PEOPLE 1ST: BRIDGES TRAINING AND IMPROVEMENT PROGRAMME

Executive Summary

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July 2020

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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PEOPLE 1ST: 'BRIDGES' SUPPORTED SELF-MANAGEMENT TRAINING AND QI PROGRAMME: OVERVIEW OF EVALUATION FINDINGS

HEADLINE RESULTS

- The People 1st 'Bridges' Supported Self-Management training and quality improvement programme resulted in tangible changes in the way that service users with stroke and neurological conditions are supported to manage their conditions.
- Practitioners gained confidence in supported self-management and expressed satisfaction in working more collaboratively with service users, feeling that they were providing a more effective and efficient service.
- Hard wiring supported self-management into paperwork, processes and systems was important to reinforce learning and consistency, promote sharing and to facilitate sustainability and evaluation.
- Strong support and interest from leadership was important in enabling staff to prioritise attendance at training and in trialling and adapting aspects of supported self-management in practice. Early-stage project 'pre-Champions' proved instrumental in supporting training delivery and engaging attendees.
- Service pressures and staff shortages impacted engagement and implementation, particularly impacting attendance at training by nursing staff and health care assistants.

INTRODUCTION

This overview presents summary findings from the evaluation of the People 1st 'Bridges' Supported Self-Management (SSM) training and quality improvement programme.

In 2017 Health Education England (HEE) in the East of England funded Bridges Self-Management, a social enterprise based at St George's, University of London, to deliver the People 1st programme to healthcare practitioners in stroke and neurological services across the eastern region. The University of East Anglia (UEA) was commissioned to undertake the first independent evaluation of the Bridges programme. People 1st was delivered over a two-year period between 2018 and 2020.

The aim of the People 1st evaluation was to understand the mechanisms for embedding and sustaining SSM in stroke and neurological services. Specific objectives were to determine if the Bridges intervention led to increased practitioner confidence in applying SSM in their interactions with patients and to identify the perceived benefits of changing practice (for patients, practitioners and teams), as well as perceived enablers and barriers to implementation.

SYSTEM CHANGE: THE BRIDGES INTERVENTION

The Bridges model of SSM is underpinned by the principles of social cognitive theory and the concept of self-efficacy. The Bridges training and quality improvement programme uses a phased approach to system change (see diagram below) and is directed towards whole teams across the patient pathway.

The 'Discovery' phase is concerned with engaging service teams with the intervention and understanding the local context to ensure that the training content delivered in the 'Knowledge Zones' is specific to the needs of service teams. In particular, the engagement process seeks to discover the main challenges facing service teams and what aspects of supported self-management and person-centred care they wish to build on.

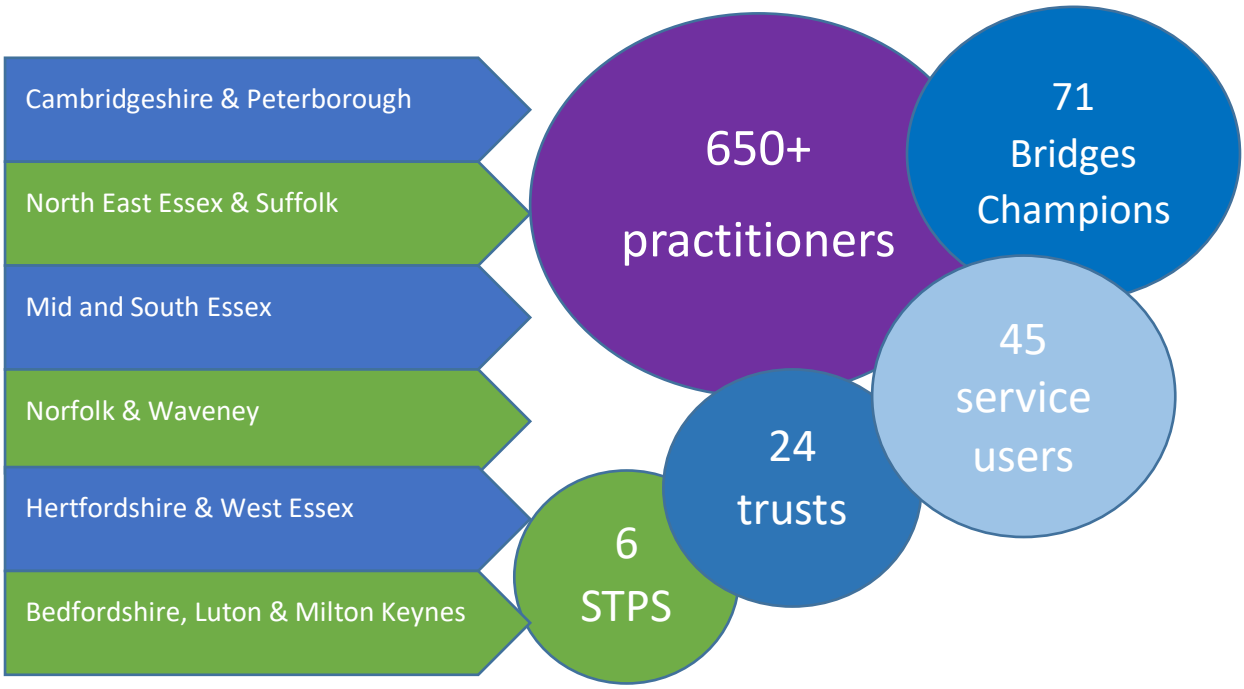
The 'Knowledge Zones' provide an opportunity for multi-professional groups to develop a shared understanding of the concept, evidence, principles, tools and techniques of SSM. In the 'Transforming' period local service teams are supported in their implementation activities by Bridges tools and resources. The 'Sustaining' phase is concerned with spreading and maintaining the provision of Bridges SSM within stroke and neurological services. A Masterclass for 'Bridges Champions' focuses on building capability for embedding and sustaining system change.

