National Institute for Health Research
Service Delivery and Organisation Programme

The Impact of Enhancing the Effectiveness of Interdisciplinary Working.

Appendices

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NHS National Institute for Health Research

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Project 08/1819/214

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This report presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and not necessarily those of the NHS, the NIHR or the Department of Health.

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Section 3: Appendices

List of Appendices

Appendix 1: Production function for the final SDO report

The production function of health at an individual level, based on the COOP project is outlined below.

Characteristic	Relationship with change in outcomes	Coefficient	Lower 95% CI	Upper 95% CI	p-value
Ratio of qualified / qualified+support staff in team					
	EQ-5D	0.002	0.00	0.003	0.006
	TOM impairment	-0.005	-0.008	-0.001	0.006
	TOM activity	-0.005	-0.008	-0.002	0.003
	TOM participation	-0.003	-0.001	-0.006	0.109
	TOM wellbeing	0.000	-0.007	0.007	0.991
Proportion of senior staff in team					
	EQ-5D				
	TOM impairment	-0.282	0.601	0.036	0.083
	TOM activity	-0.298	0.591	0.005	
	TOM participation				
	TOM wellbeing				
Percentage of face to face contacts with support staff (patient level)					
	EQ-5D	0.064	0.007	0.121	0.026
	TOM impairment	0.164	0.001	0.330	0.052
	TOM activity	0.061	0.110	0.232	0.0483
	TOM participation				
	TOM wellbeing				

Characteristic	Relationship with change in outcomes	Coefficient	Lower 95% CI	Upper 95% CI	p-value
Total contact time (log scale)					
	EQ-5D				
	TOM impairment	0.159	0.100	0.219	0.001
	TOM activity	0.175	0.144	0.237	0.000
	TOM participation	0.117	0.070	0.164	0.000
	TOM wellbeing	0.084	0.039	0.123	0.000

Characteristic	Relationship with change in outcomes	Coefficient	Lower 95% CI	Upper 95% CI	p-value
Team size					
	EQ-5D	0.001	0.000	0.003	0.005
	TOM impairment				
	TOM activity				
	TOM participation				
	TOM wellbeing				
	Patient satisfaction	0.08	0.03	0.14	0.004

Appendix 2: PPI Review of EEICC – Presentation at CRAG, Barnsley Hospital

Background: prior to the start of data collection for this project the methodology, information leaflets and consenting procedure were discussed with the PPI group based at Barnsley Hospital. Their advice and comments were taken into account and lead to minor amendments of documentation. It was agreed that we should return at the end of the project to discuss results.

Follow-up meeting: 3rd of May 2011.

Initial results were presented by Pam Enderby to a small group of six individuals. Three individuals had been at the initial meeting. The group found the results interesting and not surprising. They expressed concern at the lack of any national standards informing the skill mix, data collection and procedures of community rehabilitation and intermediate care. Much discussion focused on the lack of certainty and the destabilisation of teams given the changes to the provision of community-based services.

It was felt that it would be useful to disseminate the results of this project to a number of patient related groups including the stroke Association, the patients Association and other disease specific groups.

Pam Enderby, 10th of May 2011

Appendix 3: Ethics

National Research Ethics Service
Salford & Trafford Local Research Ethics Committee
Room 181
Gateway House
Piccadilly South
Manchester
M60 7LP

Telephone: 0161 237 2392
Facsimile: 0161 237 2383

11 September 2008

Professor Pamela Enderby
Professor of Rehabilitation
School of Health and Related Research (ScHARR)
Regent Court
30 Regent Street
Sheffield
S1 4DA

Dear Professor Enderby

Full title of study: **Enhancing the Effectiveness of Interprofessional working: costs and outcomes**
REC reference number: **08/H1004/124**

Thank you for your letter of 8 September 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

The Vice-Chair also commented that we accept the issues that you have raised with regards to the difficulty associated with using the EQ5D in any other way than described by the researchers. We also accept that the use of the EQ5D is used in normal practice in some areas and in others is merely summing up information which is collected in other ways. Therefore as long as the patient has the information sheet and is aware that they can send back the satisfaction questionnaire, or not, when convenient to them, we are happy with the arrangements they are making.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	5.6	23 July 2008
Investigator CV		
Protocol	1	23 July 2008
Covering Letter		23 July 2008
Covering Letter		08 September 2008
Letter from Sponsor	1	30 June 2008
Peer Review	1	14 January 2008
Interview Schedules/Topic Guides	1 - Interview Proforma	23 July 2008
Interview Schedules/Topic Guides	v1 - Focus Groups	23 July 2008
Questionnaire: Patient/Service User	1	23 July 2008
Questionnaire: Multifactor Leadership Questionnaire (MLQ)	1	21 July 2008
Questionnaire: Workforce Dynamics Questionnaire (WDQ)	1	21 July 2008
Questionnaire: EQ-5D Health Survey		01 September 2008
Letter of invitation to participant	1	22 July 2008
Letter of invitation to participant	v1 - Focus Groups	23 July 2008
Letter of invitation to participant	V1 - SEC	23 July 2008
Letter of invitation to participant	v1 - Learning Set	23 July 2008
Letter of invitation to participant	v1 - Final SEC	23 July 2008
Letter of invitation to participant	v1 - Interviews	23 July 2008
Participant Information Sheet: Interviews	1	23 July 2008
Participant Information Sheet: Final Learning Set	1	23 July 2008
Participant Information Sheet: Learning Set	1	23 July 2008
Participant Information Sheet: Focus Groups	1	23 July 2008
Participant Information Sheet: Service Evaluation Conference	1	23 July 2008
Participant Information Sheet: WDQ & MLQ	1	23 July 2008
Participant Information Sheet	2	01 September 2008
Participant Information Sheet: Staff Information Sheet - Implementation	2	01 September 2008

Participant Consent Form: Staff Consent - Implementation	1	23 July 2008
Participant Consent Form: Focus Groups	1	23 July 2008
Participant Consent Form: Interviews	1	23 July 2008
Response to Request for Further Information		
Service Proforma	1	23 July 2008
Letter from funder	1	20 February 2008
Indemnity arrangements	1	23 July 2008
Research Summary Diagramme	1	24 June 2008
Resource Pack		23 July 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H1004/124	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

pp **Mrs Janet Marsden**
Vice-Chair

Email: carol.ebenezer@northwest.nhs.uk

Enclosures: "After ethical review – guidance for researchers" SL- AR2

Copy to: The Research Office
University of Sheffield
New Spring Hosue
231 Glossop Road
Sheffield
S10 2GW

Dr S Nancarrow

Appendix 4: Staff Information Sheet and Consent Form

The University Of Sheffield.

School Of Health And Related Research.

The EEICC Study

Enhancing the Effectiveness of Interprofessional Team Working:

Costs and Outcomes

Staff Information Sheet for Implementation and Evaluation of the Interprofessional Management Tool (IMT)

You are being invited to take part in a research study. Before you decide if you want to participate, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask the research team if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Our research team has been commissioned by the Service Delivery and Organisation (SDO) Research and Development Programme of the Department of Health to complete a national study to develop, implement and evaluate an Interprofessional Management Tool (IMT) that services can use to evaluate their structure and work processes against data gathered from research evidence about the way that staffing variations impact on staff outcomes (such as satisfaction), service outcomes (such as costs) and service user outcomes (such as physical and social wellbeing). The study has received a favourable opinion from the Salford & Trafford Research Ethics Committee and local research governance committee approval.

The purpose of the research project is to develop, implement and evaluate an evidence based tool, the IMT, to help teams like yours in the commissioning, staffing, organisation and

management of older peoples' community rehabilitation and intermediate care services. The study will be carried out over the next 6 months.

This information sheet relates to your participation the implementation and evaluation of the IMT.

Why have I been chosen?

Your team manager has expressed an interest in your team participating in the study and we are writing to each member of your team to ask for their consent to take part. We advise that your team discusses participating in the research together at a team meeting, as it is important that you agree as a team to participate. To ensure that your participation is entirely voluntary, we are seeking the individual consent of all team members who may participate in the project.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time and do not need to give a reason for your withdrawal to the research team. However, as the project will involve team activities, we would recommend that you discuss withdrawal with your team prior to making any decision.

What do I have to do to take part?

Six components make up the "Implementation and evaluation of the IMT" and the research involves qualitative and quantitative aspects. Taking part will require the following activities;

1. **Participating in a "Service Evaluation Conference".** This one day event will allow your team to work together to evaluate your team structure and practices using the IMT and compare your perceptions against IMT scores developed from data gathered and analysed by the team prior to the event. The objectives are to allow your team to work together with researchers to evaluate your service: develop some strategic and operational priorities for change; and plan how you might attempt these changes. The ultimate aim is to decide by consensus what changes are necessary to improve the service and how to implement them.
2. **Participating in three action learning sets over a six month period as part of your normal work activities**. These half day meetings will be used to discuss progress in implementing any agreed changes; the challenges that have arisen; and how the team are going to work together to address these challenges.
3. **Complete the Workforce Dynamics Questionnaire (WDQ).** All staff will be given a copy of the WDQ, which explores your own role in your team in relation to other team members. You will be given a detailed information sheet describing the WDQ. You will be asked to complete the WDQ (which takes about 15 minutes) twice: before implementing the IMT and at the end.
4. **Complete the Multi-Factor Leadership questionnaire (MLQ):** All staff will be given a copy of the MLQ, which explores the leadership style of your team leader. You will be given a copy of a detailed information sheet describing the MLQ. You will be asked to complete the MLQ (which takes about 15 minutes) twice: before implementing the IMT, and at the end.
5. **Complete the 'Client / Service User Record Pack'**: We will also ask your team to collect anonymised patient data on a separate document called the 'Client / Service User Record Pack'. This information should be collected for every patient admitted to your service during the three months after the Action Learning Sets have finished. It will take approximately 15 – 20 minutes per patient). All patients should be followed until discharge, or for three months (whichever comes first). This will provide us with important information about the outcomes of the implementation of the IMT on patient care, which can then be compared across the 11

different participating services and to a normative data set to help determine which changes have had the greatest impact on patient and service outcomes. The information collected will be very similar to information you already collect and we have designed the data collection forms to ensure that each one requires a minimal amount of effort to complete.

6. **Participation in a final Service Evaluation Conference**: At the end of the study we will organise a one day conference for all of the 11 participating teams to attend. The conference will allow your team to the opportunity work together to reflectively evaluate how well the changes you have implemented together have gone and compare your perceptions to IMT scores from data gathered and analysed by the team prior to the event. The aim is to allow your team to work together with researchers to evaluate the development of your service: and if you feel appropriate, develop future priorities for change; and plan how you might attempt these changes.

In addition to the above some staff will be asked for further consent to take part in the following activities.

a. **Face-to-face interviews**: Up 15 staff from across the 10 teams will be invited to participate in an in-depth interview about the most effective leadership styles in interprofessional teams. This will take place with a researcher, and will be performed at a time and place that is convenient to you. You will be given a detailed information sheet and asked to sign a consent form before participating in the interview.
b. **Focus Group**: Team leaders from all 11 participating teams will be asked to take part in a focus group about the most effective leadership styles in interprofessional teams. The Focus Group will take place with a researcher, and be performed at a time and place that is convenient to participants. Participants will be given a detailed information sheet and asked to sign a consent form before participating in the interview.

What are the possible disadvantages and risks of taking part?

There are few disadvantages or risks to taking part. The programme is designed as much as possible so that most activities can be integrated into your normal work practices. You will be required to attend three Action Learning Sets, but these can run in place of some team meetings for the duration of the project. Participation in the Service Evaluation Conferences does require that your team commit to attendance at two away-day events over a 12-15 month period. However, both these above elements will be classed as continuing professional development activities. The only other commitments are the completion of WDQ, MLQ and patient record forms. Completing each of these forms takes around 15-20 minutes each. Again, the patient record forms simply formalise data gathering activity that routinely occurs, so it should not prove too onerous. Some teams who have participated in a previous project with us, now use our patient record forms as their main method of collecting patient data.

What are the possible benefits of taking part?

Service development is now often a constant part of all our jobs alongside delivering services. This project will formalise the service development activities of your team for a six month period and provide you with expert support from trained facilitators and researchers. From the information that you and other people give us, we will try to identify relationships between the way your service is staffed, managed and organised and how this impacts on your role, patient outcomes and the service as a whole. This information will be used in conjunction with other information obtained throughout the study to provide feedback using the IMT about optimal models of delivery to improve outcomes for your team, your patients, and your service. You will then be able to use this information to plan and implement improvements supported by

the research team. Finally, we will evaluate how implementing the IMT has impacted on delivery of services.

What will happen to the information I provide?

Only members of the research team will have access to any completed questionnaires. The data from the completed forms will be entered onto a database, by the research team, and compared with other information that we obtain about service structure; staff outcomes; and service outcomes (e.g. costs). The action learning sets will operate under strict ground rules which will ensure the confidentiality and anonymity of all participants. Any information shared within the set will not go beyond that specific group.

What will happen to the results of the research study?

As well as information from professionals, we will be carrying out a patient satisfaction survey and studying data from your service. All of this information will be collated into a single research report for your service. In addition, the information from your service will be included with information gathered from the other 10 services to form a report for the Department of Health. Your service will receive a summary of the report that we submit to the Department of Health as well as a report detailing your individual team's results.

Your individual team's report and the final report to the Department of Health will be available from April 2011. Your manager will have access to your team's report. For a copy of the report submitted to the Department of Health, please contact the researchers at the below address.

We will also use some of the information we gather for peer reviewed journal articles and conference presentations.

Who do I complain to?

If you wish to complain or feel uncomfortable about any aspect of the research project, please contact in the first instance your manager or team leader who will communicate your concerns to the research team.

Who do I contact for further information?

Should you have any concerns, queries or if you want to discuss any aspect of the project please contact your manager, team leader or a member of the research team:

Pam Enderby	p.m.enderby@sheffield.ac.uk	0114 222 5454
Tony Smith	tony.smith@sheffield.ac.uk	0114 222 0892
Steven Ariss	s.ariss@sheffield.ac.uk	0114 222 8371
Susan Nancarrow	s.nancarrow@sheffield.ac.uk	0114 222 8362
Adele Blinston	adele.blinston@sheffield.ac.uk	0114 222 8370

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School Of Health And Related Research.

<team>

The EEICC Study

Enhancing the Effectiveness of Interprofessional Teamworking: Costs and Outcomes

Staff Consent Form

Each member of staff within the team needs to complete one of these forms

Researchers: Professor Pam Enderby
Dr Susan Nancarrow
Mr Tony Smith
Dr Steven Ariss

1. I acknowledge that I have read and understood the information sheet for the above study and have had the opportunity to consider the information and ask questions. ☐
2. I understand that my participation in this project is voluntary and I am free to withdraw at any time without giving any reason, without my employment being affected. ☐
3. I agree to take part in the above study. ☐

Name of staff member	Date	Signature

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Name of researcher	Date	Signature

Appendix 5: Feedback forms (SEC1, ALS, SEC2)

Service Evaluation Conference Feedback

Please rate the following aspects of the session

	Excellent	**Good**	**Not good**	**Poor**
1. Organisation and domestics	☐	☐	☐	☐
2. Content	☐	☐	☐	☐
3. Notes	☐	☐	☐	☐
4. Presentation	☐	☐	☐	☐
5. Overall enjoyment	☐	☐	☐	☐

Please rate the following aspects of the course

What did you find useful about the "individual development" section of the workshop?

What was most challenging?

What was most useful in the "teamwork" section of the workshop?

In what ways has this given you insight into how the team works?

What was most useful in the "team leadership" section of the workshop?

In what ways has this given you insight into team leadership?

Do you have clear ideas for team improvement as a result of the event?

In what ways did it help having a facilitator?

Any other comments

Action Learning Workshop Feedback

Please rate the following aspects of the session

	Excellent	Good	Not good	Poor
1. Content	☐	☐	☐	☐
2. Facilitation	☐	☐	☐	☐
3. Overall enjoyment	☐	☐	☐	☐
4. Usefulness	☐	☐	☐	☐

Please rate the following aspects of the workshop

What did you find useful about the different sections of the workshop?
The "ME" section:

The "TEAM" section:

The "WORLD" section:

"WHAT NEXT" section:

What was most challenging about the workshop?

In what ways has the event given you insight into the process of change in your service?

