PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME

EVALUATION REPORT

CASE STUDY THREE: MID AND SOUTH ESSEX STP

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The authors are indebted to the many practitioners who supported this evaluation by completing questionnaires and taking part in telephone interviews. Thanks are also due to those individuals who supported the evaluation team in obtaining governance approval at participating trusts. Finally, it is important to acknowledge the support of the Bridges team, who facilitated evaluation activities at the training workshops and were open to the opportunities for learning provided by this independent evaluation.

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EXECUTIVE SUMMARY

Introduction

Mid and South Essex (MSE) Sustainability and Transformation Partnership (STP) was the third 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 October 2018 to October 2019.

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

Data collection

There was good take-up of the 125 training places on offer: 121 practitioners attended Knowledge Zone 1 (KZ1), although only 74 attended KZ2. The Champions Masterclass was not fully supported, with only 11 of the 25 places on offer taken up. Fifteen participants were anticipated, but representatives from one team did not confirm and did not attend.

Data available for inclusion in the evaluation comprised: 100 pre-training and 63 post-training questionnaires and 18+ hours of workshop observations. Exclusions from the evaluation included: representatives from trusts and from third party providers where the evaluation team had not secured governance approval.

Semi-structured telephone interviews were conducted with two practitioners, including Manager (1), and Speech and Language Therapist (1). While a number of other practitioners expressed their willingness to take part, it did not prove possible to schedule further interviews during the time frame of evaluation activities in the STP.

As part of the stakeholder engagement process, one focus group discussion was conducted with former service users exploring life after stroke and Acquired Brain Injury (ABI) and experiences of rehabilitation.

Stakeholder engagement

Awareness raising in MSE STP began in October 2018 and an engagement meeting for staff was held in December 2018. The engagement process involved six trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. The trusts invited representatives from third party providers to take part in the workshops.

There was some difficulty with engagement at two acute trusts in this STP and in trying to encourage attendance at the training the Bridges team had to revert to the provision of single site training workshops, thus reducing opportunities to focus on strengthening pathway working.

Engagement at one of the two acute trusts was challenging due to reported difficulties with staffing pressures. This continued to be the case throughout the Bridges programme and impacted the trust's ability to host Bridges workshops. In the event one introductory workshop was switched to another provider at the last moment (which occasioned a delay in the training) and a second workshop was cancelled. The UEA evaluation team did not secure governance approval for evaluation activities at this trust, despite multiple approaches over a seven month period, and the small number of staff (five) from this trust who attended training were therefore excluded from the evaluation.

At the other acute trust there was particular attrition with respect to attendance at KZ2, despite the efforts of the local key contact, multiple in-house reminders to staff and prior agreement from managers that attendance at the training was to be protected from caseload pressures. Positive feedback on the training was given by those who did attend and training content was not felt to be a factor for poor attendance at KZ2. Securing governance approval at this trust took considerable time and effort.

Findings from engagement work with former service users were similar to those obtained in the other two case study areas and pointed to the need for support for patients to build confidence to move forward and to continue with life after discharge from treatment.

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 "very relevant" to their practice and it resonated with their intrinsic motivations for working in healthcare. Practitioners appreciated the time to discuss ideas in their team and to refocus on patients in the face of service pressures.
- Bridges SSM training was seen to validate service improvement work already underway and to promote adoption of a standardised approach to patient care. It also served to highlight "bad habits."
- 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. 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, 93% 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), and encouraging patient problem solving and reflection.
- Steps were underway to spread, embed and sustain changes, such as: using a variety of methods to share learning about the approach and to bring other team members on board, altering processes and paperwork, placing visual prompts in the environment (e.g. to manage expectations about 'therapy') and planning to audit/evaluate new resources.

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

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in enhanced interactions with patients. This contributes to increased practitioner satisfaction through the provision of more meaningful and effective therapy.
- Bridges training makes quality improvement more accessible for staff by offering time to discuss and plan changes and by highlighting how small changes to practice can make a big difference to the patient experience. This may help to overcome feelings of disempowerment where staff feel that they are not able to contribute to practice development in the face of service pressures or have previously tried to make changes without success.

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 perceived benefits of the approach for patients was obtained via practitioner interviews and workshop observations.
- Practitioners felt that having Bridges conversations with patients resulted in the establishment of "more meaningful goals" and therefore more relevant therapy. In turn, the latter was felt to engender greater engagement from patients, leading to better outcomes and greater patient (and family) satisfaction, as well as reduced conflict.

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

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

CASE STUDY THREE: MID AND SOUTH ESSEX STP

The following presents a summary of evaluation results for the Mid and South Essex (MSE) Sustainability and Transformation Partnership (STP), the third of the six East of England STPs to participate in this Bridges Supported Self-Management (SSM) training and quality improvement programme.

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

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

Table: MSE Bridges SSM programme timeline

Stage	Timeline
Stage 1: Awareness Raising	October – December 2018
Stage 2: Stakeholder Engagement	April 2019
Stage 3: Knowledge Zone 1	March - April 2019
Stage 4: "Transforming"	April to July 2019
Stage 5: Knowledge Zone 2	July 2019
Stage 6: Champions Masterclass	October 2019
Stage 7: Sustainability plans	From October 2019

STAKEHOLDER ENGAGEMENT

Trust engagement

Awareness raising in MSE STP began in October 2018 and an engagement meeting for staff was held in December 2018. The engagement process involved six trusts across the STP providing acute, ESD and community services. The original target was for Knowledge Zone 1 (KZ1) workshops to take place in January and February 2019, but black and red alerts in some services led to difficulties in scheduling the training and KZ1 workshops eventually took place in March and April.

In order to facilitate training attendance in this STP Bridges offered some separate site workshops at certain trusts. Bridges' preferred option is to deliver training to representatives from across the patient pathway, which gives opportunities to focus on strengthening the patient pathway. However, to accommodate specific requests and to make it easier for acute staff to be released from their duties, Bridges agreed to the provision two smaller size single-site workshops.

The Bridges team experienced difficulty with engagement at two acute trusts in this STP. Engagement at one of the acute trusts was challenging due to reported difficulties with staffing. This continued to be the case throughout the Bridges programme and impacted the trust's ability to host Bridges workshops. One KZ1 workshop was switched to the ESD and community services provider at the last minute, occasioning a further delay in training as highlighted below in the quote from a Manager in the ESD and community services provider. A second workshop due to take place at the acute trust was cancelled.

