University of East Anglia

PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME: East of England

EVALUATION REPORT

for

HEALTH EDUCATION ENGLAND

CASE STUDY ONE: CAMBRIDGESHIRE AND PETERBOROUGH STP

Nicola Hancock and Julie Houghton

School of Health Sciences

University of East Anglia

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EXECUTIVE SUMMARY

Introduction

In 2017 Health Education England (HEE) commissioned Bridges Supported Self-Management (SSM) training as a quality improvement initiative for stroke and neurological service teams in six Sustainability and Transformation Partnerships (STPs) in the East of England. The objective was to embed and sustain a model of SSM. The University of East Anglia (UEA) was commissioned by HEE to conduct the first independent evaluation of Bridges SSM training and quality improvements.

Bridges SSM is an evidence-based educational intervention, underpinned by principles of social cognition theory, which has been co-designed and co-produced with individuals who live with long term conditions. Bridges SSM aims to contribute to improved outcomes for patients (i.e. quality of life, involvement in rehabilitation, feelings of control, and social participation), to build practitioners' confidence in supporting patients to self-manage and to deliver enhancements to service efficiency.

Evaluation methods

The main aim of the evaluation is to determine optimal pathways to embed and sustain the Bridges model of SSM in stroke and neurological teams in the East of England.

For the purposes of the evaluation, the six participating STPs are treated as separate case studies. This report documents the evaluation of the first STP to take part in the initiative, namely Cambridgeshire and Peterborough. Evaluation findings for the other five STPs will be reported separately, with an overview and case comparisons at the end of programme delivery.

Specific evaluation questions are:

- Does Bridges SSM training lead to an increase in confidence and use of SSM by practitioners?
- Is Bridges SSM a useful approach for practitioners and has the training resulted in any changes to practice?
- What are the expected outcomes for practitioners trained and able to use Bridges approach?
- What are the expected outcomes for patients who are being cared for by a Bridges-trained team compared with normal care?
- What are the mechanisms of change and enablers and barriers to implementation and sustainability?

The evaluation employed a mixed methods approach to data collection, utilising pre- and post-training practitioner questionnaires, workshop observations and semi-structured interviews with practitioners.

Case study one: Cambridgeshire and Peterborough STP

NHS staff from three organisations were involved in the training and evaluation across acute, early supported discharge (ESD) and community services.

Data collection

Data available for inclusion in the evaluation comprised: 114 pre-training and 100 post-training questionnaires and 40+ hours of workshop observations. Semi-structured telephone interviews were conducted with 10 practitioners, including Manager/Clinical Lead (2), Nurse (1), Physiotherapist (2), Occupational Therapist (2), Speech and Language Therapist (2) and Rehabilitation Assistant (1). In addition, as part of stakeholder engagement, two focus group

discussions were conducted with former service users exploring life after stroke and Acquired Brain Injury (ABI) and experiences of rehabilitation.

Stakeholder engagement

Engaging trusts with the training was a complex non-linear process, requiring multiple and varied approaches by the Bridges team to understand the patient pathway and the local context, and to engender enthusiasm for the training from the ground up.

Identifying and achieving buy-in from key influential contacts was important for successful training delivery and for supporting the implementation of change.

The Bridges evidence base, the ability of the approach to be easily integrated into routine practice, and the potential benefits of SSM for patients, staff and service efficiencies are important elements for securing engagement with the initiative.

Consultations with former service users highlighted the need for SSM to help patients and families build confidence and prepare for continuing with life after stroke or brain injury.

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 “thought provoking” and “motivating” and appreciated sharing experiences with individuals from other services.
- While some practitioners expressed the view that “we do this already” in relation to SSM, there was acknowledgement that it is good to be reminded about techniques and that there is always room to improve on practice. Bridges SSM training was seen to offer ‘permission’ to continue with, refine or recapture person-centred practice.
    - *“My approach to patients hasn’t changed over the years … I would say it’s the system of how we treat patients that has changed, so the Bridges for me just sort of brings it back to being how it should be.”* [Nurse]
- Questionnaire data points to a shift in confidence and performance of SSM tasks. This was supported by findings from workshop observations and qualitative interviews where practitioners discussed how they were making changes to their practice.
    - *“Being a bit more confident to have that conversation about ‘what do you envision over the next week you will have achieved?’ … so that people then have to start saying ‘what I’ll work on is this, this and this’ and just be a bit more concrete with it. So with that stuff I would say my confidence has definitely improved.”* [OT]
    - *“And also for the team, seeing them get that confidence in using it as well, that gives you that feeling of things having improved.”* [PT]
    - *“And [the patient] set her little hierarchy of what she was going to do and she would tick it off as she went through and I probably wouldn’t have done that [before Bridges training], I would have made a recommendation.”* [SLT]
- It was felt that further time and practice were necessary to build confidence further and to consolidate the new ways of working.
    - *“Considering how much I probably can buy into it and understand the need, I had to have really like a prompt sheet to help me use, rethink my questioning. I wasn’t spontaneously doing it. It wasn’t like I could just go on the training and switch over to ‘oh now I use this language’. I had to have the prompt sheets.”* [SLT]

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, changing the structure of assessment sessions and goal setting approaches, encouraging patient problem solving and reflection.
- Steps were underway to cascade, embed and sustain changes, such as: altering processes and paperwork, and placing visual prompts in the environment. Initiatives included:
    - Prompt cards of Bridges catch phrases or open questions
    - Using a Bridges 'phrase of the week'
    - Posters of catch phrases in doctors' office and ward books
    - Altering assessment forms and goal sheets
    - Changing discharge letters
    - Changing template of MDT meetings and sharing of information
    - Using the Bridges approach in supervisions
- Changes to clinical tools and paperwork were regarded as essential to prompt SSM behaviour and to help new members of staff.
    - *"If our service paperwork matches the Bridges philosophy more, then I think it will make it easier for the team to incorporate."* [OT]
    - *"And that's where, why we are looking at changing paperwork, so anybody coming in new, the assessment form would ask them to ask specific questions."* [PT]
- The changes to practice were perceived to have "added" another dimension to service provision.
    - *I think it added to the work we do … it added another level if you like of how we talk with patients … and I think it has been a positive experience … The knowing how to help patients move forward … it can be frustrating sometimes when people come back and there is no change."* [PT]

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

- The Bridges approach has the potential to contribute to staff well-being.
    - *"Where they get their satisfaction from is doing a good job. So if they work with somebody and they get good feedback, that's the absolute for them. So I think it's more about that than their caseload … They do get good feedback, but I think hopefully this [Bridges] will give them more."* [Manager]
- Practitioners reported experiencing greater enjoyment and increased satisfaction from working more collaboratively with patients.
    - *"I look forward to it [talking to patients], it puts a bounce in my step … I feel valued more in doing that than I do in most other aspects of my role."* [Nurse]
    - *"And actually when [the patient] gave her feedback form, we were really pleased with that because in it she said 'they helped me understand, they helped me work out the right solution' and it was like 'oh, that is what we did'.* [SLT]
- It was felt that the approach supported practitioners to be less prescriptive, allowing them to stand back more and guide, rather than instruct, patients. This reduced pressure to 'have to all the answers' and meant that practitioners could feel less responsibility.
    - *"I am feeling a lot less responsibility in a way … and I have been giving a lot less ideas to people … and it's hopefully a bit more powerful if someone comes up with the ideas themselves and then they are more committed to it."* [OT]
- Therapy was seen as more effective and frustrations about efforts going to waste were reduced.
    - *"It has given a positive experience of the outcomes and as a therapist that makes you feel that you have achieved something."* [PT]
    - *"If your first visit is not about 'doing' to somebody, it's actually about finding out about that patient … about what's important ... I think you build a good foundation … And then what happens is your sessions in the future are more fruitful and more beneficial to the patient and you end up working quite collaboratively."* [OT]

- More collaborative working was viewed as beneficial in preparing both parties for discharge. It was perceived that the approach could lead to reduced rehabilitation times as patients take more ownership and are doing more between therapy sessions.
  - *"It also supports when treatment is no longer indicated … it doesn't become an abrupt end for families … it's a process that we've been working through together … It becomes a natural place to stop."* [OT]
  - *"And for that particular person, I am hoping that they will probably finish with rehab quicker than they would have done before … it's been a slightly different way … and she has been responding well to that, and like, and hopefully that will reduce the length of time that we see that person for."* [OT]
  - *"Using the Bridges concept to then talk with patients … whether they wanted to continue and they actually felt they were doing quite well and then that actually led to me discharging quite a few people off my caseload quite early on."* [OT]

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 felt that having an initial discussion with a patient about what is important to them could result in "goals coming out naturally" and the establishment of "more meaningful goals."
- Engagement with former service users as part of the context setting for the Bridges training revealed the importance for patients of feeling they are being listened to, having their hopes and concerns acknowledged, and being understood as a person. Practitioners felt that the Bridges approach promoted a better understanding of their patients.
- Practitioners felt that if patients are able to work towards meaningful goals they will have a greater sense of commitment to and ownership of their rehabilitation journey. This should increase levels of patient satisfaction and contribute to better outcomes for patients.
- With practitioner and patient (and family) working collaboratively towards discharge, it was felt that both sides would be more prepared for discharge and that patients would be more confident in continuing to manage after the end of treatment.

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: learning atmosphere, adult learning principles, interactivity and group work, credibility of trainers, evidence base for approach, and use of 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.
- The approach has the potential to contribute to the well-being of staff through increased job satisfaction. Using the Bridges SSM approach and experiencing success will encourage sustained behaviour change.
- 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.

- The flexibility of the Bridges approach and the ability to customise it to the local service context or in line with different professional routines supports sustainability. Bridges training provides practitioners with an understanding of the underlying principles of the approach, but local customisation is anticipated and promoted, meaning that the intervention will look different in different settings, thereby increasing its relevance or coherence.
- Practitioners' are encouraged to share success stories in the Bridges workshops and in their team settings. Being able to share experiences of implementing the approach and insights gained means that continued learning is more widely distributed. This allows practitioners support each other through the process of change and helps to foster a 'community of practice'.
- A number of key pathways to sustainability were identified and discussed at the Masterclass for Bridges Champions, including:
    - Cascading training to non-trained, new and rotational staff
    - Direct observations of practice or joint working and feedback on use of approach
    - Confidence rating scales for using SSM
    - Building SSM into competency frameworks, job adverts and person specifications
    - Piloting and finalising redesigned paperwork and clinical tools
    - Ensuring accessibility and visibility of SSM resources to ensure regular use
    - Auditing use of new resources, patient compliance with SSM treatment plans
    - Continuing to address aspects of physical environment to promote SSM (e.g. using bed space and ward information boards).

Recommendations

- The positive findings of this evaluation support the ongoing integration of Bridges SSM into neuro-rehabilitation practice. In addition, the approach merits consideration for other pathways.
- While there is evidence of collective action to cascade, embed and sustain Bridges SSM and there are mechanisms (e.g. Bridges Champions) to maintain awareness of Bridges, an examination of longer term outcomes would be beneficial, including: the perceived coherence of the approach over time and in the wider teams, use of SSM with complex patients, the realisation of sustainability plans, and further data on how changes to team collaborative working have promoted efficiencies.
- Further investigation is necessary to assess the role and effectiveness of Bridges Champions in implementing and sustaining change.
- While practitioners reflected positively on the benefits of Bridges SSM for patients, this evaluation was not able to assess directly the impact of using the approach on the patient experience. The evaluation and intervention would be strengthened by greater integration of the patient voice. Patient and family member feedback on their experiences of a rehabilitation programme that embraces SSM and how this contributes subsequently to the rebuilding of their lives is essential for practitioners to continue to appraise and adapt their approach to SSM.
- Teams need support to trial and audit more formal measures for assessing the impact of the approach, including: practitioner confidence rating scales, reflection pieces, and work satisfaction scores.
- It is important for staff to have opportunities to share success stories, understand what has worked and why, and to disseminate learning within and between trusts, and across STPs in the region. It is known that Bridges wishes to develop an online platform to support ongoing learning and sharing of resources.

INTRODUCTION

Background

Stroke and other Acquired Brain Injury (ABI) is a sudden and life-changing event, which can impact all aspects of an individual's life in complex and profound ways. For example, many stroke survivors report feeling inadequately prepared for discharge from hospital and feel that support is lacking later in their recovery (Ellis-Hill et al, 2009). Stroke survivors, and their family members, have ongoing psychological and emotional needs (Hanger et al, 1998; Jones, 2006) and face enormous challenges in adjusting to this new phase of life, managing their expectations for recovery, and regaining autonomy.

Supporting individuals in their self-management skills may help them in coping with, and rebuilding, their lives after stroke (Jones and Riazi, 2011) or ABI. Evidence shows that self-management programmes can impact positively on clinical outcomes and psychological health in individuals with a range of long-term conditions (De Silva, 2011; Coutler and Ellins, 2007). For those individuals who have progressive neurological conditions, self-management may have a significant impact on how well they live with their symptoms.

Support for self-management has therefore become an important focus in health policy for individuals with long-term conditions, with the emphasis on more equal sharing of power and decision-making between health professionals and patients. This policy focus on self-management means that support and resources are needed to help patients self-manage in relation to their individualised needs and goals. Opportunities need to be fostered that encourage individuals to exercise their problem-solving skills, experience self-efficacy and apply their knowledge. Integrating supported self-management into routine care via a 'whole systems approach' can ensure the widest possible access to support that is designed to promote patients' self-efficacy through their interactions with health professionals (Sadler,et al, 2017; Jones et al, 2017, Kennedy et al, 2007).

Health professionals do not necessarily have access to guidance or frameworks that enable them to deliver tailored self-management as an integral part of routine practice across the patient pathway. Finding effective ways to encourage health professionals to embed this clinical evidence into their everyday practice has proved a major challenge (Grimshaw et al, (2012).

The People 1st Quality Improvement Initiative

In 2017 Health Education England (HEE) commissioned Bridges Supported Self-Management (SSM) training as a quality improvement initiative for stroke and neurological service teams in six Sustainability and Transformation Partnerships (STPs) in the East of England:

- Cambridgeshire and Peterborough
- North East Essex and Suffolk
- Mid and South Essex
- Norfolk and Waveney
- Hertfordshire and West Essex
- Bedfordshire, Luton and Milton Keynes.

The objective here was to embed and sustain a model of SSM across stroke and neurological service teams in the East of England.

In addition, the University of East Anglia (UEA) was commissioned by HEE to conduct the first independent evaluation of Bridges SSM training intervention and quality improvements.

Bridges SSM programme

Bridges SSM is an evidence-based educational intervention that has been co-designed and co-produced with individuals who live with long term conditions. A programme of research and development has been underway since 2008. The Bridges training programme has been implemented in a variety of UK and international settings (i.e. community and acute) and in different pathways (i.e. stroke, traumatic brain injury and acute major trauma) (Jones and Bailey, 2012; McKenna et al, 2013; Mäkelä et al, 2014; Jones et al, 2016; Singer et al, 2018; Hollinshead et al, 2019; Mäkelä et al, 2019).

The Bridges intervention is underpinned by principles of social cognitive theory and the concept of self-efficacy (Jones, Pöstges and Brimicombe, 2016). The latter concerns an individual's beliefs in their capacity to achieve certain attainments. Increasing an individual's self-efficacy is accomplished by providing mastery experiences, encouraging peer learning, via physiological feedback, and by information from a credible source, with mastery experiences being the most powerful mechanism. Bridges SSM follows seven principles:

- Goal setting
- Taking action
- Reflection
- Problem solving
- Support
- Self-discovery
- Knowledge.

Studies to date indicate that Bridges SSM can contribute to improved outcomes for patients (i.e. quality of life, involvement in rehabilitation, feelings of control, social participation) and can enhance practitioners' confidence in supporting patients to self-manage (McKenna et al, 2013; Jones et al, 2016). Bridges advocates a whole systems approach to training, involving professional groups from across the patient pathway in order to develop a shared understanding of SSM that will facilitate the implementation and sustainability of the approach over time.

The Bridges SSM programme has a number of different stages as illustrated in the accompanying diagram.

