

# **What are the experiences of therapists using the online Back Skills training and implementing it within clinical practice?**

**Baerbel Christou, Oxford University Hospitals**

**Julie Sellars, Coventry University**

## **Background**

Low back pain (LBP) has become one of the biggest public health challenges causing significant cost to the health service and indirect costs due to lost productivity and earnings to the state (Balague et al. 2012; Maher, Underwood & Buchbinder 2016). It has been widely acknowledged that the use of a cognitive behavioural (CB) approach can reduce long term disability and pain (Richmond et al. 2015) and should therefore be considered as a treatment option accessible within primary care. Consequently, NICE has reflected this evidence in its latest guidelines, recommending psychological treatments should be part of therapeutic interventions in the treatment of LBP (NICE 2016). However, the provision of combined physical and psychological treatment was regarded as the most serious gap in current service provision by the National Spine Task Force (2013).

The BeST trial evaluated the efficacy of a CB approach for LBP in a large scale RCT and found it to be clinically and cost effective (Lamb et al. 2010). In the study the CB intervention was predominantly delivered by physiotherapists who had received face to face training. The programme provides 10 hours of training containing written information, video examples and links for further reading as well as short knowledge tests. The content of the training is described elsewhere (Hansen, Daykin and Lamb 2010). The purpose of this training is to enable clinicians to set up and hold CB approach classes for patients who experience at least 'moderately troublesome LBP

pain' for at least 6 weeks duration (Lamb et al. 2010). In clinical practice, within the examined trust, patients who presented with moderately troublesome back pain which was identified using the Start Back tool were supposed to be referred after one assessment with a physiotherapist into the class (Hill et al 2011). To increase the widespread implementation of a CB approach an online tool 'Back Skills Training Programme' (BeST) for the training of NHS health professionals was launched in 2015 (backskillstrainingprogramme 2015).

Two recent studies (Richmond et al 2016; 2018) have assessed the feasibility of the online version of the programme and explored the experiences of physiotherapists implementing a CB approach. The authors concluded that the online BeST training tool is a feasible option but identified areas for improvement. This current paper explores the use of the online tool in a primary care setting, therefore, adding to the knowledge and understanding of using the online BeST tool in a clinical setting.

### **Aim:**

The aim of this study was to explore the experiences of primary care physiotherapists who had completed BeST via an online medium. In particular, we aimed to explore physiotherapists' attitudes towards the online tool, the CB approach and their perceived ability to hold the classes after receiving the training. The aim was also to provide valuable feedback to participants, managers and developers of the BeST tool.

### **Method:**

We used the methods of Interpretative Phenomenological Analysis (IPA). This qualitative research approach is committed to exploring peoples' experiences with major life experiences. Although it is predominantly used to make sense of major life

experiences of patients (Smith, Flowers and Larkin 2009: 1), it has been used to explore physiotherapists' experiences with a specific treatment method (Scott-Dempster et al. 2014). Given the fact that the CB approach is potentially a major paradigm shift for some musculoskeletal physiotherapists, it was deemed an appropriate methodology. Ethical approval was granted from Coventry University and permission from the Health Research Authority was given.

### **Sampling and Recruitment:**

A purposive sample of 6 physiotherapists were invited by letter to take part. All belonged to one large Primary Care Community Trust, and had completed the BeST training and had held at least one group session. All physiotherapists were grade six and had an average time since qualifying of 14 years.

### **Data collection:**

An interview guide was developed by BC after consulting relevant literature and advice from the other author JS. The questions were grouped into three themes:

(I) Experiences with the training, (II) Online aspect of the training, (III) Clinical practice. BC conducted semi structured, individual, in- depth interviews lasting 35-60 min. All interviews took place at the participants' work place in a private treatment room. BC is an experienced physiotherapist who underwent the BeST training prior to undertaking this study, however did not have any formal CBT training. At the point of the interview she was a colleague of the participants. All interviews were audio recorded using a digital recorder. Interviews started with broad opening questions to build trust and used probing questions later in order to trigger more in depth information (Carpenter and Suto 2008).

