

MENTAL HEALTH AND WELLBEING NETWORKS
DEVON AND TORBAY

REPORT OF THE STANDARDS AND OUTCOMES
PILOT PROJECT 2008/9

Recovery and Independent Living
Professional Expert Group

Advisory paper 4

Commissioned by Devon Primary Care Trust and Devon County Council

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STANDARDS AND OUTCOMES FOR MENTAL HEALTH AND WELLBEING

Summary and recommendations of the pilot project 2008/9

We are participating in a process of transformation for health and social care services towards becoming more person-centred and recovery oriented. How we measure outcomes may have a pivotal role in this whole process of cultural change. Personal services are shifting from a core focus on *'what we do'* to a guiding interest in *'how the person does'* with whom we are working. There is a continuing need to ensure that those who provide services do so to a high quality according to broadly agreed standards (e.g. be 'evidence based') but the present interest extends beyond this to wanting to learn how to enable each individual to become active and self determining in their pursuit of health, wellbeing and recovery and support them in finding a satisfactory life and pattern of living according to their own values. There is far more to getting well than getting a good service – although it can and should help.

A person may use a variety of services and other sources of support so their experience of personal recovery will be an outcome of their unique combination of experiences and commitment. This is well portrayed in recovery stories, which also illustrate that there can be no 'model of recovery' or 'recovery therapy'. One person may experience recovery from taking medication and attending psychotherapy, another by getting a job and finding a partner, another by leaving services altogether.

We are clear that old style measures of symptom change or service usage (clinical recovery) are an insufficient measure of personal recovery. If personal recovery is a personal experience then new measures need to be more personal and **the process of engaging with measures should itself give support to self determination and strengths based self management.** If we become less focused on *'what can I give you?'* and more on *'how are you doing?'* it follows that responses to recovery measures may be as much a commentary on what the person is making of their life as it is on the service they are receiving. ***We therefore not only need new measures but a new framework for interpreting and using the results from such measures.***

Our work to date has identified three key levels for measuring outcomes:

- 1) Individual experience
- 2) Personal evaluation of service performance by the people who use them
- 3) Service evaluation, and validation, against agreed standards

Each tells a different story. Each can comment on particular issues of interest and has advantages and limitations. None can substitute for the other. Taken together they offer a complex and rich picture of people's lives and experiences in relation to services provided to support mental wellbeing and personal recovery. Each informs choice and action at personal, practice and service levels and the responsibility for such action in response to such outcomes may similarly rest at personal, practitioner, service provider or commissioner levels.

The value of these three sets of measures can only be realised if the framework is embedded in routine practice and becomes part of how we work and how we gather information so that we know what we are doing. None offer results that can be read off as a direct commentary on service performance as all are sensitive to circumstances. But they do offer a direction for and marker of progressive cultural change, improved practice and service experience – in particular through validation of whether a service is 'up to (the 10 core) standard(s)'

The aim of this pilot project was to explore processes for measuring:

1. Personal outcomes for recovery and wellbeing.
2. The evaluation of how well services support recovery: by the people who use them.
3. The progress of services towards meeting the 10 core standards for the networks.

1. Measuring personal outcomes for recovery and wellbeing

The pilot project was commissioned following an advisory paper produced by the Recovery and Independent Living Professional Expert Group in 2008. This paper reviewed the outcome measures currently in use or under development. It considered the purpose and application of tools which measure outcomes in terms of changes in symptoms, use of services or social inclusion indicators such as employment, education or housing status. The pilot decided not to use any of the existing tools for measuring outcomes. This was for three main reasons:

- Such tools may tell us if a goal or ‘outcome’ has been achieved but not what impact that has had on the person’s life or if it has improved their wellbeing in their own terms.
- Collecting information through the use of interviews or questionnaires which measure predetermined outcomes for the purpose of service evaluation does not necessarily benefit the individual in their recovery.
- Nor does it support the desired cultural shift towards more recovery supportive relationships which are based on the application of a coaching approach to achieving those things which have meaning and value to the individual.

Instead, the pilot used a ten point self evaluation tool which looks at the areas of life in which we need to feel fulfilled or have our needs met if we are to see ourselves or be considered by others to be well or healthy. The questionnaire is called, and asks the question ‘How well is life working out for you?’ It uses language which reflects the common human experience and is delivered through discussion and conversation.

Intended to	not intended to
Embed reflective conversations into routine practice	Collect data for external use
Promote better discussion on how to proceed according to what is valued by the person	Impose ‘desirable’ outcomes on people where they do not have personal relevance.
Enable people to say if they are getting what they want and need	Make judgements about people’s ongoing need for services
Enable the worker (and the service) to be more fully engaged and attuned with the life experience of the people they are working with - regardless of whether the person is ‘getting better’ or not.	Make judgements about practitioner or service performance
Allow the worker to reflect on their experience and practice in supervision	Create ‘league tables’ of good and bad services
Over time, indicate areas for service review and potential improvement	Be used to make commissioning or employment decisions

The primary purpose of the measure is to be of benefit to the individual and supportive of recovery focused practice but it was encouraging that the data collected and analysed during the pilot also indicated a good degree of reliability and validity.

Feedback from participants and practitioners indicated that the measure was well received and promoted reflection on the progress towards individual outcomes for recovery and wellbeing. Use of the measure in routine practice appeared to have a positive impact on practice by enabling more aware responses by practitioners.

Issues were raised about the comprehensiveness of the questionnaire with many respondents making use of the final questions: *What other important areas of life would you like to include?* and *How well is that going for you?* The project conclusion was that there is merit in having a set of questions which are essentially applicable to all but on which each person can reflect and can discuss according to their personal priorities. There is value in the 'incompleteness' of the measure in that it prompts adaptation - which is consistent with the personalised nature of recovery and self management

The usefulness of the measure as a support for personal recovery and a lever for cultural change was contingent on: a sound understanding of its purpose; its application as a recovery coaching tool; and a sensitive responsiveness to the information disclosed.

The approach taken by the pilot project represents a fundamental shift in our understanding of outcomes measures from that of information collected in the interests of the service (and therefore the collective good) to the ethic of measurement which is of prime interest to the individual. This is a complex transition which will require a significant amount of preparation and training for practitioners, providers and contract managers.

The use of this measure to frame the conversations (and therefore relationships) with people who use services has the potential to act as a powerful tool for 'recovery awareness'. This is likely to be more effective than promoting such awareness through training or educational activities without also changing the underlying nature of support relationships.

Recommendations

- All service specifications should incorporate a requirement to embed the measurement of personal outcomes for recovery and wellbeing into routine practice.
- Commissioners, providers and contract managers should agree an annual cycle of audit which provides evidence that the measurement of personal outcomes is embedded in routine practice.
- How well is life working out for you? should be offered to providers as the default option for such measurement – the use of alternative measures should be carefully monitored to ensure they fulfil the same function
- Providers and contract managers should receive training in the purpose and application of this measure.
- The continuing development of the measure and the learning from wider implementation should be supported and monitored.

2. Evaluating how well services support recovery.

The second essential component of the framework is an evaluation of the experience of services by those that use them. This is a separate function to the measurement of personal outcomes for recovery and wellbeing. The pilot used *Elements of Recovery Facilitating Systems* (ERFS) which is a simplified derivation of the *Developing Recovery Enhancing Environments Measure* (DREEM). This measure of service experience is commonly used in recovery services. ERFS describes the features of a recovery oriented mental health service and captures the person's view of how well the service they use meets that profile. It is designed for use in service evaluation and to stimulate awareness of service strengths and areas for improvement.

Intended to	not intended to
<p>Enable practitioners to reflect on how their support is experienced by an individual and, if added up, the people on their case load</p> <p>Enable team leaders or managers to consider how the people served by a team or service experience both particular practitioners and the service as a whole</p> <p>Enable practitioners and managers to take appropriate action to develop good practice and for the training and equipping of teams and services.</p> <p>Successive measures over time can be used as a way of recording shifts in personal experience, measuring and mapping practice and service development.</p>	<p>Offer a direct comment on the adequacy or otherwise of a service without further discussion and interpretation.</p> <p>Collect data for external use</p> <p>Make judgements about practitioner or service performance</p> <p>Create 'league tables' of good and bad services</p> <p>Be used to make commissioning or employment decisions</p>

The pilot provided valuable learning but did not resolve the inherent difficulty of finding a 'perfect tool' to capture the experience of people using such a wide range of services. It identified several problematic issues with the application of ERFS to all the commissioned network services. These stemmed from its provenance and related to the content and language and also to the process and timing of use. Although it was considered easy to use, the pilot did not give a universal endorsement of the measure in its current form.

It did however, find that the tool's basic structure could be useful as a common basis for adaptation. The intention is not to compare or 'rank' services against each other or to arrive at a definitive statement on the quality of services but to support improvement at a team or service level. It is therefore recommended that ERFS be presented to providers as a framework for the evaluation of recovery supportive services by the people who use them. Providers (or teams) could then work with the people who use their services to modify the tool or choose an alternative which fulfils the same function.

ERFS can give practitioners and providers a snapshot of how the services they provide are experienced by those who use them and repeated measures can inform service development. This should be built into an annual cycle of audit and planning on a whole service or sampling basis (with the former being preferable). The data generated by such evaluation has value within but not beyond the service to which it applies and the evidence required by the commissioners should be of the process of implementation and consequent learning.