Diagram: Stages of Bridges SSM Programme

Stage	Description
Stage 1:	Trust engagement: awareness raising and context gathering
Stage 2:	Stakeholder engagement (former service users)
Stage 3:	Knowledge Zone 1 - Introductory workshops
Stage 4:	Implementation of Bridges SSM approach by practitioners
Stage 5:	Knowledge Zone 2 – Follow-up workshops
Stage 6:	Masterclass for Bridges "Champions"
Stage 7:	Local sustainability and evaluation plans

EVALUATION METHODS

Questions

The main aim of the evaluation is to determine optimal pathways to embed and sustain the Bridges model of SSM in stroke and neurological teams in the East of England. For the purposes of the evaluation, participating STPs are treated as separate case studies (Yin, 2009) to enable a rich description of how the Bridges intervention was delivered and experienced by practitioners in each context. Case comparisons across the six STPs will involve analysis and synthesis of similarities and differences between the cases to facilitate understanding of how different contextual features interact with the various components of intervention implementation.

Specific evaluation questions are:

- Does Bridges SSM training lead to an increase in confidence and use of SSM by practitioners?
- Is Bridges SSM a useful approach for practitioners and has the training resulted in any changes to practice?
- What are the expected outcomes for practitioners trained and able to use Bridges approach?
- What are the expected outcomes for patients who are being cared for by a Bridges-trained team compared with normal care?
- What are the mechanisms of change and enablers and barriers to implementation and sustainability?

Logic model

A logic model was developed to reflect the evaluation team's understanding of the inputs, outputs and likely impacts of the Bridges training and quality improvement. The logic model (see Appendix 1) was used to guide the design of the intervention. Variation in implementation of Bridges SSM may occur due to differences in delivery of the intervention and evaluation, the various contexts in which the intervention takes place and the number of different practitioners involved in its implementation. The development of the model early in the evaluation process was crucial to support the evaluation team in a deep understanding of the principles and processes of the Bridges SSM programme.

As Bridges is a complex intervention delivered within a complex healthcare setting, the evaluation team used a variety of frameworks to guide data collection and analysis, including adult learning and development principles, implementation assessment, and consideration of context.

Evaluation frameworks

Adult learning and development

Kirkpatrick's (1994) Four Levels of Evaluation was used to evaluate the Bridges SSM training delivery. The four levels comprise a hierarchy of outcomes, namely reaction, learning, behaviour and results. Each level is described in the following table.

Table: Four Levels of Evaluation

Level 1:	Reaction	Participant satisfaction with the training, i.e. 'smile sheets'
Level 2:	Learning	Increase in knowledge, confidence and skills
Level 3:	Behaviour	Transfer of knowledge, confidence and skills to practice
Level 4:	Results	Impact of the training

While learner reactions to training are useful for quality assurance purposes in relation to training delivery, they are not necessarily linked to learning or to the transfer of that learning into the workplace. The evaluation questionnaires (see 'data collection') incorporated elements of feedback on the Bridges training (reaction), as well as items related to confidence and performance of SSM tasks (learning and behaviour). The questionnaires also asked attendees to describe planned (after KZ1 workshop) and actual (after KZ2 workshop) changes to their practice as a result of the Bridges training. Information about changes to behaviour was triangulated with data collected in workshop observations and through semi-structured interviews with practitioners.

Implementation and sustainability

To evaluate the implementation and sustainability of Bridges SSM, the evaluation utilised Normalisation Process Theory (NPT) (May and Finch, 2009). This theoretical framework was developed to examine how healthcare interventions are implemented, embedded, and sustained or "normalised". The framework employs four constructs or 'mechanisms of social action' to examine the implementation process:

- Coherence
- Cognitive Participation
- Collective Action
- Reflexive Monitoring.

The constructs are described in the following table. The theory maintains that complex interventions in complex settings are best understood as the result of collective action that takes place when people work together, rather than as the result of individual behavioural processes.

Table: The four constructs of Normalisation Process Theory

COHERENCE or SENSE MAKING How is Bridges SSM different to what we do already?	COGNITIVE PARTICIPATION or ENGAGEMENT Do we feel Bridges is a good idea?
COLLECTIVE ACTION or WORK DONE TO ENABLE INTERVENTION How does Bridges affect our practice?	REFLEXIVE MONITORING or INFORMAL AND FORMAL APPRAISAL What do we think are the benefits of Bridges?

The NoMAD study (Rapley et al, 2018; Finch et al, 2018) developed a survey instrument containing 20 implementation assessment items based on the four constructs of NPT. The NoMAD tool is freely available for download and can be used to provide insights into health professionals' views of implementation processes. In this evaluation, items from the NoMAD tool were incorporated in the questionnaires administered to practitioners at the end of KZ1 (Coherence and Cognitive Participation) and KZ2 (Collective Action and Reflexive Monitoring). Questionnaires were co-developed with the Bridges team using this theoretical model.

In addition, items from the NoMAD tool were used to:

- Guide the development of the interview topic guide for the semi-structured interviews with practitioners
- Provide a template to examine field notes from workshop observations.

Context

As the context of interventions has an important impact on implementation, the evaluation team used an element of the Consolidated Framework for Implementation Research (CFIR) (Damschroder, 2009) to structure their thinking about context in terms of its outer and inner settings. A range of the factors considered in each of the settings is described in the table below.

Table: CFIR context

Outer setting	National policies and guidelines, professional norms, risk culture, NHS workforce challenges
Inner setting	Service structures, leadership, staff turnover, culture, quality improvement and learning climate

Data collection

The evaluation employed a mixed methods approach to data collection, utilising pre- and post-training questionnaires, workshop observations and semi-structured interviews with practitioners.

QUESTIONNAIRES
- Pre- and Post-KZ1
- Post-KZ2

OBSERVATIONS
Embedded evaluator observations of training

QUALITATIVE INTERVIEWS
Post-KZ2, semi-structured interviews with sub-groups of multi-professional participants

Triangulation of quantitative and qualitative data was intended to strengthen findings by confirmation and corroboration.

Quantitative methods

Hard copy questionnaires were administered at the beginning and end of KZ1 and at the end of KZ2 (12 weeks later). The decision to use hard copy questionnaires on training days, rather than an online format, was taken in order to maximise response rates.

The content of the evaluation questionnaires comprised a mixture of open questions and Likert scale items as detailed in the table below.   Full details of the questionnaires used in the evaluation appear in Appendix 2.

Table: Questionnaire content summary

Questionnaire items	Description
Profession and setting	Open text response
Years in profession and service	Open text response
Intrinsic motivations for working in healthcare	Open text response
Hope to gain from Bridges SSM training?	Open text response
Confidence (“can do”) in SSM tasks	Likert scale 1= Not at all to 5 = Very well
Performance (“do”) of SSM tasks	Likert scale 1 = Never to 5 = Always
Implementation assessment questions, including NoMAD Tool items	Likert scale 1 = Strongly disagree to 5 = Strongly agree
Planned/actual changes to practice	Open text response
Feedback on Bridges SSM training	Open text response

The practitioner confidence and performance measures were developed from a series of questions derived from the SEPSS-36 instrument (Duprez et al, 2016) which examines SSM under a number of categories (i.e. assess, advise, agree, assist and arrange). Given the need to incorporate other items of interest into the practitioner questionnaires, the SEPSS-36 survey instrument was felt to be too burdensome to administer to participants in its entirety. The evaluation team therefore independently mapped the SEPSS-36 items to the Bridges 11 core principles and jointly agreed with the Bridges team on a reduction to 18 items.

Questionnaire responses were entered into SPSS and data analysed using descriptive statistics. Open text responses were entered into Excel and, where appropriate, coded and categorised.

Qualitative methods

Workshop observations and qualitative interviews focused on changes to individual and team practice resulting from the Bridges training, and perceived facilitators and barriers to implementation and sustainability.

UEA evaluators observed all KZ1 and KZ2 workshops in Cambridgeshire and Peterborough STP to examine aspects of training delivery by the Bridges team, perceived challenges to implementation raised by practitioners, reported examples of changes to practice and the perceived benefit of the Bridges SSM approach. Field notes were taken and were analysed thematically.

Semi-structured interviews with a sub-sample of practitioners regarding their experience of implementing Bridges SSM in their individual and team practice were conducted following KZ2. NPT was used to inform the interview topic guide as the theory is concerned with the work that people do as individuals and in groups to implement and embed a new set of practices and was therefore apposite. As far as possible, interviewees were selected to reflect a range of professions in both acute and community settings. Interviews were recorded with the permission of the participants and transcribed using an intelligent verbatim approach (i.e. the fillers and repetitions of recorded speech were edited out to produce a readable transcript). The transcripts were read and thematically analysed by the UEA evaluation team.

The interview topic guide is in Appendix 3.

CASE STUDY ONE: CAMBRIDGESHIRE AND PETERBOROUGH STP

The following presents a summary of results for the first of the East of England STPs to participate in this Bridges SSM programme. Three trusts were involved in the initiative incorporating acute, ESD and community services. The timeline for the delivery of the Bridges intervention is shown in the table below.

Table: Bridges SSM programme timeline

Stage	Timeline
Stage 1: Awareness Raising	Dec 2017 – July 2018
Stage 2: Stakeholder Engagement	Aug 2018 and March 2019
Stage 3: Knowledge Zone 1	Sept and Oct 2018
Stage 4: “Transforming”	Sept 2018 to Jan 2019
Stage 5: Knowledge Zone 2	Dec 2018 and Jan 2019
Stage 6: Champions Masterclass	June 2019
Stage 7: Sustainability plans	From June 2019

STAKEHOLDER ENGAGEMENT

One important aspect of Bridges SSM training is that it is customised to the local context in which it is delivered. Prior to the delivery of the training, Bridges engages with stakeholders (Stage 1 = local service teams; Stage 2 = former service users) to understand their needs, concerns and challenges. As a result of Stages 1 and 2 of the Bridges programme, the content of training is tailored to address context-specific issues. This process helps to build commitment to the training by maximising its relevance or coherence (see ‘implementation assessment and sustainability’).

Trust engagement

To engage each trust in the training and qualitative improvement programme, Bridges follows a complex and non-linear process, which incorporates elements of ‘top down’ and ‘ground floor up’. As Bridges SSM training is commissioned at STP level and is not something that has been requested by staff, it could be perceived as being ‘imposed’ on a ‘top down’ basis. The Bridges team therefore seeks to engender a ‘ground floor up’ enthusiasm for the training from front-line staff prior to training delivery.

Bridges is promoted as a positive way of delivering SSM with benefits for patients, staff and service. It provides a framework for staff to deliver a consistent approach, with gains in terms of service quality and efficiency, while being an integral part of routine practice and not an add-on. The value of the approach is supported by its evidence base and the fact that it has been co-designed and co-produced with individuals who live with long term conditions. The trust engagement process involves a number of elements as described in the table below.

Table: Elements of trust engagement process

Engagement process	Explanation
Understanding patient pathway	Identifying trusts in STP and mapping out patient pathway and services
Identifying key contacts	Making contact with key individuals (i.e. therapy leads, service managers, stroke consultants) by utilising personal contacts, securing introductions by other practitioners or calling a particular service
Providing information	Sending key contacts an overview of Bridges SSM training, including evidence base, principles, and benefits (for patients, staff and service)
Question and answer sessions	Follow-up with key contacts (by email exchange, telephone call or face-to-face meeting) to answer any specific questions they may have, and to make clear what Bridges is asking from the trust
Information gathering	By means of a formal engagement meeting or "Getting to Know You" questionnaire, Bridges seeks to gain an understanding of the service, patient throughput, what practitioners feel most proud of, what they would like to do more of in relation to SSM, and what service developments they are working on
Next steps	Bridges and key contacts (from across STP) discuss allocation of 125 training places, training dates and appropriate venues. Bridges provides poster templates for key contacts to advertise training workshops. Key contacts provide support to UEA evaluation team to secure governance approval for evaluation activities

The engagement process in Cambridgeshire and Peterborough STP took >6 months. Contact with some key individuals was first made at the UK Stroke Forum in December 2017 and, due to a lack of firm commitment to the training, Bridges decided to try a new approach to securing buy-in by holding an 'Engagement Lab' with clinical leads in early July 2018. The 'Engagement Lab' was an enhanced version of a formal engagement meeting.

At the Engagement Lab, which was attended by 20 clinical leads (dietician, nurse, OT, PT, Psychologist and SLT), Bridges presented an overview of the training and quality improvement programme, the key evidence base for Bridges SSM and the benefits of using the approach (for patients, health professionals and service). The clinical leads were encouraged to identify their current challenges and what they hoped to gain from the Bridges training. Next steps were then explained.

Table: Feedback at Clinical Lead Engagement Lab, 2 July 2018

Current challenges	Hope to gain from Bridges training
Large, variable and fluctuating caseloads Shortage of beds Push to discharge, focus on targets Staffing levels Lack of time Resource constraints Lack of MDT and ward focus on rehabilitation Difficulty of signposting to other services Organisational issues	Refocus on patient and validation of person-centred care More effective goal setting Greater motivation of patients and carers More positive feedback on patient experience Better patient outcomes A framework for staff to work to Improved team confidence in impact of rehabilitation More MDT engagement with SSM

A key individual at each of the three participating trusts was instrumental in organising attendees at the Engagement Lab and in promoting the training workshops. These three individuals subsequently worked collaboratively across organisational boundaries on the scheduling of training and the allocation of training places.

A further awareness raising session was delivered by Bridges in Cambridgeshire and Peterborough STP: following a KZ2 workshop there was a briefing session for medical staff, which was attended by some of the consultants. The briefing session focused on the underlying core philosophy of Bridges SSM and its benefit. No medical staff participated in the Bridges training workshops.

As part of the engagement process, the UEA evaluation team sought to secure governance approval for evaluation activities. It was initially hoped that it would be possible to secure governance approval at STP level, but in practice it was necessary to secure approval from each participating trust.

The three key individuals at the participating trusts provided advice to the UEA evaluation team on the approval process and forwarded appropriate documentation for completion. It took 3 months to secure governance approval for the evaluation and there was a slightly different approach at each trust:

- Formal QI registration form completed and honorary contract for UEA evaluator
- QI project registration form signed off by Chief Nurse
- Divisional sign-off and no formal QI registration.

One of the participating trusts had worked previously with staff at UEA on a QI initiative and had an established process. This was beneficial in that the process and documentation could be shared with the other two trusts in the STP.

CONCLUSIONS: TRUST ENGAGEMENT

- A complex and non-linear process, requiring both a proactive and reactive approach by the Bridges team, with sensitivity to and understanding of the context.
- Getting the right balance between 'top down' and 'ground floor up': Bridges SSM training could be perceived as imposed from above as it is commissioned at STP level rather than requested, successful delivery rests on the ability of Bridges to secure enthusiasm for and commitment to the training from the ground up.
- Providing information in a variety of formats and using multiple communication methods is necessary to build understanding of the training and its potential value. This includes being clear about what is being offered to the trusts and what is expected of them.
- The Bridges evidence base, the ability of the approach to be easily integrated into routine practice, and the potential benefits of SSM for patients, staff and service efficiencies are important elements for securing engagement.
- Identifying key contacts is critical: securing buy-in from clinical leads or managers with operational and strategic insight facilitates engagement and roll-out of the training. The leads are able to organise support (e.g. PDSA training) for their staff pre-training and ensure the necessary space (both physical and thinking space) is available for staff post-training in order to take the initiative forward.
- 'Pre-champion Champions' or individuals who are pro-active and visible in demonstrating their support for the initiative. These can be managers, clinical leads, team leads or enthusiastic practitioners who are advocates for the approach. They contribute to the organisation of the training, introduce the training and evaluation at the workshops, and take part in the training.
- Support of key individuals was instrumental in helping the UEA evaluation team to secure governance approval for the evaluation.

Former service user engagement

Another key element of the engagement process for the Bridges SSM training and quality improvement is engagement with former service users (i.e. those discharged from treatment and community dwelling). The stakeholder engagement allows Bridges to contextualise training by providing context specific patient stories and by highlighting issues that stakeholders wish practitioners to be aware of. The patient voice is being used here as an extrinsic motivator to appeal to the intrinsic motivations of practitioners (i.e. their professional ideals and reasons for wishing to work in health care), to demonstrate the need for the training and the relevance of the Bridges SSM programme.

The UEA evaluation team was responsible for leading on stakeholder engagement in Cambridgeshire and Peterborough STP. Ethical approval for this activity was secured from the University's Faculty of Medicine and Health Ethics Committee.

Former service users were accessed via gatekeeper organisations (i.e. local stroke and brain injury support groups) and were invited to take part in a focus group discussion to explore their experiences of life after stroke or brain injury, their perceptions of rehabilitation, and their perspectives on managing their life and condition after discharge from treatment. The focus group topic guide is in Appendix 4.