> *"I felt very enthusiastic about it [training], but the timing was not great for us because we were right in the middle of winter pressures … it was difficult to get things organised given the timing of the call, so we were a bit delayed … and acute decided that they wanted to host it (because of their location), but actually they didn't do that, so there was quite a delay in getting it organised."* [Manager – ESD and community services]

It did not prove possible for the UEA evaluation team to secure governance approval for evaluation activities at this particular acute trust. Repeated approaches were made by the evaluation team over the period November 2018 to August 2019 and Health Education England (HEE) provided assistance by putting the evaluation team in touch with a senior local contact to help expedite the process. Despite this, no advice was received from the trust with respect to securing governance approval and the evaluation team made the decision to exclude representatives from this trust from the evaluation analysis. In the event, only a small number of representatives (five) from this trust attended a KZ1 workshop. The lack of engagement of the acute trust was disappointing for practitioners in other parts of the patient pathway as illustrated by the comment below.

> *"I think what I was really hoping for was working across the services. It would be pulling all of this together and all of us thinking about what approach we are taking."* [Manager – ESD and community services]

At the other acute trust where engagement was problematic, the local key contact reported difficulty in trying to secure enrolment on the training, despite considerable time and effort spent promoting the Bridges programme.

At this trust there was particular attrition with respect to attendance at KZ2, despite multiple in-house reminders to staff. Two KZ2 workshops scheduled to run on the same day (one in the morning and one in the afternoon) had to be reorganised into one session at the last minute due to late notifications of non-attendance. The local contact felt that this was not a reflection on the content of the training as feedback from KZ1 had been positive. It was also the case that prior agreement had been secured from relevant service managers/team leads that training time would be study leave and was therefore protected from caseload pressures. Feedback from those staff who did attend KZ2 was again positive as illustrated in the comment below.

> *"Very unfortunate re poor MDT attendance despite efforts from course organiser. Excellent resources, particularly for goal setting, positive focus on self and service improvement."* [PT]

Securing governance approval for evaluation activities at this trust also proved difficult, despite assistance from HEE. Communications regarding governance approval were ongoing from December 2018 to July 2019. The evaluation team was able to include representatives from this trust in the analysis.

CONCLUSIONS: TRUST ENGAGEMENT

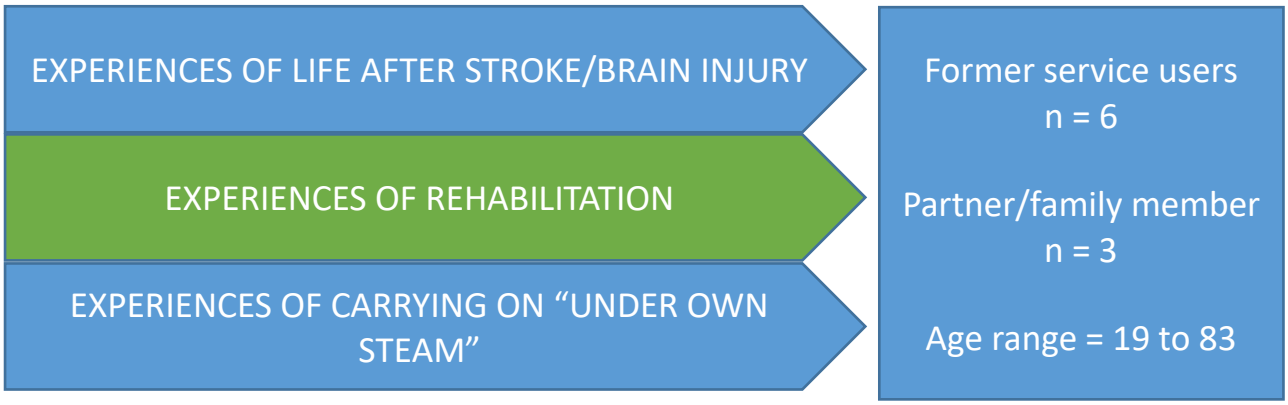
- Acute trust engagement in this STP proved challenging due to reported staffing and service pressures:
    - One trust was not able to host KZ1 workshops and sent only a small number of staff to a KZ1 workshop at another site. It did not prove possible to secure governance approval for evaluation activities at this trust.
    - There was difficulty in securing enrolment for the training at another acute trust, with particular attrition for KZ2 despite the best efforts of the local organiser. Effective and enthusiastic local leadership is essential to 'signal' the importance of engaging with the initiative. Securing governance approval for evaluation activities at this trust took 7+ months.
- The scheduling of KZ1 workshops was later than originally planned due to winter pressures
- The Bridges team was required to be flexible in the delivery of the training workshops in order to facilitate attendance. As single site training was delivered at some trusts, this reduced opportunities for cross-service interaction in the workshops.

Former service user engagement

The UEA evaluation team was again responsible for leading on stakeholder engagement in MSE STP.

One focus group discussion was conducted in April 2019 involving 9 participants. The discussion group was organised around a regular support group meeting, lasted for 60 minutes and was recorded with the consent of participants. The recording was transcribed and analysed thematically. The diagram below indicates the topics explored during the focus group discussion.

Diagram: Engagement with former service users



The themes that emerged from the focus group discussion were similar to those identified in previous stakeholder engagement in the first two STPs involved in the Bridges programme. Former service users describe the experience of dealing with the dislocation of a major life changing event and the impact it has not just on them, but also on their family.

Table: Summary of main themes from former service user engagement

EXPERIENCES OF LIFE AFTER STROKE OR HEAD INJURY
➢ A life changing event ➢ Not prepared for dealing with emotion, anxiety, and memory issues ➢ Impact on family ○ *"I had to give up my job because I can't leave [husband] on his own. That was a bit dismal … you are literally on your own, it's very hard."* [Female 1, partner]
EXPERIENCES OF REHABILITATION
➢ The benefit of being listened to and understood ➢ Being treated as a person and not a tick box exercise ○ *"It made me feel like they were really too busy and it was rush, rush, rush. They weren't listening to me, it was a ticking process."* [Female 2] ➢ Receiving personalised support and having 'mastery' experiences
EXPERIENCES OF CARRYING ON "UNDER OWN STEAM"
➢ Feeling unprepared and abandoned ○ Services are not joined up with the outside world, gaps in services and waiting lists ○ Need to know how to navigate services and connect to sources of support ➢ Reliance on family and friends ➢ Community support groups ○ *"It's such a support, not just for me but for my carer, because you need to talk to other people, you need to see light at the end of the tunnel."* [Female 2] ○ Important source of peer support, sharing experiences, helping each other, socialising, building confidence

When former service users describe their experiences of rehabilitation, they particularly remember acts of kindness from health professionals, i.e. individuals who take the time to listen and understand them and respond to them as a person. The need for the individual and their family to be prepared to deal with life after their discharge from treatment is an important aspect of the recovery process.

CONCLUSIONS: STAKEHOLDER ENGAGEMENT

- The stakeholder engagement emphasised the need for aspects of care to be addressed to help patients and their families better prepare for life after stroke or brain injury.
- Former service users emphasised the importance of being treated as a person, listened to and provided with tailored support.
- Participants indicated that the individual and their family are contending with the situation together and need to be prepared for all challenges, not just physical challenges.
- Individuals need to rebuild their confidence in order to move forward and to continue with their life.
- Being able to link to sources of peer support was regarded as invaluable.

