PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME

East of England

EVALUATION REPORT

for

Health Education England

CASE STUDY TWO: NORTH EAST ESSEX AND SUFFOLK STP

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Acknowledgements

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

North East Essex and Suffolk (NEES) Sustainability and Transformation Partnership (STP) was the second of six East of England STPs to participate in the Bridges Supported Self-Management (SSM) training and quality improvement programme.

The timeline of the Bridges programme and evaluation was November 2018 to September 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 not complete take-up of the 125 training places on offer: 101 practitioners attended Knowledge Zone 1 (KZ1) and 96 attended Knowledge Zone 2 (KZ2). Only 10 of the 25 places on offer in the Bridges Champions Masterclass were taken up.

Data available for inclusion in the evaluation comprised: 81 pre-training and 63 post-training questionnaires and 30+ hours of workshop observations. Representatives from trusts and from third party providers where the evaluation team had not pursued governance approval were excluded from data collection.

Semi-structured telephone interviews were conducted with three practitioners, including Physiotherapist (1), Occupational Therapist (1), and Psychology Practitioner (1). While a number of other practitioners had indicated 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, two focus group discussions were conducted with former service users exploring life after stroke and Acquired Brain Injury (ABI) and experiences of rehabilitation.

Stakeholder engagement

The trust engagement process in NEES STP took only six weeks and was facilitated by the fact that some key contacts had been previously trained in the Bridges approach and came on board quickly. Two trusts representing four organisations covering acute, Early Supported Discharge (ESD) and community services took part in the Bridges programme. Representatives from third party providers also took part in the workshops.

Two trusts declined to participate in the Bridges programme citing winter pressures, staffing levels and a commitment to Health Coaching as reasons for non-participation. They did, however, send some observers to the Bridges workshops.

The importance of the Bridges team engendering enthusiasm for the training from the 'ground floor up' was indicated. The fact that Bridges training has not been requested by staff, coupled with a feeling of 'we do this already' (i.e. provide person-centred care) on the part of some practitioners, can result in preconceived ideas about the programme that need to be overcome. Feedback about the training also indicated that the perception of Bridges as being relevant only to stroke could influence take-up of training places.

Identifying and achieving buy-in from key influential contacts is important for trust engagement, but also for successful training delivery and for supporting the implementation of change. Key contacts

did not always attend the training and/or introduce the Bridges SSM programme to staff at the beginning of the workshops to 'signal' the importance of the initiative for the service.

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

Findings

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

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

- Practitioners were positive about the opportunity to reflect, learn, think and plan together. They described the training as "thought provoking" and appreciated the time to discuss ideas in their team. The use of the 'patient voice' in the workshops was particularly appreciated.
- While some practitioners expressed the view that "we do this already", there was acknowledgement that it is good to be reminded about techniques and that there is always room to improve on practice. Bridges SSM training was seen to offer 'permission' to recapture person-centred practice and it was an approach that was felt to be relevant beyond the stroke and neurological services pathway.
- 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, although further time was felt necessary to consolidate the changes and to perfect their use.

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

- Practitioners reported making changes to their individual and team practice as a result of the training, such as: adapting language, changing the structure of assessment sessions and goal setting approaches, encouraging patient problem solving and reflection.
- Steps were underway to cascade, embed and sustain changes, such as: altering processes and paperwork, placing visual prompts in the environment, and using a variety of methods to share learning about the approach.

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

- Bridges was perceived to support practitioners in being less prescriptive and more able to 'get straight to the point' of what was important for patients.
- Therapy was seen as more effective and efficient as a result of Bridges.
- It was felt that small changes to practice could make a big impact on both staff and patient satisfaction, but making and sustaining such changes takes time.

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 implementation of 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. This in turn engenders greater engagement and motivation in patients and should contribute to improved levels of 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: learning atmosphere, adult learning principles, interactivity and group work, credibility of trainers, evidence base for approach, and use of peer voice and patient voice.
- The Bridges programme and drivers for change appeal to the intrinsic motivations of healthcare staff and make use of valuable extrinsic motivators such as the service user voice, peer influence, and, in time, local Bridges Champions.
- 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.
- Service pressures can impact negatively on staff morale, commitment to training and the ability to engage in quality improvement activities.

CASE STUDY TWO: NORTH EAST ESSEX AND SUFFOLK STP

The following presents a summary of evaluation results for the North East Essex and Suffolk (NEES) Sustainability and Transformation Partnership (STP), the second 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 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 NEES STP.

Table: NEES Bridges SSM programme timeline

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

STAKEHOLDER ENGAGEMENT

Trust engagement

The engagement process in NEES STP took only six weeks. The Bridges team reported positive discussions of the training and quality improvement programme at Board level, but had to utilise their personal networks to identify key contacts at the operational level in order to secure engagement with the training. Some contacts had been trained in the Bridges approach previously and came on board quickly. The Bridges team held an engagement meeting with ahead of training in order to understand participating teams' main concerns and priorities with regard to SSM. As the engagement process progressed quickly, it was not considered necessary to hold a formal full day Engagement Lab for clinical leads in order to encourage their support of the training.

Two trusts participated in the training programme representing four organisations covering acute (x2), Early Supported Discharge (ESD) and community services. Two other trusts in the STP (one providing acute services and the other ESD/community services) declined to take part in the training, although they did send some observers to the workshops. The reasons given for non-participation included:

- The logistics of hosting a training session
- The timing of the training
- Winter pressures
- Balance of capacity and demand (not able to free staff to attend training)
- Lack of ongoing funding to purchase Bridges booklets and to train new members of staff
- Provision of Health Coaching training at the trust felt to be more practical for team.

As these trusts decided not participate fully in the training, the UEA evaluation team did not pursue governance approval for evaluation activities relative to their staff and they were excluded from the evaluation.

In this STP invitations to attend the workshops were extended to third party providers. The evaluation team was not aware in advance that this was to occur and had not made provision to secure governance approval from third party providers. Attendees from these organisations were therefore excluded from the evaluation.

The following comment from one of the practitioner interviews provides an example of why there might be resistance to the training and emphasises the importance of the Bridges team engendering enthusiasm for the training from the ground up.

