

[4] http://www.bridgesselfmanagement.org.uk/bridges-publications/ (Please visit the website for more publications.)

Bridges principles and strategies

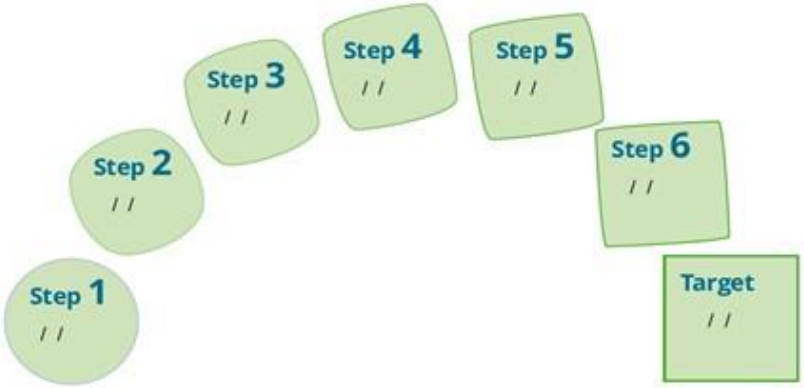


Hopes, ideas and planning things

Small steps towards the things you want to do

Looking back: what worked for me?

Your steps...



Date started: / /

Date achieved: / /

3.2 Implementation and evaluation methods

The project design itself is grounded in a participative approach, which actively supported the development of shared understandings about what constitutes a good outcome and acknowledged that these can change over time.

The evaluation process is hence intentionally geared towards **driving behavioural and cultural changes throughout and beyond the intervention,** which requires evaluation methods that provide more flexibility than pre-defined outcome measures[5].

Firstly, we used **observational and narrative data** to evaluate how the programme unfolded over time. Evaluation tools included recordings and notes from 5 focus groups with children, parents and staff; notes from discussions at training workshops; post-training feedback forms (25 from initial workshop and 24 from follow-up workshop); 24 written success stories as well as video-recorded patient stories.

Secondly, behavioural and cultural change is dynamic, which requires a **theory-oriented evaluation method** that can help to predict implementation challenges and provide possible explanations for why the observed effects happened[6]. We chose Normalisation Process Theory (NPT)[7] as a heuristic tool to guide our efforts to develop, implement and evaluate the bespoke Bridges programme in Paediatrics.

[5] Broer, T.; Bal, R. and Pickergill, M. (2017). Problematisations of Complexity: On the Notion and Production of Diverse Complexities in Healthcare Interventions and Evaluations. *Science as Culture*, 26 (2): 135-160.
[6] Dixon-Woods, M.; Bosk, C.L.; Aveling, L.; Goeschel, C.A.; and Pronovost, P.J (2011). Explaining Michigan: Developing an Ex Post Theory of a Quality Improvement Program. *The Milbank Quarterly*, 89(2):167–205.
[7] May, C. and Finch, T. (2009). Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology*, 43 (3): 535-554.

4 Engagement events

The project actively engaged **children, parents and AHPs** at separate focus group events to **refine the project aims, collect real life stories** from children and parents for training material and to **co-develop evaluation methods.**

Paediatric AHPs

4.1 Staff engagement event

A total of ten Allied Healthcare Practitioners (AHPs) from Occupational Therapy, Physiotherapy, Speech & Language Therapy & Dietetics – both clinicians and managers – attended the event. The Bridges facilitator used **trigger films** and **examples from Bridges work** in Adult Services to facilitate the discussion.

Benefits for AHPs

- Learning communication strategies that they can integrate into their everyday practice with immediate effect
- Opportunity to reflect on existing practice and shape the direction of the training workshops according to their interests and needs

Contribution to project development

- Drawing on AHPs' insights into the service to refine the project aims and jointly plan the next stages of the project
- Starting the process of engaging AHPs in the process of translating Bridges principles into a meaningful way of working within their service and building a shared understanding of the required changes

4.2 Children's and Young People's engagement events

A total of eight children (7-12 yrs.) and six young people (13+ yrs.) attended the 'Have Your Say' events from a range of services for complex disabilities. The Bridges facilitator made use of **participative art practices** to facilitate the

event and every participant received a voucher to reimburse them for their time.

Benefits for children/young people

- Learning how to tell what's important to them
- Opportunity to meet and learn from their peers

Contribution to project development

- Drawing on children's insights into the service to refine the project aims, build a shared sense of purpose and jointly plan the next stages
- Collecting stories of everyday life (hopes and dreams, health beliefs and what's important to them…) for integration into workshop

4.3 Parent's engagement events

20 parents (all mothers) attended the parent's engagement events. Their experience of using services covered a range of specialist areas including Autism, mental health, complex disability, community clinics, and special schools. The events took place in the form of focus-group discussions aided by additional action tools such as postcards, post-it notes and imaging.

