

ARTICLE

How can we train stroke practitioners about patient self-management? Description and evaluation of a pathway wide training programme

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Abstract

Objectives: This paper describes the evaluation of pathway-wide training for practitioners in a stroke self-management programme (SSMP). The Bridges SSMP teaches professionals to facilitate self-management skills in stroke survivors, using an individualised workbook. This was the first time professionals working throughout the stroke pathway received training together. The mixed-methods evaluation focused on the impact of Bridges training and the experiences of health and social care practitioners using the programme within the stroke pathway. It was informed by Normalisation Process Theory and Realist Evaluation. This paper discusses the need for a whole systems approach to stroke self-management, considering the patient, professional and organisational context to ensure sustainability in the longer term.

Method: Semi-structured interviews were carried out with stroke practitioners before and after training, exploring their experiences of the stroke pathway, perceptions of self-management and experiences using Bridges. Content thematic analysis was used to categorise recurrent and common themes in the data. Questionnaires were completed before and after training, to evaluate participants' change in beliefs, knowledge and practice of self-management.

Results: Analysis of qualitative interviews and questionnaires revealed that participants were generally positive about Bridges. However, they reported specific challenges in delivering an SMP to stroke patients, which necessitated adaptations to their everyday practice and flexibility in strategies used. The majority of participants felt their practice had changed following the training and they were more mindful of using patient-led approaches.

Conclusions: Evaluation revealed a number of positive findings and ideas for promoting sustainability of the SSMP in the longer term of direct relevance to patient self-management.

Keywords

Change management, health and social care, evaluation, multi-professional training, organisational barriers, patient-centered care, person-centered medicine, qualitative investigation, self-management, stroke, stroke pathways

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Introduction

Stroke remains the leading cause of disability in the UK despite real improvements in prevention and acute care [1]. Reduced function, quality of life and mood are common. Research has shown that people experience a number of unmet needs in the longer term and can feel unprepared to manage everyday life post-stroke [2,3]. More ways to support an individual to cope with the transition from regular to no care after stroke are needed, but self-management programmes are relatively rare [4]. Evidence relating to stroke self-management is restricted to preliminary proof of concept, feasibility and efficacy

studies and programmes are usually delivered in addition to usual rehabilitation [4-6]. It may be more efficient to integrate self-management programmes into stroke rehabilitation and care, but adoption of these methods by professionals used to an acute care model is likely to require some fundamental changes in working practices. Training of healthcare practitioners and evaluation of impact on practice is now considered an important component of any self-management programme [7].

Self-management programmes have been defined as a portfolio of techniques and tools to help patients choose healthy behaviours and involve an essential transformation of the patient-caregiver relationship into a collaborative

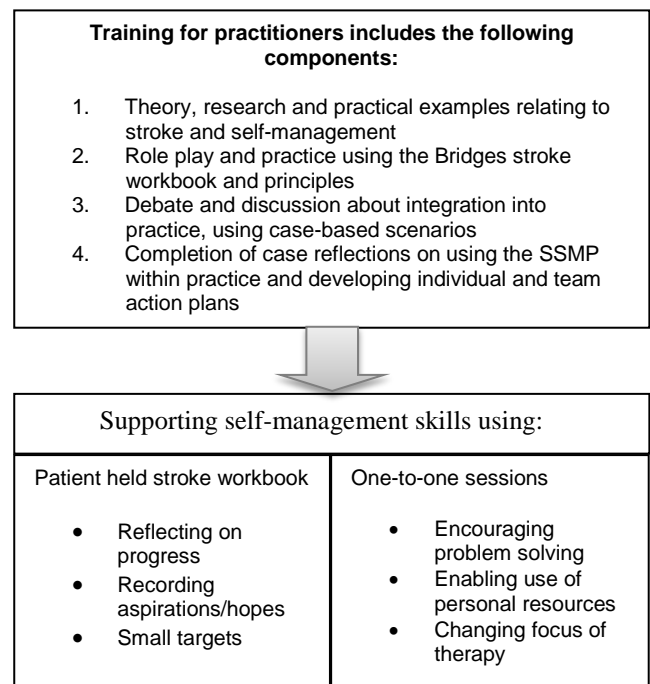
partnership [8]. UK Governmental policy in health and social care is strongly supportive of a move away from episodic acute care to individuals being more actively engaged in the management of their condition [9,10]. However, it is widely agreed that in order for programmes to be effective, there needs to be a whole systems perspective that engages the patient, practitioner and organisation together with an understanding of the individual complexities associated with living with and managing a long-term condition [11]. Findings from studies examining a whole systems approach highlight the need to give careful consideration to the pre-existing practices and beliefs of healthcare professionals and the training required to facilitate a shift from more didactic approaches to those which actively promote partnership working and engagement [12-14].