> *"I suppose because it came through the CCG and the funding was there and the training was there, it wasn't something that grew up from the ground and we were saying we need this … which to some individuals was hard, because there's certain training that they wanted or asked for and don't get and then you're being told you have to come on this training. So there were a few sort of preconceived thoughts from different members of staff."* [OT]

In this case study it also emerged from one of the interviews that the perception of Bridges as pertinent only for stroke services could influence take up of the training. While the origin of the Bridges programme is in stroke services, the approach has been extended to the acquired brain injury and acute trauma pathway and is potentially applicable to many services. This message perhaps needs to be communicated more strongly when engaging with trusts.

> *"I think a few people didn't apply for the course because they thought it was really applicable to stroke patients, but I think as a team we felt actually that all our patients benefit from this approach … so the evidence was stroke but we didn't feel it really made a difference."* [PT]

Identifying and achieving buy-in from key influential contacts is important for trust engagement, but also for successful training delivery and for supporting the implementation of change. Key contacts did not always attend the training and/or introduce the Bridges SSM programme to staff at the beginning of the workshops to signal the importance of the initiative for the service. The impact of this is demonstrated by the observation below.

> *"It would be useful to have someone from our organisation explain at the beginning, explaining why they have chosen this training and how it fits with our service."* [PT]

CONCLUSIONS: TRUST ENGAGEMENT

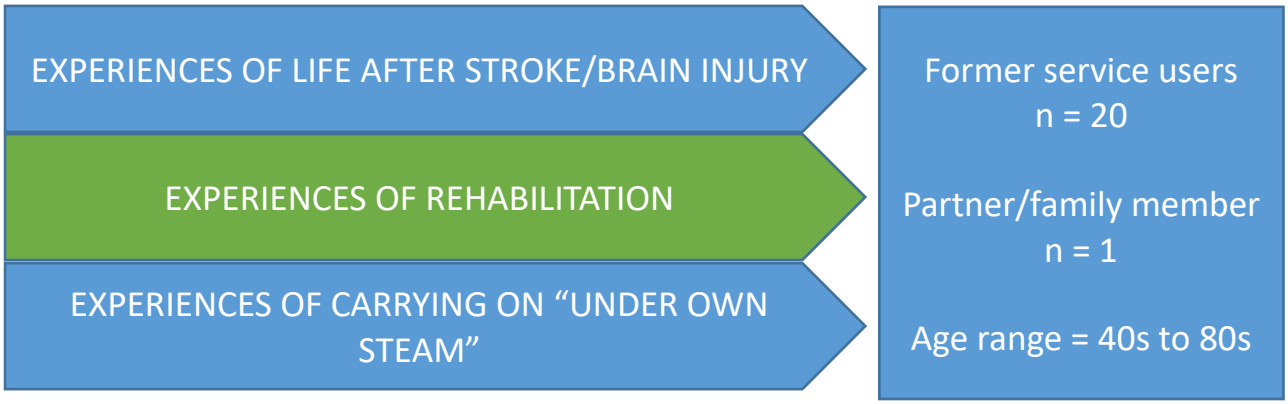
- Trust engagement process for NEES STP took only 6 weeks. The process still highlighted the importance of:
  - Identifying key operational contacts (with some contacts having prior knowledge of Bridges).
  - Building enthusiasm for the training from the 'ground floor up'.
  - Providing information about the training in a variety to formats to build understanding of what is being offered to trusts and what is expected of them.
  - Understanding the local context to tailor training content appropriately.
- Two trusts declined to participate in the Bridges programme citing winter pressures, staffing levels and commitment to Health Coaching.
- The perception of Bridges as relevant only for stroke services can influence take up of training.
- Influential individuals can 'signal' the importance of initiatives by visibly demonstrating their support, e.g. introducing or attending the training workshops.

Former service user engagement

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

Two focus group discussions were conducted involving 21 participants: one in March and the second in April 2019. Both groups were organised around regular support group meetings, lasted for 60 minutes and were recorded with the consent of participants. The recordings were transcribed and analysed thematically. The diagram below indicates the topics explored during the focus group discussions.

Diagram: Engagement with former service users



The themes that emerged from the focus group discussion were similar to those identified in the stakeholder engagement in Cambridgeshire and Peterborough STP. 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 frustration, emotion, anxiety, memory issues, concentration ➢ Impact on family
EXPERIENCES OF REHABILITATION
➢ Benefit of feeling listened to and understood ➢ Being treated as a person and not a tick box exercise ➢ Receiving personalised support and having 'mastery' experiences
EXPERIENCES OF CARRYING ON "UNDER OWN STEAM"
➢ Feeling unprepared and abandoned o *"When I got home, we had no real game plan"* [Male, focus group 2] o Services are not joined up with the outside world, gaps in services and waiting lists o Need to know how to navigate services and connect to sources of support ➢ Reliance on family and friends o The importance of their contribution is not always recognised o Family members also have to re-evaluate their future and pick-up threads ➢ Community support groups o *"It's been a sort of real life saver for me"* [Female, focus group 2] o 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

- Importance of being treated as a person, being listened to and provided with tailored support.
- Individual and 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 to move forward and continue their life.
- Being able to link to sources of peer support is invaluable.

EVALUATION DATA COLLECTION

Quantitative data

The table below illustrates the number of attendees at the Knowledge Zone 1 (KZ1) and Knowledge Zone 2 (KZ2) workshops. There was not complete take-up of the 125 training places on offer. A number of representatives (n=11) from third party providers and from non-participating trusts were excluded from the evaluation.

Table: Attendees at Bridges SSM workshops

Workshops	Timing	# attendees	# included in evaluation
Knowledge Zone 1 (n=4)	January 2019	101	90*
Knowledge Zone 2 (n=4)	April 2019	96	85*

** 11 individuals from charities and non-participating trusts excluded from evaluation*

Attendance at KZ1 prompted reconsideration of the appropriateness of Bridges SSM training for other categories of staff as illustrated by the comment below.

> *"So no Band 2s and Band 3s came on the initial training and after coming back from KZ1 we actually said it's much more appropriate for them to be coming because they do day-to-day contact with the patient and they're the ones that can embed a lot of the language and philosophy, particularly around personal care and day-to-day support."* [OT Lead]

In this case, the Bridges team scheduled an extra open workshop (KZ1 and KZ2) to give other categories of staff a chance to attend the SSM training. However, the workshop was not well attended (6 individuals).

