POLICY

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change

Implementing Recovery

A methodology for organisational change

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"If adopted successfully and comprehensively, the concept of recovery could transform mental health services and unlock the potential of thousands of people experiencing mental distress. Services should be designed to support this directly and professionals should be trained to help people to reach a better quality of life. This will mean substantial change for many organisations and individuals."

Future Vision Coalition (July 2009)

Introduction

'Recovery' is a word commonly used by people with mental health problems to describe their struggles to live meaningful and satisfying lives. The principles of recovery now provide a conceptual framework to underpin developments in mental health services in a number of countries (Australia, New Zealand, Ireland and USA). In England, they figure prominently in the recent policy document *New Horizons* (Department of Health, 2009) and have received widespread support from the major professional bodies. Although these principles do not constitute a new form of *treatment* that can be applied to people to make them 'recover', we believe that mental health services will continue to play a central role in supporting – or impeding – people in their personal recovery journeys. This paper presents a practical methodology to help mental health services and their local partners become more 'recovery-oriented' in their organisation and practices, and thereby to support these processes more effectively.

It is the third in a series arising from the Sainsbury Centre for Mental Health recovery project. The first paper, *Making Recovery a Reality* (Shepherd *et al*., 2008) provided a summary of the key principles and their implications for practitioners. The subsequent position paper, *Implementing Recovery: A new framework for organisational change* (Sainsbury Centre, 2009) presented a framework for organisational change consisting of 10 key challenges that need to be addressed by mental health services if they are to move towards becoming more recovery-oriented (see Box 1). It was developed from a series of workshops held in five mental health trusts which identified the ways in which recovery principles could best be incorporated into routine practice. The workshops were attended by more than 300 health and social care professionals, managers and representatives from local independent organisations. They also had extensive input from service users and carers.

All the NHS trusts involved in the workshops had made serious efforts to develop more recovery-oriented services and had commitment from their senior management, up to Board level, to do so. However, it was clear that there was no single overall approach and no one, unique model of a comprehensive recovery-oriented service. The key organisational challenges identified in the workshops thus provide a starting point to assist in the development of comprehensive and consistent services: they are not a 'blueprint' for achievement. The task is now to explore exactly how this organisational change agenda can best be addressed.

Box 1: 10 Key organisational challenges

1) Changing the nature of day-to-day interactions and the quality of experience
2) Delivering comprehensive, user-led education and training programmes
3) Establishing a 'Recovery Education Unit' to drive the programmes forward
4) Ensuring organisational commitment, creating the 'culture'. The importance of leadership
5) Increasing 'personalisation' and choice
6) Changing the way we approach risk assessment and management
7) Redefining user involvement
8) Transforming the workforce
9) Supporting staff in their recovery journey
10) Increasing opportunities for building a life 'beyond illness'

(from *Implementing Recovery: A new framework for organisational change*, Sainsbury Centre, 2009).

This paper presents a methodological approach to address these challenges. It can be applied both by local mental health providers (statutory and non-statutory) *and* by health and social care commissioners. Mental health trusts (and other providers) may use it as part of a focused, self-assessment process; alternatively, it can be used to facilitate discussions between local service providers and commissioners in their joint attempts to make progress towards more recovery-oriented services. We believe that it provides an innovative starting point for a truly 'person-centred' approach to service delivery.

While recognising that what we are addressing here are complex matters of organisational change, we aim to describe the challenges and the processes involved in a clear, user-friendly form. In doing so, we also hope to provide a common language which will help providers to assess their progress towards more recovery-oriented services and help commissioners and providers to work together to 'co-produce' system change. This is at the heart of the commissioning guidance recently issued by the National Mental Health Development Unit, (NMHDU/NHS Commissioning Support for London, 2009).

Developing the methodology

The methodology was developed by a group of commissioners and service providers, including representatives from statutory and non-statutory organisations and with contributions from the Recovery Centre at the University of Hertfordshire. The initial work was also discussed with a wider group of regional commissioners in the East of England. The project group focused on 'service level' outcomes, differentiating these from 'individual level' outcomes which may be used for assessing personal recovery, such as the Recovery Star (Mental Health Providers Forum, 2008).

At an organisational level there are already a number of instruments and approaches available which attempt to measure 'recovery-orientation'. These include the Developing Recovery Enhancing Environments Measure (DREEM) (Ridgeway & Press, 2004); the Recovery Self Assessment (RSA) tool (O'Connell *et al.*, 2005); the Scottish Recovery Indicator (Scottish Recovery Network, 2009); and the Recovery Promotion Fidelity Scale (RPFS) (Armstrong & Steffen, 2009). These instruments are all useful in their own ways, but they are often very laborious and time consuming to use (Dinniss *et al.*, 2007). Some also simply describe *general* good practice, rather than being *specifically* related to recovery principles; others have problems with cross-cultural generalisation of items. None have been specifically designed and developed for use in an English context (the Scottish Recovery Network comes closest). Hence, there is a need for a new instrument which can be used either as a self-assessment tool, or as part of a commissioner/provider dialogue.

