PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME

EVALUATION REPORT

CASE STUDY FOUR: NORFOLK AND WAVENEY STP

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EXECUTIVE SUMMARY

Introduction

Norfolk and Waveney (N&W) Sustainability and Transformation Partnership (STP) was the fourth 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 December 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 training: 138 practitioners attended Knowledge Zone 1 (KZ1) and 122 attended KZ2. The Champions Masterclass was well attended with 20 of the 25 places on offer taken up.

Data available for inclusion in the evaluation comprised: 98 pre-training and 106 post-training questionnaires and 18+ hours of workshop observations.

Semi-structured telephone interviews were conducted with five practitioners, including Physiotherapist (3), Occupational Therapist (1) and Therapy Assistant (1). It did not prove possible to schedule interviews with nursing or HCA staff during the time frame of evaluation activities in the STP.

Stakeholder engagement

Awareness raising in N&W STP took place January to March 2019. The engagement process involved five trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. One trust, which had recently taken over responsibility for ESD services in the east of the region, did not participate.

The UEA evaluation team was able to assist the Bridges team with an introduction to a key contact in stroke services at one of the acute trusts. This individual was instrumental in helping Bridges to identify further important contacts at the other two acute trusts in the STP. Bridges staff conducted a series of separate engagement meetings and discovery interviews in this STP. "Staffing pressures" were consistently identified as a major challenge facing the service teams.

A team leader at one of the acute trusts indicated that staff shortages were a potential barrier to engagement in the training, especially for nursing and HCA staff. The transition of ESD services from this trust to another provider also proved to be problematic for engagement with the training. In the event, Bridges offered two smaller size workshops at this acute trust in a venue located near to the acute ward in order to facilitate attendance at the training. Staff from the ESD team did not engage and the non-allocated training places were therefore offered elsewhere in the STP.

A similar format of training workshops was offered to another acute trust, i.e. two smaller size workshops rather than one for 25 attendees. In addition, the local community team associated with this acute trust requested a separate workshop as they were intending to use the Bridges training to support the development of their annual plan.

Another ESD and community service was in the process of reviewing their goal setting approach and perceived that the Bridges training would contribute positively to this. In this case, the training workshops were held in conjunction with staff from acute services.

During the engagement process, a number of questions were raised about the possible overlap of Bridges with Health Coaching. Bridges addressed this issue by adding commentary to their Frequently Asked Questions highlighting the similarities and differences between the two approaches. A concomitant commitment to Health Coaching did not act as a barrier to engagement with Bridges in this STP.

Engagement with former service users was not undertaken in this STP as analysis of data from focus group discussions conducted in the three previous 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 very "thought provoking" 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.
- As practitioners use the Bridges approach more in their practice it becomes part of their routine skill set, rather than something that needs to be consciously thought through.
- There were examples of practitioners extending use of the approach to other patient groups, e.g. patients and families in end-of-life care situations.
- 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), 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 (and other services) 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. Practitioners report increased satisfaction through the provision of more meaningful and effective therapy.
- Bridges training makes quality improvement more accessible for staff by demonstrating how small changes to practice can have an important impact on both patient and staff satisfaction.
- It was hoped that greater involvement of patients and families in the rehabilitation process, coupled with the experience of more personalised therapy, would lead to a reduction in disagreements between patients and families and staff over the management of care.

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.
- In the workshops and interviews, 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. Patients enjoyed being involved more in goal setting and planning for discharge and appreciated the tailoring of therapy to their individual interests or wishes.
- It was anticipated that using the Bridges approach will promote greater patient satisfaction and better outcomes.

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 FOUR: NORFOLK AND WAVENEY STP

The following presents a summary of evaluation results for the Norfolk and Waveney (N&W) Sustainability and Transformation Partnership (STP), the fourth 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 N&W STP.

Table: N&W Bridges SSM programme timeline

Stage	Timeline
Stage 1: Awareness Raising	January – March 2019
Stage 2: Stakeholder Engagement (former service users)	No activity in this STP
Stage 3: Knowledge Zone 1	May – July 2019
Stage 4: "Transforming"	June - October 2019
Stage 5: Knowledge Zone 2	September – October 2019
Stage 6: Champions Masterclass	December 2019
Stage 7: Sustainability plans	From December 2019

STAKEHOLDER ENGAGEMENT

Trust engagement

Awareness raising in N&W STP began in January 2019. The engagement process involved five trusts across the STP providing acute, Early Supported Discharge (ESD) and community services. One of the trusts, which had recently taken over responsibility for ESD services in the eastern part of the region, did not engage with the Bridges training initiative.

The UEA evaluation team was able to assist the Bridges team with an introduction to a personal contact in one of the acute services in the STP. This individual was instrumental in identifying key contacts for Bridges at the other two acute trusts in the STP.

Bridges staff conducted a series of separate engagement meetings and discovery interviews in this STP. "Staffing pressures" were consistently identified as a major challenge facing the service teams.

During engagement activities at one acute trust, the team lead raised staffing shortages as a potential barrier to participation in the training, together with concerns about the likely success of bringing nursing and HCA staff on board with the initiative, and the transition of ESD services to another provider. In order to facilitate attendance at the training, Bridges offered two smaller size workshops at this acute trust in a venue located near to the acute ward. The ESD team (which had moved to a new provider) did not engage and the non-allocated training places were therefore offered elsewhere in the region.

A similar format of training workshops was offered to another acute trust, i.e. two smaller size workshops rather than one for 25 attendees. The comment below exemplifies the situation with regard to engaging ward staff in the Bridges training programme.

> *"It's really easy to get therapists onto these training days, it's very, very difficult to get nurses on, because they are rostered on to the ward, they physically cannot get off the ward … so for them it has to be useful for their practice."* [PT Lead]

In the above case the local community team requested separate workshops to the acute services, as they were intending to use the Bridges training to support the development of their annual plan. Another community service in the STP was in the process of reviewing their goal setting approach and perceived that the Bridges training would contribute positively to this.

During the engagement process, a number of questions were raised about the possible overlap of Bridges with Health Coaching. Bridges addressed this issue by adding commentary to their Frequently Asked Questions highlighting the similarities and differences between the two approaches. A concomitant commitment to Health Coaching did not act as a barrier to engagement with Bridges in this STP.

