East Midlands
Academic Health
Science Network
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Improving Health, Creating Wealth

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

Lincolnshire Final Report

East Midlands Academic Health Science Network
Igniting Innovation

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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 Lincolnshire Assisted Discharge Stroke Service (ADSS). 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 Lincolnshire Assisted Discharge Stroke Service (ADSS). 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 services 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 Lincolnshire Assisted Discharge Stroke Service (ADSS).

Lincolnshire ADSS is split into four sub-teams to cover the four quarters of the area. The teams are based in Lincoln, Louth, Boston and Sleaford, and provide stroke specialist community rehabilitation. Lincolnshire ADSS receives patients from all GP practices in Lincolnshire and operates a seven day service. At the start of the Multidisciplinary Team Effectiveness Programme, Lincolnshire ADSS had 38 members of staff.

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].

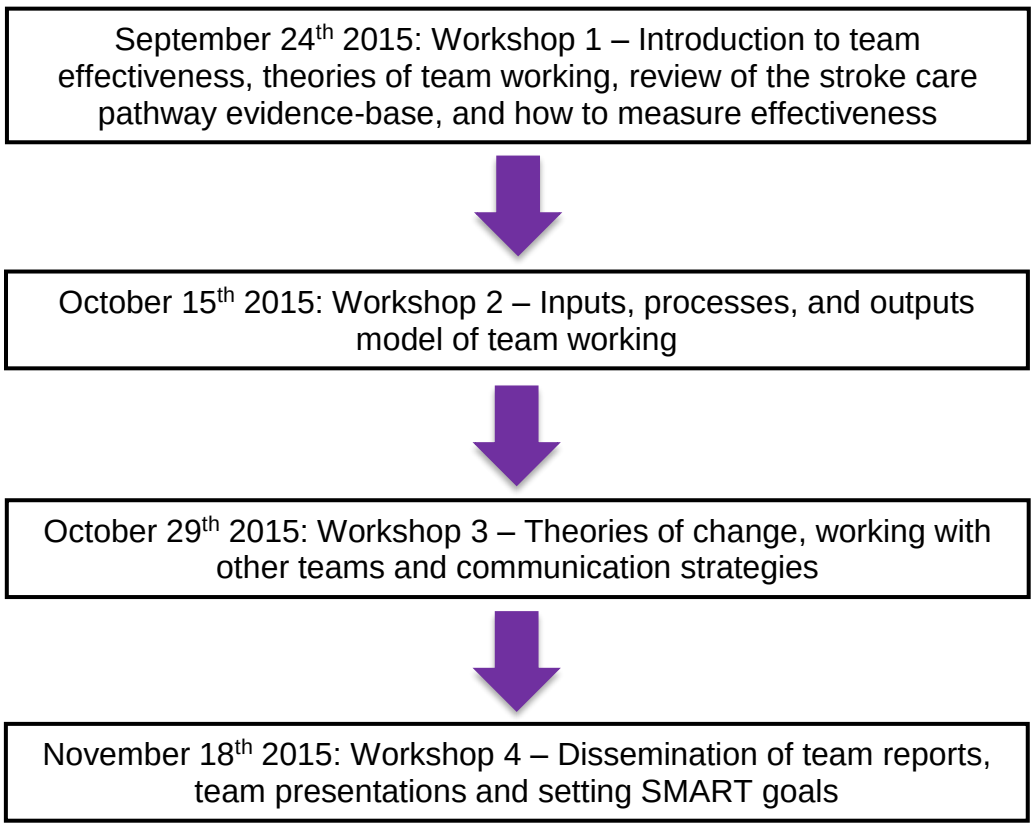
The research framework used for the programme comes from research by Borrill [10, 11] and West [12]. In identifying factors that affect team working, Borrill and West used a framework of inputs, outputs, and processes, to explore the contextual factors that affect team working in mental health teams. 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 half of each of the sub-teams that make up Lincolnshire ADSS in order that there were enough participating team members to make the workshops effective, but that the service provided by Lincolnshire ADSS was able to continue during the workshops. Team members were asked to sign a register of attendance at the beginning of each session.