Recommendations

- All service specifications should incorporate a requirement to evaluate the experience of using recovery services by the people who use them.
- Commissioners, providers and contract managers should agree an annual cycle of service development planning which incorporates the evaluation of the experience of using services.
- ERFS should be offered to providers with the invitation to work with people who use their services to adapt it as necessary for particular service delivery or adopt an alternative tool which fulfils the same function.
- Providers should, where appropriate, consult with the people who use their services about how to conduct this evaluation. This should include a consideration of the benefits of employing people who have experience of using services to carry out the evaluation.
- Providers and contract managers should receive training in the purpose and application of evaluation measures
- The continuing development of the measure, choice of alternative tools and the learning from wider implementation should be supported and monitored.

3. Core standards for the mental health and wellbeing networks.

The third element of the framework is the audit of services against agreed and consistent standards. The project built on the broad and inclusive endorsement of the 10 core standards for the Devon and Torbay mental health and wellbeing networks. It clarified the detail of service attitudes, behaviours and processes which make up the standards and developed a self evaluation framework to be used by services auditing their progress towards meeting them. The project also identified the links between the network core standards and examples of other quality assurance measures already required of providers. The resulting framework is designed to be used at the team level (or service level for smaller providers).

Intended to	not intended to
<ul style="list-style-type: none"> • Provide a description of the attitudes, behaviours and processes people who use services and their supporters can expect to experience • Support team and service review and development and inform managers and service planners about service improvement priorities • Inform the contract monitoring and review or performance management of services • Inform commissioners about how a service is performing overall and what the focus of service improvement or investment should be 	<p>Be used as a tool for external audit</p> <p>Create 'league tables' of good and bad services</p>

Recommendations

- The 10 core network standards should be incorporated into all mental health and wellbeing service specifications.
- Commissioners, providers and contract managers should agree an annual cycle of service development planning which is based on the audit and reporting of standards
- The self evaluation framework should be offered to providers and contract managers as a tool for auditing progress towards meeting the standards.
- Providers and contract managers should receive training in the purpose and application of the self evaluation framework.

2. Implementation and further development

In addition to the recommendations for each component of the framework, the project identified two key concerns for implementation. Firstly, there should be an ongoing process of learning about the tools and processes for recovery outcome evaluation and their impact on the experience of services and practice. Secondly, this should continue to be sponsored, supported and monitored across the network as a whole.

As with other areas of development, the value and impact of implementation will depend upon the time and resources given to it. Implementation and validation may be comparatively straightforward for smaller service providers with effective contract monitoring and review processes but will be more complex for larger organisations. Whilst there could be gains from a basic process of dissemination and awareness raising, there would be an attendant risk of the purpose and meaning of the framework being misunderstood or lost. The full benefit to network services and the people who use them will only be achieved with comprehensive, ongoing support. The levels of implementation are illustrated below with each level including and building on the one before.

Level of implementation	Features
Dissemination and awareness raising	<ul style="list-style-type: none"> • Circulation of the framework and associated tools to providers and other interests. • Workshops for staff, people who use services and supporters in the purpose / application of the measures.
Implementation supported through contract review and performance monitoring	<ul style="list-style-type: none"> • Framework and guidance incorporated into service specifications and audit / performance schedules. • Annual reporting of a cycle of service review and development based on the measurement of standards and outcomes – monitored through contract review. • Contract and senior operational managers trained in the purpose / application of measures.
Full network implementation	<p>A coordinated approach across the networks with a nominated lead to provide or support:</p> <ul style="list-style-type: none"> • Training and support to providers for implementation • Advice on the adaptation of measures and adoption of alternatives • Monitoring and validation • The focus and integrity of the approach • Network forum for review and learning

1 Context and background

The context for this work is set by the Devon and Torbay strategic planning group for adult mental health - the Local Implementation Team (LIT). The LIT vision for mental health and wellbeing in Devon and Torbay has been established by people who use services and their supporters together with commissioners and providers of services within the statutory and third sectors:

“We will create a comprehensive and cohesive mental health system built on the foundation stone of promoting the mental health and wellbeing for our local population. Services will increasingly be delivered within mainstream and community settings. People who need services to be delivered in specialist facilities will be actively supported to maintain and regain their health, wellbeing and support networks. The services will be based on the principles of recovery, self help, early intervention, mainstream and social inclusion. The services will be characterised by their quality, convenience and commitment to empower users and carers”¹

This vision and the strategy for its delivery² are informed by and consistent with national policy.^{3 4 5 6 7} The key aims and principles of the strategy are:

- To improve the experience and outcomes for people who use the service.
- The promotion of recovery and mental wellbeing across the system.
- More coherent and joined up systems of support across all health and social care provision.
- Simplified arrangements for getting access to services.
- A continued shift away from hospital care, except where absolutely necessary, towards innovative and flexible responses delivered in the community or at home.

To achieve this, integrated networks of care, treatment and support are being designed and developed. Unlike previous arrangements, each of these networks brings together all the aspects of the health and social care system within a defined geographical area.

The creation of the mental health and wellbeing networks has involved significant changes to services and the organisations which provide them. This has entailed the respecification of some services and a major reorganisation within the statutory specialist mental health and social care provider. Network services and resources are provided by a variety of agencies and this gives additional complexity to service design and delivery.

Against this background of structural change, services are engaged in a process of cultural change towards new ways of supporting people in their pursuit of personal recovery and wellbeing.

These changes have been supported by policy advice and guidance and this project aims to complement and add to our developing local understanding of recovery in practice.

¹ Vision for Adult Mental Health Services in Devon and Torbay: June 2005

² The Way Ahead: A strategic framework for health and social care. Devon Primary Care Trust. Devon County Council. 2008

³ Commissioning framework for health and wellbeing. DoH 2006

⁴ Our Health, Our Care, Our Say: a new direction for community services. DoH 2006

⁵ Breaking down barriers: Clinical case for change: Louis Appleby DoH 2007

⁶ A common purpose: Recovery in future mental health services. Royal College of Psychiatrists, Social Care Institute for Excellence, Care Services Improvement Partnership 2007

⁷ Making recovery a reality: Sainsbury Centre for Mental Health.2008

The commission for this project was developed through a series of events in 2007/8.

September 2007: The Recovery and Independent Living Professional Expert Group (R&IL PEG) was asked by the joint commissioner to develop proposals for the core standards for the delivery of recovery supportive services across the mental health and wellbeing networks. A PEG subgroup drafted the 10 core standards which together describe the features of a 'good recovery service'. In February 2008 a workshop of stakeholders from across the network functions refined this draft and designed a simple self evaluation scale for their application. The standards were endorsed by the PEG in March 2008 and by the LIT in June 2008. In August 2008 they were published in the network *Recovery Guide to Practice and Standards* which was sponsored by Devon Partnership Trust and endorsed by the LIT.

October 2007: The R&IL PEG was asked by the joint commissioner on behalf of the LIT to provide guidance on the measurement of recovery outcomes. This request was further endorsed by the clinical cabinet of Devon Partnership Trust in December 2007. The PEG carried out an extensive and comprehensive review of outcomes measures in current use and under development throughout the international 'recovery community'. This informed a PEG advisory paper on the setting of standards and the measurement of outcomes which was published by the PEG in January 2008.⁸ The advisory paper underpins and provides the evidence base for the work of this project and reference will be made to it throughout this report.

March 2008: The R&IL PEG hosted a stakeholder workshop to consider the content of the advisory paper and agree a network approach to the measurement of outcomes. This event was attended by people who use services, their supporters, commissioners and a broad range of clinical, managerial and governance interests from statutory and third sector providers of health and social care services. The outcome was a unanimous agreement to develop a shared approach to standards and outcomes. This included agreement that further work should be carried out to develop and test processes for the measurement of:

- Personal outcomes for recovery and wellbeing.
- How recovery supportive people consider the services they use to be.
- The progress of services towards meeting the 10 core standards for the networks.

April 2008: Following the consensus and commitment expressed at the workshop, the strategic commissioning organisations, Devon Primary Care Trust and Devon County Council sponsored this project to further develop and test out the evaluation of standards and the measurement of outcomes. It was agreed that the work would be carried out by a sub group of the R&IL PEG and that this group would present the results of their work together with their recommendations to a reconvened stakeholder workshop in March 2009.

⁸ Recovery and Independent Living Professional Expert Group (R&IL PEG) Advisory Paper No: 2: Briefing paper on the setting of standards and measurement of outcomes for the Mental Health and Wellbeing Networks of Devon and Torbay January 2008

2. Aims of the project

The overall aim of the project was to improve the recovery experience of people who use services and their supporters. This would be achieved through testing out measures for personal recovery outcomes, service evaluation and the application of the 10 core standards in a range of pilot sites from across network services.