Views of commissioners

In our discussions with commissioners it was clear that many were interested in simple metrics that could be used to 'score' the recovery orientation of a local service and 'benchmark' it against comparators. While this is understandable, it poses considerable problems for a set of principles which are difficult to define unambiguously and have complicated implications for processes and practice. Overly simplified descriptions are therefore not just difficult, they may also be misleading and may even hamper innovation and development.

Some commissioners viewed the sheer volume of international literature and the bewildering variety of existing instruments to assess organisational and individual progress towards recovery as barriers to organisational change. Others wanted to adopt a 'pick and mix' approach, selecting outcome indicators and measures that seemed to fit with local circumstances and practicability. Again, this underlined the need to develop an approach which was comprehensive, but still as simple as possible, and relevant to local services.

In the current climate of economic and fiscal uncertainty, commissioners (and providers) were also understandably preoccupied with the prospects of facing a future reduction of budgets and the need to improve effectiveness without increasing cost (Royal College of Psychiatrists, NHS Confederation Mental Health Network & London School of Economics and Political Science, 2009). We therefore wanted to ensure that recovery-oriented services were not seen as relevant only in the 'good times'

and so the majority of the implications for service change implied by the framework are cost neutral. They depend on changing the *ways* in which things are done, rather than on an injection of new resources. Some even have the potential to result in cost savings in the longer-term; for example, through reduced service use consequent upon higher rates of employment, or reduced staffing budgets resulting from the suggested changes to the professional skill-mix of the workforce.

Many commissioners also expressed an interest in using some of the levers of recent health system reform to drive the performance of providers towards more recovery-oriented delivery. These included:

- The new, standard, national Mental Health Contract (Department of Health, 2010);
- Considering how recovery-oriented practice can be costed and incentivised within the development of a national system for mental health service Payment by Results (PbR);
- Combining individual level recovery outcomes with service level change in a new kind of commissioning cycle (as in NMHDU/ NHS Commissioning Support for London, 2009);
- Incorporating a core set of indicators from other tools/measures such as the National Social Inclusion Programme indicator set (National Social Inclusion Programme, 2009);
- Using *Commissioning for Quality and Innovation* (CQUIN) to deliver recovery-oriented quality improvements (Department of Health, 2008).

Many of these initiatives may prove useful in the long term, although it will take some time before most of them are established and bedded in (for example, the new tariff for mental health services is not now expected until 2013/14). In the meantime, the range of issues highlighted here clearly demonstrate that commissioning mental health services in this country is currently in a complex and rapidly changing state. We therefore wanted to develop a tool which was of immediate practical value to providers and commissioners and to other local stakeholders – including service users and their families – and could help them in terms of delivering more recovery-oriented services *now*.

After the framework has been modified and revised through field-testing, we hope that it may inform the development of a set of standards for regulators such as the Care Quality Commission to clarify their expectations regarding the development of recovery-oriented services. This would give the necessary 'top-down' incentives for organisational change, in addition to the essentially 'bottom-up' approach described here. Both are necessary for widespread and consistent effects.

How to use the methodology

The methodology is specifically relevant to an English mental health service context, although we believe it will also be of interest to planners and service developers in other countries. Our intention is that it should be clear, systematic and not unnecessarily bureaucratic or time-consuming. We have taken a 'systems approach' to service change which aims explicitly to include all the local stakeholders in the mental health 'system' – the main NHS provider, local independent sector providers, commissioners, service users and carers. The eventual value of local systems in supporting people with mental health problems to 'recover' and live their lives as they wish will ultimately depend on the quality of partnership working between these different agencies.

The methodology helps those using it to develop an understanding of the key ideas (the 'vision') behind what constitutes recovery-oriented services for the local area, before moving on to develop a strategy for creating the necessary change to implement these services and agreeing specific targets and precise measurements. Progress is then monitored and reviewed, plans are revised, new plans formulated, implemented, further monitored, reviewed and revised. This form of internal audit loop (or 'Plan-Do-Study-Act' cycle) is recommended as the most effective process for producing sustained organisational change (Iles & Sutherland, 2001).

Assessing services at the outset

We suggest that the methodology is used in a two phase process carried out jointly between providers (or providers and commissioners) and their local stakeholders. In the first part of the process the stakeholders try to get to grips with the complexities of the ideas underlying each challenge. They then assess the level of

progression of the main mental health provider using a simple, three point classification: 'Stage 1 = Engagement', 'Stage 2 = Development' and 'Stage 3 = Transformation' (see Box 2 and the Framework on pages 8-19). This assessment provides a summary of the current situation and could be used for 'benchmarking' purposes, although its primary purpose is to develop a joint understanding of the concepts and their implications for organisational change. Providers and other local stakeholders should draw on their different perspectives to come to a shared consensus regarding the stage of development they have achieved. This can then be recorded in Template A (see page 18).

Having completed this general assessment, stakeholders then move to the second part of the process. In this they jointly agree the priorities for organisational change. They will need to prioritise action in a small number of areas and agree a small number of **SMART** (**S**pecific, **M**easurable, **A**greed-upon, **R**ealistic, **T**ime-based) goals to define the targets and monitor progress. Once the goals are set, they will be implemented, progress will be monitored and the goals will be reset and then further monitored in an iterative cycle.