Benefits for parents

- Opportunity to meet and learn from others in a similar situation
- Opportunity to provide feedback to the service

Contribution to project development

- Drawing on parent's insights into the service to refine project aims, build a shared sense of purpose and jointly plan the next stages of the project
- Collecting stories of everyday family life and what's important to families for integration into workshop

5 Refined project aims

1. **To get to the heart of what matters most to children/young people and their families quicker**
2. **To move away from a focus on impairments towards supporting children/young people and their families to explore their potential and find their own way of living the best life possible with a health condition**
3. **To reduce dependency on services**

6 Workshops for staff

The initial workshop (one-day) took place in June 2017 and the follow-up in September 2017 (half-day). 25 Allied Healthcare Professionals (AHPs) who work across the specialist child health & disability teams at the Southern Health and Social Care Trust (NI) attended. The different AHP professions were represented at the workshops as follows: 7 Speech and Language Therapists, 7 Physiotherapists, 7 Occupational Therapists and 1 Dietician.

6.1 Workshop objectives

1. **Critically reflecting on feedback from children/young people and parents**

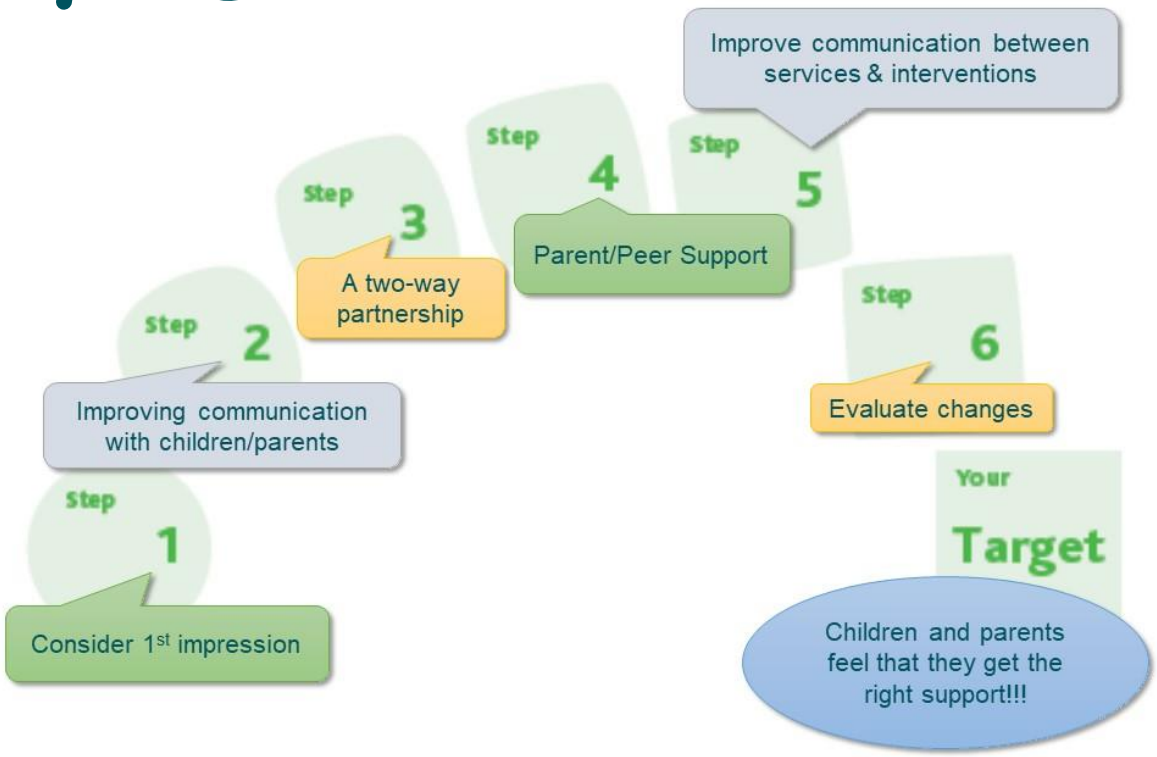
2. **Understanding the theory and evidence-base of the Bridges approach**

3. **Addressing the feedback through integrating the Bridges principles into everyday clinical practice:**