### **Data analysis:**

All transcripts were transcribed verbatim. All identifying data was removed and pseudonyms given to protect anonymity. Participants were given the opportunity to read their transcripts.

Data analysis was conducted using methods recommended by IPA (Smith, Flower and Larkin 2009). Following analysis through reading, rereading and initial note taking, emerging themes were developed. In order to help analysis, transcript extracts were produced for each participant which were manually sorted into emerging themes. Following that process four main themes and subsequent subthemes were established (Table 1).

## **Findings**

We abstracted five main themes: (1) Flexibility (2) Interactivity (3) Use of CB approach in clinical practice (4) Facilitating group work after BeST training (5) BeST needs organisational support. The main themes are described below. (See Table 1 in Appendix)

### **Flexibility**

The online BeST training was perceived as a well-designed training programme which was capable of delivering key information about the CB approach and its use in practice. The flexibility of the tool was perceived by all as the most important benefit allowing excellent accessibility. ‘

*We did not have to travel anywhere, it was really easy to access, so if you had half an hour here and there you could dive into it (C2/24-26)’*

Some participants reported the positive effect of tailoring learning material towards their personal needs. Charlie summarizes as follows:

*‘...so I could take screen shots of those and had that all on my computer, so writing notes and taking screenshots of useful information as I went along, so it was just easy, it was all in one place, I could formulate that into one document. C 3/14-19”*

In summary flexibility with regards to time and how learning material was used was an important positive aspect of the tool.

## **2. Lack of interactivity**

Despite the positive overall impression, most participants would have preferred a face to face learning opportunity as they believed it would have offered a more interactive learning approach.

*‘ It would have been really useful to me maybe as a team do some learning, do some tasks together, do some role play not just watching a computer screen (A 4/6-9)’*

Further, physiotherapists missed peer support and practice based learning activities. The online training tool used a mixture of reading materials and video examples about CB classes. The videos were regarded as helpful, however the majority of participants felt they did not reflect normal working practice and they reduced confidence to be able to hold the class of those participants.

*‘There was nobody that seemed to rock the boat or contradict C4/22-24)’.*

## **3. Use of CB approach in clinical practice**

Expectations about the content prior to training were mixed, ranging from apprehension to being intrigued and excited. This was often dependent on previous

training levels with participants with no prior training being more apprehensive. The CB approach was described as a new way of working by most participants

*‘....it is definitely different, a different way of working and one that I am not – we have not been used to before (J 5/30-32)’.*

Some physiotherapists were not sure if the CB approach could be perceived as outside their scope of practice as summarized by Sam:

*‘I feel like it’s going quite a bit away from physiotherapy’ (S 7/20-21).*

Despite some reservations by some participants all reported that they subsequently used key aspects of the CB approach, such as ‘guided discovery’ to explore how thoughts and feelings affect LBP, goalsetting, collaborative working and the treatment technique of pacing (Hansen, Daykin & Lamb 2010). in their normal, one to one physiotherapeutic practice

*‘I think it is a really good way of targeting goals and I think it is really useful’ (K 5/40-41)*

In summary, despite initial reservations, therapists implemented, to varying degree, key aspects of a CB approach after using the online training.

#### **1. 4Facilitating group work after BeST trianing**

Despite participants reporting improved knowledge and adopting the CB approach during some one to one treatments, all participants were nervous to start to facilitate the group sessions. They reported varying degrees of confidence to facilitate the groups ranging from:

*'there were nerves there (K 6/17)' to 'Terrifying (C 15/25)'.*

This strong emotion was surprising, given the overall level of experience of the clinicians. It was unclear if this was due to the online method or due to the use of the new treatment paradigm, however, some participants did attribute the lack of interaction and feedback of the online medium as a contributing factor for the lack in confidence:

*'And that was whether that was because we were starting something completely different, or whether the training felt quite passive and I just watched something rather than had someone almost assess my confidence for doing it' (P 9/23-30)'.*

Confidence did improve with practice, helped by peer support which was implemented by the team leader when lack of confidence became apparent.

