PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME

EVALUATION REPORT

CASE STUDY SIX: BEDFORDSHIRE, LUTON &

MILTON KEYNES STP

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Contents

EXECUTIVE SUMMARY

Introduction

Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Partnership (STP) was the last of six East of England STPs to participate in the Bridges Supported Self-Management (SSM) training and quality improvement programme: People 1st.

The timeline of the Bridges programme and evaluation in this STP was May 2019 to April 2020. Due to the impact of the COVID-19 outbreak, it proved necessary to curtail some activity scheduled during the latter part of the programme and some evaluation data was not available for inclusion in this analysis.

Full details of methods used in the evaluation have been reported previously (see Case Study One: Cambridgeshire and Peterborough STP).

Data collection

Bridges offers 125 training places across the STP and 110 practitioners attended the Introductory Workshops: Knowledge Zone 1 (KZ1) and 100 attended the Follow-up Workshops: Knowledge Zone 2 (KZ2). One follow-up workshop scheduled to run in April was cancelled because of COVID-19 outbreak. The Bridges Champions Masterclass that was due to take place at the end of April was also cancelled.

Data available for inclusion in the evaluation comprised: 91 pre-training and 52 post-training questionnaires and 4 hours of workshop observations. A further 45 post-training questionnaires were completed by workshop attendees but, due to the impact of COVID-19, were not accessible to the evaluation team for inclusion in this report. As the Bridges Champions Masterclass was cancelled, the evaluation team was unable to gain the same level of feedback on team implementation and sustainability plans as was possible in the other five STP areas that participated in the programme.

Semi-structured telephone interviews were conducted with three practitioners. Three other individuals indicated their willingness to take part in an interview, but it did not prove possible to schedule these within the time frame of the evaluation due to the impact of the COVID-19 outbreak on services.

Stakeholder engagement

The awareness raising and engagement process in BLMK STP took place between May and July 2019 and involved six trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. An engagement meeting was held in July 2019, with 20+ attendees. Feedback from the Bridges team about the engagement meeting suggested a sense of energy and enthusiasm for the training, tempered with some concerns about how to engage nursing colleagues in the initiative.

One acute trust was not able to secure the participation of nursing staff in the training and in December 2019 it was eventually agreed that workshops would be run for the therapists only. The introductory workshop for this trust took place in early February 2020, while the main body of introductory training in this STP took place between late October and early December 2019. Governance approval for evaluation activities was not forthcoming during the time frame of the evaluation and representatives from this trust have therefore been excluded from the evaluation analysis. (In the event, the follow-up workshop for this trust was cancelled due to COVID-19.)

Engagement with former service users was not undertaken in this STP as analysis of data from focus group discussions conducted in the first three case studies suggested that no new insights were likely to result from further activity.

Findings

The following section presents a summary of findings with respect to the specific evaluation questions.

Does Bridges lead to an increase in confidence and use of SSM by practitioners?

- Practitioners were positive about the opportunity to reflect, learn, think, and plan together. They described the training as "valuable", "inspiring" and "thought provoking". It resonated with their intrinsic motivations for working in healthcare and encompassed principles that they aspire to. Practitioners appreciated the time to discuss ideas in their team and to bring the focus back to what is important for patients.
- Bridges SSM training was seen to validate ideas for service improvement work and to promote adoption of a standardised approach to patient care.
- Questionnaire data points to a shift in confidence and performance of SSM tasks. This was supported by findings from qualitative data where practitioners described how they were making changes to their practice. Practitioners felt that further time and effort were necessary to refine and consolidate the changes and to build confidence in using the new approaches.
- At the end of KZ2, 96% of practitioners agreed that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

Is Bridges a useful approach for practitioners and has it resulted in changes to practice?

- Practitioners reported making changes to their individual and team practice as a result of the training, such as: adapting language and using open questions, changing the structure of their interactions with patients (e.g. more patient-led assessment sessions and goal setting approaches), and encouraging patient problem solving and reflection.
- Steps were underway to spread, embed and sustain changes, such as: using a variety of methods to share learning about the approach and to bring other team members on board, altering processes and paperwork, placing visual prompts in the environment (e.g. to manage expectations about 'therapy') and planning to audit/evaluate new resources. In developing new resources, some teams had sought input from current service users.
- Practitioners reported that feeling under time pressure can mean that SSM is not used consistently by staff and further time and effort is necessary to ensure that this becomes part of 'routine' practice.

What are the expected outcomes for practitioners trained and able to use Bridges?

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in enhanced interactions with patients. Practitioners report increased satisfaction through partnership working and being able to deploy their skills more effectively to deliver meaningful therapy.
- Practitioners reflected that the Bridges programme had demonstrated to them how small changes to practice can have an important impact on both patient and staff satisfaction.

What are the expected outcomes for patients cared for by a Bridges-trained team?

- The evaluation team had no direct access to current service users to explore their perceptions of the care they received in a team delivering care according to Bridges SSM principles. Information on the benefits of the approach for patients was obtained via practitioner interviews and training workshop observations.

- Practitioners commented that using the Bridges approach meant that patients and families felt more listened to and are reassured that their hopes, worries and goals have been acknowledged.
- Practitioners indicated that encouraging patients to reflect and problem solve allowed them to develop greater insight into their progress, enhanced motivation and promoted self-confidence.

What are mechanisms of change and enablers and barriers to implementation and sustainability?

- Training provides practitioners with a space away from clinical demands to reflect and think together about changes to practice that will benefit their patients. Practitioners were motivated to consider change, even in the context of a pressurised environment, and had the opportunity at the workshops to discuss and plan their initial "small steps" in the change process.
- The quality of the training was one of the enablers of implementation. Feedback suggested a number of factors contributed to a positive learning experience including: the learning atmosphere, use of adult learning principles, level of interactivity and group work, the credibility of trainers, the evidence base for the Bridges approach, and the use of the 'peer voice' and 'patient voice.'
- The Bridges programme and drivers for change appeal to the intrinsic motivations of healthcare staff ('helping others' and 'making a difference') and make use of valuable extrinsic motivators such as the service user voice, peer influence, and, in time, local Bridges Champions.
- Important drivers for successful implementation include: the need for key individuals to support and lead the improvement, engaging support of the wider team, and having sufficient training, resources, and management support.

CASE STUDY SIX: BEDFORDSHIRE, LUTON AND MILTON KEYNES STP

The following presents a summary of evaluation results for the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Partnership (STP), the last of six East of England STPs to participate in the Bridges Supported Self-Management (SSM) training and quality improvement programme: People 1st.

Full details of the methods used in the evaluation appear in the report of Case Study One: Cambridgeshire and Peterborough STP and are not repeated here.

The table below shows the timeline of the Bridges SSM programme in BLMK STP. Activity during the final months of the programme was impacted by the outbreak of COVID-19.

Table: BLMK Bridges SSM programme timeline

Stage	Timeline
Stage 1: Awareness Raising	May – July 2019
Stage 2: Stakeholder Engagement (former service users)	No activity in this STP
Stage 3: Introductory Workshops Knowledge Zone 1	October - December 2019 One acute trust: February 2020
Stage 4: "Transforming"	November 2019 - March 2020 One acute trust: February – April 2020
Stage 5: Follow-up Workshops Knowledge Zone 2	February - March 2020 *One acute trust: scheduled for April 2020 but cancelled due to COVID-19 outbreak*
Stage 6: Champions Masterclass	*Scheduled for late April 2020 but cancelled*
Stage 7: Sustainability plans	*Focus of Masterclass*

STAKEHOLDER ENGAGEMENT

Trust engagement

The awareness raising and engagement process in BLMK STP took place between May and July 2019 and involved six trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. An engagement meeting was held in July 2019, with 20+ attendees. Feedback from the Bridges team about the engagement meeting suggested a sense of energy and enthusiasm for the training, tempered with some concerns about how to engage nursing colleagues in the initiative.

One acute trust was not able to secure the participation of nursing staff in the training and in December 2019 it was eventually agreed that training workshops would be run for the therapists only. The introductory workshop for this trust took place in February 2020, somewhat later than the main body of introductory training in this STP (which took place between late October and early December 2019), and thus did not afford attendees the benefit of training with practitioners from other services across the patient pathway. Governance approval for evaluation activities at this trust was not forthcoming during the time frame of the evaluation and representatives from this trust have therefore been excluded from the evaluation analysis. (In the event, follow-up training at this trust had to be cancelled due to the COVID-19 outbreak.)