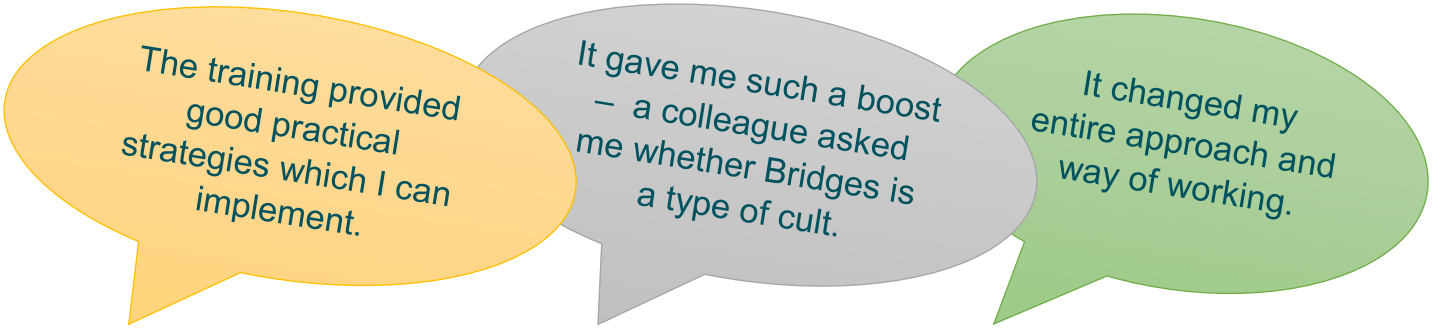
   - Developing bespoke practical methods and tools
   - Demonstrating awareness of different communication styles
   - Understanding ways of involving family, friends and carers
   - Developing shared understandings and strategies to embed and sustain changes in practice

6.2 Action plan developed during the workshop

The AHPs jointly developed ideas for change during the workshops. The agreed focus points are presented below using the Bridges stepping-stones.



6.3 Staff feedback on workshops



7 Impact

7.1 Shared multidisciplinary values

Shifting **from a therapy-led towards a collaborative, strength-based approach** implies a change in core principles that guide professional practice across disciplinary boundaries. The workshops were aimed at enabling a multidisciplinary group of AHPs to think and work differently by encouraging them to jointly reflect on their current professional values. Their tweaks to individual and team practices reveal the following **newly established values:**

1) Our role is more than fixing problems – supporting children and their families to live meaningful lives is as important

> The day after we attended the Bridges training I looked at the parent information leaflet and it was like a switch had flicked in my head. The leaflet read "we're here to assess your child, identify their difficulties and then we'll fix it". But **what we really wanted was to set up a situation where the parents would be thinking, "okay, this service is going to be here to listen to me and help me".** We wanted to tell parents that while we are here to guide and support, we aren't necessarily going to fix the problems. 'On the back of the Bridges training, the entire leaflet was rewritten. And my team is much happier with the way the leaflet reads now, setting us up as a service, which intends to work in partnership with families – and I am sure that will have a positive outcome for our service as it continues to develop.

Example 1: Rewritten information leaflet

> Before the training, I would have said that I'm going to assess your child and then we discuss how we are helping your child with these difficulties. That was me taking the power away from the parents and the children. **Now, I discuss from the outset the things that are important to them right now in their daily life and how we can work together towards solutions.** […] Regardless of whether their scores had improved on the assessment, anecdotally their lives had improved.

Example 2: Focus on daily life – not just assessing difficulties

2) We are interested in what's important to children and their families – without judging them

A five-and-a-half-year-old girl with a diagnosis of Down's syndrome came to see me in September with her mummy. She had just come out of hospital. She had been there for six weeks after major surgery and had developed two very serious infections and had been on IV antibiotics. So, mummy's priorities were nothing to do with speech and language. Her main priority was to keep her medically well, free of infection and to settle her into P1 because she was a P1 child and she'd only managed to be there for one day at that point. Given these priorities of the parent, we agreed to defer speech and language therapy intervention until a later date when these things had happened. So, I feel everyone felt quite positive after that session. I think **the mum felt quite empowered by the fact she was listened to.**

Example 3: Speech and Language Therapy not a priority

3) We value and use the expertise of children, their families and support networks

A lot of them come back with things that I certainly hadn't suggested that they did, but **because they have been given control over the process, they were able to look at their lives in general and come up with some fantastic ways of improving.**

Example 4: Giving back control

When we observe at school or playgroup we use a different approach now – we ask the education and care staff for their opinion; what works, what the issues are.

Example 5: Asking for their opinion

4) We help children and their families to recognise and build on the strengths that they and their support network have within themselves

Just by taking it away from the assessments – which can tend to be quite hard for the children as they continue to struggle with those areas, making it quite negative and disheartening for them – we've just really moved the **focus over to the child, chatting with them about what areas they are doing well in** and reinforcing those points with the children and parents, and just being really positive about it, **whilst targeting the areas they are continuing to struggle with.** Really, I feel it's just changed the outlook of that appointment and hopefully changed how they feel leaving the appointment, and just the benefit of the whole review, as well.

Example 6: Reinforcing what goes well

Throughout the course of the project, staff gave tangible examples of how they changed their work according to these **new values**. **Shared attitudes** and **improved knowledge and skills** helped **to make change happen.**

7.2 Enhanced knowledge and skills

AHPs reported that their existing knowledge and skills to provide person-centred self-management support improved throughout the course of the Bridges project in three key areas:

1) **Verbal and written communication**
2) **Person-centred goal setting**
3) **Supporting children and their families to build their confidence**

7.3 Person-centeredness[8], effectiveness and efficiency

Person-centeredness

How Bridges helped to have better conversations with children and their families to a) engage, b) enable and support and c) jointly manage daily life.

