PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME

EVALUATION REPORT

CASE STUDY FIVE: HERTFORDSHIRE AND WEST ESSEX STP

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Acknowledgements

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Contents

EXECUTIVE SUMMARY

Introduction

Hertfordshire and West Essex (HWE) Sustainability and Transformation Partnership (STP) was the fifth of six East of England STPs to participate in the Bridges Supported Self-Management (SSM) training and quality improvement programme: People 1st.

The timeline of the Bridges programme and evaluation in this STP was February 2019 to January 2020.

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

Data collection

Bridges offers 125 training places across the STP. In this STP 82 practitioners attended the Introductory Workshops: Knowledge Zone 1 (KZ1) and 62 attended the Follow-up Workshops: Knowledge Zone 2 (KZ2). The Champions Masterclass was attended by 7 individuals (out of 25 places on offer).

Data available for inclusion in the evaluation comprised: 70 pre-training and 48 post-training questionnaires and 6.5 hours of workshop observations (Champions Masterclass only).

A semi-structured telephone interview was conducted with only one practitioner. It did not prove possible to schedule further interviews during the time frame of evaluation activities in the STP.

Stakeholder engagement

The awareness raising and engagement process in HWE STP took place between February and July 2019 and involved four trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. An engagement meeting was held in April 2019. Feedback from the Bridges team about the engagement meeting suggested a certain level of hesitation from the trusts about commitment to the training.

One trust, with a neurorehabilitation ward and ESD service, did not engage with the training. In addition, at one of the acute trusts there was a delay in securing management agreement for engagement with the programme and the invitation to participate in the training was initially declined. It was subsequently decided that participation would go ahead, but the delivery of training at this trust was then delayed, with the first workshop not taking place until October 2019, somewhat after the main body of training in this STP. The delay in holding the introductory workshop meant that the follow-up workshop for this trust took place after the Champions Masterclass and, in the event, was poorly attended (only three individuals). Despite considerable efforts by the evaluation team, and assistance from HEE, it did not prove possible to secure governance approval for evaluation activities at this trust. Representatives from the trust who attended the Bridges training were therefore excluded from the evaluation analysis.

Community neurology services at another trust transitioned to a new provider during roll-out of the Bridges programme. However, despite going through a period of organisational change, this team was deeply invested in self-management and committed to the Bridges training even before the formal engagement meeting in April 2019. The service had offered self-management group programmes (general self-management introductions and condition-specific courses) to all clients for around 5+ years. In 2018, the trust had also invested in Health Coaching for all clinical staff in

community services. Representatives from this team constituted the majority of attendees at the Champions Masterclass.

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

Findings

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

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

- Practitioners were positive about the opportunity to reflect, learn, think and plan together. They described the training as "interesting" and "inspirational". It resonated with their intrinsic motivations for working in healthcare and encompassed principles that they aspire to. Practitioners appreciated the time to discuss ideas in their team and to bring the focus back to what is important for patients in the face of a perceived emphasis on tick boxes and targets.
- Bridges SSM training was seen to validate ideas for service improvement work and to promote adoption of a standardised approach to patient care.
- Questionnaire data points to a shift in confidence and performance of SSM tasks. This was supported by findings from workshop observations and an interview where practitioners discussed how they were making changes to their practice. Practitioners felt that further time was necessary to consolidate the changes and to build confidence in using the new approaches.
- At the end of KZ2, 92% of practitioners agreed that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

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

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

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

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in reported enhanced interactions with patients. Practitioners indicated that they had increased job satisfaction through the provision of more meaningful and effective therapy.
- Practitioners reflected that the Bridges programme had demonstrated to them how small changes to practice can have an important impact on both patient and staff satisfaction.

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

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

- Practitioners commented that using the Bridges approach meant that patients and families felt more listened to and developed a greater understanding of the rehabilitation process.
- Practitioners reported that patients were able to identify meaningful goals with the right support and that feedback from patients on a more collaborative approach was positive. At the Champions Masterclass one team reported that they had instigated the use of a rating scale to measure patient confidence to be discharged, with preliminary findings suggesting positive results from changing practice.

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 and feedback from practitioners suggested a number of factors contributed to a positive learning experience including: the learning atmosphere, use of adult learning principles, level of interactivity and group work, the credibility of trainers, the evidence base for the Bridges approach, and the use of the 'peer voice' and 'patient voice.'
- The Bridges programme and drivers for change appeal to the intrinsic motivations of healthcare staff and make use of valuable extrinsic motivators such as the service user voice, peer influence, and, in time, local Bridges Champions.
- Important drivers for successful implementation include: the need for key individuals to support and lead the improvement, engaging support of the wider team, and having sufficient training, resources and management support.

CASE STUDY FIVE: HERTFORDSHIRE AND WEST ESSEX STP

The following presents a summary of evaluation results for the Hertfordshire and West Essex (HWE) Sustainability and Transformation Partnership (STP), the fifth of the six East of England STPs to participate in the Bridges Supported Self-Management (SSM) training and quality improvement programme: People 1st.

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

The table below shows the timeline of the Bridges SSM programme in HWE STP.

Table: HWE Bridges SSM programme timeline

Stage	Timeline
Stage 1: Awareness Raising	February – July 2019
Stage 2: Stakeholder Engagement (former service users)	No activity in this STP
Stage 3: Introductory Workshops Knowledge Zone 1	July – August 2019 One acute trust: October 2019
Stage 4: "Transforming"	June - October 2019 One acute trust: November 2019 – January 2020
Stage 5: Follow-up Workshops Knowledge Zone 2	September – November 2019 One acute trust: January 2020
Stage 6: Champions Masterclass	January 2020
Stage 7: Sustainability plans	From January 2020

STAKEHOLDER ENGAGEMENT

Trust engagement

The awareness raising and engagement process in HWE STP took place between February and July 2019 and involved four trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. An engagement meeting was held in April 2019. Feedback from the Bridges team about the engagement meeting suggested a certain level of hesitation from some of the trusts about commitment to the training.

One trust, with a neurorehabilitation ward and ESD service, did not engage with the training. At one of the acute trusts there was a delay in securing management agreement for engagement with the programme and the invitation to participate in the training was initially declined. It was subsequently decided that participation would go ahead, but the delivery of training at this trust was then delayed, with the first workshop not taking place until October 2019, somewhat after the main body of training in this STP (which took place in July and August). The delay in holding the introductory workshop meant that the follow-up workshop for this trust took place after the Champions Masterclass and, in the event, was poorly attended (only three individuals). Despite a number of approaches by the evaluation team from June 2019 onwards, as well as support from HEE, it did not prove possible to secure governance approval for evaluation activities at this trust. Representatives from the trust who attended the Bridges workshops have been excluded from the evaluation analysis.

Governance approval for the evaluation was granted by the other two participating trusts, but the timing of the approvals precluded observation of KZ1 workshops by the evaluation team.

Community neurology services at another trust transitioned to a new provider during roll-out of the Bridges programme. Despite going through a period of organisational change, this team was deeply invested in self-management and committed to the Bridges training before the formal engagement meeting in April 2019. The service had offered self-management group programmes (general self-management introductions and condition-specific courses) to all clients for around 5+ years. In 2018, the trust had also invested in Health Coaching for all clinical staff in community services. Representatives from this team constituted the majority of attendees at the Champions Masterclass.