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

The response rate to evaluation questionnaires was good, although with some attrition for KZ2 (see table below).

Table: Number of evaluation questionnaires and response rates

Questionnaire	Number	Response rate
Knowledge Zone 1 – Pre-training	81/90	90%
Knowledge Zone 1 – Post-training	80/90	89%
Knowledge Zone 2 – Post-implementation	63/85	74%

The following table shows the characteristics of participants by profession, setting, time since qualification and years in current service. Only a small number of nurses attended the training, with potential implications for how the programme is implemented given the level of contact that nurses have with patients.

Table: Characteristics of participants in Bridges SSSM training

Participant characteristics	**KZ1**		**KZ2**	
Profession	**Number**	**%**	**Number**	**%**
Nurse	7	8.6	5	7.9
OT	20	24.7	19	30.2
PT	23	28.4	18	28.6
SLT	7	8.6	7	11.1
Psychologist	1	1.2	1	1.6
Rehabilitation/Healthcare Assistant	20	24.7	13	20.6
Missing	3	3.7	0	0.0
Total	81	100.0	63	100.0
Setting	**Number**	**%**	**Number**	**%**
Acute	39	48.1	29	46.0
Community	40	49.4	32	50.8
Both	2	2.5	1	1.6
Missing	0	0.0	1	1.6
Total	81	100.0	63	100.0
	Mean (SD)	**Range**	**Mean (SD)**	**Range**
Years in profession	11.6 (8.3)	<1-40	11.7 (8.9)	<1-41
Years in service	5.9 (5.6)	<1-25	5.5 (5.8)	<1-24

In this STP there was also not complete take-up of the 25 places on offer in the Bridges Champions Masterclass, which focuses on team plans and sustainability. The Masterclass took place in early September 2019 with 10 representatives from two acute stroke units and one ESD service.

Qualitative data

Workshop observations

The UEA evaluation team carried out 30+ hours of evaluator embedded observations of KZ1 and KZ2 workshops and the Bridges Champions Masterclass.

Semi-structured interviews

Three semi-structured interviews with practitioners took place following KZ2. The interviews were conducted by telephone and lasted between 29 and 46 minutes (average 36 minutes). The characteristics of the participants are described in the table below. 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 the telephone interviews during the time frame of evaluation activities in the NEES STP.

Table: Participants in semi-structured interviews

Interview participants	Number
Nurse	-
OT	1
PT	1
RA	-
SLT	-
Psychology Practitioner	1
Acute	2
Community	1
Years in profession (mean)	13
Years in service (mean)	6

FINDINGS

Four Levels of Evaluation

Reaction

Practitioner feedback comments on the training at the end of KZ2 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.

There was a majority of positive comments about the Bridges training, with practitioners enjoying the opportunity to reflect on their practice and appreciating the quality of the training on offer. There was recognition of the relevance of the training beyond the stroke and neurological services pathway. Negative reactions were related to the perceived difficulty of utilising the approach with patients with cognitive and communication difficulties and perceived difficulties in balancing the approach with service direction and demands. In workshop observations and in telephone interviews, practitioners commented positively about the use of the 'patient voice' in the workshops.

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

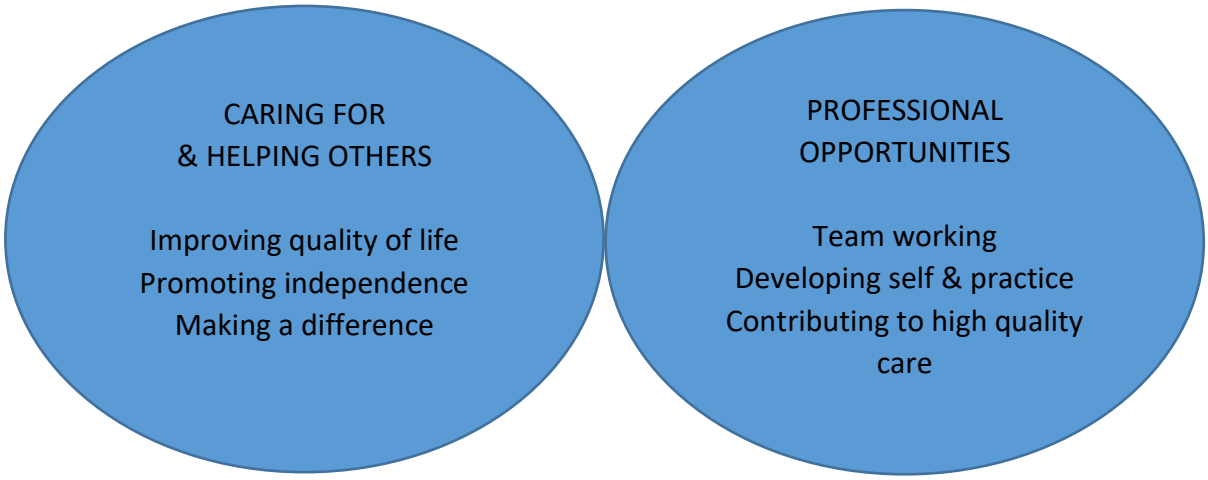
Feedback	Number*	Illustrative participant comment
☺	61	• I enjoyed the time to reflect on my practice and the opportunity to improve my quality time with our patients. The presenters were fantastic at making the group feel relaxed and share our opinions. [OT] • An interesting, thought provoking day, offered opportunities for reflection, discussion and problem solving with our team - helps to make it more likely to create changes to our practice. [SLT] • It has made me think about the language I use and how I ask questions and how I can aim to get patients to problem solve more. [PT] • It makes you question your approach to make sure you are doing the best for your patients. [Rehabilitation Assistant] • It has inspired me to return to the ideals I want to use in my practice with evidence base and structure. [PT] • Needs to be rolled out to all staff in each department to improve practice. [Healthcare Assistant]

		• Interesting and informative, delivered in a way which can easily applied in many different departments, simple ideas to make big changes. [Rehabilitation Assistant] • A very patient oriented programme and it should be one that should be widely practiced in the trusts to be able to gain more patient cooperation and efficacy of the therapeutic regime. (Healthcare Assistant]
😐	19	• I have struggled to grasp the tangibility of the Bridges approach. I feel its underlying principles correlate with the approach we take in our service. I will take more time to reflect on today. [SLT] • Has some similar approaches to health coaching, however would like to try it out and see the outcome. [PT]
☹	5	• The handout did not follow the slides, so a little confusing at times. [SLT] • May be more challenging for patients with impaired cognition. [Rehabilitation Assistant] • I like the initiative, but feel if anything we are being pushed away from this and in the opposite direction. [PT] • Bridges relies on practitioners and public having a significant ability with social skills, self-awareness and reflection. It will take a long time to develop these. [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 below.