As indicated in the quotes below, practitioners perceived that the involvement of a broad range of professionals was a valuable aspect of the Bridges training and the objective of Brides SSM is, as far as possible, to secure the participation of whole teams in the programme.

"Essential to do this as a whole team, it is very useful to discuss and share ideas with colleagues." [SLT]

"Great to take part in a training session involving stroke teams across the county, e.g. hospital and community settings. It will assist with all the teams hopefully singing from the same hymn sheet." [Rehabilitation Assistant]

"A couple of years ago I tried to get some funding agreed within our service to have the Bridges training, but no funding was agreed at the time. One of the services we work quite closely with did have some training from Bridges. I am quite interested in the self-management approach. It's something that I think would be really useful for our team." [OT]

While some practitioners had already undergone training in Health Coaching and Motivational Interviewing, Bridges training was perceived to offer the opportunity to acquire further skills and techniques.

"I have done Health Coaching and Motivational Interviewing but I think it has helped to build on that." [OT]

It was decided not to pursue engagement with former service users in this STP. It was felt that this was unlikely to add to the insights into life after stroke and experiences of rehabilitation derived from engagement work with former service users in the first three STP areas to take part in the People 1st programme.

CONCLUSIONS: TRUST ENGAGEMENT

- The trust engagement process in this STP was took place in May – July 2019 and involved six trusts. The Bridges team reported that engagement activities were met with energy and enthusiasm, although concerns were raised about involvement of nursing colleagues in the training.
- In the event, it did not prove possible to secure involvement of nursing staff in the training at one of the acute trusts. After some considerable delay, workshops were agreed for therapists only, and were scheduled somewhat later than the main body of training in this STP.
- The value of a whole team approach to training was recognised by participants.
- Bridges was perceived to add to the toolkit of practitioners, supplementing techniques such as Health Coaching and Motivational Interviewing.
- Engagement with former service users was not undertaken in this STP as analysis of data from focus group discussions conducted in the first three STP areas to take part in the People 1st programme, together with knowledge of the research literature, suggested that no new insights were likely to result from further activity.

EVALUATION DATA COLLECTION

Quantitative

Bridges offered 125 training places across each participating STP in the East of England. The table below illustrates the number of attendees at the Knowledge Zone 1 (KZ1) and Knowledge Zone 2 (KZ2) workshops. As a result of the COVID-19 outbreak, it proved necessary to cancel one KZ2 workshop scheduled to run in April 2020 at an acute trust. The training programme at this particular trust was delayed due to difficulties with engagement and involved only therapy staff.

Table: Attendees at Bridges SSM workshops

Workshops	Timing	# attendees	# eligible for evaluation
Knowledge Zone 1 (n=6)	Oct – Dec 2019 (n=5) February 2020 (n=1)*	110	97*
Knowledge Zone 2 (n=3)	Feb – March 2020 (n=5) April 2020 (n=1) cancelled**	100	99***

** Governance approval not secured at one acute trust so 13 representatives excluded from evaluation*
***This follow-up workshop was cancelled due to the coronavirus outbreak, however representatives from this trust were in any case excluded from the evaluation.*
****One individual excluded (A student who did not attend KZ1 and did not complete full questionnaire),*

No medical staff attended the training. Concern was expressed at the Bridges engagement meeting regarding the potential difficulty of engaging nursing staff in the training and, as can be seen from the table below (Characteristics of Participants), only three nurses attended KZ1. Practitioners who did take part in the training suggested that it would be useful for more nurses and members of the wider MDT to attend in order to ensure consistency of approach and to help in promoting a SSM culture within services.

> *"Should be advertised more for nurses as it could cause great impact and good changes in the NHS."* [Nurse]

> *"Excellent training day, nicely introduces self-management as a concept and approach, additional places for team would be beneficial, all clinicians may benefit as it promotes an ethos that needs consistency."* [Psychologist]

The response rate to evaluation questionnaires was good (see table below).

Table: Number of evaluation questionnaires and response rates

Questionnaire	Number	Response rate
Knowledge Zone 1 – Pre-training	91/97	94%
Knowledge Zone 1 – Post-training	89/97	92%
Knowledge Zone 2 – Post-implementation	97/99	98%
Knowledge Zone 2 – Available for inclusion	52/99*	53%

***Due to COVID-19 outbreak, 45 completed questionnaires were unavailable for processing by evaluation team for inclusion in this case study report.*

The following table shows the characteristics of participants by profession, setting, time since qualification and years in current service.

Table: Characteristics of participants in Bridges SSM training

Participant characteristics	KZ1		KZ2	
Profession	**Number**	**%**	**Number**	**%**
Nurse	3	3.3	2	3.8
OT	24	26.4	11	21.2
PT	26	28.6	18	34.6
SLT	6	6.6	3	5.8
Psychology Practitioner	2	2.2	0	0.0
Rehabilitation/Healthcare Assistant	28	30.8	18	34.6
Other (e.g. clinical coordinator)	2	2.2	0	0.0
Total	91	100.0	52	100.0
Setting	**Number**	**%**	**Number**	**%**
Acute	30	33.0	11	21.2
Community	59	64.8	38	73.1
Both	2	2.2	3	5.8
Total	91	100.0	52	100.0
	Mean (SD)	**Range**	**Mean (SD)**	**Range**
Years in profession	11 (8)	<1-33	11 (7)	<1-28
Years in service	6 (6)	<1-23	5 (5)	<1-22

Qualitative

Workshop observations

The evaluation team carried out four hours of evaluator embedded observations at one of the KZ2 workshops.

The Bridges Champions Masterclass, which provides an opportunity for teams to feedback on practice changes and to focus on strategies for embedding, sustaining, and evaluating the approach, was scheduled to take place in late April 2020. This event is open to 25 "Champions" selected by their service teams to be key individuals in promoting and sustaining the Bridges approach. Due to the impact of the COVID-19 outbreak this event was cancelled, and the evaluation team was therefore unable to obtain feedback on teams' activities with regard to implementation and their plans for sustaining and evaluating the approach.

Semi-structured interviews

Three semi-structured telephone interviews (average duration = 34 minutes) were conducted with practitioners. Interest in participating in an interview was expressed by three other individuals, but it did not prove possible to schedule the interviews during the time frame of the evaluation due to the impact of the COVID-19 outbreak.

FINDINGS

Four Levels of Evaluation

Reaction

Practitioner feedback comments on the training at the end of KZ1 were coded as positive☺, neutral😐, or negative☹ by the evaluation team. The number in each category is presented in the table below, together with a range of illustrative comments.

A total of 68 comments about the Bridges training were coded as positive, with practitioners describing the training as "valuable", "inspiring" and "thought provoking." The use of the 'patient voice' was particularly appreciated and Bridges was seen to offer practical ideas that could be readily incorporated into routine practice. There were 21 neutral comments, i.e. instances where no comments were offered. The two negative comments were concerned with the length of the training and with the perceived difficulty of implementing the Bridges approach in the face of other competing projects and priorities.

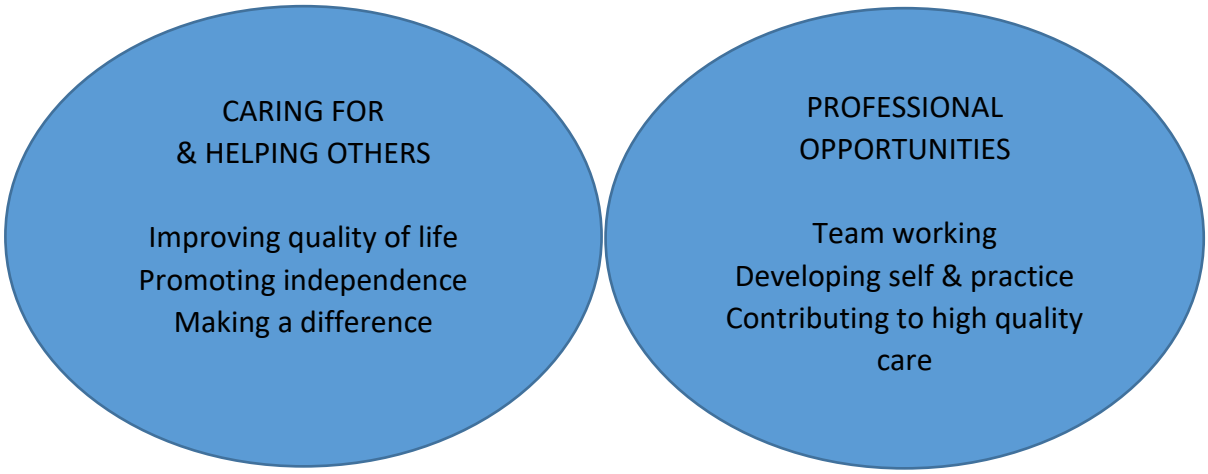
Table: 'Smile Sheets' - feedback from participants at end of KZ1