Diagram: Engagement with former service users

EXPERIENCES OF LIFE AFTER STROKE/BRAIN INJURY

EXPERIENCES OF REHABILITATION

EXPERIENCES OF CARRYING ON "UNDER OWN STEAM"

Former service users
n = 12

Partner/family member
n = 3

Age range = 30s to 80s

Two focus group discussions were conducted: one in August 2018 and the second in March 2019. The second group discussion was somewhat later than originally anticipated as the gatekeeper organisation asked the evaluation team to give a presentation about the Bridges SSM training and quality improvement programme to group members and this could not be scheduled until January 2019. Following the presentation, the group members agreed to take part in a focus group discussion and this was arranged for March 2019 around one of their regular meeting sessions.

The two focus group discussions involved twelve former service users and three family members. Both focus group discussions lasted for 60 minutes and were recorded with the consent of participants. The recordings were transcribed and analysed thematically.

The main themes to emerge from the focus group discussions are summarised in the accompanying table. These findings are similar to those identified in previous work conducted by Bridges and other researchers (Boger, Demain and Latter, 2015; Sadler et al, 2017; Clark et al, 2018). They reveal a need to provide rehabilitation that is personalised and meaningful to the individual to help them as they try to rebuild their lives.

The experience of a stroke or brain injury, or coping with a progressive neurological condition, is a traumatic event that has disconnected individuals from what they were in the past and what they thought they might be in the future. The same is true for family members who often have to re-evaluate their lives in the context of needing to provide ongoing care and support.

As well as the physical aspects of their condition, participants reported that they struggled to deal with issues such as frustration, concentration, emotion, anxiety, and being on a 'shorter fuse'. These issues impact not just the individuals themselves, but also family members who are caring for and supporting them. Participants remarked that they were not really prepared to contend with these issues. Information and support that is directed towards only physical impairment does not, therefore, necessarily address all the consequences that individuals experience.

Table: Summary of main themes from former service user engagement

EXPERIENCES OF LIFE AFTER STROKE OR HEAD INJURY

- A life changing event
    - Feeling overwhelmed
    - Dislocation from former life, every aspect of life has changed
    - Need to relearn self, pick-up threads, find new purpose
- Not prepared for dealing with frustration, emotion, anxiety, memory issues, concentration
- Impact on family

EXPERIENCES OF REHABILITATION

- Benefit of feeling listened to and understood
- Being treated as a person and not a tick box exercise
    - *"If they listened to you, that would be a good start … they are more interested in ticking boxes than looking at you as a person."* [Male, Focus Group 2]
    - *"Everybody's response will be different. Some people get angry, some people get anxious, everyone's different."* (Male, Focus Group 1)
- Proving to yourself that you can do things and receiving personalised support
    - Sense of achievement and building confidence
    - *"Me and OTs don't see eye to eye … that's where I got a bit annoyed, every day 'make a cup of tea', 'make a cup of tea' …"* [Female, Focus Group 1]
    - *"Much to my family's annoyance I like to do things for myself. Not a lot, I mean just walking to the shower and doing it on my own with nobody else. They don't like it 'cos they are worried about me, but I do like it because I can do it"* (Female, Focus Group 1)

EXPERIENCES OF CARRYING ON "UNDER OWN STEAM"

- Feeling unprepared and abandoned
    - *"I personally felt neglected, abandoned …. problems hit you like a ton of bricks. You don't really know it's going to be a problem to handle frustration."* (Male, Focus Group 1)
- Reliance on family and friends
    - The importance of their contribution is not always recognised
    - Family members also have to re-evaluate their future and pick-up threads
    - *"Mum has stopped work and so on, and my dad and my two siblings, they all do a lot to help me. It's not just you that has to cope."* (Male, Focus Group 1)
- Community support groups
    - Important source of peer support, sharing experiences, helping each other, socialising, building confidence
    - *"It's good coming to the groups, you hear about other people's experiences and then you realise you aren't going through it alone."* (Male, Focus Group 1)
    - *"I was desperate. I didn't know what to do, so I went on my computer and I found [support group] and I thought 'yeah, go on' and I wrote … and I said 'help'. It was all I said, 'help.'"* (Female, Focus Group 1)

As far as care from health professionals was concerned, stroke and brain injury survivors valued interactions where they were treated as a person and not a 'tick box exercise'. In particular, the aspects of care that they remarked on were those health professionals who "listened to and understood me", who were "interested in me" or were "kind and thoughtful".

Once the acute phase of rehabilitation is over, participants can feel that they are left to fend for themselves, with perceptions of a gap in services, a lack of continuing therapy or difficulties in navigating services to find appropriate sources of support. This situation can engender uncertainty about how best to manage going forwards.

Stroke and brain injury survivors and their family members found great benefit from connecting to local support groups where they were able to share experiences with others in a similar position, pick-up tips and advice to help manage aspects of their recovery and, in turn, be able to reciprocate by offering support and encouragement to others. Participants took inspiration from peers who were coping with circumstances that were perceived to be similar to, or worse than, their own. Participants enjoyed the social aspects of the support groups, which help to build confidence and overcome social isolation. Participants and/or family members reported that they were not always signposted to these sources of support, but had to discover them for themselves.

Partners, family members and carers are crucial to recovery and ongoing support. Participants were full of praise for the support they had received from family members and remarked that their contribution is often not acknowledged. Informal carers provide a help across a wide spectrum of need ranging from personal care, to emotional support, help with transport, and many other aspects of practical support. As such, they and the stroke or brain injury survivor comprise a unit for SSM. Some participants highlighted that tensions can arise when they want to do things for themselves and family members are concerned about their safety.

While it may have been upsetting for former service users to relive the experiences of their stroke or brain injury, they had pre-existing relationships and were used to talking about their problems and experiences as part of an established group. They were happy to share their experiences with members of the UEA evaluation team and appreciated the opportunity to contribute to a quality improvement initiative that would benefit service users in the future.

CONCLUSIONS: STAKEHOLDER ENGAGEMENT

- Importance of being treated as a person.
- Being listened to and understood and provided with personalised support.
- Individual and family are contending with the situation together.
- Being prepared for all challenges, not just physical challenges.
- Building confidence to move forward and rebuild life.
- Peer support and being able to navigate support services.

EVALUATION DATA COLLECTION

Quantitative

The Bridges SSM training and quality improvement programmes offers 125 training places across the STP.

Table: Attendees at Bridges SSM workshops

Workshops	Timing	# attendees
Knowledge Zone 1 (n=4)	Sept and Oct 2018	114
Knowledge Zone 2 (n=4)	Dec 2018 and Jan 2019	104

The scheduling of the training was influenced to a certain extent by the roster sheets for certain staff who were required to give 8 weeks' notice in order to cancel clinics. Not all staff were able to take-up (i.e. because of staff shortages) or complete training, and some individuals moved on

immediately after training. In deciding on how to allocate training places, the level of banding of staff was taken into account. Transformation and change are part of the job description for higher level banding staff, but as one practitioner indicated at interview, it may have been more beneficial to have more static staff trained as they are heavily involved in the day-to-day care of patients.

> *"Because the [training] numbers were quite small we had to make the decision about which band of staff was going to be trained. We obviously choose the higher level banding because as part of their job description it is embedding change and transformation and teaching … but it made it quite tricky in that it would have been lovely to have more of the static staff trained."* [Team Lead]

The aim of Bridges SSM training and quality improvement is to create a critical mass of trained practitioners within a team or service in order to generate change and maintain momentum. The training helps to create a shared vision of why and how to provide SSM. The training workshops give attendees an opportunity to think together and enable practitioners to support each other through the process of change.

The take up of training places was good, although with some attrition for KZ2. As previously mentioned, no medical staff attended the training, although a briefing session was organised following one KZ2 workshop to provide consultants and other medical staff with an overview of the Bridges SSM initiative. There was a reasonably even representation of practitioners from across acute and community settings (see table below on characteristics of participants in training).

An excellent response rate to evaluation questionnaires was achieved as documented in the table below. This was helped by the decision to administer hard copy questionnaires on training days rather than ask practitioners to complete electronic versions of the questionnaires at a later date.

Table: Number of evaluation questionnaires and response rates

Questionnaire	Number	Response rate
Knowledge Zone 1 – Pre-training	113/114	99.1%
Knowledge Zone 1 – Post-training	111/114	96.5%
Knowledge Zone 2 – Post-implementation	100/104	96.2%

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 SSSM training

Participant characteristics	KZ1		KZ2	
Profession	**Number**	**%**	**Number**	**%**
Nurse	15	13.3	14	14.0
OT	24	21.2	21	21.0
PT	26	23.0	22	22.0
SLT	19	16.8	14	14.0
Psychologist	3	2.65	4	4.0
Rehabilitation Assistant	25	22.1	22	22.0
Family Support Coordinator	1	0.9	0	0
Dietician	0	0	1	1.0
Missing	0	0	2	2.0
Total	113	100	100	100
Setting	**Number**	**%**	**Number**	**%**
Acute	48	42.5	44	44.0
Community	57	50.4	51	51.0
Both	3	2.7	2	2.0
Missing	5	4.4	3	3.0
Total	113	100	100	100
	Mean (SD)	**Range**	**Mean (SD)**	**Range**
Years in profession	12.0 (9.15)	0.5-38	12.4(9.80)	1-40
Years in service	5.3 (6.04)	0.4-31	5.73 (5.86)	0-20

Qualitative

Workshop observations

The UEA evaluation team carried out 40+ hours of evaluated embedded observations of KZ1 and KZ2 workshops and the Bridges Champions Masterclass.

Semi-structured interviews

Ten semi-structured interviews with a range of practitioners from across patient pathway took place following KZ2. The interviews were conducted by telephone and lasted between 30 and 50 minutes (average 40 minutes). The characteristics of the participants are described in the table below.

Table: Participants in semi-structured interviews

Interview participants	Number
Manager/Clinical Lead	2
Nurse	1
OT	2
PT	2
RA	1
SLT	2
Acute	4
Community	6
Years in profession (mean)	19
Years in service (mean)	9

FINDINGS

Four Levels of Evaluation

Reaction

In the questionnaire administered at the end of KZ1, practitioners were invited to provide their comments and feedback on the Bridges training. These comments were treated as "smile sheets" and were coded as positive☺, neutral😐, or negative☹ by the evaluator. The number in each category is presented in the table below, together with a range of illustrative comments.

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

Feedback	Number*	Illustrative participant comment
☺	91	• Excellent initiative that underpins the rehabilitation ethos that we want to see on the ward [Nurse] • Really positive, easily implemented techniques [Rehabilitation Assistant] • Thought provoking and stimulating - has managed to "re-light my fire" [SLT] • Excellent, for acute nursing this is what we learnt in training but don't do as so many pressures, [gives] permission and support on how to get back to nursing properly [Nurse] • Very helpful - opportunity to reflect on team's approach and strategies used when working with patients [OT] • It made me reflect on my own practice - I feel I deliver this approach, but not consistently - motivated to do better [Rehabilitation Assistant] • Interactivity was great – felt really empowered to put the approach into practice [OT] • The patient examples/videos – and having stroke survivor in the session – is very, very helpful [SLT] • Excellent training, well delivered with enthusiasm [PT]
😐	33	• How usable the booklets are [PT] • It took me a little while to get to grips with what Bridges is [SLT] • No comments [various - 29]
☹	19	• Still see time as a challenge and our complex, cognitively impaired [OT] • May be commissioners need this training too to set more meaningful KPI • Just feel bureaucracy and management will be the main obstacles in implementation [Nurse] • Needs to infiltrate all layers of the hospital - discharge planning teams [PT] • Should have more nurses involved [Nurse] • More information on supporting self-efficacy in people with aphasia [SLT] • A lot of information that I would have to take away with me to feel confident to understand the true process of Bridges [Rehabilitation Assistant] • Hard to link with handout at times [PT] • Clearer aims at start of day [SLT]

**Some participants offered more than one observation about the training*

The underlying philosophy of Bridges resonated with practitioners (and is something that contributes to the Coherence of the approach (see implementation assessment and sustainability). Many described the training as “thought provoking” and “motivating”. The opportunity to stand back and reflect on practice was valued, with some feeling that Bridges training offered ‘permission’ to continue with, refine, or recapture person-centred practice. Some practitioners expressed the view that ‘we do this already’ and that the approach was very much in line with their professional philosophies. While this may have resulted in some questioning of the relevance of the Bridges training, this view was qualified by reflections from other practitioners during the workshops and in the interviews about the importance of refresher training and being encouraged to think about improvements to practice, and the need to demonstrate that SSM is being applied consistently in practice.

The interactivity of the workshops was appreciated, together with the opportunity to interact with colleagues from across the service pathway and with ‘engaging trainers’. Participants appreciated the video case studies of patient experiences, as well as the presence of a stroke survivor or a service user as one of the facilitators. The use of the ‘patient voice’ in the training was felt to be very powerful and helpful, perhaps reflecting an experience that many practitioners have not been exposed to previously.

Negative comments related to certain aspects of the training, but most were concerned with the perceived challenges of implementing Bridges (e.g. time, bureaucracy, push to discharge) and the feeling that the approach ought to be more widely disseminated (e.g. involvement of discharge planners, doctors, nurses and commissioners).

Reflections on training by evaluators

In their observations of the workshops, the UEA evaluators considered the aspects of the training that were likely to motivate attendees to take the learning forward. These are summarised in the following table.

Table: Assessment of factors contributing to positive training experience

Factor	Description
Learning atmosphere	Safe space away from clinical demands to reflect on practice, learn from others, and plan changes with team members – thinking and learning together
Adult learning principles	Interactive rather than didactic, group work and feedback sessions
Credibility of trainers	Knowledgeable, experience as practitioners, enthusiastic, engaging and approachable
Evidence base for Bridges SSM	Long period of research and development (since 2008), continually evolving Co-designed and co-produced with individuals living with long term conditions and with practitioners who have been trained in the approach
Peer voice	Experience of the trainers, use of practitioner video examples, feedback from teams who have implemented Bridges SSM
Patient voice	Use of patient voice through video examples, also emphasis on co-design and co-production with service users Stroke survivor or person with long term condition present in many of the sessions – using extrinsic motivation of patient voice to advocate change and appeal to attendees' intrinsic motivations for working in healthcare
Used Bridges principles in workshops	Getting to know you, reflection, problem solving, peer support, small steps for changes to individual and team practice

In the pre-KZ1 questionnaire practitioners were asked to state the professional ideals that attracted them to work in healthcare. The free text responses were categorised and two main themes emerged. As might be anticipated for individuals working in a healthcare environment, focus of practitioners' intrinsic motivations was on helping individuals at a vulnerable stage of their lives by providing high quality care. Being able to fulfil such ideals can help to enhance practitioners' levels of job satisfaction as indicated in the quote below from one of the interviews.

> *"Where they get their satisfaction from is doing a good job. So if they work with somebody and they get good feedback, that's the absolute for them. So I think it's more about that than their caseload. They do get good feedback, but I think hopefully this [Bridges] will give them more."* [Manager]

Diagram: Intrinsic motivations for working in healthcare

CARING FOR
& HELPING OTHERS

Improving quality of life
Promoting independence
Making a difference

PROFESSIONAL
OPPORTUNITIES

Team working
Developing self & practice
Contributing to high
quality care

Practitioners were also asked if they felt their current practice allowed them to reflect those ideals and, at the end of KZ1, whether they felt that the Bridges approach would help them to make changes to practice that would bring them closer to their professional ideals. At KZ2 practitioners were asked if they felt that the Bridges training had helped them to make changes to practice to bring them closer to their professional ideals. In addition, practitioners were asked if they found their work enjoyable.

Table: Practice reflects professional ideals

Practice and professional ideals	Positive	Neutral	Negative
Current practice allows you to reflect ideals? (n=109)	73.4%	24.8%	1.8%
Bridges SSM approach will bring you closer to ideals? (n=110)	97.2%	0.9%	1.8%
Bridges SSM approach has brought you closer to ideals? (n=99)	82.8%	13.1%	4.0%
Find work enjoyable	**Positive**	**Neutral**	**Negative**
Pre-KZ1 (n=111)	82.9%	16.2%	0.9%
Post-KZ2 (n=100)	90.0%	10.0%	0.0%

Nearly three quarters of practitioners responded positively that their current practice allowed them to reflect their professional ideals, although a quarter were neutral in their response to this question. At end of KZ1, the majority of practitioners agreed that the Bridges initiative would help them make changes to practice to bring them closer to professional ideals. At KZ2 around 83% agreed that Bridges had enabled them to make changes to practice that had brought them closer to professional ideals. Practitioners also responded positively about enjoying their work.