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 (90% 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=79)	78.5%	21.5%	0.0%
Bridges SSM approach will bring you closer to ideals? (n=78)	89.7%	6.4%	3.8%
Bridges SSM approach has brought you closer to ideals? (n=63)	92.1%	4.8%	3.2%
Find work enjoyable	**Positive**	**Neutral**	**Negative**
Pre-KZ1 (n=80)	86.3%	13.8%	0.0%
Post-KZ2 (n=63)	92.1%	7.9%	0.0%

CONCLUSIONS: REACTION

- There was not complete take up of the 125 training places on offer: 101 practitioners attended KZ1 and 96 attended KZ2. Only ten of the 25 places on offer in the Bridges Champions Masterclass were taken up.
- Practitioners responded positively to Bridges SSM training, the presence of the 'patient voice' was particularly appreciated.
- SSM training resonates with practitioners' professional ideals: caring for and helping others and contributing to high quality care.
- 92% of practitioners reported that Bridges SSM had helped them make changes to their practice that had brought them closer to their professional ideals.

Learning

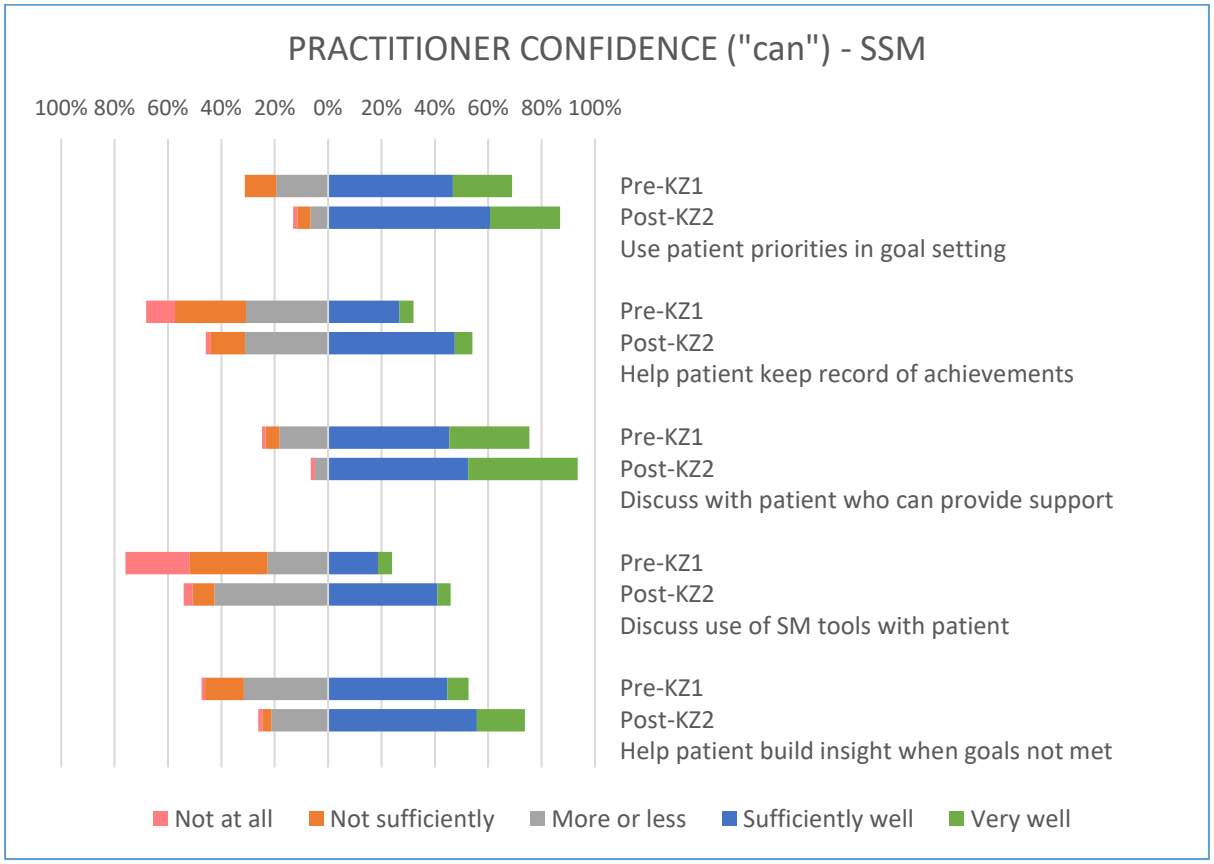
Practitioners asked to rate their confidence ("can do") and performance ("do") with respect to 18 SSM tasks related to Bridges' core principles. Confidence and performance was assessed pre-KZ1 and post-KZ2. Responses were on a five point Likert scale ranging from 1 = not at all to 5 = very well for confidence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