Feedback	Number*	Illustrative participant comment
	68	• It has really helped me to be more confident to focus on what is important to my patient in terms of goals [Rehabilitation Assistant] • I think it is really valuable and I am pleased that I am currently able to work on what is important to a person, rather than being governed by checklist assessment and service outcomes, which may not be meaningful to the person, it has been useful to consider how I can further improve my communication to promote self-efficacy [OT] • I do a lot of SM and for me this was about doing it better [PT] • Provides a framework that can be shared within a team and a language with which to explore SSM [Psychologist] • The best take home message for me has been the patient's perspective. As a nurse we are bound to be empathetic but with time we tend to miss the 'little things' which are the 'hard little things' that actually make a difference for a patient's recovery both medically and psychologically [Nurse] • Very useful for promoting ideas of very achievable change that will impact significantly on the patient process and outcome [PT] • Excellent, I feel empowered to implement theory into practice, enjoyed having members of different teams to speak with, thought it was very valuable to have both patient and therapist facilitating the workshop [SLT] • Really inspiring and thought provoking, the basics of it is a simple idea that so often gets forgotten in healthcare [PT]
	21	• No comments [21]
	2	• Slightly too long, the most mentally challenging element was at the end when tired [OT] • NHS setting/thinking needs to change – so many other projects staff are asked to get involved with, and "other" priorities such as bringing the waiting list down might overtake the focus [PT]

**Some participants offered more than one comment*

In the pre-KZ1 questionnaire practitioners were asked to state the professional ideals that attracted them to work in healthcare. The two main themes emerged as indicated in the diagram below. The themes are similar to those in the other case study areas.

Diagram: Intrinsic motivations for working in healthcare



Practitioners were very positive (98% agreed) when asked at the end of KZ1 whether they felt Bridges SSM would bring them closer to their professional ideals. At the end of KZ2 96% agreed that implementing the Bridges approach had brought them closer to those ideals.

Table: Practice reflects professional ideals

Practice and professional ideals	Positive	Neutral	Negative
Current practice allows you to reflect ideals? (n=83)	81%	19%	0%
Bridges SSM approach will bring you closer to ideals? (n=87)	98%	1%	1%
Bridges SSM approach has brought you closer to ideals? (n=51)	96%	4%	0%
Find work enjoyable	**Positive**	**Neutral**	**Negative**
Pre-KZ1 (n=89)	87%	13%	0%
Post-KZ2 (n=51)	92%	8%	0%

CONCLUSIONS: REACTION

- Practitioners responded positively to Bridges SSM training, finding the training "valuable", "inspiring" and "thought provoking." They valued the time to reflect on their practice as individuals, to interact with representatives from different services, and to discuss and formulate possible changes in their teams. The use of the 'patient voice' in the training was particularly appreciated, as well as the provision of practical ideas that can be readily incorporated into practice.
- Practitioners felt that it would be beneficial to have wider representation from the MDT at the training to facilitate subsequent implementation of the approach.
- SSM training resonates with practitioners' professional ideals: caring for and helping others and contributing to high quality care.
- At the end of KZ2, 96% of practitioners agreed that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

Learning

Practitioners were asked to rate their confidence ("can do") and performance ("do") with respect to 18 SSM tasks related to Bridges' core principles for supported self-management. Confidence and performance were assessed pre-KZ1 and post-KZ2. Responses were on a five-point Likert scales [1 = 'not at all' to 5 = 'very well' for confidence; and 1 = 'never' to 5 = 'always' for performance].

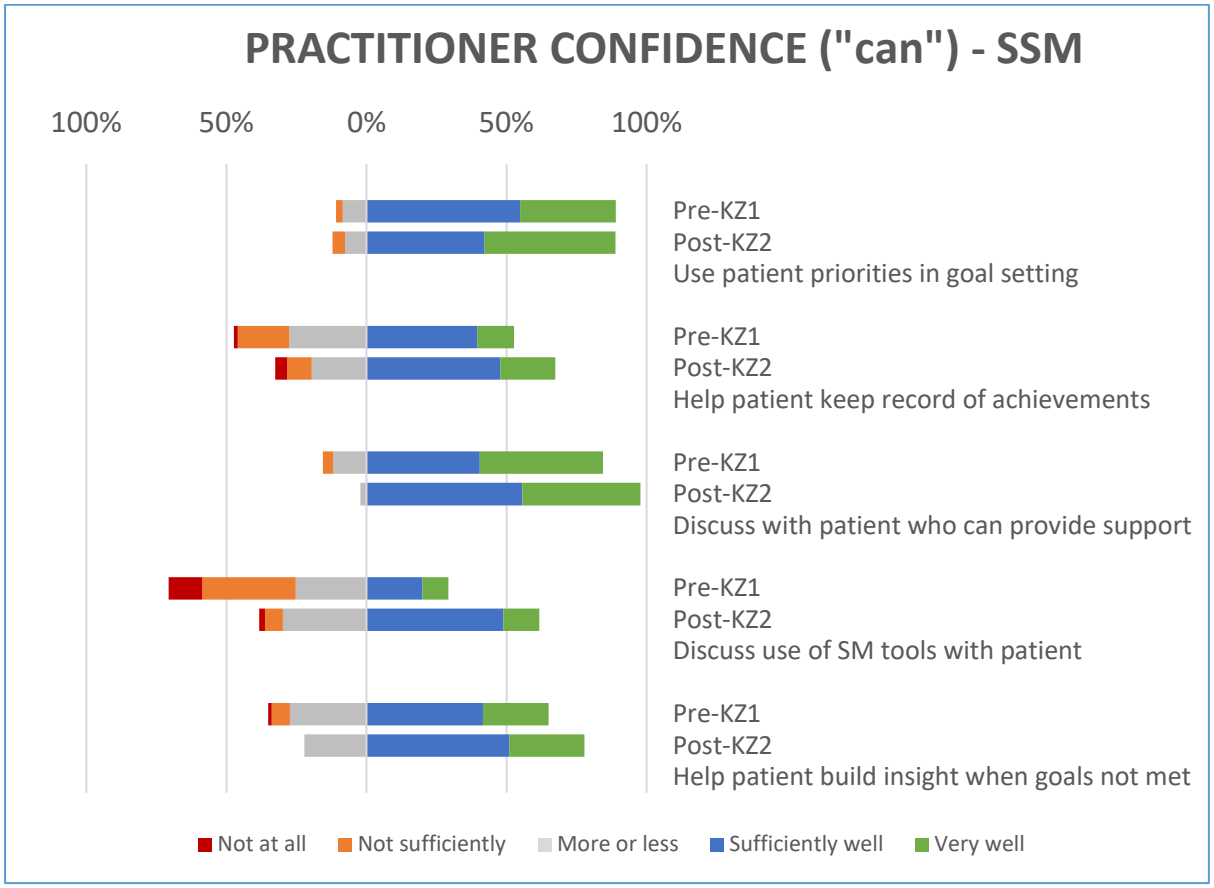
The five SSM tasks selected for presentation here are related to goal setting, patient reflection, accessing daily support, using SM devices, and developing patient insight. These tasks were selected as they represent areas where practitioners indicated they intended to make changes to practice.