> *"I would rather engage than not engage and my feeling is the more training you get on goal setting, coaching a patient, motivating them, the better … We had some Health Coaching days set up anyway around the time of the Bridges training and initially we said 'we'll just do one and not the other' but actually what came out was probably you need to do both, because it reinforces that fact that you need the patient to have their own voice and find their own solutions, build their own self-efficacy and coping strategies and then you'll have a much better outcome for that patient."* [PT Lead]

Engagement with former service users regarding life after stroke and experiences of rehabilitation was not undertaken in this STP. The findings from focus group discussions conducted in the three previous case studies were in line with those emerging from work undertaken by Bridges and other research teams suggesting that no new insights were likely to result from further activity.

CONCLUSIONS: TRUST ENGAGEMENT

- The UEA evaluation team was able to assist Bridges in the trust engagement process through an introduction to a key local contact in acute services.
- One ESD team was in the process of transitioning to a new provider and did not take part in the Bridges programme.
- "Staffing pressures" were consistently identified as a major challenge facing the teams.
- Bridges offered smaller size workshops at two acute trusts in order to facilitate attendance at the training by nursing and HCA staff.
- The Bridges training was timely for two community service teams: in one case to contribute to the development of the annual plan and in the other to contribute to a review of goal setting.
- A commitment to Health Coaching did not act as a barrier to engagement with Bridges SSM.
- 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

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 125 training places on offer.

Bridges ran a higher number of workshops in this STP. Smaller scale workshops were offered to two acute trusts in order to facilitate attendance at the training. A separate workshop was conducted for one community team that wished to use the Bridges training to support the development of their annual plan.

Twenty practitioners attended the Bridges Champions Masterclass in December 2019 (where 25 places were on offer). Representatives from one acute trust were unable to attend, but indicated that they would like to attend the Masterclass in another STP.

Table: Attendees at Bridges SSM workshops

Workshops	Timing	# attendees	# eligible for evaluation
Knowledge Zone 1 (n=8)	May – July 2019	138	137*
Knowledge Zone 2 (n=8)	Sept – Oct 2019	122	121*

** 1 individual from charity excluded from evaluation as charity not included in governance approval process*

No medical staff attended the training and feedback from practitioners signalled that it would be good to look at mechanisms to secure the buy-in of medical staff to the Bridges approach. It was felt that this would aid subsequent implementation.

> *"On presentation of the training, make it clear to invite doctors or consultants as their say may be helpful in implementing change."* [PT]

> *"The training was delivered to 'the converted' so we need to think how we can roll it out to the medical team members."* [Psychology Practitioner]

The response rate to evaluation questionnaires was good (see table below), although it did not prove possible to administer the questionnaires at one of the KZ1 workshops.

Table: Number of evaluation questionnaires and response rates

Questionnaire	Number	Response rate
Knowledge Zone 1 – Pre-training	98*/137	72%
Knowledge Zone 1 – Post-training	91*/137	66%
Knowledge Zone 2 – Post-implementation	106/121	88%

***** *Evaluation questionnaires were not distributed at one KZ1 workshop*

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

Table: Characteristics of participants in Bridges SSSM training

Participant characteristics	KZ1		KZ2	
Profession	**Number**	**%**	**Number**	**%**
Nurse	16	16.3	17	16.0
OT	19	19.4	19	17.9
PT	20	20.4	24	22.6
SLT	8	8.2	9	8.5
Psychology Practitioner	3	3.1	2	1.9
Rehabilitation/Healthcare Assistant	25	25.5	31	29.2
Other (e.g. dietician)	4	4.0	3	2.8
Missing	3	3.1	1	0.9
Total	98	100.0	106	100.0
Setting	**Number**	**%**	**Number**	**%**
Acute	31	31.6	35	33.0
Community	50	51.0	58	54.7
Both	15	15.3	13	12.3
Missing	2	2.0	0	0.0
Total	98	100.0	106	100.0
	Mean (SD)	**Range**	**Mean (SD)**	**Range**
Years in profession	13 (9)	<1-36	12 (9)	1-36
Years in service	7 (6)	<1-30	7 (6)	1-31

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

Five semi-structured interviews with practitioners took place following KZ2. The interviews were conducted by telephone and lasted an average of 30 minutes. The characteristics of the participants are described in the table below. Despite an initial willingness to take part expressed by some individuals, it did not prove possible to schedule telephone interviews with nursing or HCA staff during the time frame of evaluation activities in the N&W STP.

Table: Participants in semi-structured interviews

Interview participants	Number
Manager	-
Nurse	-
OT	1
PT	3
Therapy Assistant	1
SLT	-
Psychology Practitioner	-
Acute	4
Community	1
Years in profession (mean)	17
Years in service (mean)	12

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 61 comments about the Bridges training were coded as positive, with practitioners describing the training as engaging and thought provoking. The use of the 'patient voice' was particularly appreciated and Bridges was seen to offer practical ideas that could be readily incorporated into routine practice. There were 26 comments that were coded as neutral, including 23 instances where no comments were offered.

The small number of negative comments were concerned with the lack of involvement of medical staff in the training, concern about available time for implementation or how Bridges techniques related to specific job roles, and around use of the approach with patients with cognitive and communication deficits.

