East Midlands
Academic Health
Science Network
Igniting Innovation

Igniting Innovation

Improving Health, Creating Wealth

An educational programme to promote multidisciplinary team effectiveness in stroke specialist community rehabilitation teams

Derbyshire Final Report

East Midlands Academic Health Science Network
Igniting Innovation

Contents

1. Introduction

The East Midlands Academic Health Science Network (EMAHSN) Stroke Rehabilitation Theme aimed to deliver an educational programme with community stroke teams to facilitate multidisciplinary team effectiveness. This work was a follow-up to an earlier project* conducted by the University of Nottingham and funded by the East Midlands Health, Innovation, and Education Cluster (HIEC), which successfully piloted the programme with five Early Supported Discharge (ESD) and community stroke teams across Nottinghamshire.

The educational programme aimed to deliver a model of team effectiveness based on research conducted by Borrill and West, through a series of five workshops conducted with Derbyshire Early Supported Stroke Discharge (ESSD) Service. This model allowed the team to explore their effectiveness, identify areas for improvement, create a toolkit of strategies and theories to help them negotiate changes, and support them in measuring their effectiveness.

This report presents details of the programme delivered to Derbyshire ESSD Service. The programme was also delivered to other community based stroke teams across the East Midlands as part of an EMAHSN wide initiative.

* http://www.nottingham.ac.uk/clahrc-ndl-nihr/research/stroke-rehabilitation/esd/multidisciplinary-community-stroke-services.aspx

2. Background

Stroke is the third largest cause of death in the United Kingdom and is a leading cause of disability worldwide [1], representing the most important cause of long term disability in Europe. In the UK, there are about 1.1 million stroke survivors and approximately 152,000 strokes every year. Recovery can continue for many years after a stroke, and consequently there is an emphasis on home-based rehabilitation provided by stroke specialist community services [2].

The stroke care pathway typically begins with admission to a hyper-acute or acute stroke specialist unit in an NHS hospital for initial treatment. Optimal recovery requires the provision of specialist rehabilitation in the community setting, for patients who need it, upon discharge from acute care [3]. During the last decade there has been an increasing focus on Early Supported Discharge (ESD). ESD services comprise of multidisciplinary teams with specialist stroke knowledge. ESD teams facilitate the transfer of patients from hospital to home and provide rehabilitation and support in the early stages of adjusting to the home environment. However, not all patients are suitable for ESD and may require a slower stream of less intensive therapy provided by a Community Stroke Team (CST). Some patients may require ongoing therapy following discharge from ESD services and are referred onwards for further therapy provided by a CST. Consequently, ESD and CST services should work closely with each other, offering a seamless transfer of care.

Evidence from clinical trials and consensus documents suggest that ESD services are more likely to be effective when provided by a specialist multidisciplinary team, comprising of a physiotherapist, an occupational therapist and a speech and language therapist, with medical, nursing and social worker support, and when work is coordinated through regular meetings [4, 5].

Research into team working within other areas of health suggests that the delivery of care is truly a team effort [6]. It is recognised that team effectiveness impacts not only on healthcare delivery, but also quality improvement and patient safety.

It must be acknowledged that there is a great deal of variation in the provision and models of community stroke services, and that the model of service delivery in a particular area is likely to impact on how a team operates. Contextual factors, such as whether a team operates in an urban or rural area, are community or hospital based, and the team composition also impact on team effectiveness. Consequently this programme set out to explore some of these contextual differences, and was tailored towards the needs of each individual team.

3. The Programme

The programme was developed based on an earlier project conducted by The University of Nottingham, funded by the East Midlands Health, Innovation and Education Cluster. The workshops were developed by Dr Jen Yates, Dr Rebecca Fisher and Hazel Sayers, and were tailored for Derbyshire Early Supported Stroke Discharge (ESSD) Service.

Derbyshire ESSD is split into three sub-teams to cover Derbyshire; Derby City team, Amber Valley & Erewash team, and South Derbyshire Dales team. The teams are based in London Road Community Hospital (Derby City), Babbington Hospital (Amber Valley & Erewash), and St Oswalds Hospital (South Derbyshire Dales), and provide Early Supported Discharge. Derbyshire ESSD receives patients from all GP practices in Derby City, Amber Valley, Erewarsh, South Derbyshire and the South Dales and operates a five day service between Monday to Friday, 8:00am – 4:30pm. At the start of the Multidisciplinary Team Effectiveness Programme, Derbyshire ESSD had 21 members of staff. The Derby City team had a caseload of 15, The Amber Valley & Erewash team had a caseload of 9, and the South Derbyshire Dales team had a caseload of 4.

RESEARCH BACKGROUND

Effective teamwork is a basic prerequisite that patients in receipt of healthcare often assume to be in place [7]. However, there is a lack of team working training available from the NHS in general, and specifically within existing stroke specialist training. Multidisciplinary teams operate in many areas of healthcare, and are particularly necessary in stroke rehabilitation services in order to treat the patient holistically and help them to gain independence following their stroke. Research suggests that being multidisciplinary is an optimal component of community stroke teams [8], but it must be acknowledged that simply placing individuals of different professions under the banner of a team does not necessarily make them an effective multidisciplinary team [9].

The research framework used for the programme comes from research by Borrill [10, 11] and West [12]. In identifying factors that affect team working, Borrill and West used a framework of inputs, outputs, and processes, to explore the contextual factors that affect team working in mental health teams. Pilot work conducted by our team identified several contextual factors that were pertinent in five community stroke rehabilitation and ESD teams in Nottinghamshire. This programme used these identified factors within the inputs, processes, and outputs framework to confirm successes and issues for the team, which

led to recommendations which may enhance effective team working. Nancarrow et al, [13] used a similar research to develop a tool to enhance effective team working. They acknowledged in their research of intermediate care teams that differences in team make-up and patient outcomes may impact on the effectiveness of team working. With this in mind, we sought to tailor this programme to context and needs of the participating team.

WORKSHOP ATTENDANCE

The workshops were attended by most members of Derbyshire ESSD. Team members were asked to sign a register of attendance at the beginning of each session.

On average, participating team members attended all of the four sessions, with 18 team members attending every session.

WORKSHOP TIMELINE

October 20th 2015: Workshop 1 – Introduction to team effectiveness, theories of team working, review of the stroke care pathway evidence-base, and how to measure effectiveness

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November 10th 2015: Workshop 2 – Inputs, processes, and outputs model of team working

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November 24th 2015: Workshop 3 – Theories of change, working with other teams and communication strategies

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December 8th 2015: Workshop 4 – Dissemination of team reports, team presentations and setting SMART goals

WORKSHOP CONTENT

Workshop 1: Introduction

The first workshop began with introductions of everyone present and an introduction to the programme as a whole, with an explanation of what Derbyshire ESSD could expect from us, and what we expected from them. Team members read information sheets regarding the programme and signed consent forms to indicate that they were willing to take part. There was a general overview of the East Midlands Academic Health Science Network, and an explanation of how this programme had evolved from previous research.

The evidence-based pathway was presented and the team was asked to consider how their role in the stroke care pathway contributed to the effectiveness of the team. We then presented slides about data and discussed with the team why it is necessary for stroke teams to measure their effectiveness and what is really meant by effectiveness. We considered how effectiveness might be measured and the differences between research, service evaluation and audit with a focus on particular metrics. The team discussed how they measure the effectiveness of their service and which metrics they use.