Agreeing priorities for action

It is clear that each of the 10 key organisational challenges presents a potentially substantial agenda for change. Together they open up opportunities to transform services in ways that are much more consistent with the priorities of service users and their families, but they imply a lot of work. We accept that it is unlikely (and unrealistic) that all the 10 challenges can be addressed immediately. An organisational change strategy will need to be implemented over a number of years and the number of priorities agreed at any one time should be limited to a realistic number (say not more than five at any one time). The 10 key challenges are not listed in priority order and we have no specific views about the choice of where to start. Clearly all local services are different and all will start from a different point. Nevertheless, it would seem sensible to acknowledge existing strengths and to build on areas of relative weakness.

Based on our experience in working with trusts and other agencies that are committed to developing recovery-oriented services, our

Box 2: Definitions for the three stage classification

Stage 1: Engagement

The organisation is clearly engaged in its intent to deliver recovery-oriented services. At a Board level there is an acknowledgement and ownership that the organisation needs to change towards more recovery-oriented services. There is an awareness of existing good areas of practice and the commitment to build on these. Plans to deliver recovery-oriented services have been agreed and a timetable for implementation is in place, but there has been little progress as yet. We envisage that most trusts will start at this level on most dimensions.

Stage 2: Development

Action is being taken with some evidence of significant developments in practice, policy and culture. Good progress is being made in delivering recovery-oriented services in some areas, but this is not consistent throughout the organisation. We envisage that some of the more advanced trusts will be rated at this level for at least some of the dimensions.

Stage 3: Transformation

The vision for achieving significant change has been fully realised. The necessary policy, processes and practice to deliver a recovery-oriented service are embedded at every level of the organisation – from Boards to teams and front line workers. There are processes in place to achieve continuous improvements based on learning from ongoing review. The organisation works proactively with a range of other partners in supporting positive mental health and wellbeing. We envisage that this level will be aspirational for most trusts on most dimensions.

impression is that two particularly important challenges should be considered early on. These are Challenges '3' and '4'. Without addressing Organisational Challenge 3 (*Establishing a Recovery Education Centre*) there will be no focus for delivering the training programmes for staff and users which are necessary to drive the organisation forwards. Without addressing Organisational Challenge 4 (*Ensuring organisational commitment*) the training initiatives are likely to have only limited impact. Leadership and organisational commitment are always important in any kind of organisational change process and moving towards more recovery-oriented services is no exception (Whitley *et al.*, 2009).

Tracking progress

Once there is agreement about the service level goals to be achieved and a clear description of the actions, timescales and responsibilities for achieving them, progress can be tracked using a simple form such as that suggested in Template B (see page 19).

To assist with setting and monitoring specific targets, we have shown examples of service level indicators and potential data sources for each of the organisational challenges. These examples are intended to be illustrative rather than prescriptive and alternative indicators may be substituted or added if they reflect better the chosen targets. Providers and commissioners should determine locally which indicators they are going to use and how ambitious the targets will be. This gives them maximum flexibility, within a clear and comprehensive framework. Other recent publications such as the National Social Inclusion Programme service outcomes and indicators may also be helpful (National Social Inclusion Programme, 2009).

Future developments

The profile of recovery and discussions about how to implement recovery ideas within mental health services have gathered considerable momentum in recent years. Positive changes are taking place in many areas of organisational practice and service delivery. In this context of emerging developments, we would not expect any 'gold standards' of best practice identified early in 2010 necessarily still to be relevant in five years' time. Indeed, if this work contributes to a genuine transformation agenda, it would be a positive outcome if much of it appeared distinctly dated by 2015.

In developing the methodology, some people have suggested that we should specify minimum standards in much greater detail and develop a tool more like an International Organisation for Standardisation (ISO) accreditation scheme (see www.iso.org) whereby standards can be externally validated and benchmarked across organisations. While this remains an option for the future, we believe that it is not the best way to proceed at this time as the development of these types of standards may be too limited and formulaic. It also runs the risk of locking local providers and commissioners into a rigid view of what must be essentially innovative developments.

The methodology attempts to describe a constructive process of 'co-production' between local providers and commissioners, in partnership with service users and carers, which aims to transform services through the development of the jointly agreed, key areas of recovery-oriented practice. The key element driving this transformation will therefore be the joint work of local systems, setting priorities, agreeing goals and contracts and then moving the process forward. This is what we must maintain if *World Class Commissioning* in mental health is to be achieved.

Sainsbury Centre, the NMHDU and the NHS Confederation will now 'field test' the methodology with a number of commissioners and providers as part of the actions contained in the *New Horizons* programme (Department of Health, 2009, p.56, Action 79). We will revise and modify the methodology in the light of that experience. Future developments and updates will be posted on the Sainsbury Centre website www.scmh.org.uk.

Framework and templates

The following pages present the Framework for each of the 10 key organisational challenges. This is followed by templates to help organisations to identify their priorities.