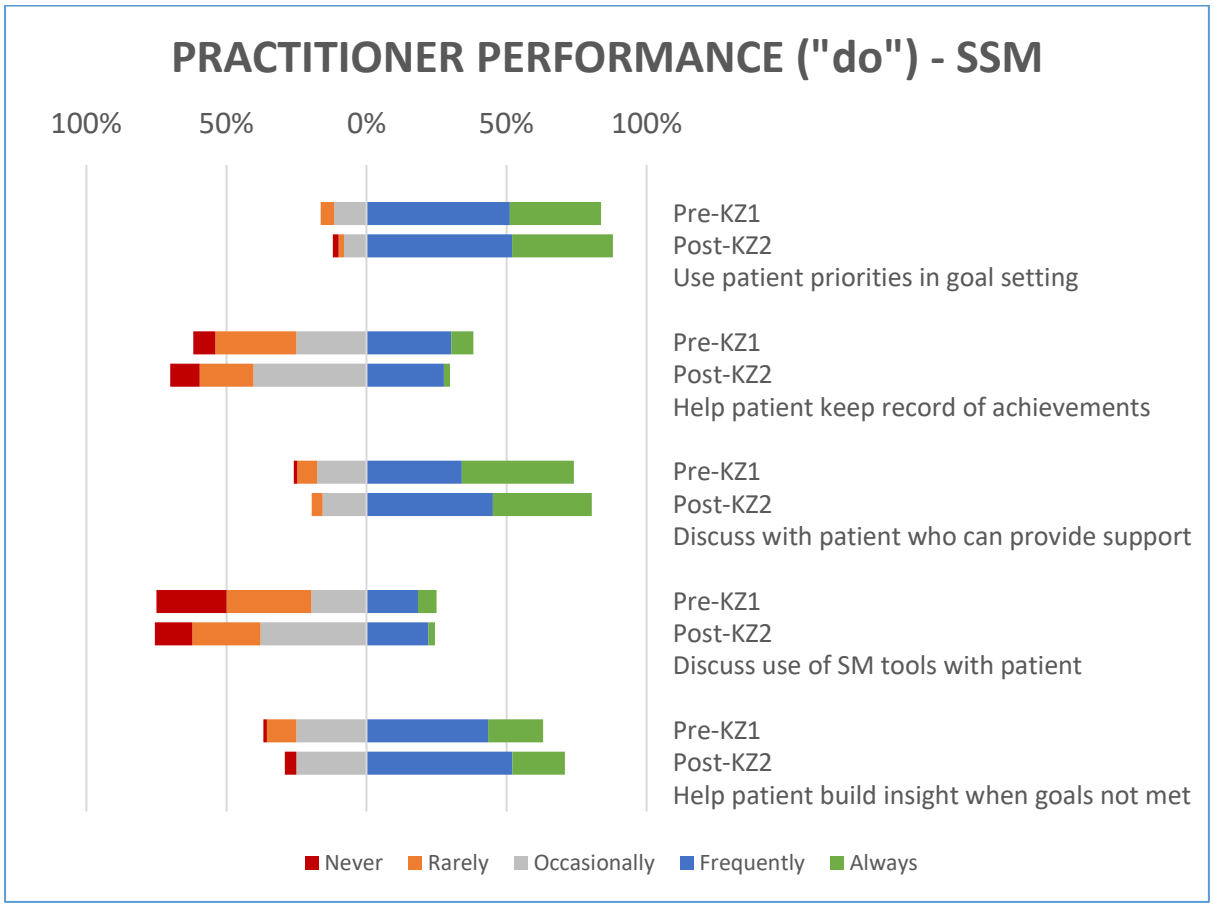
Goal setting	Allow the person to determine their own priorities when developing goals
Reflection	Assist the person to keep their own record of goals and achievements
Support	Discuss with the person who can provide daily support (e.g. family & friends)
SM devices	Discuss with the person how they can make use of SM devices in their activities
Insight	Help the person to develop insight when their established goals are not met

In the following diverging stacked bar charts practitioner percentage responses indicating that they can do the SSM task 'sufficiently well' or 'very well' appear to the right of the 0% line, while responses for 'more or less', 'not sufficiently' and 'not at all' appear to the left. The top bar for each task reflects the practitioner self-report immediately prior to the Bridges SSM training and the bottom bar is self-report at the end of KZ2.

A similar approach is taken with respect to responses for 'frequently' and 'always' with regard to performance of the five SSM tasks (which appear to the right of the 0% line), and responses for 'occasionally', 'rarely' and 'never' (which appear to the left). Again the top bar for each task reflects responses prior to Bridges training and the bottom bar reflects responses at the end of KZ2.

Diagram: Practitioner confidence and performance in five SSM tasks





The bar charts indicate a good baseline of person-centred care, together with a shift in self-reported confidence in the five supported self-management tasks. For self-reported performance of the SSM tasks, there are two areas where responses appear slightly less favourable post-KZ2, although more practitioners report doing the task 'occasionally' (i.e. helping the patient keep a record of achievements and discussing SM tools with the patient).

During their input to this evaluation, practitioners are still in the process of applying their learning and working through the implications for their practice and what needs to change. As a result of the Bridges training, many practitioners have started to trial new approaches in their practice, but feedback points to the need for further time to be able to refine and consolidate changes.

Practitioners can feel initially feel hesitant about utilising the Bridges approach. For example, when giving feedback at a KZ2 workshop one practitioner indicated that they had initially felt "it was not my style" but they were nevertheless willing to experiment to incorporate elements of the approach into their practice. While some practitioners indicated that Bridges was very much in line with their normal way of working, they still recognised that aspects of their practice could be adapted and improved on. As practitioners use the approach more, they report feeling more confident and find that the techniques come to mind more naturally and automatically, rather than consciously having to think about them.

> *"I think some people find using the language and approach easier than others. It's moving away from that medical model and for some people it feels more natural than others, but everyone has been very motivated by the idea … In the ideal world, if you had more time, if you could meet weekly and have a reflective session, obviously that would help people to grow and develop and it just becomes more automatic for us sooner."* [OT]

> *"I think some members of the team are definitely using it more than others, and that comes with your own confidence and your own enthusiasm."* [PT]

> *"It made me think more about the components, trying to support people's self-discovery and the reflection and problem solving. I think it made me think about that a little bit more. I like to think that being client-centred is something that I have been doing for some time, but I think we can always improve on that. I have had opportunities to use health coaching and motivational interviewing techniques, but I think this has built on it further."* [OT]

CONCLUSIONS: LEARNING

- Evidence of a strong, existing baseline of person-centred care.
- Evidence of improved confidence in SSM and performance of SSM tasks following the training.
- Some practitioners, due to their confidence, enthusiasm and experience are able to implement changes more readily than others. Further time and practice necessary to trial and refine changes to practice and to consolidate confidence in the approach.
- Understanding the theoretical underpinnings and evidence behind the supported self-management helps to build confidence in the approach.

Behaviour

At the end of KZ1 and KZ2, practitioners were asked about small changes they intended to make or had made to their practice. Responses were coded and categorised and are summarised in the following table. The changes are similar in nature to those reported in the previous case studies, with practitioners again identifying the need to alter processes and paperwork in order to embed the changes and ensure their sustainability. As previously indicated, the evaluation team was not able to benefit from feedback on team changes by observing the Bridges Champions Masterclass as this event was cancelled due to COVID-19.

Table: Changes to practice

Changes to practice	Description
Language	• Changing language used with patients and family members to support SM • Asking more open questions • Changing language used with other professionals to keep SM to forefront of mind
Getting to Know You	• Finding out more about the person, their story, their interests, what is important to them, their hopes and fears, unacceptable outcomes • Listening more to the patient • Seeing the person, not a patient to be discharged
Goal setting	• Reviewing goal setting and using what is important to the patient as the focus • Using fears and unacceptable outcomes in the goal setting process • Using headboards on the ward to display patients' daily goals • Encouraging patients to write down their goals • Breaking down goals into small steps • Asking "what one small thing" does the patient want to work on or would help the situation • Allowing patients to set priorities in therapy sessions • Allowing patients to set ambitious goals and helping them to gain insight in their own time
Problem solving and reflection	• Encouraging patients to problem solve and plan their next actions • Using self-rating confidence scales with patients • Encouraging patients to keep progress diaries • Resisting the urge to "take over" and allowing patients to "give it a go"

	• Using controlled risk taking and the experience of failure to build insight • Reviewing progress with patients • Demonstrating Tracker Apps to patients to give feedback on outdoor mobility
Paperwork and processes	• Using prompt sheets of Bridges catch phrases & core SM skills as reminders • Changing assessment forms, goal sheets and discharge letters to incorporate SM • Self-management leaflets, posters and information boards for patients, families, and staff • 'Helping you make progress after your stroke' information sheet (to help manage expectations) • Changing patient handover to promote use of Bridges, changing language in MDT meetings • Using Bridges case studies in in-service training and in practising difficult conversations • Displaying a patient experience feedback board • Redeveloping a group self-management programme for patients • Incorporating Bridges into weekly caseload management meetings and monthly clinical supervisions • Using the patient voice and feedback when developing new resources

As indicated previously, practitioners report that behaviour change is not an automatic process; changing a default approach takes effort.