On average, participating team members attended all four of the four workshops, with 14 team members attending every session.

WORKSHOP TIMELINE



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 Lincolnshire ADSS 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 which prompted discussion from the team as Lincolnshire ADSS is a supported discharge stroke team that predominantly caters for an early discharge but can be flexible for patients with ongoing needs.

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 three groups: Boston and Louth, Lincoln, and Sleaford to take part in focus groups which were recorded and later transcribed. The groups were chosen as these are the area teams within Lincolnshire ADSS. The groups discussed inputs to their team, and the key points were summarised on flip charts. The 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 20 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 with 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, The IPO model, and six thinking hats.

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 three 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 the team report that was prepared specifically for them based on their comments during the focus groups 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 will 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 Lincolnshire ADSS. 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 for each area team within Lincolnshire ADDS for workshop 1, workshop 3 and six month follow up meeting for each subscale is shown on the next page.

	Lincoln	Sleaford	Boston	Louth
Workshop 1				
Clarity and commitment to team objectives	3.3	3.9	3.9	3.9
Focus on Quality	2.4	3.7	3.3	3.9
Decision making and communication	2.9	3.8	3.4	3.9
Support for innovation	2.6	3.8	3.1	4.0
Workshop 3				
Clarity and commitment to team objectives	3.4	4.3	3.9	3.4
Focus on Quality	3.0	3.9	3.3	3.4
Decision making and communication	3.3	3.7	3.4	3.7
Support for innovation	3.2	4.1	3.1	4.0
Six Months Follow-up visit				
Clarity and commitment to team objectives	4.2	4.1	4.1	4.5
Focus on Quality	3.5	3.7	3.6	4.4
Decision making and communication	4.3	4.1	3.9	4.1
Support for innovation	3.8	3.8	3.8	4.1

The scores tended to increase for most area teams between workshop 1 and workshop 3. There was a slight decrease in the scores for the subscales of clarity and commitment to objectives, focus on quality, and decision making and communication for the Louth team. This is could be due to the team reflecting more deeply on how they work as a team than they had at the start of the programme.

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: ORGANISATIONAL CONTEXT

All of the area teams talked about the organisational context that the service operates in and how this promotes interaction with other teams. The team share offices with other services such as the Independent Living Team and the nursing team, and whilst this can make for a busy and noisy working environment, it has several advantages. Team members commented that they could ask staff members of the other teams for advice, such as consulting nurses on medical issues, and team leads were also able to share rehabilitation assistants between the teams when the service experienced busy times. Team members also reported that they sometimes encounter difficulties with a lack of capacity in follow-on services, such as social services, which delays patients being discharged from the ADSS and impacts on how many patients the service can admit.

PROCESS 1: OBJECTIVES

The three area teams all highlighted that there can be problems around coordinating patient visits and rotas. Part of the problem arises due to the reactive nature of the service in supporting patients through their discharge from hospital, where visits may have to be re-arranged in order to fit in a new patient at short notice. Additionally, all area teams cover large and rural geographical areas which can cause issues when rotas are planned, as whoever is coordinating the rota must balance the location of patient, the level of experience a patient needs during a visit, and the continuity of the visits. The team members felt that patients deserve consistency in the member of staff who is visiting them, but acknowledged that this can sometimes result in patients becoming reliant on a particular team member.

OUTPUT 1: CLINICAL OUTCOMES

The services uses the Therapy Outcome Measure (TOMS) but all area teams felt that this measure could be very subjective, and is often completed by different team members at admission and discharge, leading to unnecessary variability. Having the same team member complete both would be an advantage, however, the team acknowledged that this may not be appropriate if that team member has not been in involved in the continuation of the patient's care. The service identified that there is a training need around the use of TOMS that should be addressed to increase the robustness for this measure.

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 Lincolnshire ADSS to capture what was presented and discussed during the programme and to provide a resource for future learning.