“By the completion of the pilot, both the sponsors and the participating organisations will have an improved understanding of the following:

- (i) The practical applicability of the recovery standards;
- (ii) The practical applicability of the recovery outcomes measures in a variety of settings across recovery care pathways;
- (iii) Features of processes and practices that have enabled (i) and (ii) above;
- (iv) Features of processes and practices that have hindered (i) and (ii) above;
- (v) Enhanced commissioning practice that continues to develop people’s experience of recovery using in part, the way provider organisations shape processes, practices and behaviours that deliver recovery cultures”⁹

The working principles for the project were identified as:

- Recovery outcomes will be a key performance measure for commissioned mental health and wellbeing services from 2009-10.
- The measurement of recovery outcomes will be required of all commissioned services by 2010 – 11
- The commissioners will require evidence of how recovery standards and outcomes are achieved for the service, team, staff member and individual user of service (i.e. the process and practices) as distinct from extensive data collection and external analysis.
- The providers will retain the data generated within the pilot and consequent practices to use to continually improve their recovery processes and practices.
- Commissioners are likely to use sampling of individual experience to assist in the validation process of contract performance and services.
- Commissioners are interested in developing a training and education programme approach to support contracted providers to deliver recovery standards and outcomes to good levels and beyond.
- Individual recovery journeys are likely to be unique and influenced by a range of determinants. This is why the focus is being placed on evidence of process and practice and their linkages to recovery outcomes rather than creating a recovery league table approach.¹⁰

⁹ Devon Joint Commissioning Manager Adult Mental Health. LIT report. September 2008

¹⁰ ibid

3. Project description

3.1 Steering group

The work was led by a steering group which was a sub group of the Recovery and Independent Living Professional Expert Group. The steering group met monthly between April 2008 and February 2009 and reported to both the PEG and the LIT. Membership of the steering group can be found in appendix 4.

3.2 Pilot sites

17 pilot sites volunteered to test out the measures and conduct a self evaluation against the 10 core network standards and 15 sites completed or partially completed the pilot. Each pilot site had a named lead who was also a member of the steering group. Details of the pilot sites and pilot site leads can be found in appendix 4. The pilot sites represented a spectrum of network provision:

- Statutory and third sector providers.
- Small teams and independent practitioners as well as one of the largest and busiest community recovery and independent living teams.
- Young people's services through to services for older adults
- Psychological therapies in primary care through to assertive outreach, inpatient and forensic services.
- Social care services such as vocational reablement, community networks and housing support as well as specialist mental health services.

One pilot site provides services to older adults, mostly people diagnosed with dementia who also experience the many complex physical and social effects of older age. The common features of the recovery approach and Person Centred Care for older adults have been explored¹¹ and were used as the basis of adaptations to the questionnaires for this site¹² which were administered with the active involvement of carers. The results from this pilot site will be considered in a separate paper.

3.2 The measures

The project followed the recommendations of the PEG advisory paper and stakeholder workshop by testing the following:

Personal outcomes for recovery and wellbeing

The measure tested is a ten point self evaluation which looks at the areas of life in which we need to feel fulfilled or have our needs met if we are to see ourselves or be considered by others to be well or healthy. The questionnaire is called, and asks the question *'How well is life working out for you?'* It uses language which reflects the common human experience. The measure has the dual aims of embedding reflective conversations into routine practice and enabling self assessment of personal progress towards improved quality of life and wellbeing. During the pilot this questionnaire was completed at two month intervals over six months (ie three times) and is described in section 4

¹¹ Hill.J, Roberts.G, Wildgoose.J, Hahn.S: Recovery and person-centred care in dementia: common purpose, common practice. *Advances in Psychiatric Treatment* 2008.

¹² Drs Neville Todd, Laura Hill and Glenn Roberts

An evaluation of how recovery supportive services are by people who use them.

Elements of Recovery Facilitating Systems (ERFS) is a simplified derivation of the Developing Recovery Enhancing Environments Measure (DREEM)¹³. This is a consumer led measure of service experience which is becoming widely used in recovery services. ERFS uses a framework of accepted features of a recovery-oriented mental health service to measure the person's view of how well the service they use meets that profile. It is designed for use in service evaluation and to stimulate awareness of service strengths and areas for improvement. It was used once and is described in section 5.

The progress of services towards meeting the 10 core standards for the networks

Each pilot site was asked to consider how they would evaluate their services against the core network standards. The purpose was to identify the type of evidence they might use, how it could be collected without adding unnecessary bureaucracy and how this information would be used to improve service delivery. It was expected that pilot sites would draw on information already collected for contract monitoring, service evaluation, governance or external inspection. This is described in section 6

3.4 Selection of participants

The target number of participants for each pilot site was 30. This was set as the realistic number of interviews that could be conducted by sites within the timescales. In the smaller sites all the people using the service were invited to participate. Where there were more than 30 people using the service, a sampling process was used to identify participants. In one service with a very fast turnover of people using the service it was agreed that all new contacts and other people with appointments already booked during the first sampling period would be invited to participate.

Pilot sites allocated an identification number to each person using their services and this number was used for random selection (where appropriate) and the allocation of a project identification number. This number was used on all questionnaires to preserve anonymity. Written information about this process and other aspects of the pilot project was given to each participant by the practitioner administering the questionnaires.

3.5 Intervals and completion

The timing of and intervals between the sampling was determined by the length of the project. To allow time for project planning, the evaluation of data and the consideration of participant and practitioner feedback, the sampling periods were scheduled for a two week period in June, September and December but this schedule slipped in some sites. Questionnaire 1: *How well is life working out for you?* was administered three times and questionnaire 2 (*ERFS*) was administered once, at the midpoint of the pilot project.

294 (93%) participants completed the first stage of *'How well is life working out for you?'*, 212 (67%) the second and 124(39%) the third stage. 201 participants completed the ERFS questionnaire. Very few selected participants declined to complete the questionnaires. The more common reasons for non completion were given as problems with practitioner availability, no contact with the person at the time of sampling or discharge from services. In a small number, the reason given was that it was inappropriate to complete the questionnaires because of the person's support needs at the time.

¹³ Yale Programme for Recovery and Community Health. Cited in Recovery and Independent Living Professional Expert Group (R&IL PEG) Advisory Paper No: 2

3.6 Preparation of pilot site practitioners

The pilot site leads and other members of the steering group worked together to refine the measures and describe their application. Each pilot site lead took responsibility for preparing their teams and the project lead offered additional training and support. Six pilot sites took up this offer. Some pilot site leads were unable to attend all steering group meetings and two did not attend any.

There was a marked difference in the feedback from participants and practitioners from those sites which were well prepared by either the pilot site or project lead and those that had less preparation. This is discussed later.

3.7 The administration of the two questionnaires

The first principle was that the self assessment of personal recovery and wellbeing should be useful to the participant. It would provide an opportunity for reflection, reinforce progress made and identify areas of life the person wished to build on or improve. It would give an opportunity to discuss these with the practitioner most involved in providing support thus increasing their understanding of the person's situation and recovery journey.

Practitioners were asked to administer the questionnaires in the form of a conversation, encouraging exploration of the meaning of the questions for each participant. The degree to which this did or did not happen was a determinant of how useful participants found the process and this is discussed later.

The questionnaires were administered during a routine session with the practitioner most involved with the participant's support. In those pilot sites which did not work on a one-to-one system of support the interview was arranged by appointment with a member of staff who had been identified for that purpose.

The service with a very fast turnover of people and limited sessional capacity was unable to offer appointments for the later samplings to people who had been discharged from the service. The 2nd and 3rd 'How well is life working out for you?' and the ERFS questionnaire were posted to all participants with a covering letter and reply envelope.

3.8 Information collected

The information collected from each participant or practitioner comprised:

- *How well is life working out for you?* Three completed questionnaires.
- *Elements of Recovery Facilitating System (ERFS)*. One completed questionnaire
- Feedback from participants. All participants were invited to a workshop to give their feedback about both questionnaires and the pilot process. The invitation contained a reply form which was also a feedback questionnaire for those who were unable or did not choose to attend the workshop. Invitations were sent or given to 316 participants, written feedback was received from 83 (26%) and 16 attended the feedback workshop.
- Feedback from practitioners. A short feedback form was used. Practitioners were also invited to attend the feedback workshop. 35 feedback forms were received and 19 practitioners attended the workshop.

4. Measuring personal outcomes for recovery and wellbeing

We are clear services cannot 'recover someone'. Services can offer treatment, support and access to opportunities but recovery is a personal journey, experience, hope and achievement. Services can stimulate, facilitate and promote recovery; they can also hinder recovery, but they cannot generate or create it. Services can in many ways provide the preconditions of recovery but not recovery itself which has to be discovered by the person. Personal recovery pivots around people becoming active and empowered in their own lives, self determining and self managing. They may continue to use and benefit from a wide range of services – but increasingly on their own terms.

For example, housing, vocational, counselling and medical services can offer someone somewhere to live, work, time to talk and reflect on their experiences and evidence based tools as means of reducing symptoms and suffering, but none of these are guaranteed to produce personal recovery.

As we learn more about the limitations of 'giving treatment' to someone, we are learning that personal recovery is more related to personal variables such as hope, commitment, taking responsibility and control, and people developing self determination so that they actively use rather than passively receive services.

A person may also be using a variety of services such that their experience of personal recovery is an outcome of a unique combination of experiences and commitments they make, which is very well portrayed in recovery stories, which also illustrate that there can be no 'model of recovery' or 'recovery therapy'. One person may experience recovery from taking medication and attending psychotherapy, another by getting a job and finding a partner, another by leaving services altogether.