EVALUATION DATA COLLECTION

Quantitative

The table below illustrates the number of attendees at the Knowledge Zone 1 (KZ1) and Knowledge Zone 2 (KZ2) workshops. There was good take-up of the training places on offer, although a level of attrition for KZ2. A number of representatives (n=6) from a non-participating trust and a third party provider were excluded from the evaluation.

There was incomplete take-up of the 25 places on offer at the Bridges Champions Masterclass: 15 participants were expected and 11 attended on the day. Representatives from one trust did not confirm and did not attend.

Table: Attendees at Bridges SSM workshops

Workshops	Timing	# attendees	# eligible for evaluation
Knowledge Zone 1 (n=6)	March – April 2019	121*	115
Knowledge Zone 2 (n=5)	July 2019	74**	73

** 6 individuals from charities and non-participating trusts excluded from evaluation; ** 1 individual from charity excluded*

No medical staff attended the training and there was no separate briefing session for medical staff.

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	100/115	87%
Knowledge Zone 1 – Post-training	101/115	88%
Knowledge Zone 2 – Post-implementation	63/73	86%

The following table shows the characteristics of participants by profession, setting, time since qualification and years in current service. As previously commented, there was attrition of participants at KZ2, with a drop in the number of nurses attending.

Table: Characteristics of participants in Bridges SSSM training

Participant characteristics	**KZ1**		**KZ2**	
Profession	**Number**	**%**	**Number**	**%**
Nurse	19	19.0	6	9.5
OT	20	20.0	12	19.0
PT	20	20.0	15	23.8
SLT	16	16.0	13	20.6
Psychologist	3	3.0	3	4.8
Rehabilitation/Healthcare Assistant	19	19.0	12	19.1
Family support/social worker	2	2.0	1	1.6
Dietician	1	1.0	0	0.0
Missing	0	0.0	1	1.6
Total	100	100.0	63	100.0
Setting	**Number**	**%**	**Number**	**%**
Acute	38	38.0	21	33.3
Community	57	57.0	37	58.7
Both	5	5.0	5	7.9
Missing	0	0.0	0	0.0
Total	100	100.0	63	100.0
	Mean (SD)	**Range**	**Mean (SD)**	**Range**
Years in profession	12.5 (10.1)	<1-39	11 (10)	1-39
Years in service (KZ2 responses, n=46)	5.6 (6.4)	<1-36	5.5 (6)	1-29

Qualitative

Workshop observations

The UEA evaluation team carried out 18+ hours of evaluator embedded observations of KZ1 workshops and the Bridges Champions Masterclass.

Semi-structured interviews

Two semi-structured interviews with practitioners took place following KZ2. The interviews were conducted by telephone and lasted an average of 43 minutes. The characteristics of the participants are described in the table below.

Table: Participants in semi-structured interviews

Interview participants	**Number**
Manager	1
Nurse	-
OT	-
PT	-
RA	-
SLT	1
Psychology Practitioner	-
Acute	0
Community	2
Years in profession (mean)	25
Years in service (mean)	10

The target for the evaluation was to secure interviews with around six practitioners from across acute, ESD and community services. Practitioners were asked to volunteer for interview, but despite an initial willingness to take part expressed by some individuals, it did not prove possible to schedule further telephone interviews during the time frame of evaluation activities in the MSE 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 68 comments about the Bridges training were coded as positive, with practitioners valuing the opportunity to reflect on their individual and team practice. Bridges was seen to offer practical ideas that could be readily incorporated into practice and having input from a former service user (as one of the trainers) was regarded as particularly valuable in highlighting the patient experience. There were 24 individuals who did not offer any comments on the training (coded as neutral). Negative comments were concerned with the perceived difficulty of adopting the approach in acute settings and in the face of service pressures, the lack of involvement of medical staff, and the wish for further information or support around implementation (something that Bridges focuses on further in KZ2).

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

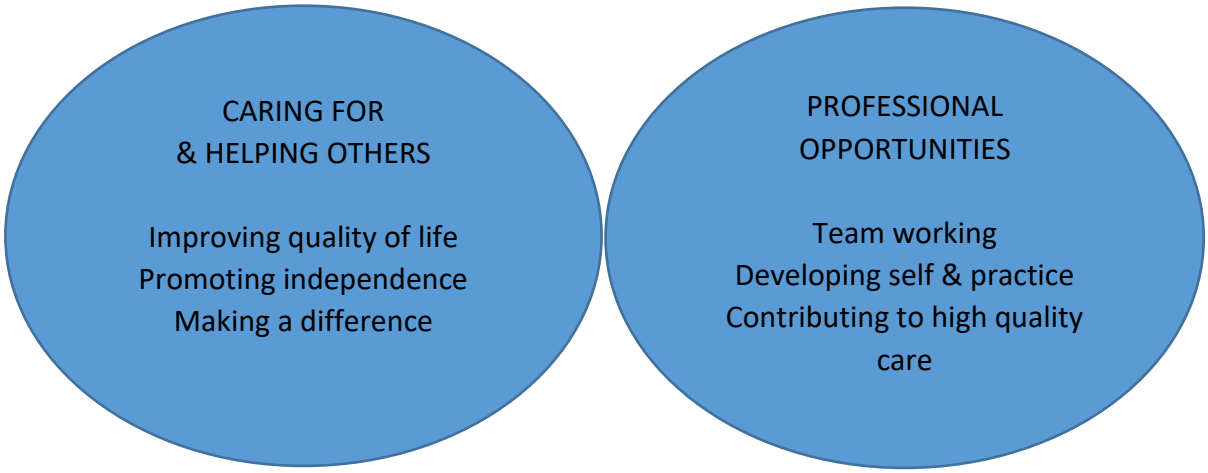
Feedback	Number*	Illustrative participant comment
☺	68	• Good to have time to think about a different approach and to be MDT thinking [Nurse] • I found it to be very interactive, useful and appropriate videos, stroke survivor's input extremely helpful and useful, great pace [SLT] • Thought provoking, with useful practical ideas to implement into practice [PT] • I thought it was a really valuable opportunity to examine your current practice, consider language and methods that might be used inconsistently across differing clients/client groups and to use practical suggestions to adapt approach [SLT] • Very engaging facilitators, great to have input from service user who shared very meaningful and powerful stories, interesting ideas that we feel keen to try and implement, very enjoyable day [Psychologist] • I think this will really help to ensure our care is person-centred and really help the person, not the stroke [Rehabilitation Assistant] • Reassuring to know we only need to "tweak" as a team, as a service we had started to embrace the principles, the training has helped consolidate this and given me confidence to practice in a "tweaked" way [OT]
😐	24	• No comments
☹	12	• Some difficulty in applying to patients in hyper-acute phases, also needs to be supported at policy level in order to implement efficiently, needs to be combined in guidelines and for commissioners to recognise benefit of moving this way [SLT]

		• Very rehab examples would be nice to see more nursing examples, how HCAs or staff nurses have implemented Bridges into day-to-day workload [Nurse] • May be difficult to implement in acute setting due to caseload and discharge pressures, I think it would be useful if the consultants/doctors attended the training to enable a more MDT approach to positive change [SLT] • I would like to have more information about other teams who have used the service, also more tips about supporting the implementation in service [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 (similar to those in the previous two case studies) as indicated in the diagram below.