Do you have a clear understanding of future actions for team improvement as a result of the event?

☐ Yes ☐ No

Why do you think this is?

In what ways did it help having a facilitator?

Any other comments

Final Evaluation Conference Feedback

Please rate the following aspects of the session

	Excellent	Good	Not good	Poor
1. Organisation and domestics	☐	☐	☐	☐
2. Content	☐	☐	☐	☐
3. Notes	☐	☐	☐	☐
4. Presentation	☐	☐	☐	☐
5. Overall enjoyment	☐	☐	☐	☐

Please rate the following aspects of the your involvement in the EEICC project

Please consider the whole experience of your involvement with the EEICC project when answering these questions.

What did you find useful about being involved with the EEICC project?

What was most challenging?

In what ways has your involvement in this project given you insight into how your team works?

In what ways has involvement in the EEICC project influenced the way your team works?

We would value your views on the following processes of the EEICC project

1. The Interprofessional Management Tool Booklet
At the start of the project, all members of the team were issued with an Interprofessional Management Tool booklet.

(a) Did you receive your copy of the Interprofessional Management Tool booklet	**Yes**	**No**	**Don't recall**
(b) Did you look at or read any of the content of the Interprofessional Management Tool	**Yes**	**No**	

In what ways could we improve the content of the Interprofessional Management Tool booklet?

How could the Interprofessional Management Tool be improved to make it more useful or accessible to teams (eg electronic format with interactive exercises / Podcasts)?

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Outcome tools

As part of your involvement with the EEICC project, your team used three outcome measures: the TOMs, EQ-5D and a patient satisfaction questionnaire. We would value your views on the use of these tools.

Please comment on the ease of use of the tools.

What did you find useful about using the outcome tools?

What was the most challenging aspect of using the outcome tools?

Has the use of the outcome tools in any way changed or informed the way your team works?

Any other comments

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Appendix 6: Service Proforma

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The EEICC Study

Enhancing the Effectiveness of Interprofessional Teamworking: Cost and Outcomes

Service Proforma

For managers / team leaders to complete

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Team Number

1. What is the name of your team or service?	
2. How long has your service existed?	
3. What is your role within your service?	

Reason for the service

4. Why was your service set up? e.g. unmet needs in the community, acute ward closure	
5. What is the primary goal of your service? e.g. prevent admissions to hospital	

Access to your service

6. Who refers into your service? (circle all that apply)	1. GP 2. Self / informal / friend / family 3. Community nurse 4. Social worker 5. Accident and Emergency 6. Ward in acute hospital 7. Community hospital 8. Other 1 (please specify) ..... 9. Other 2 (please specify) .....
7. How do clients access your service? e.g. single point of entry, telephone triage, discharge liaison nurse, assessment by team member	
8. What are the eligibility criteria for your service? e.g. medically stable, rehabilitation potential	
9. Are there any explicit exclusion criteria for your service? e.g. mental health status	

Service structure and organisation

10. What is the *main* location of your service provision? (circle one only)	1. The client's home 2. Hospital – inpatient 3. Hospital – outpatient 4. Accident and emergency 5. Nursing home 6. Resource centre 7. General practice 8. Community hospital 9. Community health service 10. Other (please specify) .....
11. If services are provided in more than one location, please specify the other locations (circle all that apply)	1. The client's home 2. Hospital – inpatient 3. Hospital – outpatient 4. Accident and emergency 5. Nursing home 6. Resource centre 7. General practice 8. Community hospital 9. Community health service 10. Other (please specify) .....
12. How would you describe your service? e.g. step-down facility, nurse-led unit	
13. What facilities are available? e.g. gym, office, kitchen, equipment	
14. How many referrals does your service take per year?	
15. What is the *average* duration of an episode of care for interventions provided by your service?	
16. What is the *maximum* duration of an episode of care for interventions provided by your service?	
17. What are the hours of operation of your service? e.g. 7 days a week, 24 hour support, on-call support, 9am-5pm, weekdays only	
18. What agencies do you work with? e.g. voluntary services, mental health services	
19. Do clients pay for your service?	1. Yes 2. No 3. Sometimes
20. What is the professional background of the team leader?	

21. Is a single client file / client record used by all providers?	1. Yes	2. No
22. Do social services have a separate file / client record to health?	1. Yes	2. No
23. Do different professions have separate files / client records?	1. Yes	2. No
24. Is there a common physical base for the team?	1. Yes	2. No
25. How often does the whole team meet for operational meetings?		
26. How often does the whole team meet for case conferencing?		

27. What is the management structure in your service?

1. Split management
   Team leader is responsible for team management; service / professional heads responsible for clinical issues
2. Specific team manager
   Single person responsible for both clinical and management issues
3. Individual profession management
   Each individual is managed by their service/professional head
4. Distant management
   Team is responsible to a manager in the organisation but the manager does not participate in the team actively
5. Other (please specify) .....
   .....

28. Please list the numbers (WTE) and types of staff that are part of your team

Staff member	Number (WTE) in team?	Casual / session only staff (please tick)	Agency that finances this staff member e.g. PCT, social services
Clinical staff			
Physiotherapist			
Occupational therapist			
Social worker			
Podiatrist			
Speech and language therapist			
Nurse			
Dietician			
Psychologist			
Doctor			
Geriatrician / consultant			
Counsellor			

Staff member	Number (WTE) in team?	Casual / session only staff (please tick)	Agency that finances this staff member e.g. PCT, social services
Clinical support staff e.g. assistants, support workers, technical instructors, home care staff			
Management staff			
Manager			
Team leader			
Community care officer			
Other			
Non clinical support staff			
Administration / secretary			
Domiciliary support staff e.g. cleaners, cooks etc.			
Other			

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Context

29. What is the *size* of the population you serve?	
30. What *type* of population do you serve?	1. Urban 2. Rural 3. Sub-urban 4. Mixed
31. What proportion of the population in your area are over 65 years old?	
32. What is the nature of your funding? e.g. recurrent	
33. Who funds your service? e.g. PCT, voluntary sector, independent sector	
34. What is your annual budget?	
35. Who makes decisions about the direction of the service?	
36. Do you have an operational plan / strategy	1. Yes 2. No
37. What is the organisational setting or host institution for the service? (select all that apply)	1. Primary Care Trust 2. Acute Trust 3. Mental Health Trust 4. Care Trust 5. Other (please specify).....

Service users

38. What are the casemix / diagnostic groupings of those utilising your service? e.g. stroke, falls, orthopaedic	
39. What is the demographic profile of your service users? e.g. age, sex, ethnicity	
40. What is your service's target population? e.g. over 65's, stroke	

41. What is the most common level of care your clients/patients require?

Please rank from 1-8, with 1 being the most common level of care required

Rank	Level of care required	Aim of this level of care
	Level 1 : Patient needs prevention / maintenance programme	• Prevent physical and psychological deterioration • Prevent loss of independence • Promote psychological well-being • Encourage healthy living • Promote positive attitude to independence
	Level 2: Patient needs convalescence	• Encourage improvement and/or maintenance of independence • Improve recuperation • Wait for aids adaptations • Wait for family adjustment support • Adjust to new circumstances
	Level 3: Patient needs slow stream rehabilitation	• Provide watchful waiting • Provide assessment/observation • Provide non-intensive rehabilitation/mobilisation • Provide confidence • Actively encourage, extend and facilitate increased speed of recovery • Provide support programme which is being carried out by patient and carers
	Level 4: Patient needs regular rehabilitation programme	• Provide rehabilitation to maintain steady and measurable progress. • Improve expected recovery trajectory.
	Level 5: Patient needs intensive rehabilitation	• Change from dependent to independence • Reduce level of dependency on carers • Achieve maximum level of function • Resolve acute disabling conditions
	Level 6: Patient needs specific treatment for individual acute disabling condition	• Target specific treatment by one profession. • Alleviate or reduce specific Impairment/Activity.
	Level 7: Patient needs medical care and rehabilitation	• Actively treat medical condition in order to prevent/modify deterioration or secondary sequelae whilst enabling patient to improve/maintain independence. • Appropriately manage medical condition whilst patient undergoing multidisciplinary rehabilitation
	Level 8: Patient needs rehabilitation for complex profound disabling condition	• Provide rehabilitation as part of long term management of condition. • Maximise level of function, prevent secondary disabling condition. and improve quality of life. • Provide particular provision of services related to those with low incidence specialised cognitive and physical disorders.

Thank you for completing this survey. Please return the completed survey in the enclosed reply paid envelope or address to;

EEICC Workforce Project
ScHARR
FREEPOST SF – 1314
Sheffield
S1 1AY

Or fax to the attention of "Tony Smith – EEICC"
on 0114 222 0791
Or return by email to tony.smith@sheffield.ac.uk

Project 08/1819/214

Appendix 7: Workforce Dynamics Questionnaire

Workforce Dynamics Questionnaire – For Staff

This survey is to be completed by each team member

This survey examines a range of issues around your experiences of working in your current job, including your job satisfaction, team working, and role overlap with other practitioners.

Please answer every question.

I. To which team do you belong?

.....

II. What is your professional group or discipline?

1. Dietician
2. General practitioner
3. Geriatrician
4. Nurse
5. Occupational therapist
6. Physiotherapist
7. Podiatrist
8. Psychologist
9. Secretary / admin
10. Social worker
11. Speech and language therapist
12. Support worker
13. Social care worker
14. Other .....

III. What is your current grade / designation (eg Agenda for Change grading)?

IV. Are you in a team leader / management role?

0 No
1 Yes

V. What is the nature of your work (circle all that apply)

1. Full time
2. Part time
3. Annualised hours
4. Set shifts each week
5. Locum
6. Other (please specify).....

VI. Gender

0 Female
1 Male

VII. What is your year of birth?

19....

VIII. How many hours are you contracted to work each week in your current job?

.....Hours per week

IX. How long have you worked in your current job?

Years.....Months.....

EEICC WDQ V3 121108 Ethics Ref 08/H1004/124 1

Role overlap

This question relates to the amount of role overlap you have with other practitioners. In column B, indicate how closely you work with the listed practitioners (even if they are not a regular part of your team). In column C, indicate *how much* your role overlaps with the selected workers by circling the number that corresponds with your estimate of the amount of role overlap. For instance, a score of '5' would indicate complete overlap of roles, whereas a score of '1' indicates no overlap of roles. If you work with a practitioner that is not listed, please write their profession into the 'other' box and complete as above.

	Column A	*Column B*						*Column C*					
		How closely do you work with the following practitioners?						*How much do your roles overlap*					
	Type of worker	Do not work with at all					I work closely with	No overlap at all					A great deal of overlap
1.	Dietician	0	1	2	3	4	5	0	1	2	3	4	5
2.	Geriatrician	0	1	2	3	4	5	0	1	2	3	4	5
3.	General practitioner	0	1	2	3	4	5	0	1	2	3	4	5
4.	Nurse	0	1	2	3	4	5	0	1	2	3	4	5
5.	Occupational therapist	0	1	2	3	4	5	0	1	2	3	4	5
6.	Physiotherapist	0	1	2	3	4	5	0	1	2	3	4	5
7.	Podiatrist	0	1	2	3	4	5	0	1	2	3	4	5
8.	Psychologist	0	1	2	3	4	5	0	1	2	3	4	5
9.	Social worker	0	1	2	3	4	5	0	1	2	3	4	5
10.	Speech and language therapist	0	1	2	3	4	5	0	1	2	3	4	5
11.	Secretary / admin	0	1	2	3	4	5	0	1	2	3	4	5
12.	Support worker	0	1	2	3	4	5	0	1	2	3	4	5
13.	Other 1...	0	1	2	3	4	5	0	1	2	3	4	5
14.	Other 2...	0	1	2	3	4	5	0	1	2	3	4	5

*support worker can include therapy assistant, generic worker etc

**include any practitioner that you work with whether or not they are a core member of your team

Please circle the most correct answer

Overall satisfaction		Extremely dissatisfied									Extremely satisfied
1. Overall, how satisfied are you with your current job?		1	2	3	4	5	6	7	8	9	10
Autonomy and role perception *n/a = not applicable*		Strongly disagree									Strongly agree
2. Most of my work involves following instructions given by other people	n/a	1	2	3	4	5	6	7	8	9	10
3. I am responsible for delegating work to my colleagues	n/a	1	2	3	4	5	6	7	8	9	10
4. I am responsible for deciding what care the patient needs	n/a	1	2	3	4	5	6	7	8	9	10
5. I make important decisions that influence the direction of my team	n/a	1	2	3	4	5	6	7	8	9	10
6. I am often placed in a position of having to do things that are against my professional judgement	n/a	1	2	3	4	5	6	7	8	9	10
7. I am proud of my profession / discipline	n/a	1	2	3	4	5	6	7	8	9	10
8. My profession is well understood by the people I work with	n/a	1	2	3	4	5	6	7	8	9	10
9. My profession is well understood by the general public	n/a	1	2	3	4	5	6	7	8	9	10
10. My role is valued as highly as that of the other members of my team	n/a	1	2	3	4	5	6	7	8	9	10
11. If I could, I would change my profession	n/a	1	2	3	4	5	6	7	8	9	10
Role overlap											
12. I am confident in my own role in my current job	n/a	1	2	3	4	5	6	7	8	9	10
13. I sometimes feel threatened by the amount that other's roles overlaps with mine	n/a	1	2	3	4	5	6	7	8	9	10
14. I have learnt a lot about the roles of other staff by working in this team	n/a	1	2	3	4	5	6	7	8	9	10
15. I undertake joint patient visits with other members of my team	n/a	1	2	3	4	5	6	7	8	9	10
16. I have learnt a lot of new skills working in my current job	n/a	1	2	3	4	5	6	7	8	9	10
17. I am at risk of losing skills by working in my current job	n/a	1	2	3	4	5	6	7	8	9	10
18. My job requires that I am flexible in my role	n/a	1	2	3	4	5	6	7	8	9	10
Uncertainty											
19. I am unclear about the future direction of my team	n/a	1	2	3	4	5	6	7	8	9	10
20. I am clear of my role within the team	n/a	1	2	3	4	5	6	7	8	9	10
21. I have a clear idea of how my team will look one year from now.	n/a	1	2	3	4	5	6	7	8	9	10
22. I feel secure in my current job	n/a	1	2	3	4	5	6	7	8	9	10

Workload		Strongly disagree									Strongly agree
23. The workload in my current job is too high	n/a	1	2	3	4	5	6	7	8	9	10
24. I am satisfied with the hours I am required to work (eg shift work etc)	n/a	1	2	3	4	5	6	7	8	9	10
25. I would like to have more flexibility in my hours	n/a	1	2	3	4	5	6	7	8	9	10
26. I am not paid enough to reflect the level of experience and responsibility my job requires	n/a	1	2	3	4	5	6	7	8	9	10
Innovation											
27. Much of my work is governed by care protocols or clinical pathways	n/a	1	2	3	4	5	6	7	8	9	10
28. I have to be innovative to work in my current job	n/a	1	2	3	4	5	6	7	8	9	10
29. My current job enables me to be innovative in my role	n/a	1	2	3	4	5	6	7	8	9	10
Integration with peers and colleagues											
30. I have access to peer support from members of my own profession	n/a	1	2	3	4	5	6	7	8	9	10
31. I have formal management support from a member of my own profession	n/a	1	2	3	4	5	6	7	8	9	10
32. I am professionally isolated	n/a	1	2	3	4	5	6	7	8	9	10
33. My team members have a clear understanding of my role	n/a	1	2	3	4	5	6	7	8	9	10
34. Team members make appropriate referrals to me	n/a	1	2	3	4	5	6	7	8	9	10
35. My contribution is listened to in team meetings	n/a	1	2	3	4	5	6	7	8	9	10
36. My team works well together	n/a	1	2	3	4	5	6	7	8	9	10
Team working											
37. My team has shared goals	n/a	1	2	3	4	5	6	7	8	9	10
38. My team often disagrees on the treatment of a patient / client	n/a	1	2	3	4	5	6	7	8	9	10
39. Team members can negotiate differences to reach a common understanding	n/a	1	2	3	4	5	6	7	8	9	10
40. There is not much conflict within my team	n/a	1	2	3	4	5	6	7	8	9	10
41. I get on well with my team members	n/a	1	2	3	4	5	6	7	8	9	10
42. My team has a clear and common focus	n/a	1	2	3	4	5	6	7	8	9	10
43. I am a valued member of my team	n/a	1	2	3	4	5	6	7	8	9	10
44. I feel confident to voice my opinion in my team	n/a	1	2	3	4	5	6	7	8	9	10
Management structures and styles											
45. I have a clearly defined line manager	n/a	1	2	3	4	5	6	7	8	9	10
46. I am satisfied with the management of my team	n/a	1	2	3	4	5	6	7	8	9	10
47. I can voice my concerns to my manager	n/a	1	2	3	4	5	6	7	8	9	10
48. My manager is accessible	n/a	1	2	3	4	5	6	7	8	9	10
49. My manager understands my role	n/a	1	2	3	4	5	6	7	8	9	10