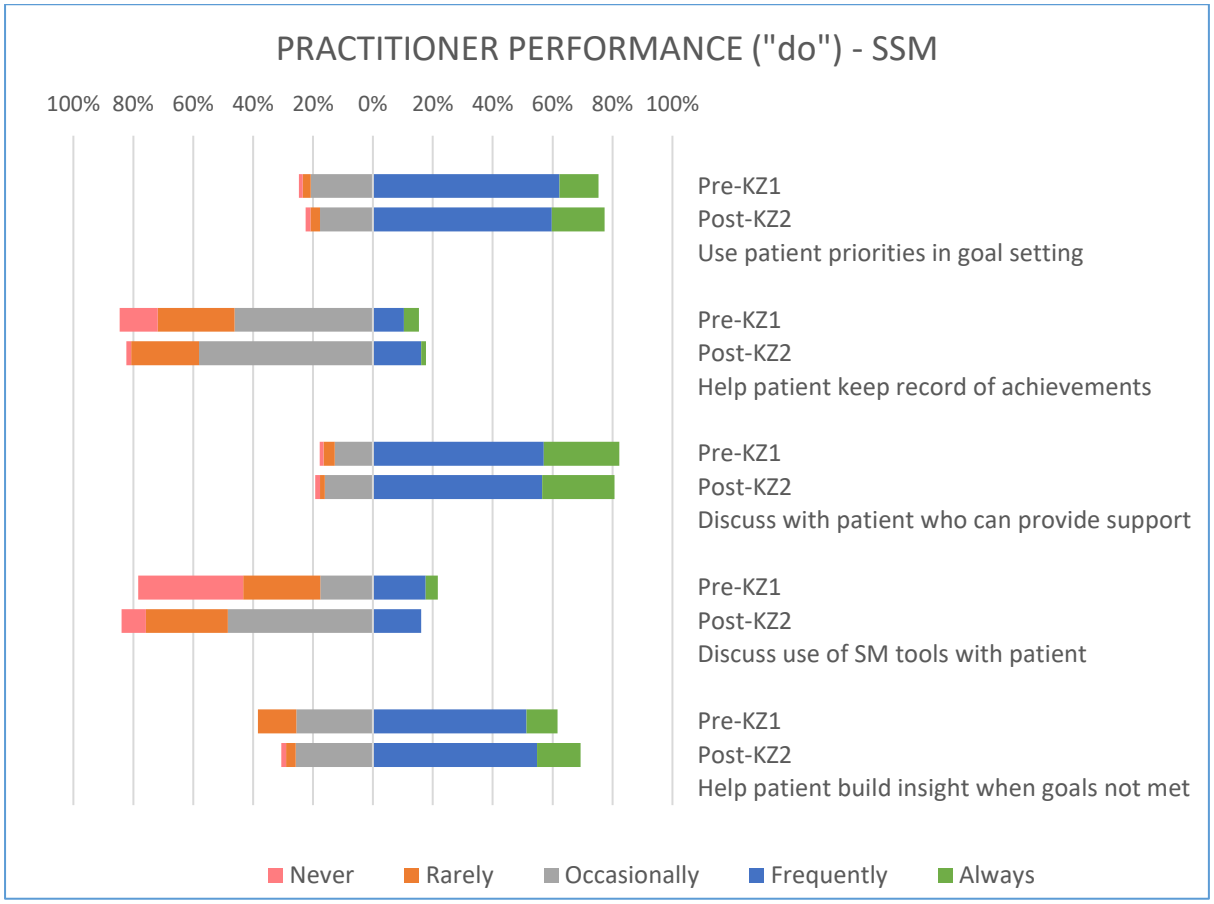
The five SSM tasks selected for presentation here are related to goal setting, patient reflection, accessing daily support, using SM devices and developing insight. These tasks were selected as they represent areas where practitioners indicated they intended to make changes to practice.

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 performance of the five SSM tasks, with "always" and "frequently" appearing to the right and responses for "occasionally", "rarely" and "never" to the left of 0%.

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. In the case of self-reported performance of the five SSM tasks, the percentage reporting that they 'never' or 'rarely' perform certain tasks has notably decreased, e.g. from 61% to 36% in relation to discussing use of SM tools with the patient.

Workshop observations and interview data indicated that practitioners felt that further practice was necessary in order to use the approach with complete confidence (e.g. getting the balance right between having an open conversation with patients while also understanding and addressing clinical impairments). Practitioners also reflected that they felt Bridges training had impacted positively on how they were delivering their therapy.

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.
- Bridges facilitates positive changes to practice, but further time and practice are necessary to refine those changes and to consolidate confidence in the approach.

Behaviour

At the end of KZ1 and KZ2, practitioners were asked about small changes they intended to make or had made to their practice. 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 Case Study One, 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 • Asking more open questions • Changing how introduce self and service • Creating a shared language • 'Words Matter' poster for team rooms
Getting to Know You	• Having a 'normal' conversation and listening to patient • Finding out more about the patient, their story, their interests, what is important to them, their fears and worries
Goal setting	• More collaborative goal setting • Asking what the patient wishes to work on • Asking what is "one small thing" you want to achieve • Breaking down goals into small steps
Reflection	• Allowing patient to reflect on progress • Encouraging patient to problem solve

	• Allowing patient to explore and fail • Using diaries, photos and videos to encourage reflection • Using confidence rating scales with patients
Paperwork and processes	• Changing assessment forms, goal sheets and discharge letters • Creating a welcome pack • Changing initial appointment letter and patient questionnaire • Visual resources on ward, e.g. welcome board • Emotional and social support initiatives, e.g. early opportunity for MDT family meeting, using patient groups and volunteers • More sharing personal information about patients with team members • Training and supporting other staff, e.g. away days, daily staff education, induction

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.

> *"We used to have some patient-held rehab plans … we've got out of the habit of using them consistently and its almost given us a spotlight back onto that and said let's look at why they're not being used and try and incorporate Bridges into that."* [OT]

> *"It's made us stop and reflect on [our assessment process] from the patients' point of view of asking so many questions. It probably doesn't always seem relevant to them … it's made us pause a bit and perhaps adapt the reasoning of why we're asking them and justifying why we're doing things."* [PT}

> *"We run a fatigue management course … and I think that sort of language is what we should be changing … I already thought it was inappropriate, but I feel like going on the Bridges course, with also some of the team being on the Bridges course, has meant that it's sort of endorsed my ideas. I think that I've got a bit more backing perhaps in being able to think about changing it."* [Psychology Practitioner]

Challenges to changing practice

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

Table: Challenges to changing practice

Challenge	Description
Time	- Time available for service development - Need to make time to keep discussions going and maintain momentum
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 (concern about low number of nurses that attended training) - Shifting professional mind sets (e.g. moving away from goals around personal care and domestic tasks) - Changing language of Consultants
Context	- Exceptional demand over implementation period - Staffing levels and staff morale - Dealing with infection outbreak - Working with rigid, service-oriented computer system

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=80)	71.3%	23.8%	5.0%
KZ2 (n=61)	70.5%	26.2%	3.3%

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

Workshop	Agree	Neutral	Disagree
KZ1 (n=80)	86.3%	5.0%	8.8%
KZ2 (n=62)	85.5%	8.1%	6.5%

In the interviews it emerged that practitioners did not necessarily think that using the Bridges approach with patients took more time, in fact they felt that it could actually save time in the longer term as a result of being able to address issues more readily, establish more meaningful therapy goals and provide more effective therapy.