The team was then introduced to research and theories around team working, and what makes an effective team. The team discussed facilitators and barriers to good team working. The team also played a team building game which required them to communicate effectively and work together to solve a riddle.

We asked the team members to complete a Team Effectiveness Questionnaire developed by Borrill and West [11] and explained that we would ask them to complete the questionnaire again later in the programme. Lastly, the team members were asked to take a ‘Day in the Life of…’ diary and fill it in for two of their working days between the workshop sessions. The diary required team members to note down their communications with other people during two typical working days so that we could see where, when, how, and with whom their interactions took place.

All team members were given hand-outs with detailed notes on the theories of team effectiveness. We also arranged with one of the team members to send the hand-outs, presentations, and extra reading so that it could be uploaded on to the team’s shared drive for future reference and access by non-participating team members.

Workshop 2: Inputs, processes, and outputs

The second workshop began with an explanation of the inputs, processes, and outputs model of team working proposed by Borrill and West [11]. The team was split into two smaller groups to take part in focus groups which were recorded and later transcribed. The groups discussed inputs to their team, and the key points were summarised on flip charts. The two groups came back together to discuss the key points and provide a sense check of what had been discussed in the focus groups. This process was repeated twice for processes, as this was felt to be a larger topic that required more time, and again for outputs. The focus groups typically lasted for about 15 minutes each as this was felt to be a manageable amount of time to discuss issues without being too overwhelming for team members. The team members were given prompt sheets to help them discuss particular inputs, processes, and outputs that previous research had identified as being relevant.

The transcriptions from the focus groups were later analysed in a pragmatic way. This informed a tailored team effectiveness report that was later fed back to the team and that identified areas for celebration and change.

Workshop 3: Theories of change, working with other teams and communication strategies

The third workshop began by looking at different theories of change management. Firstly, Lewin's three step model [14, 15] was discussed, and the team worked together to draw a force field analysis of a particular issue within their team. Lippitt's theory of change [15], which is an expansion of Lewin's theory, was considered as an alternative.

The team was introduced to the concept of fluid networking, which was felt to be important because the team interacts with several other teams, who frequently change in terms of key contacts and remit. The concept of fluid networking, also known as knotworking, relies on team members coming together with external people for a particular process, tying a knot to bond with them during that process and accepting them into the team as a temporary member. When the process has been completed and relationship is no longer required, the knot should be untied and the bond broken [6].

Normalisation theory [16] was considered as a strategy for embedding changes and facilitating their longevity. The team acknowledged that they do start new projects and are very innovative, and new ideas are successful in the short term. However, projects often slipped after an amount of time had passed and the team was keen to stop this from happening. The team was provided with a set of questions to use when planning a new project to help them consider how it might be embedded [17] . The team took part in a worked example of normalisation theory and practiced going through some of the questions.

The team then considered the communication style of Edward De Bono's Six Thinking Hats, which can be used when making decisions to ensure that all viewpoints are considered, and that all team members have had the opportunity to put their view forward. The team felt that this was useful as it helped to cross the hierarchical boundaries between staff bandings. The team practiced the technique using an example.

The team was encouraged to think about what they could do with their data and were introduced to the plan, do, study, act cycle. This was explained in detail and the team completed an example of it using an issue that they wanted to explore further. The team also looked at fishbone cause and effect diagrams to help them to understand why projects do and do not work. The team took part in a game to help illustrate the theory behind the diagram.

The team then decided on which parts of the theoretical ideas that were considered during the workshop were most useful to them and these were selected to form a tool kit that would feature in the team report and act as a resource for the team to use in the future.

The team filled in the Team Effectiveness Questionnaire for the second time and these responses were later compared to the first set of responses completed by the team. The team was also asked to prepare presentations in small groups for the next workshop, to last five minutes, about any aspect of the programme that had been covered. The team members agreed which groups they were in, and what their presentation titles would be.

Workshop 4: Dissemination of team reports, team presentations and setting SMART goals

Workshop 4 began with a review of the programme and what had been covered in each of the workshops. The small groups of team members then gave presentations prepared between workshop 3 and workshop 4, including Tuckman's Model of team formation, six thinking hats, and normalisation theory.

We facilitated the setting of SMART goals by the team using issues and recommendations from the team report. Each area team set three individual goals, and five further goals were set for the service as a whole that required all area teams to work together.

The team members were given copies of a detailed, tailored team effectiveness report that was prepared based on their comments during the focus group sessions and their answers to the team effectiveness questionnaire.

A team knowledge champion was elected from each area team to ensure that the learning of the participating team members was passed to team members who had not been able to participate, and to ensure that learning was continued when new team members joined the team. We agreed to follow-up with the team knowledge champion in six months to evaluate whether the SMART goals were met.

4. Impact

The programme sought to increase team effectiveness in Derbyshire ESSD. Through the four workshops conducted with the team the programme raised awareness of team working processes and provided strategies that the team can use in the future. The intention of the workshops was to help teams explore areas of multidisciplinary working, focus on the processes that enhance their service delivery and assist teams to reflect and resolve areas of organisational difficulty.

The impact of the programme can be demonstrated in several ways: responses to the team effectiveness questionnaire, analysis of focus group discussions, feedback from participating team members, and completion of SMART goals. These will now be discussed in more detail.

5. Team Effectiveness Questionnaire

Team members completed the Team Effectiveness Questionnaire [11] during workshop 1, at the end of workshop 3 and at a six month follow up meeting.

The questions in the questionnaire mapped on to four subscales. The clarity and commitment to team objectives subscale reflected the extent to which teams were clear about their work-related objectives and whether team members shared these objectives. The focus on quality subscale measured the extent team members engaged in debate and reviewed processes to achieve excellence in decisions and actions they took to provide services. The decision and communication subscale assessed the extent to which members of the team felt they had influence over decisions made in the team and the degree to which team members interacted on a regular basis and the adequacy of information shared among team members. The support for innovation subscale questioned the degree of verbal and practical support for the development of new ideas. The measure also referred to sharing resources, giving time and cooperating in implementing new and improved ways of doing things.

The average score for each area team within Derbyshire ESSD for workshop 1, workshop 3 and six month follow up meeting for each subscale is shown in the table overleaf.

	Derby City	Amber Valley & Erewash	South Derbyshire Dales
Workshop 1			
Clarity and commitment to team objectives	4.4	3.3	4.6
Focus on Quality	4.1	3.2	4.9
Decision making and communication	4.3	3.3	4.6
Support for innovation	4.6	3.5	4.8
Workshop 3			
Clarity and commitment to team objectives	4.7	2.5	5.0
Focus on Quality	4.5	2.7	4.7
Decision making and communication	4.7	2.5	4.8
Support for innovation	4.8	2.6	5.0
Six Months Follow-Up			
Clarity and commitment to team objectives	4.2		4.7
Focus on Quality	4.4		4.5
Decision making and communication	4.4		4.8
Support for innovation	4.5		4.8

The Derby City and South Derbyshire Dales teams saw small a trend of small increases to their scores. The Amber Valley & Erewash team saw a decrease in their scores, and is likely to be due to the team reflecting on their practices and processes more deeply as the programme took place.

The team report presented to the team at the end of the programme outlined recommendations aligned to each of the subscales of the Team Effectiveness Questionnaire which may help to increase scores further.