Diagram: Intrinsic motivations for working in healthcare



Practitioners were very positive (95% 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 93% agreed that implementing the Bridges approach had brought them closer to those ideals.

Table: Practice reflects professional ideals

Practice and professional ideals	Positive	Neutral	Negative
Current practice allows you to reflect ideals? (n=98)	73%	26%	1%
Bridges SSM approach will bring you closer to ideals? (n=100)	95%	4%	1%
Bridges SSM approach has brought you closer to ideals? (n=61)	93%	5%	2%
Find work enjoyable	**Positive**	**Neutral**	**Negative**
Pre-KZ1 (n=99)	83%	17%	0%
Post-KZ2 (n=63)	90%	10%	0%

CONCLUSIONS: REACTION

- There was good take up of the 125 training places on offer: 121 practitioners attended KZ1, although there was some attrition at KZ2 (74 attended). Only 11 of 25 places on offer at Bridges Champions Masterclass were taken up.
- Practitioners responded positively to Bridges SSM training, valuing the time to reflect on their practice as individuals and in their teams. The use of the 'patient voice' in the training was particularly appreciated, as well as the provision of practical ideas that could be readily incorporated into practice.
- Practitioners felt that it would be beneficial if representatives from the medical team attended training to facilitate incorporation of the approach in the MDT. There was also the view that the approach needs to be supported at policy level and that commissioners need to be aware of the benefits of pursuing SSM.
- SSM training resonates with practitioners' professional ideals: caring for and helping others, and contributing to high quality care.
- At the end of KZ2, 93% of practitioners agreed that Bridges SSM had helped them

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.

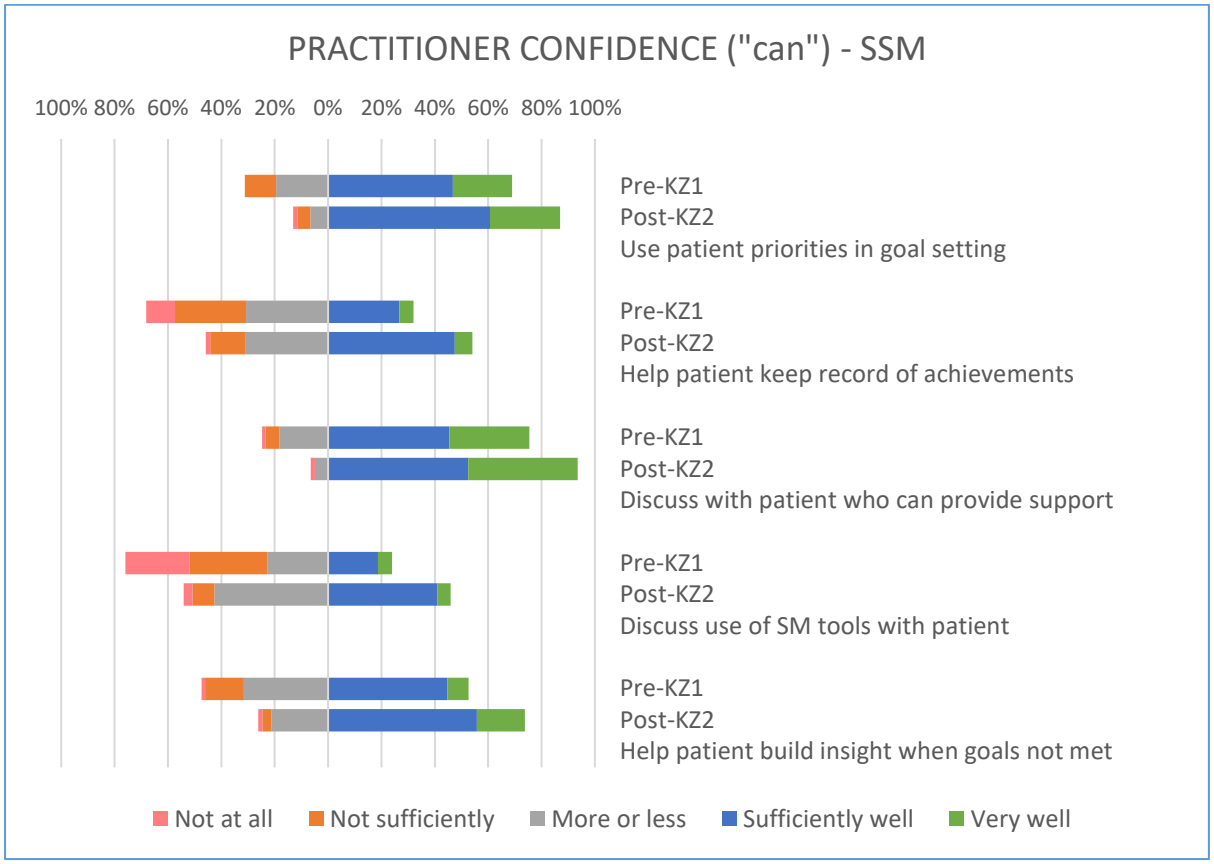
The five SSM tasks selected for presentation here are related to goal setting, patient reflection, accessing daily support, using SM devices and developing insight. These tasks were selected as they represent areas where practitioners indicated they intended to make changes to practice.