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

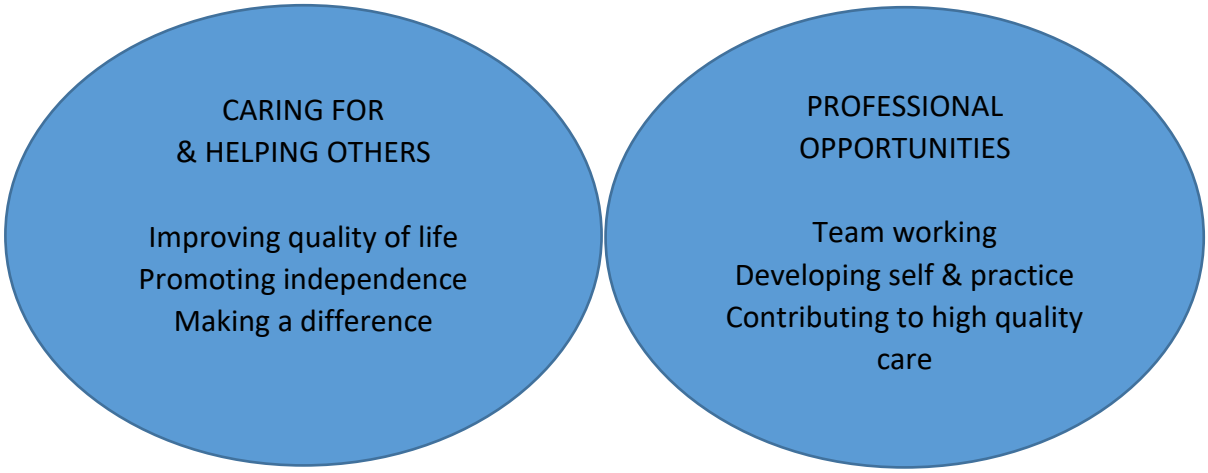
Feedback	Number*	Illustrative participant comment
	61	• Very engaging and informative session, lots of ideas and information I plan to carry over into my practice, it was really good to hear from a patient and their views and experiences [PT] • Engaging session, enjoyed opportunities to discuss Bridges principles with colleagues and what changes we can begin to implement [Rehabilitation Assistant] • Fabulous day, thought provoking, equipping us with the tools to enable our patients achieve objectives that are important to them, small steps-based practice and the concept of Bridges is amazing, I find it fascinating and wish I had heard about it sooner [Nurse] • Challenges current and ingrained thinking, I can change my way of working easily to accommodate this initiative [Rehabilitation Assistant] • This is my first experience of Bridges and I am really impressed, the approach feels right for both patient empowerment and therapist job satisfaction, the content was well-delivered and really tailored [SLT] • What a wonderful training session, very thought provoking and certainly gives me food for thought on my approach with patients, and how I have "slipped" into certain habits through the years, and stopped utilising some skills which I know are in there [PT]
	26	• No comments [23] • Passionate about goal setting, but Bridges initiative very similar to a lot of other goal setting/patient-centred training I have been on [PT] • Would like more examples of what other teams have done [OT]
	9	• I have a huge concern regarding availability of time to practise Bridges and make changes [Nurse] • It's very language based, so presents a challenge to make it more acceptable for people with limited understanding of language [SLT] • Could may be relate it more to other roles than a primary therapist point of view [HCA]

		• More HCAs, nursing staff and medical staff involvement, I was the only RN and no HCAs or doctors were present [Nurse] • It would have been useful to have a little more info on how to apply the principles with aphasic/cognitive patients [PT]

**Some participants offered more than one comment*

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

Diagram: Intrinsic motivations for working in healthcare



Practitioners were very positive when asked at the end of KZ1 whether they felt Bridges SSM would bring them closer to their professional ideals (93% agreed). At the end of KZ2, 92% 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=95)	81%	19%	0%
Bridges SSM approach will bring you closer to ideals? (n=95)	93%	6%	1%
Bridges SSM approach has brought you closer to ideals? (n=106)	92%	8%	0%
Find work enjoyable	**Positive**	**Neutral**	**Negative**
Pre-KZ1 (n=98)	89%	11%	0%
Post-KZ2 (n=106)	90%	10%	0%

CONCLUSIONS: REACTION

- There was good take up of the training places on offer: 138 practitioners attended KZ1 and 122 attended KZ2. 20 of the 25 places on offer at Bridges Champions Masterclass were taken up. Bridges offered 2 x smaller scale workshops at two acute trusts in order to facilitate attendance at the training.
- Practitioners responded positively to Bridges SSM training, valuing 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 if representatives from the medical team attended training to facilitate incorporation of the approach in the MDT.
- 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.

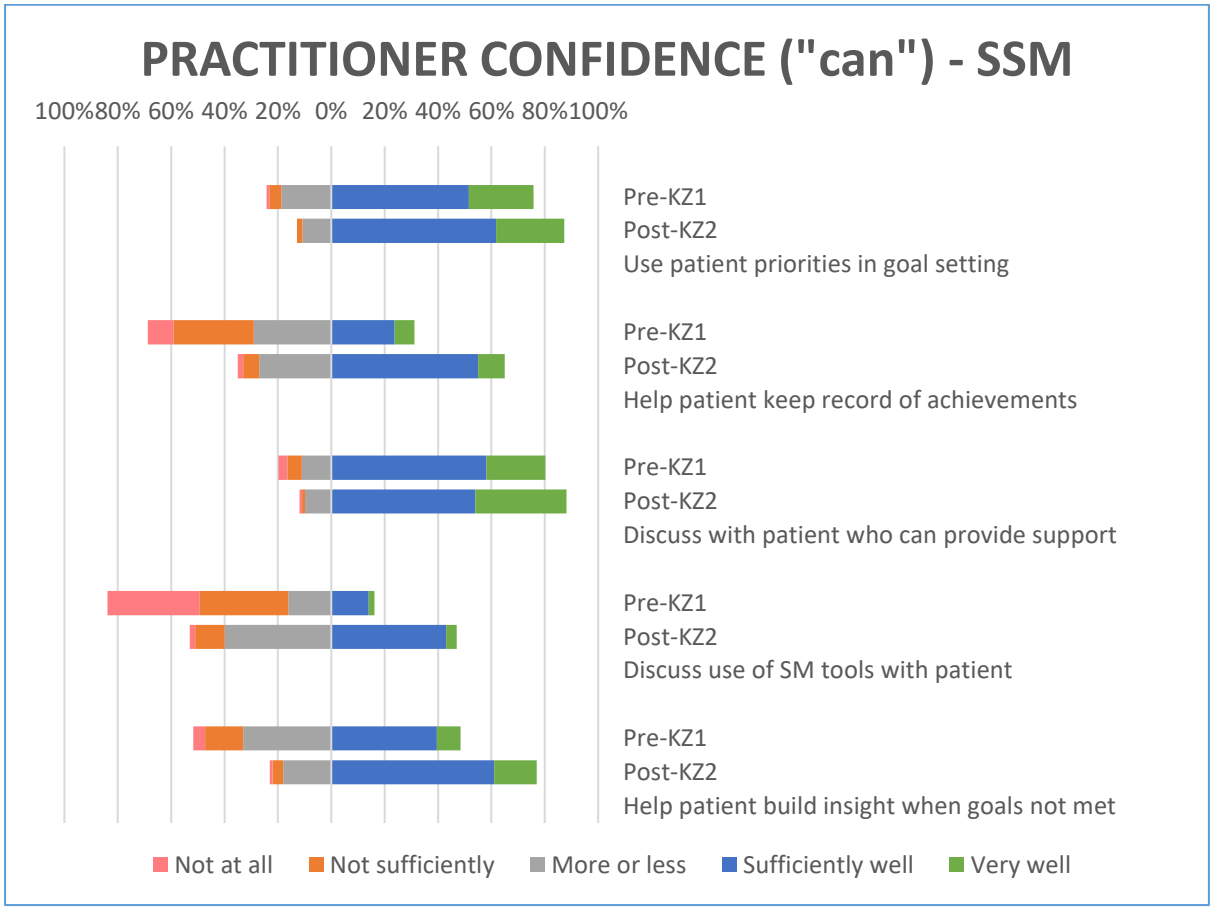
The five SSM tasks selected for presentation here are related to goal setting, patient reflection, accessing daily support, using SM devices and developing insight. These tasks were selected as they represent areas where practitioners indicated they intended to make changes to practice.