The Bridges Intervention: A phased approach to system change

SCOPE

The People 1st programme involved six Sustainability and Transformation Partnerships (STPs) across the East of England, with the participation of 24 trusts and 650+ staff including: therapists and therapy assistants, nurses, health care assistants, and psychologists.

A core group of practitioners who attended the Bridges training took on the role of 'Bridges Champions' undertaking to be 'key influencers' or 'movers and shakers' in cascading and sustaining self-management support in their service – and beyond.



In the first three STP regions to take part in the People 1st programme (as shown in the diagram above), forty-five former service users participated in a series of focus group discussions about life after stroke and head injury, experiences of rehabilitation and managing life after discharge from treatment. These consultations helped to contextualise training content and to highlight the importance of aspects of service provision to service users and their families.

EVALUATION METHODS

The evaluation employed a mixed methods approach.

The evaluation framework was developed using Kirkpatrick's Four Levels of Evaluation (1994) and key concepts from Normalisation Process Theory (May and Finch, 2009). Key questions were:

- Does the training lead to improved confidence and skills in SSM and does this translate into changes in practice?
- Does the Bridges intervention make sense to practitioners and do they feel it is a good idea?
- How does the Bridges intervention affect practice and what are the perceived benefits of the approach for patients, practitioners and teams?
- What are the routes to sustainability of SSM?

The roll-out of the People 1st programme in each STP was treated as a separate case study, with comparisons made across the six areas. The implementation of the final stages of the programme in Bedfordshire, Luton and Milton Keynes STP in March and April 2020 was impacted by the advent of the COVID-19 crisis

Ethical approval for engagement with former service users was granted by the University of East Anglia Faculty of Medicine and Health Ethics Committee. Governance approval for evaluation activities was obtained from 21 participating organisations.