Access to technology and equipment		Strongly disagree									Strongly agree
50. I have access to the *type* of equipment I need to do my job (eg equipment, aides)	n/a	1	2	3	4	5	6	7	8	9	10
51. I can access appropriate equipment *when* I need it	n/a	1	2	3	4	5	6	7	8	9	10
52. I have access to administrative support when I need it	n/a	1	2	3	4	5	6	7	8	9	10
53. I have access to a computer at work	n/a	1	2	3	4	5	6	7	8	9	10
Training and career progression opportunities											
54. I have clear career opportunities in my current job	n/a	1	2	3	4	5	6	7	8	9	10
55. I have access to training if I need it	n/a	1	2	3	4	5	6	7	8	9	10
56. I am satisfied with the career development opportunities offered by my current job	n/a	1	2	3	4	5	6	7	8	9	10
57. I am more satisfied working in my current job than in other places I have worked	n/a	1	2	3	4	5	6	7	8	9	10
58. If I want to progress professionally, I will have to leave my current job	n/a	1	2	3	4	5	6	7	8	9	10
59. I cannot see a clear direction for my future in my current job	n/a	1	2	3	4	5	6	7	8	9	10
60. I can take time off work for training if I need to	n/a	1	2	3	4	5	6	7	8	9	10
61. I have the opportunity to specialise in my current job	n/a	1	2	3	4	5	6	7	8	9	10
62. I am planning to leave my current employer in the next twelve months	n/a	1	2	3	4	5	6	7	8	9	10
63. I am planning to change my profession in the next twelve months	n/a	1	2	3	4	5	6	7	8	9	10
Feeling prepared and trained for the role											
64. I have the skills necessary to do my job	n/a	1	2	3	4	5	6	7	8	9	10
65. If I am uncertain about an aspect of patient / client care, I can always access someone who can help me	n/a	1	2	3	4	5	6	7	8	9	10
66. The quality of the care provided where I work is good	n/a	1	2	3	4	5	6	7	8	9	10
67. My service benefits the patients / clients	n/a	1	2	3	4	5	6	7	8	9	10
68. My team has clear systems for resolving disputes or workplace problems	n/a	1	2	3	4	5	6	7	8	9	10

Any other comments.....

.....

.....

Please return this in the prepaid envelope provided to:

EEICC Workforce Project
ScHARR
FREEPOST – SF1314
Sheffield S1 1AY

Appendix 8: Client Record Pack

CONFIDENTIAL

The EEICC Study

Enhancing the Effectiveness of Interprofessional Teamworking: Cost and Outcomes

CLIENT / SERVICE USER RECORD PACK

- Please use this pack to record information about the client/service user at entry to the service and discharge/end of service provision.
- Do not separate pages from each other.
- Where indicated, give the whole pack to the client/service user to complete the EQ-5D (quality of life measure) under supervision.
- Please ensure that the information recorded in this pack cannot identify the client in any way.

Many thanks for your help

INSTRUCTIONS ON ADMISSION

Please complete the following:

- Record of staff contact — Page 3
- Details of Admission — Pages 4-5

Now please turn to the EQ-5D form on pages 6-7 and pass the booklet to the client / service user, asking them to complete the survey *themselves.*

INSTRUCTIONS ON DISCHARGE

Please complete the following:

- Details of Discharge — Pages 8-9

Now please turn to the EQ-5D form on pages 10-11 and pass the booklet to the client / service user, asking them to complete the survey *themselves.*

Please give the client / service user the satisfaction questionnaire attached to this booklet and ask them to complete it as soon as possible and to return it in the prepaid envelope. **Please stress that no-one on the scheme will see the completed satisfaction questionnaire.**

RECORD OF STAFF CONTACT

01 Please indicate the type of staff involved in delivering this client's care by placing ticks in the appropriate boxes.

	Tick ✓	
Nurse		01
Occupational Therapist		02
Physiotherapist		03
Social Worker		04
Speech & language therapist		05
Podiatrist		06
Dietitian		07
Pharmacist		08
Psychologist		09
Support worker*		10
Geriatrician / consultant		11
General Practitioner		12
Administrative personnel		13
Social care worker**		14
Other (please specify type below)		99

* Support worker = therapy assistant, social care assistant, generic worker etc.
** Social care worker = community care officer, social care assessor, etc.

DETAILS OF *ADMISSION*

02 Year of birth

03 Sex — Male ☐ 01 Female ☐ 02

04 Date of admission / start date of service provision

05 Reason for referral (and diagnosis if applicable)

06 Who made the referral? (Please tick one)

- GP ☐ 01
- Self/informal carer/friend/family ☐ 02
- Community nurse ☐ 03
- Social worker ☐ 04
- Allied Health Professional ☐ 05
- Accident and Emergency ☐ 06
- Ward in acute hospital ☐ 07
- Community hospital ☐ 08
- Patient recruited from ward by scheme staff ☐ 09
- Other (please specify below) ☐ 99

07 What are the patient/user's normal living arrangements? (Please tick one)

- Lives alone in own home (owned or rented) ☐ 01
- Lives with other(s) in own home (owned or rented) ☐ 02
- Lives in relative's home ☐ 03
- Lives in residential/nursing home ☐ 04
- Lives in sheltered housing ☐ 05
- Other (please specify below) ☐ 99

08 Where is the patient receiving their care/input from your service? (Please tick one)

- Own home ☐ 01
- Relative's home ☐ 02
- Residential/nursing home ☐ 03
- Sheltered housing ☐ 04
- Acute hospital ☐ 05
- Accident and emergency ☐ 06
- Intermediate care facility ☐ 07
- Day hospital ☐ 08
- Resource centre ☐ 09
- Community hospital ☐ 10
- Other (please specify below) ☐ 99

Level of Care: Please tick the level that best describes the client's needs **(tick only one)**

09				
	0	Client does not need any intervention		00
	1	Client needs prevention / maintenance programme		01
	2	Client needs convalescence / respite		02
	3	Client needs slow stream rehabilitation		03
	4	Client needs regular rehabilitation programme		04
	5	Client needs intensive rehabilitation		05
	6	Client needs specific treatment for individual acute disabling condition		06
	7	Client needs medical care and rehabilitation		07
	8	Client needs rehabilitation for complex disabling condition		08

Enderby P & Stevenson J (2000). What is Intermediate Care? Looking at Needs. Managing Community Care 8(6): 35-40

TOMs: Please enter a score from 0 – 5 for each category in the box to the right (you may use half points if necessary if the category is not quite appropriate)

				Score eg 1.5
10	**Impairment**	0	The most severe presentation of this impairment	
		1	Severe presentation of this impairment	
		2	Severe/moderate presentation	
		3	Moderate presentation	
		4	Just below normal/mild presentation	
		5	No impairment	
11	**Activity**	0	Totally dependent unable to function	
		1	Assists/Co-operates but burden of task falls on professional carer	
		2	Can undertake some part of task but needs a high level of support to complete	
		3	Can undertake task function in familiar situation but requires some verbal/physical assistance	
		4	Requires some minor assistance occasionally or extra time to complete the task	
		5	Independent/able to function	
12	**Participation**	0	No autonomy, isolated, no social/family role	
		1	Very limited choices, contact mainly with professionals, no social or family role, little control over life	
		2	Some integration, value and autonomy in one setting	
		3	Integrated, valued and autonomous in limited number of settings	
		4	Occasionally some restriction in autonomy, integration or role	
		5	Integrated, valued, occupies appropriate role	
13	**Wellbeing**	0	High & constant levels of concern/anger/severe depression or apathy, unable to express or control emotions appropriately	
		1	Moderate concern, becomes concerned easily, requires constant reassurance/support, needs clear/tight limits and structure, loses emotional control easily	
		2	Concern in unfamiliar situations, frequent emotional encouragement and support required	
		3	Controls emotions with assistance, emotionally dependent on some occasions, vulnerable to change in routine, spontaneously uses methods to assist emotional control	
		4	Able to control feelings in most situations, generally well adjusted/stable (most of the time/most situations), occasional emotional support/encouragement needed	
		5	Well adjusted, stable and able to cope with most situations, opportunity to self-analyse, accepts and understands own limitations	

Enderby P, John A & Petherham B (2006). Therapy Outcome Measures for speech and language therapists, physiotherapists, occupational therapists and rehabilitation nursing (2nd Edition). Wileys, UK.

Refer to manual for specific rating scales and more information.

Project 08/1819/214

EQ-5D HEALTH SURVEY (ADMISSION)

We are interested in how well you feel and how your health affects the way you carry out your daily activities. We would be grateful if you could answer these questions.

Place a tick in ***one box*** in each group below to indicate which statement best describes your own health state ***today***.

Mobility	Please tick one	
I have no problems in walking about	☐	14 01
I have some problems in walking about	☐	14 02
I am confined to bed	☐	14 03

Self-care	Please tick one	
I have no problems with self-care	☐	15 01
I have some problems washing or dressing myself	☐	15 02
I am unable to wash or dress myself	☐	15 03

Usual activities (e.g. work, study, housework, family or leisure)	Please tick one	
I have no problems with performing my usual activities	☐	16 01
I have some problems with performing my usual activities	☐	16 02
I am unable to perform my usual activities	☐	16 03

Pain / discomfort	Please tick one	
I have no pain or discomfort	☐	17 01
I have moderate pain or discomfort	☐	17 02
I have extreme pain or discomfort	☐	17 03

Anxiety / depression	Please tick one	
I am not anxious or depressed	☐	18 01
I am moderately anxious or depressed	☐	18 02
I am extremely anxious or depressed	☐	18 03

Remember, these questions are about how you feel **TODAY**.

Thank you for your help in this survey.

Please hand this booklet back to the member of staff who gave it to you.

If the client/service user is unable to complete the questions, please read out the questions and possible answers and fill in the responses they give.

Please remember to complete the section below when the client / service user hands you back the booklet

19	Date of completion of EQ-5D health survey (Admission)		
20	If not completed, please indicate why	Client/Service user refused	01
		Other (please specify clearly below)	99

DETAILS OF *DISCHARGE*

21 Date of discharge or end of service provision

22 Outcome for **this** episode of care: please complete **either** A, B, C, D **or** E

A ☐ **Not accepted onto scheme:**

- ☐ Inappropriate referral 01
- ☐ Client refused / declined 02
- ☐ Referred to different service 03
- ☐ Required home care only 04
- ☐ Other (please specify below) 96

B ☐ **Episode of care completed on scheme:**

Where is client to live or where was he/she discharged to?

- ☐ Own home 05
- ☐ Relative's home 06
- ☐ Temporary residential or nursing home care 07
- ☐ Permanent residential or nursing home care 08
- ☐ Other (please specify below) 97

C ☐ **Transferred before end of episode of care:**

- ☐ Transferred to acute hospital 09
- ☐ Transferred to community hospital 10
- ☐ Transferred to other intermediate care setting 11
- ☐ Transferred to temporary residential/nursing home care 12
- ☐ Transferred to another setting (please specify below) 98

Please record why transferred

D ☐ **Patient/user died:** 13

Date of death

Cause of death (if known)

E ☐ **Other outcome not covered above** (e.g. user withdrew from service): 99

Please give detail

23 Support services in place if client to live at home (or relative's home).

Indicate whether visits are per day or per week

Home care		visits per		01
District nurse		visits per		02
Domiciliary therapy		visits per		03
Meals-on-Wheels		visits per		04
Other (please specify)		visits per		99

None	05
Don't know	77

Level of Care: Please tick the level that best describes the client's needs **(tick only one)**

24			
	0	Client does not need any intervention	00
	1	Client needs prevention / maintenance programme	01
	2	Client needs convalescence / respite	02
	3	Client needs slow stream rehabilitation	03
	4	Client needs regular rehabilitation programme	04
	5	Client needs intensive rehabilitation	05
	6	Client needs specific treatment for individual acute disabling condition	06
	7	Client needs medical care and rehabilitation	07
	8	Client needs rehabilitation for complex disabling condition	08

Enderby P & Stevenson J (2000). What is Intermediate Care? Looking at Needs. Managing Community Care 8(6): 35-40

TOMs: Please enter a score from 0 – 5 for each category in the box to the right (you may use half points if necessary). Please refer to page 5 for full details.

25	**Impairment**	
26	**Activity**	
27	**Participation**	
28	**Wellbeing**	

Enderby P, John A & Petherham B (2006). Therapy Outcome Measures for speech and language therapists, physiotherapists, occupational therapists and rehabilitation nursing (2nd Edition). Wileys, UK.

Project 08/1819/214

EQ-5D HEALTH SURVEY (DISCHARGE)

We are interested in how well you feel and how your health affects the way you carry out your daily activities. We would be grateful if you could answer these questions.

Place a tick in ***one box*** in each group below to indicate which statement best describes your own health state ***today***.

Mobility Please tick one

I have no problems in walking about	☐	29 01
I have some problems in walking about	☐	29 02
I am confined to bed	☐	29 03

Self-care Please tick one

I have no problems with self-care	☐	30 01
I have some problems washing or dressing myself	☐	30 02
I am unable to wash or dress myself	☐	30 03

Usual activities (e.g. work, study, housework, family or leisure) Please tick one

I have no problems with performing my usual activities	☐	31 01
I have some problems with performing my usual activities	☐	31 02
I am unable to perform my usual activities	☐	31 03

Pain / discomfort	Please tick one	
I have no pain or discomfort	☐	32 01
I have moderate pain or discomfort	☐	32 02
I have extreme pain or discomfort	☐	32 03

Anxiety / depression	Please tick one	
I am not anxious or depressed	☐	33 01
I am moderately anxious or depressed	☐	33 02
I am extremely anxious or depressed	☐	33 03

Remember, these questions are about how you feel **TODAY**.

Thank you for your help in this survey.

Please hand this booklet back to the member of staff who gave it to you.

If the client/service user is unable to complete the questions, please read out the questions and possible answers and fill in the responses they give.

Please remember to complete the section below when the client / service user hands you back the booklet

34	Date of completion of EQ-5D health survey (Discharge)		
35	If not completed, please indicate why	Client/Service user refused	☐ 01
		Other (please specify clearly below)	☐ 99

SATISFACTION QUESTIONNAIRE

Please give the client / service user the satisfaction questionnaire and ask them to complete it as soon as possible and to return it in the prepaid envelope provided.

Please stress that no-one on the scheme will see the completed questionnaire.

MANY THANKS FOR YOUR HELP & TIME IN COMPLETING THIS INFORMATION

Please address any queries regarding the administration of this record pack to:

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Pam Enderby	P.M.Enderby@sheffield.ac.uk	0114 222 0858
Steven Ariss	S.Ariss@sheffield.ac.uk	0114 222 8371
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Freepost address: EEICC Project Team
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Appendix 9: Outcome Measures

1. The Levels of Care Tool

What is the Eight Levels of Care tool?

The Eight Levels of Care are based on Enderby and Stevenson's Eight Levels of Care model [1,2].

Work was undertaken in 1999 in Sheffield by various intermediate care and rehabilitation stakeholders to identify gaps in the system and to identify points where intermediate care could be offered in a way more appropriate to a person's needs.

The group decided to consider people's needs and where they might best be met rather than adopting the more common approach of fitting people into services already provided.

Eight broad categories of care were defined in order to clarify the needs of people with disabling conditions. The levels of care range from Level 1 'client needs a prevention and maintenance programme' to Level 8 'client needs rehabilitation for complex profound disabling condition'.

The levels of care tool has since been used in local evaluations of community rehabilitation and intermediate care [3].