> *"I think saves time in a way because if you are being more direct and by improved communication you're able to address issues quicker. So it doesn't take more time, it's being more efficient really."* [PT]

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 eliciting more meaningful goals and shaping more effective therapy, with increased patient engagement and motivation.
- Bridges was perceived to encourage more cooperative and collaborative team working, with the potential to contribute to greater efficiency.
- There was concern that it would be difficult to change the culture on the wards given that only a small number of nurses attending the training.

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	- More collaborative and less prescriptive treatment - More personalised therapy and more meaningful goals
Patient involvement and ownership	- Feel they are getting treatment for their specific needs - Patient identified goals are more meaningful - Enhanced engagement and motivation - Changed experience of pathway and greater sense of control
Practitioners	- "Getting straight to the point" – addressing issues more quickly and being more efficient - Providing a better service - Being less prescriptive ('easy to slip into prescriptive therapy')

In the Bridges Champions Masterclass one of the teams present made the following observation with regard to the lessons learnt from implementing the Bridges approach:

> *"We 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 time is required to make those relatively small changes, and keep them going."* [Acute trust team]

CONCLUSIONS: RESULTS

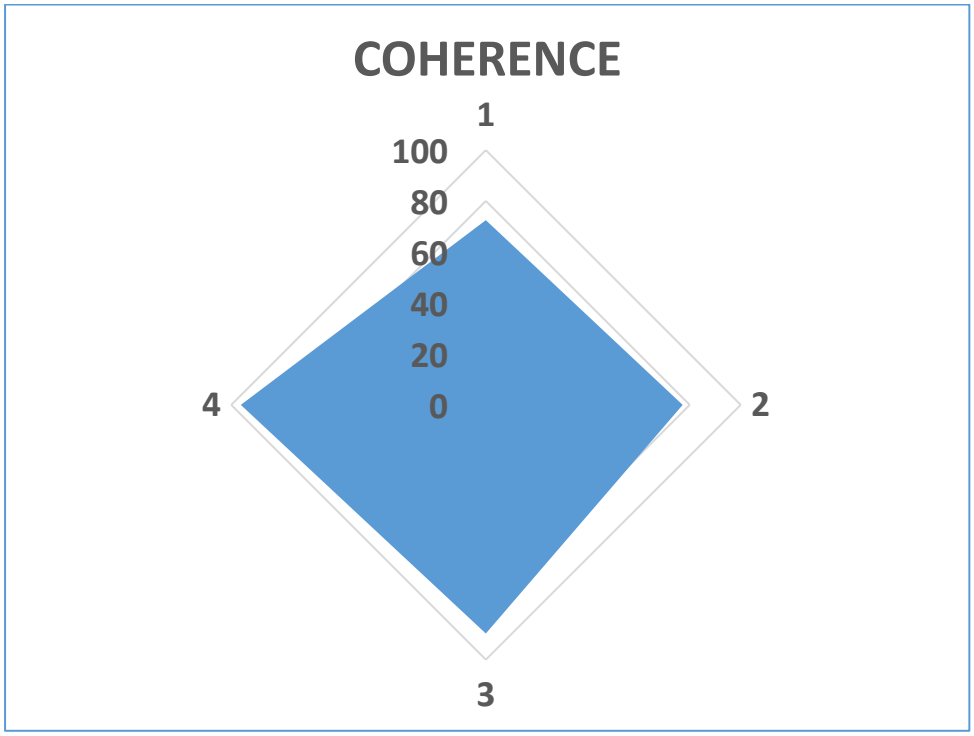
- Practitioners felt that using the Bridges approach could change patients' experience of the treatment pathway and give them a greater sense of control (something that is important for individuals who have lost so much).
- Bridges was perceived to allow practitioners to 'get straight to the point' in determining what patients wanted to achieve, thereby ensuring a more efficient service.
- Practitioners acknowledges that small changes to practice can have a big impact on patient and staff satisfaction, but that making and sustaining those changes requires time and effort.

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 (>70%) with the statements indicating that practitioners were likely to support implementation of the intervention.



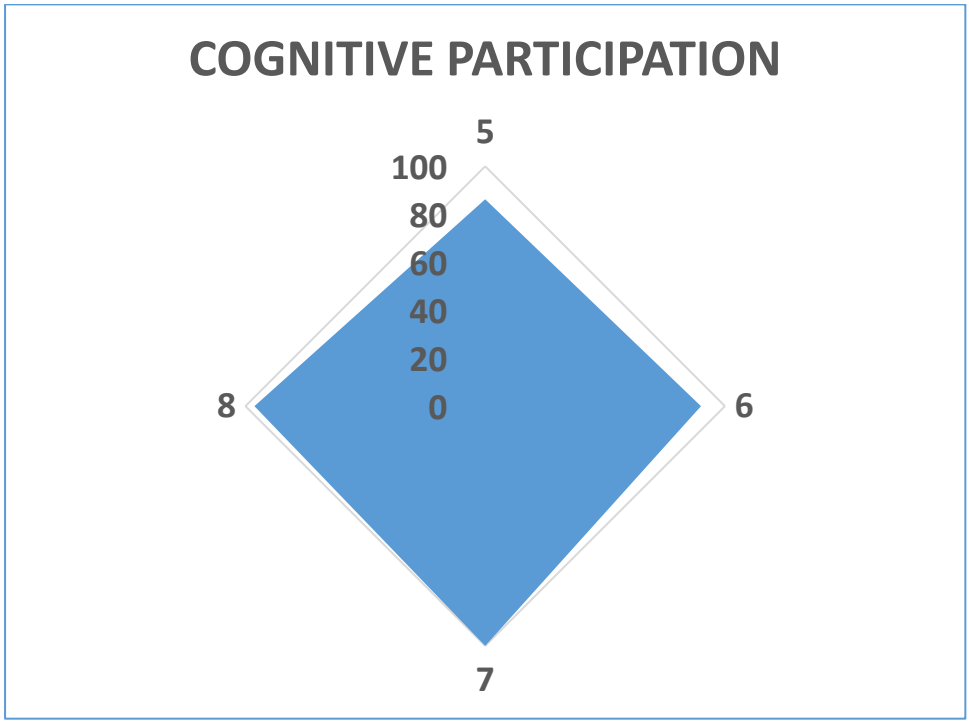
1 I can see how Bridges differs from my usual ways of working (n=80; agree 73%)
2 I think staff in my MDT will develop a shared understanding of the purpose of the Bridges initiative (n=79; agree 77%)
3 I can understand how the Bridges initiative will affect the nature of my own work (n=78; agree 90%)
4 I can see the potential value of the Bridges initiative for my work (n=80; agree 96%)