The report was split into three sections to focus on each area team in turn (Boston and Louth teams are grouped together as they are led by the same person and have similar ways of working). Each section began with a baseline measure of the composition of each area team, 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 each area team communicates with one another.

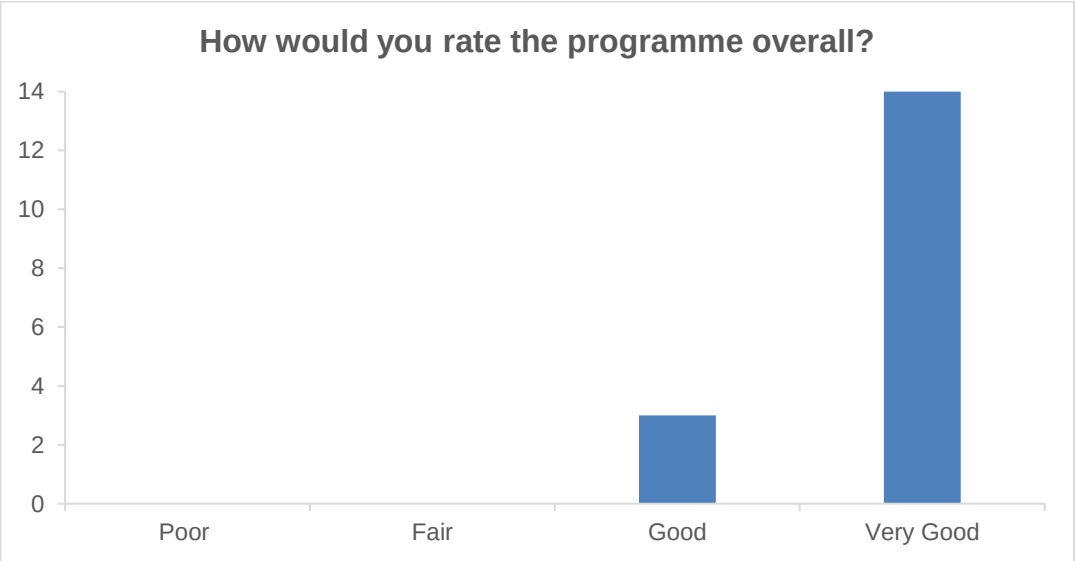
The main part of each section featured the focus group discussions and was split into sections for inputs, processes, and outputs. The main themes that emerged from the analysis were included and supported by quotes from the team members. The subscales of the questionnaire were matched up with particular 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 each area team might like to work on, taking local issues into consideration.

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

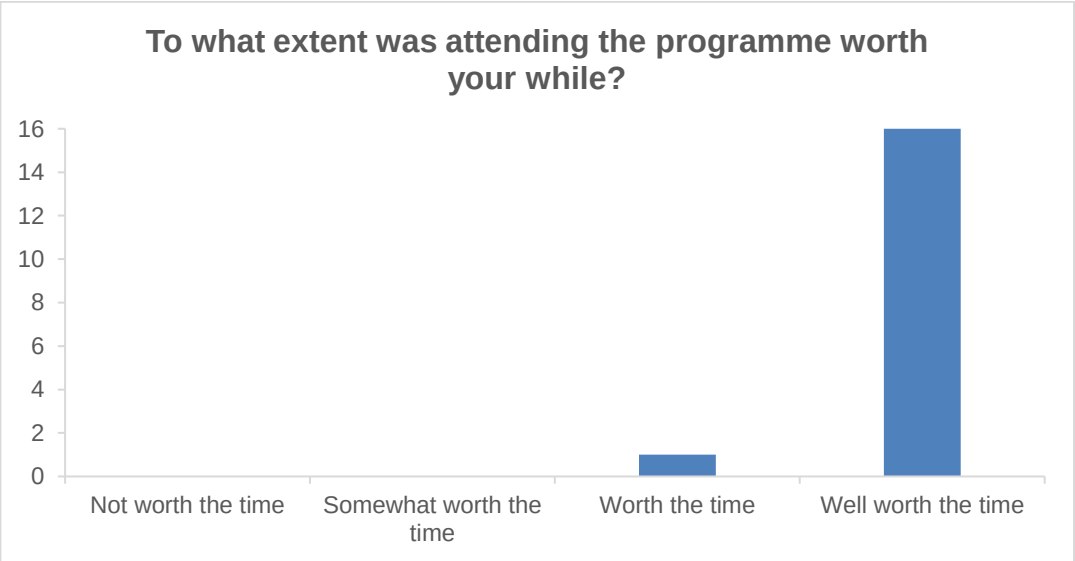
At the end of the report, a general summary drew re-occurring themes identified by each area team that were applicable to the service as whole, and identified issues that the service could work on collectively.