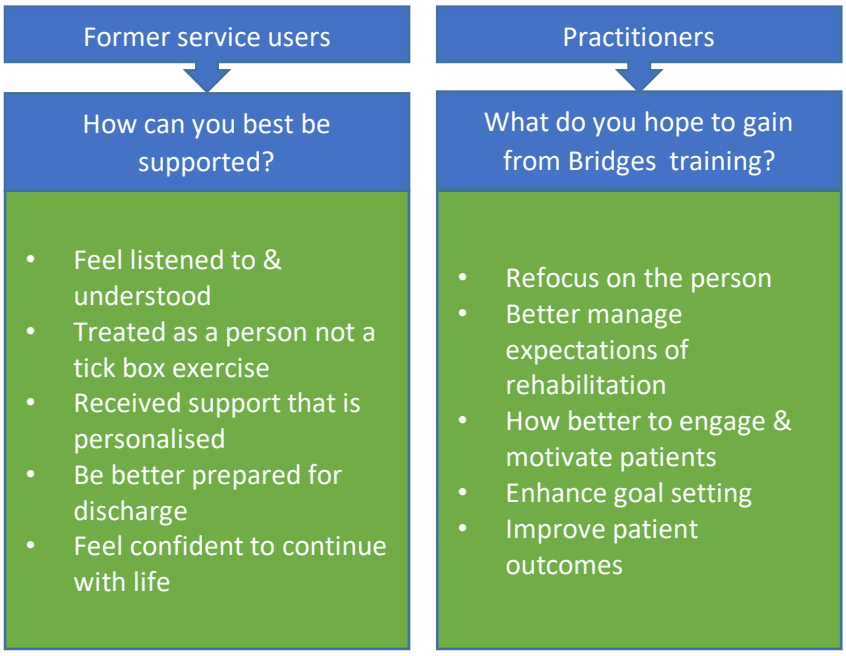
RESULTS

Why is it necessary to enhance the provision of supported self-management?

The evaluation team sought the views of former service users regarding their experiences of rehabilitation and asked practitioners what they hoped to gain from the Bridges training and quality improvement programme.

The results of thematic analysis of focus group consultations with former service users and open text responses on pre-training practitioner questionnaires are summarised in the following diagram.

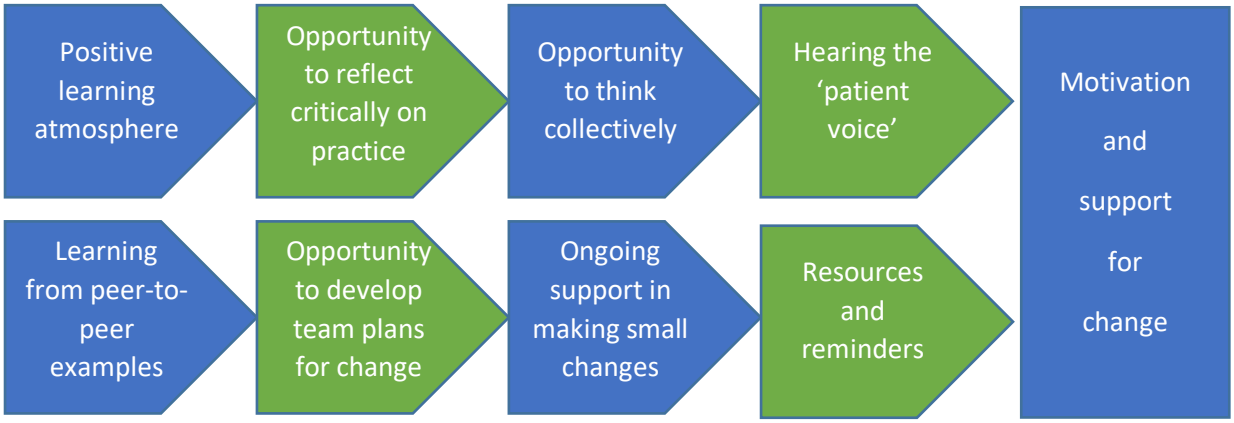
Thematic analysis: Why enhance the provision of SSM?



How did the Bridges SSM training motivate change to practice?

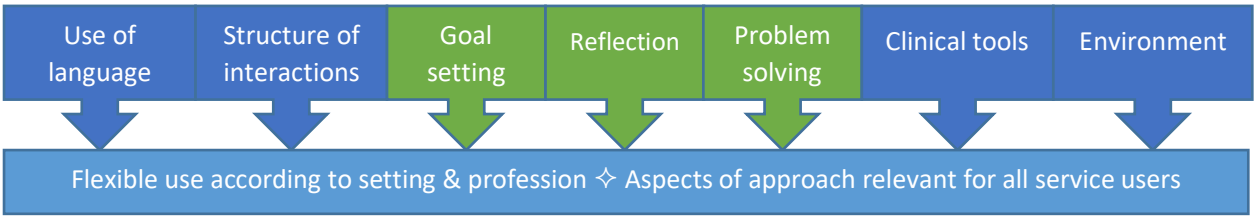
There was a positive reaction from practitioners to the training, including the interactive, multi-professional nature of the training, the credibility of the trainers, the use of the 'patient voice' and 'peer voice' and the provision of practical tips and techniques.

The training resonated with practitioners' intrinsic motivations for working in healthcare (i.e. 'helping others' and 'making a difference'), provided deeper engagement with the philosophy of self-management and gave practitioners time and space to reflect critically on practice and to focus on developing plans for change. The impetus to change behaviour was helped by peer support and leadership interest in, and support for, the changes.