The organisation of stroke care in the UK is complex and promoting a consistent approach to self-management amongst different professional groups is a challenge. Most individuals in the UK stop receiving specialist rehabilitation after 6 months but typically experience care from many teams and stroke professionals during that time [15]. Stroke care, especially in the acute stages, is largely determined by professionally-led practices and can leave minimal time for professionals to promote active engagement and self-management [16]. Common principles associated with self-management, such as collaborative goal setting and problem solving, are often perceived as time consuming and when this is limited professionals often revert to more didactic approaches to care [14,17]. This is important in the current context of health and social care in the UK, as stroke teams are under increasing pressure to deliver services in accordance with targets relating to specific outcomes, while staffing levels are unlikely to increase [18].

The stroke self-management programme

The Bridges stroke self-management programme (SSMP) is an individualised intervention based on self-efficacy principles, delivered by professionals and supported by a patient held workbook [19,20]. The programme has preliminary proof of concept and has been found to be feasible and acceptable to use alongside stroke rehabilitation. Interprofessional training in the Bridges SSMP has developed over the last 5 years and involves a 2-day workshop for practitioners to learn skills, theory and research relevant to stroke self-management and ways of applying strategies through one-to-one sessions with stroke patients. Practitioners learn methods of communicating the key principles of self-management, such as problem solving, reflecting on progress, goal setting and taking action. Figure 1 shows an overview of the Bridges programme and components of training.

Figure 1 Overview of the Bridges stroke self-management programme



In 2009, the Bridges SSMP was chosen as a priority project for evaluation as part of the UK Stroke Improvement Programme and results from this study and further evaluation studies revealed a positive change in practitioners' beliefs and attitudes towards self-management after training [5]. However, a number of challenges and barriers were noted which revealed practitioners' concerns in relation to the time required to promote self-management, using the programme with people with cognitive and communication problems and maintaining consistency when people are discharged and moved between services. The training has since been adapted to address issues raised through previous evaluations and also the content has been modified to make a distinction between a self-management programme and self-management principles. Rather than a focus on the self-management tool (in this case, a workbook), there is now a greater emphasis on promoting strategies to support patients to develop self-management skills such as self-discovery, goal setting and problem solving as they progress through the stroke pathway [17,21].

Recognition of the complexities of practitioners using a self-management programme within a stroke pathway

In London, UK patients gain rapid access to 1 of 8 London Hyper Acute Stroke units where they may stay for up to 72 hours and, if required, be transferred to an acute stroke unit and for further rehabilitation [22]. Patients may have to

transfer between many different stroke teams during a relatively short period post-stroke and some will require additional input from social care teams and the voluntary sector. The model of stroke care in London, UK has been in place since 2010 and has already demonstrated an impact on factors such as length of stay and health outcomes. However, the number of teams involved in one pathway of care creates a challenge when attempting to gain a consistent approach to self-management [23]. Complex interventions such as self-management programmes have several interacting components and the translation into practice will require sensitivity to local context and norms [8,24,25]. Gaps may exist which could prevent the programme being sustained over time and integrated into regular practice and the programme's success will require the involvement of practitioners from different professional groups and teams, as well as recognition of the complexity and individual needs of people with stroke who may have a diverse range of disabilities [26,27].