The Team Effectiveness Questionnaire was sent to the teams again at the six months follow-up, and scores remained similar to those at the end of the programme. Data were not complete enough for the Amber Valley and Erewash team to report on.

6. Inputs, Processes, and Outputs Focus Group Discussions

We used Borrill and West's [11] model of team working as a framework to reflect on issues that the team faced, and explored the inputs, processes and outputs (IPO) felt to be important to effective team working. Through focus groups with the participating team members we explored each aspect of the model, using prompt sheets as a guide. The following are a selection of the themes included in the individual team effectiveness reports.

INPUT 1: LOCATION

The teams are based in three differing locations, which present unique challenges to each area team. The Derby City team are based in the city centre of Derby, and whilst they only cover a small area, they have to contend with traffic and parking. Derby city centre also presents cultural issues as the client base for this area team is multicultural and multi-faith which requires a sensitive approach. The Amber Valley & Erewash and South Derbyshire Dales teams cover large rural areas, which can make travelling to see patients time-consuming. This impacts on the teams' capacity as much of the day can be taken up with travelling. The geographical separation of the three teams means that the area teams are not as involved with each other as they could be.

PROCESS 1: COMMUNICATION

All three area teams acknowledged that there are many streams of communication available to them, and that actually this could be making things more difficult. A number of team members work in split roles between different teams, which can lead to communication difficulties and inconsistencies as not all staff are able available each day. The team felt that some work on this area may help to improve effectiveness.

OUTPUT 1: INNOVATION

The area teams are very innovative in a healthcare environment that has limited staffing and limited resources, and use their creativity and ideas to ensure that patients receive the best service. However, the team acknowledge that they could be more innovative with increased funding, and that often a lack of finances can be a barrier to innovation. The teams attend forums and events to learn new ideas and feed these back to the rest of the team.

Using the IPO framework, team members were able to acknowledge what they do well, and highlight areas that could be improved. It was apparent that the team seldom had the opportunity to consider how team working processes might influence their effectiveness in delivering community stroke services. The immediate impact of the programme was to allow participants to reflect on their team's positive attributes, as well as begin to tackle some aspects that could be improved, highlighted during the focus groups.

7. Team Effectiveness Reports

A team effectiveness report was prepared specifically for Derbyshire ESSD to capture what was presented and discussed during the programme to provide a resource for future learning.

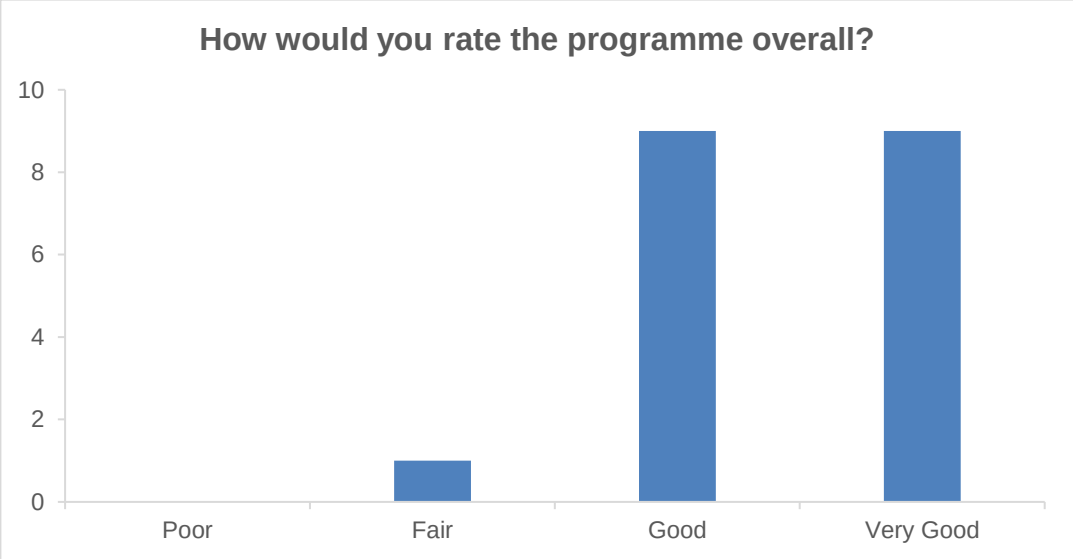
The report began with a baseline measure of team composition which described the context of the team at the start of the programme. The information from the 'Day in the life of…' diaries was summarised into a diagram and included in the report to highlight how the team communicate with one another.

The main part of the report featured the focus group discussions and was split into sections for inputs, processes, and outputs. The main themes that emerged from the analysis were included and supported by quotes from the team members. The subscales of the questionnaire were matched up with particular inputs, processes, outputs so that it could be seen clearly which aspects of team working were contributing to their scores. This section of the report also contained recommendations that the team might like to work on.

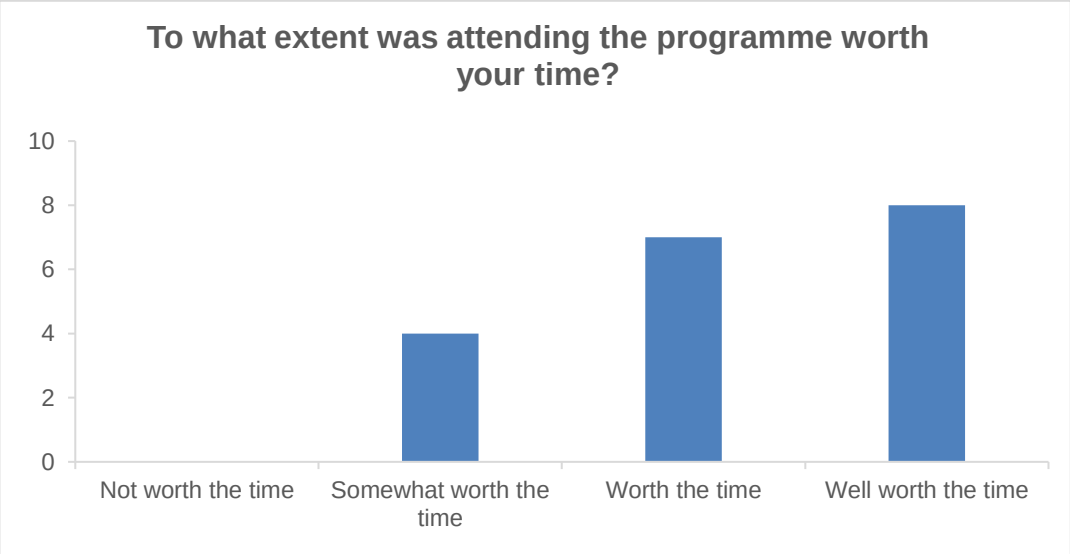
The report also contained a change toolkit, which contained theories from workshop 3 that the team had identified as being useful to them.