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ORGANISATIONAL CHALLENGE 1: Changing the nature of day-to-day interactions and the quality of experience

"We are not cases and you are not our managers!" Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

There is a recognition that recovery principles and values are important, but few systematic attempts have been made to implement them by changing staff behaviour. Staff (and service users and carers) are familiar with the general principles, but unclear about their implications for practice. Users are not generally consulted regarding the quality of services delivered and staff performance.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

There is clear evidence of a recognition that every significant encounter by every member of staff should reflect recovery principles and promote recovery values – aiming to increase self-control ('agency'), increase opportunities for life 'beyond illness', and validate hope. Some attempts have been made to ensure that these principles are reflected in practice, (e.g. pilots to involve service users and staff selection and/or evaluation) but these are not reflected in routine staff supervision. Some user involvement in staff selection, but not routine.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

Every significant encounter by every member of staff aims to reflect recovery principles and promotes recovery values – increasing self-control ('agency'), increasing opportunities for life 'beyond illness', and validating hope. Each interaction acknowledges non-professional expertise and attempts to minimise power differentials. There have been systematic attempts to ensure that these principles are reflected in day-to-day practice (e.g. local audits, use of National Patient Survey data, etc.). The importance of the quality of staff/user interactions has been incorporated into staff supervision and performance ratings. Users are routinely involved in staff selection. Human resource (HR) policies validate recovery training and link this to opportunities for staff progression.

Examples of (service level) outcome indicators

- Proportion of staff trained in basic recovery-oriented practice;
- Adoption of Sainsbury Centre's 'Ten Top Tips for Recovery-Oriented Practice' into operational policy and practice;
- Systematic surveys of user (and carer) perceptions of staff behaviour in relation to recovery principles (e.g. using modified questions from the National Patient Survey);
- Supervision and appraisal systems are revised to promote staff interactions that demonstrate partnership working with service users;
- Proportion of instances of service users being involved in staff selection.

Possible data sources

- National Patient Survey data, or similar local projects;
- Systematic survey of user (and carer) views regarding the quality of day-to-day interactions with staff and the extent to which these reflect recovery principles and values;
- Records of composition of interview panels;
- Audit of staff appraisals/supervision.

ORGANISATIONAL CHALLENGE 2: Delivering comprehensive user-led education and training programmes

"I've got into various groups, as an advocate and a representative for service users, and I found that extremely beneficial ... made you feel less isolated and that you can help others. The most help I got was from the other people in the ward who had gone through similar experiences." Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

There is a commitment to increasing the coverage of user-led teaching and training on recovery, but it remains patchy. Some training has taken place, but less than 25% of staff have been involved. There have been few attempts to embed learning from recovery stories into practice.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

A range of evidence confirms the increased profile of user- and carer-led training on recovery, supported by an agreed strategy and policy. Approximately 50% of staff have received training in recovery principles formulated and led by service users (and carers). There is some evaluation of the effects of training, but this is not done systematically. The further development of user (and carer) led training has Board approval and funding is being sought.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

A cohort of trained service users are in place acting as 'champions of change' for recovery within the organisation. Service users are acknowledged as equal partners within a comprehensive range of recovery education and training programmes and a programme of user-led training in recovery has secure funding. Users and carers are contractually engaged in the organisation to deliver training to staff on recovery principles. More than 75% of staff have received training. There is a continuous programme of evaluation and audit to measure the impact of this training and teaching standards. Positive practice changes are routinely implemented as a result of the training.

Examples of (service level) outcome indicators

- A cohort of user and carer trainers has been established and users and carers are both formulating and delivering programmes;
- A directory of accredited user and carer trainers is in place;
- Ongoing funding identified for rolling programmes of user-led training and education;
- Modular training being planned to ensure sustainability.

Possible data sources

- Systematic audit and evaluation to establish the impact of user and carer teaching and training;
- Evaluation routinely gathered at training and teaching events, an analysis of which is available in report form;
- A directory of accredited user and carer trainers;
- Protocols to demonstrate involvement at all phases of training and teaching.

ORGANISATIONAL CHALLENGE 3: Establishing a 'Recovery Education Centre' to drive the programmes forward

"The coaching programme has helped me to identify my aspirations, prioritise my goals and realise what I can realistically achieve. Before this I had never been so enthusiastic and optimistic about the future." Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

There is a recognition that current attempts to involve and support service users to deliver training on recovery have been conducted on an *ad hoc* basis. It is agreed that there needs to be a more strategic approach, but little progress has been made in developing this, or considering how it will be delivered 'on the ground'. There have been discussions about centralising training and working in partnership with user-led training groups, but these have not been finalised.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

There are plans to take a more systematic approach to support service users in the delivery of recovery training to staff. Formal contracts are being considered (e.g. with a local independent sector provider) to provide this function and there are plans to build on this model. A review of existing service user-led programmes has been undertaken with a view to refocusing these into a hub for promoting recovery-oriented practice across the organisation.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

A 'Recovery Education Centre' has been established within the organisation. This is staffed and run by 'user trainers' and delivers support and training for service users to train staff in recovery principles for teams and on wards. (It may or may not be delivered by an external, independent sector user/trainer organisation.) The Centre also runs programmes to train service users as 'peer professionals' to work alongside traditional mental health professionals as direct care staff. Arrangements for the management, supervision and support of these staff are co-ordinated by the Centre staff. The Centre offers courses to service users, their families and carers on recovery and the possibilities of self-management. There are a range of links to general educational classes in the community and pathways to courses and other learning opportunities.