It follows that if services can only provide the supports and preconditions of recovery but not recovery itself; then measures of the personal experience of recovery cannot easily or reliably be taken to be measures of services – so much as an expression of the life experience of the people using a service.

Glenn Roberts 2008

4.1 When designing the measure and the process of measurement the steering group considered how best to meet four objectives:

- 1) Any measure would aim for wide applicability i.e. be of relevance to people who use any of the services and resources within the mental health and wellbeing networks
- 2) Any measure would be useful to the participant, encouraging reflection on personal wellbeing, supporting discussions with the support provider about what is important to each person, how any identified needs might be met, and how personal experience changes over time.
- 3) The process would enable the support provider (practitioner) to understand and respond better to personal needs, hopes, concerns and aspirations. This applies primarily to the immediate response within the support relationship but cumulative learning would inform practitioner, team and service development.
- 4) The process of outcomes measurement would support the cultural shift towards personal responsibility for wellbeing, self management and increased direction and control over support received.

4.2 Many, if not all, providers are required to produce evidence of supporting people to achieve externally defined outcomes. These performance indicators may be specific to the focus of the service (eg vocational or housing support) and will include aspects of social inclusion such as: employment, housing, healthy lifestyles and social and community engagement. They are also incorporated into the 10 core network standards:

Standard 8: Social Inclusion

All services demonstrate socially inclusive practice which is supportive of people living ordinary lives in ordinary settings and considers in particular people's needs for accommodation, occupation, education, personal relationships, money and participation in community activities

The pilot project experienced and resisted a degree of pressure to use such predefined outcomes or to use other measures which use this approach. The merits and limitations of such an approach have been discussed¹⁴ and a great deal of interesting work is being done in this area.¹⁵ ¹⁶ We do not question the impact of social exclusion on mental health or the essential contribution that work, housing, societal roles and relationships and good physical health make to mental wellbeing. Our reservations were twofold:

- Such measures do not tell us if achieving a goal or outcome has improved personal wellbeing or improved the quality of life in the person's own terms. One example of such an outcome is [I can live independently](#).¹⁷ Achieving and maintaining independent living will be an important aspiration for many - but has the person's life improved? Are they happy, confident and secure with a sense of achievement or struggling, anxious and missing the companionship of communal living?
- How an outcome is expressed can either open or close down the recovery conversation. Staying with above example; developing the resources to live independently may be important to people using very intensive support services but would be a puzzling outcome to suggest to the larger group of people using other network services whose ability to live independently has never been in question - and that perhaps marks the end of the discussion. However, if we ask the person if the place they live feels safe and like home we are exploring a need common to us all and one which may be threatened or enhanced in many different ways. So, the person who responds 'of course' to a question about living independently may respond very differently when thinking about how their living situation feels - perhaps into areas of domestic abuse, fears of debt and mortgage arrears, disputes with neighbours or many other directions which might otherwise not enter into the support conversation. All these are important to bring into the discussion, not necessarily as problems for a service to respond to but for the person to consider the impact on their wellbeing, what they want to do and what support they need to do it and for the practitioner to understand the person's life better. It may also accentuate strengths on which to build strategies for wellbeing - the contribution their garden makes to their wellbeing, pride in DIY skills etc. The desired outcome is that the person considers that they have a safe and secure environment from which to develop – and that will look different and be expressed differently for each person.

¹⁴ Recovery and Independent Living Professional Expert Group (R&IL PEG) Advisory Paper No: 2: Briefing paper on the setting of standards and measurement of outcomes for the Mental Health and Wellbeing Networks of Devon and Torbay January 2008

¹⁵ Outcomes framework for mental health: National Social Inclusion Programme 2009

¹⁶ Outcomes compendium: NIMHE, Barts and the London School of medicine and dentistry 2009

¹⁷ Mental Health Recovery Star: Triangle Consulting & Mental Health Providers' Forum

4.5 Feedback from participants and practitioners

The feedback from participants and practitioners was gathered through questionnaires and in a workshop held for that purpose. The feedback from all sources is summarised together to reflect the common themes which emerged. There was a broad consistency in these themes between practitioners and participants and also between written feedback and the workshops. Participants and practitioners were asked to comment on the:

- Content
- Process
- Usefulness (in supporting personal recovery or developing recovery practice)

It is important to preface the summary of feedback with a piece of unintentional but crucial learning. This relates to the preparation of practitioners in the pilot sites and therefore their understanding of the purpose of the measure and their ability to explain this to participants. Some sites had time to discuss the purpose and process in some depth with the project lead and practitioners in three sites had previous experience of using measures with a broadly similar approach such as the *Recovery Markers* subsection of DREEM.²⁰ Other sites had much less preparation and were further disadvantaged because their pilot site lead was unable to attend steering group meetings regularly.

It is clear from both participant and practitioner feedback that two different approaches were applied: in some sites the measure was used as the basis for the conversations previously described. In other sites there was a tendency to present the questionnaire as a service evaluation tool with the key purpose being data collection rather than discussion. This had a significant impact on how useful the experience was for both parties.

It is also important to note that many practitioners and participants completed the feedback questionnaires with single “yes” or “no” answers whilst others wrote detailed comments. The overall ratio of positive and negative answers was not always reflected in the detailed comments so, where possible, the information below shows both the numerical proportions and the tenor of the more detailed feedback.

• Content

We asked two specific questions about the questionnaire itself: Did it ask the right questions to enable people to discuss the things which were important to them? And were people happy with the language used? The questionnaire itself asked people to identify any area important to their life which was not covered. We also asked practitioners whether we had missed any important areas to measure.

Of the 82 participants who expressed a view 65 (79%) said that it had asked the right or mostly right questions but 17 (21%) commented that it had not – mostly because it missed areas of importance to them. Both sets of feedback forms and the questionnaires themselves identified areas that participants and practitioners felt had not been covered. The most common of these were: finance: family, peer and social relationships; work; faith; and physical health.

It is possible that these areas would have been covered had practitioners been more confident about exploring the potential and individual meaning(s) of each question.

²⁰ Yale Programme for Recovery and Community Health. Cited in Recovery and Independent Living Professional Expert Group (R&IL PEG) Advisory Paper No: 2

17 people commented on the language used with the majority reporting that it was easy to understand and appropriate, For example: *Very respectful about me as a person and not just an illness*. Some people felt the language was too 'woolly' and not specific enough and a few that it needed simplifying. The feedback from the workshop was that the ordinary and positive language was valued by both those who asked and completed the questionnaires.

- **Process**

We asked participants how it felt to complete the questionnaire and have the discussions which arose and we asked practitioners how easy or difficult it was to administer it.

Of the 63 people who responded: 49 (78%) were broadly positive and 13 (21%) were clearly negative. Of the latter, 10 included a comment that no discussion had taken place:

There were no discussions – it felt like a waste of time

For many people the exercise had clearly prompted reflection and discussion:

Very positive on the realisation of how I was feeling. Facing up to my thoughts

I find it empowering and daunting at the same time, as when I look back at how ill I was, I know how close I was to being completely engulfed

Mainly positive because of (name of worker) pointing out progress and presenting challenges in a positive way

I believe that it was helpful to complete this questionnaire as hopefully it will ensure that services remain person centred

The questions were very helpful, situated around recovery, all mental health, lots of issues raised

The feedback from practitioners was that the questionnaire was easy to administer and that it became more so with repeated use and as the purpose became clearer:

By the third questionnaire I was able to converse with the clients I interviewed well as I had developed a rapport with them

It became easier as I developed my confidence and focus on the facilitation of a discussion rather than a questions session

Went very well, was surprised that both patients spent a good deal of time on this and gave thought to answers, was expecting a rushed / get it over with response

The questions were straightforward and our own coaching skills/qualities allowed clients to explore the questions further and to openly discuss how well life has been working out for them

I found it easy to administer to the people I met with. It opened up conversations which I have had a chance to follow up

Several comments were made about the need for sensitivity in the timing of asking the questions. The pilot created artificial targets for completion within specific time frames and this was felt to be unhelpful on several occasions:

It was helpful as it focussed on so many key areas of life. The second time we filled one out though, was a disaster as I was ill and we did ERFS at the same time and my worker was more interested in talking about his views of the service he worked in than my problems – which he completely missed

It had to fit with the importance of the meeting, with the service user's immediate concerns being met and therefore it felt difficult at times to complete at times of high distress etc

This was reflected in the workshop:

Timing was questionable at times

The need for human sensitivity and an appropriate response

- **Usefulness**

We asked participants how helpful it was to complete the questionnaire (did it support their recovery?) We asked practitioners if it had made them think about their current practice; if it had changed the discussions they had with the people they support and whether any particular question has exposed an unmet need.