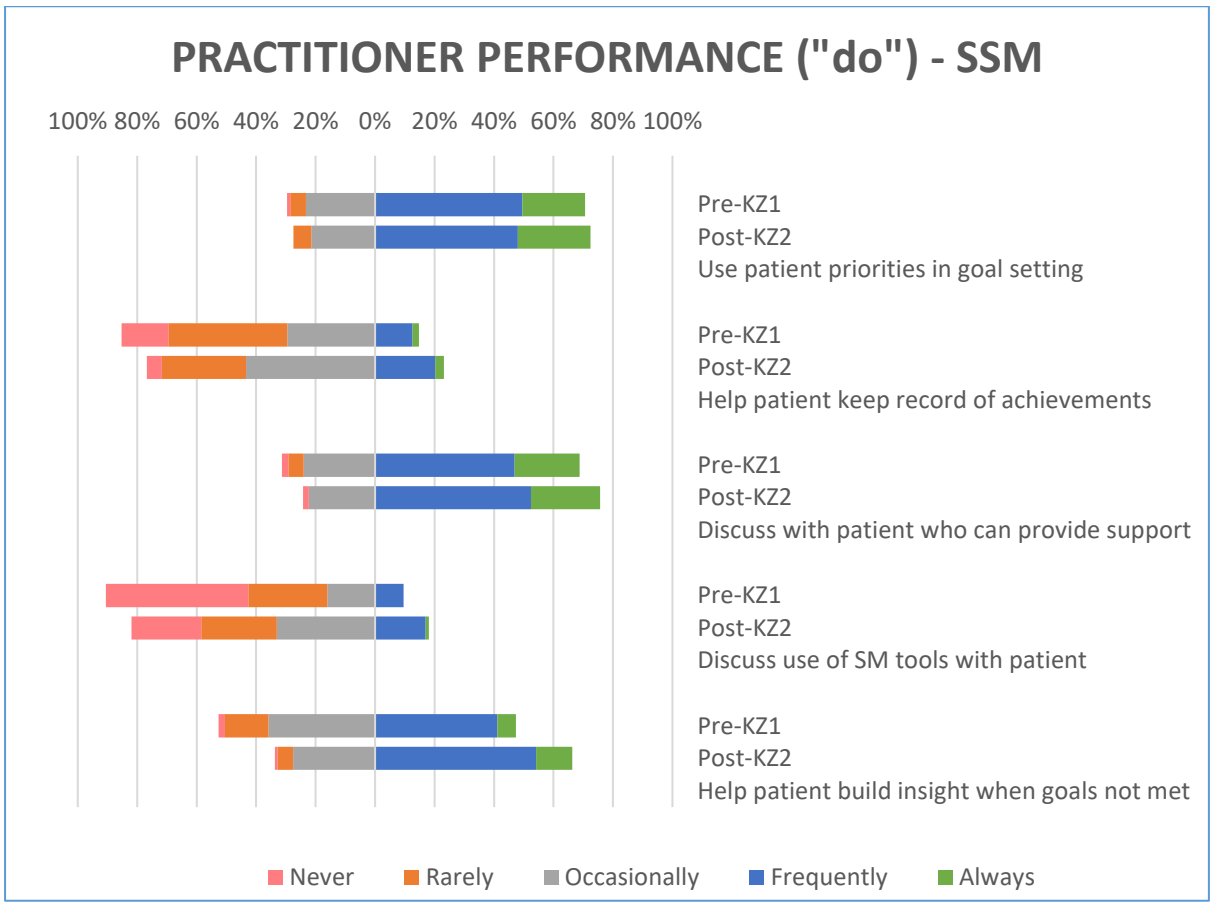
Goal setting	Allow the person to determine their own priorities when developing goals
Reflection	Assist the person to keep their own record of goals and achievements
Support	Discuss with the person who can provide daily support (e.g. family & friends)
SM devices	Discuss with the person how they can make 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 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.

The following quote illustrates how change to behaviour does not come automatically - how practitioners need time to consolidate the Bridges approach in their practice so that the skills become part of their routine without being consciously thought through.

> *"I think it's having more confidence with the tool, because it becomes more natural. So when I had my very early on conversations with Bridges it felt quite slow and I was really having to think quite hard on my feet, whereas yesterday doing this "to do list" [with aphasic patient] it almost came quite naturally. I think the more you use the model, it becomes more of your natural everyday questioning. So I think the more you use it the better."* [OT]

> *"It becomes more fluent as you do it more. When you are having to stop and think about what you are saying may be it takes a marginal increase in length of time, but not significant."* [PT Lead]

In certain circumstances, practitioners can feel that they are stepping out of their comfort zone when using the approach (see next section on Behaviour) and it can take time to develop confidence in this regard.

> *"At the end of sessions historically I said 'oh that was really good, well done" whereas I'm having to consciously go 'how do you think that went' or 'what would you do next time' and it's been really valuable actually getting their feedback … and only yesterday I did not have to think about 'oh I need to think about my self-management questions', I felt myself automatically going with the patient 'well what do you need to do in order to go home' and then I sat there thinking it's becoming more automatic and natural in my practice instead of me having to consciously think about it so much."* [OT]

In the follow-up workshops, practitioners reported being able to use the Bridges language more readily and with greater confidence. In the Champions Masterclass, members of one community team reported using the Bridges approach to structure communications with family members and patients in situations of end-of-life care, reflecting growing confidence to utilise the toolkit. Therapists in one acute team reported providing Bridges training to their orthopaedics department, perceiving the approach to be pertinent for this service.

