

An evaluation of the use of  
neuropsychology formulation  
meetings within community  
neurorehabilitation teams

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## 1. Background

### 1.1 Literature Review

**1.1.1 Understanding neurological conditions.** The number of people living with a neurological condition in England is rising, and these conditions can significantly burden the individual, their families and carers, the NHS, and society (NHS England, 2019; The Neurological Alliance, 2018). Neurological conditions can be categorised into: sudden onset (e.g. acquired brain injury), intermittent and unpredictable (e.g. epilepsy), progressive (e.g. Parkinson's disease) and stable (e.g. cerebral palsy) (NHS England, 2019). Individuals with neurological conditions are considered to have the lowest health-related quality of life of any long-term condition (NHS England, 2019), and are often faced with several physical, cognitive, emotional and psychosocial difficulties (Wilson, 2008). Individuals living with a neurological condition are at risk of experiencing difficulties in relation to mood, identity and adjustment (Williams & Evans, 2003), with findings suggesting that 52% of patients have one or more co-morbid mental health conditions (anxiety and depression) alongside their neurological condition (The Neurological Alliance, 2017). This demonstrates the importance of addressing the emotional and cognitive needs of individuals living with a neurological condition.

**1.1.2 Supporting individuals with a neurological condition.** Individuals living with a neurological condition should have access to integrated and personalised care; however, patients often do not have access to a full range of health professionals, or their care is not integrated (The Neurological Alliance, 2018). To promote good care and maximise patient outcomes, patients should have access to a multidisciplinary team (MDT), provided via a multispecialty provider in a community setting (The Neurological Alliance, 2018). Previous research into NHS services found that there were fewer than 1.5 community team professionals per 4000-5000 neurologically impaired patients (McMillan & Ledder, 2001). However, over the past 20 years, the NHS has attempted to improve community care for neurological conditions. In 2015, NHS England commissioned Thames Valley Strategic Network to lead a national programme of work, with the objective of encouraging the use of community-based care models, to improve the quality of life for individuals living with a neurological condition (NHS England, 2019).

Community neurorehabilitation services aim to support patients and their families to manage, reduce and adjust to the deficits precipitated by their condition (Williams & Evans, 2003). Historically, community services have focussed on rehabilitating physical impairments (McMillan & Ledder, 2001); however, it has been recognised that cognitive, emotional, physical and psychosocial functioning are interlinked and therefore rehabilitation should adopt a holistic biopsychosocial approach that attends simultaneously to these dimensions (Cole, 2013; George & Engel, 1980). The holistic approach is considered one of the best ways to provide rehabilitation to those who experience a neurological condition, with these services focussed on increasing a patient's awareness, increasing acceptance and understanding, alleviating cognitive deficits, developing compensatory skills, and providing vocational counselling (Wilson, 2002; Wilson & Betteridge, 2019). Research has supported the efficacy of neurorehabilitation (van Heugten, Wolters Gregório, & Wade, 2012), and in a meta-analysis it was found that neurorehabilitation programmes can improve community integration, functional independence and productivity, even many years post-injury (Cicerone et al., 2011). The importance of integrating psychology into neurorehabilitation has been documented (Wilson & Betteridge, 2019); however, research has found that services are often under-resourced. For example, McMillan and Ledder (2001) found that 40% of teams had no direct access to professional psychological advice and 60% had no clinical psychologist in their team.

**1.1.3 Formulation in clinical practice.** Formulation is a core competency of a psychologist and is understood as a framework for identifying an individual's difficulties, making sense of the development and maintenance of those difficulties and helping to inform interventions (Ingham, Clarke, & James, 2008; Wood, 2016). Neuropsychological formulation is guided by empirical and theoretical literature regarding cognitive functioning, and utilises biopsychosocial and systemic models to develop an understanding of a patient's presentation (Wilson & Betteridge, 2019). Neurorehabilitation programmes, such as the one at the Oliver Zangwill Centre (Wilson, 2008), recommend a holistic biopsychosocial formulation that places the patient at the centre and incorporates all aspects of the system surrounding the individual, to help identify rehabilitation needs (Wilson & Betteridge, 2019). Whilst a clinical psychologist/neuropsychologist may lead this process, interdisciplinary working will help promote a holistic assessment that provides a thorough understanding of the

individual. It is recommended that this process is conducted transparently with the patient and/or their family and carers, as it promotes a shared understanding of the problems and can facilitate motivation to engage in the rehabilitation programme (Wilson & Betteridge, 2019). More research would be recommended regarding the integration of neuropsychological formulation within clinical practice.

Due to changes and cuts within NHS services, there has been an emphasis on clinical psychologists using consultation and leadership to demonstrate their value beyond individual interventions (Wood, 2016). A growing area of interest has been to utilise formulation at a team level (Hollingworth & Johnstone, 2014). Team formulation has been described as a process of facilitating a group of professionals to construct a shared understanding of a server user's difficulties (Johnstone & Dallos, 2013). Working psychologically with teams is considered a way for clinical psychologists to utilise skills such as formulation to support teams to identify an appropriate intervention, particularly for those with complex needs (Rainforth & Laurenson, 2014). The use of team formulation to support MDT members has had a positive impact on care planning, staff-patient relationships, staff satisfaction, increasing understanding of patients, team working, intervention planning and promoting psychological mindedness (Craven-Staines, Dexter-Smith, & Li, 2010; Hollingworth & Johnstone, 2014; Wainwright & Bergin, 2010). The benefits of team formulation have been recognised by both clinical psychologists and non-psychologist staff members (Christofides, Johnstone, & Musa, 2012; Hood, Johnstone, & Christofides, 2013). Despite the positives highlighted above, there is limited research conducted on how to implement team formulation (Wood, 2016), and research has identified inconsistencies in the way that team formulation is utilised in services (Cole, Wood, & Spindelov, 2015). In a recent systematic review, it was found that the term 'team formulation' encompasses three different types of practice: 1. highly structured consultation; 2. reflective practice meetings; and 3. informal sharing of ideas (Geach, Moghaddam, & De Boos, 2018). Therefore, if team formulation is understood and implemented in different ways, it is difficult to make conclusions regarding the use of team formulation as a unitary practice (Geach et al., 2018). Overall, there is a lack of research into the use of team formulation and the majority has been conducted within mental health services. The use of team formulation within neurorehabilitation services is a gap in research.

## 1.2. Commissioning and Project Aims

**1.2.1 The service.** Locala is a social enterprise covering NHS services across Kirklees, Bradford, and Calderdale. They provide a range of services, including adult community therapy, which involves a MDT providing treatment, rehabilitation, advice and support to people living in Kirklees. The purpose of the service is to support people to achieve goals in relation to daily living and quality of life. The team offers help to people with a range of difficulties; however, one focus is providing community rehabilitation to individuals living with a neurological condition. The community neurorehabilitation team includes occupational therapists (OT), physiotherapists (PT), speech and language therapists (SALT), dieticians and assistant practitioners. The team is currently under-resourced and does not have a neuropsychologist embedded within the team.