CONCLUSIONS: REACTION

- Practitioners responded positively to Bridges SSM training finding it "thought provoking" and "motivating." They appreciated the opportunity to share their experiences with individuals from other services.
- While some practitioners expressed the view that "we do this already" in relation to SSM, it was nevertheless acknowledged that it is important to be reminded about techniques and there is always room to improve practice.
- Workshop observations suggested a number of factors contributed to a positive learning experience including: learning atmosphere, adult learning principles, interactivity and group work, credibility of trainers, evidence base for approach, and use of peer voice and patient voice.
- SSM training resonates with practitioners' professional ideals: 'caring for and helping others' and contributing to high quality care.
- Practitioners felt that Bridges SSM could help them make changes to their practice to bring them closer to their professional ideals.

Learning

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

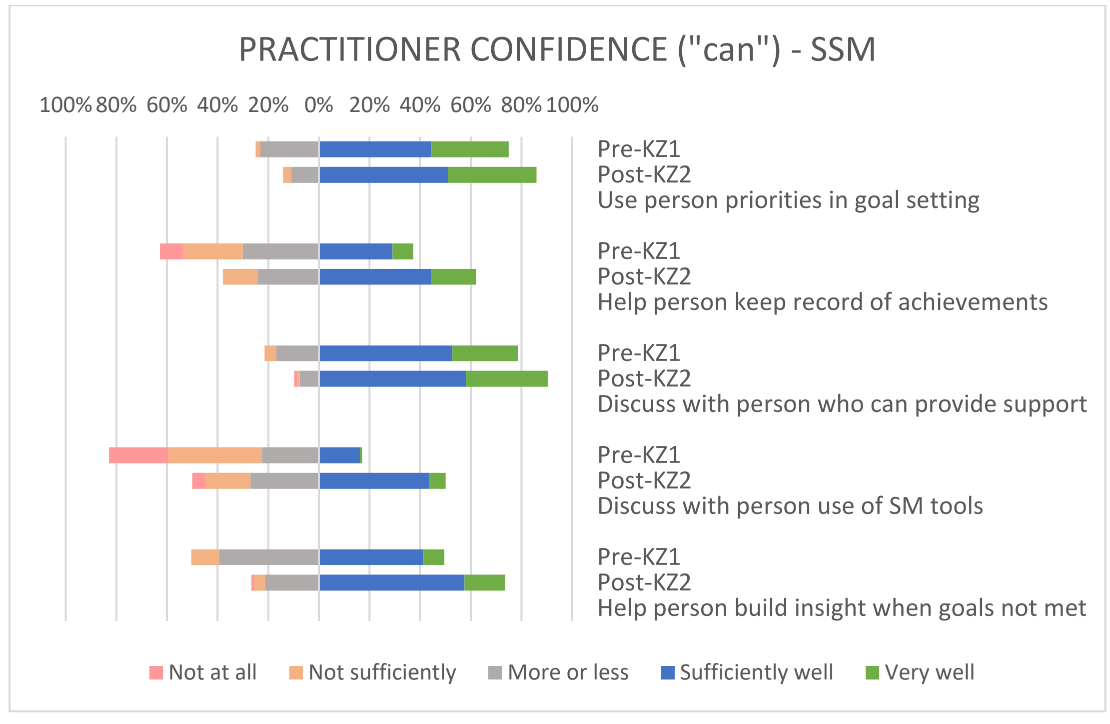
Five SSM tasks have been selected for presentation here: goal setting, patient reflection, accessing daily support, using SM devices, and developing insight. These were selected as many practitioners indicated in their feedback questionnaires at the end of KZ1 that they intended to make changes in these areas.

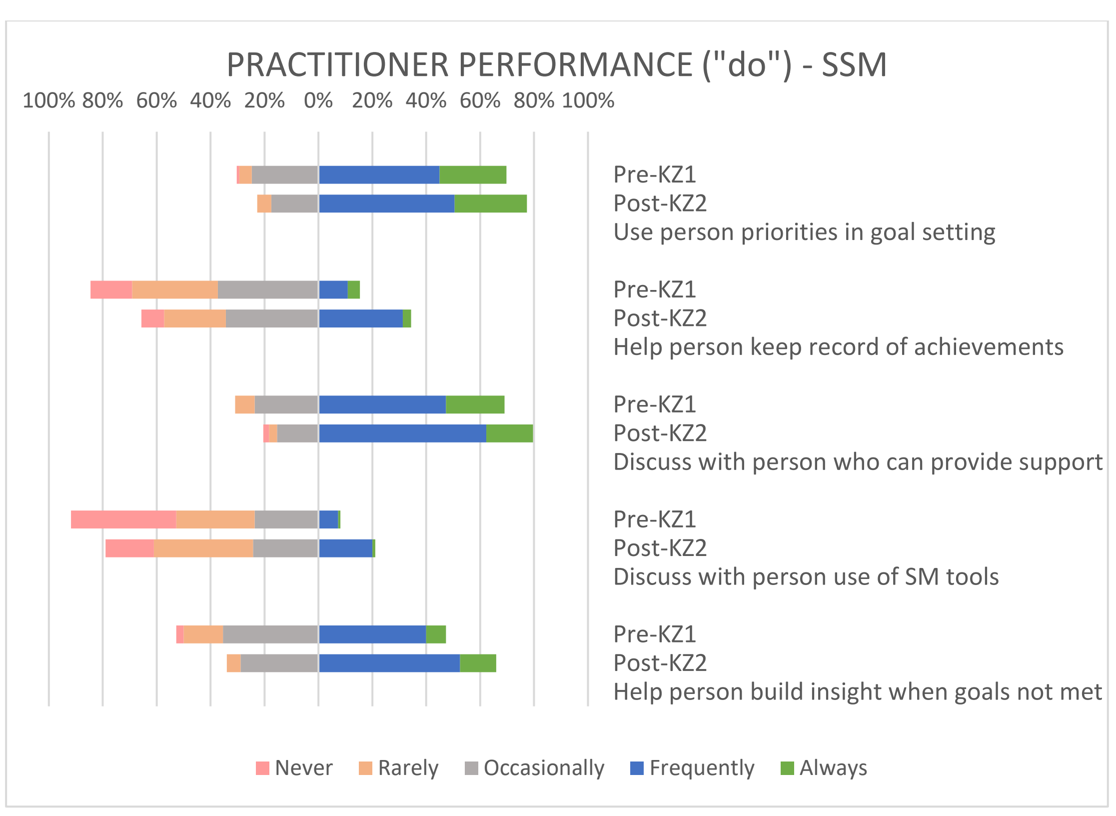
Goal setting	Allow the person to determine their own priorities when developing goals
Reflection	Assist the person to keep their own record of goals and achievements
Support	Discuss with the person who can provide daily support (e.g. family & friends)
SM devices	Discuss with the person how they can make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

In the diverging stacked bar chart practitioner percentage responses indicating that they can do the SSM task "very well" or "sufficiently well" appear to the right of the 0% line, while responses for "more or less", "not sufficiently" and "not at all" are to the left of the 0% line. 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 "always" and "frequently" with regard to performance of the five SSM tasks, and responses for "occasionally", "rarely" and "never".

Diagram: Practitioner confidence and performance in five SSM tasks





The results show a strong, existing baseline of confidence in and performance of person-centred care and this is not surprising as attendees at the Bridges training were all experienced professionals, with their underlying intrinsic motivations for working in health care (i.e. helping others) and professional philosophies that advocate a person-centred approach. Some had previously attended other self-management training (including Bridges) and/or had training in certain other techniques (e.g. health coaching, various psychological approaches). Nevertheless, there is evidence of greater self-reported confidence in and performance of these SSM tasks, indicating that practitioners have taken the learning on board and are transferring it into their everyday practice.

Results from workshop observations and interview data support these findings. Practitioners reported feeling more comfortable and confident in their assessment and therapy sessions, and more able to step back and offer control to patients, providing guidance as needed rather than dictating the agenda.

> *"Being a bit more confident to have that conversation about 'what do you envision over the next week you will have achieved?' … or 'when we have our next meeting what are you hoping that is going to look like?', so that people then have to start saying 'what I'll work on is this, this and this' and just be a bit more concrete with it. So with that stuff I would say my confidence has definitely improved."* [OT]

> *"I feel I have been doing a lot better in terms of trying to seek much more personal information about a patient and just trying to find out a little bit more about them. I would say not consistently, but I try as much as possible."* [PT]

> *"And also for the team, seeing them get that confidence in using it as well, that gives you that feeling of things having improved."* [PT]

> *"And the other thing is, I've noticed that I can do a lot more is to provide some of the therapy assistants, and so we use the kind of Bridges conversations about … I think for the therapy assistants it's about how they can use the conversations to work with patients as well … it's about using that in the supervision to talk about what kind of conversations they could have with patients."* [OT]

Practitioners reported feeling confident to incorporate different strategies into their practice (e.g. using video recording to build insight and encourage reflection). They also expressed the view that offering more control to patients meant that they as practitioners were challenged more to respond to incorporate patient ideas into therapy and that this made practice more interesting.

> *"And [the patient] set her little hierarchy of what she was going to do and she would tick it off as she went through and I probably wouldn't have done that, I would have made a recommendation."* [SLT]

Practitioners were trialling and tailoring the Bridges approach, but, as with many things in life, it was felt that further time and practice were necessary to build confidence further and to consolidate new ways of working.

> *"We are looking at doing some joint working, shadowing and things like that, but I think people need to be more confident in what they are doing in their own practice before we branch out into that."* [SLT]

CONCLUSIONS: LEARNING

- Evidence of a strong, existing baseline of person-centred care.
- Questionnaire data points to a shift in confidence in SSM and performance of SSM tasks following the training. This is supported by findings from workshop observations and semi-structured interviews.
- Practitioners were trialling and testing Bridges SSM and felt that time and practice were necessary to build further confidence in the approach and to consolidate and refine changes to practice.

Behaviour

At the end of KZ1 and KZ2, practitioners were asked about small changes they intended to make or had made to their practice.

Open text responses were coded and categorised and are summarised in the following table.

Table: Changes to practice

Changes to practice	Description
Language	• Changing language used with patients • Asking more open questions • Using Bridges SM catch phrases • Changing how introduce self and service
Getting to Know You	• Having a 'normal' conversation • Finding out more about the patient, their story, their interests, and what is important to them • Asking about fears and worries • Sharing nuggets of personal information about the patient with team members
Goal setting	• Encouraging patient to think about priorities, next steps and goals for future • Asking what the patient wishes to work on • Asking what is "one small thing" you want to achieve • Breaking down patient goals into small steps or stepping stones • Documenting goals in patient's own words • Use "to do" lists for patients between therapy sessions
Reflection	• Avoiding saying "well done" to patient • Asking patient to reflect on progress • Encouraging patient to problem solve • Using diaries and videos to encourage reflection • Using confidence rating scales with patients
Paperwork and processes	• Changing assessment form to reflect SSM approach, e.g. what is important to you?, actions for me & actions for you, to do lists • Changing goal sheets • Changing discharge letter, e.g. written to patient and not GP • Changing structure of MDT meeting & sharing information, • Supporting other staff in using approach

Practitioners were able to identify many ways in which they could incorporate Bridges SSM into their practice. Even for experienced members of staff, there was recognition that making such changes required practice in order to build confidence and to ensure that the changes became part of routine practice.

Many of the reported changes to practice were related to the use of language and asking more open questions. By changing language to be more patient friendly and inclusive, practitioners intended to promote SM and encourage greater independence, or more active patients, from the outset. The focus on changing language could reflect its perceived importance by practitioners in changing the culture of their service, and also the perceived value of something that can be readily incorporated

into practice. In the interviews with practitioners it emerged that changing language was something that did not necessarily happen automatically after training and needed to be worked on.

> *Considering how much I probably can buy into it and understand the need, I had to have really like a prompt sheet to help me use, rethink my questioning. I wasn't spontaneously doing it. It wasn't like I could just go on the training and switch over to 'oh now I use this language'. I had to have the prompt sheets."* [SLT]

Practitioners explored a number of mechanisms to help embed a change of language in their practice, such as:

- Prompt cards of Bridges catch phrases or examples of open questions
- Changes to assessment paperwork
- Trying to use a Bridges 'phrase of the week'
- Displaying a poster of Bridges catch phrases in the doctors' office and in ward books.

Practitioners reported that they had changed how they introduced themselves and their service to patients at the first assessment session, with the emphasis more on what the patient wished to achieve and what the service could then offer in terms of support and contact time. This was perceived as an important change as previous practice would have entailed running through the assessment form and then at the end asking the patient about what they wanted to achieve. It was felt that the new approach helped to support patient expectations from the outset.

> *"Following Bridges … the initial time of seeing someone, saying 'what is important to you' as the starting point rather than go through all the initial assessment stuff as you normally would."* [OT]

Practitioners also reported taking the time to find out more about their patient by having a 'normal conversation' and gathering details of their life story and interests, and what is important to them, i.e. finding out more about them as a person. This information gathering fed into goal setting with patients, whereby the focus is more on what is important to the patient and what they wish to achieve, rather than only therapy goals or referral forms dictating the course of action. In situations where patients were feeling overwhelmed, practitioners felt that drilling down and asking about "one small thing" the patient wanted to achieve was very useful in being able to help patients move forward and overcome the "blank sheet".

> *"So what I went to go and do for this patient this morning, from the referral, we didn't actually touch on. It was more about he wanted to go back to work .. and everyone else was talking about having wet room built."* [OT]

> *"Some of them, it's just so many things, it's too vast. So there is that ability to focus on one or two simple things."* [PT]

Indeed having an initial discussion with the patient about what is important to them could result in "goals coming out naturally" and to the establishment of "more meaningful" goals. If patients are able to or encouraged to identify and set their own goals, practitioners felt that this confers a greater sense of ownership and encourages patients to work more. Practitioners also felt that having open conversations helped patients to accept adaptations to what they hoped to do and gave them the opportunity to try things in a safe way. If patients are doing more between therapy sessions, it was felt that this would result in better outcomes and potentially lead to a reduction in rehabilitation time. Maximising the participation of patients was regarded as contributing positively

to the rehabilitation journey and building confidence for continuing beyond formal therapy sessions (i.e. overcoming the sense of abandonment reported by former service users).

> *"It's hopefully a bit more powerful if someone comes up with the ideas themselves and then they are more committed to it."* [OT]

Practitioners reported using the Bridges techniques of setting "stepping stones" towards goals, exploring barriers and resources with patients, and encouraging patients to reflect on their own progress, rather than simply saying "well done". By way of example, the ESD service reported development of a patient pack whereby patient and practitioner complete goals and identify stepping stones towards goals.

> *"The patient wanted to spend some informal time back at work and I asked him to write a reflection on it, because one of our goals was writing …. and it was such a really good insight and we spent quite a bit of time discussing the things that had come up that had surprised him … that had triggered a new goal and I came away thinking 'I wouldn't have done that before'. So I definitely see changes in my practice that I feel are valuable."* [SLT]

There were examples of the template of MDT meetings changing as a result of the Bridges training, with greater discussion of patient goals, how these link to professional goals and how the team is going to work towards them. This sharing of knowledge within the team was perceived to promote more cooperative and coordinated working, whereby individuals were able to challenge one another constructively and support each other through the process of implementing change by discussing if, and how, to use the Bridges approach with particular patients and feeding back on how the approach was working. The Bridges principles and approach were also used in complex case discussions to guide the development of treatment plans outlining simple steps: you said, you did, we did, we can do, what worked, and next steps.

Changes to processes and paperwork were regarded by practitioners as essential to embed and sustain Bridges SSM in practice. Changes to paperwork included:

- Assessment forms
- Patient packs
- Goal sheets
- Discharge letters.

By way of example, one of the reported changes to assessment forms was having a series of open questions about what is important to the patient and what they want to achieve as the starting point, rather than at the end of the form. It was felt that this would prompt SSM behaviour and in particular would help to facilitate that behaviour in members of staff who had not been Bridges trained or in new members of staff. The structure of existing assessment templates was perceived to make interactions with patients feel more like running through a checklist, something that was commented on negatively by former service users in the focus group discussions. By taking a more open approach, the same information is collected but in a way that allows the patient to do most of the talking. Such a technique is felt to require more confidence, but is valuable in that it allows both parties to get more immediately to what is important and thus ensures more beneficial therapy.

The change to discharge letters involved writing them more for the patient, outlining their priorities, actions that have been completed, detailing what has worked, and outlining next steps.