Methods

Evaluation aims

The aim of this project was to introduce the Bridges SSMP to all health and social care teams involved in stroke care in one London stroke pathway. This would involve training representatives of different stroke care teams in the same workshop and would include social care practitioners in the training for the first time. Specific aims of the evaluation included:

- To explore the experiences (barriers and facilitators) of using the Bridges SSMP amongst practitioners from different health and social care teams working in the stroke pathway
- To examine impact on the beliefs and attitudes to self-management amongst practitioners
- To examine impact on cross-team working and knowledge sharing throughout the stroke pathway

Methods: evaluation design

The evaluation focused on 2 areas: the impact of the Bridges SSMP training and the experiences of health and social care practitioners in using the programme as part of their practice in the stroke pathway. As such, the evaluation required multiple methods and followed an approach informed by both Normalisation Process Theory NPT and Realist Evaluation [28,29].

NPT advocates the consideration of 4 components when evaluating and testing a complex intervention [28]. These include 1) *coherence* to explore how much meaning and sense participants make of the programme; 2) *cognitive participation* exploring commitment and engagement of participants; 3) *collective action* in terms of

what work needs to be done to make the intervention function and 4) *reflexive monitoring* in which participants reflect on and appraise the intervention. We chose to focus on *coherence*, as this was one of the first times training had involved professionals from different teams, including practitioners from social care and the voluntary sector.

We also used the overarching principles of context, mechanisms and outcomes as described in realist evaluation [29]. We anticipated that a shared philosophy of self-management support within a pathway could facilitate greater harmonisation of care and smoother transitions between teams for patients, so it was important to explore participants' experiences of cross team working and whether they felt attending workshops and learning together had any impact on knowledge sharing about self-management and improved continuity of care for patients. The following methods were used to understand the context in which the teams worked and to evaluate the content and delivery of the training and the impact on practice:

1. Mapping of the stroke pathway of care, the teams and professionals involved and how patients would usually be transferred across and between teams. This was to gain an understanding of how long patients would stay in each team and the criteria for transfer and discharge from services.
2. Observation of team meetings prior to training and interviews were carried out with managers and team members in order to understand current methods of sharing practice and models of working. Field notes were written up and summarised and informed the content of the training.
3. Semi-structured interviews with team members before and after training, to explore experiences of working together in the stroke pathway, perceptions of self-management and experiences of using Bridges. Content thematic analysis was used to categorise recurrent and common themes in the interview data.
4. Questionnaires were completed before and after training, to evaluate participants' change in beliefs, knowledge and practice of self-management and their views on cross-team working. This included a section where participants were asked to rate their level of agreement/disagreement with a number of statements related to stroke self-management (see Table 1).
5. Case reflections were undertaken by participants to capture their experiences of using the Bridges SSMP with specific stroke survivors. A series of questions were incorporated into a template to facilitate reflection on what worked/didn't work and why and what changes (if any) there had been to practice in relation to self-management.

Following the mapping and observation stages, the Bridges SSMP training was modified to reflect local context and include issues relevant to shared working

across the stroke pathway. A quota system was used for the training to maximise cross team participation. Training was also modified to incorporate policy and content appropriate for social care practitioners.

It was recognised that if teams and professionals did not acquire a belief in the principles of self-management through behaviour change strategies, then they may revert to usual rehabilitation practice [27]. A list of 'top tips' outlining strategies used by practitioners from other stroke teams was developed and disseminated to participants by email. A shortened version of the Bridges training was delivered to managers and local GPs to inform them about the programme and encourage promotion within their teams. Teams were also encouraged to nominate a 'Bridges champion' to act as a facilitator of the programme within everyday practice.

Ethical approval

Formal ethical approval was not deemed necessary for this evaluation and was therefore not applied for.