The Neuropsychology service at Pinderfields Hospital, Mid Yorkshire NHS Trust has historically offered supervision to the community neurorehabilitation MDT. In the past, these meetings have been unstructured and provided the team with an opportunity to briefly discuss current cases, referrals and/or interpretation of neuropsychological assessment. However, over the past two years, the neuropsychology service has revised the format of these meetings and has introduced team formulation meetings to discuss complex neurorehabilitation cases, utilising a biopsychosocial model (see Figure 1). These meetings occur monthly, and the focus is to discuss one complex case, with a view to developing a shared formulation that will guide intervention planning. This approach is aimed to promote joint working, the use of shared team formulation, and goal setting in line with models of best practice in neurorehabilitation settings (Wilson & Betteridge, 2019).

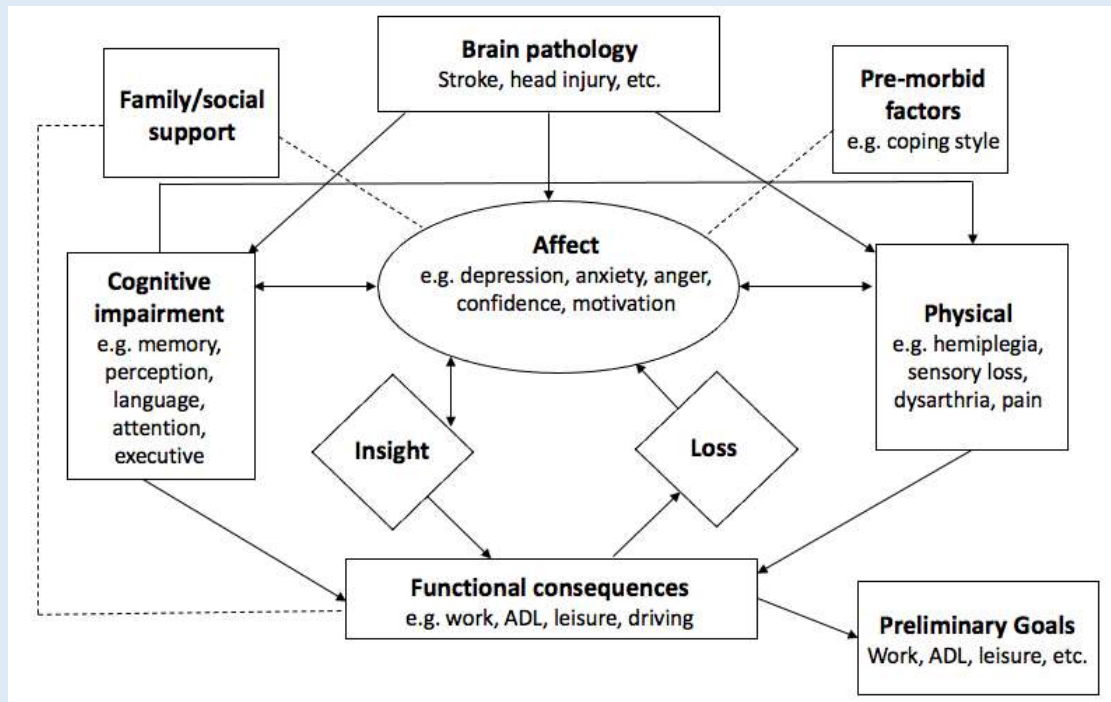


Figure 1. Biopsychosocial model (adapted from the Oliver Zangwill Centre).

**1.2.2 Aims.** This Service Evaluation Project (SEP) was commissioned by Dr Trishna Gandhi (Clinical Psychologist) of the Clinical Health and Neuropsychology Department at Pinderfields Hospital, Mid Yorkshire NHS Trust. The aim of the SEP was to evaluate and understand the potential benefits that the formulation meetings have had and identify any changes that could be made. In collaboration with the commissioner, the SEP aimed to achieve the following:

1. To collate feedback regarding what is helpful and unhelpful about the use of this formulation framework, with a view to informing future meetings.
2. To explore if the use of shared formulation has helped clinicians working towards their neurorehabilitation goals with clients.
3. To find out if the formulation sessions have enabled the wider MDT to further develop their reflective skills and expertise working within a neurorehabilitation setting.



## **2. Methodology**

### **2.1 Design**

This project used a qualitative method design. Qualitative methods are indicated when a project requires rich and in-depth information about participants' experiences, which could not be captured utilising quantitative methods (e.g. online survey) (Ritchie & Lewis, 2003; Tracy, 2019). Individual semi-structured telephone interviews were initially considered, as they provide in-depth data and allow participants proportionate speaking time (Lambert & Loiselle, 2008). However, due to time constraints and the value of discussions during group interactions (Tracy, 2019), a focus group was used instead. This was initially meant to be face-to-face; however, due to restrictions following the COVID-19 pandemic, this group was facilitated virtually using Skype for Business. Previous research has found that using virtual methods to facilitate focus groups is theoretically sound and meets the criteria for traditional focus groups as outlined by Krueger (1994) (Turney & Pocknee, 2005). The project researcher facilitated the focus group, and an assistant psychologist from the Mid Yorkshire Trust co-facilitated the group.

### **2.2 Participants**

The community neurorehabilitation MDT clinicians, who had attended the formulation meetings were invited to take part in the project. There are approximately 15 clinicians who had attended the formulation meetings. Clinicians were emailed the information sheet (PIS; Appendix A) by the project commissioner and asked if they would like to participate in the project. Interested participants informed the project commissioner or researcher via email. The SEP aimed to recruit between six and eight participants, as recommended for focus groups (Ryan, Gandha, Culbertson & Carlson, 2014). Six clinicians agreed to take part in the project. Due to the relatively small sample size, demographic information will not be reported, to maximise anonymity of participants.

### **2.3 Data Collection**

The focus group took place in July 2020. The focus group lasted approximately 70 minutes. Participants were emailed the consent form (Appendix B) and signed and returned this via email to the project researcher before beginning. As highlighted, the

focus group was facilitated using Skype for Business and was audio-recorded and transcribed verbatim. The researcher had a topic guide (Appendix C) to ensure that the research aims were addressed during the group.

## 2.4 Data Analysis

Using the framework outlined by Braun and Clarke (2006; see Figure 2), thematic analysis was used to analyse the data. Thematic analysis has been described as a method for, “identifying, analysing and interpreting patterns of meaning (‘themes’) within qualitative data” (Clarke & Braun, 2017, p. 297). Thematic analysis provides a rich description of the data and was chosen as it was an appropriate method to address the proposed research aims. Thematic analysis provides a method that explores individual personal experiences, and analysis can be completed in a ‘bottom-up’ way, as it is unbounded by theoretical commitments (Clarke & Braun, 2017).