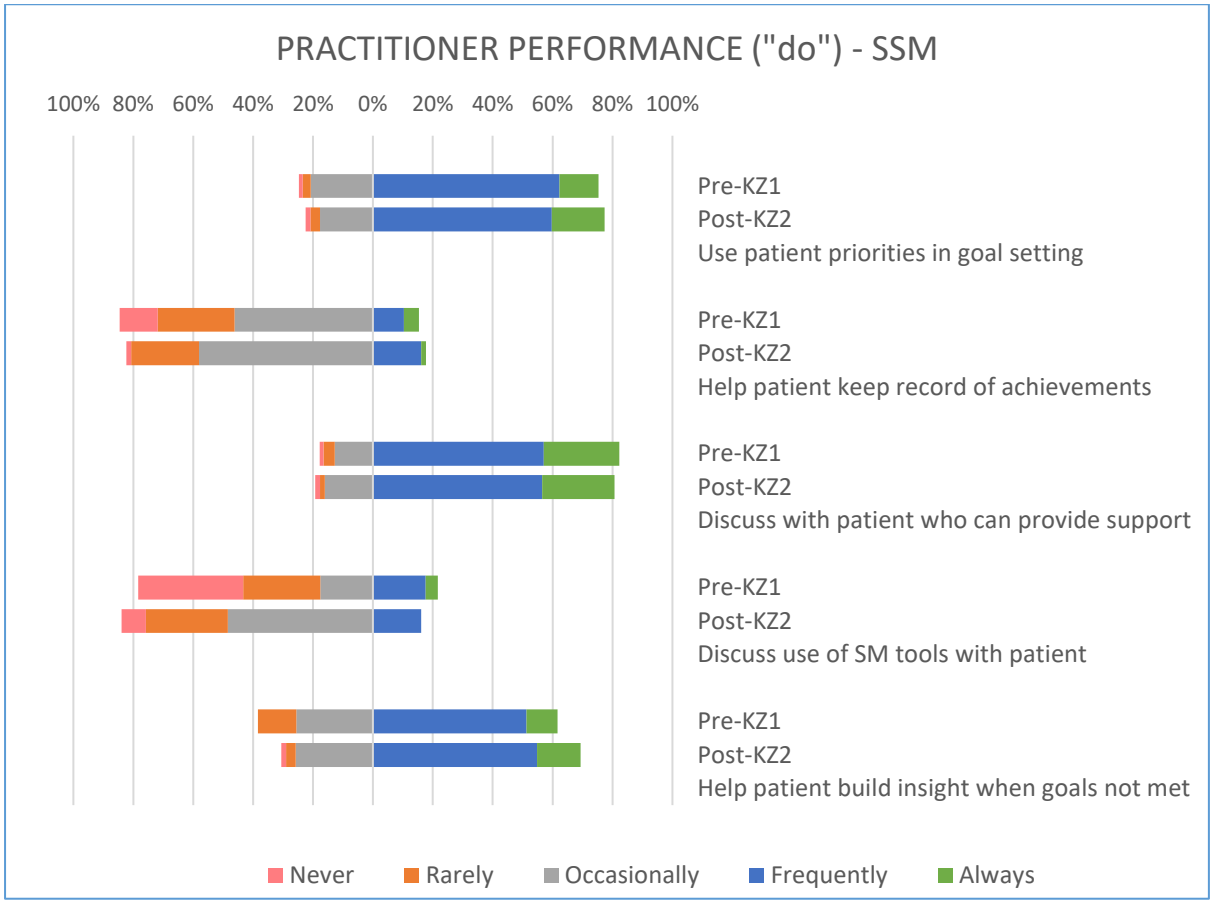
Goal setting	Allow the person to determine their own priorities when developing goals
Reflection	Assist the person to keep their own record of goals and achievements
Support	Discuss with the person who can provide daily support (eg family & friends)
SM devices	Discuss with the person how they can make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

In the first 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 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 in the second bar chart with respect to responses for "always" and "frequently" with regard to performance ("do") 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 with respect to the five SSM tasks between KZ1 and KZ2. For self-reported performance of the SSM tasks there is a shift in those reporting that they "never" or "rarely" perform the task.

Workshop observations and interview data indicated that practitioners felt that further time and practice was necessary in order consolidate their use of the approach. By way of example, in the following quote a Speech and Language Therapist reflects on the process of abandoning GAS goals and adopting a more Bridges-style approach as a result of the training. Supported by their manager, this team decided to devote more time to the first goal setting conversation with patients in order to 'lay the foundations for somebody taking a bit more responsibility.' It was anticipated that once the process felt more 'natural' the allocation of extra time might not be necessary.

> *"After the training we decided as a collective to abandon GAS and introduce a Bridges approach … and I remember feeling very pressured, you know, this feels very luxurious spending so much time at this stage, but we've seen a real pay-off from those kind of conversations … We've become so geared to 'doing' to keep things running quickly that when you step outside and try to give someone more time, it's something that's new and a little bit different, it felt a bit unnatural."* [SLT]

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.
- Practitioners felt further time and practice was necessary to refine changes to practice and to consolidate confidence in the approach, with perceived benefits in making the changes.

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 two 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 • Using less clinical language • Changing language in documentation
Getting to Know You	• Allowing patients time for their story • Finding out more about the patient, their story, their interests, what is important to them, their fears and worries

	• Introducing a Stroke Passport or This is Me document
Goal setting	• Abandoned GAS goals • Establishing a more collaborative and consistent goal setting approach • Asking what is "one small thing" you want to achieve • Breaking down goals into small steps • Using patient "to do" lists
Reflection	• Utilising patient self-rating confidence scales at the start and end of sessions • Encouraging patients to problem solve – ask what works, what have you tried • Developing a self-reflection tool to use in therapy • Encouraging use of diaries & mobile phones to record progress
Paperwork and processes	• Using a prompt sheet of SM phrases • Changing assessment forms, goal sheets and discharge letters • Creating patient passports • Recording goals so they are more accessible for the patient • Visual resources on ward, e.g. 'expectations' poster, 'I can' boards at bedside • Changing the structure of outpatients exercise programme (more 'life friendly') • Considering change to re-referral/SOS service for patients • More sharing of personal information about patients with team members, e.g. 'random facts' about patients • Training and supporting other staff, e.g. MDT review, journal club, lunch and learn, mentoring rotational staff • Collecting feedback from patients and family, other services (e.g. ESD)

The following quotes illustrate how the Bridges training served both to remind practitioners about certain aspects of patient-centred care or prompted them to reflect on how aspects of practice might be perceived from the patient perspective. Bridges also served to validate changes to practice that were already under consideration (although perhaps provided additional framing for the issue) and made practitioners more aware of the power of language.

> *"There's a real combination … it validated some of the work that we'd got going on … that was just really helpful … and there were things we changed as a direct result of Bridges. I was listening and I thought oh my goodness, we call the first visit that ESD do when somebody is discharged from hospital a 'safety check' and I thought that language is giving*

such a risk averse message. You shouldn't be worried about people being at home. We immediately changed that to 'welcome home visit.'" [Manager]

"The key thing [Bridges] helped me do is abandon the GAS approach, which we were sort of enslaved to, which had its advantages … but perpetuated an expert position and sometimes turned a patient-stated goal into something bewildering and inaccessible … Immediately after the training we decided as a collective to abandon GAS and introduce a Bridges approach." [SLT]

"Really changed my approach and communication style, flipped a lot of what I thought was good practice around, changed my approach to rehab." [OT]

Challenges to changing practice

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

Challenge	Description
Time	- Time available for service development - Takes time to build rapport, difficult when rapid turnover of patients
Patient characteristics and readiness	- How to approach the high expectations that some patients have - Getting patients to recognise their existing skills and coping mechanisms
Culture	- Changing culture on wards - Shifting professional mind sets
Context	- Service demands and pressure to get patients through the system - Staffing levels and staff morale - Stigma around "talking" to patients, not seen as work, have to justify - Balancing risk and clinical requirements with what is important to the patient - How to share information effectively across pathway

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 and indicate that after KZ2 there was still some uncertainty about using the approach with complex patients.