8. Evaluation of the Programme

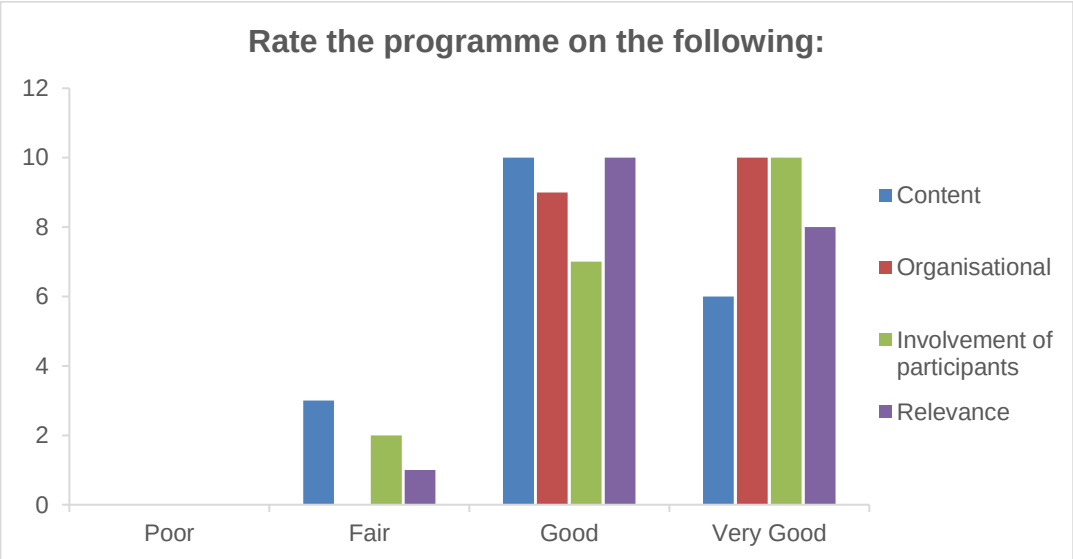
The team completed evaluation feedback forms at the end of the programme. The graphs below show the responses to the questions. Nineteen team members participated in the last session and provided feedback.



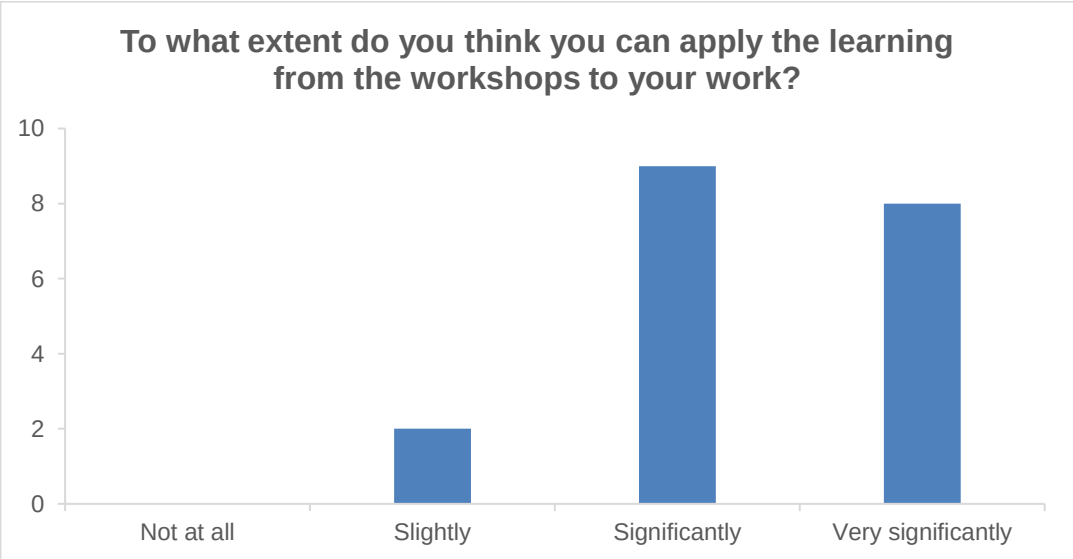
Overall, 95% of the team members who evaluated the programme felt that the programme was either good, or very good.



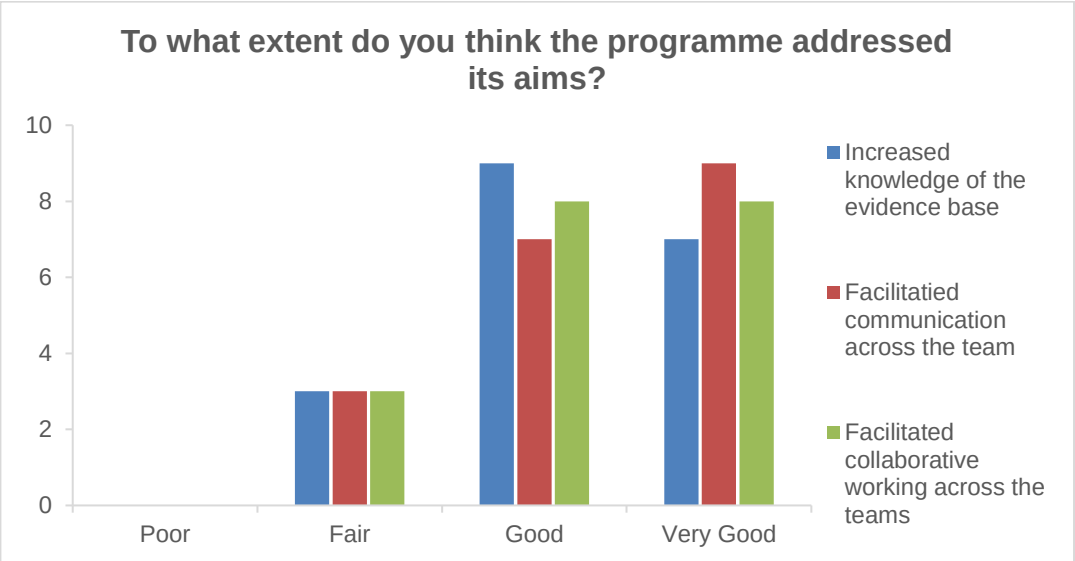
79% of the team felt that attending the programme was worth their time or well worth the time.



Most participating team members rated the content, organization, involvement of participants and relevance as either good or very good.



89% of the participating team members felt that they could significantly or very significantly apply the learning from the workshops to their work.



Most of the participating team members felt that the programme was good or very good at addressing the aim of increasing the knowledge of the evidence base, facilitating communication across the team, and facilitating collaborative working across the team.

We also asked for feedback about how the programme could be improved. Some team members commented that they would have liked more cross working between the area teams, but other team members commented that they would have appreciated more time alone with their area teams. One team member also suggested that we visit their workplaces to see how they work first hand.

The participating team members reported “a sense of the teams coming together, sharing knowledge - it was very well organised to facilitate 'shared' learning!” and that they felt they had a “space to come together as a team in a safe environment to explore our practice”. The team commented that they now have “practical solutions in order to move our team forward” and that they have “a good idea of where/what we're going to take from the programme”.

Overall, participating team members felt that the programme was “a really valuable service for the whole team”, and a “super enjoyable programme which will benefit staff and patients”.

9. SMART Goals

During the final workshop, service wide goals as well as individual team goals were set which teams would work towards over the following six months. At six months, the success of achieving the goals was evaluated through a follow-up visit to meet with the Team Knowledge Champions at the Royal Derby Hospital.