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 refine changes to practice and to consolidate confidence in the approach.
- As practitioners use the approach more in their practice it becomes part of their routine skill set, rather than something that needs to be consciously thought through.
- The usefulness of the Bridges approach was perceived to extend beyond stroke and neurological services, e.g. end-of-life care and orthopaedics.

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
Getting to Know You	• Finding out more about the patient, their story, their interests, what is important to them, their fears and worries • Listening to patients • Developing Getting to Know You\This is Me booklets
Goal setting	• What is important to patient as the focus • Using fears and unacceptable outcomes in goal setting process • Breaking down goals into small steps and using patient "to do" lists • Allowing patients to set priorities in therapy sessions
Problem solving and reflection	• Encouraging patient to problem solve – ask what works, what have you tried • Supporting failure to build insight • Using self-rating scales
Paperwork and processes	• Using prompt sheet of Bridges catch phrases & core SM skills diagram • Changing assessment forms, goal sheets and discharge letters • Earlier focus on patient thickening own drinks & self-medication • More joint working – nurses, HCAs and therapists • Sharing information about changes in MDT • 'Bridging' family members to manage expectations • Visual resources on ward, e.g. 'expectations' poster • Regular 'welcome meeting' for patients and families on inpatient rehab ward • Training and supporting other staff, e.g. bank/agency, new staff • Collecting feedback from patients and family, other services, e.g. ESD

Feedback from practitioners in the workshops and at the Champions Masterclass indicated that they felt their language prior to the Bridges training was often not empowering for patients and that goal setting was very much therapist-led and 'separate' (i.e. PT, OT, SLT working in an individualised way with patients). In the quotes below a Physiotherapist and a Therapy Assistant reflect on how changing language can alter the delivery of care, with the Bridges language providing a consistent framework for staff.

> *"My team leader said 'I've never seen training produce a change in a team so quickly', which I think is lovely feedback … the language element for us was probably the stand out thing … asking those open questions … not just saying 'well done' all the time … As a staff group we've felt quite a big change and in our morning handovers somebody will interject 'I Bridged them' and we all know what that means and what they are trying to achieve by it."* [PT]

> *"We'll be mobilising someone, for instance, and say 'you're doing really well', but the patient doesn't think that … and I thought oh God, we say this all the time but they don't perceive that. So I've tried to change that to 'how do you feel that went?' to see what they feel about it and how it can be improved on."* [Therapy Assistant]

Practitioners reported stepping back as a result of the Bridges training and allowing patients to try things, an approach that can initially feel like stepping out of a "comfort zone."

> *"Very soon after our first Bridges workshop I had a very challenging patient and historically I would have said 'it's not safe for you to have a shower at the moment' … the transfers were very risky … but using my tool I said 'how do you think you are going to get on?' and the patient said 'I'm going to give it a go' and at the end I asked the patient 'how do you think that went?' and they said 'that bit was really good, but that was a bit dodgy' … but they felt it went really well and the next day I let them do it again … and they were really happy."* [OT]

> *"I think the 'give it a go' was one of the big phrases that stood out for me. Just try it, as long as it's not going to cause them harm, have a go as a discovery mission for both you and the patient. When I get people out of bed we normally do the rollover and push up from the side line technique and I would usually be quite a perfectionist and careful about that, but I've been a little bit more 'ok can you roll on your side and have a go at getting up' and actually see how they do it and as long as it doesn't look awful I let it go."* [PT]

At the Champions Masterclass, one acute team reported that the Bridges approach was being used to support behaviour change around thickening of drinks, medication assessments, choice of clothing and continence. Encouraging patients to take responsibility for thickening their own drinks and to self-medicate allowed them to practise in preparation for discharge. Offering choice over clothing and following the patients' previous approach to continence issues was felt to encourage a greater sense of self and normality for patients.

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, especially for nurses and HCAs
Patient characteristics and readiness	- How to approach the high expectations that some patients have - Push back from some patients – "you are the expert" - 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
Context	- Service demands and pressure to get patients through the system - Staffing levels and staff morale - Balancing risk and clinical requirements with what is important to the patient

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=95)	68%	26%	6%
KZ2 (n=103)	65%	26%	9%

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

Workshop	Agree	Neutral	Disagree
KZ1 (n=95)	85%	11%	4%
KZ2 (n=103)	72%	15%	13%

The following quotations from interviews with practitioners offer reflections on the issues of using Bridges with complex patients and when under time pressure. While the difficulties of these situations were acknowledged, it was nevertheless felt that Bridges approach could be successfully employed.

> "*A patient I saw yesterday has got severe receptive and expressive aphasia, however the 'to do list' was a really useful tool to do with them so that they can clearly see what steps we need to do in order to leave hospital and that to do list came into our planning meeting yesterday so the family could clearly see where we were up to … and what they've got to do in order for the patient to come home .. and I think the patient really enjoyed making that to do list, they really felt part of making that plan to get home … and that helps our rapport and relationship."* [OT]

> *"I think because as therapists we kind of naturally get it, we naturally understand the technique … it's been easier for us to go forward with it. I think for the nursing staff they are finding it a bit more of a challenge and I know time is their biggest bug bear. I think it's also*

the time to remember to actually do it and to have the time to think about the approach they're going to take rather than just do instinctively what they've always done." [PT]

"I don't see how it could take more time … we're quite fortunate as therapists to perhaps have more time than may be nursing staff … I haven't found that implementing any of the Bridges training has taken more time." [Therapy Assistant]

"There will always be time pressures. However, with patients such as ours [frail, elderly], if you don't take the time, they'll become very, very stuck … you have to have a mechanism for engaging with them otherwise you literally cannot move them on and it's not good for them and it's certainly not good for you … The most important thing about Bridges is changing the focus, being more patient-focused … and the more in tune you are with that person's goals, the more you can work together and your rehabilitation should be more effective." [PT Lead]

CONCLUSIONS: BEHAVIOUR

- Practitioners were motivated to make changes to their practice as a result of Bridges training, including: adapting language, the structure of interactions with patients, goal setting approach, encouraging patient reflection and problem solving, altering paperwork and processes to embed SSM.
- By making changes to practice practitioners were able to identify benefits to using the approach, such as 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.
- Nursing and HCA staff may need further support to introduce and consolidate changes.