Table: Confident to use Bridges approach with complex patients

Workshop	Agree	Neutral	Disagree
KZ1 (n=100)	83%	11%	6%
KZ2 (n=56)	70%	27%	3%

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

Workshop	Agree	Neutral	Disagree
KZ1 (n=100)	92%	6%	2%
KZ2 (n=57)	86%	11%	3%

With regard to the use of time, a manager expressed the view that it was worth investing time in the near term to consolidate the Bridges approach (in this case around goal setting), with a view to gaining in the longer term by having patients more engaged with therapy and improving more quickly. This manager had expressly given permission to staff to spend longer on refining their new approach to goal setting with patients following the Bridges training.

> *"I said this is short term pain for long term gain, so you can embed this process and become skilled at it. Then in the long term we ought to have more patients that are more engaged with their therapy and people should potentially be improving at a faster pace because they should be practising their exercises or activity programmes outside of their therapy sessions."* [Manager]

CONCLUSIONS: BEHAVIOUR

- Practitioners were motivated to make changes to their practice as a result of Bridges training, including: adapting language, changing the structure of interactions and goal setting approaches with patients, encouraging patient reflection and problem solving, and altering paperwork and processes to embed SSM.
- By making changes to practice practitioners were able to identify benefits to using the approach, such as shaping more meaningful and effective therapy, with increased patient engagement and motivation.
- Service demands and pressure to expedite patients through the system can act as a barrier to developing and refining a new approach and may require key individuals to help create circumstances in which staff feel they have permission to innovate.
- There is a need to re-acknowledge the benefit of the therapeutic consultation or encounter with patients, i.e. 'talking' is also part of 'treatment.'

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 (& family) feels listened to and feels their specific needs have been identified
Professional-patient interaction	- Supports fulfilling and essential conversations with patients - Encourages recognition of patients' personality and character – a better sense of the individual

	- More collaborative and less prescriptive treatment - More personalised and meaningful therapy - Managing patient and family expectations regarding rehabilitation - More successful management of discharge
Patient involvement and ownership	- Feel they are getting treatment for their specific needs - Patient identified goals are more meaningful - Enhanced engagement and motivation - Positive feedback - Improved patient mood scores
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 - Potential to reduce conflict with patients and family about therapy

The following quotes from the interviews indicate the perceived value and impact of the Bridges approach. In particular, the Bridges approach to goal setting was seen to enable the establishment of more meaningful and aspiration goals that would add to a patient's quality of life in the longer term.

> *"We've had a couple of very notable successes … people who, right from the outset it felt a bit different … I suspect we did have a kind of different relationship with the patient to the one that might have developed had we taken the previous approach … the patient set goals which were very ambitions and I think the GAS framework would have squashed some of that ambition … but the patient has pursued those goals, solving problems along the way … and those goals have extended way beyond the six week pathway and are being pursued in community therapy … and it feels that by not shutting down that aspiration, which is a terrible thing to think that you've done at times because you are more about the short term realism .. the patient is doing well."* [SLT]

> *"I think if the overall impact in promotion self-management is that the patient and family is more engaged in their treatment then they should have a better outcome, so it feels like a fundamental to me … if people are fully engaged and included in the processes that are going on within our services, then there should be better understanding and there should be less conflict, because there is quite a bit of conflict within the ward setting in terms of people adjusting to the change."* [Manager]

As a result of the Bridges training, one neurophysiotherapy service reported changing the structure of an outpatient exercise class programme making it less prescriptive and reducing the level of direct supervision and support over the duration of the eight week programme. This was coupled with greater use of patient reflection and self-rating of confidence in managing their condition. At the Champions Masterclass, the team reported positive feedback from patients - "you listened to me

and what I need", "you understand that we are human" – and at the completion of a recent exercise programme the team stated that 75% of participants had rated their ability to manage their condition as >7/10. The team also indicated that it had been possible to discharge some long-term patients following a Bridges-style conversation about their goals and wishes, which had identified that the patients felt that physiotherapy had become a way of life but was actually no longer required.

CONCLUSIONS: RESULTS

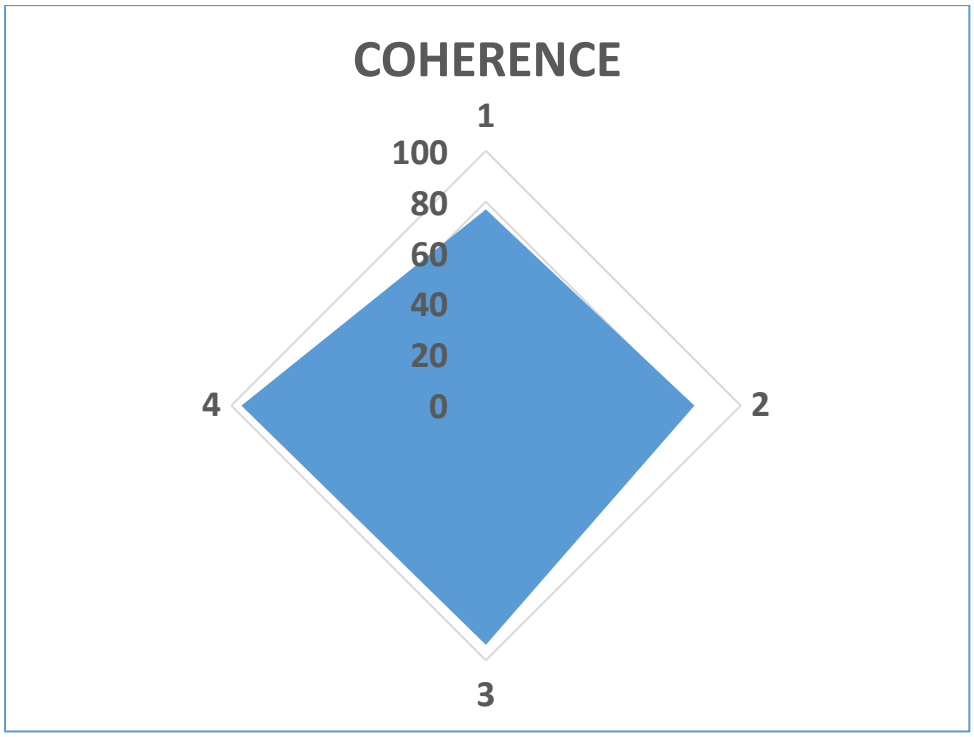
- Bridges was perceived to facilitate enhanced interactions with patients, leading to more meaningful therapy and increased motivation of patients.
- Using the Bridges approach has the potential to increase patients' and families' understanding and experience of the rehabilitation process and contribute to improved satisfaction and reduced conflict.
- Securing greater patient engagement with therapy was seen to offer the possibility of patients improving at a faster pace and feeling better prepared for discharge.