Examples of (service level) outcome indicators

- Establishment of 'Recovery Education Centre', with stable funding, employing at least 3-4 user trainers;
- Competencies, standards and support identified for peer support workers;
- 'Recovery Education Centre' active in training and supporting 50 service users each year as peer professionals within the service (and other local services, statutory and independent);
- Employment of multiple peer professionals within existing teams (including inpatient wards).

Possible data sources

- Records of 'Recovery Education Centre' training programmes delivered, curriculum, numbers of staff/service users trained or supported;
- Audit of staff and service users on satisfaction of programmes delivered by the centre;
- Evidence of partnership agreements with external bodies such as university departments, colleges etc.;
- Numbers of peer-led training courses run;
- Number of peer specialists trained to agreed standards and competencies.

ORGANISATIONAL CHALLENGE 4: Ensuring organisational commitment, creating the 'culture'. The importance of leadership

"We are committed to services that build on the individual's inner resilience and coping strategies and not on interventions that undermine or stifle these innate qualities of hope and potential."
Trust Mission statement

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

There is recognition throughout the organisation that the culture needs to change from a 'problem-based' approach (focus on illness and symptoms) to a 'strengths-based' approach. Plans are in place to review internal 'pathways' (referral systems, assessments, care programme approach (CPA), discharge planning, etc.) to make them more recovery-oriented, but little progress has been made. There are committed individuals leading the implementation of recovery principles, but they are isolated and only operating at a team level, or at senior level, not both.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

The Board has endorsed a Recovery Strategy, including core underpinning principles and values. This is reflected in the wording of external and internal publications. The organisation is active at all levels communicating its recovery approach. There is evidence of Board workshops, staff presentations and training programmes. Recovery forums have been established in partnership with service users. Some internal 'pathways' (referral systems, assessments, CPA, discharge planning, etc.) have been reorganised, with user involvement, so as to support recovery processes. Whilst there are a number of recovery initiatives, it is recognised that cultural change has not yet occurred at all levels and in all parts of the organisation. Monitoring recovery practice does not appear in staff supervision.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

Recovery concepts are evident at all levels of the organisation. There is strong leadership and action at Board level to ensure that this is reflected through all levels of management and by front line staff. There is recognition of the need to develop partnership working with service users so that professional expertise does not dominate over the wisdom of 'lived experience'. The service promotes an environment of hope and optimism that recognises the uniqueness and strengths of each individual. Recovery values are embedded in every operational policy, management process including recruitment, supervision, appraisal and audit. All key internal 'pathways' (referral systems, assessments, CPA, discharge planning, etc.) have been reorganised, with user collaboration, so as to better support recovery processes.

Examples of (service level) outcome indicators

- Policies and procedures demonstrate organisational commitment;
- Evidence that internal 'pathways' have been reviewed, in collaboration with service users, and redesigned so as to better support recovery processes;
- Recording of care processes reflect shift in cultural approach towards strengths-based approach;
- The organisation has established routine audit of service user experience and satisfaction and follows through on feedback received;
- Routine use of individual recovery outcome measures.

Possible data sources

- National and local surveys of service users;
- Audit of locally agreed staff performance indicators with desired outcomes identified by service users and carers;
- Recruitment practices reflect willingness to appoint staff with a history of 'lived experience' (see Organisational Challenge 8);
- Revised policies for risk assessment and management;
- Internal and external communications and publications reflect recovery values;
- Case records (for recovery outcome measures).

ORGANISATIONAL CHALLENGE 5: Increasing personalisation and choice

"I now feel in the driving seat for my life and wellbeing." Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

There is recognition that traditional care planning must be changed to give a much greater emphasis to users' priorities and the achievement of 'life goals', but this is not actively monitored. There is some use of instruments, such as the Wellness Recovery Action Plan (WRAP), but these are not generally used. There have been some attempts to increase the use of 'personal budgets', but this is not widespread.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

There is a growing move towards greater personalisation and choice in terms of treatment and management options. New policies reflect a revised approach to shared decision making and joint planning. There is evidence that more than 50% of users feel actively involved in directing their CPA process and determining the content of their care plan. The organisation has produced a range of information and interventions to support self-management approaches. There has been a substantial increase in the uptake of direct payments and the use of personal budgets. There has also been a significant expansion in the use of jointly agreed 'advance directives' (e.g. joint crisis plans). Attempts are being made to incorporate WRAP objectives into care plans.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

The planning and delivery of all services is designed to address the unique circumstances, history, needs, expressed preferences and capabilities of each service user. There is a clear emphasis on 'life goals' as opposed to symptom treatment goals. Users are routinely supported to control and direct their own care plans, at a level they are comfortable with. More than 75% feel consulted and involved. Organisational policies affirm that service users should direct their own care process. If necessary they are given support to do so (e.g. advocacy). WRAP and joint crisis plans are in routine use. There is continuous evaluation to measure organisational commitment to personalisation and choice.