8. Evaluation of the Programme

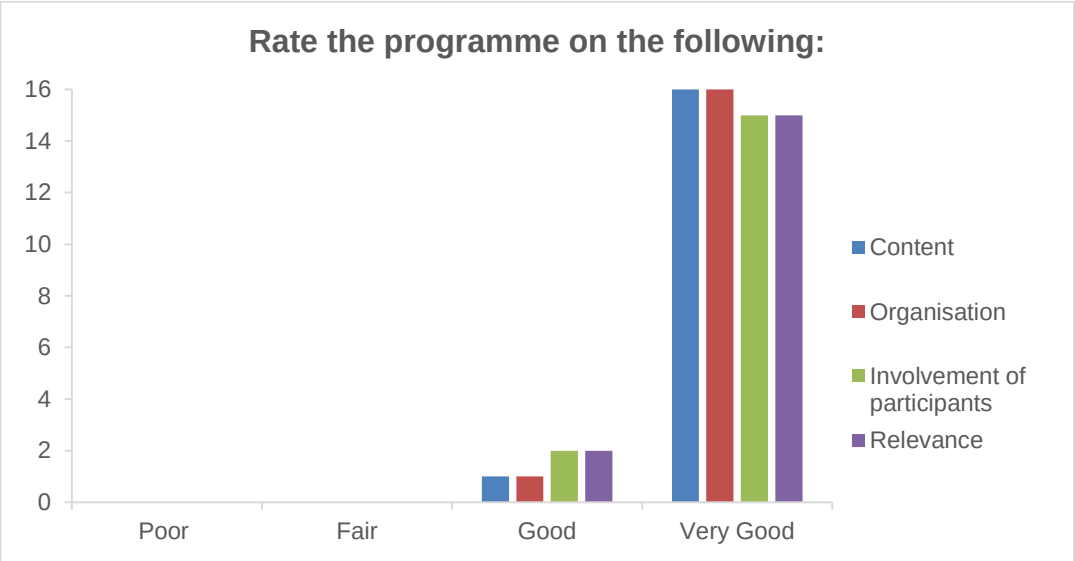
The team completed evaluation feedback forms at the end of the programme. The graphs below show the responses to the questions. Ten team members participated in the last session and provided feedback.



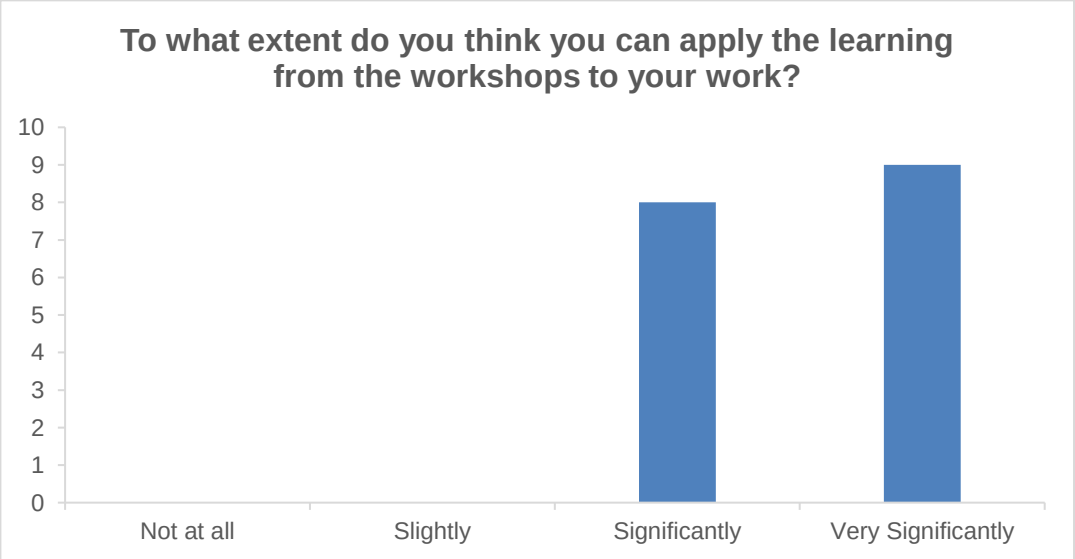
Overall, all participating team members felt the programme was either good, or very good.