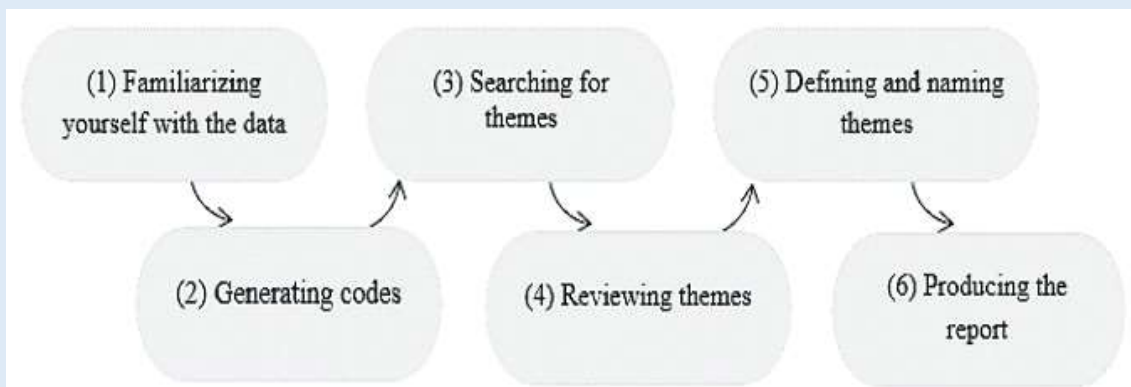


Figure 2. Braun & Clarke’s (2006) six-phase framework for doing thematic analysis.

## 2.5 Ethical Considerations

Ethical approval was sought and granted by the University of Leeds School of Medicine Research Ethics Committee (DClinREC19-003) on 10<sup>th</sup> March 2020. Amended ethical approval, to include the facilitation of a focus group using an online platform, was granted on 22<sup>nd</sup> May 2020. The SEP was also approved by the Mid Yorkshire NHS Trust R&D department (Appendix D).

Participants were emailed the PIS to ensure that they were able to give informed consent to participate in the project. Participants signed a copy of the consent form and returned this via email before the focus group took place. Participants were made aware

of their right to withdraw at any stage. The audio recording of the focus group was transcribed immediately after the group and then deleted. Participants were assigned participant numbers, and all data was anonymised within the report.

It was not expected that participants would find the group distressing; however, they were told that they could leave the group at any stage and could contact the project commissioner or researcher following the group if they wanted to discuss anything further.

## **2.6 Credibility Check**

In order to check the quality of the analysis, the themes were discussed and agreed on with the project commissioner. A credibility check of the themes was also carried out by another psychologist in clinical training, who was independent of the project.

## **2.7 Reflexivity**

Within qualitative research, it is important for the researcher to consider their personal stance in relation to the topic and have an awareness of any potential biases (Tracy, 2019). Prior to clinical training, I have worked in neuropsychology services and have seen how beneficial it is to have psychology embedded within services. I was aware of the challenges that some neurorehabilitation services experience with regard to funding, and have witnessed how a lack of psychology input can create challenges within a team. I was mindful of my experiences and pre-existing assumptions and feel that my personal stance is unlikely to have biased the results, but remains important to acknowledge.

## **3. Results**

All six participants attended and contributed to the discussion during the focus group. Figure 3 below illustrates the themes and subthemes described by participants. Each theme will be described in detail and illustrated with anonymous extracts from the raw data. Further illustrative quotes can be found in Appendix E.

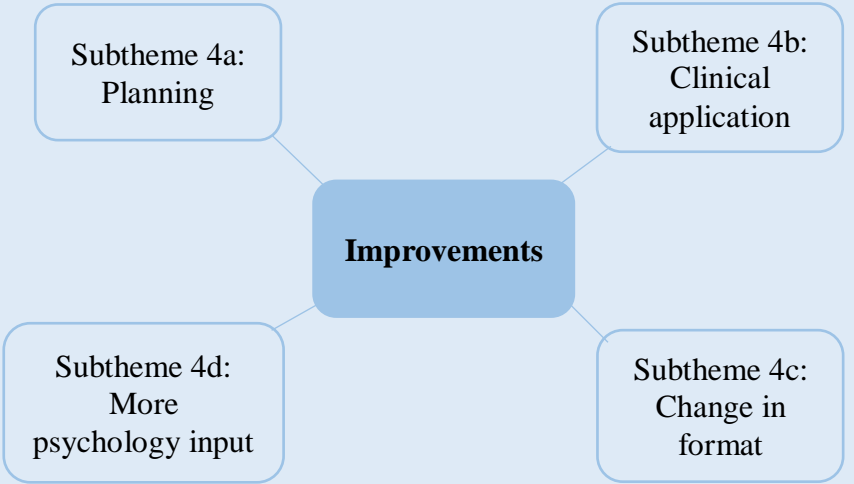
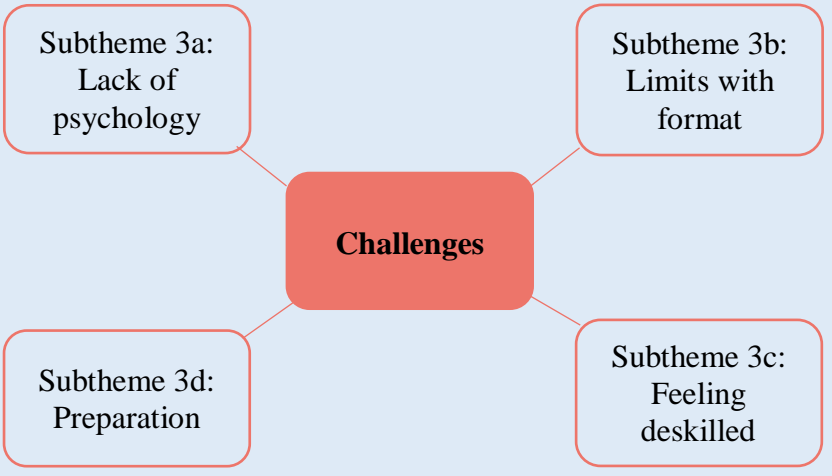
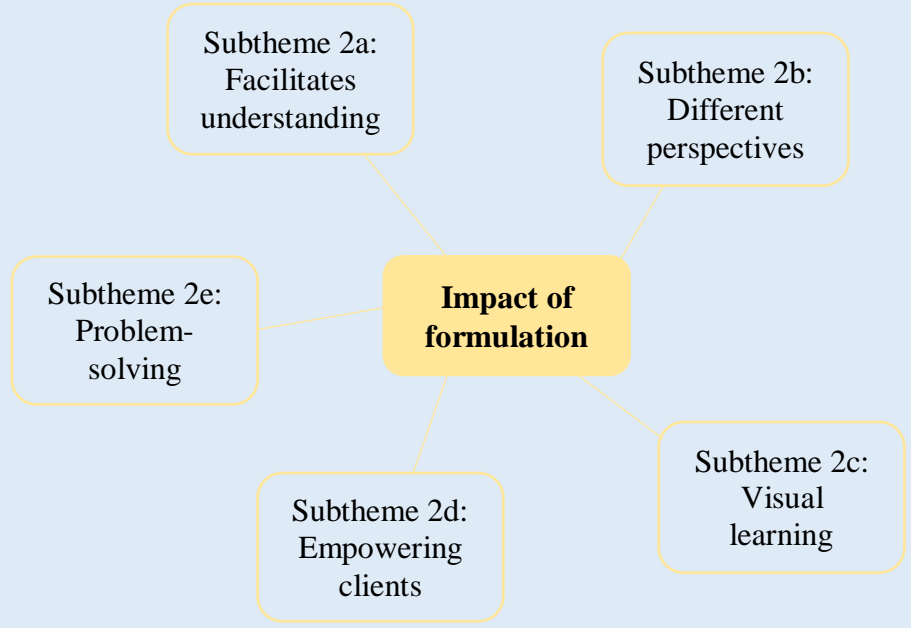
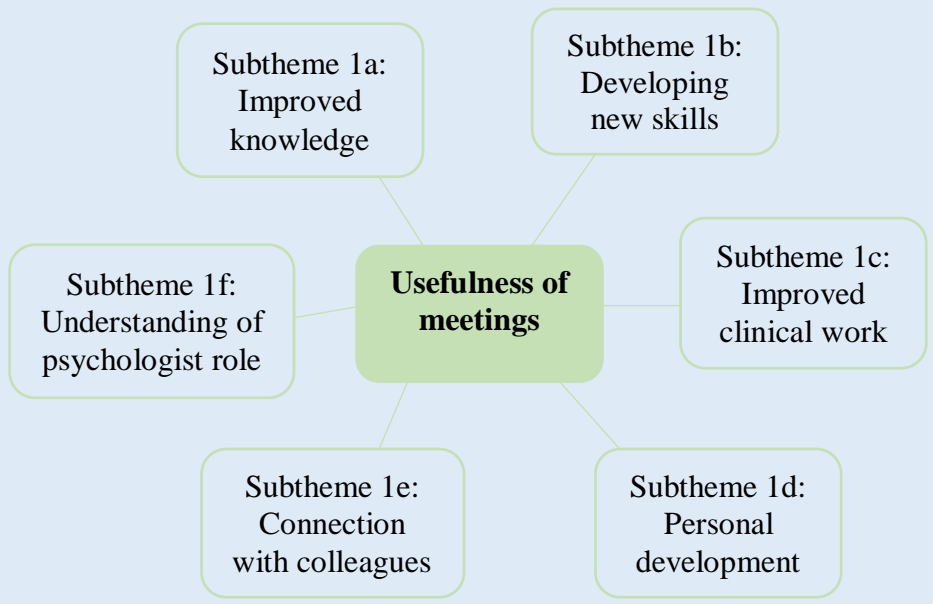