> *"My default is to provide information and advice and tell people what they should do. Sometimes that works for some people in some situations. But I have been working a lot more on getting them to problem solve and facilitating them to make a decision and I have done quite a lot more on getting people to reflect. That really struck a chord with me. I really needed to get them to analyse how they were doing. It's all very well and good for me to say 'Oh you are walking so much better' but actually it was more valuable if I asked 'Well, how did you feel about that? Did that feel better? Why did that feel better to you?' I found that quite effective to give people confidence."* [PT]

Challenges to changing practice

In the workshop and interviews, practitioners reported various perceived challenges to changing practice.

Challenge	Description
Time	- If busy, can forget to use Bridges approach consistently
Patient characteristics and readiness	- Language barriers and different health expectations among patients - How to utilise the approach best with more complex patients - Getting patients to recognise their existing skills and coping mechanisms
Culture	- Overcoming your assumptions about patients and your perception of 'non-compliance' - Ensuring sufficient spread of the approach to support a culture change - Developing a shared understanding of self-management among patients, families, professionals, managers & commissioners
Context	- Service demands and pressure to get patients through the system - Service changes and transitions

One challenge reported by practitioners is achieving consistency in utilising the approach, with prompt cards employed as reminders about self-management skills, use of language and questioning style. Achieving consistency was regarded as important not only for individual practitioners, but also for teams and across service boundaries.

Dealing with expectations is also reported as a challenge. This includes the expectations of service users, their families, other members of the MDT, other services, and commissioners – and these expectations do not always coincide. Practitioners reported that some service users resist attempts at encouraging self-management with the response "You are the expert. You tell me." These service users often have the expectation that therapists are going to "do" something to them.

> "*The Bridges way of thinking with SSM fits in very much with the commissioners idea, although their idea of SM and my idea of SM are slightly different … every individual, especially those with progressive conditions, need some support to maintain change and improvement and you can't just send people off into the wilderness … whereas I think our commissioners would like them to be self-managing within six weeks."* [PT]

> *"There is always this perception, especially with physiotherapy, that it is going to 'fix me' and I think that will be an ongoing challenge for a long time. But certainly with this [service self-management] leaflet we hope that we can encourage patients to think about what they are going to get out of this without being done to, which is important."* [PT]

At the end of KZ1 and KZ2, practitioners were asked how confident they felt about using the Bridges approach with complex patients and when they are under time pressure. Responses are shown in the table below.

Table: Confident to use Bridges approach with complex patients

Workshop	Agree	Neutral	Disagree
KZ1 (n=88)	76%	24%	0%
KZ2 (n=47)	58%	36%	6%

At the end of the transforming period, practitioners still had some uncertainty about employing SSM techniques with complex patients. However, as exemplified in the quotes below, practitioners understood that the Bridges techniques and tools could be used flexibly with patients and families.

> *"I think cognitive impairment and language impairment is very, very broad. So I think just trying to adapt as much as possible and I don't think assumptions should necessarily be made. You need to be aware of these factors, but I think it is really important still to try and encourage people to have as much voice for themselves as possible."* [OT]

> *"Some patients respond incredibly well and some you can literally see everything lights up for them. Others, it's clearly harder for them and I think perhaps I need to refine or work on my skills … I think it is about finding the language that works for them. For some people it needs a lot more facilitation."* [PT]

The responses to the question of feeling confident in using Bridges when under time pressure are shown below.

Table: Confident to use Bridges approach with patients when there is little time

Workshop	Agree	Neutral	Disagree
KZ1 (n=88)	92%	7%	1%
KZ2 (n=47)	81%	19%	0%

For some practitioners, the perception of time pressures can act as a barrier to implementing aspects of the approach and for others there is the question of needing time to develop new resources (e.g. visual resources to use with aphasic service users). However, there was also the view that using the approach does not take extra time and in fact can save time as therapy is more targeted and therefore treatment is more effective.

> *"It's a lovely and very meaningful initiative, but I was crippled with time and other work pressures demanded by my job role, and I feel bad that I am unable to use the learning due to work pressures."* [Nurse]

> *"For me, changing your language does not take any extra time, it really doesn't. And actually if you are goal setting properly, may be exploring really what people want and how they think they are going to get it, it may take a little bit longer, but then they are engaged in it. So I think that investment in time early on has pay back further along the line. Because if the rehab process becomes passive and we do to them, they will go backwards. When we finish, which we inevitably do have to finish, and they will not be 100% better, they will go backwards. So I think it is changing a mind set. I think there are a huge amount of small changes that don't take that long and it's just prioritising your time differently."* [PT]

> *"I don't think it takes more time. One recent example, a patient who had a stroke a couple of years ago and who had got a bit stuck. The patient had had a bit of a gap but he had previously had therapy for over a year. I very much focused on enabling and allowing him to have control of what was happening and making sure I was listening to him and trying to encourage him to have the skills to move forward and manage his life. Whereas I think if I had gone along with of the line of 'here is your planner and these are your goals and this is what we need to do' then I am not sure we would have reached the same point so quickly. He felt he was able to use the skills that he had learnt to transfer into managing his life. His*

confidence seemed to have improved and he had improved satisfaction with what he was able to do." [OT]

"I think some of my SLT colleagues would say, with the aphasic patients, you need a lot more visual aids to facilitate and they are struggling with the time to make the visual aids." [PT]

CONCLUSIONS: BEHAVIOUR

- Practitioners were motivated to make changes to their practice as a result of Bridges training, including: adapting language and the structure of interactions with patients, revising their approach to goal setting, encouraging patient reflection and problem solving, and altering paperwork and processes to embed SSM.
- When feeling under time pressure, practitioners reported that it is easy to forget to employ SSM tools and techniques if they have not become part of routine practice. It takes time for new behaviours to become automatic rather than consciously thought through.
- Service demands and pressure to expedite patients through the system can act as a barrier to developing and refining a new approach.
- Ensuring widespread adoption of SSM language and techniques was perceived as essential to secure a culture shift, but that further time and effort was necessary to ensure that members of the wider team were able to use the approach consistently.

Results

The evaluation team did not have access to formal patient outcome data and was not able to observe changes to practice in situ. The informal assessment of the benefits of the approach as perceived by practitioners are documented in the table below. The evaluation team had recourse to feedback from practitioners via three semi-structured telephone interviews, open text responses on questionnaires and workshop observations. As previously reported, it was not possible to observe the Bridges Champions Masterclass where team representatives present feedback and discuss the value and benefits of introducing the Bridges approach.

Table: Perceived benefits of Bridges SSM approach

Benefit	Description
Building trust and rapport	- Patient (& family) feels listened to and feels their specific needs have been identified and are reassured that their goals have been acknowledged
Professional-patient interaction	- Encourages recognition of patients' personality and character giving a better sense of the individual - Promotes partnership working and less prescriptive, more meaningful rehabilitation

	- Patients can be supported to identify meaningful goals - Patients feel greater ownership of activities - Facilitates the building of insight as patients can see progress, or lack of it, more clearly - Ascertaining patients' hopes and fears is beneficial when dealing with degenerative conditions
Patient involvement and ownership	- Feel they are getting treatment for their specific needs - Patient identified goals are more meaningful and lead to enhanced engagement and motivation - Positive feedback from patients and families
Practitioners	- Helps to develop a different relationship with patients, more of a partnership - Facilitates deployment of practitioner skills more effectively - Changes perception of 'compliance' and challenges assumptions made about patients - Establishes therapy that adds to patients' quality of life - Provides additional tools to help when patients have "got a bit stuck" - Potential to see patients improving at a faster pace - Helps in preparing for "difficult conversations" - Facilitates quality improvement initiatives

At one KZ2 workshop some practitioners observed that when utilising the Bridges approach they had looked at their patients in a different way. They had challenged their own thinking and assumptions about patients, probed more to understand patients' motivations, and offered patients more responsibility. One practitioner remarked that by using open questions, changing language to support self-management and adjusting how they approached goal setting with patients, they felt that they had more "good rehab patients" i.e. they were no longer viewing their patients as non-compliant.