Several comments from practitioners emphasised the perceived importance of securing multi-professional buy-in for the training. It was felt that this would help to support implementation of the Bridges approach and enhance rehabilitation culture.

> *"I really wanted to get our nurses and HCAs on the course to help build rehab ethos across the board. I have done Bridges before many years ago and found it helpful but wanted more numbers in our service to be 'on board' with this approach."* [OT]

> *"Useful ideas to implement within the team. It would have been useful to attend with other members of stroke MDT, so could more easily implement the training."* [Dietician]

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

CONCLUSIONS: TRUST ENGAGEMENT

- The trust engagement process in this STP proved challenging. One trust did not engage with the training. At another trust there was a delay in securing management agreement for participation, a further delay in the delivery of the training, a drop in attendance at the follow-up workshop and no governance sign-off for evaluation activities.
- One community team was transitioning to a new provider during the Bridges programme, but this did not impact on engagement with the training. The service team was deeply invested in self-management and signed up to the training even before the formal Bridges engagement meeting in April 2019.
- A commitment to Health Coaching did not act as a barrier to engagement with Bridges SSM.
- Practitioners emphasised the importance of securing multi-professional buy-in to the training, including medical staff, to help support implementation of the Bridges approach and to enhance the local rehabilitation culture.
- It was decided not to pursue engagement with former service users in this STP as this was unlikely to generate new insights into life after stroke and experiences of rehabilitation.

EVALUATION DATA COLLECTION

Quantitative

Bridges offered 125 training places across each STP in the East of England. The table below illustrates the number of attendees at the Knowledge Zone 1 (KZ1) and Knowledge Zone 2 (KZ2) workshops. As can be seen, there was not full take-up of the places on offer and the Bridges Champions Masterclass in January 2020 was also not well attended, with only 7 out of 25 places taken up.

Table: Attendees at Bridges SSM workshops

Workshops	Timing	# attendees	# eligible for evaluation
Knowledge Zone 1 (n=3)	July - August 2019 (n=2) October 2019 (n=1)	82	71*
Knowledge Zone 2 (n=3)	Sept – Nov 2019 (n=2) January 2020 (n=1)	62	59**

** Governance approval not secured at one acute trust so eleven representatives excluded from evaluation*
***Three representatives from acute trust excluded from evaluation*

No medical staff attended the training. Practitioners attending the training expressed disappointment at what they perceived was insufficient involvement of all members of their MDT.

> *"Particularly from the rehab unit, no nurses went on the training, a couple of HCAs, but no qualified nurses. If they did go, they have been very quiet about it and haven't come to subsequent meetings. It's a real shame, because from an inpatient unit point of view I think it is essential to have the nursing team on board because they are the ones that are there all the time and are supporting all the day-to-day functions."* [OT]

> *"I personally think all healthcare professionals should have this training in some form."* [Rehabilitation Assistant]

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

Table: Number of evaluation questionnaires and response rates

Questionnaire	Number	Response rate
Knowledge Zone 1 – Pre-training	70/71	99%
Knowledge Zone 1 – Post-training	67/71	94%
Knowledge Zone 2 – Post-implementation	48/59	81%

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

Table: Characteristics of participants in Bridges SSM training

Participant characteristics	KZ1		KZ2	
Profession	**Number**	**%**	**Number**	**%**
Nurse	16	22.9	8	16.7
OT	16	22.9	10	20.7
PT	13	18.6	12	25.0
SLT	4	5.7	0	0.0
Psychology Practitioner	5	7.1	3	6.3
Rehabilitation/Healthcare Assistant	13	18.6	14	29.2
Other (e.g. dietician)	3	4.3	1	2.1
Total	70	100.0	48	100.0
Setting	**Number**	**%**	**Number**	**%**
Acute	21	30.0	16	33.3
Community	47	67.1	31	64.6
Both	2	2.9	1	2.1
Total	70	100.0	48	100.0
	Mean (SD)	**Range**	**Mean (SD)**	**Range**
Years in profession	12 (8)	<1-36	11 (8)	<1-30
Years in service	6 (6)	<1-26	6 (5)	<1-19

Qualitative

Workshop observations

A delay in securing governance approval for the evaluation precluded observation of KZ1 workshops by the evaluation team. Due to other commitments, the evaluation team was also not able to observe any of the KZ2 workshops. The team carried out 6.5 hours of evaluator embedded observations at the Bridges Champions Masterclass in January 2020, which was attended by 7 practitioners.

Semi-structured interviews

No volunteers for interview came forward at the KZ2 workshops and the evaluation team made an approach to team leads at two trusts in order to try to secure participation. One individual (OT) came forward as a result of this process and a semi-structured telephone interview (duration = 36 minutes) was scheduled following the Champions Masterclass. Interest in participating in an interview was expressed by two other individuals who attended the Masterclass, but it did not prove possible to schedule the interviews during the time frame of the evaluation in this STP.

FINDINGS

Four Levels of Evaluation

Reaction

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

A total of 51 comments about the Bridges training were coded as positive, with practitioners describing the training as useful and inspirational. The use of the 'patient voice' was particularly appreciated and Bridges was seen to offer practical ideas that could be readily incorporated into routine practice. There were 13 comments that were coded as neutral, including 11 instances where no comments were offered.

The negative comments were concerned with the lack of involvement of all members of the MDT in the training (perceived to make implementation more problematic), as well as how to employ the approach with patients with cognitive and communication difficulties and in the face of service pressures. It was also perceived that the approach was therapist-centric and a broader range of video or case examples in the training content would help illustrate how it could be embraced by different professions.

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

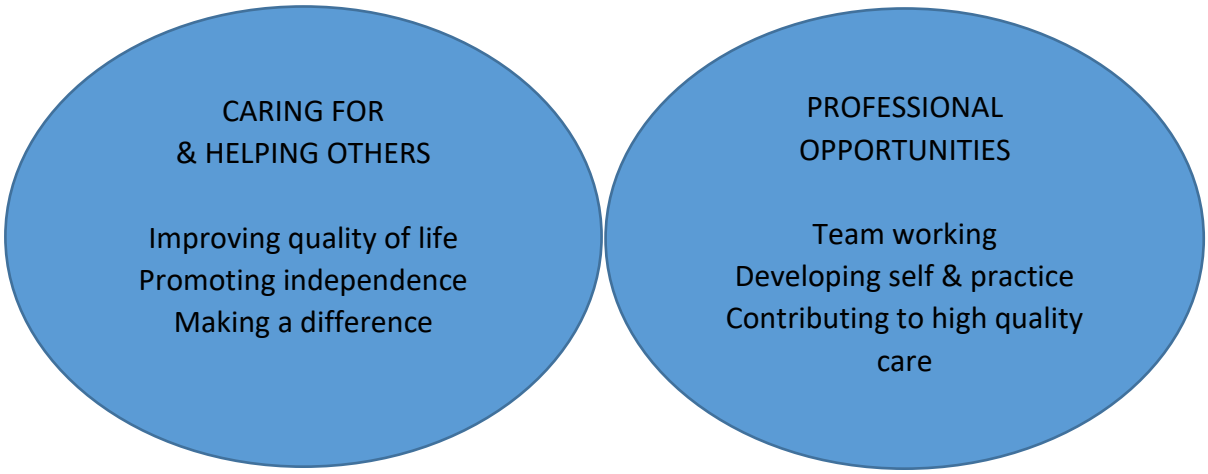
Feedback	Number*	Illustrative participant comment
☺	51	• I found this training really useful, I feel that by taking a few small steps I will be able to alter my practice for the better through language and encouraging more self-awareness [OT] • Really useful and relevant to my practice, fantastic having the valuable input from a trauma patient who has experienced health care professionals and listening to her stories really makes me think about my practice [Nurse] • Was nice to have our colleagues all at the training, helps us all to be accountable for changes, was nice to have patient and professionals' experiences [OT] • I think that having this theoretical evidence behind the approach will allow me to use this with increased confidence, the shared language allows you to discuss this more readily which is good as it helps to improve reflection and discussion within the team [SLT] • I feel the training was rather inspirational, has reminded me to ask more questions and be more aware of patients' reflection [Rehabilitation Assistant] • All services should utilise the patient post-discharge feedback to aid service development [PT] • Great course - really helps to bring you back to what is important, and why you become a therapist, and not getting caught up in NHS processes and targets [OT] • Really clear and relevant initiative that can be integrated into practice, well presented, very interactive and comfortable forum to contribute thoughts, including a presenter who has experienced the "patient experience" was particularly enlightening and enhanced the session, very helpful handouts [PT]