Examples of (service level) outcome indicators

- Evidence that all care pathways have been reviewed to identify points for choices to be exercised and for shared decision making e.g. treatment options, medication, choice of clinician;
- Availability of advocacy services;
- Progress towards agreed targets for personal budgets;
- Dedicated posts are established to assist with the 'personalisation agenda', e.g. 'brokers' (for individual budgets), advocates, etc.;
- Published information is available to assist service users to make informed choices about treatment options (medical, psychological and social);
- Policies are revised to stress personalisation in care planning and the encouragement of self-management;
- Clinical governance structures include promotion of personalisation and choice as standing items.

Possible data sources

- Data regarding the uptake of 'individual budgets' (numbers and amount of variation);
- Numbers receiving advocacy services;
- Organisational policies and procedures relevant to choice and personalisation;
- Service user surveys (e.g. National Patient Survey) focusing on the extent to which choice, agency and control are experienced;
- Information leaflets;
- Content of training courses which demonstrates a focus on personalisation.

ORGANISATIONAL CHALLENGE 6: Changing the way we approach risk assessment and management

"The possibility of risk is an inevitable consequence of empowered people taking decisions about their own lives." Department of Health

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

The organisation is aware of the value of systems and procedures that support open, transparent risk assessment and management policies within a recovery framework. Some staff are conversant with this approach and some attempts are made to involve service users in the process, but it is 'patchy' (less than 25% of staff involved). There is ambivalence about the value of 'positive' risk taking and this has not been addressed at a Board/general policy level. Staff remain preoccupied with risk as a staff issue alone.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

There is a recognition of the need for safety while actively promoting 'positive' risk taking. The organisation has introduced formal procedures that support open, transparent risk assessment and management policies within a recovery framework, but these have not been implemented throughout the organisation. These issues have been discussed at Board level, but no clear policies have resulted. Some staff training has been undertaken and around 50% of staff are implementing policies to involve service users in their own risk assessment.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

The organisation has in place systems and procedures that support open, transparent risk assessments and management policies within a recovery framework. The process routinely involves service users and their knowledge of themselves to formulate safe and effective management plans. All staff are fully conversant with this approach to risk assessment and management and are comfortable with it. There is a clear commitment on the part of the organisation as a whole to value 'positive' risk taking and a willingness to examine and learn from incidents and support staff, rather than 'blame' them if untoward incidents do occur. This has been made explicit to staff by the Board and has been reflected in action. The organisation has successfully reconciled the need to balance its duty of care to provide safe services while promoting a positive approach to risk assessment and management.

Examples of (service level) outcome indicators

- Staff have received training in the application of recovery principles to risk assessment and management and this is built into all inductions;
- Risk assessment and management procedures (e.g. CPA) contain a clear expectation that service users will be routinely involved in these processes and this is systematically audited;
- Training in the use of 'Joint Wellbeing Plans' has been delivered and these have been incorporated into routine practice;
- The organisation routinely examines serious and untoward incident reports with a view to 'learning the lessons' rather than apportioning blame;
- Risk management policies reflect a shift towards supporting positive risk taking, while ensuring appropriate corporate governance and adherence to safe practice and regulatory requirements.

Possible data sources

- Staff training records;
- CPA audit results;
- Clinical governance records;
- Board policies.

ORGANISATIONAL CHALLENGE 7: Redefining service user involvement

"*Nothing about us without us*" Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

The organisation has accepted that service users (and carers) should play an important part in the planning and delivery of care, but it is still apparent that the final decisions remain with the 'professionals'. There is some evidence of systematic changes to enhance the role of users and carers as partners in care, but their knowledge and expertise is still seen as secondary, rather than primary. The principles of 'user involvement' are accepted, but this is not reflected in true 'partnership working'.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

The organisation has accepted the role of service users (and carers) as equal partners in care. A Board-level policy on user involvement at all levels in the organisation from clinical care to strategic planning has been agreed and is being implemented. This acknowledgement of the central contribution of users and carers is reflected in policies and procedures governing the delivery of individual care and the work of teams. Approx. 50% of staff understand how to adapt their role to be 'educators' ('coaches') and 'mentors', rather than traditional 'therapists'.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

The organisation has clearly accepted the role of service users (and carers) as equal partners in care. It recognises that their knowledge and experience is vital ('experts by experience') and that they – and their networks – may have solutions to many of the problems that staff find most difficult. This acknowledgement of the need for partnership is clearly reflected in policy and practice at all levels – individual practitioners, teams and managers. All staff understand how to deliver their expertise in the context of more equal 'partnerships in care' and they are comfortable with their new position ('*on tap, not on top*'). The organisation is continually reviewing its processes for partnership working with service users and continually 'raising the bar' in terms of extending the role of service users in controlling the care process. This not seen as an abnegation of professional responsibilities, nor a downgrading of professional expertise, instead it is seen as a higher form of professional practice.