Several examples were offered of how the approach had worked successfully:

- A service user saying "no" to all rehab suggested by therapist was asked "How would you like to approach things?" and this prompted discussion and engagement.
- Asking a service user "How did that feel?" after an exercise session helped to build insight into their progress and motivated them to continue.
- Engaging family support with 'non-compliant' service users to encourage them to do more in working towards the goal of walking helped the service users to see more clearly the steps necessary in working towards their goals, e.g. sit to stand. Service users were reassured that their goal of walking had been acknowledged.

- Asking a service user with dementia "What do you think we can do to improve your walking?" and receiving the response "Exercise" demonstrated that the service had more insight than had been assumed by the practitioner.

The following quotes from interviews and open text responses on questionnaires indicate the perceived value and impact of the Bridges approach.

> *"Inspires clinicians as small changes in practice can make a large difference to the patient experience."* [PT]
>
> *"It has definitely made me become more aware of a patient's hopes and fears and allowed me to be more in tune with them, which enables me to use my skills as a therapist to direct them and empower them to adopt the SM approach."* [OT]
>
> *"I really enjoyed the training. It has made me reflect on some of my ways of working and I have changed some of my long-held views."* [PT]
>
> *"This has been fantastic training for our team and helped to share and shape ideas into clear workstreams or projects to improve the quality of service for our patients."* [PT]
>
> *"I feel it has a strong values basis, so has integrity. I am confident that it will result in better patient experiences if we can implement the model and principles effectively."* [Rehabilitation Assistant]

Practitioners remarked on the positive experience of seeing patients engaged with rehabilitation and doing well, feeling that this was acknowledgement that their input was appreciated.

> *"I think it is just much nicer to be able to work in partnership with people. I think that is the benefit. People have increased satisfaction if we can see outcomes for patients are improving. That is important. That is a nice feeling isn't it when you can see somebody feels empowered. That in itself can be a rewarding part of the job."* [OT]

CONCLUSIONS: RESULTS

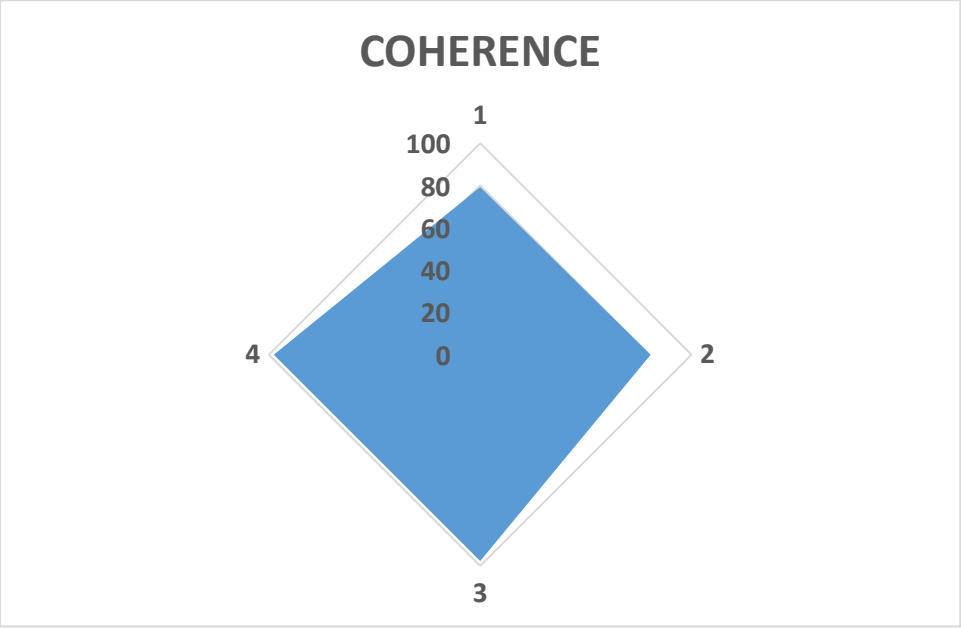
- Bridges was perceived to facilitate enhanced interactions with patients, leading to more meaningful therapy, increased motivation, and therefore better outcomes.
- It was felt that using the Bridges approach has the potential to increase patients' and families' understanding and experience of the rehabilitation process and to contribute to improved satisfaction.
- The Bridges approach can help to move things forward in situations where patients have "got a bit stuck" by promoting confidence building and problem solving.
- Utilising the Bridges approach was seen to have the potential to enhance job satisfaction as practitioners feel they are successfully deploying their skills and are rewarded by seeing patients feel more empowered.
- Bridges SSM was perceived to offer a framework for developing a consistency of approach and shared ethos.

Implementation assessment and sustainability

As outlined in the methods section of Case Study One, the Normalisation Process Theory (NPT) framework (and its associated NoMAD survey instrument) has been utilised to examine how the Bridges intervention has been implemented, embedded and sustained. The NPT framework employs four constructs to examine this process: coherence, cognitive participation, collective action and reflexive monitoring. In the following section, results from the analysis of each of the four constructs of NPT are explored.

Coherence

The following radar plot illustrates the responses of participants to the NoMAD survey instrument questions related to coherence or sense making of the intervention. The plot presents the percentage of participants agreeing ('agree' and 'strongly agree') with the four statements of the construct.



1 I can see how Bridges differs from my usual ways of working (n=87; agree 79%)
2 I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative (n=88; agree 81%)
3 I can understand how the Bridges initiative will affect the nature of my own work (n=87; agree 98%)
4 I can see the potential value of the Bridges initiative for my work (n=87; agree 98%)

The Bridges training prompts practitioners to reflect on their practice. It can act as a reminder or refresher for practitioners, revealing to them certain aspects of their practice that they can adapt or improve upon and reminding them to listen to the patient voice. Some practitioners felt that the Bridges training validated their current approach by demonstrating the evidence base. It allows practitioners to reconnect with their professional values and motivations for working in healthcare, by putting the patient at the centre.

> *"Very informative training. I assumed I did this naturally and spontaneously - a large part I do or feel I do. This has shown me a structured way to involve the patient and their input, increase my planning and support their management of their condition."* [Rehabilitation Assistant]

"We all like to think we do excellent practice and even if we don't do things as well as we could do, we like to think we are doing it for the right reasons. But I think sometimes we have been quite paternalistic in our role in that we tell patients what they have to do and they go away and do it … I thought I do lots of knowledge giving and I do lots of feedback, but do I get the patients to self-reflect? I do not." [PT]

"I feel that our team has been forward thinking and we are already working on self-management and have always worked to patient-centred goals, the training enforces this and reminds us to encourage patients to problem solve and be more independent." [Rehabilitation Assistant]

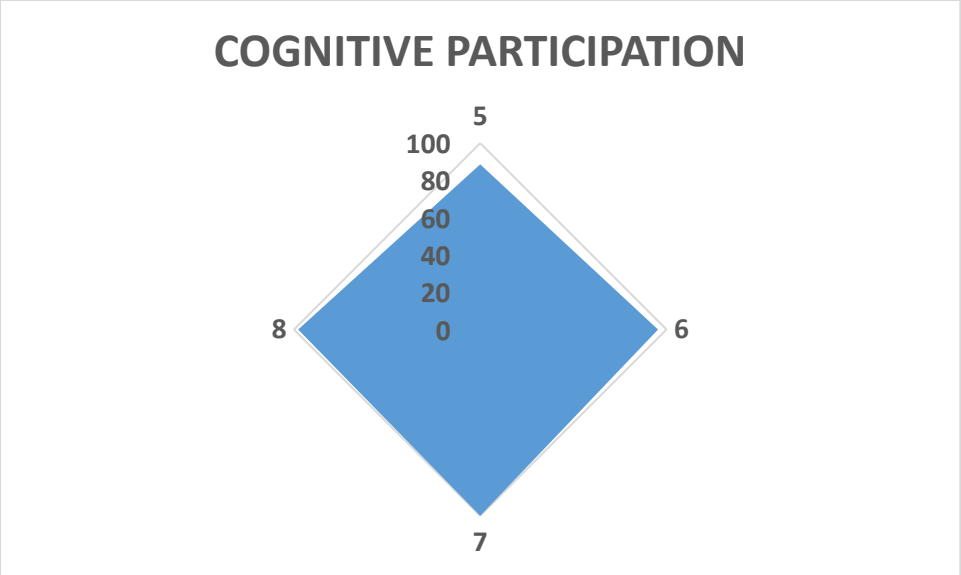
"There are a lot of similarities to the OT ethos, but the training is a reminder that our patients have their own voice and choices, and to continue our patient-centred approach and adapt our practices to self-management promotion." [OT]