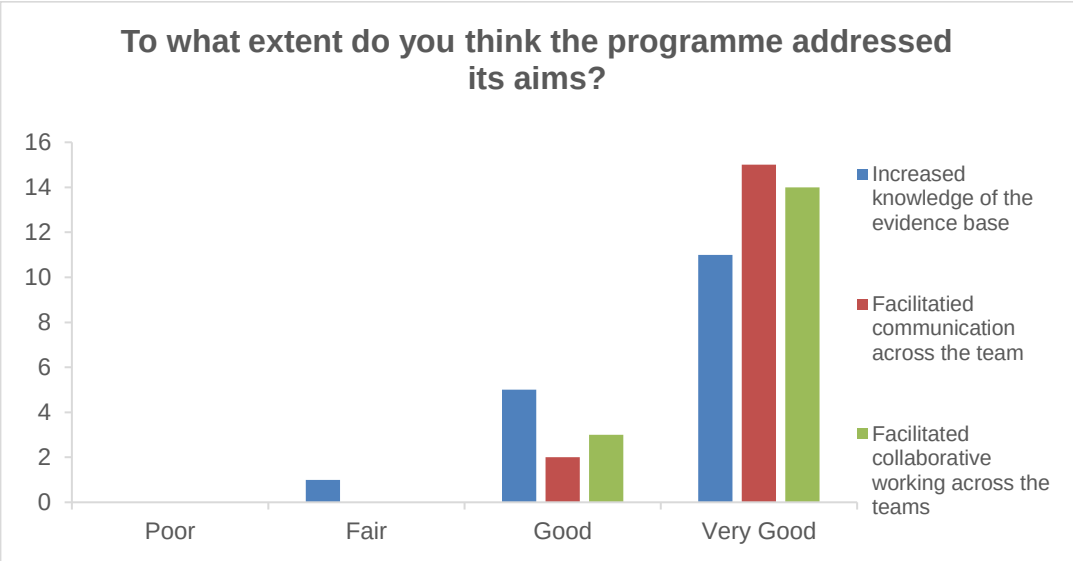
94% of the team felt that attending the programme was well worth their time, with the remaining team member reporting that the workshop was worth the time.



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



All 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. All participating team members felt that the programme was good or very good at addressing the aims to facilitate communication across the team, and facilitate collaborative working across the teams.

We also asked for feedback about how the programme could be improved and one suggestion was to give clear objectives to the attendees prior to attending. We have taken this on board by meeting with the full team at Leicester ESDS prior to the programme beginning to introduce the programme and talk to them about what can be expected.

The participating team members commented that the workshop on change was very useful and "could see how they [the models of change] can be used within the teams". Having space to reflect and "discuss issues that affect the team in a relaxed way" was appreciated, and assisted team members in the role by providing a "better understanding of some of the team's concerns". One participating team member commented that they thought "some of the topics covered will be really useful to relay to other team members, improving the overall team dynamic". Another team member felt that the programme "will make it easier to approach other staff members about team effectiveness issues".

Overall, participating team members felt that the programme was "very well presented in a relaxed setting" and that "it was a good opportunity to look at what we do well, and what we do not so well and where we can improve".