Level of care		Aim of this level of care
0	Client does not need any intervention	
1	Patient needs prevention / maintenance programme	• Prevent physical and psychological deterioration • Prevent loss of independence • Promote psychological well-being • Encourage healthy living • Promote positive attitude to independence
2	Client needs convalescence	• Encourage improvement and/or maintenance of independence • Improve recuperation • Wait for aids adaptations • Wait for family adjustment support • Adjust to new circumstances
3	Client needs slow stream rehabilitation	• Provide watchful waiting • Provide assessment/observation • Provide non-intensive rehabilitation/mobilisation • Provide confidence • Actively encourage, extend and facilitate increased speed of recovery • Provide support programme which is being carried out by Client and carers
4	Client needs regular rehabilitation programme	• Provide rehabilitation to maintain steady and measurable progress • Improve expected recovery trajectory

5	Client needs intensive rehabilitation	• Change from dependent to independence • Reduce level of dependency on carers • Achieve maximum level of function • Resolve acute disabling conditions
6	Client needs specific treatment for individual acute disabling condition	• Target specific treatment by one profession • Alleviate or reduce specific Impairment/Activity
7	Client needs medical care and rehabilitation	• Actively treat medical condition in order to prevent/modify deterioration or secondary sequelae whilst enabling Client to improve/maintain independence • Appropriately manage medical condition whilst Client undergoing multidisciplinary rehabilitation
8	Client needs rehabilitation for complex profound disabling condition	• Provide rehabilitation as part of long term management of condition • Maximise level of function, prevent secondary disabling condition and improve quality of life. • Provide particular provision of services related to those with low incidence specialised cognitive and physical disorders

The Eight Levels of Care as it appears in the Client Record Pack

Level of Care: Please tick the level that best describes the client's needs **(tick only one)**

0	Client does not need any intervention		00
1	Client needs prevention / maintenance programme		01
2	Client needs convalescence / respite		02
3	Client needs slow stream rehabilitation		03
4	Client needs regular rehabilitation programme		04
5	Client needs intensive rehabilitation		05
6	Client needs specific treatment for individual acute disabling condition		06
7	Client needs medical care and rehabilitation		07
8	Client needs rehabilitation for complex disabling condition		08

Enderby P & Stevenson J (2000). What is Intermediate Care? Looking at Needs. Managing Community Care 8(6): 35-40

2. The Therapy Outcome Measures

What is the Therapy Outcome Measure?

The TOM was designed to be a simple, reliable, cross-disciplinary and cross-client group method of gathering information on a broad spectrum of issues associated with therapy/rehabilitation. It is a reliable measurement tool for physiotherapists, occupational therapists, speech and language therapists and rehabilitation nurses [4].

The TOM allows therapists to describe the abilities of a patient in four domains based on World Health Organisation definitions [4 5]:

Impairment	Dysfunction resulting from pathological changes in system
Activity	Consequence of impairment in terms of functional performance (disturbance at the personal level)
Participation	Represents disadvantages experienced by the individual as a result of impairment and disabilities.
Wellbeing	Reflects interaction with and adaptation to the individual's surroundings.

How do I administer the TOM?

A rating from 0 to 5 is made on each domain, where a score of 0 is severe, 3 is moderate and 5 mild. For example a score of 0 for 'Activity' represents a patient who is totally dependent/unable to function; a score of 3 for 'Impairment' represents a patient who has a moderate dysfunction resulting from pathological changes; a score of 5 for 'Participation' represents a patient who is integrated and able to maintain their expected different roles in society, is valued by others, and exercises choice and autonomy [6 7]. A score of 0.5 or ½ a point may be used to indicate if the patient is slightly better or worse than a descriptor.

For your reference we have included detailed descriptions of each TOM domain for the adapted TOM scale 'complex and multiple difficulty' on the following pages.

TOM adapted scale 18 - complex and multiple difficulty*

Impairment

0 No purposeful active movement, severe abnormality of muscle tone and patterns of movement, sensory loss, may have severe fixed deformities, severe respiratory difficulties. Presence of pathological reflexes.

1 Grossly abnormal muscle tone, occasionally some voluntary movement towards stimulus, some contractures, some pathological reflexes, sensory impairment, severely restricted range of movement, frequent respiratory difficulties.

2 Altered muscle tone, some purposeful active movement. Some abnormal primitive reflexes. Some joint contractures, may have sensory impairment.

3 Some useful strength, but abnormal muscle tone, co-ordinates movement without accuracy, requires large stable base and low centre of gravity, moderate sensory impairment.

4 Slight abnormality of strength, muscle tone, range of movement, minimal involuntary movements. Slightly impaired neurology with mild weakness or in-coordination.

5 Age appropriate tone, strength, range of movement and co-ordination.

Activity

0 No purposeful active movement, totally dependent, requires full physical care and constant vigilant supervision. May have totally disruptive and uncooperative behaviour. Dependent on skilled assistance.

1 Bed/chair bound but unstable to sit independently. Some very limited purposeful activity. Needs high level of assistance in most tasks. Some awareness, some effort and recognition to contribute to care. Dependent on skilled assistance.

2 Head and trunk control. Limited self help skills. Initiates some aspects of ADL. Transfers with one, mobilises with two. Requires physical and verbal prompting and supervision for most tasks and movements. Participating in care and engaging in some structured activity. Dependent on familiar assistance.

3 Transfers or walking requires supervision or help of one. Undertakes personal care in modified supported environment. Appropriately initiating activities, needs assistance or supervision with unfamiliar or complex tasks. Initiates activities appropriately.

4 Carrying out personal care and tasks but is less efficient, clumsy, requires extra time or may need encouragement, uses memory prompts and other aids effectively. Minimal or occasional assistance required for some complex or unfamiliar tasks.

5 Age appropriate independence.

Participation

0 Unable to fulfil any social/educational/family role. Not involved in decision making/no autonomy/no control over environment; no social integration.

1 Low self-confidence/poor self esteem/limited social integration/socially isolated/contributes to some basic and limited decisions. Cannot achieve potential in any situation.

2 Some self-confidence/some social integration/makes some decisions and influences control in familiar situations.

3 Some self-confidence; autonomy emerging. Makes decisions and has control of some aspects of life. Able to achieve some limited social integration/educational activities. Diffident over control over life. Needs encouragement to achieve potential.

4 Mostly confident; occasional difficulties integrating or in fulfilling social/role activity. Participating in all appropriate decisions. May have difficulty in achieving potential in some situations occasionally.

5 Achieving potential. Autonomous and unrestricted. Able to fulfil social, educational and family role.

Wellbeing

0 Severe Constant - High and constant levels of distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Unable to express or control emotions appropriately.

1 Frequently severe - Moderate levels of distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Becomes concerned easily, requires constant re-assurance/support, needs clear/tight limits and structure, loses emotional control easily.

2 Moderate consistent - Distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy in unfamiliar situations, frequent emotional encouragement and support required.

3 Moderate Frequent - Distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Controls emotions with assistance, emotionally dependent on some occasions, vulnerable to change in routine, spontaneously uses methods to assist emotional control.

4 Mild Occasional - distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Able to control feelings in most situations, generally well adjusted/stable (most of the time/most situations), occasional emotional support/encouragement needed.

5 Not inappropriate - Well adjusted, stable and able to cope emotionally with most situations, good insight, accepts and understands own limitations.

*(taken from Enderby P, John A & Petherham B Therapy Outcome Measures for Rehabilitation Professionals. Second Ed. 2006, appendix 7, page 122-3)

The TOMS as it appears in the client record pack

TOMs: Please enter a score from 0 – 5 for each category in the box to the right (you may use half points if necessary)

10	**Impairment**	
11	**Activity**	
12	**Participation**	
13	**Wellbeing**	

Enderby P, John A, Petherham B (1998). Therapy Outcomes Measures for Physiotherapists, Occupational Therapists & Rehabilitation Nurses. Singular Publications, London.

3. The EuroQoL or EQ-5D

What is EQ-5D?

The EQ-5D is a standardised instrument to measure health status or health-related quality of life. The EQ-5D is designed for self-completion by respondents. It is cognitively simple, taking only a few minutes to complete. Instructions for respondents are included in the questionnaire.

There is good evidence for reliability, validity and responsiveness for the EQ-5D and is recommended where a change in health is expected [9]. It has also been translated and validated in several different languages.

EQ-5D HEALTH SURVEY (ADMISSION)

We are interested in how well you feel and how your health affects the way you carry out your daily activities. We would be grateful if you could answer these questions.

5

Place a tick in ***one box*** in each group below to indicate which statement best describes your own health state ***today***.

Mobility	Please tick one	
I have no problems in walking about	☐	14 01
I have some problems in walking about	☐	14 02
I am confined to bed	☐	14 03

Self-care	Please tick one	
I have no problems with self-care	☐	15 01
I have some problems washing or dressing myself	☐	15 02
I am unable to wash or dress myself	☐	15 03

Usual activities (e.g. work, study, housework, family or leisure)	Please tick one	
I have no problems with performing my usual activities	☐	16 01
I have some problems with performing my usual activities	☐	16 02
I am unable to perform my usual activities	☐	16 03

Pain / discomfort	Please tick one	
I have no pain or discomfort	☐	17 01
I have moderate pain or discomfort	☐	17 02
I have extreme pain or discomfort	☐	17 03

Anxiety / depression	Please tick one	
I am not anxious or depressed	☐	18 01
I am moderately anxious or depressed	☐	18 02
I am extremely anxious or depressed	☐	18 03

Remember, these questions are about how you feel **TODAY**.

Thank you for your help in this survey.

Please hand this booklet back to the member of staff who gave it to you.

If the client/service user is unable to complete the questions, please read out the questions and possible answers and fill in the responses they give.

Further information

Eq-5D website http://gs1.g4matics.com/EuroqolPublishWeb/

Haywood KL, Garratt AM, Fitzpatrick R. Quality of life in older people: a structured review of generic self-assessed health instruments. *Quality of Life Research* 2005;14: p1651-1668

4. Patient satisfaction survey

About the surveys

sdo

The patient satisfaction instrument was developed and validated in the context of the National Evaluation of Intermediate Care, conducted by the Leicester and Birmingham Universities[10]. The researchers have successfully used these surveys in other evaluations of intermediate care.

The EEICC Study

Enhancing the Effectiveness of Interprofessional Teamworking: Costs and Outcomes.

Patient Information Sheet

Our service is currently involved in a research project. The purpose of the research is to determine the number and types of staff needed to provide care for people in our care, and how to organise services in the most cost effective way.

The research is being undertaken by researchers from the University of Sheffield and is funded by the Department of Health.

For the purpose of the research, we may provide some information to the research team about the care you receive from our service, such as the numbers and different types of staff involved in your treatment, and the outcomes of your care.

The information will be collected by the usual staff that provide your care and may involve answering a few extra questions about your care, however this should only take a few minutes. When you are discharged from our service, we will provide the relevant information to the research team.

Please note that you will not be identified in any way from the information provided to the research team. If, however, you do not want this information to be used for the research, please let your care provider know at any time during your care provision, and we will ensure that your information is excluded from the study.

We will also give you (and your carer, if relevant) an anonymous questionnaire which will ask you about your satisfaction with our service. This can be returned to the research team, at your own convenience, in the self-addressed envelope provided if you wish.

Who do I contact for additional information?

Should you have any concerns, queries or if you want to discuss any aspect of the project please ask your care provider in the first instance, or contact the researchers Professor Pam Enderby, Tony Smith or Steven Ariss at any time on the details below.

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Address: **EEICC**
University of Sheffield
Regent Court
30 Regent St
Sheffield S1 4DA

Telephone: Pam Enderby – 0114 222 0858 p.m.enderby@sheffield.ac.uk
Tony Smith – tony.smith@sheffield.ac.uk
Steven Ariss – 0114 222 8371 s.ariss@sheffield.ac.uk

Patient/service user questionnaire

Thank you for agreeing to take part in this review of community and intermediate care services.

The findings of this survey will help us to know what people like you think of the service and how it can be improved. Your answers are of course strictly confidential.

Once you have completed the questionnaire, please return it in the addressed, postage paid envelope.

Thank you

Service Manager

Please return the survey in the reply paid envelope or to the FREEPOST address below:

EEICC Workforce Project
ScHARR
FREEPOST - SF 1314
Sheffield
S1 1AY

Intermediate Care: *Patient/service user Questionnaire*		
	Please tick (✓) whether you strongly agree, agree, disagree or strongly disagree with each of the following statements. If you can't answer or have no opinion, please respond 'unsure'.	
1	My admission to the service was very efficient	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
2	The staff were very careful to check everything when I was admitted to their care / the service	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
3	The admission fitted in with my home arrangements	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
4	The team gave me all the information I wanted about my condition	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
5	The team gave me all the information I wanted about the care I was receiving	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐

6	While on the scheme I received care whenever I needed it	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
7	I had problems getting pain relief when I needed it	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐ Not applicable ☐
8	While on the scheme I received care from a doctor whenever I needed it	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
9	I had all the facilities necessary to care for me	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
10	I felt as safe receiving treatment at home/the residential home as in hospital	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
11	The team did their best to help me become more independent	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐

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12	I felt able to talk to the team about any problems or worries I had	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
13	Sometimes visits from the team disrupted my home arrangements	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
14	The staff always had time for me	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
15	I have been treated with kindness, respect and dignity by the staff from the service	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
16	The staff worked together and knew what each other was doing	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
17	I was well prepared for my discharge from the service	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐

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18	My discharge from the service was too early	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
19	The care I received after discharge was well co-ordinated	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
20	The team did everything that they could to make me well again	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
21	The care I received on the scheme was just about perfect	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
22	There are some things the team could have done better	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐
23	I'm happy with the amount of recovery I made while on the service	Strongly disagree ☐ Disagree ☐ Unsure ☐ Agree ☐ Strongly agree ☐

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DO YOU HAVE ANY OTHER COMMENTS ABOUT THE SERVICE?

4.1. THANK YOU FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE

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Appendix 10: Search Terms

Search terms for the Concept Analysis (LR1)

Interdisciplinary OR interprofessional OR multiprofessional OR multidisciplinary OR Inter-disciplinary OR inter-professional OR co-operat* OR multi-professional OR multi-disciplinary OR "Inter disciplinary" OR "inter professional" OR "multi disciplinary" OR "multi professional"	AND	team* [includes team, teams, team work, teamwork or teamworking] OR cooperat* OR collaborat* OR Physician-Nurse Relations OR Communication	AND	Primary care OR Community care

Search terms for review of processes and outcomes of interprofessional teamworking (LR3)

Interdisciplinary OR interprofessional OR cooperat* OR collaborat* OR multidisciplinary OR Inter-disciplinary OR inter-professional OR co-operat* OR multi-disciplinary OR "Inter disciplinary" OR "inter professional" OR "multi disciplinary"	AND	Length of Stay Patient Admission Patient Discharge Patient Readmission Patient Transfer Quality of Health Care Outcome and Process Assessment (Health Care) Outcome Assessment (Health Care) Treatment Outcome Treatment Failure Mortality Cause of Death Hospital Mortality Survival Rate