The following section outlines the goals and how the teams have worked towards these:

Service wide goals

1. Alignment of referral forms from the hospital wards.

This was a substantial task due to the number of key stakeholders involved and the methods of referrals already in place, and is therefore is ongoing. In the context of larger scale transition within the Trust, there have been short term changes to the paperwork with support and guidance of the acute services, which have been nurse led. Challenges have included: not all teams have access to the System One software and the wide variety of specialist areas from which referrals are accepted. Community staff have been proactive in attempts to influence the process and are keen to align referrals through a single point of access. Links exist between community clinicians in Derbyshire and the stroke units they receive referrals from and it was felt that the stroke units would be amenable to adapting their referrals as required. This goal represents an input in the Inputs, Processes, and Outputs (IPO) model because it relates to the organisational context in which the service operates in terms of receiving referrals.

2. Explore solutions to in-reaching more effectively and align across the teams.

Work is currently on hold for this goal due to the restructure of services locally. A pilot of formal in-reaching onto the wards was undertaken in December 2015 that identified barriers to discharge, the results of which were shared with the management team. There are questions as to whether this model of in-reach is the most appropriate as it was not universally well received by inpatient staff. There are discussions around the rotation of staff between teams that may allow for greater flexibility and sharing of knowledge and skills. The team plan to explore the feasibility of staff rotations before deciding upon a model to seek financial support for. More recently, informal in-reaching has been occurring when capacity allows and this has been deemed to be going well. This goal is related to the processes aspect of the IPO model because it represents the process of how the team achieves its objectives of reducing inpatient stay and enabling patients to return home quickly.

3. Conduct a service wide audit to identify the most appropriate ways of sharing information.

The teams looked at their current practice and identified a number of potential areas for improvement. One suggestion was the use of a ledger to avoid appointment overlaps, but it was felt this generated more work in the longer term when changes needed to be made. Attempts have been made to increase email communication as well as face to face contact, as this was felt to be the most effective form of communication for the teams. This goal represents the process of communication within IPO model.

4. Explore cross-boundary working between the teams to potentially reduce travel time.

This has been done on a case by case basis depending on team capacity, backed by trust initiatives to support discharge and prevent blockages. There have been a number of challenges such as different systems of documentation and access to equipment, but also opportunities for Band 4 staff to act as keyworkers. On balance, the teams felt this was a positive experience, providing an efficient service, but required guidance going forward as to how far this would continue. It was agreed to continue on a case by case basis in conversation with senior clinical staff. This goal is related to the input of organisational context within the IPO model.

5. Collect a core dataset for all patients across Derbyshire to create a central database.

A standard core dataset is now being collected for all patients across Derbyshire, however this is not as yet being held centrally. This goal represents a clinical outcome, which is an output of the IPO model.

Derby City team goals:

1. Increase intensity of rehabilitation by implementing a group session as a pilot.

A bid for this service has been formulated and circulated for comments; this is due to be re-submitted for management approval. An exercise intensity working group has been set up across the service to identify potential areas for improvement as well as explore options.

2. Time table visits to allow the team to predict their capacity.

This goal remains a work in progress as the shared calendars have only been in place for two weeks. Already there are clear benefits, however there are also obvious limitations as not all calendars can be seen and not all staff have smartphones or remote access to diaries. Ongoing support is required from IT to enable the appropriate diaries to be shared as well as additional access to mobile devices.

3. Develop self-management strategies for the patients.

The team are in the process of developing a number of programmes, including a sensory leaflet to be provided to patients to support self-management. Time constraints have so far limited this goal being completed, but once finished, the team plan to share the programmes.

The goals outlined above are related to the process of objectives, and the output of innovation, which were identified as important to the team through focus group discussions using the IPO model as a framework. Time tabling visits (goal 2) enables the team to plan their time more effectively in order to positively affect outputs such as clinical outcomes and cost-effectiveness. The implementation of group sessions (goal 1) and development of self-management strategies (goal 3) show how the team are using innovative strategies to enhance effective multidisciplinary team working.

Amber Valley and Erewash team goals:

1. Clarify communication channels to determine an effective communication system on a daily and weekly basis.

This goal remains a work in progress due to team expansion. However, a number of changes have been made to the way in which the team communicate. These include: increasing the MDT meeting to twice weekly to accommodate more part time staff and a more consistent use of the ledger and notification systems on System One. In addition, there is now a duty rota for both referrals and discharges, so lines of communication are much clearer. There have been a number of challenges in addition to IT support, mainly due to the number of different staff involved, preferences in communication styles and IT abilities. The issues identified will be discussed further at the upcoming development day.

2. Determine a clear means of establishing capacity.

All staff now participate in the duty rota, with moral support if needed. Alongside the “ring-fencing” of a slot for new patients, this has given everyone a clearer appreciation of the capacity of the team. In addition, the increase in Technical Instructor (TI) time has created further capacity through increasing the availability of qualified staff.

3. Implementing an effective duty rota

Establishing the duty rota is considered to be a positive change for the team. All staff participate in the duty rota on a regular basis, and the times in which staff are on duty is balanced across days of the week and morning and afternoon slots to ensure an equitable workload. The duty rota functions to enable the on duty staff member to coordinate the team during the morning, follow up with new patients, and advise other team members of any changes to appointments during the day.

The goals outlined above are related to processes within the IPO model which were identified as important to the team through focus group discussions using the IPO model as a framework. These goals relate to the process of objectives, in particular how the team coordinates itself, and also communication. The model suggests that processes will have an effect on outputs such as clinical outcomes, innovation and cost effectiveness. Therefore, by working towards improving these processes, the team could potentially influence their outputs in a positive way and enhance effective multidisciplinary team working.

South Derbyshire Dales team goals:

1. Review the capacity and look at the geographical location of patients for when the new Technical Instructor starts (early 2016).

The Technical Instructor (TI) has been in post since February and has had a positive impact on the team, especially as they are full time and generic. In addition to this, the vacant physiotherapist post has now been filled, resulting in the team's capacity being doubled and increasing the number of patients being seen. Consequently, there has been an increase in demand for OT input, some of which the team plan to accommodate by up skilling the TI for equipment assessment as well as accessing the community neuro OT for support.
The diverse geography of patients remains a complex problem and discussions are ongoing as to the best way to proceed.

2. Set up the iPad and use for taking on referrals. Explore the possibility of Skype MDT meetings.

The TI is in the process of loading apps onto the iPad but has yet to use with patients. Due to staff preference for face to face meetings, remote MDT meetings have not been actively pursued. The hardware is in situ and once the software is installed, then it will be ready for use if and when needed, however a generic login is needed and IT are supporting staff with this currently.

3. Development of in-reaching onto the wards and developing links with the hub.

This goal is currently on hold due to long term staff absence, therefore reduced capacity.

The goals outlined above are related to inputs, processes and outputs, which were identified as important to the team through focus group discussions using the IPO model as a framework. Goal 1 represents the input of team composition, and the IPO model suggests that this input will have an effect on both processes, such as objectives, decision making and communication, and outputs such as clinical outcomes, innovation and cost effectiveness. Goal 2 is related to the output of innovation, and goal 3 is related to the process of objectives, specifically coordination. The model suggests that processes will have an effect on outputs such as clinical outcomes, innovation and cost effectiveness. Therefore, by working towards improving this process, the team could potentially influence their outputs in a positive way.

10. Finances

The table below presents the spending for running the programme with Derbyshire ESSD. All costs for the project were managed through the University of Nottingham AGRESSO accounts system, using the project code SR4805.

Non-staff costs for completing the programme with Derbyshire ESSD.