😐	13	• Much of the Bridges approach is already very much how I practise due to my training [Psychologist] • No comments [11]
☹	12	• Didn't touch on how this applies with patients with cognitive or communication difficulties [PT] • Would have been useful to attend with other members of stroke MDT so could more easily implement the training [Dietician] • It feels a little bit therapist-focused to me, as a nurse I want to hear more innovations and ways nurses can improve their patients' journey rather than task-oriented role [Nurse] • Would have liked more time to practise/develop skills, perhaps more experiential/practical experience to role play, asking each other questions [Psychologist] • Informative and very interactive session, I feel nurses and AHPs are good at implementing the strategies discussed but limited change of ethos due to medical approach [PT] • I think it will be difficult [to implement] with the current pressures on the acute stroke unit [SLT] • It would be nice if the training was more all-encompassing of HCPs, it feel very geared towards PT and OT, the SLT section was very limited and there was no acknowledgement of the dietician's role [Dietician] • At times the training felt it lacked linearity, I like to have the handout follow with the presentation, this made it hard to follow and make notes [OT]

**Some participants offered more than one comment*

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

Diagram: Intrinsic motivations for working in healthcare



Practitioners were very positive (91% agreed) when asked at the end of KZ1 whether they felt Bridges SSM would bring them closer to their professional ideals. At the end of KZ2 92% agreed that implementing the Bridges approach had brought them closer to those ideals.

> *"Great course - really helps to bring you back to what is important, and why you become a therapist, and not getting caught up in NHS processes and targets."* [OT]

Table: Practice reflects professional ideals

Practice and professional ideals	Positive	Neutral	Negative
Current practice allows you to reflect ideals? (n=67)	76%	24%	0%
Bridges SSM approach will bring you closer to ideals? (n=64)	91%	8%	1%
Bridges SSM approach has brought you closer to ideals? (n=48)	92%	8%	0%
Find work enjoyable	**Positive**	**Neutral**	**Negative**
Pre-KZ1 (n=68)	81%	18%	1%
Post-KZ2 (n=48)	85%	15%	0%

CONCLUSIONS: REACTION

- Practitioners responded positively to Bridges SSM training, finding the training "interesting" and "inspirational". They valued the time to reflect on their practice as individuals and to discuss the implementation of changes in their teams. The use of the 'patient voice' in the training was particularly appreciated, as well as practical ideas that can be readily incorporated into practice.
- Practitioners felt that it would be beneficial to have wider representation from the MDT at the training to facilitate subsequent implementation of the approach.
- SSM training resonates with practitioners' professional ideals: caring for and helping others and contributing to high quality care.
- At the end of KZ2, 92% of practitioners agreed that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

Learning

Practitioners 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.

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

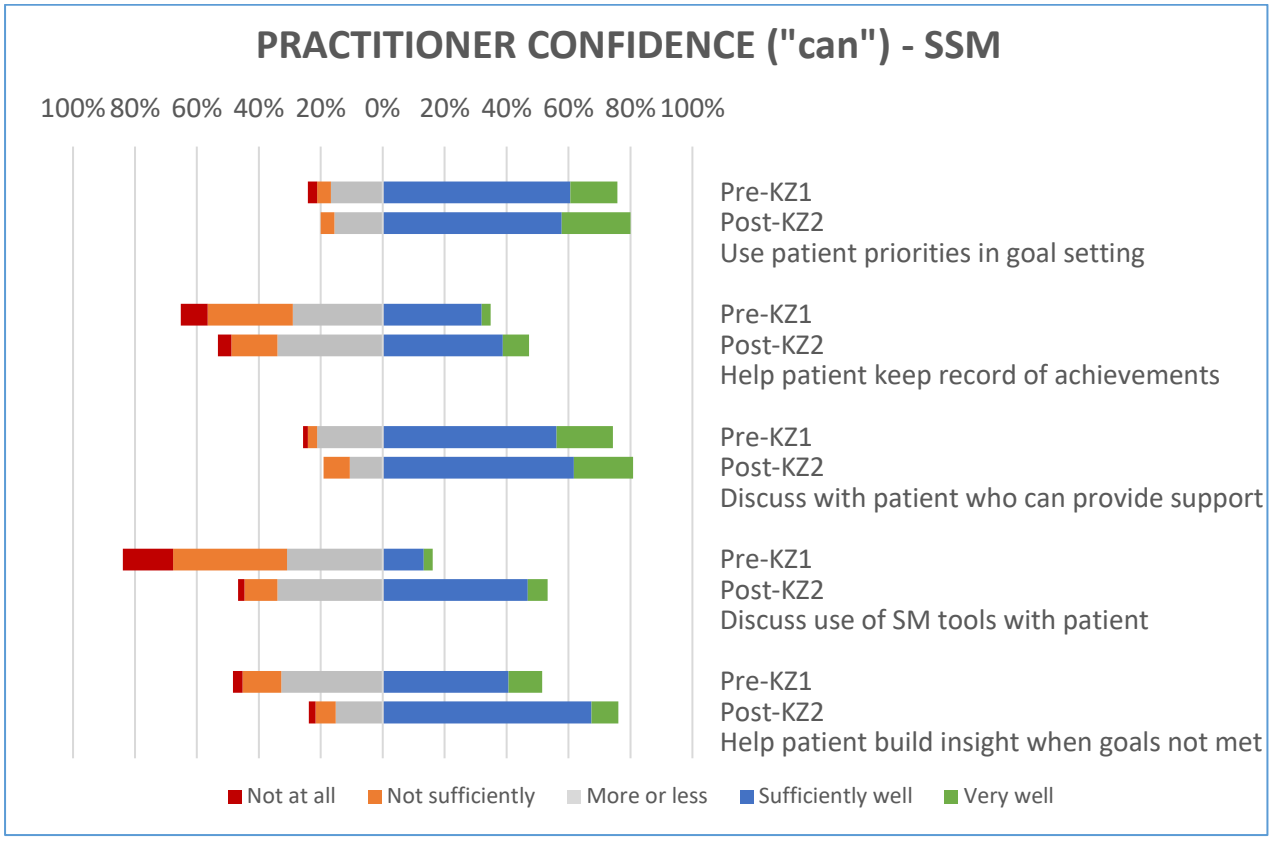
Goal setting	Allow the person to determine their own priorities when developing goals
Reflection	Assist the person to keep their own record of goals and achievements
Support	Discuss with the person who can provide daily support (e.g. family & friends)
SM devices	Discuss with the person how they can make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