Appendix 11: Papers contributing to an understanding of collaboration

Study Identifier	Discipline/ Setting	Concepts/Definitions/Models & Frameworks
Bennett-Emslie & McIntosh (1995)[1]	General practitioners, health visitors and health workers	Reviewed 14 general practices, interviewing 70 general practitioners, health visitors and health workers in the UK. Participants identified frequency of team meetings as single most critical factor that fostered collaborative teamwork.
Hennemann et al (1995)[2]	Nursing - Literature Review (therefore non-specific)	Collaboration "requires competence, confidence and commitment on the part of all parties, Respect and trust, both for oneself and others, is key. Patience, nurturance and time are required to build a relationship so that collaboration can occur". Although organizations can be instrumental in supporting collaboration, they cannot ensure its success. Collaboration occurs between individuals, not institutions. Only persons involved ultimately determine whether or not collaboration occurs From concept analysis, following associated with collaboration: • joint venture, • cooperative endeavor, • willing participation, • shared planning and decision-making, • team approach, • contribution of expertise, • shared responsibility, • nonhierarchical relationships, • shared power based on knowledge and expertise.
Liedrtka J.M. & Whitten E. (1998)[3]	Management	Investigates factors contributing to and detracting from collaboration across professional groups. Uses both objective performance data and perceptual data obtained from the physicians, nurses, and administrators. Similar set of factors emerged across all three service lines and professional groups. Factors highly correlated with perceived success of collaborative efforts in producing

		positive outcomes in both quality and efficiency of care, patient satisfaction, and improved work environment. Findings highlight importance of • shared values • trust, and • personal engagement- All empirically linked with participants' perceptions of successful collaboration. Failed to find improvement in objective performance data. In addition, individual professional groups were found to have differing views of collaborative environment.
Wells et al (1998)[4]	Nursing	Following attributes relate to collaboration: • **open communication** • **cooperation** • **assertiveness** • **negotiation** • **coordination**
Larson 1999[5]	Nursing	Perceptions of physicians and nurses vary in extent to which collaboration and joint decision making are valued, the definition of what constitutes adequate and appropriate interprofessional communication, the quality of nurse-physician interactions, and understanding of respective areas of responsibility as well as patient goals. Reasons for differences have been attributed to gender, historical origins of professions, and disparities between physicians and nurses with regard to socioeconomic status, education, and socialization. Failure of physicians and nurses to interact in a coordinated and positive way results in unhealthy work environments and poor patient outcomes. Both professions must examine their will to improve interprofessional interactions.
Mariano (1999)[6]	Nursing	For cooperation to become generally accepted requires full understanding of interdisciplinarity and what promotes or hinders it. Resocialization, training, and new skills required of educators, practitioners, and administrators.
El Ansari et al (2001)[7]	Not specified	Despite growing literature that collaboration is a 'good' thing, need for evidence of effectiveness. Nature of evidence to assess effectiveness is less clear. Examines components that contribute to challenges that confront evidence on collaboration. Considers differing interpretations placed on evaluation. Explores how ways of determining outcomes of collaboration and levels of outcome measurement to assess collaborative effectiveness are influenced by multifactorial nature of

		concept. Evidence on impact of collaboration influenced by diversity of perspectives and conceptual facets, and difficulty in measurement. Other factors are choice of macro or micro evaluation, of proximal or distal indicators, of short and long-term effects, or of individual-level or collective community-level outcomes. Suitability of randomised controlled trials for measurement of collaborative outcomes as well as requirement of mixed methods evaluations are highlighted. For collaboration to be successful, requires appraising its effectiveness to reduce nature of inconclusive evidence and to improve practice of partnerships, coalitions and joint working in health and social care.
Paul & Peterson (2001)[8]	Occupational therapy	Collaborative practice models may be viable means for improving health care delivery. Outlines how interprofessional education, practice, and research can establish economic benefits and effective clinical outcomes outside of discipline specific investigation
Whitehead (2001)[9]	Health promotion	Examines issues surrounding nursing's hesitancy in adopting collaborative working practices. To promote collaborative practice, nurses need to be aware of range of teams and agencies involved in health promotion and acknowledge the client as an equal member of team. Better education, training and shared learning initiatives are essential to improve collaborative practice.
Kenny (2002)[10]	Nursing	Interprofessional working….marks departure from historical "uni-professional" ways of working, where activities of professions are confined within their own discipline, and multiprofessional, where professions recognize that other disciplines have important contribution to make to care delivery. In context of interprofessional working, practitioners are being urged to learn from and about each other so that they might effectively work across professional boundaries. Potential inhibitors to interprofessional collaboration exist at three levels • Interorganizational - differences in power and resources available to groups may have an impact on collaboration. • Interprofessional - actual or perceived differences in status, training and skills may inhibit groups working together effectively to achieve a commonly held aim. • Interpersonal - the race, class and sex of participants may create barriers that prevent communication and collaboration. None of these levels exists independently and each intimately affects the others.
Bronstein	Social work	Social workers have worked with colleagues from other

(2003)[11]	Literature review and concept analysis	disciplines since early days yet, without clear models to guide interdisciplinary work. Current trends relevant to interdisciplinary practice are noted to emphasize its importance. Describes two-part model. Part one consists of five components that constitute interdisciplinary collaboration between social workers and other professionals: • interdependence, • newly created professional activities, • flexibility, • collective ownership of goals, and • reflection on process. Part two consists of four influences on collaboration: • professional role, • structural characteristics, • personal characteristics and • a history of collaboration. Implications for social work practice are discussed.
Leathard (2003)[12]	Not specified	IDT work raises questions about partnership working
D'Amour et al (2004)[13]	Not specified	"an interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided"[14] (Way & Jones 2000)
Dieleman et al (2004)[15]	Primary health care team	• Open communication • Respect for other team members, • Understanding of their roles and expertise, • Being open to learning
McCallin (2005)[16]	Not specified	Interprofessional practice is based on collaboration. Cannot assume that health professionals have either skills or attributes required for interprofessional practice. They may need to learn how to collaborate. Developing interprofessional practice requires commitment to engage in shared learning and dialogue. Dialogue has potential to encourage collegial learning, change thinking, support new working relationships, and improve client care
Schmalenberg et al (2005)[17]	Physicians, managers and staff nurses	Literature review and interviews. Structural enablers included joint nurse/physician practice committees, integrated patient records, joint practice record review, and the use of protocols or critical pathways in the care of specific patient groups. With regard to interpersonal relationships and interactions, they mentioned trust, respect, shared leadership, recognition of unique contribution, collegiality, and open communication as

		enabling factors.
Wachs (2005)[18]	Occupational Health	No single discipline can meet all needs of workers and workplace. However, teamwork can be time-consuming and difficult if attention is not given to role of team leader, necessary skills of team members, and importance of supportive environment. Bringing team members together regularly to foster positive relationships and infuse them with philosophy of strength in diversity is essential for teams to be sustained and work to be accomplished.
Yeager (2005)[19]	Nursing	In health care system in which patient complexity, outcome indicators, and informed families represent current reality, interdisciplinary approach to care is crucial to successful navigation of a patient's experience in ICU. To guide practitioners toward favourable patient progression, thorough understanding of interdisciplinary collaboration is necessary. Focuses on definitions of, benefits of, and barriers to interdisciplinary collaboration and provides practical solutions for implementation.
Belza (2007)[20]	Nursing Not specified	All benefit when collaborate/work effectively as IPT. Members can join forces, establish goals, and create plan to move forward together. Identifying specific tasks for each team member is critical step. Members can capitalize on each other's skill sets/build synergy through partnerships. Most effective when we believe in ourselves and our ability to make a difference, not just as individuals but collectively, as a unit. Working together leads to less duplication of efforts. Putting new innovations in place requires skill sets of early adopters. Conducting periodic evaluations requires openness to making shifts in plan to optimize outcomes. Patients/families benefit from effective collaborations through improved outcomes/cost-effective provision of services. Applying 7 habits of highly effective people to highly effective interprofessional collaboration: Independence (includes 3 habits: 1. Be Proactive, 2. Begin with the End in Mind, and 3. Put First Things First) Interdependence (includes 3 habits: 4. Think Win/Win; 5. Seek First to Understand, Then to Be Understood; and 6. Synergize). 7. Renewal
D'Amour et al 2008[21]	Not Specified	Suggests that collective action can be analyzed in terms of four dimensions operationalized by 10 indicators Two dimensions involve relationships between individuals and

		two involve organizational setting (which influences collective action). Four dimensions are interrelated and influence each other. 1) **Shared Goals and Vision:** existence of common goals and their appropriation by the team, recognition of divergent motives and multiple allegiances, and diversity of definitions and expectations regarding collaboration; 2) **Internalization:** awareness by professionals of their interdependencies and of importance of managing them, and which translates into a sense of belonging, knowledge of each other's values and discipline and mutual trust. 3) **Formalization** (structuring clinical care):"the extent to which documented procedures that communicate desired outputs and behaviours exist and are being used". Formalization clarifies expectations and responsibilities. 4) **Governance**: leadership functions that support collaboration. Governance gives direction to and supports professionals as they implement innovations related to interprofessional and interorganizational collaborative practices. Together, four dimensions and interaction between them capture processes inherent in collaboration. They are subject to influence of external and structural factors such as resources, financial constraints and policies.
Fewster-Thuente & Velsor-Friedrich (2008) [22]	Nursing	Collaboration defined as "a complex phenomenon that brings together two or more individuals, often from different professional disciplines, who work to achieve shared aims and objectives."[23] Attributes of collaboration include shared power based on knowledge, authority of role, and lack of hierarchy. Teamwork only one attribute of collaborative relationship. Applies transaction process of King's theory of goal attainment which results in collaboration among nurses/physicians/allied healthcare professionals. Barriers: patriarchal relationships, time, gender, lack of role clarification, and culture
Downe et al (2010) [24]	Midwifery	Effective collaboration between professional groups increasingly seen as essential element in good quality and safe health care. Presents current accounts of collaboration—or lack of it—in maternity care in the United Kingdom, United States, and Australia. Examines tools designed to measure collaboration and teamwork within general health care contexts. Finally, set of characteristics proposed for effective collaboration in

		maternity care, as basis for further empirical work.
Petri (2010)[25]	Systematic review of interdisciplinary collaboration in health care.	Explores interdisciplinary collaboration within health care. Interdisciplinary collaboration commonly described using terms problem-focused process, sharing, and working together. Elements that must be in place before interdisciplinary collaboration can be successful are interprofessional education, role awareness, interpersonal relationship skills, deliberate action, and support. Consequences of interdisciplinary collaboration are beneficial for patient, organization, and healthcare provider. Comprehensive definition of interdisciplinary collaboration within context of health care presented as outcome of analysis. Further inquiry should focus on development of valid measures to accurately evaluate interdisciplinary collaboration in health care.

[1] Bennett-Emslie G. & McIntosh J. (1995) Promoting collaboration in the primary care team - the role of the practice meeting. *Journal of Interprofessional Care* 9(3), 251-256.

[2] Henneman EA, Lee JL, Cohen JI. Collaboration: a concept analysis. *Journal of Advanced Nursing*. 1995;21(1):103–109.

[3] Liedrtka J.M. & Whitten E. (1998) Enhancing care delivery through cross-disciplinary collaboration: a case study. *Journal of Healthcare Management* 43, 186.

[4] Wells ND, Johnson R, Salyer S. Interdisciplinary collaboration. *Clin Nurse Special.* 1998;12 (4): 161–168.

[5] Larson E. The impact of physician-nurse interaction on patient care. *Holistic Nurs.* 1999;13:38–47.

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Appendix 12: Nine Instruments identified for measuring team effectiveness

Instruments	Description
The Index of Interdisciplinary Collaboration (2002)[1]	Builds on existing literature and a model of interdisciplinary collaboration to present an instrument, the index of interdisciplinary collaboration (IIC), to measure extent of collaboration between social workers and other professionals. The 49-item scale reflects the model components: interdependence (items 1-16), newly created professional activities (items 17-23), flexibility (items 24-29), collective ownership of goals (items 30-38), and reflection on process (items 39-49).
Modified Index for Interdisciplinary Collaboration (2007)[2)]	Modified Index for Interdisciplinary Collaboration to create tool to measure perceptions of collaboration by all members of hospice team. Questions on 42-item instrument reworded to be more inclusive. This new Modified Index for Interdisciplinary Collaboration (MIIC) showed strong reliability. Further use and testing is recommended.
The Interprofessional Socialization and Valuing Scale (2010)[3]	24-item self-report measure based on concepts in interprofessional literature concerning shifts in beliefs, behaviors, and attitudes that underlie interprofessional socialization. Designed to measure degree to which transformative learning takes place, as evidenced by changed assumptions and worldviews, enhanced knowledge and skills concerning interprofessional collaborative teamwork, and shifts in values and identities. The scales of the ISVS were determined using principal components analysis. Three scales accounted for approximately 49% of variance in responses: (a) Self-Perceived Ability to Work with Others, (b) Value in Working with Others, and (c) Comfort in Working with Others. These scales showed good fit with the conceptual basis of the measure. ISVS provides insight into the abilities, values, and beliefs underlying socio-cultural aspects of collaborative and authentic interprofessional care in the workplace, and can be used to evaluate impact of interprofessional education efforts, in house team training, and workshops.
Medical Team Training Questionnaire (MTT Questionnaire) (2008)[4]	Developed from Team Training questionnaire (used to evaluate medical quality improvement teams in facilitated improvement projects within Department of Veterans Affairs (VA - U.S)).Earlier questionnaire modified to elicit more specific information related to communication and teamwork between clinicians.
Perceived Efficiency	Based on following six items:

Index (2005)[5]	1. To what extent do you consider that all team members work towards the same goal? 2. To what extent do you regard the work of the team as efficient? 3. To what extent do you regard your organization/unit as successful? 4. Do you consider your organization/unit as distinguished for high quality? 5. How well does your team meet the needs of the clients, patients etc? In total, how satisfied are you with the work of your team?
Team Climate Index (2005)[6]	17 items/statements (Cronbach's a = 0.93). Dealt with: (a) ability to give feedback, to listen, to express opinions clearly and 'to give and take'; (b) the existence of mutual empathy, interest and attention, an informal and supportive atmosphere, satisfying relationships and acceptance of emotions as well as rational opinions; (c) respect for deviating opinions, constructive criticism and an ambition to achieve consensus as well as a capacity for conflict management; and (d) encouragement of individual performances and activity in team discussions.
Team Climate Inventory (1998) [7]	Used extensively in researching levels and quality of teamwork within healthcare teams, especially in primary and community care (Poulton & West 1999, Williams & Laungani 1999).
Team Decision Making Questionnaire (2008)[8]	19-item measure consisting of 4 subscales including Decision Making, Team Support, Learning, and Developing Quality Services. Team Decision Making Questionnaire (TDMQ) demonstrated internal consistency, stability over time, and construct validity. Internal consistencies were excellent and Cronbach's Alphas (N = 102) for the 4 components ranged from 0.83 to 0.91. The internal consistency for the total instrument was 0.96. Test re-test reliability (N = 22) measured with Intraclass Correlation Coefficient was good.
Teamwork in Healthcare Inventory (2002, 2005)[9][10]	27 characteristics of effective teamwork represented using both positively and negatively worded statements.

Appendix 13: Workforce change instruments

Modelling tools

Four of the retrieved instruments were defined as modelling tools: Christmas Trees, Witness, Venism and Nursing Workforce Planning Tool. Modelling tools attempted to model the current or projected workforce or a process. The Christmas Tree and Witness will be discussed in more detail.

Christmas Tree

Description and use

The Christmas Tree or Trees is a workforce planning and development tool developed for the NHS by Homerton University. The tool can be used to plan and develop the NHS workforce for example for workforce redesign or service reconfiguration. The tools versatility means that it can be used at a local level for a whole Trust or a department or a specific staff group within a trust or for the NHS service nationally[1].

The tool is visually represented as a Christmas tree with nine branches that indicate the different levels within the NHS careers framework[2]. Bottom branches signify lower levels in the careers framework; initial entry level jobs, support workers and thus are the larger branches. The branches get gradually smaller as they move upwards. The higher branches are smaller and represent consultant practitioners and more senior staff.

Trees can be developed nationally for the NHS to demonstrate the current workforce and plan the future workforce requirements. At a local level trees can be developed to demonstrate current and projected future workforce demands for teams, departments or different staff groups.

Evidence

No evidence was found for the use and impact of the Christmas Tree model on workforce planning within the NHS. However, the tool was updated in 2007 suggesting that it is been used.

WITNESS

Description and use

Another modelling tool developed for planning the NHS workforce is WITNESS. The WITNESS tool models different processes using Monte Carlo Stimulation and can be useful for planning the future workforce (Healthcare Workforce Portal http://www.healthcareworkforce.nhs.uk/).

Evidence

Two case studies were retrieved on the use of the WITNESS tools in NHS Trusts which demonstrate its value as a workforce planning tool. Within the Sheffield Teaching Hospitals NHS Trust use of the WITNESS Tool to plan the effect of a new contract on waiting times for various types of surgeries. The results showed that the new contract would make it impossible to meet the Government's 18 week Patient Charter Guarantee. These findings were presented to the Health Authorities who agreed to provide additional funding[3]. Calderdale and Huddersfield NHS Trust utilised WITNESS for bed planning. The Trust planned to reduce the number of beds for elderly patients and used the tool to model different treatment patterns to decide how to reduce the number of beds required. The treatment pattern necessary for this reduction was determined and the model also demonstrated that the new treatment pattern produced more variation in bed occupancy and that there need to be more flexibility of staffing for unexpected events[4].

Resources

Nine of the retrieved tools or instruments were categorised as Resources. Tools defined as resources were generally resource packs or information for Trusts or departments to work through and use for reference purposes. Resource Packs developed by the NHS National Workforce Projects and the Working Differently – Assistant Practitioner Project will be discussed in more detail.