Challenges to changing practice

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

Challenge	Description
Slipping back into old habits	- Especially when under pressure
Confidence	- Asking patient about fears and worries - How to ask and how to respond
Time	- Using Bridges SSM will take more time
Patient characteristics and readiness	- Cognitive impairment and communication difficulties - Low mood and motivation - Expectations - Not in "right place" for rehabilitation – timing of SSM
Culture clash	- Medical model versus rehabilitation - Patient goals versus service goals - Task orientation of nursing
Context	- Environment of acute ward - Health and safety culture and risk taking - How to make linkages and share information about patients across service boundaries

In the workshops, one of the main challenges to utilising the approach was perceived to be patient characteristics and readiness. This encompassed several aspects, such as level of cognitive impairment and communication difficulties, level of apathy, and patient expectations (e.g. having unrealistic goals or expecting to be "fixed" by "experts"). There was also a feeling that patients had to be ready for the introduction of SSM and that they might not be in the "right place" to take this on board because of feeling overwhelmed with their situation or not accepting of their diagnosis.

Questionnaire data also provides evidence of this view. At the end of KZ1 and KZ2, practitioners were asked how confident they felt about using the Bridges approach with complex patients. Responses are shown in the table below and indicate that this is an area where there is some uncertainty about the approach.

Table: Confident to use Bridges approach with complex patients

Workshop	Agree	Neutral	Disagree
KZ1 (n=111)	73.0%	18.9%	8.1%
KZ2 (n=97)	53.6%	32.0%	14.4%

In the interviews, practitioners expressed the view that the language of Bridges could be used with all patients, and where aspects of the approach might be more challenging with complex patients it was also possible to use SSM with family members. Recognising that Bridges needed to be adapted in accordance with patient characteristics and readiness, varying between a 'light touch' and the 'full approach', nevertheless practitioners were able to evidence how the approach had worked with some of their more challenging cases. The accompanying patient vignette below was recalled by a practitioner at one of the workshops and is illustrative of some of the results experienced. In this

case it helped a non-engaging patient to move forward. Once again, practitioners also reported that using the Bridges SSM approach to focus on “one small thing” that the patient would like to work on was seen as particularly beneficial when patients were feeling overwhelmed by their situation or, for instance, when they came into an outpatient clinic with a “blank sheet” in terms of what they wanted to get out of their therapy session.

PATIENT VIGNETTE

A patient I got involved in … quite cognitively impaired and had not really been engaging and doesn’t necessarily communicate. And one of the junior doctors had been struggling with him and we hadn’t really made much progress and we decided he wasn’t for rehab potential. And we got involved and just spent a little bit of time just trying to talk to him about some of the things that were familiar to him … and we had a look through some of his personal belongings and talked to him a bit more about his personal side of things and then subsequently I think we were able to get a lot more out of him and actually then physically he did relatively well following that. [PT]

In the KZ1 workshops participants had some concerns about having more open conversations with patients that potentially including talking about the patient’s hopes and fears or unacceptable outcomes. It was felt that this could potentially reveal a range of issues that the practitioner would be unable to “fix” and was regarded as “scary when I think about what I can offer”. Bridges trainers advised that staff would need to be supported to have such conversations with patients, but that patients still had these fears and worries irrespective of whether or not they shared them with practitioners and that having the opportunity to express themselves and have their fears and worries acknowledged was beneficial for patients and their family members. In the focus groups with former service users, participants spoke positively about those health professionals who had “listened to me”, “understood me” and were “kind and thoughtful”, reflecting the importance of patients having the opportunity to feel validated by expressing their thoughts and concerns.

In the KZ2 workshops and in the interviews, participants gave examples of using this approach successfully. One example was an interaction with a patient with Motor Neurone Disease who had “given up”. The practitioner reported having a direct conversation with the patient about what would make life worth living. This resulted in the patient opening up and being able to identify goals. In another example a practitioner reported asking a patient with Multiple Sclerosis what would be an unacceptable outcome for them. The patient responded with surprise and stated that they had never been asked that question before as the focus had always been on clinical outcomes. The patient’s goal was in fact to return to work and not, as had been the focus, to walk 10 metres without an aid. There were also examples of when using the approach had resulted in some difficult

encounters, such as an angry response from a patient with severe mental health issues who felt that self-management could mean that they would be abandoned and unsupported

Another challenge perceived by practitioners was a culture clash in terms of operating with the Bridges SSM ethos in an environment influenced by the medical model of "fixing" people. This was particularly the case in the acute setting where the pressure to discharge and the routinised nature of nursing tasks were felt to impact negatively on SSM. This challenge encompassed a number of elements, such as the quick turnover of patients reducing the opportunity to utilise Bridges SSM, although practitioners acknowledged that using the Bridges language and having open conversations with these patients was still possible. Bridges trainers advised that it was important to plant the seeds of SSM in the acute phase, so that patient expectations are primed as they progress to ESD and community services. In some cases practitioners felt that a focus on patient goals could be at odds with service goals.

> *"There's a lot of patients who come in for a very short amount of time and then exit the system … and it's realising that there are key patients that we can focus on who would really benefit from the process and patients who it's not even appropriate to start, or you might just have a very brief conversation with. There's a lot of discharge pressures … and I was feeling a little bit bad about not neglecting a lot of patients who I knew would benefit from this, but actually knowing that potentially this acute phase isn't the most appropriate time to start those conversations."* [PT]

> *"That's where this Bridges thing can become quite challenging … so whilst you're actually encouraging people to say 'look this is me, this is what I want', sometimes it's taken away, because of pressures on the medical team … everywhere is short of beds …. And it kind of detracts away from that initial approach."* [Rehabilitation Assistant]

Time was another challenge mentioned by practitioners during the workshops. The perception was that using the approach with patients would take more time. Questionnaire responses also indicate that this was a concern as shown in the table below. At the end of KZ1 and KZ2, practitioners were asked if they felt confident in using the Bridges approach with patients when there is little time.

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

Workshop	Agree	Neutral	Disagree
KZ1 (n=111)	88.3%	7.2%	4.5%
KZ2 (n=97)	63.9%	28.9%	7.2%

In the interviews it emerged that practitioners did not necessarily think that using the Bridges approach with patients took more time, in fact they felt that it could actually save time in the longer term as a result of establishing more meaningful therapy goals and providing more effective therapy.

> *"I feel that the time you invest early will save you time in the long run from my experience, the concerns about time for me are more about the embedding this in the system."* [PT]

> *"I think it takes more thinking time on my part, but I think that's because I am starting to use the language better and think about it a bit more. But I don't think the session needs to be any longer."* [SLT]

There also needed to be recognition that time spent finding out about a patient during an initial assessment session was still part of 'treatment' or 'therapy' for that patient. In the example below,

a nurse reported on reintroducing an element of working practice as result of the Bridges training: she met with every new patient within 24-48 hours of them arriving on the ward to find out about them, to talk about rehabilitation in general and what the pathway for them was likely to be. Information about the patient was then shared with the MDT to help shape the rehabilitation approach for the individual. Similarly, the quote from the physiotherapist also illustrates the view that 'talking is treatment.'

> *"So the conversation with the patient usually is 30 minutes minimum to 45 minutes and then it can be the same with the family, but the value is huge. You can see during the interaction with the patient they are very grateful for somebody sitting down and spending time with them to talk about what matters to them rather than their illness."* [Nurse]

> *"Then if your first session is purely discussion, understanding the diagnosis, talking about their knowledge, their target goal setting, their problem solving and all that side of things, that's ok. You are still treating them [even] if you haven't given them activities to do or exercises or whatever, you haven't seen what they can do functionally."* [PT]

Where practitioners did feel that time was a challenge was in finding the time to discuss and plan team changes to practice.

CONCLUSIONS: BEHAVIOUR

- Practitioners were motivated to make changes to their practice as a result of Bridges training, including: adapting language, the structure of interactions with patients, goal setting approach, encouraging patient reflection and problem solving, altering paperwork and processes to embed SSM.
- By making changes to practice practitioners were able to identify benefits to using the approach, such as developing more meaningful goals, increased patient engagement and motivation, and shaping more effective therapy.
- Bridges was perceived to encourage more cooperative and collaborative team working, with the potential to contribute to greater efficiency.
- There was acknowledgement that the Bridges approach can be helpful with complex patients and can be used flexibly according to patient characteristics and readiness.
- The time invested in talking to patients to understand what is important to them was felt to save time in the longer run and should be seen as part of 'treatment' or 'the rehabilitation intervention.'

Results

The evaluation team had recourse to feedback from practitioners in the workshops, semi-structured interview data and information gathered from the Champions Masterclass. 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.

Table: Perceived benefits of Bridges SSM approach

Benefit	Description
Building trust and rapport	- Patient feels more value and appreciated as a person - Patient feels listened to and feels their specific needs have been identified - Family feels listened to - Patient more respectful of practitioner's judgement and prepared to take things forward - Fears and worries are acknowledged (even if not resolved)
Professional-patient interaction	- More collaborative and less prescriptive - More personalised treatment and more meaningful goals - Both parties more prepared for end of therapy - Building patient (& family) resilience
Patient involvement and ownership	- Feel they are getting a more tailored service for their specific needs - Patient identified goals are more meaningful - Patients have greater sense of engagement with rehabilitation and do more - Greater satisfaction and more positive feedback
Practitioners	- Feel more effective and not wasting time - Positive feedback of seeing patients move forward - Being less prescriptive, takes pressure off, do not have to have all the answers - Therapy sessions more enjoyable - Feel challenged more

Practitioners indicated that utilising the Bridges SSM was a "positive way of working which shifts the balance of the working relationship". To a certain extent it was felt that it takes the pressure off practitioners in that they are not having to come up with all the answers. Practitioners also reported that they got more enjoyment from their sessions and felt greater satisfaction from being able to do a better job and that they were not wasting time. It was perceived that the Bridges approach enabled practitioners and patients to establish more meaningful goals. This meant that patients were more committed to their rehabilitation, felt greater ownership and were doing more. Practitioners reporting being more aware of the language they used and how this could impact on patients and their rehabilitation journey.

The potential impact of this was perceived to be better outcomes for patients and a potentially shorter rehabilitation time, with both parties being more prepared for discharge as this is something that is being worked towards collaboratively from the outset. Participants perceived that an improved experience for patients would result in more positive feedback from patients and families. In the workshops and in the interviews when reporting on their interactions with patients using the

Bridges SSM approach, practitioners indicated that patients had provided them with positive feedback.

> *"And I think for that particular person, I am hoping that they will probably finish with rehab quicker than they would have done before … it's been a slightly different way, I have sat down with her [and said] 'I am going to come and see you in a week's time, what are you going to have achieved in that week, not what are your daughters going to have done for you?' … and she has been responding well to that, and like, and hopefully that will reduce the length of time that we see the person for."* [OT]

> *"It also supports when treatment is no longer indicated … it doesn't become an abrupt end for families … it's a process that we've been working through together .. It becomes a natural place to stop."* [OT]

> *"And actually when she gave her feedback form, we were really pleased with that because in it she said 'they helped me understand, they helped me work out the right solution' and it was like 'Oh that is what we did.'"* [SLT]

> *"Using the Bridges concept to then talk with patients … whether they wanted to continue and they actually felt they were doing quite well and then that actually led to me discharging quite a few people off my caseload quite early on."* [OT]

Practitioners were aware of the importance of measuring the impact of using the Bridges SSM approach and expressed the view that many of the available outcome measures were not necessarily suitable for capturing the benefits of the approach. One aspect of working on the sustainability and evaluation of Bridges, concerned changes to paperwork and processes to accommodate the Bridges approach and then auditing the use and usefulness of those changes. Using confidence rating scales was considered a good mechanism to demonstrate the impact of Bridges on patient self-efficacy. Practitioners also indicated that they were working on more formal measures to evaluate Bridges. This is discussed further in the following section on implementation assessment and sustainability.

> *"They do get good feedback, but I think hopefully this will give them more. And I think the other thing is we can then get that on as a Patient Reported Outcome Measure on our KPIs rather than the very process driven KPIs that we have. I think that's an incredibly good thing, because if we can actually say this is what we are doing and this is what our patients are saying to us, that captures much more why people do the job."* [Manager]

> *"The value is huge … [when] I know that I'm going to go and be talking to patients, I think yes the next hour is going to be something nice, rather than dealing with the mundane chores of this role quite frankly, and the things I find out are delightful about people and I feel like it's a, I feel valued more in doing that than I do in most other aspects of my role."* [Nurse]

CONCLUSIONS: RESULTS

- Bridges has the potential to contribute to staff well-being.
- Practitioners reported more satisfaction and greater enjoyment of their work when using the Bridges approach.
- It was perceived that the approach could contribute to better outcomes and potentially reduced rehabilitation time for patients.
- It was considered important to demonstrate formally the impact of using Bridges SSM but outcome measures need to be adapted to capture the benefits of the approach.

Implementation assessment and sustainability

As indicated previously, the evaluation team used Normalisation Process Theory (NPT) to examine the implementation of the Bridges intervention and how successfully the approach could be embedded and sustained in practice. Assessment questions related to the four constructs of NPT were included in the evaluation questionnaires and semi-structured interviews. Data were analysed to ascertain the level of convergence with each construct. A higher level of convergence indicates that an intervention is more likely to be successfully implemented, embedded and "normalised".

The evaluation team sought to identify aspects of the Bridges SSM training programme and quality improvement initiative that contributed positively to each of the four constructs. These are documented in the following table.

Table: Factors contributing to four NPT constructs

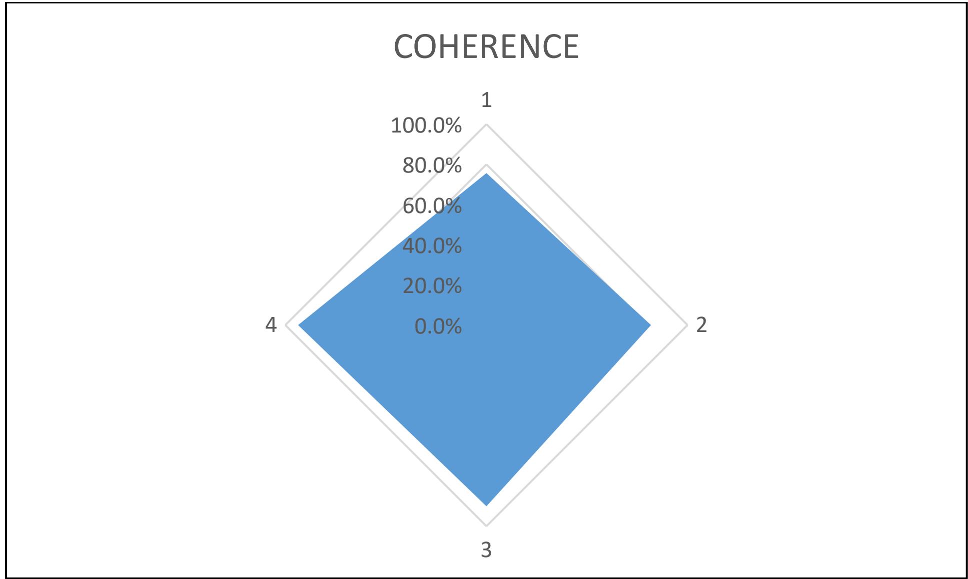
NPT CONSTRUCT	FACTORS PROMOTING CONVERGENCE
COHERENCE The perceived relevance of Bridges	- Engagement and awareness raising at trusts by Bridges staff prior to training - Confidence in research evidence underlying Bridges principles - A "whole systems" approach – training of practitioners from across the patient pathway, thinking and learning together - Use of patient voice by Bridges – demonstrating the need for a change in practice and resonating with practitioners' aspirations for patient care - Peer influence – using examples of success in Bridges workshops and encouraging staff to share successes in team meetings as motivation for reluctant adopters - KZ2 workshops – sharing reports of success in using the approach in individual practice and providing time and space for consideration of changes to team practice - Champions Masterclass – sharing reports of success and changes to team practice and providing time and space to plan for evaluation and sustainability - Bridges Champions – skilled, enthusiastic and committed to use of SSM
COGNITIVE PARTICIPATION Engagement with Bridges	- Bridges organisation of training, i.e. convenience of scheduling and location of training - Use of patient voice - Bridges Champions as key change and sustainability agents – leading and supporting others, sharing successes, diffusing knowledge to peers - KZ1 generates motivation and enthusiasm for change - Involvement of different professions and grades of staff - KZ2 and Masterclass – to reinforce enthusiasm and share successes
COLLECTIVE ACTION Making Bridges work in practice	- Bridges contextualises training, provide examples of successful incorporation elsewhere - KZ1 – teams discuss how they can incorporate into daily work - Bridges support during "transforming" period between KZ1 and KZ2 - Time and space post-training to discuss and agree "What does Bridges look like for us?" - KZ2 – teams discuss/plan how to embed team changes - Masterclass – Champions discuss path to sustainability
REFLEXIVE MONITORING Appraising the value of Bridges	Informal: - Individual appraisal of approach when using with patients - Feedback at KZ2 and Masterclass - Discussions in MDT Formal: - Team plans for formal assessment – working out appropriate outcome measures - UEA evaluation questionnaires – confidence and performance of SSM, and implementation assessment - UEA interviews with health professionals

In the following section, each of the four constructs of NPT is explored in turn in more detail, combining the results of quantitative and qualitative data.