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	- Encourages recognition of patients' personality and character – a better sense of the individual - More collaborative and less prescriptive treatment, partnership working - Great 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, building patient awareness of what is needed to go home, being part of the process, sharing responsibility
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 - Shared planning for discharge, 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 - Potential to reduce conflict with patients and family about therapy and discharge - Contributing to team cohesion

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

> *"I think it's helped their awareness of what is needed for them to go home, but also … the self-discovery and them problem solving things they're struggling with … have a go and then reflect on it. It may not be the perfect way a therapist would suggest, but they've had a go at doing it and they've kind of got ownership of how they've managed to do that certain activity or certain transfer."* [OT]

> *"I think there's lots of benefits in terms of making us more relaxed as a team and a little more conversant about what is important, so I think we're doing a little bit more chatting about not just how do they get out of bed, how do they walk, but actually what they feel is really important and the personal conversations you're having … a little bit more sharing of that."* [PT]

> *"The patient really felt part of making that plan to get him home … it was really nice to see him almost enjoying the process and knowing what's next … and that really helps our rapport and relationship. And then using that tool ["to do list"] later with the family, they can see that I'd really tried to listen to what he wanted and shared responsibility for discharge planning."* [OT]

Practitioners commented that finding out more about the person allowed them to tailor therapy more appropriately and creatively, thus making it more enjoyable for both parties.

"I feel I really get to know the patient as they were before their stroke and I can try and tailor their therapy to things they really enjoy. It has made therapy a bit more creative and I think people have really enjoyed that. The other day someone really enjoyed fishing, so we were trying to do some upper limb rehab with a walking stick pretending we were going to reach for a fishing rod and the patient really enjoyed that and if we hadn't done the 'Getting to Know You' booklet I wouldn't have known that about the patient and therapy might not have been fun for them." [OT]

As in the other case studies for this evaluation, there were instances of using the Bridges approach successfully with patients who were originally considered "unBridgeable" or "lacking rehab potential." The approach was also found to be helpful in structuring communications with families and patients in situations of end-of-life care.

The following quote from a presentation at the Champions Masterclass summarises the perceived benefit of the Bridges approach by members of a team on an acute stroke ward.

"W*e have realised that relatively small changes to the way we work can have a big impact on both patient and staff satisfaction. However a lot of effort is required to make those relatively small changes, and keep them going."* [Acute stroke team]

CONCLUSIONS: RESULTS

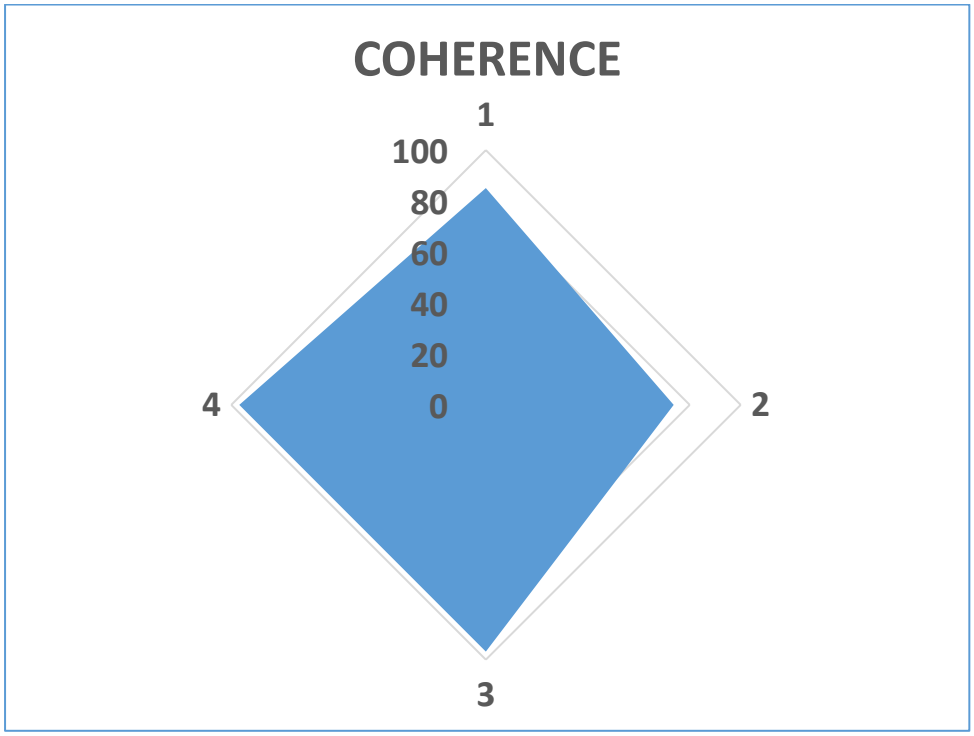
- Bridges was perceived to facilitate enhanced interactions with patients, leading to more meaningful therapy and increased motivation of patients.
- Using the Bridges approach has the potential to increase patients' and families' understanding and experience of the rehabilitation process and contribute to improved satisfaction.
- 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.
- It was hoped that greater involvement of patients and families in the rehabilitation process, coupled with the experience of more personalised therapy, would lead to a reduction in disagreements between patients and families and staff over the management of care.
- Bridges was seen to have wider applicability than stroke and neurological rehabilitation (e.g. in end-of-life care and orthopaedics).

Implementation assessment and sustainability

In the following section, each of the four constructs of NPT is 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. In each case, there was strong agreement (>74%) 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=94; agree 85%)
2 I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative (n=95; agree 74%)
3 I can understand how the Bridges initiative will affect the nature of my own work (n=95; agree 97%)
4 I can see the potential value of the Bridges initiative for my work (n=95; agree 97%)

For some practitioners the Bridges approach resonates very much with their professional training and while this can engender a feeling of 'we do this already', it was also readily acknowledged that there is always room for improvement and that it is easy to slip into "bad habits" or forget to employ certain skills. Bridges training offers tips and techniques to refine and enhance a good baseline of person-centred care. As previously indicated, it was felt that enhancing the awareness of the approach among medical staff would contribute positively to the implementation process.