NHS National Workforce Projects Resource Packs

To support NHS trusts in meeting new targets and to support working within specific priority services the NHS National Workforce Projects has developed resource packs. Resource packs for the

dental workforce, the 18 week patient pathway, long term conditions workforce and the maternity service workforce have been developed.

Each pack consists of seven sections:

Section 1: background information on the service or new initiative

Section 2: review of current initiative in the area including information on services that have successfully implemented changes.

Section 3: information on workforce development issues, workforce planning step guide, workforce readiness checklist

Section 4: frequently asked questions

Section 5: case studies and projects, programmes and initiatives

Section 6: useful resources and contacts

Section 7: glossary

Workforce, service or HR planners and relevant staff are the target audience for these guides. The guides could also be a useful resource for staff development days, training programmes or as a daily workforce guide.

Evidence

No literature was found on the use or evaluation of these packs. A short evaluation survey is been undertaken for the Dental pack including online questionnaire completion and follow-up phone interviews[5 6]. Workshops were held to support the dissemination and implementation of the Long Term Conditions Workforce Development Pack.

Working Differently - Assistant Practitioner Project

Description and use

The *Working Differently* resource was produced during a project to introduce Assistant Practitioners to the Cumbria and Lancashire Strategic Health Authority (SHA) area during 2005/6 was developed by Cumbria and Lancashire SHA, University of Central Lancashire and other organisations within the SHA area[7]. The resource incorporates learning from the introduction of the Assistant Practitioner Programme within the Cumbria and Lancashire SHA (Cumbria and Lancashire SHA 2005-2006b)[8].

The resource is now available to help other SHA's to introduce Assistant Practitioners within their local area and could be particularly useful for SHA human resources or training departments. The pack contains the background documentation from the introduction of the programme an overview of the project and information on the work involved in introducing and setting up the project. Suggestions and ideas for how other SHA's could introduce Assistant Practitioners are also included.

The documents within the resource are organised into seven sections:

1. Introductions
2. Infrastructure
3. Role Redesign
4. Practice Educator
5. Promoting Assistant Practitioners
6. Recruitment of trainees
7. Evaluation Process and Learning to Date

Evidence

Evaluation is being carried at all stages of the Assistant Practitioners programme. Currently only evaluation from the first phase is available (Cumbria and Lancashire SHA 2005-2006a). First, the SHA developed job descriptions and competences for the Assistant Practitioners role then recruited 46 trainees to work as Assistant Practitioners in November 2004. Each of the trainees was assigned a mentor. The project managers met with the trainees and mentors and surveyed other key staff at each of the pilot sites. This ensured that the early learning from the project was obtained from a variety of perspectives. Three of the 46 trainees that started have left the programme. Feedback from all of the key staff was generally positive highlighting teething problems with the first phase of the scheme. Feedback from the trainees about their new role was positive. Trainees did find that some staff were resistant to their new role and that there was not always time available to spend on develop the competencies for their new role. Trainees enjoyed the social aspect of meeting with the other trainees and would recommend the programme to other practitioners. Feedback from the mentors indicated that they felt that needed more information about the programme and their and the assistant practitioners role to enable them to fully support the trainees. The practice educators had also experienced some teething problems but

were very positive about their role. The learning from this first phase was incorporated into the documentation provided in the resource. A longer-term evaluation of the project is being carried out. The evaluation will consider impact measures for the organisations and feedback from all of the key staff at each of the pilot sites.

Toolkits

Eight of the retrieved instruments were defined as toolkits. Drive for Change and the Public Health Skills Assessment Tool will be discussed in more detail.

Drive for Change

Description and use

The Drive for Change website was developed as a joint project for Cabinet Office and Trade Unions Congress. "*Drive for Change* provides a practical guide for improving services through the effective engagement of the trade unions and the workforce. Involving unions and staff in decision-making processes is a vital feature of high performance workplaces."[9]

The drive for change toolkit is split into three sections:

- self assessment
- the drivers for change
- focused action planning

The toolkit can be worked through in order or specific themes can be selected to support services requirements.

Evidence

"The *Drive for Change* approach to engaging unions and staff in service improvement has been piloted in four organisations across the public services. These pilot studies are used throughout this toolkit to provide practical examples of how employee engagement has already been used to drive forward improvements in service delivery."[10]. The four case studies are based in Holloway Prison, Birmingham City Council, Cheshire and Wirral Partnership NHS Trust and Sheffield Joint Learning Disabilities Service demonstrating the different types of services that

can use the Drive for Change toolkit. The website also had a section on sharing good practice although this is only available if you join the community of practice. No literature on the drive for change initiative or toolkit was found through the literature searches and thus it is assumed that no formal evaluation has been conducted.

Public Health Skills Assessment Tool

Description and use

The public health skills assessment tool was developed to support health visitors with their developing role within Public Health. The Department of Health identified health visitors as having a key role within public health in the UK. The aim of the development of the tool was to provide health visitors with a personal development planning tool and to provide a tool for researchers to use when evaluating public health initiatives. The tool was designed to assess competence of health visitors to deliver public health interventions.

The development of the tool used methods of instrument design from psychology and the social sciences and involved five stages. The first stage developed the competency domains needed by health visitors to function as public health practitioners. Then competency statements and a self-assessment scoring system were developed. A questionnaire was then produced to test these competencies. The tool was then pilot tested and following this a final version of the assessment tool was produced. The tool consists of 56 items within 10 competency domains[11].

The tool was developed specifically for health visitors but could also be used by any practitioners working within public health and could also be used to assess the impact of public health interventions. Additionally, the tool can be used as a personal development planning tool for practitioners.

Evidence

The literature search retrieved one article on the Public Health Skills Assessment Tool which describes its development and application[12]. The tool found key areas where health visitors needed more support and further development to be effective public health practitioners. Working with a number of primary care trusts the authors have developed training programmes for health visitors to address these areas. Retesting of the health visitors has found an improvement in the public health skills of health visitors.

Tools adapted from other sectors

Two of the retrieved instruments were tools adapted from other sectors: the Toyota Production System and CANDO will be discussed in more detail.

CANDO

Description and Use

CANDO is a business improvement technique generally used in the manufacturing industries. "The CANDO approach has its origins in Japanese manufacturing systems and links with successful change management by generating a high degree of motivation and involvement in an organisation."

"The key principles of CANDO are:

- C – clean;
- A – arrange;
- N – neatness;
- D – discipline; and
- O – ongoing improvement."[13]

CANDO aims to encourage teams to evaluate their own working practice and current workplace. They will then create a clean, ordered and disciplined environment to work in. Ideally, teams will share what they have learnt with other teams in the organisation leading to the dissemination of ideas through the whole of a workforce. With CANDO workers are directly involved in making changes to their workplace instead of having changes enforced by their managers.

Evidence

The literature search retrieved three articles on CANDO, two considering the effects of the introduction of CANDO within the NHS[14] [15] and a paper on the effect of introduction of CANDO (described as "the 5 Ss") in a public hospital in Sri Lanka[16].

The first research paper, which uses a multi-method approach considers the introduction of CANDO in the NHS, how to effectively manage the change process using CANDO and how to assess the impact of the change[17]. The research found barriers and enablers to the CANDO and change process through interviewing staff in the training and development department

involved in the CANDO pilots. The introduction of the CANDO process was difficult for many staff especially as the department had to provide the same level of service throughout the process. Being involved in CANDO encouraged the staff to consider their own practices more instead of just accepting a set way of completing tasks. Feedback revealed that it was felt that the Trust could have done more to facilitate the process and that CANDO should be rolled out across the whole trust as part of a culture that is reflective and always attempting to improve processes. Many of the staff felt that more time was needed for the process. As well as their experiences of the process participants were asked about the immediate benefits to them. Most staff commented that their working environment was better and that they could more easily find the paperwork and equipment they needed. The department now appeared to be more aware of the process and procedures and the flow of work. Longer term benefits were connected to customer service, policies and health and safety.

The case study considers how CANDO which is generally associated with the manufacturing sector could be used in the health sector and the change process that would be required to supports its implementation[18]. Importantly, the change process is considered through the eyes of the change agents themselves. Champions/Advocates within the team that promote change/make it possible are referred to as change agents. The research brings together the experiences of 4 hospital mangers and 20 team participants who were involved in implementing change within a UK NHS Trust. The managers were interviewed and the team participants completed a questionnaire.

The managers were involved in implementing 16 CANDO projects in an 18-month period and each of the participants were involved in one or more of the projects. The responses from the interviews were generally positive about the effectiveness of CANDO as a tool for implementing change. Interviewees felt

that the CANDO model itself did not need to be adapted, for Healthcare organisations, but that how it had been implemented did. For CANDO to work one interviewee felt that everyone needed to be involved not just a few key people. Additionally, it was felt that the CANDO tool needed to be part of the wider picture instead of being introduced as a separate project. It would need to be implemented as part of the Trusts wider change programme with clear information about how it fitted in. The research was undertaken near the beginning of the project and used only a small sample so further large scale research over a period of time would be necessary to evaluate the effectiveness of CANDO as a tool to implement change within Healthcare organisations.

The other case study describes the introduction of the Five-S tool in a public hospital in Sri Lanka[19]. The Five-S is a tool from Japan. The five Japanese words and concepts associated with them translate to the five aspects in the CANDO model. The Five-S model was used as the initial step to introducing total quality management. Since the introduction of total quality management the hospital has dramatically improved its performance and won awards for service quality at a national level. While there are multiple reasons for the improvement in performance the article reports that the Five-S tool played a significant part in this improvement.

Five-S was introduced throughout the whole organisation with eight teams managing the process. Measurement of service improvement was assessed through 15 performance indicators. The improvements in service were achieved over a period of two years. The Five-S tool introduces fundamental changes and enabled complete reorganising of the systems within the hospital. For the process to be successfully staff at all levels need to be involved and supportive. The three studies demonstrate that CANDO has potential for use in implementing change in the NHS.

Toyota Production System

Description and use

The Toyota Production System (TPS) was developed at Toyota and is generally used within the manufacturing industry. The TPS is used to improve

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productivity through encouraging staff to undertake regular problem solving and reorganisation or redesign of their work. Initially all the systems within an organisation are examined for problems with necessary alterations performed to enable them to perform correctly. Once this initial overhaul of systems has occurred whenever staff experience a problem they should work with other colleagues to develop a solution that enables work to be completed and removes the original problem.

Evidence

The literature search retrieved two journal articles on the use of the Toyota model within healthcare[20 21]. Thompson and colleagues. (2003) describe the introduction of the TPS at University of Pittsburg Medical Centre (UPMC) Health System[22]. The TPS was introduced to improve patient care by making better use of scarce resources and also by assessing the systems that could be compromising patient care and improving them where necessary. To implement TPS strong leaderships is required along with time and resources. The case study found that introducing the TPS saved thousands of hours and dollars and that TPS if there is enough preparation and involvement of the staff can bring about improvement in patient care. UPMC is now introducing TPS in other hospitals indicating that they have found it beneficial.

Raab and colleagues consider the effect of the introduction of TPS on the diagnosis of thyroid gland fine-needle aspiration[23]. The TPS was implemented to reduce diagnostic errors in this process. Following the Toyota process redesign there were significantly fewer diagnostic errors for patients having thyroid fine-needle aspiration.

Both case studies demonstrate benefits of introducing TPS. However both studies are from the United States requiring caution when applying the findings to the UK where healthcare systems differ.

Table 1 - Workforce Change Tools and Instruments

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Christmas Tree Model http://www.nhsemployers.org/pay-conditions/pay-conditions-1061.cfm	Excel base tool that creates Christmas tree models of staffing currently and assesses future staffing needs. Graphs created allow you to look at how staff are distributed across the different Agenda for Change Bands.	Developed by Homerton University for NHS Employers	Modelling	None	NHS – can be used at local or national level for departments, trusts, professional groups, whole NHS	Initiation and Implementation	Multidisciplinary	Profiling the current workforce and Making an assessment of current and future demand and supply of particular skills/occupations	The Christmas Tree model was updated in 2007 indicating that it is being used. The tool has been used to create local national and professional group Chirstmas Tree Models
Venism[24]	Systems dynamic modelling tool. used for developing, analysing, and packaging high quality dynamic feedback models.	Developed by Ventana Systems UK	Modelling	None	Healthcare, Navy	Contemplation	Multidisciplinary	Profiling current workforce and Making an assessment of current and future demand and supply of particular skills/occupations	Ventura have developed a GP manpower model using Venism. Outside Healthcare the Royal Navy and US Navy have used Venism.

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Witness[25]	Modelling tool that uses Monte Carlo stimulation to model different processes.	No information found	Modelling	None	Healthcare	Contemplation, Evaluation	Multidisciplinary	Profiling current workforce and Making an assessment of current and future demand and supply of particular skills/occupations	Two case studies based in NHS trusts on the use of WITNESS were retrieved. WITNESS was used for bed planning in Calderdale and Huddersfield NHS trust to plan the necessary treatment patterns to reduce the number of beds for elderly patients. WITNESS has also been used by Sheffield Teaching Hopsitals NHS Trust to secure additional funding.
Nursing workforce planning tool[26]	Designed to help Nursing managers and other workforce planners to plan their nursing workforce.	No information found	Modelling	None	Nursing	Contemplation, Initiation	Unidisciplinary	Profiling the current workforce and Making an assessment of current and future demand and supply of particular skills/occupations	**No evidence was retrieved on the use of the nursing workforce planning tool.**

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Health and Social Care Workforce Strategy Resource Pack	Resource pack to assist the Health and Social Care Workforce with planning, producing and submitting their workforce strategies.	Pack developed by Greater Manchester Strategic Health Authority (SHA) (now part of NHS North West) to help develop Health and Social Care Workforce (2006).	Resource	None	Health and social care workforce	Contemplation, Initiation, Implementation	Unidisciplinary	Developing and implementing strategies to address future workforce needs	Literature search did not retrieve any papers on evaluation of this pack. Resource pack provided as example of good practice on Healthcare Workforce Portal indicating it was helpful within Greater Manchester SHA and is felt to be useful to other trusts.

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
How to Change Practice	Developed by NICE to assist managers and clinicians in influencing changes in practice.	Rigorous development. Initially, Kings Fund conducted literature search and synthesised evidence on types of barriers to implementing change and also interventions to encourage clinicians to change their practice. NICE held workshops with different target audiences to explore barriers and interventions. Targeted	Resource	None	Healthcare	Contemplation, initiation and implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	Within the guide there are two case studies of how Plymouth Teaching PCT and Cornwall and Isles of Scilly used a mixture of the different interventions detailed in part 3 to implement NICE guidance.

		consultation on draft before guide was published.							
Job shadowing guidance pack	Pack to help healthcare organisations to introduce a job shadowing scheme	Developed by National Workforce Projects	Resource	None	Healthcare organisations	Contemplation, Initiation and Implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	No evidence
Measuring and predicting turnover and wastage 'how to guide'	Guide to help improve and develop greater understanding of importance of monitoring workforce for wastage turnover and stability. Guide to help organisations understand their workforce dynamics	No information found	Resource	None	Healthcare organisations	Contemplation, initiation and implementation	Multidisciplinary	Profiling the current workforce and Making an assessment of current and future demand and supply of particular skills/occupations and Developing and implementing strategies to address future workforce needs	No evidence

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
18 week Resource Pack http://www.healthcareworkforce.nhs.uk/resources/18_weeks/18_weeks_resource_pack.html	7 sections: 1. Background to programme 2. review of current initiatives 3. Workforce development issues includes 6 step plan to planning workforce. 4. FAQs 5. Case studies 6. Useful contacts and resources 7. Glossary	Developed by NHS National Workforce Projects	Resource pack	None	NHS Trusts – all staff	Contemplation Initiation Implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	No evidence found.
Dental Workforce Resource Pack[27]	As above	Developed by NHS National Workforce Projects	Resource pack	None	Dentists working within NHS	Contemplation Initiation Implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	The Dental Workforce resource pack is available to download from the Healthcare workforce website and they are currently undertaking a short evaluation survey involving completion of questionnaires and follow-up phone interviews.