After starting to facilitate classes, participants encountered some difficulties dealing with complex group dynamics. The BeST training aims to teach a bespoke and quite prescriptive model of group therapy targeting key modifiable risk factors (Fordham et al. 2017). However, this does not prevent difficult situations occurring, such as patients not complying with the approach or being unwilling or unable to engage. Some participants felt they were lacking in the skill to deal with challenging situations

*'I think it would have been nicer to have had a bit more of a guidance what to do if it goes completely off tangent and how to bring them back to that' (P 10/15-18).*

This perceived lack of skill was a key factor that affected the confidence of participants holding the classes. Referring patients into the CB classes posed another challenge for participants, they felt BeST was prescriptive and imposed a

restriction of professional autonomy and discouraged clinical judgement. BeST protocol directs clinicians to refer all patients with moderately troublesome LBP of 6/52 or more to the classes, which was perceived as problematic as participants felt discouraged to use their clinical judgement ‘

*...we have hopefully got the skills to be able to identify those patients that need more of that education side of things and those of them that have specific biomechanical musculoskeletal problems that need addressing specifically (A 13/28-33)’.*

The assessment of the patient before attending BeST focuses predominantly on psychosocial aspects of LBP, which was considered, by some, to be insufficient.

*‘..and to be able to do a bit more of a thorough assessment on each patient to start with (A 15/39-41)’.*

This perceived lack of professional autonomy and use of clinical judgement led to some clinicians being reluctant to refer into the class. It is noteworthy that patients were also referred into the BeST class by clinicians who had not completed the online BeST training and they found referring into class even more challenging due to the lack of in depth understanding of content and referral criteria for the classes.

*‘ I don’t think it was deemed as a positive option for our patients’ (C 20/19-20).*

This issue was recognised by the management during the implementation and consequently all clinicians received appropriate training.

## **5. BeST needs organisational support**



Participants considered managerial support as vital during the training and the implementation of BeST. However, some of the Physiotherapists felt that it could be difficult as some senior staff did not undertake the BeST training:

*‘So we then need input from our Band 7 who was the team lead. But our Band 7 haven’t actually done the training (C 19/3-6)’.*

Further, physiotherapists felt that overall coordination to implement the classes was essential for implementation, and this was sometimes not available.

*‘And there was no organisation of adapting it within our patient group, how we run our assessments, how our time is allocated for those patients how they will fill in the paperwork and everybody was then trying to do individual groups of work, bodies of work.’ (C 5/18-24).*

This highlights that it is vital that those organising the services recognise that the time demands for managing patients with LBP with a CB approach may be different to conventional management, something also highlighted by Richmond et al (2018).

## **Discussion**

This qualitative evaluation focuses on the influence of the BeST online teaching method on the experiences of clinicians learning and implementing a CB approach. Our innovation was to focus on the online teaching aspect which is in slight contrast to a previous review of Richmond et al. (2018) which focused on exploring physiotherapists’ experiences of implementing a CB approach and identifying barriers to long-term implementation. Our study was conducted by a clinician working within a clinical practice setting. The qualitative methodology does not aim to provide a quantitative evaluation of implementation of BeST; its strength is to offer

additional insights into real life and in depth experiences of physiotherapists using the BeST tool (Holloway 2008:185).