"As a community team we have a more holistic approach to our patient care and therefore a lot of the principles used in Bridges are already being used - we probably just don't know it. However, the training has been useful in explaining why this approach is useful and has given ideas about how our system can be re-thought to become more patient-centred rather than a tick list." [SLT]

"I think the biggest thing for me was it [the training] consolidating a lot of practices that I had already been undertaking and my style was very much similar to the Bridges approach … I think I have been very aware of my language with patients and the wording, about the self-discovery, and I think that is something that has come more to the forefront of my mind … I don't tend to 'do to' patients an awful lot and there is in the profession this kind of feeling that we are losing our hands-on experience … I think I reflected on well no actually my way of working isn't wrong, it is just different." [PT]

Cognitive Participation

Cognitive participation relates to the degree of engagement with Bridges in order to build and sustain a community of practice around this approach to SSM. Responses to these implementation assessment questions were positive.

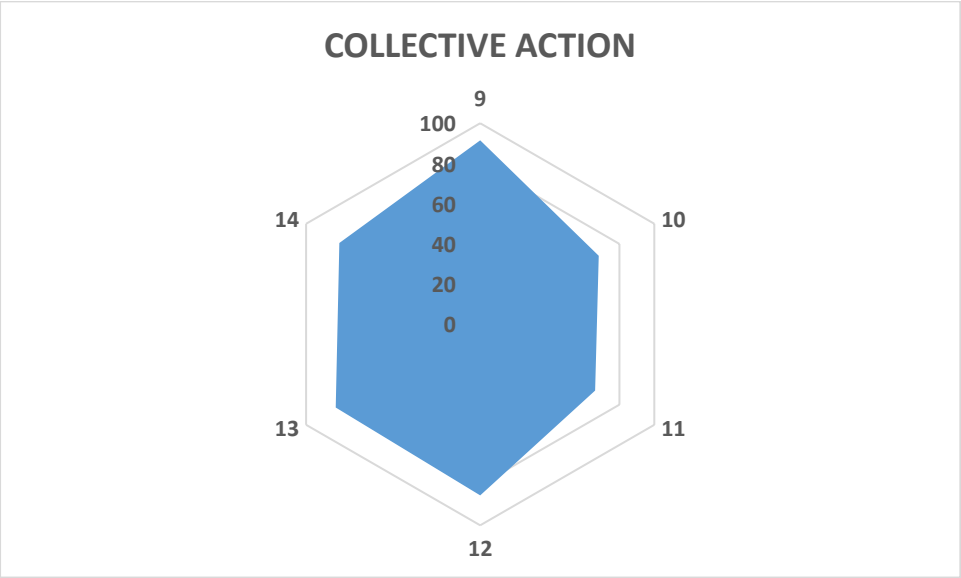


5 I think there are key people who will drive the Bridges initiative forward (n=88; agree 89%)
6 I believe that participating in the Bridges initiative is a legitimate part of my role (n=88; agree 96%)
7 I am open to working with colleagues in new ways to use the Bridges initiative (n=88; agree 100%)
8 I will work to support the Bridges initiative (n=88; agree 98%)

In order to support the implementation of Bridges, it is important that there are individuals who by virtue of their position or their enthusiasm are able to drive the initiative forward. Feedback on the training suggested that attendees were "keen and motivated" and organised themselves into working groups to take changes forward.

Collective Action

Collective action relates to the work that individuals do to enable the intervention, either as individuals or in groups. Around 92% of practitioners agreed that Bridges could be easily integrated into their work. However responses were less positive in respect of confidence in other people's ability to use the Bridges approach and whether all members of the team were working to support Bridges.



9 I can easily integrate the Bridges approach into my existing work (n=47; agree 92%)
10 I have confidence in other people's ability to use the Bridges approach (n=47; agree 68%)
11 All members of my team work to support the Bridges approach (n=47; agree 66%)
12 Sufficient training is provided to enable staff to implement the Bridges approach (n=47; agree 85%)
13 Sufficient resources are available to support the Bridges initiative (n=47; agree 83%)
14 Management adequately supports the Bridges initiative (n=47; agree 81%)

As the first quote below illustrates, one of the challenges for practitioners is to encourage the adoption of the Bridges approach in the wider team. This was perceived to require the winning of hearts and minds to encourage buy-in and ownership. In making changes to practice, practitioners employed the technique advocated by Bridges in relation to goal setting with patients, i.e. looking at incremental "small steps" to change. Some 'quick wins' were important to help keep the momentum going.

> *"I am very mindful that it is very easy for people coming back off a course to say 'we've done this amazing course and we want you to do this and this.' As with Bridges principles, if we come along and tell our colleagues to do something it's not effective, we have to get them on board and have ownership of it."* [PT]

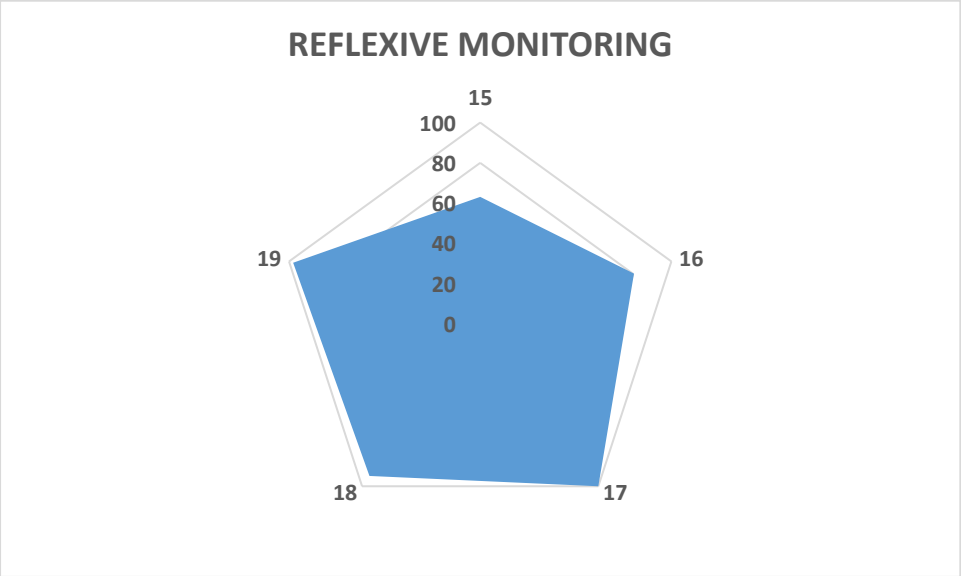
> *"I think embedding is a good word. So it's not an extra, it's just part of how we do things. That's the most valuable thing in my learning from this. To create change everyone needs ownership of it and you try and foster it, but if it is something extra, if people perceive it as something extra they have to do, they perceive it as onerous and they are less likely to do it. If it is just how you do things rather than something extra, it is more likely to be sustained." [PT]*

"It's a bit like you do with Bridges, it's stepping stones. So you choose one or two areas to focus on. So we have got some posters and some prompt sheets up on our wall with all the different principles, so it helps to remind us. I think through supervision and team meetings that is where you have the opportunity to try and keep the momentum going so it then becomes more automatic rather than something you are having consciously to learn." [OT]

"Lots of support and encouragement and requests for feedback from managers and lots of interest … We are quite autonomous with what with decide to do with it and we are encouraged to be like that. There has been no requirement to justify the need to go on the course." [PT]

Reflexive Monitoring

Reflexive monitoring concerns the ways in which health professionals assess the effects and value of an intervention such as Bridges. This can be done informally and formally, as well as individually and collectively. The construct also encompasses whether the intervention is felt to be amenable to improvement and modification by users.