Engaging children and their families

Issues raised at engagement events

How can we get better at dealing with conflicting expectations between parents and us?

Paediatric AHPs

There is too much focus on the diagnosis – no holistic approach.

Tell me what I can do – not what I can't!

We like our children and us to be more involved in agreeing therapy goals.

Staff attitudes after workshops

Really promote child-centred approach and what matters to them by listening and asking what the child and family need now – timely intervention with the focus on the individual.

A focus on developing a relationship from the start can help to manage conflicting expectations.

If we identify the goals important to the child and family early on, then they are likely to get involved with the process and use the strategies discussed as families feel valued, listened to and empowered.

Example of change in practice

We originally called our paperwork a Case History Questionnaire, we changed it to **Getting To Know You** - that small change made it much more positive. We also added two questions; **"What are the main issues for your child?"** and "**What one thing would make a positive difference?"** We left a lot of room for the answers, parents fill out this section in detail and often add an extra page – they go for it! We get so much useful information and **the first appointment is given to discussing those issues**, we talk about what's difficult and what helps and works well.

Example 7: Getting to know you

[8] Concept adapted from: Health Education England, Skills for health & social care (2017). Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support. A core skills education and training framework.

Enabling and supporting children and their families

Issues raised at engagement events

How can we make interventions more meaningful to children and parents?

Paediatric AHPs

We feel judged by schools and therapists based on age-appropriate goals for healthy children. It makes us feel as if our children and we have failed to achieve something.

Skills training in clinic often fails to transfer into home environment.

Tell me what I can do – not what I can't!

Staff attitudes after workshops

Work with family to create activities child enjoys and that the whole family can participate in

The targets should be more functionally based and more meaningful to the family – building up their ability to self-manage and problem solve.

Example of change in practice

When a child attended for a review appointment, which was after the self-management course, I changed my approach and asked more open-ended questions on how the strategies I had given them had been brought into their everyday life, rather than just focussing on the difficulties in specific areas.

The parents reported that the child had started joining them more often in outdoor family activities like mountain-hiking and that their swimming lessons had really improved. So, they found a big difference in his motor skills and confidence.

'Before the self-management course in my review appointments I would have brought them in and gone through the formal assessments, all the standardised scores and looked at and focussed on the areas of difficulty from the programme, rather than just speaking about how it has functionally impacted on the child and the family. So, as a result of that, **the parent and the child were happy they'd achieved everything they needed to and they were given the strategies to continue this in their everyday life.**

Example 8: From standardised scores to functional impact

Issues raised at engagement events

How can we make interventions more meaningful to children and parents?

Paediatric AHPs

Staff attitudes after workshops

Look at the child through the eyes of the family – understanding of family dynamics and how the child fits in

Example of change in practice

'A Day in the Life' – is paperwork we use to get in to the nitty gritty of people's lives - what their routines are, who's looking after the children, where they go after school. We were amazed at how much we found out… we regularly heard that children spent a long time in the car picking up siblings from clubs, often there's not a lot of family time to do therapy. We pinpointed other people - maybe a child-minder could include therapy in group play, or granny could do some therapy in the park on the way home from school, so it became part of playtime. **We found parents were relieved to find they didn't have a therapy programme to do when they get home after a busy day** – much better approach to use other people who are there and accessible to the child.

Example 9: Integrating therapy into daily routines

Collaboratively managing daily life

Children with lifelong conditions have to constantly weigh up their clinical against their social needs[9], which can lead to **tension between clinical and personal priorities.** In order to be able to provide adequate support with making difficult decisions paediatric rehabilitation goals need to move beyond a focus on skills development towards enable children and their families to **live meaningful lives.**

Issues raised at the engagement events

Staff attitudes

Hopefully children and parents will feel better supported, if we address input holistically – think beyond the clinical room.

We rarely reassess, instead we talk with parents and children about what has changed since we last saw them - what they include in daily life, what works, what doesn't - giving them control and power. They look at their lives and often make suggestions. We see their lives have improved.

Example 10: Ditch re-assessments

Examples of change in practice

We ask older children, who've experienced a lot of intervention, "what would you like to work on? What's important to you just now?" Sometimes they say they don't want to be coming to therapy because they're happy with where they've got to and what they've achieved. Previously, I might have reassessed, which would have highlighted difficulties and emphasised problems, creating a 'fix it' mindset. We still recognise they have areas of difficulty, but they've moved towards discharge and they made the decision themselves "I'm happy with where I'm at, I'll call you if I need you" - it's much better for their self-esteem.

Example 11: I'll call you if I need you

[9] Sattoe, J.N.T.; Bal, M.; Roelofs, P.D.D.M., Bal, R.; van Staa, A.; and Miedema, H.S. (2015). Self-management interventions for young people with chronic conditions: A systematic overview. *Patient Education and Counselling*, 98 (6): 704-715.