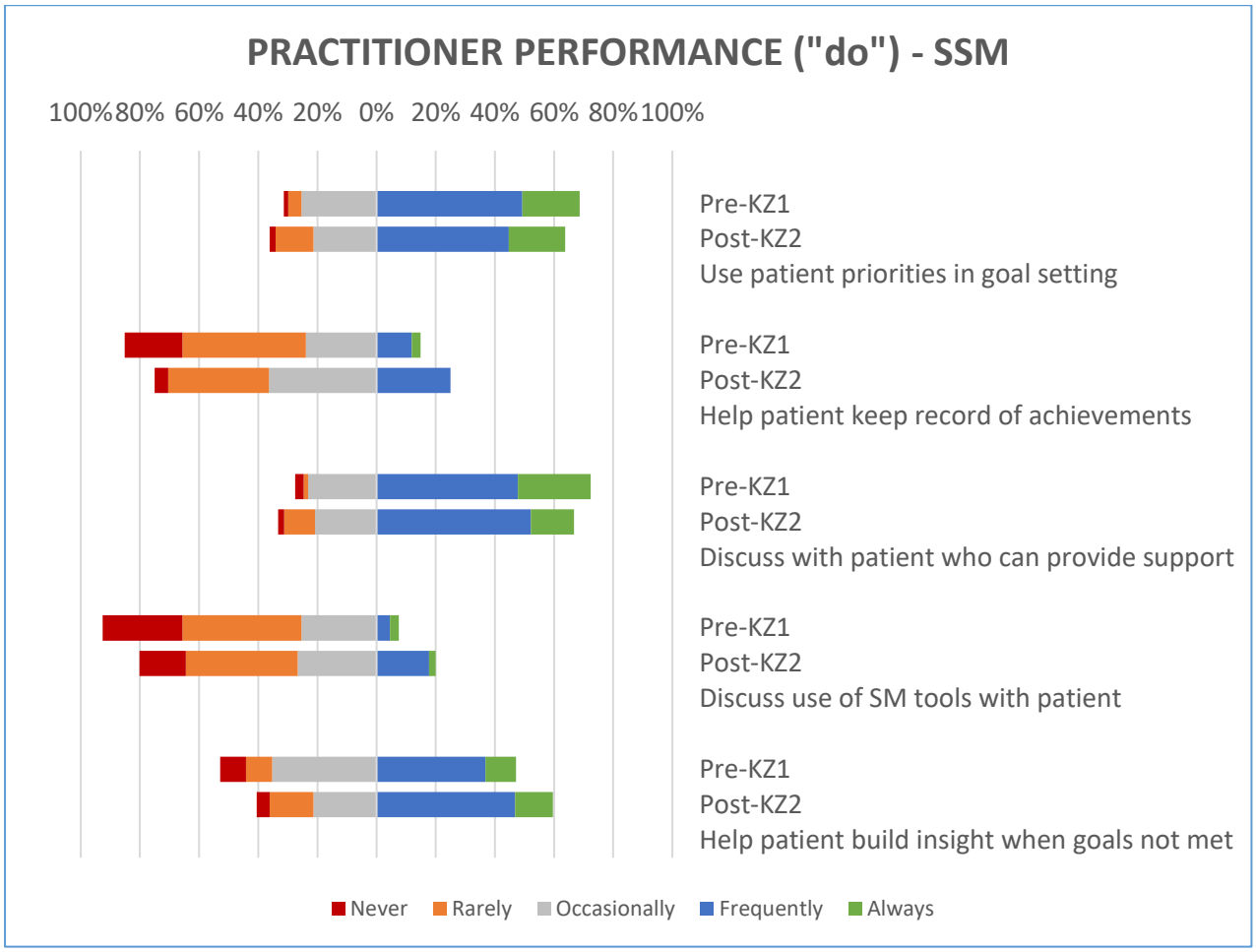
In the diverging stacked bar chart practitioner percentage responses indicating that they can do the SSM task "very well" or "sufficiently well" appear to the right of the 0% line, while responses for "more or less", "not sufficiently" and "not at all" appear to the left. The top bar for each task

reflects the practitioner self-report immediately prior to the Bridges SSM training and the bottom bar is self-report at the end of KZ2.

A similar approach is taken with respect to responses for “always” and “frequently” with regard to performance of the five SSM tasks (which appear to the right of the 0% line), and responses for “occasionally”, “rarely” and “never” (which appear to the left).

Diagram: Practitioner confidence and performance in five SSM tasks





The bar charts indicate a shift in practitioner confidence between KZ1 and KZ2 with respect to the five SSM tasks, particularly in relation to discussing use of self-management tools and helping the patient to build insight when goals are not met. For self-reported performance of the SSM tasks, there are two areas where responses are slightly less favourable post-KZ2 – in relation to using patient priorities in goal setting and discussing with the patient who can provide support.

During their input to this evaluation, practitioners are still in the process of applying their learning and working through the implications for their practice and what needs to change. Goal setting and the involvement of families are areas where many practitioners wish to introduce improvements and, as a consequence of the Bridges training, have started to trial new approaches.

> *"We have looked at how we do goal setting. This is still a work in progress. We have to use GAS goals. But ahead of the meeting where goals are set we are trying to put in a session to talk through goals and help fill in the small steps sheets, to make goals as client-centred as possible, rather than being service driven and GAS goals."* [OT]

> *"Bridges has made us rethink and relook at how we involve families and has given us resources and tools to do so."* [OT]

As in previous case studies, practitioners indicated that it takes time to refine and consolidate new skills such that they can be employed automatically rather than needing to be consciously thought through. In trying to use the Bridges approach, practitioners can be taken out of their comfort zone.

> *"I like to think I do those things anyway, but it's always useful to keep training, keep reminding, to try to continue to embed those practices in a more automatic way, to try and do it more automatically. Like with driving a car, it's a fairly conscious process to start with. I think I am a fair way down the line, but with all the pressures of NHS services those things can sometimes get lost."* [OT]

> *"This approach speaks to me and is an approach that we are using regularly with all patients in our team. I think that having the theoretical evidence behind the approach will allow me to use this with increased confidence."* [SLT]

> *"I think partly by nature, partly by being an OT, partly the time pressures, I feel my comfort zone is to try and give the answers and fix this and do that, so for me it's stepping back from that and trying to give them the opportunity to be expert in their care. Trying to incorporate that into each session, trying to get them to reflect after the session, what might have gone well or what they would take away from those sessions."* [OT]

CONCLUSIONS: LEARNING

- Evidence of a strong, existing baseline of person-centred care.
- Evidence of improved confidence in SSM and performance of SSM tasks following the training.
- Further time and practice necessary to trial and refine changes to practice and to consolidate confidence in the approach. Understanding the theoretical underpinnings and evidence behind the approach helps to build confidence.