The BeST training tool was perceived as a well-designed, easy to follow online training tool. The flexibility of access was perceived as one of the biggest advantages, in particular the lack of travel and the ability to revisit the content after the training was completed. It was perceived as an appropriate tool to improve knowledge, however not everybody was satisfied with its use in isolation and would have valued additional face to face interactions. Richmond et al. (2016) in their comparative study of face to face and online methods, whilst concluding that knowledge transfer in a face to face environment was similar in effectiveness to that in an online method, found satisfaction levels lower for participants using the online method. This led Richmond et al (2016) to conclude, that steps to improve satisfaction for the online user would be beneficial to improve engagement. Interestingly, a large meta-analysis about internet learning in health professionals (Cook et al. 2008) found satisfaction levels to be very slightly higher for the online medium, therefore differences in satisfaction in this study may have arisen because of the course content itself rather than the nature of the medium. This study, however, is looking at a variety of trainings which are not necessarily teaching psychological aspects of treatment as in BeST which could explain the discrepancy.

It is noteworthy that none of the participants reflected on the potential cost effectiveness of the online medium. This is possibly due to the fact that none of the participants had managerial responsibilities such as commissioning of training. However, it would be useful for physiotherapist to be made aware of the cost benefits of different training medium.

Some participants seemed to hold strong biomechanical views even after the training. This may be due to the fact that the CB approach was a new concept of treatment for the majority, indeed some considering to be outside of their scope of practice. In fact, some clinicians found it very difficult to adopt a psychosocial approach and prefer to use a biomedical approach despite training. This is in keeping with previous research indicating that physiotherapists can perceive the use of psychosocial practice as outside their practice despite training (Synnott et al. 2015). These biomedical views conflicted with referral criteria for classes and consequently led to difficulties referring into the CB class. To select which patients should be referred, clinicians expressed a preference for using clinical judgement alongside the Start back tool to predict the risk of chronicity for patients experiencing LBP. This might suggest that the training was not sufficiently able to shift some physiotherapists' approach from a biomechanical to a more psychosocial. This resulted in a perceived curtailment to participants' professional autonomy by BeST leading to the conclusion that the online BeST training was, at least in parts, insufficiently able change important belief systems such as the need for screening for the risk of chronicity.

Richmond et al. (2016) had the same outcome during their feasibility study of online versus face to face training for the CB approach. They found that the change in attitude towards psychosocial belief system was more difficult to achieve in an online learning environment as opposed to a face to face situation. Richmond et al. (2016) suggest that the online BeST tool uses a constructivist learning paradigm which constructs knowledge built on current understanding through improving understanding gained through different learning activities such as interactive learning, self-directed study discussion forums. However, the experiences of

participants only reflects this partially as many participants identified the lack of interactive activities as the predominant disadvantage of this training. It could therefore be argued that online BeST uses a predominant cognitivist learning paradigm as used in most short online courseware which can suffer from poor learner engagement and lack of motivation (Harasim 2012:89).

Measures to improve learners' engagement within the online tool such as discussion forums and the use of peer support as well as additional in house face to face workshops might facilitate constructivist learning. This is supported by previous literature (Littlewood et al. 2015) which identifies that research evidence and knowledge transfer is not the central drive for change of physiotherapy practice, but previous beliefs prior to teaching and interaction with colleagues and opinion leaders which is difficult to achieve via an online medium. Further research into optimal further training strategies to achieve the change in attitude towards a psychosocial treatment approach would therefore be useful.

Some participants felt that the development of practice skills online was unsatisfactory. In particular, therapists found it difficult to deal with unexpected situations occurring in class such as patients not following the approach or challenging group dynamics. This resulted in poor confidence for some participants. These findings could suggest that the online medium of the BeST training contributed to the lack of self-efficacy to start holding the CB approach classes.

We found that peer support when holding the initial classes made individuals feel more confident. The lack of a practical learning opportunity online might mean that although participants understood, they were unable to move onto the next step of applying it, thus leading to poor self-efficacy.