Item	Cost
Venue	£1630.00
Travel	£100.00
Transcription	£550.00
Total	£2280.00

11. Return on investment

Attributing costs and benefits to the running of this programme is difficult. The aim of the programme was to facilitate discussion amongst teams and empower them to improve their service through providing knowledge and identifying goals for improvement.

The cost to Derbyshire ESSD service was the time taken for fourteen members of the team to attend the four workshops. During this time, the service was able to function as the attendees represented approximately half of the team. Through the role of the Team Knowledge Champions, the knowledge gained through the workshops could be shared with non-attending team members to ensure that the whole team was empowered.

Derbyshire ESSD Service has a caseload of approximately 200 patients each year and our work to empower the team could potentially have a positive influence on the care of these patients.

12. Challenges

TRAVELLING

All workshops were held in a hotel in Derbyshire, at a distance of approximately 30 miles away from Nottingham. This resulted in an almost three hour round trip for EMAHSN facilitators but fortunately we were able to start at 9:30am and finish by lunchtime, which helped the team fit clinical visits around the workshops. The location of the workshops was also felt to be central and accessible to team members from each area team.

MAKING THEORETICAL IDEAS RELEVANT TO THE TEAM

We were very conscious that much of the theories and ideas included in the workshops were likely to be new to the participating team members, and may not be immediately thought of as being a part of healthcare. Therefore, it was very important to make sure that everyone attending the workshops understood the theories and ideas in the context of their own service, and that the information presented was useful and relevant to the team. This was achieved through using real life examples from the team, and looking at theories with worked examples that the team were involved in. The team had opportunities to ask questions and we were happy to clarify things and explain them in a different way to ensure understanding. The presentations given by the participating team members in Workshop 5 helped to solidify their knowledge and show that they understood how to apply what they had learnt to their everyday work.

13. Project Dissemination

An individual team report was produced for all members of Derbyshire ESSD. All participating team members were given a hard copy of the report, and a PDF version was emailed to the team administrator to place on the shared drive.

The resources from the project, such as PowerPoint presentations, hand-outs and extra reading were provided to the team members and emailed to the team administrator to place on the shared drive.

The programme was featured in the EMAHSN blog: http://emahsn.org.uk/emahsn-blog/stroke-rehabilitation-multidisciplinary-team-effectiveness-programme.

The programme also received a mention in the EMAHSN July 2015 newsletter: http://us3.campaign-archive1.com/?u=cd7ca63548334f177dc525c41&id=edafe8203c#mctoc7.

The developments of this programme were highlighted in a presentation by Dr Brian Crosbie about the earlier pilot work, at the Health Services Research Network Conference in July 2015.

Findings from the each programme of workshops conducted with the teams across the East Midlands are currently being prepared for publication in a peer reviewed journal.

The team attended an East Midlands wide network event hosted by the EMAHSN in June 2016. Here they showcased their SMART goals identified in the programme by presenting a poster and feeding back to other teams across the East Midlands. An outline of the event as well as a copy of the poster presented is included in the final pages of this report. The Derby City team poster was judged by a panel including patient representatives to be outstanding and was therefore awarded first prize at the event.

14. Future steps

The programme continues to be rolled out across the East Midlands and has also been successfully delivered with Lincolnshire Assisted Discharge Service, Northamptonshire Community Stroke Team and Leicestershire Early Supported Discharge Service.

We continue to investigate options to gain accreditation for the programme and are investigating the sustainability of the programme through developing a community of practice amongst the East Midlands teams.

15. Conclusion

This programme addressed a distinct gap in the training provided for members of staff of community stroke rehabilitation teams, by providing education and training about team effectiveness in the context of a multidisciplinary community healthcare team.

Whilst a Team Effectiveness Questionnaire did not reveal a change in the level of team effectiveness for two of the area teams, it did reveal that levels of team effectiveness were consistently high. The decrease in scores experienced by one of the area teams are likely to be due to the team reflecting more deeply on their practices and processes during the course of the programme. We were able to use this information, in conjunction with our findings from the focus group discussions, to highlight areas where the team works really well, and to develop recommendations for how the team could improve.

The team felt that having the time and space to reflect on their issues was very important. Our role in facilitating those discussions, using an established framework to guide the discussions helped us to work with the team to develop recommendations and SMART goals that the team are able to work towards.

The knowledge, skills, and resources that the team took away from the programme will help the team to be more proactive in dealing with issues of effectiveness, working across teams, and dealing with change. This can help the team continue to work effectively and deliver an effective service in the face of future changes such as staff turnover.

The programme highlighted to the team the need to be reflective, in order to recognize where improvements may be made, but also to celebrate and capitalise on success. It is envisaged that through establishing this need, the culture of the team will become one where reflection is encouraged, and team members feel empowered to drive service improvement through their reflective behaviours.

This report has been written by Dr Jen Yates, Hazel Sayers, Lal Russell and Dr Rebecca Fisher on behalf of the Stroke Rehabilitation Programme of the East Midlands Academic Health Science Network.
For more information please contact: rebecca.fisher@nottingham.ac.uk

Regional Networking Event 29th June 2016
Improving community stroke services: How far have we come?

Why
This was an event focused on provision of community based stroke care for stroke survivors in the East Midlands. It celebrated service improvement initiatives and provided networking and shared learning opportunities for attendees.

Aims of the event
The overall theme of the event was a celebration of multidisciplinary team working and provision of stroke rehabilitation in the community. The aim was to empower and support staff and highlight service improvement initiatives from teams across the East Midlands. A further aim was to highlight outputs from the East Midlands Academic Health Science Network (EMAHSN) stroke programme, providing learning and signposting opportunities.

Who was present?
Seventy people attended the event including 4 commissioners, 51 service providers, 4 researchers and 2 service users from across the East Midlands. There were also guests from the Yorkshire and Humber region.

The guest speaker was Jocelyn Cornwell, Director of the Point of Care Foundation. Jocelyn advocates for bringing patients, families and staff together to improve the way care is given and highlighted a fundamental connection between staff and patient experiences of care.

Presentations
The event was chaired by Suzanne Horobin (East Midlands Clinical Network, Cardiovascular lead). Dr Rebecca Fisher (EMAHSN Stroke programme lead) gave an overview of EMAHSN stroke programme activities focused on commissioner support, measuring performance of services and multidisciplinary team working. This was followed by poster presentations from nine community stroke teams across the East Midlands who had participated in the EMAHSN multidisciplinary effectiveness programme.

Presentations are available on the EMAHSN website

Key points of discussion

Discussions on the day highlighted both the excellent work being done throughout the region as well as the challenges faces by teams working with stroke patients in the community.

Clinicians appreciated the opportunity to network, share good practice and innovative ideas whilst acknowledging common problems and barriers. Teams found it reassuring to hear they face similar problems and encouraging to discover what has worked elsewhere.

The stroke patient representatives provided invaluable insights into the stroke pathway from a user's perspective which clinicians felt would enhance the service they provided.

There was general agreement that the day's event had helped "map" the community services in a more tangible sense. This allowed teams to "benchmark" informally against each other as well as navigate the services in clinical practice.