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.

The statements explore the extent to which participants perceive that Bridges differs from what they do already, whether they believe it will be possible to build a shared understanding of Bridges in their MDT, their appreciation of their own responsibilities regarding the implementation of Bridges, and how they see the benefit of Bridges. In each case, there was strong agreement (>75%) with the statement. The quantitative findings are backed up by qualitative data from interviews and workshop observations.



1. I can see how Bridges differs from my usual ways of working (n=111; agree 75.7%)
2. I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative (n=110; agree 81.8%)
3. I can understand how the Bridges initiative will affect the nature of my own work (n=111; agree 90.1%)
4. I can see the potential value of the Bridges initiative for my work (n=110; agree 93.6%)

While 76% agreed with the statement that they could see how Bridges differs from their usual ways of working, nearly a quarter of participants did not. In the workshops some practitioners expressed the view that 'we do this already'. In the interviews a more nuanced understanding of this view emerged. Some practitioners indicated that while they thought they had the underlying Bridges philosophy towards SSM, in practice they were not following the approach consistently. Others stated that the Bridges training had served as an important reminder of aspects of practice that had been forgotten or eroded as a result of day-to-day pressures. Practitioners expressed the view that it is always possible to improve on practice and that Bridges had allowed them to do this, taking things to 'another level'. The following quotes are provided to illustrate these findings.

> *"I think I have become a lot more confident with using the Bridges concept to talk to patients and actually that wasn't there."* [OT]

> *"I think I personally have the Bridges philosophy, but I don't think I was implementing it very well …. A lot of people say that they use it … but if you look at their notes you don't see anything that reflects that."* [SLT]

> *"I've got experience of self-management having worked in the area for quite a long time, but it has reminded me of the importance of it." [PT]*

> *"I think they tend to work in those kind of ways [SSM] … I am not saying they won't improve what they do, because I think it [Bridges] absolutely will."* [Manager]

> *"I think in a way I am in an environment where we work similar to Bridges anyway. This has basically been an add-on to what we are doing, a change to what we are doing to some extent, but making that another level, making it that little bit more."* [PT]

For other practitioners, it seemed that the Bridges SSM training gave them "permission" to reconnect or re-engage with their professional values or ideals and to deliver the service that they wished to deliver. Practitioners were fairly confident that staff in their MDT would develop a shared understanding of the purpose of Bridges. Practitioners reported changes to the template of MDT meetings to incorporate some discussion of how the Bridges approach could be, or was being, used with patients. Using Bridges with patients and reflecting on its benefits served to enhance coherence. Sharing success stories with colleagues or in team meetings served to promote coherence more widely.

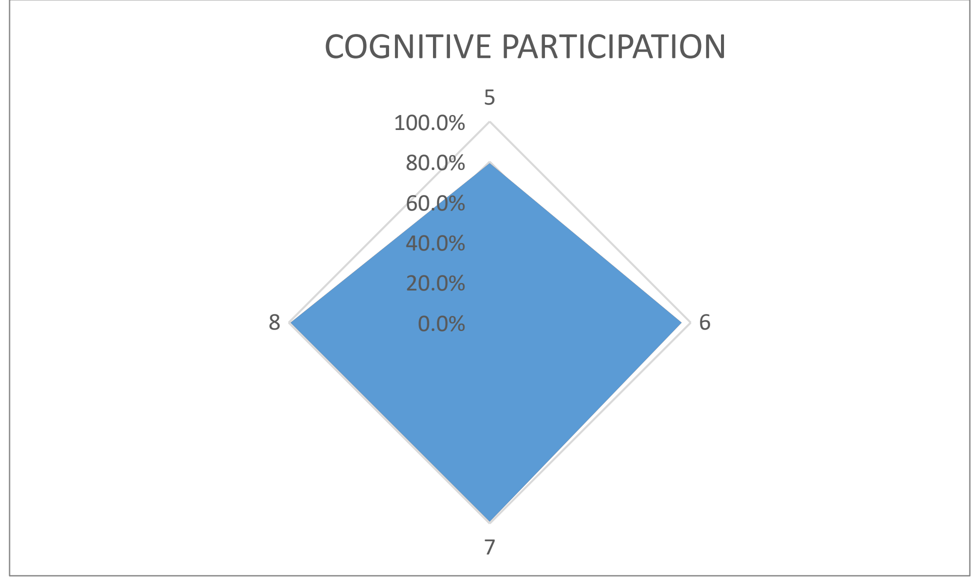
> *"My approach to patients hasn't changed over the years … I would say it's the system of how we treat patients that has changed, so the Bridges for me just sort of brings it back to being how it should be."* [Nurse]

> *"This will enable us to re-engage with our patient-centred values."* [OT]

> *"When I did the training I was excited, because I like the feeling of people being in control of their own journey, because it is their journey to recovery … and I think giving people that control could probably really support them a lot."* [SLT]

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.



5. I think there are key people who will drive the Bridges initiative forward (n=111, agree 79.3%)
6. I believe that participating in the Bridges initiative is a legitimate part of my role (n=111, agree 95.5%)
7. I am open to working with colleagues in new ways to use the Bridges initiative (n=111, agree 99.1%)
8. I will work to support the Bridges initiative (n=111, agree 99.1%)

Practitioners regarded Bridges as a legitimate part of their role (96% agree), indicated that they were open to working with colleagues in new ways in order to use the Bridges initiative (99%) and that they will work in support of Bridges (99%). These results are conducive for the building and sustaining of a community of practice around SSM.

There was some hesitancy as to whether there were key individuals to drive Bridges forward (79% agree). Interview data was able to illuminate this finding. Influential individuals are important for the successful uptake of Bridges, either by visibly practising SSM or by actively promoting it and encouraging others to incorporate it. Within the community team there was the view that the Bridges initiative was high on the agenda and was being championed by the manager. The selection of individuals to act as Bridges Champions was seen as important for embedding and sustaining the approach in the longer term.

> *"Within the team there has been a lot of work, after the training, 'right, how can we use this?' It's definitely been quite high up on the agenda ... the team lead has been really pushing it … there's definitely a lot more post-training support around this I would say."* [OT]

> *"We have a development morning and the topic was moving forward with Bridges and that was encouraged by our lead, but we were left to do it … so it fell onto the leads … but now our little cohort of [Bridges] Champions will be meeting on a regular basis."* [SLT]

> *"We have regular emails which keep Bridges approaches fresh in our mind. I think they are making sure that it doesn't drop off the radar and I think having the Bridges Champion, it's quite good because then they can come back. And it's about the motivation for the team, so if there is a good news story, so as my colleague, how she used the Bridges approach, then we talk about that in our weekly meeting."* [OT]

In the acute teams, practitioners reported finding it more difficult to find the time to bring people together, decide on an action plan and secure ownership for moving team changes forward. In one acute team, a clinical lead asked for guidance from the trust's Transformation Team on driving projects forward during challenging times and how to structure the implementation into more manageable steps.

> *"On the acute side it has been very challenging because we have got a lot of different professions who are working quite differently and it's, everyone has got some good ideas, but I think the challenge has then been bringing people all together to look at how we actually push that forward to make some concrete changes … it still sort of needs some key people I think to drive a lot of the things forward, make small changes."* [PT]

> *"Due to the difficulties with having that hard evidence or proof that this is going to save length of stay, save money, it's quite difficult to engage operational teams and high level management. None of us have got extra time, none of us have got project resources or admin support … I am basically trying to squeeze it in."* [PT]

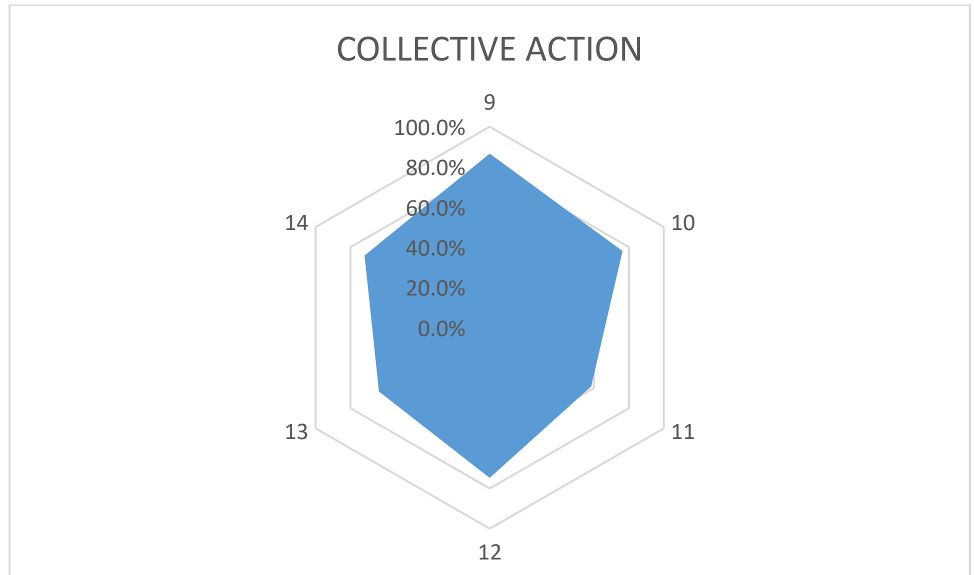
In relation to cognitive participation, patients also need to engage with the Bridges approach. During the workshops a number of observations were offered regarding the challenges of using the Bridges approach when faced with certain patient characteristics, i.e. level of cognitive impairment and communication difficulty, low mood and low motivation. When trying the Bridges approach in practice, practitioners highlighted that redefining roles and expectations would not be successful in all circumstances.

> *"I think in some ways you can try it with everybody, but not everybody is going to be happy to come along and have that discussion."* [PT]

> *"I can think of some patients where they really buy into it and may be even sort of cognitively really get the idea and their mind set is to be self-managing, finding solutions. Whereas some patients are very much, want to be looked after. So it's a bit more challenging and they are expecting me to come up with the answers ….helping them discover a bit more about what's important to them, understanding what has happened to them, I think I have done a bit more of that with those patients, which I think helps."* [SLT]

Collective Action

Collective action relates to the work that individuals do to enable the intervention, either as individuals or in groups. Around 87% of practitioners agreed that Bridges could be easily integrated into their work. Responses were less positive with regard to whether all team members were working to support the Bridges approach (58% in agreement) and whether sufficient resources were available to support the Bridges initiative (64% in agreement).



9	I can easily integrate the Bridges approach into my existing work (n=97, agree 86.6%)
10	I have confidence in other people's ability to use the Bridges approach (n=97, agree 76.3%)
11	All members of my team work to support the Bridges approach (n=96, agree 58.3%)
12	Sufficient training is provided to enable staff to implement the Bridges approach (n=95, agree 74.7%)
13	Sufficient resources are available to support the Bridges initiative (n=96, agree 63.5%)
14	Management adequately supports the Bridges initiative (n=96, agree 71.9%)

Reinforcing previous indications reported here, practitioners felt that Bridges could be readily incorporated into practice, with the proviso that it would take time and practice to build confidence around the new techniques.

Altering team processes and paperwork were regarded as essential in order to embed the Bridges SSM approach, with clinical tools and paperwork being redesigned to prompt SSM behaviour and to reflect the structure of how therapy sessions were performed with patients. These changes were regarded as essential both for practitioners who had been Bridges trained, but also for those who had not attended training and for new members of staff. Indeed, devising appropriate induction and training packs and building SSM into the assessment of competencies were seen as vital for sustaining the Bridges approach.

> *"The concept of Bridges is very new and we just need to work slowly and steadily and hopefully it can just become part of our language."* [OT]

> *"If our service paperwork matches the Bridges philosophy more, then I think it will make it easier for the team to incorporate."* [OT]

> *"And that's where, why we are looking at changing paperwork, so anybody coming in new, the assessment form would ask them to ask specific questions."* [PT]

Bridges was also perceived to offer a common framework for staff, something that would bring teams together and foster joint working around patient-centred goals. Practitioners reported that they had to think about how to structure their working such that, for instance, they were working on patient-led goals collaboratively rather than each professional working with the patient on an independent basis.

> *"It's just part of what we do now … something everybody is responsible for … there's a favourite word we have now … "Oh that was very 'Bridgey', well done" or "Let's Bridgify that."* [SLT]

> *"I suppose it gives them a framework, a common framework, to work with, because as I said I think a lot of people had already done training before, but that's kind of pockets, whereas this is a common framework for them all. So it gives them a common framework, it gives them a common language to use and it gives them almost like a baseline to start from together. And it will get them thinking about what their expectation is when they start working with somebody. So it will be, you know, automatically you are thinking about self-management and therefore they might think differently about how they approach that episode of care."* [Manager]

> *"It [patient goal sheet and stepping stones] can be something that all of us are interacting with … So that will be a bit more of a conversation and I think that is probably, as you often hear, what used to happen is a lot more collaboration between you, but I think it has been purely down to time pressures, you are really just out by yourself and see how many you can see, and just crack on and work quite, almost independently."* [OT]

Therapist practitioners reported working with rehabilitation assistants or more junior members of their team on how they could incorporate elements of Bridges into their interactions with patients. One practitioner expressed the view that this might help to alleviate the sense of frustration that some therapy assistants experienced when going out to community appointments and finding that patients have not been working between sessions and have not made progress.

> *"So the team I would say has changed and also with the therapy assistants as well … because they get quite frustrated when they are just turning up and doing the same thing and leaving and then going back the next week and the person hasn't done anything. So they are trying to buy into a bit as well, so that they can have a conversation with the patient and find out*

this is what they want to do, are they actually going to do it, are they struggling, so rather than just, so people will engage with what you are doing for an hour and then you leave and nothing will really happen for a week and then you go back and they will be engaged for an hour, but the outcome is pretty minimal, what is going to happen from there. So a lot more conversations within the team I suppose which perhaps weren't happening in that way before." [OT]

Being able to support each other through the process of change was important. Interviews revealed that Bridges had become a common feature of regular team meetings, with MDT templates being changed to include a Bridges element. Reported challenges were engaging with all MDT staff, the turnover of staff and incorporating non-trained and rotational staff into the initiative.

"Within our weekly MDT we are trying to say so what are we, what kind of Bridges approaches are we taking to these particular patients, often the patients and families who are very complex. So we are trying to support each other when we're talking about a complex patient. How are we supporting them through what they are going through, but how can we use a Bridges approach at the same time." [OT]

"The people who haven't been trained … I feel we are separating them slightly from the team with the language of 'oh that sounds quite Bridges or we could do that for Bridges' and those static staff know about self-management, but might not understand that Bridges is a form of self-management training, so there has been a little bit of a worry and work around that." [PT]

"But we could almost do a kind of training pack that we could use and kind of share across the acutes and community … rather than everyone having to reinvent the wheel, it is easier to deliver … you can do it in a less time consuming way." [Manager]

There were perceived benefits to this new collective approach. Practitioners felt that using Bridges principles in the management of complex patients to structure discussions within the MDT had reduced repetition of work and led to the setting of more realistic objectives, expectations and structured timeframes.

The process of establishing a fully embedded SSM service for all stroke and neuro rehabilitation patients was regarded as a long-term endeavour. In one trust a 30, 60, 90 day-target QI approach was utilised to structure transformation plans and to identify "quick fixes" to maintain momentum, with the end goal anticipated to involve a five year time frame.

"We've worked towards a model of 30 day, 60 day, 90 day .. we're going to work out what steps, because it is probably a five year plus target, but to break it down so people feel we are getting there and we are making changes, even if they are tiny, because that end goal is quite a long way off and obviously includes getting our operational teams and wide management teams involved … which takes quite a lot of time." [PT]

Working to share the approach across service or organisation boundaries was regarded as a long-term objective, involving the need to address issues such as patient confidentiality.