9. SMART Goals

During the final workshop, Lincolnshire ADSS identified three SMART goals that the team 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 a countywide meeting held the Horncastle base.

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

Service wide goals

1. Development of a mission statement for the service, for inclusion in ADSS leaflet.

Due to structural re-organisation within the trust, this goal remains outstanding and is on the agenda for the next team lead meeting. The service is now under the management of a single Matron instead of four different ones, and it is hoped this new sense of unity will allow team leads to bring feedback from individual teams together and review the format of the ADSS leaflet in preparation for developing a mission statement. This goal represents the process of objectives in the Inputs, Processes, and Outputs (IPO) model, as having a clearly defined goal can help the team co-ordinate their actions.

2. Conduct a Six Hats discussion and decision making process on whether team member photographs should be added to the ADSS leaflet.

This process has not yet taken place and further discussions are needed as there are strong pros and cons to including team member photographs. There are strong feelings within staff groups as to whether this is a benefit to patients, exposes staff unduly or creates additional work and cost in keeping the leaflets contemporary. In addition to ongoing debate, the trust communication team will be contacted to establish if there are any governance issues or a protocol for such actions. This will be discussed at the next team lead meeting, and now that the teams are under the management of a single Matron it is felt a consensus should be easier to reach. This represents the process of communication within the Inputs, Processes, and Outputs (IPO) model, and relates to how team members can communicate with patients to set expectations of therapy.

3. Discuss training in the use of TOMS and standardisation of the measure at the County Meeting.

It has been agreed that the individual undertaking the initial assessment should, where possible, be the same person repeating the assessment. It is acknowledge that although this is common practice, it isn't always possible. In-house training is planned to support all staff with the consistent use of this tool, but unfortunately due to limited OT time, patient care has been prioritised over training. The teams are planning to come together twice a year and undertake a calibration exercise at the next meeting. Due to the nature of this goal it is ongoing. This goal is an output within the Inputs, Processes, and Outputs (IPO) model as it related to the clinical outcomes for patients.

Boston & Louth Team goals:

1. Explore how appointments are being arranged to plan them in, in a more effective way taking into account the geography and need of the patient.

The original suggestion of using timed appointment sheets was not implemented as it was felt this would put undue pressure on staff and potentially be excessively time consuming. Instead, the team have been proactive in increasing the amount and timeliness of communication both between team members and with patients, in a method that suits the individual. Appointments are being in booked in am or pm slots using System One. Staff report feeling very positive about adopting this patient focussed approach and since making these changes, there have been no complaints or negative feedback from patients. These changes have been fed back up to commissioners and clinical governance leads when discussing patient questionnaire results.

2. Use the Six Hats tool to decide whether a coordinator admin role would be useful to the team, and potentially trial this to produce evidence for the Matron.

This tool was used to facilitate the decision to instigate a four day a week coordinator role based in the Boston office, working for both teams. This was deemed to have been a success; releasing qualified time for clinical activity and improving data collection. However, the subsequent team re-organisation has meant that the County ADSS role at Lincoln was re-established and countywide tasks have been taken back. This has enabled the rehabilitation assistants to be released from the rota for clinical duties.

3. Set up regular training for the team members and new starters around competencies, review and update the induction process and reference pack for new team members.

This goal remains in progress due to the structural re-organisation that has taken place and the recent turn-over of staff. The Physiotherapy competencies and training modules have been reviewed already and there are plans to complete the OT modules in June. Now that all four team leads are in post, a refresher programme for established Rehabilitation Assistants and Assistant Practitioners is also planned.

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. The use of time-tabled appointment sheets (goal 1) was not implemented but instead the process of communication has been used more effectively and this will impact positively on outputs such as clinical outcomes and cost-effectiveness. Implementing the role of coordinator proved very successful (goal 2) in helping the team to coordinate their objectives during a challenging period which could positively impact on clinical outcomes for patients. The role is no longer needed after structural reorganisation across the service, but the team have experience of working in this way and will be able to use this technique in future if the situation calls for it. Regular training (goal 3) is part of working in an innovative way by updating and enhancing skills and allowing for new ideas to be shared amongst the team. These activities will enhance effective multidisciplinary team working.