Feedback from participants:

My experience has been extremely positive. When I commenced involvement I felt unsure where I and the service fitted into this wider network, but this has progressed to now feeling actively involved in the network

Excellent team effectiveness training

I have found working with the EMAHSN Stroke Programme a very positive experience. I have been treated in a very professional way and communication has been excellent

I have found the team effectiveness meetings very beneficial, which I hope then enables me to empower my patients

It has helped to bring varied services together to share similar experiences Galvanised work on pathways and highlighted the gaps and need for developments

EMAHSN Stroke Programme has been very useful in bringing people together and developing the stroke pathway with professionals and patients alike

Having been on the team effectiveness programme, this follow up event was a good chance to reflect and what we gained from this experience

Thoroughly enjoyed the Programme. It was extremely well run and the content has benefited our team

Really useful for information sharing, networking and dissemination of resources

This is my first involvement with the Stroke Programme – given me some great ideas about how to develop services in the South Yorkshire and Humber region. Thanks for allowing us to attend

After each event I've left with a renewed desire to continue to push for success and improved services

I am from Doncaster so wasn't involved. I have been very impressed by all the work the Network has done.

This is an inspirational group of professionals passionate about stroke and driving best practice

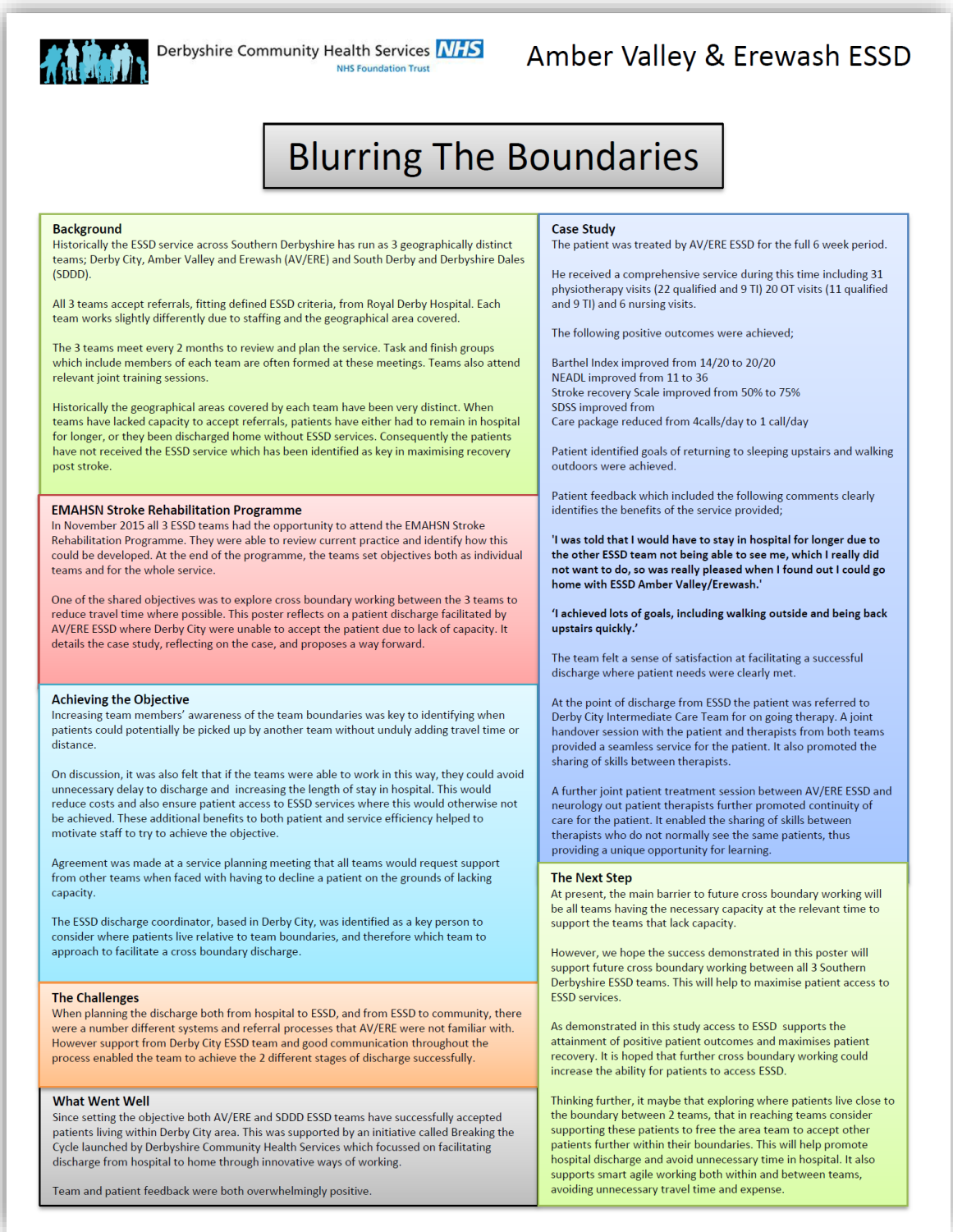
Events have always been excellently organised and structured and a real champion for stroke

From an industry perspective it was great to be involved!

In summary, discussions proved to be constructive, offering opportunities for reflection and joint problems solving. Individuals described being encouraged and inspired, leaving motivated to continue to meet the challenges of working with stroke survivors in the community.

The EMAHSN stroke team would like to thank all those who participated in the team effectiveness programme and engaged in the networking event to make it such a successful day. We hope this opportunity to refresh and strengthen the networks throughout the East Midlands will support clinical practice, service delivery and ultimately patient care.

Posters presented by the teams:



Derbyshire Community Health Services NHS
NHS Foundation Trust

Amber Valley & Erewash ESSD

Blurring The Boundaries

Background
Historically the ESSD service across Southern Derbyshire has run as 3 geographically distinct teams; Derby City, Amber Valley and Erewash (AV/ERE) and South Derby and Derbyshire Dales (SDDD).

All 3 teams accept referrals, fitting defined ESSD criteria, from Royal Derby Hospital. Each team works slightly differently due to staffing and the geographical area covered.

The 3 teams meet every 2 months to review and plan the service. Task and finish groups which include members of each team are often formed at these meetings. Teams also attend relevant joint training sessions.

Historically the geographical areas covered by each team have been very distinct. When teams have lacked capacity to accept referrals, patients have either had to remain in hospital for longer, or they been discharged home without ESSD services. Consequently the patients have not received the ESSD service which has been identified as key in maximising recovery post stroke.

EMAHSN Stroke Rehabilitation Programme
In November 2015 all 3 ESSD teams had the opportunity to attend the EMAHSN Stroke Rehabilitation Programme. They were able to review current practice and identify how this could be developed. At the end of the programme, the teams set objectives both as individual teams and for the whole service.

One of the shared objectives was to explore cross boundary working between the 3 teams to reduce travel time where possible. This poster reflects on a patient discharge facilitated by AV/ERE ESSD where Derby City were unable to accept the patient due to lack of capacity. It details the case study, reflecting on the case, and proposes a way forward.

Achieving the Objective
Increasing team members' awareness of the team boundaries was key to identifying when patients could potentially be picked up by another team without unduly adding travel time or distance.

On discussion, it was also felt that if the teams were able to work in this way, they could avoid unnecessary delay to discharge and increasing the length of stay in hospital. This would reduce costs and also ensure patient access to ESSD services where this would otherwise not be achieved. These additional benefits to both patient and service efficiency helped to motivate staff to try to achieve the objective.

Agreement was made at a service planning meeting that all teams would request support from other teams when faced with having to decline a patient on the grounds of lacking capacity.