Behaviour

At the end of KZ1 and KZ2, practitioners were asked about small changes they intended to make or had made to their practice. Team changes were reported at the Bridges Champions Masterclass. Responses were coded and categorised and are summarised in the following table. The changes are similar in nature to those reported in the previous case studies, with practitioners again identifying the need to alter processes and paperwork in order to embed the changes and ensure their sustainability.

Table: Changes to practice

Changes to practice	Description
Language	• Changing language used with patients and family • Asking more open questions • Avoiding jargon
Getting to Know You	• Finding out more about the person, their story, their interests, what is important to them, their hopes and fears, unacceptable outcomes • Utilising 'My Story' sheets • Changing the admission process to find out more about person and family, manage expectations and ask about goals
Goal setting	• Reviewing goal setting and using what is important to patient as the focus • Using fears and unacceptable outcomes in the goal setting process • Breaking down goals into small steps • Allowing patients to set priorities in therapy sessions
Problem solving and reflection	• Encouraging patients to problem solve and employ previous learned experiences • Using self-rating confidence scales • Encouraging patients to keep reflection diaries • Stepping back and letting patients have a go at tasks • Reviewing progress with patients
Paperwork and processes	• Using prompt sheets of Bridges catch phrases & core SM skills • Changing assessment forms, goal sheets and discharge letters • Focus on communication between nursing and therapy staff • Reviewing 'Welcome Home' visit process to encourage more self-management • Ensuring initial contact with patient is less process driven and question heavy • Changing initial visit letter to prompt patients to think about goal areas and

	expectations prior to visit and fill in a preparation form • Using patient stories in MDT • Spot checking goal sheets to ensure that goals are more person-focused and feeding back to team • Moving from 5-day to 7-day timetables • Introducing more activities in acute setting to stimulate patients • Utilising outcome measure at beginning and end of stay related to confidence in continuing 'under own steam' at home • Setting up SSM information boards • Putting up posters in staff rooms about Bridges meetings and agreed actions • Incorporating SSM into induction process and thinking about in-service refresher training • Thinking about how to include patient voice in review of goal setting process and developing appropriate efficacy measures • Developing efficacy measures – looking at patient questionnaire around support in setting and reaching goals, staff confidence questionnaire around goal setting

Challenges to changing practice

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

Challenge	Description
Time	- If busy, can forget to use SM approach consistently
Patient characteristics and readiness	- How to approach the high expectations that some patients have - How to utilise the approach best with more complex patients - Getting patients to recognise their existing skills and coping mechanisms
Culture	- Changing culture on wards - Shifting professional mind sets – how to engage medical team members with the approach, encouraging more nurses and HCAs to come on board
Context	- Service demands and pressure to get patients through the system - Balancing risk and clinical requirements with what is important to the patient - Service changes – awaiting new KPI following change of provider

As reported in other case studies, practitioners perceived the main challenges to changing practice as time, service pressures and changes, patient characteristics, and ensuring sufficient spread of the approach in order to generate a culture shift. Where practitioners are working in teams where only a small number have been Bridges trained, the challenge is to secure support as they try to enact change and to build confidence in 'influencing others'.

> *"I think the training and initiative are good, but it has come at a challenging time for the service."* [PT]

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

Table: Confident to use Bridges approach with complex patients

Workshop	Agree	Neutral	Disagree
KZ1 (n=65)	71%	26%	3%
KZ2 (n=42)	71%	19%	10%

At the end of the transforming period, practitioners still had some uncertainty about employing SSM techniques with complex patients. As illustrated in the quote below, there is a need to trial different elements of the approach according to the characteristics of patients; in some cases it will be 'full' Bridges SSM and in others more of a 'light touch'.

> *"With the more cognitively impaired patients it is perhaps taking the smaller things and recognising that they are still valuable. They might not necessarily fit our whole dream model of how Bridges will look. It feels really positive and valuable when you have got those patients that can really engage with those conversations. It does feel harder when they can't, but I don't necessarily think that we cannot use any of the principles. It's perhaps picking and choosing which bits and it is perhaps more about the language and helping them feel more positive about something."* [OT]

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

Workshop	Agree	Neutral	Disagree
KZ1 (n=66)	90%	10%	0%
KZ2 (n=42)	88%	10%	2%

Practitioners reflected that, when feeling under time pressure, it is easy to forget to use the SSM approach if it has not been embedded as part of routine practice, one example given was staff remembering to remind patients to fill in reflection diaries. It was perceived that perfecting the use of SSM techniques and tools may take more time initially, but with repeated use will become automatic rather than consciously thought of.

> *"In terms of the start point and getting people familiar and trying to use it, it does take more time, partly because people are still learning and you are having to think about things more rather than just doing it automatically. Once you have embedded it and you can use it within your sessions, the small changes in terms of how you use your language or how you might do goal setting with people, I don't necessarily think would take more time, it's just a change in how you do it."* [OT]

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.
- When feeling under time pressure, practitioners reported that it is easy to forget to employ SSM tools and techniques if they have not become part of routine practice. It takes time for new behaviours to become automatic rather than consciously thought through.
- Service demands and pressure to expedite patients through the system can act as a barrier to developing and refining a new approach.
- Ensuring widespread adoption of SSM language and techniques is perceived as essential to secure a culture shift. It will take time to ensure that all staff are using the approach consistently.
- Staff need peer and leadership support in order to drive through change and to build confidence in 'influencing others'.

Results

The evaluation team had recourse to feedback from practitioners in the Champions Masterclass and via one semi-structured telephone interview. 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 (& family) feels listened to and feels their specific needs have been identified
Professional-patient interaction	- Encourages recognition of patients' personality and character – a better sense of the individual - More collaborative and less prescriptive treatment, partnership working - Patients able to identify meaningful goals with the right support - Greater patient ownership of activities - More personalised and meaningful therapy - Managing patient and family expectations regarding rehabilitation, allows patients to see progress, or lack of, more clearly - More successful management of discharge - Ascertaining patients' hopes and fears is beneficial when dealing with degenerative conditions

Patient involvement and ownership	- Feel they are getting treatment for their specific needs - Patient identified goals are more meaningful - Patients able to identify meaningful goals with the right support - Enhanced engagement and motivation, e.g. volunteering new milestones - Positive feedback from patients and families - Shared planning for discharge with patients feeling more prepared
Practitioners	- Developing a different relationship with patients - Establishes therapy that adds to patients' quality of life - Promotes interdisciplinary working around steps towards patient goals - Potential to see patients improving at a faster pace - Contributing to team cohesion - Staff feel better prepared for difficult meetings with patients and family members

The following quotes from the interviews indicate the perceived value and impact of the Bridges approach.