As previously indicated, while a large percentage of practitioners indicate that they can see how the Bridges approach differs from their usual ways of working, there is also a sense of 'we do this already.' However, in the workshops and in the interviews, practitioners argued that it is always possible to improve on practice and it is useful to be reminded about person-centred approaches in order to overcome bad habits. The quote below illustrates how Bridges is seen to enhance the provision of person-centred care.

> *"Before I went on Bridges, with the goal setting, I felt like I very much involved my patients but I think I do it better now in the language that I use."* [OT]

Cognitive Participation

Cognitive participation relates to the degree of engagement with Bridges in order to build and sustain a community of practice around this approach to SSM.

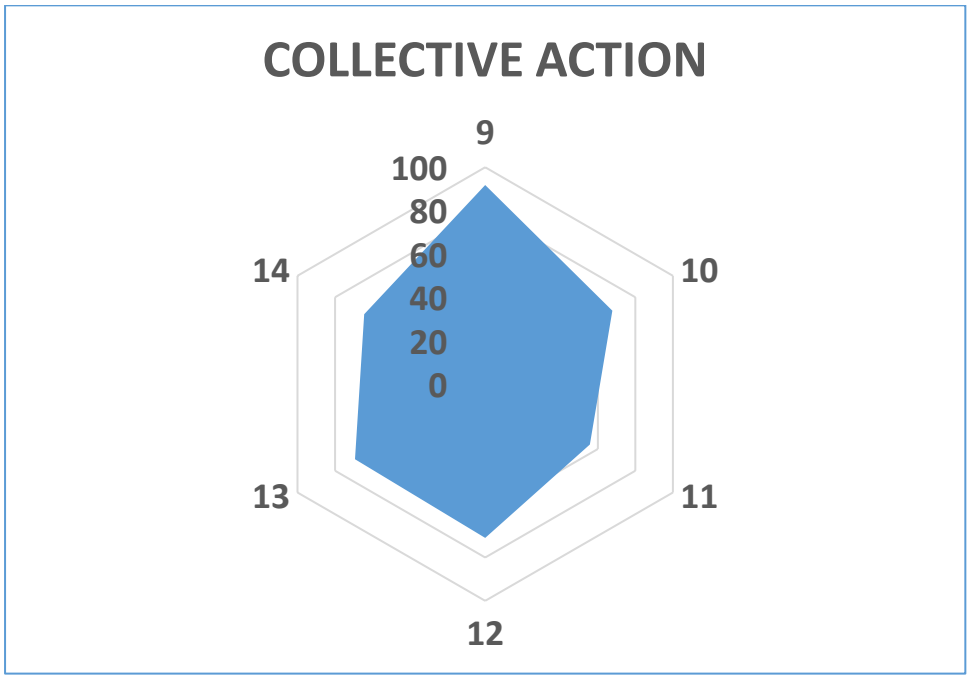


5 I think there are key people who will drive the Bridges initiative forward (n=80; agree 86%)
6 I believe that participating in the Bridges initiative is a legitimate part of my role (n=80; agree 90%)
7 I am open to working with colleagues in new ways to use the Bridges initiative (n=80; agree 100%)
8 I will work to support the Bridges initiative (n=80; agree 96%)

Practitioners regarded Bridges as a legitimate part of their role (90% agree), indicated that they were open to working with colleagues in new ways in order to use the Bridges initiative (100%) and that they will work in support of Bridges (96%). There was some hesitancy as to whether there were key individuals to drive Bridges forward, but nevertheless 86% were in agreement with this statement. The training was seen to offer practitioners "permission to do person-centred care." These results are conducive for the building and sustaining of a community of practice around SSM.

Collective Action

Collective action relates to the work that individuals do to enable the intervention, either as individuals or in groups. Around 92% of practitioners agreed that Bridges could be easily integrated into their work. Responses were less positive with regard to whether all team members were working to support the Bridges approach (56% in agreement) and whether sufficient resources were available to support the Bridges initiative (64% in agreement).