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Long-term conditions workforce development resource pack[28]	As above	Developed by NHS National Workforce Projects	Resource pack	None	NHS Trusts - all staff involved with patients with long-term conditions	Contemplation Initiation Implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	To support the implementation and dissemination of the Long Term Conditions Workforce Development resource pack a number of workshops were held in Manchester, London, Exeter and Birmingham. A short evaluation survey is currently being undertaken of the pack. Additionally, pack users can send details of how the are using the resource pack.
Maternity Services Workforce Development Resource Pack[29]	As above	Developed by NHS National Workforce Projects	Resource pack	None	NHS Trusts - all staff involved with patients with long-term conditions	Contemplation Initiation Implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	No evidence.
National Workforce Data Definitions[30]	List of data items with agreed definitions	No information found.	Resource list	None	Workforce planners and HR leads at NHS Trusts, PCTs and SHAs		Multidisciplinary		No evidence.

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Working Differently - Assistant Practitioner Project	Pack contains background documentation from introduction of Assistant Practitioner Programme within Cumbria and Lancashire SHA.	Developed by Cumbria and Lancashire Strategic Health Authority (SHA), University of Central Lancashire and organisations within SHA area.	Resource pack	None	SHA's	Contemplation and Initiation.	Mulitdisciplinary	Developing and implementing strategies to address future workforce needs	The first phase of the project has been evaluated. The findings feed into the resource pack. A longer-term evaluation of the project is currently being carried out.
NHS Benchmarking database[31]	Database of NHS Acute and Primary Care data sources	Developed by the NHS National Workforce Projects.	Resource pack	Trusts can benchmark themselves against other Trusts.	NHS	Contemplation and Evaluation	Multidisciplinary	Monitoring and review	No evidence found but mental health data sources have been added to the database.
Planning Now For Your Future Workforce Needs[32]	**Guide to long term workforce planning to help planners to navigate**	Developed by NHS National Workforce Projects	Resource Pack	None	NHS organisations	Contemplation, Initiation and Implementation.	Multidisciplinary	Developing and implementing strategies to address future workforce needs	No evidence

	challenges that may arise when developing long term plan.								

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Drive for change[33]	3 aspects: self-assessment, drivers for change and focused action planning	*D*eveloped as joint project for Cabinet Office and TUC. Aims to involve unions and staff in decision making to improve services.	Toolkit	None	Public Services – staff and unions	Contemplation, Initiation and Implementation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	4 case studies in Holloway Prison, Birmingham City Council, Cheshire and Wirral Partnership NHS Trust and Sheffield Joint Learning Disabilities Service demonstrate benefits.
Hospital at Night baseline tool Hospital at Night Baseline Report[34]	Assessment of implementation/ readiness for Hospital at Night through questions on 9 enablers and opportunity to share challenges and best practice	Developed by the NHS workforce review team.	Toolkit	None	NHS Trusts – staff involved in implementing Hospital at Night Programme	Contemplation Initiation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	Tool has been further developed to Hospital at Night Acute Mental Health Self-Assessment Tool

Hospital at Night Acute Mental Health self-assessment tool[35]	As above but focused on implementing Hospital at Night in Mental Health Trust	Developed by the NHS workforce review team.	Toolkit	Assessment tool can also be used to evaluate impact over time	Acute and Mental Health Hospitals introducing Hospital at Night	Contemplation Initiation Implementation Evaluation	Multidisciplinary	Developing and implementing strategies to address future workforce needs	No evidence found.

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Learning Needs Analysis	Analysis to help determine learning needs of individual, team or workforce.	No details	Toolkit	Once training has taken place tool can be used to reassess learning	Tool could be designed for different staff groups.	Contemplation, Imitation and Evaluation	Multidisciplinary	Profiling the current workforce and Making an assessment of current and future demand and supply of particular skills/occupations and Developing and implementing strategies to address future workforce needs and Monitoring and Review	The literature search retrieved two references on the development and implementation of learning needs analysis tools within the NHS (Hughes 2006 and Forbes, et al 2006).
Measuring improvement from Workforce change[36]	Tool to measure different aspects of workforce change to determine if impact of new or different ways of working	Developed by NHS Modernisation Agency	Toolkit	Reduced delays, reduced waste, improved staff experience,	NHS Organisations	Evaluation	Multidisciplinary	Monitoring and review	No evidence found.

				improved patient experience					
Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
NHS Workforce Scorecard[37]	Measures appropriate performance measures in Strategic Health Authorities and health at the local community level	Process of developing scorecard took place over three phases each involving piloting in number of NHS organisations. Scorecard further developed following pilot and developments within NHS which impacted on measures to be included.	Toolkit	None	NHS organisations	Contemplation, Initiation, Implementation and Evaluation.	Multidisciplinary	Monitoring and review.	The scorecard was piloted in a number of NHS Trusts. A case study of Derby Hospitals Foundation Trust noted that after the pilot the HR department is still continuing to use strategy plans and scorecards.

Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
No Delays Achiever http://www.nodelaysachiever.nhs.uk/	The No Delays Achiever is a tool for service improvement. It is web-based and incorporates a trust's own uploaded data with service improvement tools to help to identify problems along pathway that could cause delays and offers interventions to address them.	No information found.	Toolkit	None	NHS organisations	Contemplation, Initiation, Implementation and Evaluation.	Multidisciplinary	Monitoring and review.	On the No Delays Achiever website there are a number of case studies on methods used by different NHS organisations to reduce delays in their patient's pathways.
Public Health Skills Assessment Tool (Brocklehurst, N. & Rowe, A. 2003).	Personal development planning tool designed for Health Visitors. Also used as Workforce planning tool. Tool measures self-assessed knowledge, skill and experience on key domains of public	Developed by Neil Brocklehurst and Ann Rowe	Toolkit	The audit can be used at different stages to assess impact of workforce change	Tool was designed for Health Visitors but could be further developed for other staff groups	Contemplation Initiation Evaluation	Unidisciplinary	Profiling the current workforce and Making an assessment of current and future demand and supply of particular skills/occupations and Developing and implementing strategies to address future workforce needs	Paper on development and application of tool Brocklehurst, N. & Rowe, A. 2003).

	health practice.								
Tool name and source	Description	Tool Development	Type of tool:	Impact measure	Tool aimed at	Stage of change	Tool is unidisciplinary, multidisciplinary etc	Tool is to achieve	Evidence
Workforce planning step guide[38]	Six step guide to workforce planning	Developed by NHS workforce review team	Toolkit	None	NHS organisation	Contemplation, Initiation, Implementation and Evaluation	Multidisciplinary	Profiling current workforce and Making assessment of current and future demand and supply of particular skills/occupations and Developing and implementing strategies to address future workforce needs	Resource developed into e-learning programme indicating its potential value. Additionally, six step guide included in following different workforce planning guides discussed in this report: Planning Now For Your Future Workforce Needs Guide, Long term conditions workforce development, Dental workforce development pack.
CANDO[39 40]	Business improvement technique. Key principles of CANDO are Clean, Arrange, Neatness, Discipline, and Ongoing improvement	Developed by Japanese Manufacturing Industry	Tool adopted from other sector	Studies using CANDO have developed instrument to measure impact	NHS Trusts – staff at all levels.	Contemplation, Initiation, Implementation and Evaluation	Multidisciplinary	Monitoring and review	Three papers discuss use of CANDO in Healthcare organisations[41 42 43]. They demonstrate CANDO has potential when implementing change in NHS.

Toyota Production System	Business improvement technique	Developed by the Japanese Manufacturing Industry	Tool adopted from other sector	Studies using Toyota have developed measures to assess impact.	NHS organisation	Contemplation, Initiation, Implementation and Evaluation	Multidisciplinary	Monitoring and review	Two articles on use of Toyota model within healthcare[44 45]. Both demonstrate benefits of introducing TPS. Both studies are from United States and care is required when applying findings to UK healthcare system.

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Appendix 14

Actions carried out around each of the issues

Examples of the types of actions undertaken by teams .

Communication & Relationships-Internal: n=16

Examples of the types of actions taken forward around communication include;

a. Providing feedback to service managers regarding things that aren't working well
b. The use of a 'feedback' or 'honesty' box to provide feedback to the team about things that are working well, and that could be improved.

The detailed processes involved in organising and conducting the team meetings came under close scrutiny, and appeared to be important for the way that information is managed and disseminated within team meetings. For instance;

- Varying the times of team meetings so that all staff are able to attend at least some meetings.
- Regularly taking minutes at the team meetings
- Having a larger service meeting once a month
- Ensuring that two way communication is possible within team meetings
- Having a weekly locality meeting
- Planned regular meetings with set agenda
- Ensuring the agenda covers the needs of team members, especially regarding the discussion of clinical issues
- Designated chair for the meetings
- Hold regular meetings with agenda posted on notice-board well beforehand
- Ensuring that the discussion of important clinical matters is not lost in the general business of the team meetings

Service Development Activities: n=13

The teams identified a number of actions that directly related to team building and service development activities including case reviews and other reflective practices, specific skill development across the team,

supporting changing roles, journal clubs, providing access to learning resources & visits to other services.

- Visit other teams
- Develop a resource area
- The development of a process/method of group reflection
- Process for debriefing in place & review & modify
- Time-out afternoon/Focus group
- Team building day

Patient Treatment, Communication, Capacity & Outcomes: n=11

Actions taken forward in this category included: amended referral procedures/criteria, capacity and demand issues (including workload and time-management), development and feedback of outcome measures and patient views, throughput and care needs of patients. These actions also included communication and relationships with patients and family members.

These were broken down into more detailed action plans which often included many different activities. These activities included:

a. Introducing systems to provide feedback to the team at regular intervals, including embedded feedback in monthly supervision and locality meetings (report positive items such as successful resolution of problems)
b. Evaluate the impact of service and role changes, such as staff rotations and feed the results back to the team.
c. Develop and integrate formal systems for capturing patient views, such as patient satisfaction surveys. Many teams already collect patient satisfaction information but not all of them incorporate it into their team feedback cycles.
d. Introduction of an 'appreciation box' as a mechanism to provide feedback to staff.

CPD, Rotation & Career Progression: n=10

Continuing professional development and career progression activities were a popular category of action plans. The difficulty of prioritising time for personal development was a clear issue. Whereas some teams suggested specific activities which fitted in with work practices and lunch breaks, other teams identified the need to protect time for personal development. Access to courses was often problematic and in-house training was put forward to address this shortfall. Other actions were: support for staff members to attend different work experience settings, and other team level support such as evaluating experiences of rotation and timetabling training for staff. Examples of activities include;

- Use of staff journal clubs
- Using existing clinical time to facilitate joint learning experiences, for example, through joint assessments

- Inviting speakers to attend lunch time seminars
- Develop in-house training programme
- Timetabling a rota for training for staff

Whilst these actions were often dependent on being arranged at an individual or small group level, factors which could significantly help or hinder these actions operate on a team/service level. Protection and monitoring of these activities was therefore found to be important for successful implementation.

Clarity of Vision, Uncertainty & Changes to Service: n=9

Actions in this category relate to the reported lack of a shared, consistent definition of the service. The aims, goals, overall vision and day-to-day guidelines of the service were often reported to be unclear and prone to unexplained changes. Some team members disliked what they saw as the declining importance of an ethos of rehabilitation. Participants felt that their service was defined more by external pressures than clear, internally defined service values.

There seemed to be general acceptance that external pressures did play a part in the changeable role of the service. However, team members expressed a desire for improved communication on these matters.

A tension was displayed in the discussion and development of these actions, between the efficacy of the team in clarifying and defining their service by themselves and a reliance on higher management, commissioners and other external forces in defining their service. Some teams recognized that resolution of this issue required a combined bottom-up and top-down approach: an important step towards addressing these problems was improved communication. Lack of clear vision at a team level was reported to be associated with lack of involvement with change processes, lack of communication from management about the impact of strategic decisions on the team and uncertainty about the future. These issues proved to be complex and difficult to fully address.

On the other hand, where problems were able to be addressed by changes within the team (e.g. influencing the values of temporary staff) these were easily achieved.

Specific actions included;

- Gaining information from service management ('from above') to clarify the purpose of the service
- The team to establish a shared vision:
    - Approach managers to ask for their view on the vision
    - Look at the vision adopted of other teams
    - Consultation with the team through a team meeting to develop a vision within the team, which includes defining referral criteria.
- Look at addressing the tensions between the dual purposes of goal setting (i.e. contractual/therapeutic)

Communication & Relationships – external (n=8)

A common theme amongst the teams was a view that the service/team was poorly understood from the outside. Action plans included a range of activities intended to raise the profile and improve the image of the service.

- Visit nursing homes/ community settings with a view to selling CRT services
- Improve the way that the service is viewed by others and maintaining awareness of the service (district nurses, GPs, social workers in acute settings, discharge coordinators etc).
- Improved integrated working with bedded unit staff
- Invite representatives from other organisations to team meetings for awareness & updates
- To promote a better image and understanding of intermediate care, especially within the hospital.
- Leaflets with patients
- Single point of access manned by clinicians
- GP surveys
- Rotation into the hospital like discharge liaison staff
- Attending ward meetings and giving talks on IC
- Providing feedback to wards in the form of vignettes
- Direct targeting of patients, for instance by providing information in the pre-assessment packs
- Rotations with the ECP and community matron
- Staff involved in pre-assessment

Facilities, Resources, Procedures & Admin: n= 5

Across the teams, a total of 85 items relating to resources and procedures were identified (mean 7.1 per team, range 2 - 16). Five actions that related to changes in this theme area were pursued. Two teams chose to review their coordination procedures. Other actions included the use of 'vacant hours', care planning procedures, and creating a quiet area to work in.

Actions included:

- General review of coordination processes and systems including:
- Possible coordination role of admin staff (to help free-up clinical time)
- Keeping 'new-patient' slots open in the diary possibly every other day 1.00-2.00 p.m. (capacity/diary management). This would have the added benefit of having times when joint availability was more likely.
- Ensure equity for new patient allocation
- Exploring more productive use of 'vacant hours'
- Creating quiet areas to e.g. concentrate on work and make important phone calls
- Care planning and documentation of care:

- Set out goal of patients and estimated stay on ward. This will require a better estimate of discharge date, and in turn requires planning which integrates the relatives as well as the patient.
- Documentation – clarification of what needs documenting – e.g. frequency of bathing... there needs to be a review of documentation.

Joint-working: n=5

Some teams welcomed the opportunity to introduce or improve joint working practices. For some teams this was to address general personal development issues, whilst for others it was proposed to improve interdisciplinary understanding. However, other teams felt that joint working could be employed to address very specific lack of integration within the team. Some of the specific activities related to these actions are below.

- Individual Residential Rehabilitation staff to make requests to attend home visits (for continuity of care and increased understanding of the community care role of the team)
- Shadowing
- Improved joint working with support workers
- Assessment/audit of current joint working practices

Management, Leadership and Decision making: n=2

This topic formed action plans for 2 of the teams. The particular issue identified by both teams was team members taking responsibility for supporting more effective leadership. This reflects the feedback given by participants regarding the value of the leadership exercises which encourage joint responsibility around improving leadership issues. Respondents reported finding it useful and interesting to start thinking about leadership in terms of a 2 way relationship and distributing leadership tasks amongst team members.

- You will make some important decisions about LB's (team leader) time management/delegation/caseload
- There is too much to do, and this obstructs effective leadership, which is often confined to managing staff shortages
- Communication so that the team is 'all singing from the same hymn sheet'.
- Try to delegate tasks, in particular where there is good learning and development opportunities

Role mix, Professional roles and Responsibilities: n= 0

Whilst 15 individual issues on this topic were identified by 7 of the teams, these did not form part of any action plans. However, actions taken forward by the teams contained elements which included a consideration of roles and impacted on individual and collective responsibility.

Morale & motivation: n=0

A few teams explicitly mentioned morale and motivation as issues, but no actions were taken forward in this theme. However, morale and motivation were clearly associated with many of the actions taken forward. This feature is probably due to the teams' further exploration of these issues during the events to uncover the underlying reasons for lack of morale and motivation, and these causes were then addressed as actions.

Appendix 15—Further Case Studies

Team DO

This team from the North East had strong morale and a strong sense of team cohesion. They had a major change in shift patterns shortly before the intervention which had positive and negative impacts. They felt that they lacked a clear understanding of each others' roles, and suggested ideas to enhance this, including the development of induction packs and shadowing.