15 I am aware of reports about the effects of the Bridges initiative (n=46; agree 63%)
16 Staff in my team agree that the Bridges initiative is worthwhile (n=46; agree 80%%)
17 I value the effects that the Bridges approach has had on my work (n=46; agree 100%)
18 Feedback about the Bridges initiative can be used to improve the approach in the future (n=47; agree 94%)
19 I can modify how I work with the Bridges approach (n=46; agree 98%)

Practitioners were extremely positive about the effects of the Bridges approach on their work and appreciated the flexibility and adaptability of the Bridges intervention.

Feedback from other team members and from service users had been sought when developing various self-management resources. For example, one community team had developed an 'Introduction to Self-Management' poster for patients, including an outline of their role within this. Feedback on the draft poster was obtained from staff and from service users. The team was also intending to involve service users in redesigning their discharge letter.

> *"The idea is to contact people just about when they are due to be discharged or having that discussion, just to find out exactly what they would like within their discharge report. First of all, do they want one? If they do, what sort of information would they like to see? What would they find helpful? Sometimes when you have been working in an area for some time there is an assumption made of what should be in the discharge report."* [OT]

As demonstrated in the quote below, the potential value of wider deployment of the Bridges approach is recognised by practitioners, although contextual factors, e.g. organisational changes, can impact implementation.

> *"It has not been been in all honesty a priority to use Bridges to change the team or the way that we work because we are going through a much bigger [organisation] change. But we*

have certainly spoken of Bridges as a strategy to use across the whole of therapy, joining up services, not just the neurological team." [PT]

As previously indicated, the Bridges Champions Masterclass did not take place in this STP due to the COVID-19 restrictions, so the evaluation team was not able to gain additional information on team plans for sustaining and evaluating the Bridges approach.

CONCLUSIONS: IMPLEMENTATION ASSESSMENT & SUSTAINABILITY

- There was positive momentum towards successful embedding and sustainability of the Bridges approach.
- A number of potential drivers for successful implementation were identified:
    - The need for key individuals to support and drive forward the quality improvement
    - The importance of cascading and establishing support for the Bridges approach by all team members
    - The value of sufficient training, resources and management support.
- As the Bridges Champions Masterclass was cancelled due to the COVID-19 outbreak, the evaluation team was not able to observe team discussions, presentations and plans for embedding and sustaining the Bridges approach.

Context

The evaluation team utilised an element from the Consolidated Framework for Intervention Research (Damschroder, 2009) to consider aspects of the inner and outer context that might impact on implementation.

Table: Inner setting factors important for implementation

Inner setting	Description
Service drivers	Bridges training is perceived to bring the focus back to the patient and what they want, as a counterpoint to the emphasis on service drivers. This reconnects practitioners with their professional motivations and values, i.e. 'making a difference' to people's lives
Service structures	Service transformations and service goals and expectations around self-management can influence implementation *"The Bridges way of thinking with promoting support self-management fits in very much with the Commissioners' ideas, although their idea of self-management and my idea of self-management are slightly different."* [PT] *"It has not been been in all honesty a priority to use Bridges to change the team or the way that we work because we are going through a much bigger [organisation] change. But we have certainly spoken of Bridges as a strategy to use across the whole of therapy, joining up services, not just the neurological team."* [PT] Securing the participation of nursing and HCA staff in the training is challenging, but perceived as essential for successful implementation of Bridges across the patient pathway. It was perceived that supported self-management training needs to be more of a priority for nursing managers
Staffing and resources	Stable teams versus staff churn Finding time to develop resources to support changes to practice

Table: Outer setting factors important for implementation

Outer setting	Description
Global pandemic situation	Impact of response to COVID-19 outbreak – affected final stages of roll-out of Bridges programme
Changing patient needs	Provision of care needs to be more in line with management of long-term conditions faced by patients, there is a need to encourage greater engagement of patients and build their confidence, the need to be 'truly' patient-centred
Professional cultures	Need to promote a shared ethos of SSM Professional mindsets – therapists' concerns about losing hands-on techniques
Risk culture	Societal attitudes to risk and health and safety concerns can impact acceptance of focus on patient-led goals, acceptance of positive risk taking in a controlled environment
NHS workforce	Staff morale and retention, stable teams versus high turnover, use of agency staff Staff perceive that Bridges allows them to reconnect with their professional philosophies and values, this can enhance feelings of job satisfaction

CONCLUSIONS: CONTEXT

- Practitioners felt that the Bridges approach brings the focus back to the patient and their specific needs and wishes. This regarded as important to counteract a perceived emphasis on service drivers, targets and checklists.
- Service pressures and organisational changes can impact negatively on commitment to training and quality improvement activities. Leadership support is important to encourage and motivate staff.
- Securing the participation of nursing staff is regarded as essential for successful implementation of Bridges.

CONCLUSIONS: KEY FINDINGS

CONCLUSIONS

Does Bridges lead to an increase in confidence and use of SSM by practitioners?

- Practitioners were positive about the opportunity to reflect, learn, think and plan together. They described the training as "valuable", "inspiring" and "thought provoking". It resonated with their intrinsic motivations for working in healthcare and encompassed principles that they aspire to. Practitioners appreciated the time to discuss ideas in their team and to bring the focus back to what is important for patients in the face of a perceived emphasis on service drivers, checklists, and targets.
- Bridges SSM training was seen to validate ideas for service improvement work and to promote adoption of a standardised approach to patient care.
- Questionnaire data points to a shift in confidence and performance of SSM tasks. This was supported by findings from qualitative data where practitioners described how they were making changes to their practice. Practitioners felt that further time and effort were necessary to refine and consolidate the changes and to build confidence in using the new approaches.
- At the end of KZ2, 96% of practitioners agreed that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

Is Bridges a useful approach for practitioners and has it resulted in changes to practice?

- Practitioners reported making changes to their individual and team practice as a result of the training, such as: adapting language and using open questions, changing the structure of their interactions with patients (e.g. more patient-led assessment sessions and goal setting approaches), and encouraging patient problem solving and reflection.
- Steps were underway to spread, embed and sustain changes, such as: using a variety of methods to share learning about the approach and to bring other team members on board, altering processes and paperwork, placing visual prompts in the environment (e.g. to manage expectations about 'therapy') and planning to audit/evaluate new resources. In developing new resources, some teams had sought input from current service users.
- Practitioners reported that feeling under time pressure can mean that SSM is not used consistently by staff and further time and effort is necessary to ensure that this becomes part of 'routine' practice.
- Steps were underway to spread, embed and sustain changes, such as: using a variety of methods to share learning about the approach and to bring other team members on board, altering processes and paperwork, placing visual prompts in the environment (e.g. to manage expectations about 'therapy') and planning to audit/evaluate new resources. In developing new resources, some teams had sought input from current service users.

CONCLUSIONS

What are the expected outcomes for practitioners trained and able to use Bridges?

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in enhanced interactions with patients. Practitioners report increased satisfaction through partnership working and being able to deploy their skills more effectively to deliver meaningful therapy.
- Practitioners reflected that the Bridges programme had demonstrated to them how small changes to practice can have an important impact on both patient and staff satisfaction.

What are the expected outcomes for patients cared for by a Bridges-trained team?

- The evaluation team had no direct access to current service users to explore their perceptions of the care they received in a team following the Bridges SSM approach. Information on the benefits of the approach for patients was obtained via practitioner interviews and workshop observations.
- Practitioners commented that using the Bridges approach meant that patients and families felt more listened to and are reassured that their goals have been acknowledged.
- Practitioners indicated that encouraging patients to reflect and problem solve allowed them to develop greater insight into their progress, motivated them and promoted self-confidence.

What are mechanisms of change and enablers and barriers to implementation and sustainability?

- Training provides practitioners with a space away from clinical demands to reflect and think together about changes to practice that will benefit their patients. Practitioners were motivated to consider change, even in the context of a pressurised environment, and had the opportunity at the workshops to discuss and plan their initial "small steps" in the change process.
- The quality of the training was one of the enablers of implementation. Workshop observations suggested a number of factors contributed to a positive learning experience including: the learning atmosphere, use of adult learning principles, level of interactivity and group work, the credibility of trainers, the evidence base for the Bridges approach, and the use of the 'peer voice' and 'patient voice.'
- The Bridges programme and drivers for change appeal to the intrinsic motivations of healthcare staff and make use of valuable extrinsic motivators such as the service user voice, peer influence, and, in time, local Bridges Champions.
- Important drivers for successful implementation include: the need for key individuals to support and lead the improvement, engaging support of the wider team, and having sufficient training, resources and management support.