Did the learning improve confidence and translate into changes in practice (behaviour)?

Practitioners reported improved confidence for a range of SSM tasks and made a series of changes to their individual and team practice following the Bridges training. They reported that time and practice are necessary to refine changes, to consolidate learning and to become familiar with new techniques and tools.

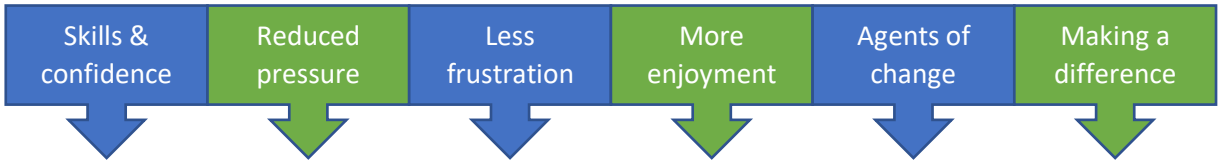


- Adapting language, using open questions, finding out more about the person, and altering the structure of interactions with service users and relatives, as well as other team members, to promote self-management.
- Pursuing a more person-led approach to goal setting and offering more control of therapy sessions to service users.
- Encouraging greater patient reflection rather than automatically giving feedback and allowing patients to problem solve rather than providing solutions.
- Revising paperwork, processes and systems to embed SSM (e.g. welcome packs, assessment forms, goal sheets, discharge letters, MDT meeting templates, induction and training tools, supervisions and competencies).
- Placing visual resources in the ward and work environment (e.g. SSM information boards and posters, patients' daily goals).

What were the perceived benefits for service users and their families?

Practitioners perceived that following a Bridges SSM approach provided several benefits for service users and their families. The evaluation team was not able to observe practice directly or to explore perceptions of SSM with current service users. The scope of this evaluation did not permit a pre-and post-implementation study to directly assess impact on service users.

What were the perceived benefits for practitioners?

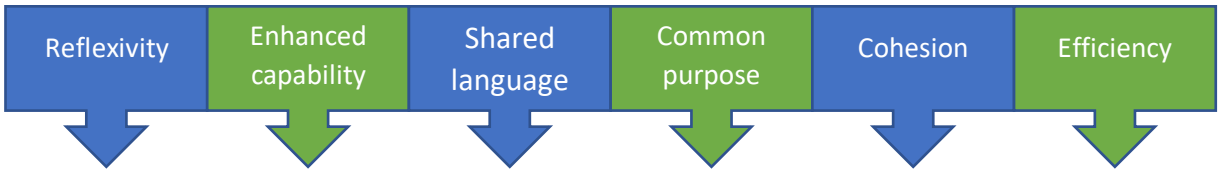


- Practitioners gain increased knowledge, skills, and confidence in providing SSM, with new techniques and tools to add to their toolkit.
- Practitioners report greater enjoyment in working collaboratively with service users, they feel less pressure from having to "have all the answers" and less responsibility when service users are controlling the agenda.
- Managing expectations of rehabilitation from the outset and listening to the hopes and fears of service users and family members was felt to increase understanding and to diffuse potential conflict situations.
- Enhanced listening and communication skills can be employed with service users, with colleagues and in personal life. Bridges SSM was felt to help preparation for difficult conversations.
- Practitioners stated that they had greater satisfaction from providing care in line with their values-based motivations, i.e. the approach offers "permission" to put service user at the centre

of rehabilitation and enables practitioner to “make a difference” by regaining aspects of practice perceived to have been eroded by “system pressures.”

- Practitioners experienced the reward of providing more effective therapy with better outcomes for service users, thus reducing a sense of frustration about their efforts going to waste.
- Practitioners have a greater appreciation of QI and themselves as agents of change. The programme demonstrates that small changes to practice can have a bit impact on service users and staff. Practitioners become part of the Bridges Community of (Best) Practice in SSM.

What are the benefits for service teams and organisations?