Of the 82 participants who expressed a view 63 (77%) indicated that it had been helpful and 19 (23%) that it had not. Comments included:

Relevant to my life and led to discussions about my situation or my care that were helpful

It was helpful to think about progress and positive outcomes

It helped me to gauge feelings and reflect on my quality of life and state of mind

It made me reflect on those points and appreciate the areas I've moved on and consider the ones I'm still a bit stuck with

I don't feel it has supported my recovery as such, but it is helpful to realise how I have changed from questionnaire to questionnaire

The sense from the more negative feedback was that there had either been no discussion of the issues raised by the questionnaire or that no response had come as a result such discussions:

It was not helpful – nothing came of it

Didn't make any difference

I feel that all this has been a total waste of time. Where is the help and support? We need people to talk to and give advice and guidance, not more bloody paperwork

Pointless, what 'discussions'?

Practitioners' responses about the impact on practice and the support relationship also fell into the two categories described. 25 replies indicated that it had added to their practice and/or reinforced the practice they were working towards:

Yes – it is good to talk about sense of worth and what is appreciated as opposed to dealing with practical matters

Makes you look 'deeper' in practice and see more of a person. Enables clearer understanding of a person's goals

Yes, I can become focused on current issues / needs for a client and lose sight of the issues / needs which are important for someone to retain hope

Yes, it has encouraged further discussions about what is important to people in their lives and brought about conversations of areas that are missing for people

How important a person's sense of self may vary from what you see/is shown. (My perception is different.)

Definitely it has opened up opportunities to explore our practice and how we can reflect upon our assumptions, i.e. make more of other's recovery progress. Conversations have taken place that have highlighted a need to support people when they are ready to move on

Yes, it has given me a tool/framework to ask more holistic focussed questions, especially earlier on in work with people

9 felt it had not added to or made them think about their practice:

No (apart from ruminations about how many more forms I will have to complete for each client in the future preventing me spending time with clients)

22 practitioners reported that doing the questionnaire had revealed unmet or previously unexplored needs and 12 that it had not:

Yes, especially question 5. Participants highlighted how friends and family don't lean on them for emotional support for fear of affecting their mental health. Discussions around this are still taking place

Yes, some clients have stated that they would like more support in working towards living independently, especially from their care coordinators in the community

Yes, faith/ family – exploration of need / belief

Raised some interesting points / areas to revisit with service user

Yes, person not able to discuss further at time – to be followed up

Yes, discussion more openly about sexual identity

Not necessarily, but I understood more about the individual's life and perceptions and would have responded or signposted to other agencies if the need had arisen

Practitioners were also asked if participation in the pilot had had an effect on their understanding of recovery and their practice.

26 practitioners felt that participating in the pilot had improved their understanding of recovery and 14 that it had not (few of the latter enlarged on why this was so):

Gave me a greater understanding of what service users required and needed for a better quality recovery service

The opportunity to see the bigger picture (whole life) beyond diagnosis /label is far more in keeping with recovery practice

It was interesting to see how they viewed their position as opposed to what we think

Some areas I would not necessarily have thought about asking i.e. equal value. It has been helpful to find out where people's needs are not being met within certain areas, to open a conversation

Yes, it has helped us to recognise how well we support clients to live well and encourage them to achieve the things they want in their lives

Although it hasn't broadened my 'knowledge/understanding of recovery outcomes', it has provided me with a succinct and open ended set of questions to use

It enables us to signpost to other agencies that can support with social and financial issues

Helps us to reflect upon the ways that we support clients and recognise areas of life that we might be missing, highlighting recovery needs that we need to work towards supporting

2 practitioners from sites where the emphasis had been on data collection pointed out the shortcomings of this approach:

I feel the questionnaire will only give the data, the figures, you will have missed out on the conversation, and the narrative has been the most useful for me

Having feedback from the young people themselves, not just a questionnaire as I feel this does not produce or show how the development of your service or practice is measured

The primacy of the conversation also emerged from comments written on the questionnaire itself. So, for example, the item *I have privacy, time and space to think about myself and my life* was commented on by several people in that they had too much and were inclined to unduly ruminate on their problems.

4.6 What did the collection of data tell us?

In order for measurement to be useful, it needs to have the properties of reliability and validity. Reliability is consistency such that the measurement of a stable attribute, if measured more than once, will give the same measurement. A good example is bathroom scales – if you are trying to lose weight and the scales give a different measurement; you want to know that the difference is due to you having lost weight and not because of a problem with the scales. If we are assessing changes in personal recovery, we want to know that change has occurred because of the perceptions of the respondent and not because there is a problem with the measurement scale.

There are different sorts of reliability. Of particular relevance to our newly developed Personal Recovery scale is whether or not the different items on our scale are related to each other, i.e. is there internal consistency? Internal consistency is usually measured with a statistic called Cronbach's alpha. This is calculated on the basis of the correlations between all the different items on a questionnaire. The aim is to measure whether several items which aim to measure the same general construct (in our case personal recovery) produce similar scores. The rule of thumb is that an alpha of 0.6 to 0.7 is OK, but 0.8 or higher is good. Reliability is a precursor to validity because if data are not reliable, they cannot be valid. Reliability was estimated using Cronbach's alpha which was 0.83 based on 257 people who fully completed the questionnaire at stage 1. This is an encouraging indication that the individual items relate well to one another

Validity is an indication that the measure that we are using measures what it purports to. In this case this would mean that the questionnaire items are relevant to personal recovery and wellbeing. We have attempted to assess validity by asking respondents the extent to which the 10 personal recovery items cover the important areas of life for them. The questions regarding validity in the questionnaire itself seemed to make sense to respondents and this was confirmed in the feedback. There was little missing data (as we would hope if the questionnaire is being used as a basis for conversation).

The item asking people 'how well do these questions cover the important areas of your life?' was answered in the same way as other items by using a scale from 0 to 9. The mean response to this item was between 5 and 6 overall and 145 (51%) of the Stage 1 respondents specified an area important to them. The most prominent of these were: social life including family; money, work and training; emotional & psychological issues; and physical health. Rather than extending the number of questions, emphasis should be placed on developing the understanding of how these factors help or hinder people in meeting their needs rather than being outcomes in themselves.

These indicators of reliability and validity are encouraging but not altogether surprising as the questionnaire is based on a well established framework for emotional health and wellbeing in the theory of the Human Givens.

In addition to the individual use of measures of recovery, services may choose to summarise their data and these summaries could be useful in discussions with staff. It would be important to remind staff that any apparent movement in these summaries should not give rise to either undue elation or disappointment because of the many unknown influences that can change an individual's responses. However, an examination of summarised data over time could provide an indication of areas for discussion, especially if the mean scores are consistently lower for particular items.²¹

²¹ The project is grateful to Ann Ley (DPT R&D) for her analysis of and commentary on the data and to Rohan Davidson (CCT) for information and project administration.

Tables 1a and b show the information used for analysis. Nine sites submitted complete sets by the cut off deadline. The site which provides services to older adults will be the subject of a separate report so the analysis in this section is based on eight sites (shown in yellow below). Various factors prevented the data from other sites being used for this report but their data was analysed and a report made available to each pilot site lead. Table 1b shows the total number of responses from all 15 pilot sites.

Table 1a: Pilot site response

Pilot Site	Stage 1	Stage 2	Stage 3	All stages
ARC	Yes	Yes	Yes	Yes
CCT women's networks	Yes	Yes	Yes	Yes
Cypress	Yes	Yes	Yes	Yes
Exeter R & IL	Yes	Yes	Yes	Yes
Exeter R & R	Yes	No	No	No
Langdon	Yes	Yes	Yes	Yes
MIND housing support	Yes	No	No	No
N. Devon AO	Yes	Yes	Yes	Part
N. Devon Link Centres	Yes	Yes	Yes	Part
Older Persons Mental Health	Yes	Yes	Yes	Yes
PLUSS	Yes	Yes	Yes	Yes
Rethink Riverside	Yes	Yes	No	No
Russell Clinic	Yes	Yes	Yes	Yes
W. Devon PMH	No	Yes	Yes	No
Young Devon	Yes	Yes	Yes	Yes
Total number of sites	14	13	12	9

Table 1b: Participant response

Source & No. of participants	Stage 1 No. & %	Stage 2 No. & %	Stage 3 No. & %	All Stages complete
Older Adults (30)	30 (100%)	25 (83%)	8 (27%)	8 (27%)
Others (286)	264 (92%)	187 (65%)	112 (39%)	95 (33%)
Total (316)	294 (93%)	212 (67%)	124 (39%)	103 (34%)

Diagram 1 (next page) shows the combined mean score for each of the ten questions. Each question asks the participant to mark the degree to which they agree with a description of a feature of positive emotional health and wellbeing. 0 would indicate that they do not agree with it at all (and therefore it is an area of need to consider focusing support on), 9 would indicate satisfaction with that aspect of life. The combined scores show responses mostly a little higher than the 'moderately agree' range of 4. – 5. The highest mean score was 6.71 for the statement 'I have someone I can trust and whom I can turn to for help'. The lowest mean scores were 4.72 for the statement 'I feel of equal value to others' and 4.88 for the statement 'I have a sense of meaning and purpose in life and feel hopeful about my future'.

The combined mean scores tell us nothing about the pilot sites or the progress of participants towards personal wellbeing and recovery but, were they for a single site and showing consistent significant differences in scoring over time, they could indicate areas for exploration. Taking the lowest scoring item as an example, staff could discuss with people using services how the way support is provided can best promote a sense of self worth or reduce stigma and discrimination. It must be emphasised that this would be useful as a starting point for further discussion – not a commentary on the quality of service provision or evidence of wellness (or lack of it) in the individual.