Other goals were to develop a team vision; have a structured approach to development and training by introducing shadowing, developing induction packs, a resource area and journal club and finding out what courses are available; improving internal communication through using an email/telephone list, improving meetings and monitoring communication issues; visiting other teams to see how they worked.

Four goals were attained: induction packs, shadowing and improved team meetings and introduction of an email and telephone list. However, other goals (visits to other teams, accessing courses, journal club) were not achieved and the reason was lack of time/funds and the prioritisation of patient care. Staff rotation and leaving also hindered achievement of some goals. The development of a resource area was an ongoing action.

Team DO showed substantial improvements in WDQ management structures and styles (+15%); team working (+11%); integration (+14%); access to technology and equipment (4%); clarity of vision (+18%) and the team's perception of care quality (+5%). There was a decline in training and career progression opportunities (-5%); uncertainty worsened by 17%; and surprisingly, there was a slight decline in overall satisfaction of 1%.

Teams G, H & I

These 3 teams from Northern England belonged to the same large NHS service. They covered 3 different geographical areas and were co-located in a building on a business park. The service had recently won the tender to cover a much larger area and had therefore expanded and recently co-located to these new premises. We started working with each team separately for the SECs. However, during the first TLS the teams protested that they could not continue with the intervention as 3 separate teams. Despite having separate team leaders, the teams did not have a clear individual identity. This seemed partially due to the co-location and partially due to the frequency of staff rotations around the 3 teams. Therefore, only

2 of the teams had a TLS#1 and we combined members from all of the teams for the second TLS. Support workers were poorly integrated into the team and despite all efforts none attended the SEC or TLSs.

We continued to work with the combined service for the intervention and staff data needed to be combined at a service level as the staff moved very frequently between different teams.

There were some similarities regarding the issues and actions identified by the teams and we worked with the representatives who attended the TLSs to combine the actions and form a coherent plan. During this process some previously stated actions were no longer considered to be appropriate or high priority. Eight actions were eventually taken forward under the themes of facilities, resources, procedures and administration; internal communication and relationships; patient treatment and outcomes; continued professional development; external communication and relationships. An identified problem regarding development of the team was a lack of knowledge about other teams and their approaches to the identified issues.

All but one of the actions were developed. Two of these actions were fully implemented (consistent locality meetings; introduction of Therapy Instructor meetings) and were considered successful. Significant work was carried out around 6 other complex initiatives (changed rapid response capacity; introduced a quiet work area; appointed a Support Worker leader to aid integration; improved patient and colleague feedback; developed in-service training and induction). These continued to be developed, refined and monitored. One action was put on hold (integration with the bedded unit) due to uncertainty regarding the external service being put-out to tender.

The combined teams had an overall improvement in WDQ management structures and styles (+5%); access to technology and equipment (+5%); a slight improvement in uncertainty (+2%); and overall satisfaction increased slightly at 1%. There was a decline in integration with peers and colleagues of 5%; the teams' perception of care quality declined by 12%.

Team Q

Team Q were a local authority managed team from the rural West Midlands. They decided to take actions on external communications and relationships; professional development (improving knowledge and skills); quality and outcomes of care; internal communication and relationships.

They were successful in developing processes for debriefing and acknowledging informal debriefing processes. However, they needed to work on full implementation of this without increasing paperwork. They improved coordination of care plans, increased joint (multi-disciplinary)

reviews and instigated the handover of patients within the team (intending to reduce numbers of visits and improve patient outcomes).

Plans to improve external communication and to develop knowledge and skills relied on using existing meetings and 'working lunches'. Representatives from other organisations were invited to attend team meetings and to speak to the team, and skills sharing and training sessions were introduced. However, these initiatives were hampered by a lack of time and a 'crappy' room.

Team members reported unintended consequences of the intervention including getting to know each other better, talking together, sharing responsibilities and being more motivated. They expressed an interest in carrying on with all 4 actions, but were aware of imminent integration and the need to renegotiate with the new team. Working lunches and speakers were particularly successful and they recommended that these continue.

The senior staff emphasized that individual staff have the skills required to work to an integrated model and this will be important for the future, even if this team is changed. One other important factor mentioned was that despite the changes happening around the team, their leadership has remained the same and this is felt to have been significant.

Team working and integration both improved slightly, by 3% and 2% respectively; WDQ management structures and styles improved by 5%. At the same time, job satisfaction declined by 4%; uncertainty was substantially worse (14%); and training and career progression opportunities declined by 5%.

Team D

Team D are an NHS managed team based at a modern community hospital in the South East of England. The hospital has 25 in-patient beds with additional day-surgery provision, a minor injuries unit and an operating theatre. The hospital is also the base for community health services (including GP surgery and pharmacy).

The team initiated actions related to clear vision; admission; internal communications (meetings); joint working; patient outcomes. Their five aims were to establish philosophy/aims; review referral criteria: care pathways; improve weekly meetings; arrange joint visits; improve patient feedback and use outcome measures. However, the actions changed considerably by the time of the next meeting.

The team members became concerned with uncertainty engendered by external changes, this included changes in social services (especially regarding referrals and discharges), another new manager and a review of therapy services. External communication issues had been identified, a visit

from the CEO had been planned, and team promotion activities had taken place (production of team leaflet & planning joint visits). Priorities had been identified regarding an upcoming audit (discharge forms and quality of notes). Office refurbishment and improved I.T facilities (including a request for TOM and open fields to be included in electronic patient records) were underway and weekly meetings had been improved (documentation and attendance). Referral criteria were being explored. Mandatory training had been reviewed and the team were beginning to look at professional development issues (e.g. journal club). The team were working with falls services to improve referrals.

The team achieved some actions and reported making improvements:

- Improved their I.T. facilities (although this resulted in reduced desk space changing of the office layout was reported to be good);
- Referral to therapists in team became more appropriate;
- Minute taking in meetings improved and people felt empowered in team meetings;
- Joint visits helped to understand other disciplines' views, helped knowledge and aided better referral;
- Team members were involved in producing the team leaflet.

The team identified several new issues throughout the project:

- Ward meetings - timing needs to improve to support CRT involvement;
- Not feeling part of the ward team;
- Staff did not know who we are;
- Some nursing staff don't welcome us, especially senior nursing staff;
- The need to differentiate professional roles within the team.

They also continued with realising ways to address these problems: being more assertive (for example in promoting rehabilitation over nursing task focus); learning from the Tuesday meeting improvements could be applied to Thursday meetings (with the ward team); possibility of joining a journal club in nearby team.

The team were satisfied with outcome measures (TOM) and patients' verbal feedback procedures. They became more supportive to each other. They increased the team profile, and the understanding of rehabilitation in the

wider organisation, and felt that they were recognised as a knowledgeable team. They felt that they better supported early discharge and admission prevention.

At the end of the project a revised action plan had been put in place. The team were continuing to identify and refine their understanding of issues and implement actions to address these issues. The philosophy and aims of the team are still a major issue (are they a discharge planning service, or do they have more ambitious rehabilitation aims). They were continuing to work on: improving referral of appropriate patients into the team; I.T. changes; meeting improvements; promoting the service.

Team D showed little improvement on any of the domains of the WDQ. Despite the improvements to their facilities, the overalls scores for access to technology and equipment declined by 3%. Team integration showed a small improvement of 2%; as did clarity of vision (2%), and quality improved by 1%. However, uncertainty worsened by 10%; management structures and styles by 3%; and training and career progression opportunities by 5%.

Team E

Team E are an NHS managed team based at a modern community hospital in the South East of England. The hospital provides a range of community and hospital services including physiotherapy, X-ray, minor injury unit, out-patient clinics and a 6-bed birthing centre. It has 24 in-patient beds for rehabilitation and medical treatment. A Day Centre offers Falls Prevention and other sessions for adults.

The team chose to pursue actions in 3 main themes: patient treatment, capacity and outcomes; external communication; CPD and career progression. Their 7 aims were to: look at better ways of spending vacant hours; explore the amount of time spent on each patient; promote the team externally (including producing a new leaflet, visiting other services, and inviting PCT management to shadow team members); initiate a journal club; reinstate protected CPD time; visit other organisations to develop individual experience; develop in-house training.

There were many issues which the team members felt hindered their development work. These issues included: a lack of clear vision "We feel like we are being everything to everyone and this feels unsustainable"; uncertainty (in 4 months have had 3 team managers and no-one currently in post); increased caseload (making it harder to balance demands between ward, day centre, home visits and harder to preserve time for CPD); lack of engagement by PCT senior management (they had arranged 2 visit dates which had been cancelled).

In addition the team had to cope with changes outside their control: handover procedures changed between the ward and the team (care became less coordinated and communication a lot worse between the team and the ward); there was an increase in Neurology patients and more joint working (with new groups). However, in common with other teams experiencing change, uncertainty and lack of clarity they reported that they were getting the job done despite all of the above.

The team continued throughout the project with ongoing recognition of issues and development work: team meetings were not working very well (action to take proper minutes); physiotherapists were to do review of falls prevention programme and explore how can effectiveness be measured; difficulty speaking to clinicians/ referrers on telephone (as out of office a lot); it was suggested that a formal key worker system be initiated.

The team achieved many actions over the length of the project. They initiated visiting and working with a range of external organisations (including a care home, GPs, stroke rehabilitation, speech and language therapy and other intermediate care teams) which contributed to professional development goals, promoting the service and improving communications and relationships with external organisations. They produced a team leaflet, but were having problems getting copies printed.

A CPD buddy scheme was set up with monitoring procedures and protected monthly time slots, and a journal club was started. Meetings were improved and made more efficient. A greater appreciation of each others' roles was reported as well as a better working environment, and thinking about what makes a good team work: "how we work together".

At the end of the project the team had held 3 training sessions and had more planned. One of the team had joined the stroke pathway committee and the team now ran a Parkinson's' group. The falls prevention programme had been evaluated and modified. A new physiotherapist discharge form was being used for the day centre and a new OT admission form was being used. The team had also improved the working environment with new windows and a stationary cupboard.

The WDQ responses by Team E showed mixed results. Overall clarity of vision changed little (-1%). Team working and overall satisfaction improved by 6% and 4% respectively, however integration declined by 4%. Uncertainty declined by 8%, as did access to technology and equipment (-4%). Training and career progression opportunities improved by 5%, which was the focus of much of the intervention,.

Team F

Team F are a local authority managed team in a city in North England. They are based at a residential unit with 2 main aspects to the services they provide. There is a residential rehabilitation arm of the team and a community support arm. The team has a small amount of NHS allied health professionals, but most service-user contact is with enablement workers and rehabilitation assistants.

The team identified 8 actions to take forward in the following broad themes: CPD and training; external communication and relationships; internal communication and relationships; patient treatment and outcomes.

They decided to work on improving internal communications and relationships through shadowing and residential staff attending home visits (this was also intended to improve understanding of service-user's home situations to refine rehabilitation goals and provide better continuity of care). They also decided to improve handover information especially for temporary staff who did not share the enablement values of the permanent team members.

They decided to look into the possibility of opportunities for extra training, including mental health training. The team were concerned that their service users seemed to have greater dependency and multiple, complex problems. It was decided to monitor this trend.

Actions associated with communication and relationships with external organisations were: improving knowledge of local PCT services; raising the profile of the service within other organisations; and improving information received from other organisations, particularly with reference to medical information about people referred into the service.

Team members reported benefits resulting from their actions soon after implementation. Shadowing, joint visits and improved handovers: the team felt able to improve the patient centredness of the service. Staff reported increasingly thinking about service-users in the residential unit as people who will return to live at home rather than just in the context of the unit. They also reported instilling enablement values across the team and reducing the types of events which discourage service-users from managing without assistance and taking a step back in their rehabilitation.

The team expressed that they had an improved knowledge of PCT services: some information about commonly used services were kept in a file and team members were aware of internet resources. However, they found that the quantity of services (and changes to services) makes the compilation of an accessible resource impractical.

The team reported an improved ability to accommodate very frail/highly dependent service-users. This was due to a shift in the culture of the service brought about by a positive attitude to the benefits of rehabilitation; improved relationship with the Community Support Team (acute admission prevention/early pick-up); mental health training has also added to the abilities of the service to accommodate a wider range of service-users with more complex needs.

The team felt that various factors had hindered their ability to fully implement actions including: lack of time; fragmentation of line management responsibilities; staff and organisational changes; lack of understanding of rehabilitation (new team members); inability to identify responsible people in other organisations to draw problems to the attention of.

Further actions were planned including: further integration of residential and home visit staff; raising the profile of the service; further training; and dedicated team reflection time. However, the team had experienced extreme change and uncertainty over the course of the project. This resulted in amalgamation with another team from an adjacent area during the project. Shortly after the project finished the team experienced the withdrawal of the community support function and a management restructuring. The remaining team members felt that the aims of the service were not supported at strategic levels in either partner organisations.

Team F had some of the most negative changes in WDQ scores. They showed a slight decline in team working and integration scores (-2% and -3% respectively). Training and career progression opportunities dropped by 18% whilst uncertainty worsened by 16%. Clarity of vision also dropped by 8% and overall satisfaction declined by 8%. Role perception and autonomy increased slightly, by 2% and 4.5% respectively, however role flexibility declined by 3%.

Team U

Are a small jointly managed (integrated NHS and Local Authority) intermediate care team in a semi-rural location on the edge of a conurbation in the East Midlands.

The team did not identify many issues. Actions taken forward were under the main themes of: team building; clarity of vision; leadership. They chose to take forward 3 actions: the development of a process of team reflection; developing a coherent team vision; making decisions about the team leader's time management, delegation and caseload.

Whilst some actions (team reflection and team vision) were considered successful, workload and delegation actions and latterly the physical integration of colleagues at another location had been less successful.

Progress had been hindered by changes in the external world, in particular recent dis-investment plans by the local authority.

It was felt that given more time the team would have benefited far more from the project. A major theme was that of acceptance and how the team had come to know that 'they do a good job'. One aspect of the project viewed as a positive outcome was 'being able to dissect a case and justify rationale for decision making'. This contributed to greater understanding of roles. Another positive outcome of change within the team was 'being able to listen to others'.

In summary particular benefits gained from the project were improved understanding of roles, sharing information and opportunities for reflection.

Regarding future change, in light of current external change the team felt highly pessimistic about achieving improvements without support. One stream of work discussed was the move towards the provision of rehabilitation and support to enable more purposeful activities for service users. This is something that would be highly valued and would help to orientate the team towards perceived professional values and goals. Nonetheless this was viewed as ambitious in the current climate of dis-investment and resource constraint.

The team agreed that they would be seeking to protect what they currently had as the main aim of their work in the coming months. This would be achieved through continued communication and the acceptance of responsibility by the whole team.

The team did agree that some changes made during the project would be sustained by using the lessons about how change had been achieved. With this in mind further dates for team reflection sessions were set and responsibility for the lead roles of sessions was also decided.

Team U showed improvements in management structures and styles (5%) and integration (4%). They showed a surprisingly large decline in role perception (-8%); career and training development opportunities (-18%); access to technology and equipment (-9%); uncertainty (-30%); clarity of vision (-7%); perception of quality (-3%) and overall satisfaction (-13%). The intention of staff to leave their employer over the next twelve months worsened by 25%.

Team PB

This team are a ward based NHS intermediate care service in a community hospital. Their primary function is to facilitate early discharge from acute hospital and to prevent admission to hospital: predominately step down with some step up. They admit patients through a single point of entry from acute settings following full assessment. The team have just under 38 full time equivalent staff members.

The involvement of the team with the project was halted after 17 months from the start of the study date. They had only completed the first SEC and the first TLS, and were about 9 months behind schedule. The reason for finally withdrawing them from the study was that they were not able to provide a date for the next event due to other pressures: mainly clinical work which they prioritised.

Taking time off from clinical duties to attend the project events was a particular problem for ward based services. They had difficulty with getting alternative cover and organising shifts. Smaller community based teams managed to maintain a skeleton staff and postpone non-urgent work to allow a large number of team members to attend the events. Larger services which incorporated more than one team were best placed to take part in the project events as cover could be provided by another team for the day or half day as and when required.

The study therefore exposed a significant limitation for some teams in taking part in team development and service improvement activities. It is possible that the pressure to prioritise clinical work in ward based settings might also hinder personal development activities.

We obtained baseline WDQ characteristics of Team PB, but despite much perseverance, they were unable to provide follow-up data, so we do not have WDQ change scores for this team, however their results have been included in the analysis on an 'intention to treat' basis.