Figure 3. Thematic map of the themes and subthemes from the focus group

### 3.1 Theme 1: Usefulness of Meetings

Participants consistently reported the usefulness of attending the meetings. This theme consisted of six subthemes.

**3.1.1 Subtheme 1a: Improved knowledge.** Participants described how the meetings had helped improve their knowledge and understanding of working with clients and their difficulties.

*“It has helped gain insight into psychological strategies on dealing with specific conditions.”* (Participant 3).

*“It brought up new areas, like identity, I have not thought about that until it was raised in the meetings.”* (Participant 4).

**3.1.2 Subtheme 1b: Developing new skills.** Attending the meetings has helped participants develop new skills that are useful to engage clients.

*“Nuggets of information are tools that we can use.”* (Participant 1).

*“Lots of practical suggestions about using different models to try and get people to set goals.”* (Participant 2).

**3.1.3 Subtheme 1c: Improved clinical work.** There was a theme around participants feeling more able to adapt their interventions, ensuring that they are person-centred and beneficial for clients.

*“Helped us communicate with people where we can go with our intervention and has made it more focussed.”* (Participant 2).

*“I have learnt about making therapy more efficient”.* (Participant 1).

**3.1.4 Subtheme 1d: Personal development.** The meetings have helped participants to become more reflective, particularly with regard to their clinical practice and recognising when interventions are not always appropriate.

*“If you are working with someone who is not at that place and they are not motivated, we ploughed on, but it has made me mindful that it is not due to our effort or skills and we need to accept it’s not always the right time.”* (Participant 1).

**3.1.5 Subtheme 1e: Connection with colleagues.** Attending the meetings has provided participants with an opportunity to share experiences and connect with both the MDT and psychology colleagues.

*“Having everyone there together is really useful.”* (Participant 3).

*“Helped us develop better relationships with psychology and know who is in the team”.*  
(Participant 1).

**3.1.6 Subtheme 1f: Understanding of psychologist role.** Participants described an increased understanding of the role of a psychologist.

*“Increased our understanding of psychology and gives us a window of something we want to know more about.”* (Participant 2).

## **3.2 Theme 2: Impact of Formulation**

Participants reflected on the positive impact of utilising a formulation approach during meetings. This theme consists of five subthemes.

**3.2.1 Subtheme 2a: Facilitates understanding.** Using the formulation has helped participants develop a better understanding of the client and their difficulties.

*“We input the patient on the model which helps shape the way we think.”* (Participant 1).

*“Little nuggets of information which make you think, I hadn’t thought of it like that.”*  
(Participant 2).

**3.2.2 Subtheme 2b: Different perspectives.** The formulation model has helped participants think about clients from a wider perspective and incorporate other factors.

*“We sometimes miss the bigger pictures and the model we have been using has been broader and encompassed other aspects, such as, roles and responsibilities.”*  
(Participant 2).

*“We are looking in more depth at family dynamics and I am putting more emphasis on engaging in the family life than I would have before.”* (Participant 1).

**3.2.3 Subtheme 2c: Visual learning.** Presenting the formulation in a visual form helped to summarise information and promote a shared understanding.

*“When you are trying to organise all of the information in your own head it is not quite as obvious so bringing it to paper and putting it into separate boxes makes a massive difference.”* (Participant 3).

**3.2.4 Subtheme 2d: Empowering clients.** Using the formulation has helped to empower clients to take ownership over their rehabilitation.

*“The patient sets their goals, but it helps us understand where they are coming from”.* (Participant 4).

*“Helps focus on maximising independence, so we can tailor rehab so the person has control and the tools to manage their own rehab.”* (Participant 1).

**3.2.5 Subtheme 2e: Problem-solving.** Using the formulation has been useful for clients that are complex, who the team feel ‘stuck with’.

*“We tend to bring the most complex.”* (Participant 3).

*“It is most helpful for complex patients we are currently seeing that we are stuck with.”* (Participant 2).

### **3.3 Theme 3: Challenges**

Despite participants reporting the benefits of the formulation meetings, they did identify some challenges. This theme consists of four subthemes.

**3.3.1 Subtheme 3a: Lack of psychology.** There was a shared frustration among the team, due to a lack of psychology input within the team. The MDT feel that they are having to try and fill a gap that they are not necessarily trained to do.

*“We are trying to bridge a gap that needs addressing.”* (Participant 3).

*“We have a lot of other things to be skilled on and it is just another thing and we are not psychologists.”* (Participant 2).