Richmond et al. (2016) did not find large differences in self-efficacy and knowledge transfer when comparing online and face to face training, despite face to face being the preferred medium. This may mean that the lack of self-efficacy was due to the new philosophy of a CB approach, rather than instead of the online learning method per se. Further, it is widely acknowledged that lack of confidence is a normal process when starting something new and that confidence can increase with experience (McLeod 2013). This is supported by Gosling (2014: 19) who states that courses and workshops can be useful to promote new practices and ideas, but the implementation of new skills can be difficult. Despite the medium of training further support is essential to facilitate the implementation of the training into practice. It might be suggested that learning informally in the workplace can be most effective and peer review can be a useful tool to achieve this. This supports the argument that adequate support from other clinicians during implementation might be as important, or even more important, than practical skill rehearsal prior to implementation. Further, our findings suggest that clinicians need organisational support during the implementation of BeST.

**Limitation:**

This research examined the experiences of six therapists with seven years or more professional experience from one Primary Care Trust. All participants were of white ethnicity and worked in a predominantly rural Trust. Therapists with different levels of experience, cultural backgrounds or working in a different care setting may have expressed other experiences.

The researcher had many years of experience in interviewing as a clinician. All initial transcripts were analysed by the researcher, and the analytical findings challenged by a supervisor during the planning process, the initial coding and data analysis.

## **Conclusion**

The online BeST tool is a novel training tool with the aim of providing a cost effective learning opportunity in the CB approach. This training can lead to the implementation of an evidence-based, long term management approach to LBP potentially resulting in improved treatment outcomes and reduced ongoing care costs (Balague et al. 2012).

The tool provides a potentially cost effective way to achieve staff training, which is essential. However, our findings demonstrate that BeST is lacking interactivity during the training. This can potentially result in a lack of confidence, a lack of skill development and difficulties in adopting a psychosocial explanatory model by physiotherapists.

Our findings supports that BeST is a useful tool, we suggest that it should be enhanced with face to face learning activities such as in service training and peer support. Further, the development of an online discussion forum for clinicians could be beneficial.

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## Appendix 1

Main theme	Quote	Participant
Flexibility	<i>We did not have to travel anywhere, it was really easy to access, so if you had half an hour here and there you could dive into it</i>	C 2/24-26



	<i>'...so I could take screen shots of those and had that all on my computer, so writing notes and taking screenshots of useful information as I went along, so it was just easy, it was all in one place, I could formulate that into one document.'</i>	C 3/14-19"
Lack of Interactivity	<i>' It would have been really useful to me maybe as a team do some learning, do some tasks together, do some role play not just watching a computer screen</i>	(A 4/6-9)'
	<i>'There was nobody that seemed to rock the boat or contradict</i>	C4/22-24)'. '
Use of CB approach in clinical practice	<i>'...it is definitely different, a different way of working and one that I am not – we have not been used to before</i>	(J 5/30-32)'. '
	<i>'I feel like it's going quite a bit away from physiotherapy' (S 7/20-21).</i>	(S 7/20-21). '
	<i>'I think it is a really good way of targeting goals and I think it is really useful'</i>	(K 5/40-41) '
Facilitating group work after BeST training /	<i>'there were nerves there'</i>	K 6/17
	<i>'Terrifying'</i>	C 15/25
	<i>'And that was whether that was because we were starting something completely different, or whether the training felt quite passive and I just watched something rather than had someone almost assess my confidence for doing it'</i>	P 9/23-30
	<i>'I think it would have been nicer to have had a bit more of a guidance what to do if it goes completely off tangent and how to bring them back to that'</i>	P 10/15-18

	<p><i>...we have hopefully got the skills to be able to identify those patients that need more of that education side of things and those of them that have specific biomechanical musculoskeletal problems that need addressing specifically</i></p>	A 13/28-33
	<p><i>‘..and to be able to do a bit more of a thorough assessment on each patient to start with</i></p>	A 15/39-41
B e S T            n e e d s organisational support	<p><i>‘So we then need input from our Band 7 who was the team lead. But our Band 7 haven’t actually done the training</i></p>	C 19/3-6
	<p><i>‘And there was no organisation of adapting it within our patient group, how we run our assessments, how our time is allocated for those patients how they will fill in the paperwork and everybody was then trying to do individual groups of work, bodies of work.’</i></p>	C 5/18-24