> *"Bridges excites me and keeps me in work."* [HCA]
>
> *"It was an excellent training, it helped me to view my job from a different perspective and helped to improve my work experience."* [Nurse]
>
> *"Very useful tool to create a positive experience in a difficult situation.*" [PT]
>
> *"The shared language allows you to discuss things more readily, which is good as it helps to improve reflection and discussion within the team."* [SLT]

At the Bridges Champions Masterclass one team observed that implementing Bridges had demonstrated to them that making small changes to practice could have a big impact on interactions with patients, leading to more positive outcomes and feedback. There was concern about the focus of many extant outcome measures and the ability of these to capture adequately the impact of changing practice and the benefits of this for patient experience.

CONCLUSIONS: RESULTS

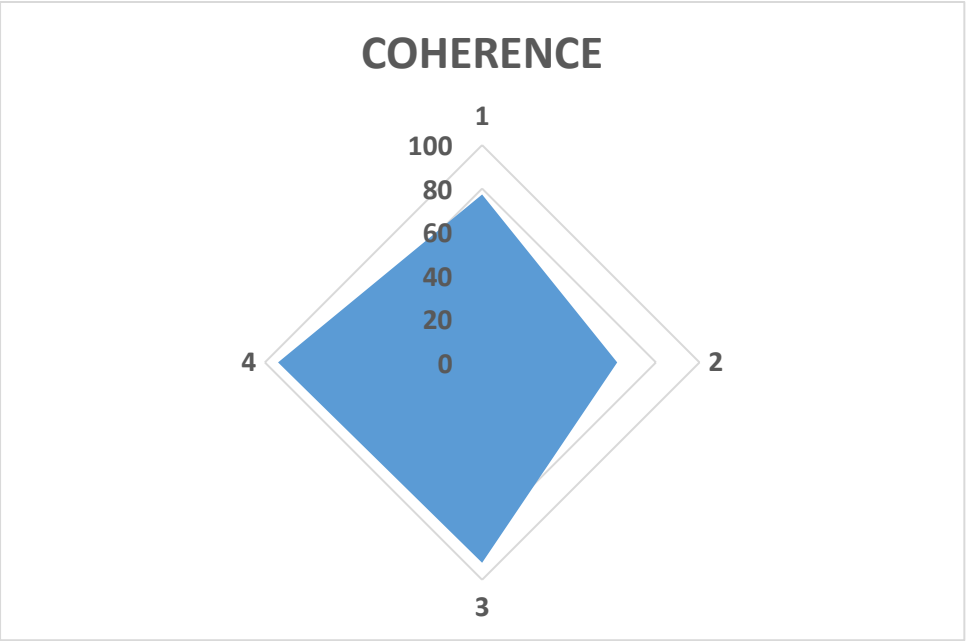
- Bridges was perceived to facilitate enhanced interactions with patients, leading to more meaningful therapy, increased motivation, better preparation for discharge and better outcomes.
- Using the Bridges approach has the potential to increase patients' and families' understanding and experience of the rehabilitation process and contribute to improved satisfaction.
- Practitioners reported changes in job satisfaction as a result of Bridges.
- The shared language of Bridges SSM was perceived to contribute to improved team communication and reflection.
- There was concern about the adequacy of extant outcome measures and their ability to capture the full impact of utilising the Bridges SSM approach.

Implementation assessment and sustainability

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

Coherence

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



1 I can see how Bridges differs from my usual ways of working (n=66; agree 77%)
2 I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative (n=66; agree 62%)
3 I can understand how the Bridges initiative will affect the nature of my own work (n=64; agree 92%)
4 I can see the potential value of the Bridges initiative for my work (n=66; agree 94%)

The majority of practitioners acknowledged that they could see how Bridges differs from their usual ways of working. However, for some practitioners the Bridges approach resonates very clearly with their professional training (e.g. "being client-centred is the core of OT training") and they do not feel that it differs significantly from their normal practice. Nevertheless, it was acknowledged that the Bridges training is useful, not only as a reminder or refresher about key person-centred skills, but as a mechanism to think more collectively about a coordinated team approach. The Bridges training is perceived to offer "permission" to put the patient back into the centre of practice. It serves to validate existing ideas for change and acts as a catalyst to put those ideas into action.

"I am looking for training to give me further 'permission' to approach patients in a less prescriptive way, there is often conflict between what you were taught in university around your vocation and real life practice." [SLT]

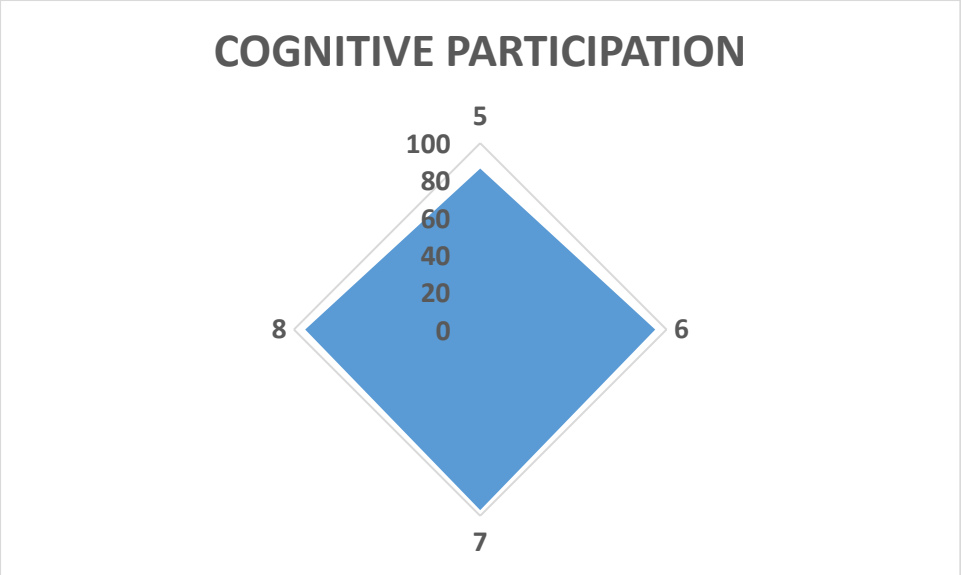
"A refresher into ideals I probably aspire to and guidance on how to implement a more SM approach in practice." [OT]

"A lot of the Bridges approach is consistent with my training but useful to think about things as a team and be more explicit about it." [Psychologist]

"The reason you go into the job is to help people be more independent and help improve quality of life. Particularly when you have worked in the NHS for a long time you can get sucked dry a little bit in terms of tick boxing this and target that, and you actually forget that the patient is in the middle of everything and that is where they should be. So I think it felt really positive because you have got the opportunity to think about how we can put the patient back into the middle of things, with big ideas and small ideas. It's a good opportunity to step back and reflect on your own practice, but also for me as a senior OT to reflect on the service and how we can make some positive changes and try to implement some of those ideas that probably we have had for some time, but given this opportunity, the tools, the ideas to do so, and recognising that it doesn't all have to be big things. It could just be about how one simple conversation can make a big difference for patients." [OT]

Cognitive Participation

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



5 I think there are key people who will drive the Bridges initiative forward (n=66; agree 86%)
6 I believe that participating in the Bridges initiative is a legitimate part of my role (n=66; agree 94%)
7 I am open to working with colleagues in new ways to use the Bridges initiative (n=66; agree 97%)
8 I will work to support the Bridges initiative (n=66; agree 94%)

By offering training to whole teams, Bridges is able to foster a community of individuals with enthusiasm to carry change forward. This enthusiasm is helped when key individuals, e.g. team leads or service managers, are advocates for the approach themselves or support others in championing the approach. Conversely, lack of engagement from ward managers may serve to influence the degree of commitment of nurses and healthcare assistants to the Bridges training and implementation.