Examples of (service level) outcome indicators

- Service users (and carers) report that they feel consulted as full 'partners in care'. They report a style of working where staff share their expertise and experience, rather than commanding attention;
- The language of 'partnership' is used consistently in written materials produced by the organisation to describe the processes of care and service delivery;
- Service users and carers have signed care plans to confirm that they have been involved in the process of care planning at an individual level;
- Robust plans are in place to ensure that service users and carers are fully involved in service planning and governance structures.

Possible data sources

- Staff training records;
- National Patient Survey data, or similar local surveys;
- Informal feedback from individuals (e.g. Patient Governors);
- Board policies and minutes, newsletters, press releases, etc.;
- Audit of care plans;
- Patient Council reports, Board reports, notes of Local Involvement Networks (LINks) meetings.

ORGANISATIONAL CHALLENGE 8: Transforming the workforce

"When my last worker met with me I was left with a feeling of hopelessness, it was all about my symptoms. When I see you we talk together about what I want for my future and I am full of optimism." Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

The Board and senior managers have recognised that transforming the workforce may require a change in the skill mix and balance between traditional mental health professionals and people whose expertise comes from 'lived experience'. There are examples of staff with 'lived experience' being employed in care-giving roles, e.g. Support Time and Recovery (STR) workers, but these are isolated, with little managerial support and supervision. Human resource (HR) and occupational health services have not been reformed and no thought has been given to issues of 'career progression' for peer staff.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

The trust has clear plans in place that will lead to the creation of 'peer specialist' roles across the organisation. These plans include clear job descriptions, identification of training resources, supervision and management responsibilities, strategies for placement in teams, timescales for completion, etc. A small number of service users have been appointed into paid positions in the workforce, but on a limited scale (e.g. 5-10 posts scattered through the organisation). Plans are in place for pilots which will provide more intensive input (e.g. at least two service users per team) with appropriate managerial support. Issues regarding career progression for peer specialists have been discussed. The trust has begun to address the specific HR and occupational health problems associated with the recruitment of greater numbers of people with direct experience of mental health problems into the workforce.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

The organisation has fully accepted that people who have direct experience of living with mental illness can, with appropriate training and support, make a significant contribution to the workforce. Most teams have an equal number of peer professionals working alongside other professionals. Peer specialists are seen as having unique qualifications and experience which is different from, but equal to, those of traditional mental health professionals. They are therefore paid and given status according to their experience and expertise in delivering this role. HR processes and occupational health assessments have been adjusted so as not to provide obstacles to the employment of people with mental health problems (as required by the Disability Discrimination Act [DDA] and the targets under Public Service Agreement [PSA] 16). Clear arrangements for supervision and career progression are in place.

Examples of (service level) outcome indicators

- Clear identification of responsibility for delivering training and support for peer professionals (e.g. partnership agreement with external specialist provider);
- Clear job descriptions and person specifications agreed for peer professionals;
- Peer specialists to be the first point of contact wherever possible at each stage of care pathway;
- Number of staff employed as 'peer specialists';
- Numbers of people with mental health problems employed in the current workforce (PSA 16 targets) regularly monitored.

Possible data sources

- Revised HR, occupational health and Criminal Records Board (CRB) policies eliminating barriers to employment;
- Staffing records;
- HR data on skill mix and trends;
- Recruitment data recorded for DDA.

ORGANISATIONAL CHALLENGE 9: Supporting staff in their recovery journey

"Hear what I have to say and support me to do it" Staff member

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

There is awareness that many staff have their own experiences of living with mental illness and of recovery, but this remains largely unacknowledged and they are not encouraged to use these experiences to inform their work practice. There is still considerable stigma among staff regarding revealing mental health problems and this has not been addressed privately, or in the context of recovery training. Staff have been given little help in thinking about how to develop different ways of delivering their expertise.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

The organisation recognises the need to support staff in the disclosure of their own lived experience of mental health problems and this is included as an optional part of recovery training. The organisation recognises the need to ensure that there are opportunities within individual supervision to address these issues. The organisation is developing a shared approach with staff to deliver its vision regarding recovery. Staff generally report feeling included in this process and can see a clear way forward.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

Staff do not fear stigma or prejudice from colleagues in the workplace if they reveal their personal experience of living with mental illness in an appropriate setting. All staff have received appropriate induction and training and have been supported to help them use their personal knowledge and experience to help others and to optimise their own wellbeing. The organisation has in place comprehensive provisions to optimise staff health and to constructively address staff health problems (e.g. augmented occupational health services). The personal qualities and prior experience of staff are valued and included as selection criteria. The organisation formally recognises the commitment and creativity of staff and fully involves them in the implementation of the recovery vision.

Examples of (service level) outcome indicators

- Comprehensive policy and practice developments reflecting the need to optimise staff mental health, e.g. programmes to support staff in personal self-care and self-management;
- Anonymous staff satisfaction surveys, with evidence that results are acted upon;
- Recruitment practices have been amended so as to positively reflect the value of lived experience among staff, as well as formal qualifications;
- There is Board-level commitment to the principles of Mindful Employer (www.mindfulemployer.net).