Effectiveness

How Bridges helped to gain meaningful therapy outcomes for children and families

Our evidence from patient stories suggests that working in a more person-centred way has increased the effectiveness of interventions by achieving more meaningful outcomes for children and their families.

I think we provide more **effective care** now, **which is of immediate benefit that families see quickly.** Children are discharged, which is happening more regularly, or filtered through to other services. Parents and children leave with a sense of empowerment, they already help themselves and parents know what they can do to help their child or change things in their family.

Supporting meaningful outcomes

Issues raised at the engagement events

How can we improve the effectiveness of interventions by engaging children and parents more?

Paediatric AHPs

We enjoy doing exercise programmes that involve rating. Seeing our progress at every session has helped to build our confidence.

We need help with supporting our children to do as much as possible for themselves without asking too much from them or putting them up for failure

Staff attitudes

Focusing on their goals and not mine. Involving the family as a whole – if it is meaningful to the child and parents, the intervention should make more of a difference to their lives.

Making it more a partnership and inclusive process will lead to improved motivation and satisfaction for patient, family + therapist

Example of change in practice

I used Bridges with a teenage girl who was presenting with severe sensory processing difficulties; she was a highly anxious girl and was struggling, particularly in school, having meltdowns. Her family were struggling as well because the way her sensory processing affected her meant she was very sensitive to noise, smells and also to people being around her, bumping into her and touching her. So, she was quite often in a highly alert state and operating from a very stressed place.

When she came in we just started chatting about that, and her mum was very much involved along with other family members. We looked at the things that they really wanted to try and achieve. The main thing was to get her to be calmer and more able to cope with these situations that she was dealing with, particularly in school.

I asked her to give me an idea of how she felt in different situations. And we decided to use a scale from one to ten, with one being very stressed and ten being very calm, and on coming into the clinic she said that she was operating at a number six. But she said when she is at school, she's operating at a five or below. Obviously, our ultimate goal was to bring that score up and to make her feel calmer. She was beginning to be able to understand her feelings and what she was experiencing; and in being able to measure it, I felt she was becoming much more self-aware and in tune with her own feelings.

From that, we chatted about different situations and activities that could help her become calmer. By the end of two one-hour sessions and with different OT activities and intervention she was telling me she was an eight or a nine score, which was a really positive outcome. Then we had to transfer that across to home and school.

We talked more about activities. She was very involved in choosing the activities that she would like to do and I think that helped as well because she was taking more ownership. From that, our outcomes have been really positive. **She is a lot calmer, she is carrying out activities, she's more self-aware, she's more able to be proactive in helping herself to regulate her emotions and sensory issues** and I know before I used Bridges I would have probably just gone in there and carried out a whole battery of different assessments with her. But the difference was when she came in **she was fully involved,** and **her mummy and her family were fully involved** from the beginning. And, I think in that respect, **there was much more cooperation and much more partnership and the outcomes were very positive.**

Example 12: Managing stress

Support for parents

Issues raised at the engagement events

How can we integrate peer-support for children and parents into our services?

Paediatric AHPs

Staff attitudes

Will hopefully lead to better relationships with parents and lead to more self-efficacy with better outcomes for goals

Example of change in practice

We ran a summer scheme, the feedback was very positive and the overwhelming aspect was how much parents enjoyed connecting. They'd all shared the difficult journey of diagnosis, treatment and hospital appointments. Coming together, having space and time to meet and learn from each other about managing their children's condition was really helpful. Parents said:

"I got so much out of attending the scheme, sharing and learning about our children's condition from all the other mothers."

"I enjoyed the opportunity to meet families with children who have the same condition, it was nice to get a chance to discuss our children together."

We going to take this a step further, to develop a resource for families - based on real life, real stories and real situations – so we can continue sharing and learning from each other in the lovely way that parents do.

Example 13: We're stronger together

Efficiency

How Bridges helped to gain meaningful results for children and families quicker

By getting to the heart of what is important to children and their families quicker, **less time was wasted working towards outcomes that are not important to them.** Reducing time on therapy and review meetings has helped to maximise time for family, school and everyday life, while freeing up time for AHPs to see new patients.

Staff attitudes

Going straight into working on the areas that matter most to child/family – so that we don't waste time by working on something that is not important to them

It has helped me to identify my role in empowering and enabling parents and children, which might remove dependency from the therapist

Example of change in practice

Referrals had increased and people were waiting longer to be seen. We considered how we could see more new patients and still review the existing caseload. Now we offer parents the option of a **review by phone**, every three months. Parents decide if they are happy with their child's splint or whether it needs to be readjusted and we only see children when they need their splint readjusted, not just for review.