Results

Four introductory Bridges SSMP workshops were delivered with an intervening 3 months before the follow-up workshops. Sixty-six practitioners from 8 teams across 5 health and social care organisations (hospital, community trusts, voluntary sector, local authority) participated, which included 11 different professions. The findings from 2 main components of the evaluation; semi-structured interviews and questionnaires, are presented below. In-depth semi-structured interviews were carried out before and after training with 11 practitioners (16% of participants) from each part of the stroke pathway. They included physiotherapists, occupational therapists, speech and language therapists, nurses, support workers and social workers. Analysis of interview data revealed 5 preliminary themes relating to the training and using the Bridges SSMP in practice.

1. The need for a flexible approach

The emphasis in the training was on being flexible with the introduction of the stroke workbook, getting the interest of the stroke patient to introduce the concept and principles of self-management. Several participants highlighted the benefit of a flexible approach to using the workbook:

"...I realised I shouldn't get hung-up on using 'the workbook' in its fullest sense. People are going " if we don't use the workbook in exactly the same way we've gone through in training...we haven't gone through it in that level of detail then we haven't done it properly." ...actually Bridges is an approach to self-management, a whole range of self-management skills, rather than just use of a piece of card and paper." T2

"I think it's good to say you don't have to use it in its entirety, you can take bits and dip in and out, which I think is great." T1

Participants also talked about using different sections of the workbook to encourage interest from stroke patients. They reported initially being unfamiliar with the content, but with further use they felt more comfortable introducing the book and selecting appropriate sections to discuss:

"...I think there's a practical example of a guy called Brian, a long term goal he has and actually breaking down the steps to achieve that goal. I think his goal is going out to the shops. And that is such a common one that people have, so a lot of people have been really able to relate to that and to use it as a way of breaking down 'how will I do that'." T2

2. Changes in practice

Participants all reported some change in their practice since the training. Whilst principles such as goal setting were not necessarily new, the training acted as a refresher on how to use these methods to promote self-management:

"I think we already use them. But the good thing about training like that is, even if it's not entirely relevant to your work, it reminds you. It's like a refresher. It reminds us about giving people hope, listening to people's goals, giving them a positive message. I guess it's about remembering those incidents when we all said someone wouldn't be able to do something and then they proved us wrong." T8

The Bridges SSMP has a strong emphasis on individualised goal planning based on ideas generated by patients rather than being directed by professionals. Participants reported that the training had facilitated a greater understanding of the value of supporting patients' hopes and plans and creating a more individualised approach to goal setting for each person:

"...it is about instilling hope in people and I really do think that and I think you can get bogged down with working on someone's arm or on this and on that and it's like about actually thinking of things a bit more broadly. So it has definitely under pinned things I think." T6

3. The experience of mixed group training

All participants felt it was beneficial to mix people from different teams in the workshops, but did want a greater mix, as some workshops had a majority attendance by one team. However, participants appreciated being able to share perspectives in an interprofessional group and put faces to names:

"Well as a networking thing for a start as I don't really know people at the hospital that well. So just to get to know a few faces...that helped. And then if you want to hand it over or ask them anything. And they've got a different perspective on it to what we've got, because

we're more community and they're still acute. So it did help." T5

"In both workshops with the discussion time you sort of learnt about other people's experiences and their approach." T3

The stroke pathway has a number of different teams and professional groups and many participants had no prior experience of training with practitioners from outside their own team. Participants felt the cross team training did help towards a shared approach to self-management through the pathway:

"I think we're all aware that we should be working more closely together in regards to goal planning and things like that. I think just having been on the training it makes you more aware and then this [workbook] is something; you know it's a tool that you can actually use." T4

4. Awareness of self-management through the stroke pathway

Overall, participants felt there was more awareness of self-management as it was mentioned more in discussions at multi-disciplinary meetings. This included mention of Bridges by GPs, some of whom had attended the manager's session. It was less clear whether collectively across the whole pathway there was a consistent level of raised awareness amongst team members which could be sustained beyond the training:

"I suppose the training is giving some kind of shared ethos or philosophy to dip into which can help and hopefully the patient isn't going to have to start the whole goal setting process again, but has got a record of you know I've been working on this and I've achieved this." T6

"There have been a number of meetings recently where people have said well could we introduce Bridges here? So I think people are flagging it up to each other and reminding each other that it's there and it's something we can use. I think people are more conscious of trying to use it and making the most of it." T2

Participants felt less able to comment on whether other teams outside of their own were using the approach and were not necessarily convinced that the whole pathway was continuing to use the SSMP consistently.