Diagram 1: The mean score for each question (eight pilot sites combined)

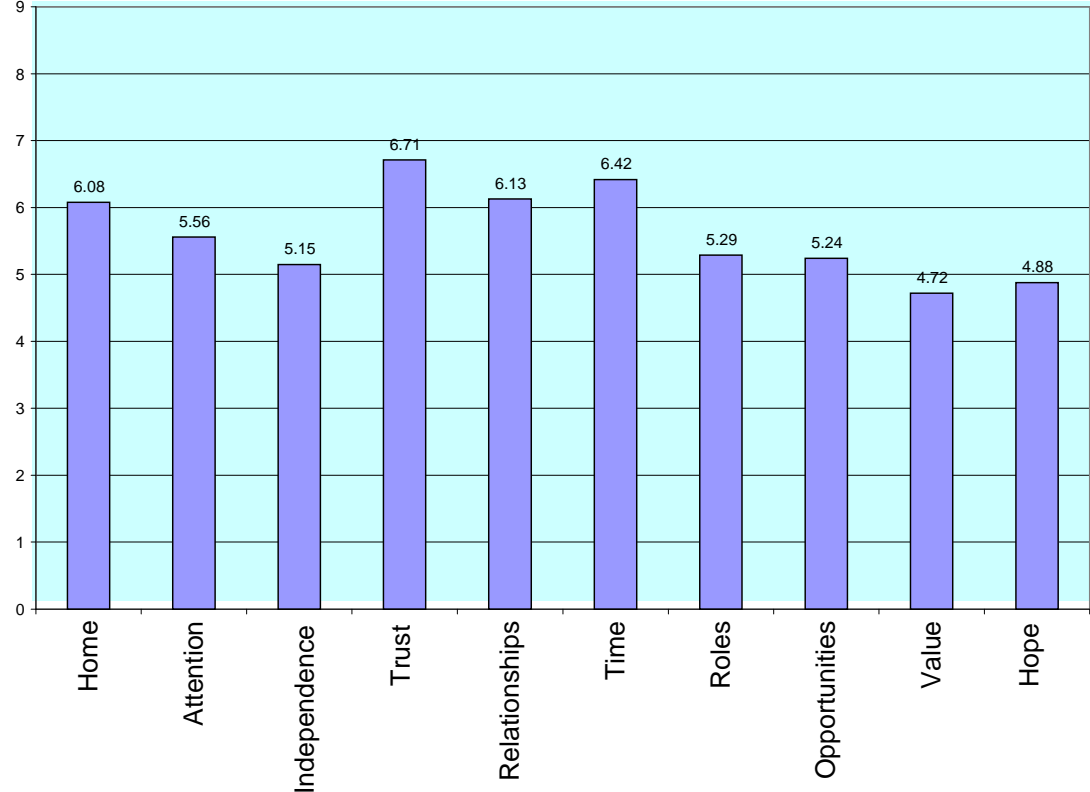


Diagram 2: example of variations over short sampling periods.

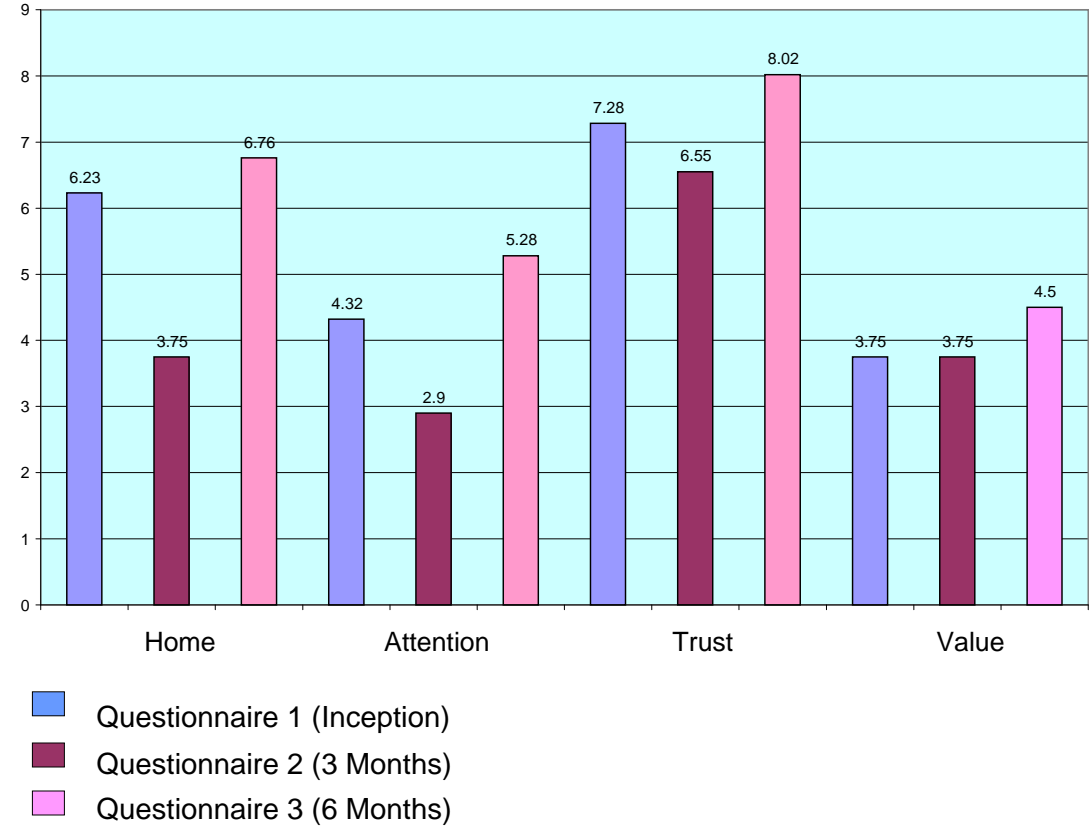


Diagram 2 (previous page) illustrates the limitations of the data and the danger of reading too much into it. It shows the mean scores for four questions from the three sampling periods in one service. This site had 20 respondents. Two statements: 'My living situation is safe and feels like a home to me' and 'I am able to both give and receive appreciation and attention' showed a marked dip in the second sampling followed by a significant increase in the third. The standard deviation in the second sampling for these questions was 1.71 and 2.34 respectively which indicated that the mean score was not influenced by a few very low scores. Some other questions showed a slight dip but not to the same degree.

The variation looks as though it should be significant: if the service provided support in a residential setting it might (or might not) indicate that there had been a period of difficulty where the unit felt unsafe and staff attention had been distracted – but this was a counselling service provided to people living in their own homes. We cannot identify the reasons from the data and nor should we try to.

4.7 Discussion

The intention was to design a tool which would be of use to people in recovery and those working with them. The purpose of the tool would be to facilitate reflection by the person on their life experience, to take stock, and get an overview. This could be used to review the individual's hopes and goals for personal recovery, to support more aware discussions between people using services and those supporting with them about how to proceed according to what is valued by the person, to ask questions concerning whether people are getting what they want and need, and to enable the worker (and the service) to be more fully engaged and attuned with the life experience of the people they are working with - *regardless of whether the person is 'getting better' or not*. The worker could also use these outcomes and their experience of using such measures to reflect on their experience and practice in supervision.

Such a measure of personal recovery can comment on: 'how my life is working out' from a personal viewpoint at a point in time. Successive measures enable the person to reflect on how they evaluate their experience of life and living and how that changes over time but cannot be used as a reliable commentary on service effectiveness or the objective circumstances of the individual's life.

The feedback was used to consider how well we had met our four objectives:

Does the measure have wide applicability? Is it of relevance to people who use the services and resources across the mental health and wellbeing networks?

The measure was derived from the Human Givens, a framework for emotional health which identifies the needs we have in common to maintain our emotional wellbeing and live a 'good life'. There were initial doubts about the applicability of these areas in services which were commissioned with a primary function in one particular aspect of life such as vocational reablement or housing support services. On consideration, it was agreed that, although a specialist service might be provided, the overall aim remained that of supporting the person to live well – so (for example) achieving employment or stable accommodation was not an end to itself but a means to the person meeting the needs for a good quality of life which we all share and which we meet through highly individual combinations of resources, activities and relationships. The feedback indicated that the repeated use of *how well is life working out for you?* had, for many people, added to the practitioner / participant understanding of the part such resources, activities and relationships played in the person's life and how they could be supported.

Concerns were expressed that the measure might expose areas of need the service could not respond to and this was indeed the case sometimes. This was a positive rather than negative effect as practitioners reported that it prompted discussions about how those needs could be met and how the practitioner could support the person to get access to the information and support they required.

The other focus of discussion was the 'completeness' of the questionnaire and whether or not it captured the areas of life which were important to people in different life circumstances and using different services. In the feedback 21% of participants reported that it had missed specific areas of importance to them such as finance; family, peer and social relationships; work; faith; and physical health. This prompts us to consider whether this is a problem to be resolved by redesign and additional questions or a strength in that it enables each person to interpret the questions according to their personal values and perspectives. The open ended question can be used to further customise the tool by adding in what matters to the person. – and to change this as their life moves forward.