One area where Bridges can serve to foster change is in nurse-therapist communication and collaboration. As evidenced in the quotes below, this is an area where practitioners perceive differences in professional philosophies and routines, and where the shared language and approach of Bridges SSM offers the potential to alter professional-to-professional interactions.

> *"Quite a few people from the team underwent training, particularly from the therapy team. There is lots of interest and enthusiasm for Bridges. It also helps that the lead OT and manager is very pro-Bridges. It helps to make changes and provide reasons for change."* [OT}

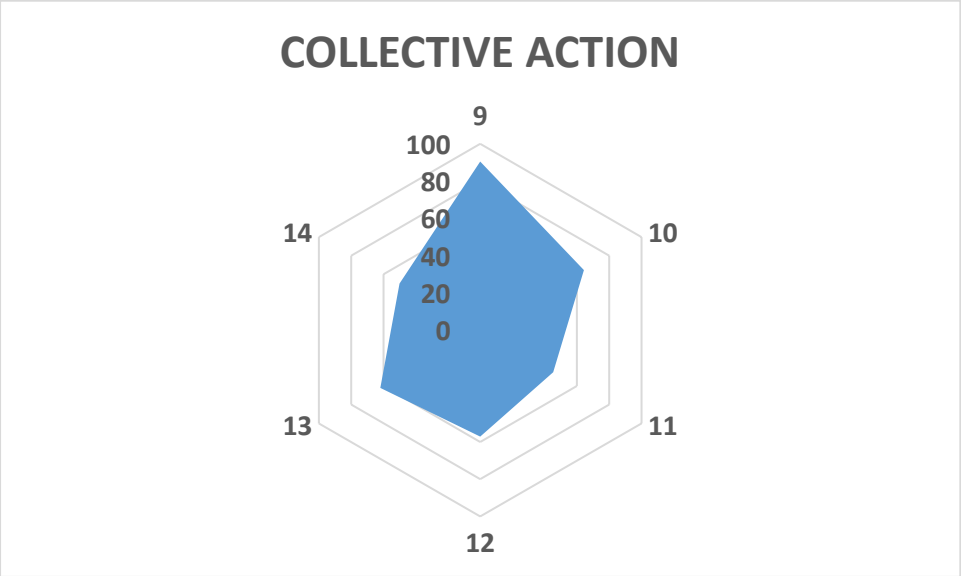
> *"I found it useful to learn what barriers the therapists come across. I feel that there needs to be more team work between nurses and therapists."* [Nurse]

> *"With the nurses there is a difference in terms of training and models of practice that we use. Nurses use a much more medical model and less of the language that Bridges uses. So when we are doing handover or talking about some of the patients' goals with the nurses, that is*

where some of that language might come in – have the nurses thought about having a conversation about problem solving the issue rather than the more medical model." [OT]

Collective Action

Collective action relates to the work that individuals do to enable the intervention, either as individuals or in groups. Around 91% of practitioners agreed that Bridges could be easily integrated into their work. However responses were less positive with regard to confidence in the other statements that make up this construct.



9 I can easily integrate the Bridges approach into my existing work (n=42; agree 91%)
10 I have confidence in other people's ability to use the Bridges approach (n=42; agree 64%)
11 All members of my team work to support the Bridges approach (n=42; agree 45%)
12 Sufficient training is provided to enable staff to implement the Bridges approach (n=42; agree 57%)
13 Sufficient resources are available to support the Bridges initiative (n=42; agree 62%)
14 Management adequately supports the Bridges initiative (n=42; agree 50%)

Areas of concern expressed by practitioners include being able to bring sufficient members of the wider team on board with the approach to ensure consistency of practice and to foster a culture shift. In some cases practitioners were working in teams where only a small number of individuals had attended the Bridges training. In such instances, practitioners could feel unsupported and somewhat daunted at the prospect of trying to achieve change. The Bridges team encouraged these practitioners to think in terms of achieving peer-to-peer support for change by looking beyond their service boundaries and linking with other Bridges-trained teams within their STP. In all cases, being able to influence other team members and provide induction and ongoing training was regarded as essential to embed and sustain the approach.

> *"It's a good model if the team and trust are on board to support implementation."* [OT]

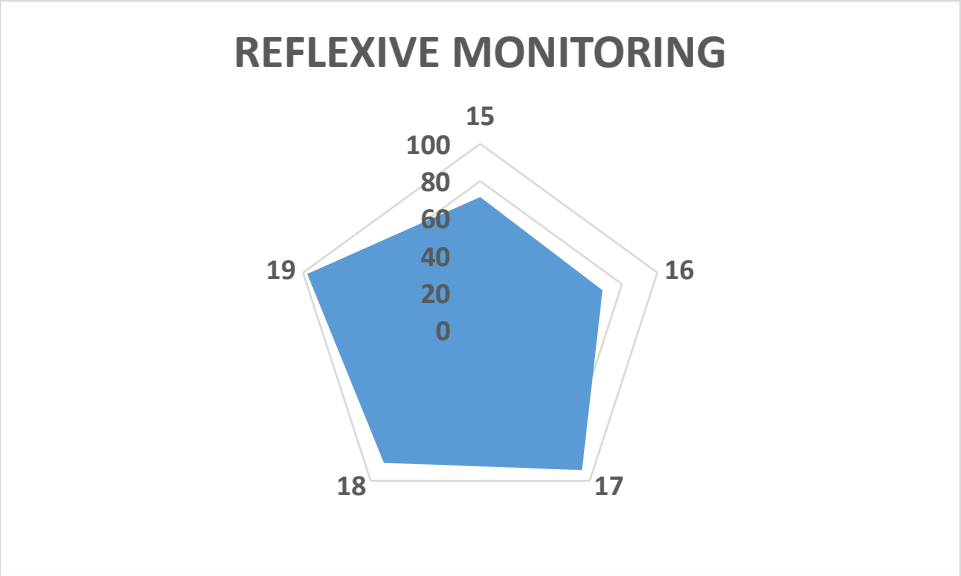
> *"I think it's essential to have the nursing team on board because they are the ones that are there all the time and they are the ones who are supporting all the day-to-day functions."* [OT]

> *"Although the therapists are very engaged, we also have quite a few locum staff and for some of the things we are doing it needs them on board. We are trying to make everyone aware of what we are implementing and also looking at whether it is part of a ward induction for new staff."* [OT]

"We had the Masterclass in January and then teamed up with other neuro colleagues who are on site to discuss how to work together, are there things to share and not duplicate. This is in its infancy, but there are bits we are working on with other services." [OT]

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=42; agree 71%)
16 Staff in my team agree that the Bridges initiative is worthwhile (n=42; agree 69%)
17 I value the effects that the Bridges approach has had on my work (n=42; agree 93%)
18 Feedback about the Bridges initiative can be used to improve the approach in the future (n=42; agree 88%)
19 I can modify how I work with the Bridges approach (n=42; agree 98%)

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, 93% agreed with the statement 'I value the effects that Bridges has had on my work'. At the Bridges Champions Masterclass, teams described plans to gain feedback and evaluate the measures they were introducing. Examples included:

- Thinking about how to include patients in a review of the goal setting process
- Developing efficacy measure (patient questionnaire) around support in setting and reaching goals
- Develop a questionnaire around staff confidence in goal setting
- Auditing the use of new paperwork and processes
- Spot checking goal setting forms to ensure they are more patient centred and providing feedback to the team.