5. The role of the stroke co-ordinator

One theme evident from all participants' interviews was that the process of handing over information and using Bridges consistently could be improved by having a key staff member to take on the role. Participants universally felt the stroke co-ordinator was in a good position to do this, for example, by reminding staff that Bridges had been started with a patient earlier in the pathway and encouraging other teams to continue using it and maintain a consistent approach to self-management:

"Because [stroke co], who is our end point he's always been very good at, he comes to our MDT meetings, we get good feedback about how our patients are going and he's very present and good about feeding things through." T6

Several teams had referred patients to other services having already introduced Bridges, but this tended to be to surrounding boroughs or to the stroke co-ordinator working with the patient in the community:

"This second chap he desperately wants to get back to driving he's only 61. So that's what I passed on to [stroke co-ordinator] and he has since gone out talked about Bridges and him driving and all of a sudden he's engaging." T5

As well as helping to maintain consistency and promote awareness of using Bridges, the stroke co-ordinator acted as a communication link between stroke survivors discharged to the community and acute hospital teams. Participants valued receiving feedback about how patients continued to use Bridges later in their journey, as it made them feel it was worth taking the time to introduce it initially:

"So I think I wouldn't have had any feedback on these 2 gentlemen if we'd not have had [stroke co-ordinator] involved as a regular, sort of meeting up with him. Because if they are having community physiotherapy we are not in touch with that team regularly." T3

Can a self-management programme be used in the stroke pathway?

A questionnaire was designed to assess change in knowledge and understanding of self-management across all participants and to obtain feedback on the impact of training and whether an SSMP can work across a stroke pathway. Participants were questioned as to their level of agreement/disagreement with the principles of Bridges SSMP and asked for feedback on barriers, enablers and any changes in practice.

The first section of the questionnaire comprised statements relating to self-management. A sample of the statements used is shown in Table 1. In questionnaires from the follow-up workshops, there was a greater level of agreement with statements which exemplified the key components of the Bridges SSMP post-training than before the training. The biggest score differences (before and after the training) were amongst non-professional healthcare staff (healthcare and rehabilitation assistants), followed by physiotherapists. The team with the biggest average change in attitude towards using self-management principles was the re-ablement team (social care), followed by the voluntary sector.

Table 1 Examples of statements used in the questionnaire, which participants were asked to complete before and after training

Statement	Points system*			
	Strongly agree	Agree	Disagree	Strongly disagree
When goals suggested by patients are unrealistic, it holds back progress	1	2	3	4
The clinician should usually lead the goal setting process	1	2	3	4
My own beliefs about success with a goal influences the level of goals set by a patient	4	3	2	1
The goals/targets should always be written in the patient's own words	4	3	2	1
A patient's confidence has very little influence on the success of goals	1	2	3	4

*Participants were asked to circle how strongly they agreed or disagreed with the statement (without knowing how many points were attributed to each answer). Points were added up for each practitioner, and a higher score indicates a stronger belief in self-management principles. Scores from before and after questionnaires were compared.

Table 2 Summary of areas of changes in practice reported by practitioners after receiving training in Bridges Stroke self-management programme

Theme	Specific comments
Goal setting	Goal setting more individualised
	Care more goal focused
	Aware of goal setting and allowing setting of unrealistic goals
	Letting patients be more ambitious with goals
	Using 'steps' to help plan longer term goals
	More thoughtful about who goals are being set for
Promoting independence	Encourage patients to be as independent as possible and give positive feedback
	Promoting independence; patient/service user-focused
Patient-focused	Led by patients; details of patient knowledge and expectations
	Make sure patient is more involved
	Asking patients what they want to achieve
	Focused on patient-centred goal setting
Self-efficacy in practice	Increased confidence in self-efficacy skills
	Level of understanding and involvement of self-efficacy in practice
	Use more task analysis to set therapy sessions and increase success/re-inforce self-efficacy
Used principles	Applied principles
	Use principles and book as a tool
	More focus on self-management principles, not just with stroke
Useful Workbook	Workbook very useful
Miscellaneous	Awareness of importance of hope
	Improved knowledge and skills about self-management

The second part of the questionnaire explored perceived barriers and facilitators to using Bridges SSMP and changes in practice post-training. Participants were also asked about their perceptions of cross team working before and after the training.