- Training provides space and time away from the demands of everyday practice for staff to think reflexively about processes and system factors that can inhibit person-centred practice.
- Team members are upskilled and have additional ways of working with patients, adding an extra dimension to service provision, and helping with patients who are “not for rehab potential” or who have “got a bit stuck.” Some teams had sought to spread the approach to other pathways, e.g. palliative care and orthopaedics.
- Teams work more efficiently by identifying and addressing issues of concern to service users more quickly. A shared language, improved communication and greater sharing of information about service users wishes and goals increases team cohesiveness.
- The hard wiring of SSM into paperwork, processes and systems acts to reinforce learning, promote consistency of approach, and enable monitoring and sharing of information.
- There is the benefit of working towards a common purpose and developing new practice norms through a shared language and framework.
- QI is more accessible. Staff feel that ideas for service improvement have been validated and that they are able to contribute to change.
- Whilst the focus of this evaluation was on practitioner learning and behaviour change across neurorehabilitation services, some attendees felt that the Bridges SSM approach had wider application and would be beneficial learning for all professionals and services within the NHS to boost awareness of SSM and strengthen understanding of the ethos of rehabilitation. As a result, some practitioners had taken action to introduce the Bridges SSM approach to other rehabilitation teams, including, for example, orthopaedics and end-of-life care.

What are the enablers and barriers to implementation?

General

- The Bridges approach makes sense to practitioners as it resonates with the professional ideals that brought them into healthcare and is focused on what is important to patients. For many practitioners, the renewed emphasis on putting the person at the centre of the rehabilitation process was regarded as an important counterpoint to service-driven targets.
- Practitioners reported that Bridges provided tools and techniques that could be easily integrated into their individual practice and had positive benefits for service users and staff. The collective action necessary to disseminate, embed and maintain the approach in service teams requires time and leadership support so that paperwork, processes and systems can be adapted to help secure culture change.

Context

- The accompanying diagram shows differences in implementation across the six participating STPs.
- Identifying key influential contacts was important in achieving buy-in to the Bridges SSM programme. Existing personal relationships between the Bridges team and/or UEA evaluation team facilitated this process. These individuals provided a 'signal value' for the programme, supported its delivery and implementation and acted as "Pre-Champion Champions."
- Gaining governance approval for People 1st evaluation activities identified a weak or opaque governance infrastructure. The process was facilitated in one of the STPs (Cambridgeshire and Peterborough) as one of the trusts had collaborated previously with UEA and had developed an approval process and paperwork that could be shared.
- Engagement with the Bridges programme proved more challenging for practitioners in acute settings. This manifested in two ways: 1) Staffing pressures meant that ward managers felt unable to prioritise attendance at the training for nurses and HCAs and 2) Practitioners needed to work harder to deliver Bridges SSM where systems are geared to the medical model and focused on impairment, and where the delivery of care is task oriented.
- Leadership support for change gives staff confidence to innovate and improve. There were positive examples of management and team lead support, e.g. giving staff permission to invest time in the short term to perfect a new goal setting approach with a view to saving time in the future via better patient outcomes, supporting positive risk taking (to build insight) and acknowledging that 'therapeutic talk' and relationship building with patients is treatment.
- The Bridges approach to system change is initiated at the ground floor level and is the accumulation of small improvements over time. To drive and sustain change the opportunity to share experiences and feedback positive results is key, with feedback from service users amplifying the need for innovation and motivating practitioners to continue with their improvement ideas.
- Practitioners expressed concern about the need for metrics that are pertinent to SSM and demonstrate the true value of the service they provide. Procedure-driven standardised approaches need to be balanced with softer intelligence or 'thick data' that captures fully the service user experience and perspective.

Future opportunities for supported self-management approaches and evaluation:

The evaluation team worked collaboratively with the Bridges team throughout the People1st project. The appetite for future work around SSM from clinical teams was clear to both parties. The following potential opportunities emerged from the team's observations:

- Feedback from practitioners indicated that Bridges SSM approach was perceived to have applicability beyond neurorehabilitation. This view is endorsed by the evaluation team.
- The impact of the COVID-19 outbreak, which has included a move to more 'remote' styles of care and rehabilitation, has made it even more crucial to maximise the impact of every practitioner-service user interaction. Feedback from practitioners was that using Bridges SSM allowed them to: identify more immediately how service users felt they could best be supported, provide more personalised treatment, encourage and enable problem solving and reflection by service users, and help them to build their confidence. Further evaluation of the approach in remote and face-to-face consultations in the current crisis and as the health service evolves beyond COVID-19, is indicated.