Our **waiting time has been cut from 12 weeks to 1 month**. **Parents really appreciate not having to travel,** often long distances, we've also **cut down the time children were taken out of school** and we saw an **increase in splints being used.**

Example 14: More time for new patients – more time for children and parents

8 Embedding and sustaining Bridges in practice

The Bridges facilitator used Normalisation Process Theory (NPT)[10] as a tool to **foresee and explain emerging implementation challenges** throughout the course of the project and to **provide possible explanations for why the observed effects happened**. NPT provides a structure to analyse the work people do to integrate a new way of working by distinguishing between four key elements: Coherence, Cognitive Participation, Collective Action, and Reflexive Monitoring.[11]

Developing a shared sense of what needs to be done

Multi-level support within the Trust

Right from the outset, the project had support from people working across different levels within the Trust. Two AHPs, clinical and managerial, and a senior manager responsible for staff development considered Bridges to be beneficial for their service and in alignment with the Trust's overall goals. All three expected a Bridges improvement project to enable AHPs to **transfer power back to children and parents, whilst reducing dependency on services.** They identified the former as likely to be valued by their service users and the latter to address the organisational challenge of coping with increasing demand and complexity.

While both AHPs had attended Bridges training in self-management support for adults and considered the principles applicable in the paediatric context, this was new terrain for Bridges. The senior manager agreed with Bridges to pool their expertise to **jointly develop a first of its kind training programme** in paediatrics.

[10] May, C. and Finch, T. (2009). Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology*, 43 (3): 535-554.
[11] http://www.normalizationprocess.org/

Shared sense of purpose between service users and staff

The project started with engagement events for children, parents and AHPs to ensure that the overall purpose was clear for everyone involved. During these events, **a shared sense of purpose evolved across the groups** and found expression in the **refined project aims** (see p. 8).

Implementation challenge 1:

Younger children (7-12 yrs.) struggled to grasp the concept of providing feedback on services, which required finding a different way to **ensure that the children's viewpoints were taken into account.** The Bridges facilitator explored what is most important to them, what they enjoy most and what they find most difficult. Their views became part of the workshop content and AHPs reflected on how their clinical practice relates to the children's everyday life. Later in the project, some children contributed their drawings of hopes and dreams that were used to create reminder postcards for staff to emphasise the importance of a holistic and strength-based approach.

Children and parents responded overall very positively to the service changes made as a result of this project and **shared a sense of improvement with staff** as the examples in chapter 7 show.

Implementation challenge 2:

There was **some dispute between staff and parents** about what 'good support' looks like, which poses a risk to engagement if it remains unresolved.

> There is insufficient support for certain conditions. Rather than getting the necessary professional input during individual therapy sessions, we feel that we have to do the therapy ourselves.

In order to sustain Bridges this requires teams to find ways of turning disagreements into opportunities to look at something from a different perspective and find carefully considered solutions.

Implementation challenge 3:

The feedback from parents covered a wide range of suggestions for change and **AHPs have addressed some issues more than others**, which can potentially cause disagreement about the achieved benefits of the project for children and parents. This requires a mechanism to collect and respond to service user feedback on an ongoing base in future and to evaluate and report changes consistently.

Shared language and values across professions

During the two multi-disciplinary workshops, the Bridges facilitator supported AHPs to develop a shared action plan (see p. 10). **The Bridges approach** functioned as an overarching framework that has **provided a shared language and practical strategies to establish new ways of working** based on shared values across different disciplines and teams.

> I had been using bits and pieces of a Bridges approach in daily practice prior to receiving my training. But now, given the framework of Bridges, I feel I'm doing it much more consistently; I feel I'm getting much more information from the patients and I feel that the targets that my team sets are much more practical, functional and patient-centred; and I can see it in the answers I'm getting from the parents and children.

AHPs used the newly acquired knowledge and skills to develop strategies to address the feedback from children and parents who attended the engagement events. During the three months between the initial and follow-up workshop, the Bridges-trained AHPs put their plans into action in individual practice and tried to **get team members on board** who did not attend the workshops.

Implementation challenge 4:

Other team members not being trained posed more of a challenge to establish a shared team ethos than AHPs expected at first. They lost confidence to be able to explain the Bridges concept to colleagues after their attempts to take the concept back to their teams.

96% of AHPs after the 1st workshop versus **84%** after the 2nd workshop **felt confident to be able to explain the Bridges concept to their colleagues**

More structured training and support is needed to help AHPs to share the Bridges concept with other colleagues.

At the follow-up workshop, the Bridges-trained **AHPs exchanged their experiences of integrating Bridges into practice** to remind each other and deepen their shared sense of how to work differently across teams. They expressed the need to establish regular meetings like this to keep Bridges going.

Commitment and engagement by everyone involved

Personal and organisation commitment from the Trust and Bridges

Staff across different organisational levels were prepared to invest time, energy and resources into the project from the very start. **At senior level,** the Southern Trust and the social enterprise Bridges demonstrated commitment through **offering pooled resources** to develop the first paediatric Bridges self-management programme as both saw potential to jointly support shared learning beyond the scope of this project.