Our conclusion was that there is merit in having a set of questions which are essentially applicable to all (ie have validity) but on which each person can reflect and can discuss according to their personal priorities. There is value in the 'incompleteness' of the measure in that it prompts adaptation - which is consistent with the personalised nature of self management. This goes some way towards addressing the apparent paradox between recovery as a personal experience and asking 'set' questions to define recovery. It also reinforces the person's control over the focus and content of the support provided.

Is the measure useful to the participant? Does it encourage reflection on personal wellbeing and support discussions about the things which are important to each person?

The primary function of the measure was to support personal reflection and progression and engage commitment to personal recovery – i.e. as a recovery coaching tool. The degree to which it achieved this was contingent on several factors:

- The understanding of the practitioner about the purpose of the tool and how well this was communicated to the participant.
- The value placed on the tool by the practitioner and the degree to which this was communicated to the participant.
- The response of the practitioner to issues which arose – how well they responded in practical and emotional terms to the content of the discussions. For some participants the experience was 'pointless' because nothing changed as a result. This may imply an expectation that the practitioner should 'do something' as a result of receiving information. If that something is an exploration of how the person can better be supported to meet their needs then it will be a legitimate and useful expectation within the principles of recovery and recovery coaching. If the expectation is that the practitioner will take control and responsibility for an action then it will be unhelpful. This highlights the importance of both parties understanding the application of the questionnaire – i.e. it is not the tool itself but the way in which it is put to work which has value.
- The timing and sensitivity with which the measure was administered. The pilot project time scale created artificial targets for completion of the questionnaires and this had two unhelpful effects. Some participants were asked to complete a questionnaire when their personal needs were such that this was an intrusion in much needed support or

clinical time. It also reinforced a perception of the use of the measure for data collection and external use rather than something which is for the benefit of the individual.

- The degree to which the participants had ‘ownership’ of the measure and saw the benefit of it to themselves. The pilot required practitioners to take and submit the questionnaire for measurement and data collection. It was suggested that participants keep a copy for their own use and, for some, it was used as a baseline against which they could map their progression over time. This was not the case in most pilot sites which unfortunately reinforced the perception of the tool as being of external rather than personal value.

Does the process enable the support provider (practitioner) to understand and respond better to personal needs, hopes, concerns and aspirations?

The intention was to embed recovery conversations and a recovery coaching approach into routine practice and to use *how well is life working out for you?* as a tool to support this. There was considerable feedback to indicate that this was achieved and that some assumptions about what is important to people had been challenged but the overall impact was contingent on the factors described above and two other connected factors:

- The previous experience of practitioners in using other outcomes measures with the same broad (personalised) approach was helpful. This may prefigure what we hope to see over time: that learning is cumulative and that with practice, our individual and shared understanding will develop.
- Conversely, it was clearly difficult for some practitioners to put aside a long experience of using measures to obtain data (usually for someone else’s purpose). This experience has often been of measures which were designed for research purposes but subsequently applied to clinical practice - for which they were often ill suited and therefore not valued or well used. The pilot asked practitioners to not only use a different measure but to adopt the new and very different ethic of *measurement which is of prime interest to the individual*.

The above points are not a criticism but a comment on the need for preparation and ongoing training and support for practitioners and people who use services in the purpose and use of measures for personal outcomes.

Does the process support the cultural shift towards personal responsibility for wellbeing, self management and increased self direction and control?

To understand how measures of personal outcomes for recovery and wellbeing can support this cultural shift we need to consider the relationship between *the tool*, *the worker* and *the task*. The tool is only important insofar as it enables the worker to do the task (of supporting self directed recovery and wellbeing) better. The design and selection of a tool can help but there is a risk of depending too much on the tool to do the task rather than the person using it and the way in which they do so. It is equally important that the worker becomes skilled in using the tool and is always mindful of the task to which it is being applied.

This was illustrated by the feedback and results from some pilot sites. When workers were not well oriented, briefed or tutored it was clear that the pilot had little or no positive impact on practice or the nature of the support relationship. This was in marked contrast to the majority of sites where positive change was reported.

The other key factor is, of course, the degree to which the person using the service understands, values and engages with this process of self reflection. This will come primarily from the attitude of the worker and the way they use the tool.

The project concluded that this approach to measuring personal outcomes for recovery and wellbeing can provide a powerful support for cultural change in that it the 'right tool' but only if there is a sustained and coordinated programme of communication, training and development which is targeted at both practitioners and participants.

How can personal measures of recovery outcomes inform service improvement?

This section has emphasised the principle purpose of *how well is life working out for you?* to be of use to people using services. It can also support practitioners to be more aware of what is important to the people they work with and facilitate recovery coaching relationships.

The information gained by using the measure can also be summarised and these summaries could be useful in discussions with staff about service improvement.

It is important to remember the limitations of such information because of the many influences that can change peoples' responses. However, an examination of summarised data over time could provide an indication of areas for discussion, especially if the mean scores are consistently lower for particular questions.

It is also important to remember the effect of collecting data on how participants and practitioners understand the purpose of the measure and who 'owns it'. The pilot showed that a perception of gathering information for external use had a significant impact on how useful it was felt to be by the participant.

The pilot concluded that:

- The measure *how well is life working out for you?* has a good degree of reliability and validity.
- It was well received and appeared to have a positive impact on practice by enabling more aware responses.
- Its usefulness as a support for personal recovery and as a lever for cultural change is contingent on a sound understanding of its purpose and application.

Recommendations

- All service specifications should incorporate a requirement to embed the measurement of personal outcomes for recovery and wellbeing into routine practice.
- Commissioners, providers and contract managers should agree an annual cycle of audit which provides evidence that the measurement of personal outcomes is embedded in routine practice.
- *How well is life working out for you?* should be offered to providers as the default option for such measurement – the use of alternative measures should be carefully monitored to ensure they fulfil the same function
- Providers and contract managers should receive training in the purpose and application of this measure.
- The continuing development of the measure and the learning from wider implementation should be supported and monitored.

5. Evaluating the experience of using recovery supportive services

“Any services, or treatments, or interventions or supports must be judged in these terms: How much do they allow us to lead the lives we wish to lead?”²²

5.1 The measure

The PEG advisory paper explored the service evaluation tools currently available and recommended piloting the use of Elements of a Recovery Facilitating System (ERFS) developed from DREEM²³ by Pricilla Ridgeway at Yale. This recommendation was unanimously endorsed at the workshop referred to in section 1.

DREEM and ERFS were derived from extensive qualitative research into the qualities valued by people who use services in supporting their personal recovery. DREEM is regarded as one of the best measures of its type but has also been criticised as overly comprehensive and laborious to use routinely²⁴. ERFS asks participants to consider 20 features or qualities of recovery services and rate the extent to which they are present in the services they use. This is done on a five point scale – ‘always’, ‘often’, ‘sometimes’, ‘rarely’ or ‘never’ present. For example:

	Always	Often	Sometimes	Rarely	Never
I am supported to succeed in normal life roles such as worker, student, and tenant.					
I am told about my rights and how to uphold them					
I am helped to create and maintain family and social contact					
I am helped with my basic needs such as income, housing, and transport					

Concerns were expressed at the workshop and in the steering group about some of the language used in ERFS and also the applicability of the described qualities to all network services. It was suggested that there should be a ‘not applicable’ option. After considerable discussion it was agreed that to introduce a new option within the rating would compromise the validity of the tool but it would be acceptable to anglicise and slightly modify the language. There was email correspondence with Pricilla Ridgeway (the principal author of ERFS) about this. The amended questionnaire used in the pilot sites is attached at appendix 2.

5.2 Implementation

The questionnaire was used once in September 2008 (the midpoint of the pilot). In all sites except one it was administered face to face during a support session or meeting organised for this purpose. The second ‘*How well is life working out for you?*’ questionnaire was administered at the same time. One service was unable to do this for the reasons described in section 3.8 so the questionnaires were sent by post to participants with a covering letter and reply envelope.

²² Perkins, R. Repper, J 2003

²³ Developing Recovery Enhancing Environments Measure: Yale Programme for Recovery and Community Health. Cited in R&IL PEG Advisory Paper No: 2

²⁴ Dinniss, S., Roberts, G., Hubbard, C., Hounsell, J. & Webb, R. (2007) User-led assessment of a recovery service using DREEM. *Psychiatric Bulletin*, 31, 124–127.

5.3 Feedback from participants and practitioners

The feedback from participants and practitioners was gathered as described in section 4 for *'How well is life working out for you?'* As before, participants and practitioners were asked to comment on the content, process and usefulness of the questionnaire.

Also as before, it is important to note that many practitioners and participants completed the feedback questionnaires with single "yes" or "no" answers whilst others wrote detailed comments. The overall ratio of positive and negative answers was not always reflected in the detailed comments so, where possible, the information below shows both the numerical proportions and the tenor of the more detailed feedback.

- **Content**

We asked if the questionnaire posed the right questions to enable people to discuss the aspects of the service they receive which were important to them.