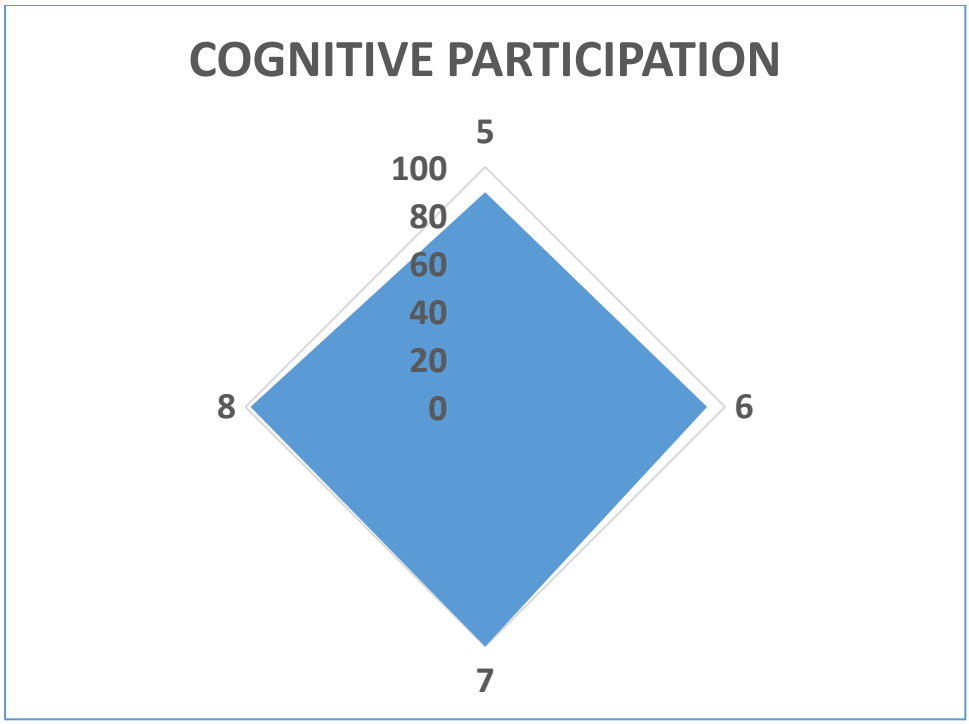
> *"We like to think we work, gel very well as a team, but we can always do much better. So I think for some people, they were a little bit sceptical about how it might work … but they came out [of the training] feeling much more positive."* [PT Lead]

"I thought this is what I learnt years ago [in nurse training before Project 2000] and what I try to put into practice all the time even now. I didn't find it ground breaking but I took some small ways of thinking differently about things … I try to give good care and give people time and listen to people … and I can see the Bridges training has those values at its core, but I strongly believe that everyone should be doing that anyway." [Therapy Assistant]

"It's not that far apart [from our practice] but it gives more theory and back-up to what we were doing." [PT Lead]

Cognitive Participation

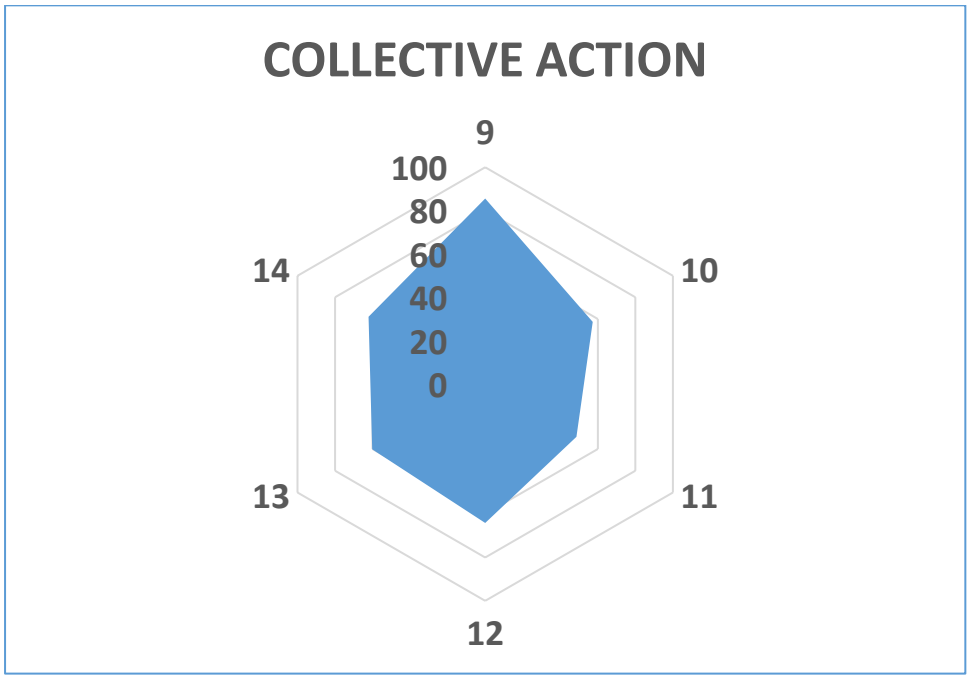
Cognitive participation relates to the degree of engagement with Bridges in order to build and sustain a community of practice around this approach to SSM. Responses to these implementation assessment questions were very positive.



5 I think there are key people who will drive the Bridges initiative forward (n=95; agree 90%)
6 I believe that participating in the Bridges initiative is a legitimate part of my role (n=94; agree 93%)
7 I am open to working with colleagues in new ways to use the Bridges initiative (n=95; agree 100%)
8 I will work to support the Bridges initiative (n=95; agree 98%)

Collective Action

Collective action relates to the work that individuals do to enable the intervention, either as individuals or in groups. Around 86% of practitioners agreed that Bridges could be easily integrated into their work. Responses were less positive with regard to confidence in other people's ability to use Bridges (57% in agreement) and whether all team members were working to support the Bridges approach (49% in agreement).



9 I can easily integrate the Bridges approach into my existing work (n=104; agree 86%)
10 I have confidence in other people's ability to use the Bridges approach (n=103; agree 57%)
11 All members of my team work to support the Bridges approach (n=103; agree 49%)
12 Sufficient training is provided to enable staff to implement the Bridges approach (n=103; agree 64%)
13 Sufficient resources are available to support the Bridges initiative (n=103; agree 60%)
14 Management adequately supports the Bridges initiative (n=103; agree 62%)

The following quote illustrates the contrasting situations that can be encountered when practitioners endeavour to implement changes to practice. The 'signal value' of team leads demonstrating their support for initiatives is important for maintaining enthusiasm and commitment to the change process.