The ESSD discharge coordinator, based in Derby City, was identified as a key person to consider where patients live relative to team boundaries, and therefore which team to approach to facilitate a cross boundary discharge.

The Challenges
When planning the discharge both from hospital to ESSD, and from ESSD to community, there were a number different systems and referral processes that AV/ERE were not familiar with. However support from Derby City ESSD team and good communication throughout the process enabled the team to achieve the 2 different stages of discharge successfully.

What Went Well
Since setting the objective both AV/ERE and SDDD ESSD teams have successfully accepted patients living within Derby City area. This was supported by an initiative called Breaking the Cycle launched by Derbyshire Community Health Services which focussed on facilitating discharge from hospital to home through innovative ways of working.

Team and patient feedback were both overwhelmingly positive.

Case Study
The patient was treated by AV/ERE ESSD for the full 6 week period.

He received a comprehensive service during this time including 31 physiotherapy visits (22 qualified and 9 TI) 20 OT visits (11 qualified and 9 TI) and 6 nursing visits.

The following positive outcomes were achieved;

Barthel Index improved from 14/20 to 20/20
NEADL improved from 11 to 36
Stroke recovery Scale improved from 50% to 75%
SDSS improved from
Care package reduced from 4calls/day to 1 call/day

Patient identified goals of returning to sleeping upstairs and walking outdoors were achieved.

Patient feedback which included the following comments clearly identifies the benefits of the service provided;

'I was told that I would have to stay in hospital for longer due to the other ESSD team not being able to see me, which I really did not want to do, so was really pleased when I found out I could go home with ESSD Amber Valley/Erewash.'

'I achieved lots of goals, including walking outside and being back upstairs quickly.'

The team felt a sense of satisfaction at facilitating a successful discharge where patient needs were clearly met.

At the point of discharge from ESSD the patient was referred to Derby City Intermediate Care Team for on going therapy. A joint handover session with the patient and therapists from both teams provided a seamless service for the patient. It also promoted the sharing of skills between therapists.

A further joint patient treatment session between AV/ERE ESSD and neurology out patient therapists further promoted continuity of care for the patient. It enabled the sharing of skills between therapists who do not normally see the same patients, thus providing a unique opportunity for learning.

The Next Step
At present, the main barrier to future cross boundary working will be all teams having the necessary capacity at the relevant time to support the teams that lack capacity.

However, we hope the success demonstrated in this poster will support future cross boundary working between all 3 Southern Derbyshire ESSD teams. This will help to maximise patient access to ESSD services.

As demonstrated in this study access to ESSD supports the attainment of positive patient outcomes and maximises patient recovery. It is hoped that further cross boundary working could increase the ability for patients to access ESSD.

Thinking further, it maybe that exploring where patients live close to the boundary between 2 teams, that in reaching teams consider supporting these patients to free the area team to accept other patients further within their boundaries. This will help promote hospital discharge and avoid unnecessary time in hospital. It also supports smart agile working both within and between teams, avoiding unnecessary travel time and expense.

Supporting Self-management after Stroke

Derbyshire Community Health Services NHS
NHS Foundation Trust

Introduction

We found the team effectiveness training gave us time to reflect on our strengths as a team and to identify areas that we wanted to develop. We learnt about theories to support effective team working and change (De Bono, Change theory).

Team Goals

1) To support self-management programmes for our patients and their carers - 1 year

2)To increase intensity of rehabilitation through both self-management and a group clinic- 1 year

3)To improve team time effectiveness, productivity and capacity by use of an electronic timetable - 6 months

Lewin's Change Theory: Force Field Analysis

Helping forces	Hindering forces
Team motivation	Cultural shift
Cost effectiveness	Carer strain
Evidence based	Team time

The Team

Authors: The ESSD Derby City team Karen Clements, Hayley Grice, Fiona Mann, Lorna Mills, Zoe Martin, Zoe Zydzienowski, Liz Barnes, Lesley Boyle, Laura Bales, Liz Reed, Sharni Roe & Jessica Beavan

- Bid for group clinic submitted -Self-management leaflet in use -Training of upper limb interventions completed -Cross pathway working groups regarding upper limb, exercise and cognition -New team members inducted and positive contribution	- Requires additional resources-business case bid submitted -Time to develop resources can be limited -IT problems with accessibility and compatibility to implement team timetable

Next steps

1) Continue self-management development programme

2) Continue to develop stroke services across the pathway

3) Ensure close working relationship with Derbyshire ESSD teams

4) Use stroke competency frameworks for all professions in ESSD

How can small ESSD teams work more effectively?

Charlotte Cadman (PT) and Andy Richardson (OT) - South Derbyshire South Dales ESSD team

An evidence based research initiative from the East Midlands Academic Health Science Network (EMAHSN) offered training, expertise and support on ESSD team development:

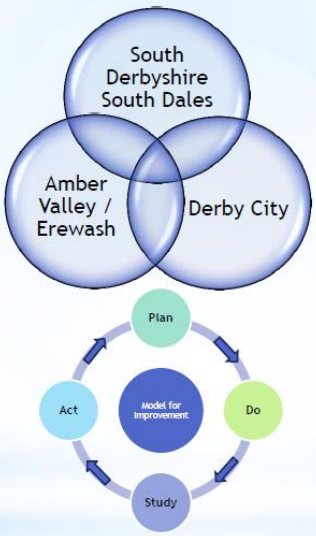
- Understanding teams – what works
- Models of managing change and transition
- Implementation from research to practice
- Evaluation and analysis of teams
- Evaluating change and learning

(Fisher, 2011)

Problem: Capacity to accept referrals in individual teams varies. Suitable candidates have at times been denied ESSD, as locality teams lack capacity. The teams worked together to develop the goal to increase efficiency.

Objective: Integration of locality teams, overlapping services, to increase overall capacity for referrals. Timescale: 6 months

The **Plan, Do, Study, Act**, Model was adopted as a way of preparing, implementing and analysing the proposed change . Further analysis was completed, and a learning-based action plan was formulated (Langley et al, 2009)



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Facilitators : Willingness to accept change, encouragement from EMAHSN

Barriers: Equipment , operational differences Care manager difference

Plan - The objective was identified and agreed with all 3 teams. This was communicated through emails between the ward therapists, team leaders and admin team at the RDH.

Do- Patients identified as suitable for ESSD with no capacity in their teams were accepted by neighbouring teams. Allowing earlier discharge and stroke specialist rehabilitation in patients' own homes

Study – Patients were successfully discharged to ESSD teams from a neighbouring locality, increasing team effectiveness.

Act – Actions have been developed to improve the efficiency of this new way of working in the future.

Re-plan

The next steps as an effective team Actions:

Recognised needs:

- Equipment access – pin no.
- Earlier referral to Care Manager
- SystmOne TPP notes for all teams

Achievements:

- Patients discharged with early- specialist rehabilitation in their own home.
- Patient outcome measures showed improvements .
- Cost savings - In patient bed days saved.
- Compliments received , patient satisfaction.
- Established links with the other teams. Cohesion of new members of ESSD team.

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East Midlands
Academic Health Science Network
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East Midlands Academic Health Science Network
C Floor, Institute of Mental Health,
University of Nottingham Innovation Park,
Triumph Road, Nottingham, NG7 2TU
T: 0115 823 1298 **E:** emahsn@nottingham.ac.uk
W: www.emahsn.org.uk @EM_AHSN