Implementation assessment and sustainability

In the following section, each of the four constructs of NPT is explored, demonstrating progress towards implementation and sustainability.

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. In each case, there was strong agreement (>75%) with the statements indicating that practitioners were likely to support implementation of the intervention.



1 I can see how Bridges differs from my usual ways of working (n=100; agree 77%)
2 I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative (n=99; agree 82%)
3 I can understand how the Bridges initiative will affect the nature of my own work (n=99; agree 94%)
4 I can see the potential value of the Bridges initiative for my work (n=100; agree 96%)

While questionnaire responses indicated that the majority of practitioners felt that the Bridges intervention made sense, for some there was still the view that 'we do this already.' During interview, one manager commented that such a view could be the result of poor insight and that it is incumbent on all practitioners to reflect on their practice and to be more aware of bad habits that may have developed.

> *"I think everybody needs to look at what they are doing. We all fall in to habits that you're not even aware of. So [Bridges] is a very familiar approach … this is how I was trained to work … but actually there were all sorts of really good tips around how you phrase things that I thought was relevant to everybody."* [Manager]

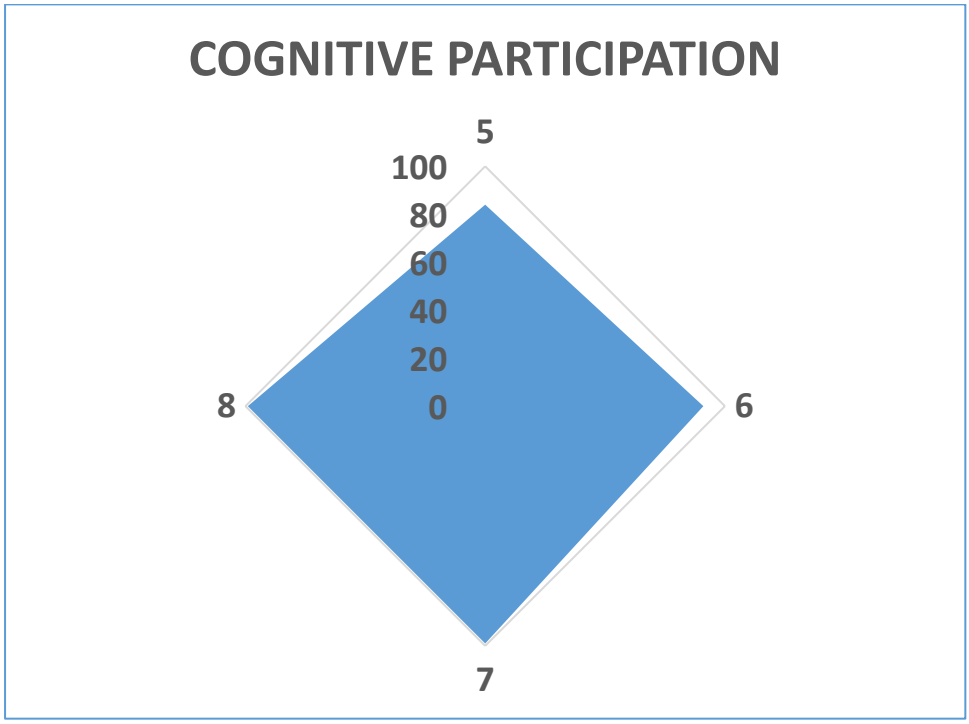
"There's a framework, it reminds me to question more, not to provide the answer … I think that is a bad habit to have as a therapist … to volunteer the solution … that's just a habit formed through time pressures and whatever else, but that's something I'm certainly trying to improve." [SLT]

"It was good to think about the things we can do to make therapy more meaningful to people and discuss it with therapists from different settings." [OT]

"I thought it was a really valuable opportunity to examine your current practice, consider language and methods that might be used inconsistently across differing clients/client groups and to use practical suggestions to adapt approach." [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=100; agree 84%)
6 I believe that participating in the Bridges initiative is a legitimate part of my role (n=100; agree 91%)
7 I am open to working with colleagues in new ways to use the Bridges initiative (n=100; agree 99%)
8 I will work to support the Bridges initiative (n=100; agree 99%)

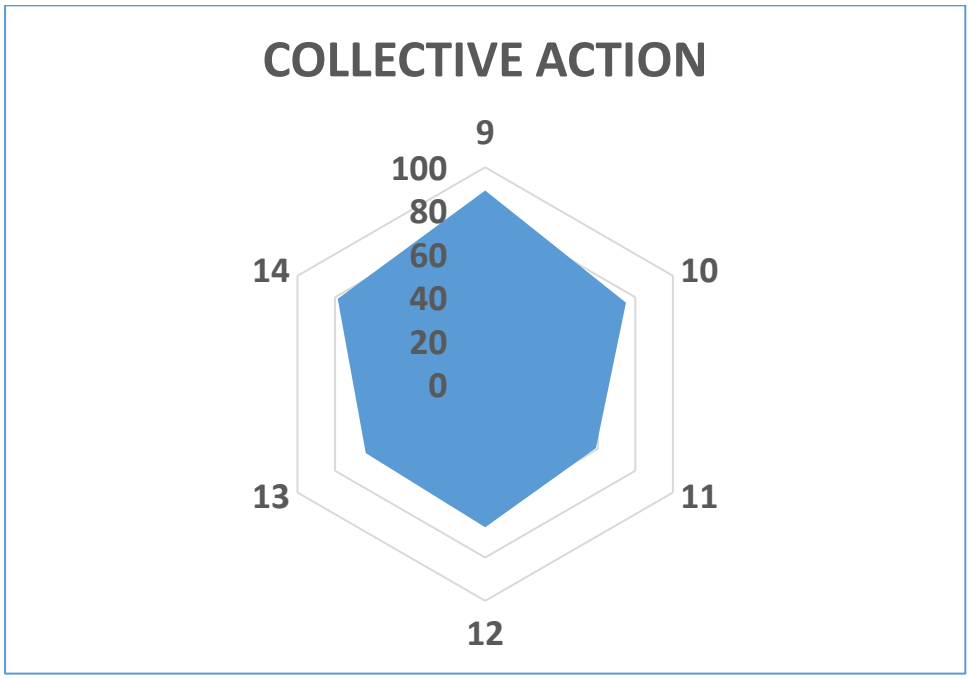
There was some hesitancy as to whether there were key individuals to drive Bridges forward, but nevertheless 84% were in agreement with this statement.