**3.3.2 Subtheme 3b: Limits with format.** Despite reporting the benefits of the formulation model, participants expressed limits to using this format, suggesting that it was not always appropriate.

*“Using the formulation has helped me unpick (the patient) but has not helped me move forward with him.” (Participant 6).*

*“I don’t think the model works as well if we look at a specific condition.”  
(Participant 1).*

**3.3.3 Subtheme 3c: Feeling deskilled.** There was a theme around participants feeling deskilled when working with clients who experience co-morbid mental health difficulties and when there may be psychological barriers preventing engagement.

*“I struggle with the more complex mental health patients.” (Participant 6).*

*“There is a lot of trauma with some people and quite often they tell us and it’s knowing how to manage this.” (Participant 5).*

*“A lot of barriers I see are psychological, emotional, motivation and acceptance.”  
(Participant 3).*

**3.3.4 Subtheme 3d: Preparation.** Participants reported that preparation can be time-consuming, which consequently means that they are not always prepared for the meetings.

*“Need to identify what we want to focus on and be more prepared but we don’t always have time.” (Participant 1).*

## **3.4 Theme 4: Improvements**

Participants made some suggestions with regard to improvements that could be made moving forward. This theme consists of four subthemes.

**3.4.1 Subtheme 4a: Planning.** In order to get the most from the meetings, participants suggested that more planning and preparation before meetings is needed.

*“Preparing the psychologist that the next session will be about this person with this issue so there is more preparation on both sides.” (Participant 3).*

*“At the meeting can we plan for the next meeting and say this is what we are doing next time does anyone have a case.” (Participant 4).*



**3.4.2 Subtheme 4b: Clinical application.** Although participants have found the meetings useful for developing new skills, they expressed needing further support to make those skills practical.

*“Strategies have been discussed but it would be great to hone in on them and actually make them practical in situations.”* (Participant 2).

*“The practical side of things, when you are in the situation how do you deal with it?”*  
(Participant 5).

**3.4.3 Subtheme 4c: Change in format.** Participants expressed that they may benefit from adapting the format of meetings.

*“It might be that we have to do things differently because we have learnt a lot but we are learning less with the same format.”* (Participant 2).

*“Meetings need to evolve.”* (Participant 1).

**3.4.4 Subtheme 4d: More psychology input.** There was a shared consensus among the team in relation to a clinical need for having more time with psychology or a psychologist embedded within the team.

*“More psychology would complement what we do and promote MDT working.”*  
(Participant 5).

*“It would be better for the patient to have more psychology input.”* (Participant 2).

## 4. Discussion

The purpose of this SEP was to provide insight into staff members’ experiences of the neuropsychology formulation meetings. Despite there being a small number of participants, the themes emerging from the data did reach saturation. The major themes identified were usefulness of meetings, impact of formulation, challenges and improvements.

There was a consistent theme around the usefulness of meetings, as participants reported that the meetings had resulted in improved knowledge and had enabled them to develop new skills and improve their clinical work. Participants also reported how the meetings had supported their personal development and have provided them with the

opportunity to connect with colleagues and develop an understanding of the psychologist role. These findings do suggest that the meetings have had multiple benefits for participants.

The impact of utilising a formulation approach in these meetings was discussed, with participants identifying the benefits, including: facilitates understanding, thinking from different perspectives, visual learning, empowering clients, and problem-solving. The biopsychosocial formulation model utilised in meetings promotes a holistic understanding of patients and is considered the best way to provide rehabilitation to those who experience a neurological condition (Wilson & Betteridge, 2019). These findings demonstrate how participants have valued the formulation approach and support the clinical effectiveness of utilising this model.

Despite participants reporting the benefits of the formulation meetings, they did identify some ongoing challenges. These meetings are provided on a monthly basis and the team expressed an overall lack of psychology input. Due to individuals with a neurological condition experiencing difficulties in relation to mood, identity and adjustment (Williams & Evans, 2003), access to psychology is important and supports similar findings whereby community neurorehabilitation services are under-resourced and have limited access to psychology (McMillan & Ledder, 2001). Other challenges were noted, with participants feeling deskilled working with individuals experiencing comorbid mental health difficulties, where psychological barriers may be impacting their rehabilitation. Additional challenges raised were limits to the format of meetings and the preparation that is required to attend. To reduce the impact of these challenging experiences, the themes will be considered in future recommendations.

During the discussion, the team did identify some improvements that could be made moving forward. They identified the following: more planning; support with clinical application; change in format; and more psychology. It is important to be mindful that psychology is not embedded within the community neurorehabilitation team and is a limited resource. Therefore, there may be limits in relation to what the neuropsychology service can offer the team moving forward. Nevertheless, these suggestions will be discussed and considered in future recommendations.

The results from this SEP support previous findings, which have demonstrated the benefits of incorporating a formulation model to support clinical practice, such as: it

provides a thorough understanding of an individual (Wilson & Betteridge, 2019); it enhances staff members' understanding of patients perceived as complex (Rainforth & Laurenson, 2014); and presenting information in a visual form helps to promote understanding and enables unified teamwork (Winson, Wilson, & Bateman, 2016). It also supports the recommendation that patients who experience a neurological condition should have access to an interdisciplinary team, whereby their care is integrated, as it promotes joint working and shared understanding (The Neurological Alliance, 2018).

Research recommends that the process of formulation should be conducted transparently with patients and/or their family and carers (Wilson & Betteridge, 2019). However, due to psychology being a limited resource, the formulation has been provided at a team level. There is growing interest in formulation being provided at an MDT level, with research producing positive results (Craven-Staines et al., 2010; Hollingworth & Johnstone, 2014; Wainwright & Bergin, 2010). Geach et al. (2018) found that the term 'team formulation' encompasses different types of practice. Within this service, formulation has been provided as highly structured consultation. The findings of this SEP provide further support for previous research highlighting the benefits of utilising formulation at a team level within services, and address a gap in research whereby formulation is provided at a team level within a neurorehabilitation context.

#### **4.1 Strengths and Limitations**

This SEP has implemented a feasible methodological design that addresses the proposed aims of the project. The use of a focus group enabled participants to engage in group discussion and elaborate on their views and experiences. Secondly, appropriate quality checks were completed, which enhanced the quality of the data collected. This SEP provides evidence for the importance of integrating psychology into services; however, it also demonstrates the challenges that NHS services encounter with funding and cuts. Finally, this SEP supports the benefit of utilising a biopsychosocial formulation model to support neurorehabilitation and addresses a gap in research demonstrating the benefits of using formulation at a team level within a neurorehabilitation context.

There are several limitations to address. Firstly, although six participants is appropriate for qualitative research (Tracy, 2019), a larger sample size would have been more representative. As highlighted, the team is made up of different professions; however, it is important to acknowledge that SALT and dietetics were not represented in

the sample. The impact of selection bias should be considered. Participants who volunteered may have been more motivated to feed back their experiences, which may not be representative of how all members of the MDT viewed these meetings. Furthermore, participants have a good working relationship with the neuropsychology service and may have been reluctant to provide feedback about a service provided by colleagues with whom they have a good working relationship. Also, psychology is a limited resource and participants may have been worried that any negative feedback may have impacted on the support that they received moving forward; however, participants were reassured that this was not the purpose of the project.