Lincoln City goals:

1. One Rehabilitation Assistant taking responsibility for in-reaching into the hospital on a full time basis.

This goal has been achieved and there is a single Rehabilitation Assistant who takes responsibility for in-reaching with an additional Rehabilitation Assistant acting as a backup if required. This has provided increased consistency in terms of input on the wards, doubling the in-reach capacity.

2. Developing the Assistant Practitioner role to include mentoring the Rehabilitation Assistants

This goal has been achieved by establishing a clear and transparent supervision framework. Rehabilitation Assistants now receive supervision on a monthly basis from therapists and Assistant Practitioners alternately. The team report feeling well supported in this process and are satisfied with the current arrangements.

3. Explore the use of equipment and review this to ensure that rehabilitation is provided rather than equipment where possible.

When reviewing this as a team, staff were unclear of the origins of this goal as a number of those involved in setting the goals have either moved on or were unable to attend. It was agreed this not an area of concern for the team currently, therefore no action was required.

The goals outlined above are related to the processes of objectives and psychological mindedness, and the output of innovation, which were identified as important to the team through focus group discussions using the IPO model as a framework. Goal 1 relates to how the team coordinate themselves and this process impacts positively on clinical outcomes. Establishing the supervision framework (goal 2) represents the process of psychological mindedness within the team, as supervision is important to the well-being of the team. Effective supervision can positively impact clinical outcomes and provide a forum for innovation. The third goal is no longer applicable to the team, but innovative ways of providing rehabilitation without relying on equipment when it is unnecessary should be encouraged.

Sleaford Team goals:

1. Admin training within the team so that all team members can increase their admin skills.

This goal is no longer required as the team now have access to designated admin support.

2. Conduct an audit into how often and why lunch times are being missed by team members in order to ensure lunch times are protected.

An audit hasn't been undertaken, however a number of challenges have been identified. These include: limited facilities to take lunch away from desks and pressure if running late to travel during breaks. Clear guidance has been given to all staff regarding personal responsibility and entitlement to protected break times. Advice has been given to make time for breaks, including breaking journeys and parking up. It was highlighted that the team are conscientious in attempting to optimise clinical contact, but this can be at the detriment to staff health and wellbeing. This will be monitored going forward and regularly reinforced at team meetings.

3. Increase the appointment window to half an hour each side of an appointment in order to reduce stress when travelling.

Patients are only being issued with approximate appointment times therefore this action was not completed. Instead, staff are reinforcing the approximate nature of time slots and this is documented on their rehabilitation files. Staff did not report feeling undue stress regarding appointment times, but acknowledged a conscious effort is being made to contact patients in a timely manner if they were running significantly late.

The goals outlined above are related to the process of objectives, which were identified as important to the team through focus group discussions using the IPO model as a framework. All goals related to the process of objectives, and in particular how the team co-ordinate themselves. Changes to this process can have a positive 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.

10. Finances

The table below presents the spending for running the programme with Lincolnshire ADSS. 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 Lincolnshire ADSS.

Item	Cost
Venue	£1800.00
Travel	£200.00
Transcription	£700.00
Total	£2700.00

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 Lincolnshire ADSS 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.

Lincolnshire ADSS has a caseload of approximately 150 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 Lincolnshire, at a distance of approximately 50 miles away from Nottingham. This resulted in a three hour round trip for EMAHSN facilitators and consequently shortened the time the workshops could run from and to due to travelling arrangements.

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 4 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 Lincolnshire ADSS. 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.

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.