A previously Bridges-trained AHP in a managerial role helped to form a core group of AHPs, who helped with organising engagement events and raising awareness among their colleagues. Another **Bridges-trained AHP**, who had used Bridges in her clinical practice, was prepared to invest time and energy in **co-facilitating the workshops for her colleagues** with an external Bridges facilitator. Since Bridges was treading new ground with this paediatric project, the **Bridges facilitator** was **committed to work side-by-side with staff and service users to learn about their experiences** of using and providing the service.

Increasing engagement from AHPs and service users

The **commitment and engagement of the wider group of AHPs** who attended the Bridges workshops built up, **when they** began to embed Bridges into practice and **experienced the benefits for service users as well as for themselves** first-hand. The same was true for **children and parents.** Staff noticed that they **engaged more**

in therapy interventions, when they felt joy or **saw the immediate benefit** to them.

> I was seeing a child who was struggling with balance, instead of giving him a home exercise programme, I asked him for his ideas – he got really excited and said 'Yeah! I could chalk a line on the floor and practice walking along it'. It was a lovely moment actually, I felt that I got a lot more out of the treatment, as well as him, more job satisfaction – seeing his enthusiasm for the very satisfactory exercise he had chosen.

Example 14: I got more out of the treatment, as well as him

During the second Bridges workshop, AHPs shared their success stories such as example 14 and committed to capturing them in self-organised film sessions resulting in the production of several film clips which can be shared within their teams and more widely. **Experiencing and sharing success has helped AHPs to build their confidence.** After the first Bridges workshop, 92% of participants felt confident to use Bridges in their practice, with 32% feeling very confident. Their level of confidence increased after the second Bridges workshop three months later to 94% feeling confident, with 62% feeling very confident.

92% of AHPs **felt confident to use Bridges** in their practice **after the initial workshop**

94% of AHPs **felt confident to use Bridges** in their practice **after the follow-up workshop**

100% of AHPs **intended to keep using Bridges** in their everyday work

Collective action

Joined work to integrate changes into existing practice

Permission to work differently

The demand for paediatric rehabilitation services has steadily increased over the last years with great complexity being evidenced. While AHPs feel the pressure of having to demonstrate how they make the best possible use of limited resources by achieving high scores on objective outcome measures, this alternative approach has given them **permission to give ownership back to the children and parents.** Enabling AHPs to work in a way that is **person-centred, evidence-based and efficient** appeared critical.

Not spending unnecessary time on my aims but focusing on theirs

*What has been beneficial is **having evidence** to underpin this way of working*

Implementation challenge 5:

While the perception of Bridges as a legitimised way of working is core to sustain and build on the already achieved positive outcomes, AHPs reported concerns that it was not fully compatible with existing approaches.

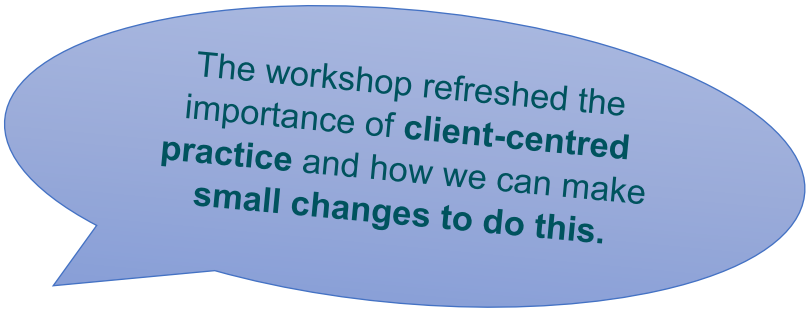
There is too much focus on outcome measures, which are quantitative	Merging it with other approaches that are currently endorsed/implemented by the department e.g. care aims, Therapy Outcome Measures – Core Scale (TOMs)

One of the action points from the follow-up workshop to address this issue was to focus on collective practice and organisational influences.

How can we use this work strategically – use to influence?

Small changes that make a big difference

The new way of working combined easily with existing practice as AHPs made **small tweaks** to how they work – making **Bridges a routine part of what they do every day.**



I've made one simple change to my language when introducing myself – now I ask "what's brought you along today?" This opens up the conversation and we discuss what's important, we talk about family life and how we can work together to improve things.

Example 15: One simple change

Changing paperwork and processes

The strong focus on **integrating Bridges principles into team processes and documentation** (e.g. example 7 and 9), rather than restricting the programme to up-skilling individual practitioners, has helped to embed Bridges routinely into clinical practice. Using paperwork as agreed guidance and reminder to work differently not only **ensures sustainability**, but **makes it also a legitimate way of working** within a team or service.

Understanding and appraisal of changes by everyone involved

The AHPs directly involved in the project shared their experiences of changing their practice during the follow-up workshop and they produced video clips of success stories since. The purpose of sharing challenges and successes has been two-fold.