"It would be really lovely across the county to have a very similar start to the pathway, to make sure it kicks into their part of the pathway and there's a lot of challenges about sharing. How do we share that information and is there a way of the patient owning it and then carrying it within their pathway … the first focus has been getting stuff set up here and trying to make sure that everyone has a little bit of ownership." [PT]

"I think in terms of how it works in the acute and how that then feeds into our, because they come directly, feed into our pathway. I think it will take a while." [Manager]

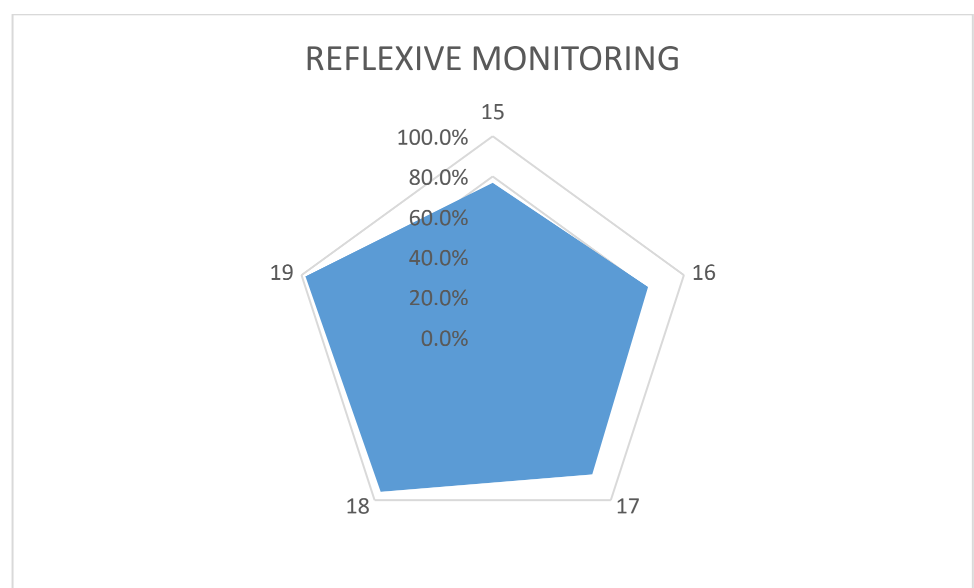
Some 72% of practitioners agreed that management adequately supported the initiative, with 21% being neutral in their response. There was also concern about sufficient resources being available to support the initiative. This was expressed particularly with regard to Bridges booklets, an aspect of the SSM approach intended to act as a mechanism of peer support for patients and family members. In the interviews, practitioners indicated that they had not used the booklets to any great extent, partly because of trying to determine how best to use them in their practice, but also because of a lack of funding for further copies. Practitioners did state that they were nevertheless able to use elements of the material incorporated into the booklets, e.g. stepping stone sheet for patient goal setting.

"I suppose in some ways I think I am doing things myself in little steps and the first little step is around using language … and then may be start using the books. But the other reason, we had a discussion as a team and we were a bit worried about how we move forward and one we use up the few that we have, financially how are we going to get more booklets?" [SLT]

"So we have no budget to buy those. Absolutely none." [Manager]

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=95, agree 76.8%)
16 Staff in my team agree that the Bridges initiative is worthwhile (n=96, agree 81.3%)
17 I value the effects that the Bridges approach has had on my work (n=95, agree 84.2%)
18 Feedback about the Bridges initiative can be used to improve the approach in the future (n=97, agree 94.8%)
19 I can modify how I work with the Bridges approach (n=97, agree 97.9%)

As practitioners start introducing the Bridges approach into their individual practice, they assess how it fits into their clinical routines and the benefits it has for their patients and for themselves as professionals. In the feedback questionnaire, 84% agreed with the statement 'I value the effects that Bridges has had on my work'. In the interviews, practitioners gave many different indications of how they perceived the value of Bridges as they assessed and reflected on its impact on their own work. These related to being able to obtain greater engagement from patients.

> *"I think it added to the work we do … it added another level if you like of how we talk with patients … and I think it has been a positive experience … The knowing how to help patients move forward … it can be frustrating sometimes when people come back and there is no change."* [PT]

> *"If your first visit is not about 'doing' to somebody it's actually about finding out about that patient … about what's important … I think you build a good foundation .. And then what happens is your sessions in the future are more fruitful and more beneficial to the patient and you end up working quite collaboratively."* [OT]

The perceived benefits for practitioners included greater enjoyment, feeling valued, feeling less responsibility, and being more effective.

> *"… having a dependency, which is a real difficult adjustment to make, and I think probably having someone to sit there and listen to them and talk to them is useful for them and for me. It is the most enjoyable part of my day frankly … I look forward to it, it puts a bounce in my step … I feel valued more in doing that than I do in most other aspects of my role."* [Nurse]

> *"I am feeling a lot less responsibility in a way … and I have been giving a lot less ideas to people .. and it's hopefully a bit more powerful if someone comes up with the ideas themselves and then they are more committed to it."* [OT]

> *"… it has given a positive experience of the outcomes and as a therapist that makes you feel that you have achieved something."* [PT]

One of the challenges with implementing Bridges was perceived to be formal evaluation of the approach by the teams themselves (aside from the UEA evaluation). Near term, the auditing of notes and use of amended paperwork and clinical tools was envisaged, but practitioners felt that extant impact measures were not necessarily suitable for the Bridges approach and teams were working on ways to capture evidence of impact.

> *"I think unless you're on the front line and interacting with the patients and that you physically see the difference that this [Bridges] makes to somebody, I'm not sure that the value of it is as widely appreciated as may be it should be."* [Nurse]

One community team was developing two patient questions around self-management that could be used before and after therapy as measurable outcomes: one from a service perspective (therapy staff took adequate time to understand me and my life) and one from a patient perspective (how confident are you in your ability to deal with future challenges relating to your health condition?). The ESD team also intended to change their patient feedback form to incorporate more Bridges-related questions.

Confidence based rating questions or scales were seen as one mechanism to evidence the impact of using Bridges from the patient perspective. Using patient stories or vignettes was seen as another means to capture evidence of successes with Bridges, as well as patient compliance with action plans and treatment plans, and confidence with discharge.

Building Bridges in to staff induction, training and competencies, plus incorporating SSM into job specifications featured in practitioners' longer term plans for sustainability. It was felt that confidence scales related to working in a Bridges way could be used with staff. In one acute setting, peer feedback was used in double-up sessions with patients to monitor and assess the use of SM language. The process of language change was felt to be slow, but positive. Direct observation of practice was regarded as another step towards embedding and sustaining the approach, as a CPD exercise.

Practitioners were very positive about the ease with which Bridges can be improved and adapted in the future. Being able to customise the approach to the service context or professional context is a factor that will likely support sustainability of Bridges longer-term.

At the Masterclass for Bridges Champions (Stage 6 of the Bridges Programme), teams outlined plans for a pathway to sustainability for SSM. These are summarised in the following table and included: finalising and piloting redesigned documentation, auditing use of new documentation and recording of SSM in electronic and paper notes, induction and training, and addressing aspects of the environment.

Table: Perceived pathways to sustainability of Bridges SSM

Area	Description
Staff training	Complete training/briefing of non-trained staff New staff/student start packs Refresher training Direct observation of practice or observation checklist and feedback during joint sessions Confidence rating scales using SSM Reflection sheets to evidence use Competency framework for SSM SSM in job adverts and person specifications
SSM resources	Pilot and finalise redesigned paperwork and clinical tools Implement new resources Ensure accessibility and visibility of SSM resource to ensure regular use
Environment	Finalise 'All About Me' bed space information boards Implement ward information boards Posters on ward and in staff rooms
Evidence and outcomes	Audit use of new resources Audit electronic and paper notes for evidence of SSM Agree and finalise patient confidence and satisfaction measures Audit compliance with SSM action and treatment plans Audit consistency of use by staff Audit impact on caseload, length of stay, readmissions to A&E

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 establishing support for the Bridges approach by all team members
    - The value of sufficient training, resources and management support.
- The briefing and training of non-trained members of staff and the induction of new members of staff were seen as important for sustainability. Proactive processes were underway to engage more team members in the approach by using Bridges in supervisions with non-trained staff, undertaking briefing sessions and planning the development of training packs.
- Practitioners questioned the level of resources and management support for sustaining the approach, particularly in respect of protected time and assistance in planning and implementing change and in the funding of supplies of Bridges-booklets.
- The identified flexibility of the Bridges approach and the ability to customise it to the local service context or in line with different professional routines is a factor that will support sustainability.
- The evaluation timeframe did not afford the opportunity to examine the role and effectiveness of the Bridges Champions in the process of embedding and sustaining long-term change. Further evaluation is recommended.

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.

The first table looks at factors within the inner setting that can impact on implementation.

Table: Inner setting factors important for implementation

Inner setting	Description
Trust priorities	Bridges fit with strategic priorities of trust *"Self-management is on every agenda imaginable … so it [Bridges] fits in with that … it's very much in line with our purpose and values"* [Manager]
Service structures	Team size and structures *"They are always cross-working … so they are all working with each other to share that knowledge whether it is Bridges or whether it is something else"* [Manager] *"It's really a small team, so it's quite collaborative and everyone is quite switched on to try new things"* [OT] *"It has been very challenging because we have got a lot of different professions who are working quite differently … having the bigger, wider team means that it is harder to get those changes forwards … nobody wants to takeover in terms of being the leader of it or taking on too much themselves"* [PT]
Service changes	Timing of training advantageous for new ESD service where processes and paperwork under review *"We are a new service and we have got lots of changes going on anyway. It's an ideal time to adapt things"* [SLT] *"For the ESD team, because it is a newer team, I think there may have been greater benefits … in terms of giving them more confidence and bring them together as a team"* [Manager] One acute trust undergoing consultation and service changes and this, together with staff shortages, made commitment to training and implementation of QI more challenging
QI environment	One trust had established QI approval process for project Discussion of Bridges was incorporated into regular development mornings *"After the Bridges training, quite quickly there was a study day … it's been how does it [Bridges] fit within out working and our team"* [OT] Bridges training gave 'permission' for staff to put patient back at the centre of care in the face of other service drivers, and gave staff confidence to innovate and improve
Staffing	Benefit of stable staff base in community team *"And we don't have big staff movement and I think that is different from the acute. I think that is where we are lucky actually"* [Manager] SLT staff in one trust on risk register, so were not able to participate in training or to nominate a Bridges Champion Increase in bed base in one acute trust without any additional uplift in therapy staff, leading to more pressure and impacting time available to drive and support change
Resources	Demand versus capacity *"There are always more demands than we have capacity. That is the reality"* [Manager] Lack of funding to purchase further Bridges booklets Lack of protected time to plan and implement change
Turnover of patients	Turnover of patients in acute setting means 'light touch' SSM more applicable with some patients

Table: Outer setting factors important for implementation

Outer setting	Description
Changing patient needs	Growth in number of individuals living with long term conditions requires new skills and ways of working for staff Acute medical model with focus on "fixing" patient vs more person-centred approach focused on living well with long term condition
Professional training	Differences in focus in health education internationally, more didactic approaches versus emphasis on professional autonomy Feedback from practitioners at Masterclass that this can encourage more directed approach with patients
Risk culture	Societal attitudes to risk and health and safety concerns can impact on acceptance of patient-led goals Therapists as 'risk takers'
NHS workforce	Staff moral and retention Bridges can help to increase job satisfaction, as providing service more in line with professional ideals and this has the potential to influence retention of staff

CONCLUSIONS: CONTEXT

- Bridges SSM fits with strategic priorities of trusts.
- There are a variety of ways in which the approach is contextualised in acute versus community settings, relating to differences in terms of staff turnover, co-location of teams and patient turnover.
- The timing of training to coincided positively with development of a new Early Supported Discharge service, meaning that the new team could engage in a SSM approach from near service outset.
- Service changes and pressures can impact negatively on commitment to training and quality improvement activities.

LIMITATIONS

Limitations of the evaluation include:

- 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 practitioners.
- The evaluation team did not have the opportunity to observe the Bridges SSM approach in practice. Processes related to implementation were explored through workshop observations and practitioner interviews.
- The evaluation was time limited. Data on implementation and sustainability was collected at KZ2 workshops, via practitioner interviews and at the Champions Masterclass. This was still early in the process, so the evaluation is not able to comment on longer term outcomes.
- The timescales for the evaluation did not permit an assessment of the role and impact of the Bridges Champions on sustainability.
- The practitioners who volunteered to be interviewed for the evaluation were likely to be more enthusiastic and supportive of the Bridges SSM approach. However, they did indicate where they experienced difficulties in using Bridges (i.e. patient characteristics and readiness) and highlighted barriers to implementation (i.e. time).
- The evaluation team did not have information on the exact numbers and composition of teams in the stroke and neurological services pathway, so is not able to comment on whether the number of practitioners attending training was sufficient to establish a ‘critical mass.’

CONCLUSIONS: KEY FINDINGS AND RECOMMENDATIONS

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 “thought provoking” and “motivating” and appreciated sharing experiences with individuals from other services.
- While some practitioners expressed the view that “we do this already” in relation to SSM, there was acknowledgement that it is good to be reminded about techniques and there is always room to improve on practice. Bridges SSM training was seen to offer ‘permission’ to continue with, refine or recapture person-centred practice.
- There is evidence of a shift in confidence and performance of SSM tasks from questionnaire data, supported by findings from workshop observation and qualitative interviews.
- Practitioners felt that further time and practice were necessary to build confidence and to consolidate new ways of working.

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, structure of assessment sessions, goal setting approaches, encouraging patient problem solving and reflection.
- Steps were underway to cascade, embed and sustain changes, such as: processes, paperwork and visual prompts in the environment.
- Changes to clinical tools and paperwork were perceived as essential to prompt SSM behaviour and to help new members of staff.
- The changes to practice were perceived to have “added” another dimension to service provision.

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

- The Bridges approach has the potential to contribute to staff well-being.
- Practitioners reported experiencing greater enjoyment and increased satisfaction from working more collaboratively with patients.
- It was felt that the approach supported practitioners to be less prescriptive, allowing them to stand back more and guide, rather than instruct, patients. This reduced pressure to ‘have to all the answers’ and meant that practitioners could feel less responsibility.
- Therapy was seen as more effective and frustrations about efforts going to waste were reduced.
- More collaborative working was viewed as beneficial in preparing both parties for discharge. It was perceived that the approach could lead to reduced rehabilitation times.

CONCLUSIONS

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 felt that having an initial discussion with a patient about what is important to them could result in "goals coming out naturally" and the establishment of "more meaningful goals."
- Engagement with former service users as part of the context setting for the Bridges training revealed the importance for patients of feeling they are being listened to, having their hopes and concerns acknowledged, and being understood as a person. Practitioners felt that the Bridges approach promoted a better understanding of their patients.
- Practitioners felt that if patients are able to work towards meaningful goals they will have a greater sense of commitment to and ownership of their rehabilitation journey. This should increase levels of patient satisfaction and contribute to better outcomes for patients.
- With practitioner and patient (and family) working collaboratively towards discharge, it was felt that both sides would be more prepared for discharge and that patients would be more confident in continuing to manage after the end of treatment.

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 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: learning atmosphere, adult learning principles, interactivity and group work, credibility of trainers, evidence base for approach, and use of 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.
- The approach has the potential to contribute to the well-being of staff through increased job satisfaction. Using the Bridges SSM approach and experiencing success will encourage sustained behaviour change.

CONCLUSIONS

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

- 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.
- The flexibility of the Bridges approach and the ability to customise it to the local service context or in line with different professional routines supports sustainability. Bridges training provides practitioners with an understanding of the underlying principles of the approach, but local customisation is anticipated and promoted, meaning that the intervention will look different in different settings, thereby increasing its relevance or coherence.
- A number of key pathways to sustainability were identified and discussed at the Masterclass for Bridges Champions, including:
    - Cascading training to non-trained, new and rotational staff
    - Direct observations of practice or joint working and feedback on use of approach
    - Confidence rating scales for using SSM
    - Building SSM into competence frameworks, job adverts and person specifications
    - Piloting and finalising redesigned paperwork and clinical tools
    - Ensuring accessibility and visibility of SSM resources to ensure regular use
    - Auditing use of new resources, patient compliance with SSM treatment plans
    - Continuing to address aspects of physical environment (e.g. bed space and ward information boards).
- Longer term evaluation would be beneficial to examine the realisation of sustainability plans.