Observations at the Bridges Champions Masterclass highlighted that not all participants felt fully supported and/or encouraged by their team leaders when trying to implement changes in practice. This was at an acute trust where, as previously mentioned, there was difficulty in running the KZ2 workshop due to last minute notifications of non-attendance. While Bridges training makes quality improvement more accessible for staff and motivates practitioners to make changes to their practice, this needs to be backed up by leadership that encourages staff to maximise their contribution to quality improvement and service development. The lack of leadership support may serve to demotivate enthusiastic adopters.

The situation above is in complete contrast with that in another team where the manager agreed that staff could allocate extra time to develop, embed and grow confident in a new approach to goal setting.

Collective Action

Collective action relates to the work that individuals do to enable the intervention, either as individuals or in groups. Around 89% 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 (59% 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=56; agree 89%)
10 I have confidence in other people's ability to use the Bridges approach (n=56; agree 75%)
11 All members of my team work to support the Bridges approach (n=56; agree 59%)
12 Sufficient training is provided to enable staff to implement the Bridges approach (n=56; agree 66%)
13 Sufficient resources are available to support the Bridges initiative (n=55; agree 64%)
14 Management adequately supports the Bridges initiative (n=56; agree 79%)

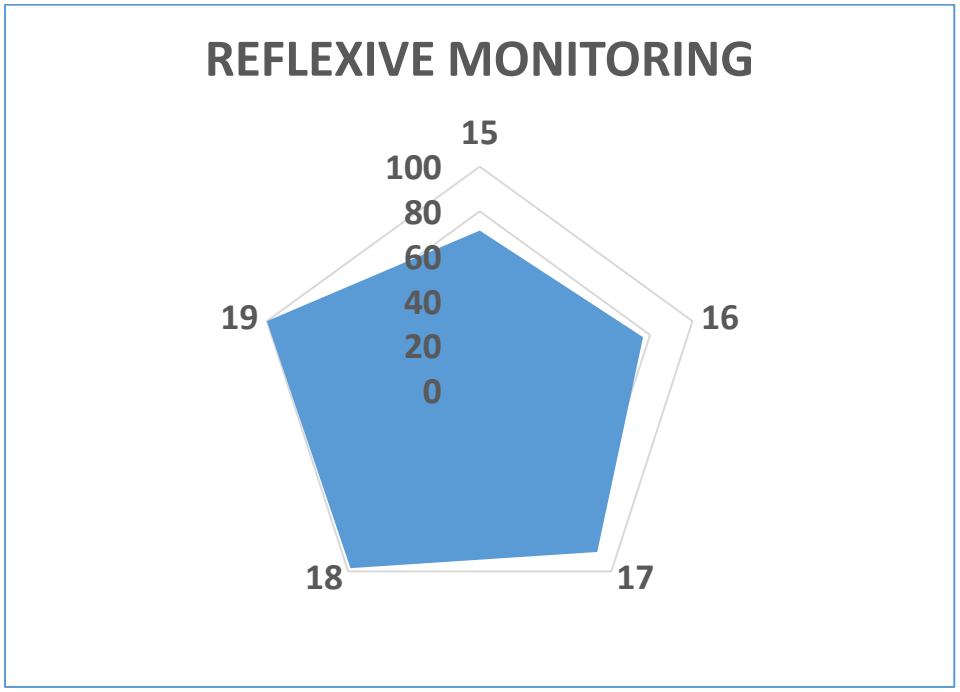
The importance of spreading involvement in the approach was highlighted by several practitioners.

> "To make a difference, the culture needs to change. Bridges needs to be rolled out to everyone." [Rehabilitation Assistant]

> "Would like to see this filter through to medical teams." [SLT]

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=56; agree 71%)
16 Staff in my team agree that the Bridges initiative is worthwhile (n=56; agree 77%)
17 I value the effects that the Bridges approach has had on my work (n=56; agree 89%)
18 Feedback about the Bridges initiative can be used to improve the approach in the future (n=55; agree 98%)
19 I can modify how I work with the Bridges approach (n=55; agree 100%)

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, 89% agreed with the statement 'I value the effects that Bridges has had on my work'. In the Champions Masterclass, participants observed that further time was necessary to embed changes to practice and then to audit and evaluate the impact of new processes and paperwork.

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.
- Practitioners questioned the level of resources and management support for sustaining the approach.
    - As Bridges training empowers practitioners to take forward quality improvement ideas, this needs to be backed up by leadership support that encourages staff to maximise their contribution to service development.
    - In particular staff need to understand processes of influencing both “out” and “up”, so that they are able to enlist senior sponsorship.
- 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	Bridges training gives 'permission' for staff to put patient back at the centre of care in the face of other service drivers *"Very relevant and has helped us as a team to review our working practices that have become often very 'tick box based', I feel that we all have the patients as our main focus but this is not always prioritised in our day-to-day work"* [Nurse]
Service structures	More collaborative team working perceived as necessary Bringing/keeping nursing staff on board
Staffing and resources	Exceptional demand Reduced staffing levels and low staff morale Staffing pressures impacted on engagement with training Senior staff support for quality improvement initiatives Finding time to come together and share learning

Table: Outer setting factors important for implementation

Outer setting	Description
Changing patient needs	More patients with long term conditions, need to encourage them to take more responsibility, important for them to have a sense of control when have lost so much
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 morale and retention Staff felt Bridges allowed them to refocus on their professional philosophies and values.

CONCLUSIONS: CONTEXT

- Practitioners felt that Bridges gave them 'permission' to revisit their professional core beliefs regarding person-centred care in the face of service demands.
- Service pressures can impact negatively on commitment to training and quality improvement activities. Leadership support is important to encourage staff to contribute to service development.

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 "very relevant" to their practice and it resonated with their intrinsic motivations for working in healthcare. Practitioners appreciated the time to discuss ideas in their team and to refocus on patients in the face of service pressures.
- Bridges SSM training was seen to validate service improvement work already underway and to promote adoption of a standardised approach to patient care. It also served to highlight "bad habits."
- 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. 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, 93% 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), and encouraging patient problem solving and reflection.
- Steps were underway to spread, embed and sustain changes, such as: using a variety of methods to share learning about the approach and to bring other team members on board, altering processes and paperwork, placing visual prompts in the environment (e.g. to manage expectations about 'therapy') and planning to audit/evaluate new resources.

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

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in enhanced interactions with patients and thereby increasing practitioner satisfaction through the provision of more meaningful and effective therapy.
- Bridges training makes quality improvement more accessible for staff by offering time to discuss and plan changes and by highlighting how small changes to practice can make a big difference to the patient experience. This may help to overcome feelings of disempowerment where staff feel that they are not able to contribute to practice development in the face of service pressures or have previously tried to make changes without success.

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 Bridges conversations with patients resulted in the establishment of "more meaningful goals" and therefore more relevant therapy. In turn, the latter in engenders greater engagement from patients, resulting in better outcomes and enhancing patient (and family) satisfaction, as well as reducing the potential for conflict.

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

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