In total, 55% of participants had experienced barriers to using Bridges SSMP in their practice. The main barriers reported were (in order):

- 1) Not having enough time (due to a heavy workload)
- 2) Treating a patient with communication difficulties, therefore didn't find it appropriate
- 3) Not enough stroke patients coming through the service

- 4) The length of stay and environment wasn't conducive to spending time with patients to support self-management e.g., acute setting

Overall, 95% of participants said the training gave them ideas of how to use Bridges SSMP throughout the stroke pathway. Seventy-eight percent thought Bridges SSMP could be used successfully within their stroke pathway. The main reasons cited were:

1. It will facilitate consistency throughout the stroke pathway, as all are working towards self-management for patients leading to better handovers and continuous support for patients

2. It will improve communication between teams working in the stroke pathway

Overall, 53% of participants thought their practice had changed since the workshops, 21% thought there had been no change and 26% were unsure. However, 42% of participants thought there was a stronger focus on self-management in their own team since the training. The acute stroke unit team reported the greatest change (88% of the team). Only 25% of participants thought there was a stronger focus on self-management in the whole stroke pathway, but a higher number (64%) were unsure. This may reflect the amount of time participants had to implement the training before the evaluation was carried out. Table 2 shows examples of the areas of practice participants felt had changed after receiving training.

Overall, 99% of participants felt the training enabled them to meet other staff along the stroke pathway, but only 19% of participants felt their team was better connected to other teams after training and 49% were not sure. The most common reasons given were that the links between teams were already satisfactory before the training and many had not seen consistent evidence of Bridges SSMP used between teams.

Comments from both questionnaires and interviews highlighted concerns amongst practitioners about the sustainability of the Bridges SSMP in the longer term and the organisational barriers that exist in a complex care pathway. This includes staff turnover and the perceived time pressures required to integrate a self-management programme into an already pressured service. Nonetheless, participants suggested ways in which the programme could be sustained including refresher sessions for new staff and those who had already been trained and the use of 'Bridges champions' in each team.

Discussion

In this paper, we have presented for the first time a novel, individualized stroke self-management programme, evaluated throughout a stroke pathway. Overall, practitioners were willing to take part in training and were enthusiastic to apply some or all of the principles into their practice. Our aim was to explore the experiences (barriers and facilitators) of using the Bridges programme amongst practitioners from different health and social care teams working in the stroke pathway. The barriers consisted of organizational issues, such as stroke patients moving too quickly between teams, lack of time and the influence of the environment (particularly in the acute care setting). The key principles of self-management, including supporting people to take control of their health, were sometimes hard to achieve in the structured environment of a hospital setting. In the community settings there were other competing pressures such as restricted time and the need to provide other forms of therapy. However, the shared learning provided an opportunity to debate the practical implications of delivery and how a consistent approach to self-management could be sustained. It also promoted

discussion about ways in which pertinent information about the use of Bridges can be managed within a complex pathway and promoted ideas such as having a standing item of 'self-management' discussed at multi-disciplinary team meetings.

The skills required by practitioners to deliver a self-management programme either in full or in part are critical and training is clearly a significant factor in whether the programme will be adopted and implemented consistently within a service [7]. The follow-up training focused on practical implementation facilitated through discussion around participants' case reflections. Practitioners highlighted the benefit of a structure provided by the workbook, but also the opportunity to learn strategies to use when patients were perceived to be unable to embrace the workbook in full. They regarded the stroke co-ordinator as an important channel of communication about patient's progress between teams using the programme. It was felt that the workbook could aid the transfer of information about patients' goals and progress, but that it would need to be overseen by a named person, either the stroke co-ordinator or a Bridges champion within the team. The transfer of information between teams working with different structures and processes can be problematic, but participants felt this could be helped by patients having ownership of their stroke workbook which includes information about their progress and goals [30]. This has the potential to reduce the time required for assessment of patients' needs and goals as they are transferred between services and could improve continuity of care.