14. Future steps

The programme continues to be rolled out across the East Midlands and has also been successfully delivered with Northamptonshire Community Stroke Team, Derbyshire Early Supported Stroke Discharge Service 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 in The Boston, Louth and Sleaford teams, it did reveal that levels of team effectiveness were consistently high. The Lincoln team did see an increase in scores on the Team Effectiveness Questionnaire during 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.
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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

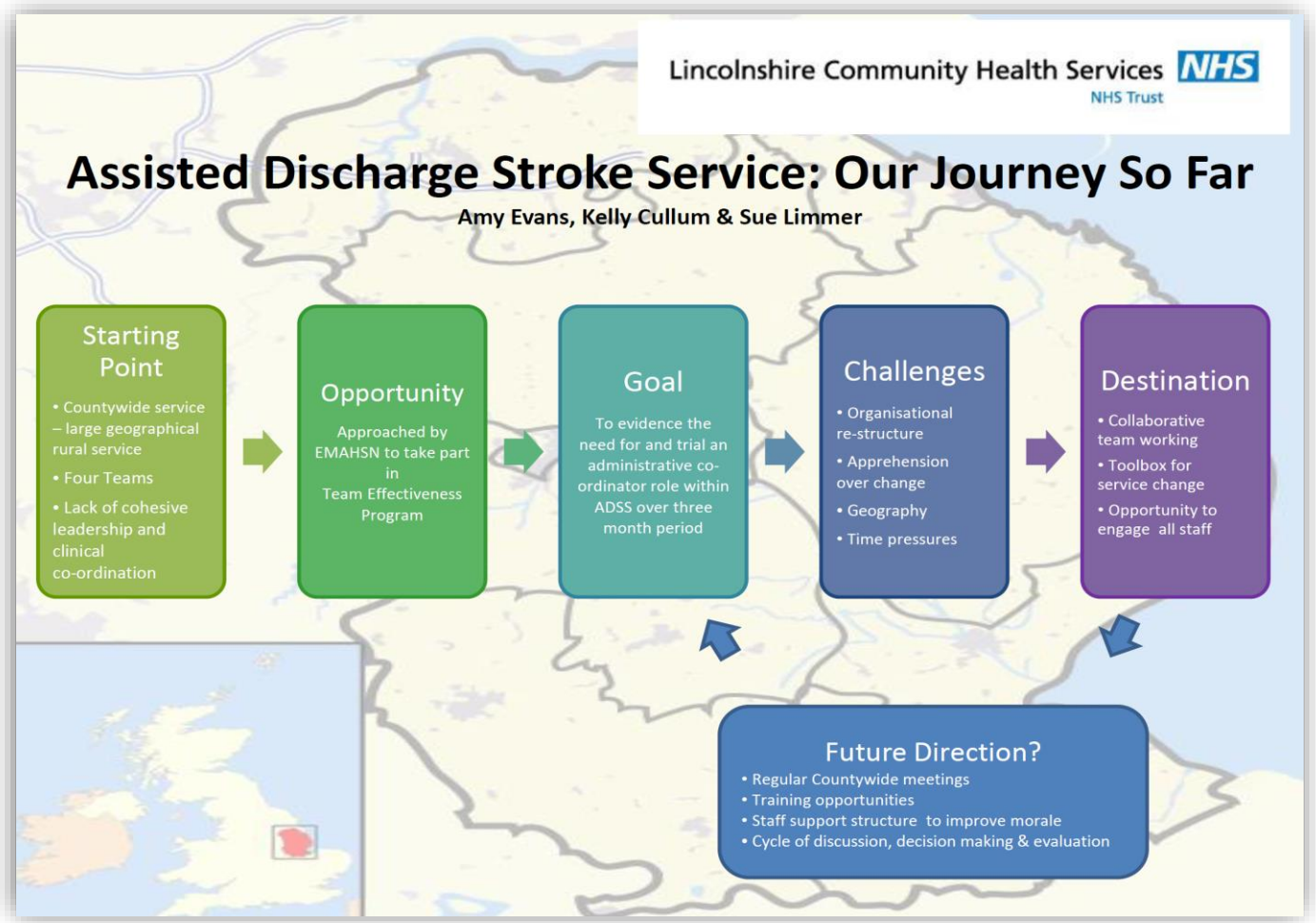
From an industry perspective it was great to be involved!

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

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.

Poster presented by the team:



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