Possible data sources

- Board strategy papers, evidence of routine reports on staff wellbeing;
- HR and occupational health policies;
- Staff sickness level returns;
- Staff morale surveys;
- Staff sickness/turnover rates;
- Staff survey returns.

ORGANISATIONAL CHALLENGE 10: Increasing opportunities for building a life 'beyond illness'

"I am no longer my illness." Service user

Stage 1: Engagement

A commitment to implement recovery is in place, with some plans agreed on how to do so

The organisation has an inter-agency strategy to promote social inclusion, but little concrete progress has been made. The organisation is reviewing (or has reviewed) with service users and carers what needs to be in place in the community to support recovery. Some effective partnerships do exist with independent sector providers (housing, employment, education, etc.) but this is patchy. Similarly, some work has been done to reduce stigma in the community, but this is relatively unfocused and too general to have specific impact. Evidence-based, supported employment (Individual Placement and Support, IPS) is not widely available.

Stage 2: Development

Action is being taken, with some evidence of significant changes in practice, policy and culture

The organisation has in place a strategy for the development of 'mainstream' community support (including housing, employment, leisure and mental health promotion) and good progress has been made regarding implementation. The organisation has effective partnerships in place to provide improved access to paid employment. It has begun to appoint IPS-trained employment specialists to some teams. Operational policies have been revised to promote community integration on discharge from inpatient care. All service users have an agreed plan that they and their carers feel is safe and will sustain their recovery. Work has been done to reduce stigma and discrimination among certain key agencies (e.g. housing, employers, police and neighbourhoods). These projects have been led by suitably trained service users.

Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

The organisation recognises that full citizenship and community integration is essential in promoting individual recovery. It has developed a range of effective partnerships with external organisations to support individuals in building a life for themselves independent of formal mental health services. There is a focus on promoting settled accommodation; maintaining and developing relationships; paid employment and training; and full inclusion in ordinary community activities. Peer support networks have been developed to sustain community inclusion. There is a particular emphasis on the importance of paid employment and IPS workers have been established in all teams. Issues for promotion of health and wellbeing across diverse cultures have also been addressed. The organisation supports social inclusion through a comprehensive range of targeted anti-stigma work in the communities that it serves. These projects have been led by suitably trained service users and there is active follow-up.

Examples of (service level) outcome indicators

- Partnerships with employment and training specialists are in place;
- Rates of service users attaining and sustaining paid employment are regularly monitored (PSA 16);
- Number of employment specialists trained to deliver Individual Placement and Support (IPS) in each team;
- Number of care plans with adequate assessments of employment needs and appropriate action plans;
- Other Public Service Agreement (PSA) Indicators (e.g. 8, 15 and 21) are also regularly monitored and the results fed in to action plans;
- The organisation routinely audits the effectiveness of discharge plans to sustain recovery;
- Use of National Social Inclusion Programme Indicator set (2009).

Possible data sources

- Key Performance Indicator information on PSA 16 Targets for numbers of people in employment and settled accommodation;
- Service level agreements with employment providers and other partners;
- Discharge rates from services;
- Service user and carer questionnaires regarding satisfaction with discharge arrangements from inpatient care;
- National Social Inclusion Programme Service Outcome Indicators data set (NSIP, 2009).

TEMPLATE A

This form should be completed by the provider organisation's lead for recovery, in collaboration with local stakeholders (service user carer groups, independent sector providers and commissioners) following discussions about the Organisational Challenges (1-10). These discussions should be open and honest and a consensus reached regarding appropriate assignment to each broad level of progress. Each Challenge can be 'scored', but the primary aim is to agree priorities and the starting point for further, more detailed action planning (see Template B).

Organisational Challenge	Stage 1	Stage 2	Stage 3	Priority for action (1-10)	Comments
	(tick ✓ one)				
1. Changing day-to-day interactions					
2. Comprehensive user-led education and training					
3. Establishing a Recovery Education Unit					
4. Ensuring organisational commitment					
5. Increasing choice and 'personalisation'					
6. Changing approaches to risk assessment and management					
7. Redefining user involvement					
8. Transforming the workforce					
9. Supporting staff in their recovery journey					
10. Building a life 'beyond illness'					

TEMPLATE B

This form should be used once Template A has been completed to develop specific action plans in relation to particular Organisational Challenges. Local targets, timescales and evidence sources should be agreed jointly.

ORGANISATIONAL CHALLENGE:
CURRENT STANDARD Stage 1 [ ] Stage 2 [ ] Stage 3 [ ] (Please tick one) Describe:
Local goals (agreed by commissioners and providers) 1. 2. 3. Date:
Specific actions required to make progress on goals before next review 1. 2. 3. Evidence sources: Commissioner name: _____ signature: _____ Provider lead name: _____ signature: _____ Next Review Date: _____

About the authors

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Copies of the following can be downloaded from www.scmh.org.uk

Making Recovery a Reality (2008);
Ten Top Tips for Recovery-Oriented Practice (2008);
Implementing Recovery: A new framework for organisational change. Position Paper (2009).

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