This evaluation aligns with previous research exploring the role of practitioners in the delivery of self-management programmes and highlights the need for greater understanding about attitudes and beliefs towards such programmes [27,31]. If practitioners have reservations or are unclear about the value of self-management principles, they will be less inclined to integrate such methods into their practice, especially if time is restricted. The Bridges programme is based on self-efficacy principles using a method of goal setting which is driven by both longer term goals and recording progress with small tasks to improve mastery [17,32]. This can require professionals to make subtle changes to their practice. Here, instead of their role as an expert, there is promotion of a shared approach to rehabilitation and the encouraging of patients to problem solve and self-discover in order to gain confidence in managing their progress in the longer term [17]. Some practitioners felt that these methods were not dissimilar to the approaches they already used, but felt that the Bridges SSMP did help to validate these ways of working and reinforce the principles to colleagues, patients and their families.

Stroke is a complex disability with many people experiencing long lasting problems with mobility, speech and cognition [33]. The difficulty of using an SSMP with patients with severe cognitive and communication problems was highlighted. In the acute hospital setting, patients' fatigue and stroke severity were reported as being a common barrier to using the programme in full. Practitioners did find ways of initiating its use such as

involving relatives, so the concept of self-management was introduced. Teams in the community faced challenges including dealing with more crucial social issues and the numbers of staff involved with the care of one patient, particularly those with complex disabilities. The use of an interactive online discussion board where practitioners can share ideas and strategies for promoting self-management was suggested and is now being implemented. It is hoped this will also impact on sustainability and provide an alternative method of maintaining interest in the programme.

Overall, this evaluation study has directly assisted our understanding of organisational and professional issues which can impact on adoption and implementation of an individualised stroke self-management programme. The intricacies and complexities of working to support self-management in people with stroke was highlighted. However, following training, a trial period and time for reflection, many practitioners had found ways of overcoming some of the barriers to using the programme and had suggested new ideas for furthering the content and delivery of future training for stroke teams [34]. This study also helped to explore how much meaning and sense participants make of the programme and highlighted the areas that could restrict coherence. We have started to explore commitment and engagement of practitioners and methods used by stroke teams to make the programme work for their service. These ideas have been used to inform the development of a sustainability project in the same stroke pathway. Further questions about feasibility, including the economic impact of the programme, are currently being explored in a feasibility cluster trial.

There were a number of limitations to this evaluation. A restructure in the social care team meant the mix of health and social care practitioners in workshops was less than originally anticipated. Organisational changes and high staff turnover in some of the participating teams meant that it was impossible to ensure whole teams were trained in the Bridges SSMP. Previous research has shown us that manager 'buy-in' is essential to the success of the programme and senior managers found it difficult to find time to attend the training. This limitation was partly overcome by organising condensed training sessions for managers and GPs. Another limitation was that this was an evaluation of a pre-planned project, rather than a research study, meaning that stroke survivors could not be interviewed for their opinions due to ethical considerations. Unfortunately, there were no existing patient satisfaction mechanisms in place in the services which could have been utilized in the analysis.

Conclusion

In order to integrate self-management principles and methods into current stroke care and rehabilitation, it is important to understand the motivations and attitudes of professionals working in the pathway. This study has attempted to initiate this process, but more exploration is required to inform future programmes and training is

required for successful implementation. The evaluation by practitioners regarding the format and delivery of training was broadly positive, but in order to assess coherence and cognitive participation with the stroke self-management programme, training needs to be credible and demonstrate an understanding of the organisational context and level of expertise of the different professional groups.

Acknowledgements and Conflicts of Interest

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