Although the use of focus groups provides in-depth information, one criticism is that participants can find them anxiety-provoking and may feel uncomfortable expressing views that are different to the majority (Lambert & Loiselle, 2008). Furthermore, although facilitating a virtual focus group did not appear to impact on participants' engagement in the group, one issue with Skype for Business is that you can only see four people on the screen at a time; so, when facilitating the group, it was important to be mindful of this to promote inclusivity.

#### **4.2 Impact of COVID-19**

This project took place during the COVID-19 pandemic and it is important to consider any potential impact on the project. Following restrictions and guidance, the community neurorehabilitation team continued to provide a service; however, they experienced redeployment of colleagues and had to adapt service delivery. Furthermore, due to time constraints and adapting ways of working, the formulation meetings occurred less frequently and were facilitated virtually. It was important to be mindful of the impact that this could have had on staff views and experiences. However, this was acknowledged at the beginning of the group, and staff members were able to reflect on their experience of the formulation meetings, despite the impact of COVID-19. Therefore, whilst it is important to acknowledge the potential impact, it did not seem to bias the results. As highlighted, the main impact that this had on the project was that the focus group had to be facilitated virtually, rather than face-to-face.

#### **4.3 Conclusion and Recommendations**

The SEP was designed to evaluate and understand the potential benefits that the formulation meetings have had and identify any changes that could be made. The results

address the proposed aims and highlight how staff have valued and benefited from attending the formulation meetings and provide information that can be used to inform future meetings. Participants were extremely grateful for the support that they have received from the neuropsychology service and were thankful for having the opportunity to reflect on those meetings.

Although participants outlined a number of suggestions regarding improvements that could be made, it is important to be mindful that there may be limits to what the neuropsychology service can offer due to capacity. However, in table 1 some key recommendations have been suggested.

Table 1. Key Recommendations.

<b>Recommendations</b>
<p>1. Arranging a meeting between the neuropsychology service and the community neurorehabilitation team would be beneficial. The purpose of this meeting would be to match expectations and discuss a plan moving forward.</p>
<p>2. To address some of the challenges and improvements that the team identified, if possible, additional support from the neuropsychology service could include:</p> <ul style="list-style-type: none"> <li>• Facilitating training sessions and/or developing webinars (e.g. skills-based, condition-specific) – This may support clinical application and help staff members feel more skilled when working with clients when there may be psychological barriers preventing engagement.</li> <li>• Access to resources – The team identified that having a folder with appropriate resources in would help consolidate skills they learn in meetings.</li> </ul>
<p>3. Having a clinical psychologist/neuropsychologist embedded within the team would be beneficial. Therefore, the neuropsychology service could support the team to develop a business case.</p>
<p>4. The team have valued the meetings and they have been useful. Moving forward, regular review/evaluation of meetings would be recommended.</p>

5. As it is recommended that the formulation is shared with patients and/or their families and carers, it may be that consideration is given to this process. This may be particularly useful for supporting engagement with clients whereby specific barriers are impacting on their rehabilitation (e.g. limited insight).

### **5. Dissemination**

- The findings from this SEP were presented to the Leeds Clinical Psychology programme at a SEP conference in October 2020.
- The findings were shared with the project commissioner and will be shared with the wider neuropsychology department on 10<sup>th</sup> November 2020. They will also be presented and shared with the community neurorehabilitation team on 17<sup>th</sup> November 2020.
- A research paper based on this SEP will be prepared for publication in The Neuropsychologist.

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## Appendix A – Participant Information Sheet

### Information Sheet

Hi my name is Lewis Langford, I am a Clinical Psychologist in training at The University of Leeds. I am contacting you as I am carrying out a service evaluation project to evaluate the neuropsychology formulation meetings that occur within the community neurorehabilitation team. In order to do this, I am inviting you to take part in a focus group that will occur using an online platform due to the current COVID-19 pandemic. I will be facilitating the focus group and will also have a co-facilitator, xxx, who is an Assistant Psychologist within the trust. As the focus group is occurring online, you would be required to have access to a device that allows you to participate.

Please take the time to read the following information carefully to help you decide whether or not you would like to participate in the study. It is important that you understand why the research is being done and what it will involve.

#### **Title of project**

An evaluation of the use of Neuropsychology formulation meetings within community neurorehabilitation teams.

#### **What is the purpose of this study?**

The purpose of this project is to evaluate the Neuropsychology formulation meetings that occur within the community neurorehabilitation teams and understand the potential benefits they have had or identify any changes that could be made.

#### **Why have I been invited to take part?**

You have been invited to take part in this focus group as a staff member who currently attends these meetings.

#### **What do I have to do?**

If you agree to take part you will be asked to participate in a focus group with other members of your team. During the group we will discuss the Neuropsychology formulation meetings to try and understand the potential benefits they have had or identify any changes that could be made. You would be expected to reflect on your experiences of these meetings. The group will last for approximately 60-90 minutes. In order to analyse the data, a recorder will be used during the meeting which will capture audio information. If you wish to take part in the current study please respond to the email sent by Emma Briggs and she will inform us of your attendance. Once we have confirmed the number of people that wish to attend, we will be arranging a suitable time and date for the focus group.

**Do I have to take part in the study?**

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and then will be asked to sign a consent form. You can decide to withdraw at any time before or during the study by removing yourself from the group, which can be achieved by exiting the online platform. You do not have to give a reason for not participating. In addition, should you not wish to answer any particular question or questions, you are free to not answer or decline.

**What happens if I say yes but then later decide I don't want to take part?**

If you change your mind before attending the group you can email myself or Dr Trishna Gandhi to inform us that you will not be attending. If you attend the group and change your mind you can withdraw from the study by removing yourself from the focus group. As all information is being captured by an audio recorder it would be difficult to exclude any information that you provided before removing yourself. Therefore, any information that is captured before you remove yourself will still be included in the analysis; however, all information is reported anonymously.

**What happens to the information I give?****Electronic Data**

To capture information during the focus group, a recorder will be used which will later be transcribed. Audio recordings will be transferred to a secure University of Leeds server on the day of recording, and then deleted from any devices used to record the meeting. All data will be deleted by the DClin Psychol research coordinator, 3 years after the completion of the project.

**Paper Based Data**

Consent forms will be stored in a locked filing cabinet at the University of Leeds, in an office which is locked when empty. Paper based data will be sent for destruction by the company contracted by the University of Leeds for this purpose. It will be destroyed 3 years after the end of the project to allow time to refer back to it in the event of any questions following the write-up.

All of the data obtained will be treated as confidential and stored securely as is required by the Data Protection Act. The data collected will be used as part of a service evaluation project, which will be written up as a research report. No identifying information about you will be included in the report. For further information, please see the University of Leeds Research Privacy Notice:

<https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf>

**Will I be contacted following the study?**

You will not be contacted about any of the information you provide during the project. However, once the focus group is finished, if you feel that you did not have the opportunity or you have any additional information that you want to share, you are welcome to contact myself or Dr Trishna Gandhi using the details below.