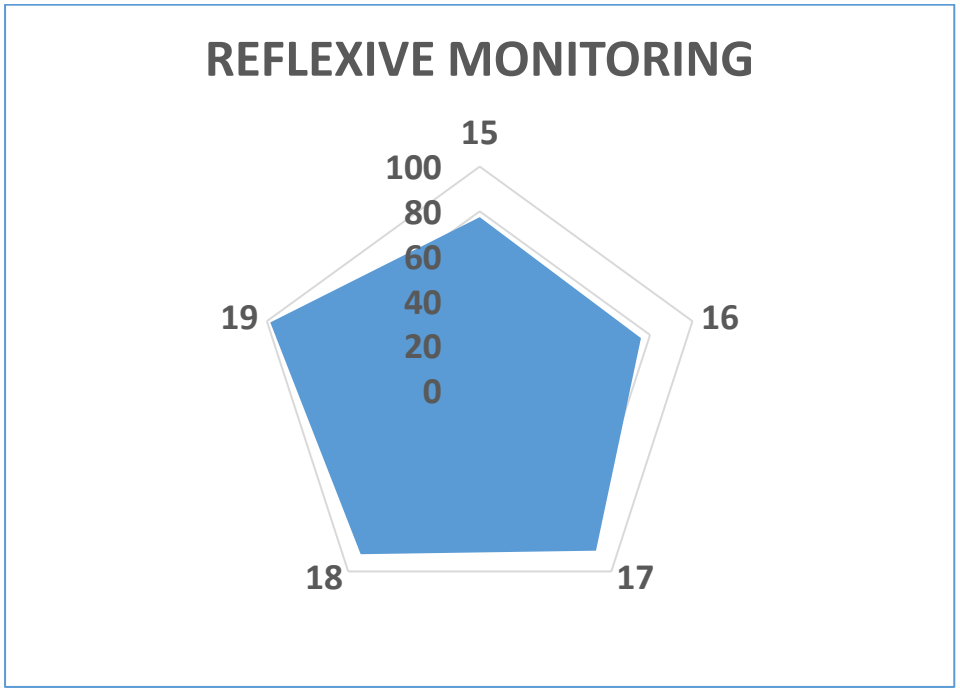


9 I can easily integrate the Bridges approach into my existing work (n=61; agree 92%)
10 I have confidence in other people's ability to use the Bridges approach (n=62; agree 68%)
11 All members of my team work to support the Bridges approach (n=52; agree 56%)
12 Sufficient training is provided to enable staff to implement the Bridges approach (n=62; agree 71%)
13 Sufficient resources are available to support the Bridges initiative (n=62; agree 69%)
14 Management adequately supports the Bridges initiative (n=62; agree 65%)

Feedback from practitioners highlighted some concern about the coverage of Bridges training in respect of insufficient numbers of Health Care Assistants, Rehabilitation Assistants and Nurses attending the training. The presence of such individuals was felt to be important because of their level of day-to-day interaction with patients. Nurses who did attend the training observed that it was challenging to integrate the Bridges approach into the very task orientated structure of nursing and in the face of time and resource pressures. In order to address the issue of coverage and promote sustainability, a Bridges induction pack was planned for those who had not benefitted from the training, as well as daily training for staff, inclusion of Bridges in the agenda of away days, and a briefing session for medical staff.

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=62; agree 77%)
16 Staff in my team agree that the Bridges initiative is worthwhile (n=62; agree 76%)
17 I value the effects that the Bridges approach has had on my work (n=61; agree 86%)
18 Feedback about the Bridges initiative can be used to improve the approach in the future (n=63; agree 91%)
19 I can modify how I work with the Bridges approach (n=62; agree 98%)

As practitioners start introducing the Bridges approach into their individual practice they assess how it fits into their clinical routines and the benefits it has for their patients and for themselves as professionals. In the feedback questionnaire, 86% agreed with the statement 'I value the effects that Bridges has had on my work'.

Practitioners reflected that using the Bridges approach made patients and families feel more listened to and they were therefore more engaged and motivated in working towards goals that are more meaningful to them. This was perceived to make the practitioners' job easier and more worthwhile. Asking the patient about what is important to them was seen to 'get straight to the point' and, as such, was considered to be more efficient as it allows issues to be addressed more quickly.

CONCLUSIONS: IMPLEMENTATION ASSESSMENT & SUSTAINABILITY

- There was positive momentum towards successful embedding and sustaining 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 establishing support for the Bridges approach by all team members.
    - The value of sufficient training, resources and management support.
- The briefing and training of non-trained members of staff and the induction of new members of staff were seen as important for sustainability. Proactive processes were underway to engage more team members in the approach by using Bridges in supervisions with non-trained staff, undertaking briefing sessions with medical staff, developing training/induction packs and the inclusion of Bridges in away day discussions.
- Practitioners questioned the level of resources and management support for sustaining the approach, particularly in respect of protected time and assistance in planning and implementing change.
- 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 *"You sometimes get carried away with the pathway and the assessments and your SSNAP targets … it was nice going back."* [OT]
Service structures	More collaborative team working perceived as necessary Small number of nurses attending training perceived to make it difficult to engender shift of culture on the wards Use of IT felt to impede focus on patients
Staffing and resources	Exceptional demand, coupled with infection outbreak Reduced staffing levels and low staff morale Lack of protected time to plan and implement change

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 are 'risk takers'
NHS workforce	Staff morale and retention Staff felt Bridges gave them 'permission' to return to 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 staff morale, commitment to training and ability to engage in quality improvement activities.

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 "thought provoking" and appreciated the time to discuss ideas in their team. The use of the 'patient voice' in the workshops was particularly appreciated.
- While some practitioners expressed the view that "we do this already", there was acknowledgement that it is good to be reminded about techniques and that there is always room to improve on practice. Bridges SSM training was seen to offer 'permission' to recapture person-centred practice and it was an approach that was seen to be relevant beyond the stroke and neurological services pathway.
- 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, although further time was felt necessary to consolidate the changes and to perfect their use.

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

- Practitioners reported making changes to their individual and team practice as a result of the training, such as: adapting language, changing the structure of assessment sessions and goal setting approaches, encouraging patient problem solving and reflection.
- Steps were underway to cascade, embed and sustain changes, such as: altering processes and paperwork, placing visual prompts in the environment, and using a variety of methods to share learning about the approach.

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

- Bridges was perceived to support practitioners in being less prescriptive and more able to 'get straight to the point' of what was important for patients.
- Therapy was seen as more effective and efficient as a result of Bridges.
- It was felt that small changes to practice could make a big impact on both staff and patient satisfaction, but that making and sustaining such changes takes time.

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 utilising 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. This in turn engenders greater engagement and motivation in patients and should contribute to improved levels of patient satisfaction and better outcomes.

CONCLUSIONS

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

- Training provides practitioners with a space away from clinical demands to reflect and think together about changes to practice that will benefit their patients. Practitioners were motivated to consider change, even in the context of a pressurised environment, and had the opportunity at the workshops to discuss and plan their initial "small steps" in the change process.
- The quality of the training was one of the enablers of implementation. Workshop observations suggested a number of factors contributed to a positive learning experience including: learning atmosphere, adult learning principles, interactivity and group work, credibility of trainers, evidence base for approach, and use of peer voice and patient voice.
- The Bridges programme and drivers for change appeal to the intrinsic motivations of healthcare staff and make use of valuable extrinsic motivators such as the service user voice, peer influence, and, in time, local Bridges Champions.
- 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.
- Service pressures can impact negatively on staff morale, commitment to training and the ability to engage in quality improvement activities.