- The limited engagement of medical staff in such a programme, and the potential impact of enhancing a rehabilitation ethos in medical consultations were such engagement to happen, is worthy of exploration.
- The 'Patient voice' resonated with practitioners during training and some had taken steps to gain feedback from service users when developing new SSM resources. Exploration of how practitioners can increase the involvement of service users in co-designing and shaping service delivery would be valuable, truly placing service users at the heart of service decisions.
- Examination of longer-term outcomes, including the realisation of sustainability plans and how changes to team working and collaboration have promoted efficiencies, is now indicated.

People 1st: Comparison of programme delivery by STP

Cambridgeshire & Peterborough	North East Essex & Suffolk	Mid & South Essex	Norfolk & Waveney	Hertfordshire & West Essex	Beds, Luton & Milton Keynes
• Extended engagement process but good participation • Positive nurse/HCA involvement • Briefing for medical staff • Relationship with Bridges/UEA • Key influential contacts • Governance process • Strong leadership support for implementation • Timing of training advantageous for new ESD service • Focus on pathway • Good cross-service collaboration • Maintained momentum & organised second Masterclass	• Short engagement process but incomplete participation • Perception of training as relevant only for stroke • Low level of nurse/HCA involvement • Relationship with Bridges/UEA • Less visible support from key influential contacts • Patchy leadership support for implementation • Service pressures over implementation period	• Challenging engagement at two acute trusts • Some single site rather than across service training delivery • Attrition at follow-up workshops • Low level of nurse involvement at follow-up • Less visible support from key influential contacts • Patchy leadership support for implementation • Service & staffing pressures over training & implementation period	• Good engagement & participation • Some single site training delivery for acute services • Service provider transition impacted participation (one ESD team) • Positive nurse/HCA involvement • Relationship with Bridges/UEA • Key influential contacts • Strong leadership support for implementation • Some spread of approach to other services • Staffing pressures a major challenge for service teams	• Challenging engagement & incomplete participation • Low level of nurse involvement at follow-up • Patchy leadership support for implementation • Examples of positive changes • Concern about acceptable outcome measures to demonstrate impact • Service pressures & changes impacted participation & implementation	• Short engagement process but incomplete participation • Low level of nurse/HCA involvement • Impact of COVID-19 on programme delivery • Key influential contacts • Leadership support for implementation • Service & organisation change priority focus • Changes to practice & 'quick wins' • No Champions Masterclass, question mark over sustainability plans

Strengths of the evaluation

- A large-scale training and quality improvement programme with embedded evaluation, involving 24 trusts across six STPs, with the participation of 650+ staff.
- A pre and post mixed methods design, guided by organising frameworks, with triangulation of findings from quantitative and qualitative data, case studies and case comparisons.
- A high response rate for questionnaires (~90%).
- The Bridges programme and evaluation was an iterative process. Findings from the evaluation of the programme in each STP were fed back to practitioners at the post-implementation Champions Masterclass and to the Bridges team. Analysis of consultations with former service users helped to inform training content.

Limitations of the evaluation

- The evaluation was not able to observe interactions between professionals and service or team meetings directly. Practitioners could perceive that they are delivering person-centred care but in practice may still favour 'expert' direction. Evaluation would be strengthened by greater integration of the patient voice.
- 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 service users was obtained via practitioner interviews and workshop observations.
- It did not prove possible to interview enough nurses and HCAs within timescales of evaluation activity in each STP. These professional groups faced challenges in engaging with the Bridges programme.
- The individuals who took part in the telephone interviews are likely to be more motivated towards the implementation of the Bridges approach.
- A longer evaluation time scale is necessary to establish sustainability of the approach, and to gain insights into the role of the Bridges Champions, and local formal evaluation activities of the impact for service users and professionals.

CONCLUSIONS

The positive findings of this evaluation support the ongoing integration of Bridges SSM into neuro-rehabilitation practice across the East of England. In addition, the approach merits consideration for other service user pathways.

There was evidence of collective action to cascade and embed Bridges SSM and of mechanisms to sustain the approach (e.g. hard wiring SSM in processes and systems and the ongoing role of Bridges Champions in driving change forwards). Incremental small changes in the provision of SSM builds capacity in teams and services, and ongoing leadership support is crucial to implement change. However, it would be useful to examine longer term outcomes including the realisation of sustainability plans and how changes to team collaborative working have promoted efficiencies.

Teams need ongoing encouragement and support to develop and trial appropriate outcome measures for SSM and such measures should be incorporated into key performance indicators.

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