Sharing challenges and successes to capture impact

The stories have helped to capture the impact of Bridges to **evaluate the intervention.** It has helped the AHPs directly involved in this project to see the benefits and **build their commitment and engagement** to keep using Bridges in their practice as shown on page 26.

Demonstrating the benefits to other team members and across the organisation is essential to **establish Bridges as a legitimate way of working** long-term as the concerns summarised under implementation challenge 5 on page 27 have revealed. In order to ensure sustainability evaluation methods that capture the impact of applying Bridges principles in practice need to be integrated into existing evaluation processes within the service and organisation. AHPs have already started to work on this by collecting stories that enable them to capture dynamic changes, which require more flexibility than predefined outcome measures provide. Capturing individualised self-efficacy and emotional measures has begun to become part of clinical practice as the example about managing stress on page 19 demonstrates. Developing more consistent processes of capturing and reporting such outcomes as part of service performance measures will be important to get buy-in from those responsible for organisational governance and commissioners in future.

Sharing challenges and successes for shard learning

Since changing underlying values to service delivery needs to be tailored to local circumstances and situations that are likely to change over time, **clinical practice has to be constantly adapted on the basis of experiences** from everyone involved. This process has been started with the engagement events and needs to be continued with embedded mechanisms for **regular exchange of feedback between service users and staff.**

AHPs have exchanged stories and experiences of challenges and successes for **shared learning among themselves** during the follow-up workshop.

Implementation challenge 6*:*
One challenge they experienced was "slipping back into old way of working". They used postcards addressed to themselves and sent off by the Bridges facilitator six weeks after the follow-up workshop to remind themselves on changes they liked to maintain.

The postcards and the workshop, however, only provided a one-off opportunity to reflect on current practice. AHPs are currently in the process of finding ways to share experiences and collect regular feedback through, for example, regular meetings and video-recorded patient stories that can be used for **in-service staff training, joined reflection and continuous re-adjustment of the chosen aims and actions** beyond the timeframe of this project.

Findings from this project have been presented at meetings to **share learning with other areas within the Trust** and the learning and training material will be put to use regionally at **Bridges workshops for other Trusts** in the near future.

9 Key learning points

- AHPs valued the Bridges approach as an overarching multi-disciplinary framework that made them feel liberated to work differently and get to the heart of what is important to children and their families quicker – **achieving more meaningful therapy outcomes with existing resources.**
- **Engaging children and parents** in co-developing new ways of working and engaging them in a more mutual relationship **is feasible** and was **well received.**
- Change can be best achieved by focusing on **small changes** that AHPs can easily combine with existing practice helping them to **build their own confidence and embed Bridges routinely** into their everyday practice.
- Considering **sustainability** from the outset by focusing on **integrating Bridges principles into team processes and documentation** appeared critical.
- **Training more team members from other professions** would make it easier to establish and maintain a **whole team approach**
- Changing underlying values to service delivery requires ongoing support and mechanisms to enable **joined reflection and continuous re-adjustment of the chosen aims and actions** beyond the timeframe of this project.
- **Embedded evaluation methods** are key to **legitimise** this different way of working.

10 Appendix: Examples of impact at a glance

Throughout the course of the project, staff gave tangible examples of changes to their clinical practice.

Person-centeredness

Example 1: Rewritten information leaflet highlighting that the service exists to listen, guide and support – to establish a more equal relationship from the outset

Example 2: Focus on daily life, rather than just assessing difficulties – has helped improve lives regardless of whether scores had improved

Example 3: Deferring Speech and Language Therapy as not a priority to the mother and daughter right now – listened and supported parent and child with what is most important to them

Example 4: Giving back control – has enabled children and parents to come up with their own suggestions that therapists had not thought of

Example 5: Asking education and care staff for their opinion –to acknowledge and build strength and expertise within the child's support network

Example 6: Reinforcing what goes well – has helped to be positive and build confidence

Example 7: Getting to know you form instead of Case History Questionnaire – has improved personalised and two-way information, discussion and support from the outset

Example 8: From standardised scores to functional impact – has helped to achieve more meaningful outcomes such as increased engagement in family activities

Example 9: Integrating therapy into daily routines – has helped to reduce burden of therapy programmes for children/parents and made therapy activities more meaningful and fun

Example 10: Ditch re-assessments – has given parents and children more control over interventions by enabling them to talk about what they include in daily life, what works, what doesn't

Example 11: I'll call you if I need you – two-way conversations have helped to improve the self-esteem of older children by letting them move towards discharge, rather than highlighting their difficulties

Effectiveness

Example 12: Managing stress effectively by using open-ended questions and scores related to different settings and situations in the child's everyday life – helped to achieve more meaningful outcomes for the child and family

Example 13: We're stronger together – providing opportunities for parents to meet families with children who have the same condition to share meaningful real-life experiences

Efficiency

Example 14: More time for new patients – more time for children and parents through changing review process for splints