The results from the study will be fed back to you as a team in a presentation. The presentation will not include any identifiable information and the purpose is to explore how the team has found the Neuropsychology formulation meetings as a whole.

**Who has reviewed this study?**

This study has been reviewed by a sub-committee of the School of Medicine Research Ethics Committee, University of Leeds (**DClinREC19-003**).

**If I have questions about the study who can I ask?**

If you require any further information please contact the Doctoral student who is completing this research, Lewis Langford ([umlla@leeds.ac.uk](mailto:umlla@leeds.ac.uk)). You can also contact the commissioner of the project Dr Trishna Gandhi ([trishna.gandhi@nhs.net](mailto:trishna.gandhi@nhs.net)). You can also contact Dr Gary Latchford ([g.latchford@leeds.ac.uk](mailto:g.latchford@leeds.ac.uk)) who is supervising this project and based at the University of Leeds, Clinical Psychology programme.

**Support**

If you are upset or distressed about anything that is discussed during the focus group, then you are welcome to contact myself or Dr Trishna Gandhi on the above details to discuss. If you feel more comfortable speaking to someone else, then you can contact your line manager at work or you can contact occupational health.

**Thank you for reading this information sheet.**

## Appendix B – Participant Consent Form



UNIVERSITY OF LEEDS

**Consent to take part in, ‘An evaluation of the use of Neuropsychology formulation meetings within community neurorehabilitation teams.’**

Add your initials  
next to the  
statement if you  
agree

I confirm that I have read and understand the information sheet, dated [       ] explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any point before or during the focus group without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report that results from the research. I understand that my responses will be kept strictly confidential.	
I agree for the data collected from me to be stored and archived at the University of Leeds.	
I understand that the report may include information that I have provided, such as statements I say; however, this will be completely confidential and no identifiable information will be used.	
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project.	

Name of participant	
Participant’s signature	
Date	
Name of person taking consent	
Signature	
Date	

### Appendix C – Topic Guide

1. Introductions – aims and purpose of the focus group, structure of the group, length, expectations, group rules, data protection, confidentiality and recording of the group.
2. Questions for Focus Group:
  - What impact does formulation have – if any – on neurorehabilitation work? (e.g. goal setting, shared goals, length of care, MDT collaboration).
  - Thinking about the meetings, is there anything that has been particularly helpful or unhelpful? (e.g. preparation beforehand, content of the formulation, spending time thinking about the patient holistically).
  - Is there anything that you think could be different about the meetings? (e.g. frequency, time, location, format).
  - What impact – if any - have these meetings had on your understanding of psychology? (e.g. role of a psychologist, appropriate referrals, etc.).
  - Have these meetings helped you develop any specific skills or changed how you work with clients?
  - If there was more time, do you think there are more things that psychology could offer?
3. Reflections on experience of participating in the focus group
4. Closing – questions, further information or comments

**Appendix D – R&D Email Approval**

From: DOUGLAS, Victoria (MID YORKSHIRE HOSPITALS NHS TRUST)  
Sent: 27 November 2019 10:21  
To: GANDHI, Trishna (MID YORKSHIRE HOSPITALS NHS TRUST); DOUGLAS, Victoria (MID YORKSHIRE HOSPITALS NHS TRUST)  
Cc: MY.RESEARCH (MID YORKSHIRE HOSPITALS NHS TRUST)  
Subject: RE: Service evaluation & HRA decision tool

Dear Trishna

Apologies for the delay in responding. Thank you for the attached HRA decision and the project information. As the HRA have confirmed this would not be classed as research you do not need to gain any further approvals from the RM&S office here.

You will however require Head of Clinical Service authorisation before proceeding as you have already stated below.

Good luck with your evaluation.

Kind Regards

Vicky

Victoria Douglas

Research Facilitator | Research Management and Support | Mid Yorkshire Hospitals NHS Trust Please could you amend my email address in your records as we have now migrated to nhs.net. Any emails sent to midyorks.nhs.uk will only be forwarded for a short period.

Please note change of email address below

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t. 01924 543175 | e.

victoria.douglas6@nhs.net<mailto:victoria.douglas6@nhs.net> | a. RM&S Office, Unit 10, Clarke Hall Farm, Pinderfields Hospital, Aberford Road, Wakefield, WF1 4AL

The Research Team are part of the Medical Directorate (My usual working week is Tuesday to Friday 8.30am to 2.30pm)

From: GANDHI, Trishna (MID YORKSHIRE HOSPITALS NHS TRUST)

[<mailto:trishna.gandhi@nhs.net>]

Sent: 19 November 2019 09:50

To: Victoria.Douglas1@midyorks.nhs.uk

Subject: Service evaluation & HRA decision tool

Dear Victoria

I have commissioned a service evaluation in the Clinical Health Psychology department and I am aware that in order to proceed with this project I would need



to confirm with yourselves in R&D that the project is not research. I have attached a screenshot of the HRA decision tool I have completed and also the commissioning form for the project. I would be happy to provide any further information if required.

I would be grateful if you could confirm that I am okay to proceed? Once you are okay with this, I will also send the details to our head of service for further confirmation.

Best wishes  
Trishna

Dr Trishna Gandhi  
Senior Clinical Psychologist  
Department of Clinical Health Psychology Gate 3A Rehabilitation Department  
Pinderfields Hospital Wakefield  
WF1 4DG  
01924 541510/543799

### Appendix E – Themes, Subthemes and Illustrative Quotes

Theme	Subtheme	Illustrative Quote
Usefulness of meetings	Improved knowledge	<p>We don't usually have the time to think about things but this gives us that dedicated time. (Participant 1).</p> <p>It helped gain insight into psychological strategies on dealing with specific conditions. (Participant 3).</p> <p>The formulation we use gives a greater depth of knowledge. (Participant 4).</p> <p>It brought up new areas, like identity, I have not thought about that until it was raised in the meetings. (Participant 4).</p> <p>Insight into the FND programme. (Participant 3).</p>
	Developing new skills	<p>Lots of practical suggestions about using different models to try and get people to set goals. (Participant 2).</p> <p>Nuggets of information are tools that we can use. (Participant 1).</p> <p>Tools and tips are really useful. (Participant 1).</p> <p>The hints and tips we have before have been so useful, it's almost we want more of that. (Participant 3).</p> <p>Looking at someone's life story and focusing on their values. (Participant 1).</p>
	Improved clinical work	<p>Acceptance that it is not always the right time for rehab. (Participant 1).</p>