> *"Our team leader is hugely open to this sort of thing and loves to see change happening. She has been really supportive of all the things that we've been working on … For our nursing staff … I don't think there has been very much steering of it [Bridges implementation] and I think that for some of them [nurses], unless they see a change higher up, they don't change, and that's some of the feedback I have had, unless it has got senior steerage it won't change. But we as a therapy group have been highly supported."* [PT]

Some teams were creatively seeking solutions to the challenge of practitioners finding the time to work on their implementation ideas following the training, as evidenced by the quote below from a member of an acute service team.

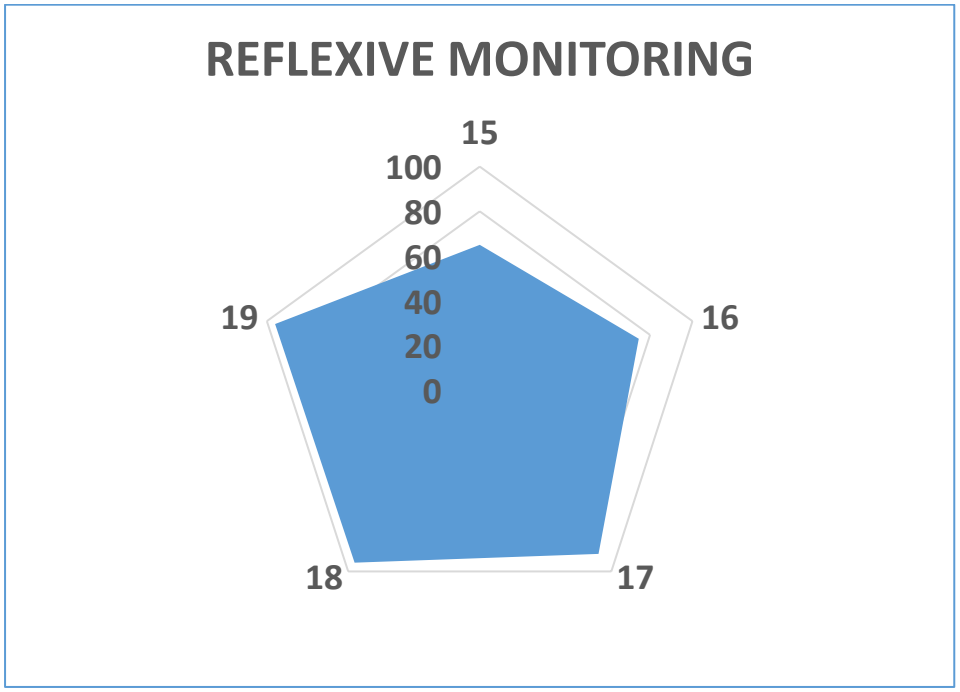
> *"We [therapy team] have specific times set aside for training and we came up with the idea that we would let the nursing staff have that time and staff the ward for that time, so swap it round so that the nurses and HCAs had a time set aside where they could leave the ward."* [Therapy Assistant]

As previously indicated, it was felt that it would take time to ensure that practitioners were confident with using the new approach and also to ensure that the approach was appropriately cascaded throughout the wider teams. In particular, changing language with patients needed to be part of an ongoing process with staff encouraged to put on their "rehab hat" (as opposed to their "acute hat") more frequently as patients move through their recovery journey.

> *"It is a good initiative but it will take a while to involve all who need to be and empower them to take part."* [Nurse]

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=103; agree 65%)
16 Staff in my team agree that the Bridges initiative is worthwhile (n=103; agree 75%)
17 I value the effects that the Bridges approach has had on my work (n=103; agree 90%)
18 Feedback about the Bridges initiative can be used to improve the approach in the future (n=103; agree 95%)
19 I can modify how I work with the Bridges approach (n=103; agree 96%)

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, 90% agreed with the statement 'I value the effects that Bridges has had on my work'. At the Bridges Champions Masterclass, teams described plans to audit and/or gain feedback on the changes they were introducing in order to compile more formal evaluation reports on their initiatives.

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. The 'signal value' of team leaders demonstrating their active support for staff as they endeavour to introduce changes to practice is important for sustaining enthusiasm and motivation.
- 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	Timing of Bridges training complements other ongoing projects, e.g. Health Coaching training and review of goal setting; formulation of annual plan Pressure to process patients through the system. Bridges training brings the focus back to the patient and what they want *"One of the biggest challenges is time … as an acute hospital there is so much pressure to get people moving."* [OT]
Service structures	More collaborative team working perceived as necessary Bringing/keeping nursing and HCA staff on board Organisational change can impact engagement with training and QI activities, e.g. transitioning between service providers
Staffing and resources	Staffing levels – below that recommended in National Guidelines, staffing pressures impacted on engagement with training and consistently mentioned as major challenge of service teams 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
Professional cultures	Challenging "old school" expert-led approaches to patient care
Risk culture	Societal attitudes to risk and health and safety concerns can impact acceptance of focus on patient-led goals Therapists as 'risk takers' – stepping out of comfort zone and allowing patients to 'have a go' *"Bridges is based in an ideal world, but in the real world it is hard to embed some of these changes when understaffing and litigation fears emphasise risk assessments and safety checks over open conversations."* [Nurse]
NHS workforce	Staff morale and retention, stable teams versus high turnover, use of agency staff Staff felt Bridges allowed them to reconnect with their professional philosophies and values

CONCLUSIONS: CONTEXT

- Practitioners felt that the Bridges approach bring the focus back to the patient and their specific needs and wishes.
- Service pressures and organisational changes 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 "thought provoking" 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.
- As practitioners use the Bridges approach more in their practice it becomes part of their routine skill set, rather than something that needs to be consciously thought through.
- There were examples of practitioners extending use of the approach to other patient groups, e.g. patients and families in end-of-life care situations.
- 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), 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.

CONCLUSIONS

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

- Bridges motivates practitioners to reinvigorate their clinical practice, resulting in enhanced interactions with patients and thereby increasing practitioner satisfaction through the provision of more meaningful and effective therapy.
- Bridges training makes quality improvement more accessible for ground floor staff by offering time to discuss and plan changes and by highlighting how small changes to practice can make a big difference to patient (& professional) experience.
- It was hoped that greater involvement of patients and families in the rehabilitation process, coupled with the experience of more personalised therapy, would lead to a reduction in disagreements between patients and families and staff over the management of care.

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.
- In the workshops and interviews, 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. Patients enjoyed being involved more in goal setting and planning for discharge and appreciated the tailoring of therapy to their individual interests or wishes.
- It was anticipated that using the Bridges approach will promote greater patient satisfaction and better outcomes.

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.