Practitioners expressed concern about how to demonstrate success in using Bridges and about the acceptance by management and commissioners of "soft intelligence" e.g. patient stories and feedback.

> *"It's just a nice outcome measure for us [how confident on a scale of 1 to 10 do you feel to be discharged and continue under your own steam at home], because all of our other service outcome measures don't really tell you anything. They are either not sensitive enough or they*

just don't measure what we do. So although it is a very simple question, it encompasses all the disciplines and it's really challenging to get an outcome measure that does that." [OT]

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 again identified as:
    - The need for key individuals to support and drive forward the quality improvement
    - The importance of cascading and establishing support for the Bridges approach by all team members
    - The value of sufficient training, resources and management support.
- There was concern about the adequacy of extant outcome measures and their ability to capture the full impact of utilising the Bridges SSM approach. Practitioners pointed to the need to develop, trial and gain support for new measures.
- 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.

Context

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

Table: Inner setting factors important for implementation

Inner setting	Description
Service drivers	Pressure to process patients through the system. Bridges training is perceived to bring the focus back to the patient and what they want. This, in turn, reconnects practitioners with their professional motivations, i.e. 'making a difference' to people's lives *"Excellent training course, great to hear a patient's side rather than doing things for targets"* [Rehabilitation Assistant] *"When you have worked in the NHS for a long time you can get sucked dry in terms of tick boxing this and target that … it felt really positive to have the opportunity to think how we can put the patient back in the middle of things"* [OT] Bridges training reinforces and strengthens local commitment to supported self-management, helped by the 'signal value' of leadership *"It also helps that the lead OT and manager is very pro-Bridges. This helps to make changes and provide reasons for changes"* [OT] Practitioners can struggle with how to formulate outcome measures that demonstrate the success of Bridges SSM, perceiving the need for greater acknowledgement of the value of "soft intelligence" of patient experience versus "hard numbers" *"All of our other service outcomes measures don't really tell you anything, they are either not sensitive enough or they just don't measure what we do"* [OT]
Service structures	Team structures and locations influence the sharing of learning and ability to make changes. Large, dispersed teams can struggle with implementing and enlisting peer support for changes to practice, particularly when only a small number of individuals have been Bridges trained Securing the participation of nursing and HCA staff in the training is challenging but perceived as essential for successful implementation of Bridges across the patient pathway. Needs to be more of a priority for nursing managers *"I think it is essential to have the nursing team on board because they are the ones that are there all the time and they are the ones who are supporting all the day-to-day functions"* [OT] Changes in service provider creates uncertainty, brings changes to practice (e.g. cut in length of treatment pathway), need to adapt to new organisational culture and new KPIs. Such changes can influence staff morale and the way in which interventions are implemented Frequent service changes were perceived to create "change fatigue" and engender reluctance to embrace further practice or process changes
Staffing and resources	Stable teams versus staff churn Finding time to come together and share learning is more difficult with dispersed teams

Table: Outer setting factors important for implementation

Outer setting	Description
Changing patient needs	Provision of care needs to be more in line with management of long-term conditions face by patients, there is a need to encourage greater engagement of patients and build their confidence, the need to be 'truly' patient-centred Outcome measures need to be adapted to incorporate changing patient needs and to capture delivery of patient-led care
Professional cultures	Challenging "old school" expert-led approaches to patient care and promoting greater emphasis on rehabilitation
Risk culture	Societal attitudes to risk and health and safety concerns can impact acceptance of focus on patient-led goals, acceptance of positive risk taking in a controlled environment
NHS workforce	Staff morale and retention, stable teams versus high turnover, use of agency staff Staff perceive that Bridges allows them to reconnect with their professional philosophies and values, this can enhance feelings of job satisfaction

CONCLUSIONS: CONTEXT

- Practitioners felt that the Bridges approach brings the focus back to the patient and their specific needs and wishes. This was seen an important to counteract a perceived emphasis on tick boxes and targets.
- Service pressures and organisational changes can impact negatively on commitment to training and quality improvement activities. Leadership support is important to encourage and motivate staff, especially in situations where staff may be experiencing 'change fatigue'.
- Securing the participation of nursing and HCA staff is regarded as essential for successful implementation of Bridges. It was felt that endorsing the Bridges approach should be more of a priority for nursing managers.
- Staff turnover can influence implementation and sustainability and where staff work in large dispersed teams this can impact on the sharing of learning, ability to plan changes to practice and access to peer support.
- Practitioners need support to develop outcome measures that adequately capture the effectiveness of the service they provide.

CONCLUSIONS: KEY FINDINGS

CONCLUSIONS

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

- Practitioners were positive about the opportunity to reflect, learn, think and plan together. They described the training as "interesting" and "inspirational". It resonated with their intrinsic motivations for working in healthcare and encompassed principles that they aspire to. Practitioners appreciated the time to discuss ideas in their team and to bring the focus back to what is important for patients in the face of a perceived emphasis on tick boxes and targets.
- Bridges SSM training was seen to validate ideas for service improvement work and to promote adoption of a standardised approach to patient care.
- Questionnaire data points to a shift in confidence and performance of SSM tasks. This was supported by findings from workshop observations and an interview where practitioners discussed how they were making changes to their practice. Practitioners felt that further time was necessary to consolidate the changes and to build confidence in using the new approaches.
- At the end of KZ2, 92% of practitioners agreed that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

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

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

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

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in reported enhanced interactions with patients. Practitioners indicated that they had increased job satisfaction through the provision of more meaningful and effective therapy.
- Practitioners reflected that the Bridges programme had demonstrated to them how small changes to practice can have an important impact on both patient and staff satisfaction.

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 from a service team utilising the Bridges SSM approach. Information on the benefits of the approach for patients was obtained via a practitioner interview and workshop observations.
- Practitioners commented that using the Bridges approach meant that patients and families felt more listened to and developed a greater understanding of the rehabilitation process.
- Practitioners reported that patients were able to identify meaningful goals with the right support and that feedback from patients on a more collaborative approach was positive. At the Champions Masterclass one team reported that they had instigated the use of a rating scale to measure patient confidence to be discharged, with preliminary findings suggesting positive results from changing practice.

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 and feedback from practitioners suggested a number of factors contributed to a positive learning experience including: the learning atmosphere, use of adult learning principles, level of interactivity and group work, the credibility of trainers, the evidence base for the Bridges approach, and the use of the 'peer voice' and 'patient voice.'
- The Bridges programme and drivers for change appeal to the intrinsic motivations of healthcare staff and make use of valuable extrinsic motivators such as the service user voice, peer influence, and, in time, local Bridges Champions.
- Important drivers for successful implementation include: the need for key individuals to support and lead the improvement, engaging support of the wider team, and having sufficient training, resources and management support.