		<p>Looking through this model has made us more reflective. (Participant 2).</p> <p>Our acceptance, so if you are working with someone who is not at that place and they are not motivated, we ploughed on but it has made me mindful that it is not due to our effort or skills and we need to accept it's not the right time. (Participant 1).</p> <p>It is not just the acceptance of the patient but it's our acceptance as well. (Participant 1).</p>
	Personal development	<p>Helped us communicate with people where we can go with our intervention and has made it more focussed. (Participant 2).</p> <p>Helped us hone in on a more values based approach. (Participant 1).</p> <p>Added quality to our interventions. (Participant 2).</p> <p>I have learnt about making therapy more efficient. (Participant 1).</p>
	Connection with colleagues	<p>Having everyone there together is really useful. (Participant 3).</p> <p>We are not in the same team but we have that link. (Participant 1).</p> <p>Having each other there to say have you thought about this. (Participant 3).</p> <p>Helped us develop better relationships with psychology and I know who is in the team and who to go to. (Participant 1).</p> <p>Can ring psychology when we are unsure. (Participant 2).</p> <p>It's sharing knowledge, often when we bring things to the meeting someone has had something similar and they say we tried this and you may not have thought of that. (Participant 4).</p>

	Understanding of psychologist role	<p>I am able to ring up psychology and discuss appropriate referrals. (Participant 4).</p> <p>Increased our understanding of psychology and gives us a window of something we want to know more about. (Participant 2).</p> <p>I want to absorb everything but it's just not enough time to do that. (Participant 3).</p>
Impact of formulation	Facilitates understanding	<p>We input the patient on the model which helps shape the way we think and we look at all aspects of the person's life. (Participant 1).</p> <p>The model was brilliant and made us think more. (Participant 2).</p> <p>Little nuggets of information which make you think, I hadn't thought of it like that. (Participant 2).</p>
	Different perspectives	<p>We sometimes miss the bigger picture and the model we have been using has been broader and encompassed other aspects, such as, roles, responsibilities. (Participant 2).</p> <p>We are looking in more depth at family dynamics and I am putting more emphasis on engaging in the family life than I would have before. (Participant 1).</p>
	Visual learning	<p>When you are trying to organise all of the information in your own head it is not quite as obvious so bringing it to paper and putting it into separate boxes makes a massive difference. (Participant 3).</p> <p>I must be a visual learner because I really liked seeing it in front of me and separating it out. (Participant 3).</p>

	Empowering clients	<p>The patient sets their goals, but it helps us understand where they are coming from. (Participant 4).</p> <p>Helps focus on maximising independence, so we can tailor rehab so the person has control and can have the tools to manage their own rehab. (Participant 1).</p> <p>Help patients understand how they can better deal with their situation. (Participant 6).</p> <p>Helped to move forward with maximising independence. (Participant 1).</p> <p>It helps us to support them with their goals. (Participant 4).</p>
	Problem-solving	<p>It has given us a structure, a problem-solving structure and it has been useful. (Participant 2).</p> <p>We tend to bring the most complex. (Participant 3).</p> <p>It is most helpful for complex patients we are currently seeing that we are stuck with. (Participant 2).</p> <p>Problem-solving and seeing things from a different viewpoint. (Participant 2).</p>
Challenges	Lack of psychology	<p>We are trying to do a psychology job and that's the problem, we need this information to do what we are missing. (Participant 2).</p> <p>We have a lot of other things to be skilled on and it is just another thing and we are not psychologists. (Participant 2).</p> <p>It makes us less effective if we don't have that (psychology), that the annoying thing to think I probably could have done more with that person and now I will have to discharge them. (Participant 2).</p>

	Limits to format	<p>If we do not have a definite patient in mind, if we are just doing a general review I don't think the model works as well. (Participant 1).</p> <p>Using the formulation has helped me unpick (the patient) but has not helped me move forward with him. (Participant 6).</p> <p>I don't think the model works as well if we look at a specific condition, such as, end of life, it has to be quite concrete and you need an actual case in mind with a specific problem. (Participant 1).</p>
	Feeling deskilled	<p>Struggling with patients that are non-compliant and getting to the bottom of it with them. (Participant 6).</p> <p>Problems in relation to paranoia and mental-health. (Participant 6).</p> <p>I have no formal training with mental health so when I am working I am dealing with things from my own experience and knowledge, so anything to help me with patients with mental health difficulties would be great. (Participant 5).</p> <p>I struggle with the more complex mental health patients. (Participant 6).</p> <p>There is a lot of trauma with some people and quite often they tell us and its knowing how to manage this. (Participant 5).</p> <p>A lot of the barriers I see are psychological, emotional, motivation and acceptance. (Participant 3).</p>
	Preparation	<p>We are not always entirely prepared. (Participant 2).</p> <p>Need to identify what we want to focus on and be more prepared but we don't always have time. (Participant 1).</p>

		<p>It's a lot of work to get prepared for the meetings. (Participant 1).</p> <p>I was asked to do it the morning of, so I did not have time to read through my case properly. (Participant 4).</p>
Improvements	Planning	<p>Preparing the psychologist that the next session will be about this person with this issue so there is more preparation on both sides to get the most out of the time. (Participant 3).</p> <p>We need to think about what we need and be specific with what support we want. (Participant 2).</p> <p>At the meeting can we plan for the next meeting and say this is what we are doing next time does anyone have a case. (Participant 4).</p> <p>Prepare the psychologist for the topic and then say can you think of some hints and tips. (Participant 3).</p> <p>Conversation beforehand so we can all prepare. (Participant 1).</p> <p>Sometimes its self-led and we go off on tangents, but if it was more prepared and the psychologist knew what was coming would we get more hints and tips. (Participant 3).</p>
	Clinical application	<p>The practical side of things, when you are in the situation how do you deal with it? (Participant 5).</p> <p>More tools in the box and knowing how to deal with something when it crops up in the moment. (Participant 5).</p> <p>We have learnt skills but we need more practice with them. (Participant 2).</p>

		<p>Suggestions and strategies have been discussed as part of a case but because you don't use it straight away. It would be great to hone in on them and actually make them practical in situations. (Participant 2).</p> <p>Having strategies and tools in a folder so we can go to it. (Participant 1).</p> <p>I thought the strategy was brilliant but I haven't used it and its thinking about how to apply it. (Participant 2).</p>
	Change in format	<p>It might be that we have to do things differently because we have learnt a lot but we a learning less with the same format. (Participant 2).</p> <p>We need to identify what we need maybe in a different format. (Participant 2).</p> <p>Meetings need to evolve. (Participant 1).</p> <p>Sessions that are more topic-specific rather than case-specific. (Participant 3).</p> <p>We are at a point where we need more tools. (Participant 2).</p>
	More psychology	<p>We need a psychologist in the team. (Participant 1).</p> <p>(psychology) Could see patients. (Participant 2).</p> <p>Would be useful to have psychology input more intensively, as you learn a lot more from seeing somebody working. (Participant 2).</p> <p>Provides a link to do the bit we don't have time for that takes up a lot of our time. (Participant 5).</p>



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		<p>The gap is that we have not been fortunate enough to have a role model with patients because we don't seem them being treated by psychology. (Participant 2).</p> <p>More psychology would complement what we do and promote MDT working. (Participant 5).</p> <p>It would be better for the patient to have more psychology input. (Participant 2).</p> <p>When we do cognitive assessments and I compare to a psychologists it is just in so much more detail and I think we need a psychologist. (Participant 1).</p>
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