RECOMMENDATIONS

- The positive findings of this evaluation support the ongoing integration of Bridges SSM into neuro-rehabilitation practice. In addition, the approach merits consideration for other pathways.
- While there is evidence of collective action to cascade, embed and sustain Bridges SSM and there are mechanisms (e.g. Bridges Champions) to maintain awareness of Bridges, an examination of longer term outcomes would be beneficial, including: the perceived coherence of the approach over time and in the wider teams, use of SSM with complex patients, the realisation of sustainability plans, and further data on how changes to team collaborative working have promoted efficiencies.
- Further investigation is necessary to assess the role and effectiveness of Bridges Champions in implementing and sustaining change.
- While practitioners reflected positively on the benefits of Bridges SSM for patients, this evaluation was not able to assess directly the impact of using the approach on the patient experience. The evaluation and intervention would be strengthened by greater integration of the patient voice. Patient and family member feedback on their experiences of a rehabilitation programme that embraces SSM and how this contributes subsequently to the rebuilding of their lives is essential for practitioners to continue to appraise and adapt their approach to SSM.
- Teams need support to trial and audit more formal measures for assessing the impact of the approach, including: practitioner confidence rating scales, reflection pieces, and work satisfaction scores.
- It is important for staff to have opportunities to share success stories, understand what has worked and why, and to disseminate learning within and between trusts, and across STPs in the region. It is known that Bridges wishes to develop an online platform to support ongoing learning and sharing of resources.

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APPENDIX ONE: LOGIC MODEL

Embedding a sustainable model of supported self-management in stroke & neurological services

INPUTS

- Trust engagement
- Stakeholder engagement
- Co-designed Bridges Self-Management Training
- Bridges Self-Management Tools
- Participation of local service teams
- Evaluation

ACTIVITIES

- Engagement workshops
- Stakeholder consultations
- Introductory Multi-professional workshops
- Implementation & support
- Follow-up workshops
- Champions Masterclass
- Evaluation

OUTPUTS

- Engagement with training
- Context specific training
- Reach of training
- Delivery of practice with SSM focus
- Model of sustainability
- Dissemination
- Evaluation – local & UEA

OUTCOMES

Short-term

- Increase in skills & confidence in using SSM
- SSM incorporated into routine individual practice

Longer-term

- SSM incorporated into routine team practice
- SSM sustained in routine practice & part of service ethos

IMPACTS

- Increase in practitioner resilience, engagement & satisfaction
- Increase in team/service efficiencies
- Empowered patients and improved outcomes
- Community of practice and dissemination to other areas and services

Programme theory:
Unmet LT emotional & social needs of stroke & neurological patients can be addressed by embedding SSM into routine clinical care. Whole team training will encourage practitioners to reflect critically on their practice & motivate them to make and to sustain changes at the individual & team level.

APPENDIX TWO: PRACTITIONER QUESTIONNAIRES

PRE-KZ1

POST-KZ1

POST-KZ2

PEOPLE 1ST | BRIDGES SERVICE IMPROVEMENT PROGRAMME
PRACTITIONER QUESTIONNAIRE (PRE-KZ1)

What are the professional ideals that attracted you to work in healthcare?

To what extent do you feel that your current practice allows you to reflect those ideals?
[Please tick a response]

Never	Rarely	Sometimes	Very often	Always
☐	☐	☐	☐	☐

Do you find your work enjoyable? [Please tick a response]

Never	Rarely	Sometimes	Very often	Always
☐	☐	☐	☐	☐

What is your profession and role? Which Trust are you with?

____

How many years have you worked in your profession?

____

How long have you worked for your current service?

____

Do you work in an acute or a community setting?

____

What do you hope to gain from the Bridges training & support?

CURRENTLY, TO WHAT EXTENT DO YOU FEEL YOU **CAN DO** AND, IN PRACTICE, **ACTUALLY DO** THE FOLLOWING:	**PLEASE TICK YOUR RESPONSES FOR: I CAN DO THIS**						**PLEASE TICK YOUR RESPONSES FOR: I DO THIS**				
	Not at all	**Not sufficiently**	**More or less**	**Sufficiently well**	**Very well**		**Never**	**Rarely**	**Occasionally**	**Frequently**	**Always**
Ask the person what they expect in the near future from living with their stroke or neurological condition	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Ask the person what they know about their stroke or neurological condition	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Ask the person how they can share their emotions about their stroke or neurological condition with important others	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Ask the person how much confidence they have in their own abilities	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Ask the person what they can and will do in their daily personal care or activities	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
During every interaction, ask the person what information they or their family/friends need	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Help the person to formulate questions to discuss with other health professionals	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Involve family members when providing information and instruction	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Allow the person to determine their own priorities when developing goals	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Jointly with the person develop a plan of action to achieve their goals	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Help the person to make joint decisions about their treatment with me or other therapists	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

CURRENTLY, TO WHAT EXTENT DO YOU FEEL YOU **CAN DO** AND, IN PRACTICE, **ACTUALLY DO** THE FOLLOWING:	**PLEASE TICK YOUR RESPONSES FOR: I CAN DO THIS**						**PLEASE TICK YOUR RESPONSES FOR: I DO THIS**				
	Not at all	**Not sufficiently**	**More or less**	**Sufficiently well**	**Very well**		**Never**	**Rarely**	**Occasionally**	**Frequently**	**Always**
Discuss with the person who can provide daily support (e.g. family, friends, wider social network)	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Discuss with the person how they can make use of self-management assistive devices (e.g. Bridges booklets) in their daily activities	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Assist the person to keep their own records of goals and achievements	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Examine progress towards goals together with the person	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Acknowledge the person's experiential learning as valuable information in building their confidence	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Use the person's choice as the basis for care, even if it is not ideal from a medical perspective	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Help the person to develop insight when their established goals are not met	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

Adapted from: SEPSS-36 Academic Centre for Nursing & Midwifery, Ghent University and Research Centre Innovations in Care, Rotterdam University of Applied Sciences

PEOPLE 1ST | BRIDGES SERVICE IMPROVEMENT PROGRAMME
PRACTITIONER FEEDBACK QUESTIONNAIRE (POST-KZ1)

What is your profession and role? _______________________________

Do you work in an acute or a community setting? _______________________________

I feel confident that the Bridges initiative will help me to make changes in my practice that will bring me closer to my professional ideals [Please circle a response]

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
☐	☐	☐	☐	☐

Please give an example of one change you will make in your own practice as a result of the Bridges training

Do you have any comments or feedback on the Bridges training or the initiative?

Please indicate [with a tick] the extent to which you agree or disagree with the following statements:	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I feel confident that I can use the Bridges approach with patients when there is little time	☐	☐	☐	☐	☐
I feel confident that I can use the Bridges approach with complex patients (i.e. those with cognitive and/or communication deficits and/or low mood)	☐	☐	☐	☐	☐
I feel supported by my organisation to provide self-management support	☐	☐	☐	☐	☐
I feel confident that stroke and neurological patients and their families/friends can manage their life well after discharge from the service	☐	☐	☐	☐	☐
I can see how the Bridges initiative differs from my usual ways of working	☐	☐	☐	☐	☐
I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative	☐	☐	☐	☐	☐
I understand how the Bridges initiative will affect the nature of my own work	☐	☐	☐	☐	☐
I can see the potential value of the Bridges initiative for my work	☐	☐	☐	☐	☐
I think there are key people who will drive the Bridges initiative forward and get others involved	☐	☐	☐	☐	☐
I believe that participating in the Bridges initiative is a legitimate part of my role	☐	☐	☐	☐	☐
I am open to working with colleagues in new ways to use the Bridges initiative	☐	☐	☐	☐	☐
I will work to support the Bridges initiative	☐	☐	☐	☐	☐

Includes: NOMAD implementation measure, Finch et al, 2015

PRACTITIONER QUESTIONNAIRE – POST-“TRANSFORMING” (POST-KZ2)

What small change(s) did you make to your practice as a result of the Bridges training?

Do you feel that the Bridges training has helped you to make changes to your practice that have brought you closer to your professional ideals? [Please tick a response]

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
☐	☐	☐	☐	☐

Do you find your work enjoyable? [Please tick a response]

Never	Rarely	Sometimes	Very often	Always
☐	☐	☐	☐	☐

What is your profession and role? Which Trust are you with?

____

How many years have you worked in your profession? How long in your current service?

____

Do you work in an acute or a community setting?

____

Do you have any general comments about the Bridges training or service improvement initiative?

CURRENTLY, TO WHAT EXTENT DO YOU FEEL YOU **CAN DO** AND, IN PRACTICE, **ACTUALLY DO** THE FOLLOWING:	**PLEASE TICK YOUR RESPONSES FOR: I CAN DO THIS**					**PLEASE TICK YOUR RESPONSES FOR: I DO THIS**				
	Not at all	**Not sufficiently**	**More or less**	**Sufficiently well**	**Very well**	**Never**	**Rarely**	**Occasionally**	**Frequently**	**Always**
Ask the person what they expect in the near future from living with their stroke or neurological condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ask the person what they know about their stroke or neurological condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ask the person how they can share their emotions about their stroke or neurological condition with important others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ask the person how much confidence they have in their own abilities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ask the person what they can and will do in their daily personal care or activities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
During every interaction, ask the person what information they or their family/friends need	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Help the person to formulate questions to discuss with other health professionals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Involve family members when providing information and instruction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allow the person to determine their own priorities when developing goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Jointly with the person develop a plan of action to achieve their goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Help the person to make joint decisions about their treatment with me or other therapists	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

CURRENTLY, TO WHAT EXTENT DO YOU FEEL YOU **CAN DO** AND, IN PRACTICE, **ACTUALLY DO** THE FOLLOWING:	**PLEASE TICK YOUR RESPONSES FOR: I CAN DO THIS**						**PLEASE TICK YOUR RESPONSES FOR: I DO THIS**				
	Not at all	**Not sufficiently**	**More or less**	**Sufficiently well**	**Very well**		**Never**	**Rarely**	**Occasionally**	**Frequently**	**Always**
Discuss with the person who can provide daily support (e.g. family, friends, wider social network)	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Discuss with the person how they can make use of self-management assistive devices (e.g. Bridges booklets) in their daily activities	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Assist the person to keep their own records of goals and achievements	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Examine progress towards goals together with the person	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Acknowledge the person's experiential learning as valuable information in building their confidence	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Use the person's choice as the basis for care, even if it is not ideal from a medical perspective	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Help the person to develop insight when their established goals are not met	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

Adapted from: SEPSS-36 Academic Centre for Nursing & Midwifery, Ghent University and Research Centre Innovations in Care, Rotterdam University of Applied Sciences

PLEASE INDICATE WITH A TICK THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS:	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I feel confident that I can use the Bridges approach with patients when there is little time	☐	☐	☐	☐	☐
I feel confident that I can use the Bridges approach with complex patients (i.e. those with cognitive or communication deficits and/or low mood)	☐	☐	☐	☐	☐
I feel confident that stroke and neurological patients and their families/friends can manage their life well after discharge from the service	☐	☐	☐	☐	☐
I can easily integrate the Bridges approach into my existing work	☐	☐	☐	☐	☐
I have confidence in other people's ability to use the Bridges approach	☐	☐	☐	☐	☐
All members of my team work to support the Bridges approach	☐	☐	☐	☐	☐
Sufficient training is provided to enable staff to implement the Bridges approach	☐	☐	☐	☐	☐
Sufficient resources are available to support the Bridges initiative	☐	☐	☐	☐	☐
Management adequately supports the Bridges initiative	☐	☐	☐	☐	☐
I am aware of reports about the effects of the Bridges initiative	☐	☐	☐	☐	☐
Staff in my team agree that the Bridges initiative is worthwhile	☐	☐	☐	☐	☐
I value the effects that the Bridges approach has had on my work	☐	☐	☐	☐	☐
Feedback about the Bridges initiative can be used to improve the approach in the future	☐	☐	☐	☐	☐
I can modify how I work with the Bridges approach	☐	☐	☐	☐	☐

Includes elements of NOMAD implementation measure, Finch et al 2015

APPENDIX THREE: SEMI-STRUCTURED INTERVIEW TOPIC GUIDE

PRACTITIONER – POST-TRANSFORMING INTERVIEWS TOPIC GUIDE

INTRODUCTORY QUESTION

1. Can you describe your role in stroke and neurological rehabilitation? Work setting? Type of patients? How long in profession/service?

USING BRIDGES APPROACH

2. Can you describe the small change(s), if any, you decided to make to your own **individual** practice after the Bridges training workshop? How did that go?
    - Facilitators and barriers to implementation? Can you tell me more? Give me an example?
    - Able to use with all patients? Examples?
    - Under time pressure? Examples?

Prompts [from NPT]:

- How did you feel the Bridges approach fitted with/differed from your normal way of working? [NPT – Coherence – Differentiation] Examples?
- How did you decide what changes to make? Feel confident to make the changes? [NPT – Coherence – Individual Specification]
- How would you describe the value of using the Bridges approach in your work? [NPT – Coherence – Internalisation] Examples?
- What do you think the impact has been (for self, patients)? Examples? Do you have any ways of measuring the impact of Bridges (especially for service user outcomes)? [NPT – Reflexive Monitoring – Individual Appraisal]
- Are there other changes that you plan to make to your practice as a result of the Bridges training? Adapting Bridges in any way? [NPT – Reflexive Monitoring – Reconfiguration] Examples?

3. What small change(s), if any, did you decide to make to **team practice** as a result of the Bridges training? How did that go?
    - Facilitators and barriers to implementation? Can you tell me more? Give me an example?

Prompts [from NPT]:

- Do you feel that staff in your team have developed a shared understanding of the purpose of the Bridges initiative? [NPT – Coherence – Communal Specification]
- Has there been sufficient involvement of all professions in implementing Bridges? Some people more on board than others? [NPT – Cognitive Participation – Legitimation]
- Who do you feel were the key people in your team driving the implementation of Bridges? [NPT – Cognitive Participation – Initiation]

- What methods were used to encourage team members to engage with the Bridges initiative and support its implementation? [NPT – Cognitive Participation – Enrolment]
- How easy has it been to implement the Bridges approach in the team? [NPT – Collective Action – Interactional Workability]
- How confident are you that all members of the team are working to support the Bridges approach? [NPT – Collective Action – Relational Integration]
- Has using Bridges required any changes to how you work together as a team? Examples? [NPT- Cognitive Participation – Activation]
- Do you feel that people in your team have the right skills to implement and sustain Bridges? [NPT - Collective Action – Skill Set Workability]
- What support has been offered by your service/organisation for the implementation of Bridges? Resources? Support of managers? [NPT – Collective Active – Contextual Integration]
- Has the team developed any ways of measuring the impact of the Bridges approach? [NPT – Reflexive Monitoring – Systemization]
- What impact do you think the changes have had on team working, service, patients? [NPT – Reflexive Monitoring – Communal Appraisal]
- Are there other changes that you plan to make to team practice as a result of the Bridges training? Adapting Bridges? [NPT – Reflexive Monitoring – Reconfiguration]

TO FINISH

4. Anything else you would like to discuss further or to add?

APPENDIX FOUR: STAKEHOLDER FOCUS GROUP TOPIC GUIDE

FOCUS GROUP TOPIC GUIDE

Thank you for agreeing to support our Bridges quality improvement programme.

We are interested in learning about you as a group and finding out about your experiences of rehabilitation.

Introductions

Introduce yourself using your first name and say, briefly, how you came to be a member of the group?

PART 1: Exploring experiences of life after brain injury/stroke (emotional and social needs)

1. What are some of the things you enjoy doing, either the same as before your brain injury/stroke or perhaps new things?
2. What are some of the things you have struggled with since your brain injury/stroke?
3. Can you tell us about an experience that made you feel that you were getting better?
4. How have relationships with other people changed since your brain injury/stroke?
5. Right now, where do you get support from?
6. What support is (or has been) most useful to you?

PART 2: Feedback on service

1. Can you tell me about how you felt when you got home after being in hospital?
2. How did you feel about getting on with your life?
3. Thinking of the healthcare professionals you worked with:
    a. What was the best thing(s) they did? (give examples)
    b. What was the worst thing(s) they did? (give examples)
4. Thinking of your therapy sessions: who decided what was important to work on? (give examples)
5. Often therapists use goal setting. Can you describe what usually happened? Can you talk me through how the goals were decided?
6. How did you feel when therapy stopped?
7. If you had a problem after leaving therapy what did/would you do?
    a. How did you know where to go for support?
8. If you had three wishes for what healthcare professionals should do differently, what would they be?

PART 3: Anything else

1. Is there anything else about your experiences of rehabilitation that you would like to mention?