Of the 56 participants who expressed a view 36 (64%) reported that the questionnaire had asked the right questions and 20 (35%) that it had not:

It helped me to make comments about the service

Yes, they were the right questions, straight, concise and to the point. They allowed me to put down what I wanted

To some extent, There needs to be a 'not applicable' option, as there were questions on services I don't need to use and I therefore answered 'never' which could look like it's a bad service

I feel this questionnaire had no connection to the treatment I was provided

Most questions not relevant to the service I use

It tended to lean towards people who had been diagnosed with mental health problems and had attended hospitals

Some questions linked completely separate issues and I wanted to answer 'yes' to one of them and 'no' to another but he had to put 'sometimes' instead (eg race religion and culture ; family and social contact.)

Practitioner feedback reflected a similar mix of applicability. In pilot sites within what would previously have been described as secondary mental health services the questions were felt to be applicable. This was not as true of services which fell within the mental wellbeing and access function or in community networks, housing support or vocational services:

Reasonably easy, some questions totally unassociated to my role and the young people I work with

Easy to administer but there were a lot of 'not applicable' responses due to the language. It seemed to be more adapted to residential settings

The questions do not really fit with our service which is based on people supporting each other – they found the idea of 'staff' doing things for them or to them a bit strange. We had a laugh about it as a group but it might have been quite negative

This was picked up in the feedback workshop: There is a need for a N/A (not applicable) column as some agencies do not provide certain areas mentioned on the questionnaire and some relationships do not cover certain issues for reasons other than a lack of recovery focus.

The language used in the questionnaire attracted two criticisms; that it was patronising and that it was not always compatible with recovery principles. It was also suggested that it would be more helpful to begin each question with 'in my view' or 'in my experience'.

The overall language is infantilising. Being 'taught to cope' is not recovery language. 'Staff seem to hold hope for me' is very demeaning and some staff have pretty screwed up lives themselves

The language wasn't appropriate and easy to use

This questionnaire used all the right recovery language but didn't feel recovery at all – 'staff do, staff teach' etc. very patronising

- **Process**

We asked participants how it felt to complete the questionnaire and have the discussions which arose and we asked practitioners how easy or difficult it was to administer it.

Of the 58 participants who expressed a view 31 said 'ok' or 'fine' or similar, and 21 used words such as 'uneasy', 'confused' or 'uncomfortable'. 10 also said that there had been no discussion of the questionnaire or the issues arising from it:

I felt uneasy with the questions and didn't want to discuss them

It felt like an activity for which I had to put time aside and steel myself to confront unpleasant actualities

It made me think about things I hadn't thought about, useful things that need to be brought up

No discussion was had at all; it was done as a tick box exercise

Comfortable with questions and discussion

It highlighted the issues of limiting factors like only having one hour per week – sometimes it's not enough

Felt ok doing it, discussions limited

Generally, practitioners found this questionnaire straightforward to administer with 14 responding "easy", "no problem" or "simple"

Easy as questions were structured well

But others found it less straightforward:

The questionnaire was awful. A lot of service users were confused by it. Lots of questions were not applicable but there was no N/A box

As with the other questionnaire, it was felt that there needed to be sensitivity about when this questionnaire should be used. There were two themes: using support time for an exercise which is primarily of benefit to the service (as opposed to individual recovery) and sensitivity to the support needs of the person at that time:

A nightmare! I was given this questionnaire at the same time as the other one in this survey and they took over my whole clinical meeting. I was ill at the time and needed help not forms

Extra time should be set aside for doing this sort of thing

My care coordinator should not have given me this questionnaire as we spent an hour arguing over our opposing views of the service he is part of... This form should not be part of a clinical meeting; it should be done separately as I need my time with my care coordinator to maintain my mental health. I went into an unnecessary crisis due to these surveys imposing on the limited time my care coordinator has to spend with me due to his large caseload

This was also raised at the workshop: The timing of the questionnaire is vital to its effectiveness. This should be down to the feelings of the people who are providing and using support and should be considered carefully.

Another issue raised was 'who should be asking these service evaluation questions?' It was suggested that it could be difficult for participants to give direct and honest answers to the questions because they might feel they were a judgment on the person who was both supporting them and asking the questions:

We need independent people doing this form with us

All felt a little difficult doing this with staff – gave them space and reassured them they could be as honest as possible about the service

One service user felt that people may want to answer these questions in private

Clients held back negative thoughts because they did not want to offend

- **Usefulness**

We asked participants how helpful the questionnaire was (did it support their recovery?) We asked practitioners if it had made them think about their current practice; if it had changed the discussions they had with people and whether any particular question has exposed an unmet need.

Of the 60 people who expressed a view 39 (65%) reported that it had been helpful and 21 (35%) that it had not. The majority of those who reported that it had been helpful answered with the single word "yes" whilst more of those who answered "no" added a comment. Therefore the comments below do not reflect the majority view but there were insufficient positive comments to show a more accurate balance:

It told me nothing I didn't already know and lots of the questions were inappropriate for me as I'm perfectly able to cope myself with things like finance, housing, transport, work, rights etc.

The questions were broad and covered a lot of meaningful subjects, a lot to do with recovery and support

Was not really relevant to the service I use

Not in the slightest

At best it highlighted various problematic areas but as I am eminently aware of these much of the time the experience was merely depressing

This questionnaire wasn't as helpful as the other

The difficulties in my life stemmed from long term physical health problems and although these have a psychological impact, that is secondary. I felt the questionnaire was particularly relating to mental health issues and some people might feel uncomfortable about this – not see it as applicable to them. Also, as I commented above, it is my professional and financial circumstances that have caused greatest stress and this did not seem to be included, as far as I recall, in the questionnaire

Practitioners were split fairly evenly between those who did and those who didn't feel that this questionnaire had encouraged them to consider their current practice or influenced the discussions they had with people (few of the latter expanded on the reasons for this so again, the comments do not reflect the balance of overall opinion):

Yes, seeing myself through their eyes and how things are not always experienced in the way they are intended, I need to check this out more

Yes, in terms of communication skills, not assuming, pre-empting and acknowledging each person's unique experience of the network

Yes, but I wouldn't say my practice has changed

The importance and experience of our service – that people feel empowered in their lives

It did bring up issues and has made things more open for discussion.

Yes, people have said since completing this that they do not feel they have much of a say in how the service is run. We need to look into this. Maybe organise a fortnightly forum?

Has encouraged me to look at how clients see the service

Yes, it did bring up issues and has made things more open for discussion

Yes, it has highlighted people's recovery needs and an opportunity to discuss ideas to help people progress in their recovery. The questions are holistic and cover a lot about people's health and wellbeing. They are questions we do not ask every day but have started embracing.

I think it has encouraged us to do more with the tenants regarding the running of the project

I find it difficult to have time to think about my current practice because of an excess of paperwork (such as this)

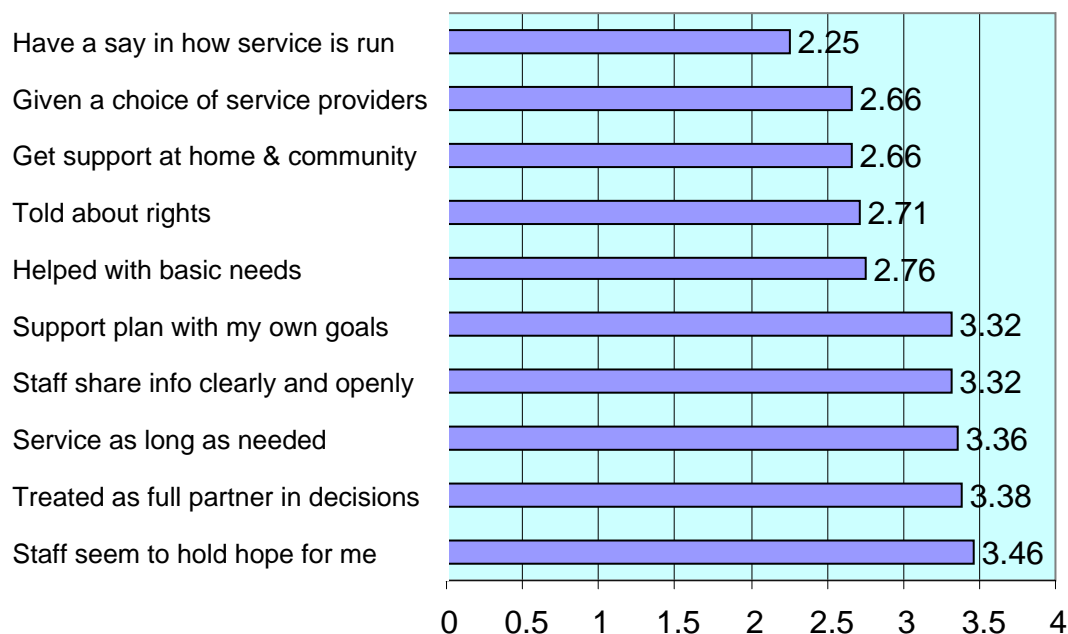
5.4 What did the collection of data tell us?

ERFS is a simplified version of DREEM which has not undergone a full psychometric evaluation and so its reliability and validity are unknown.²⁵ Pilot use of ERFS resulted in an Alpha 0.94, indicating good reliability.

The picture with regard to validity is more mixed. The ERFS recovery measure was demonstrated to be valid for the particular populations of some, but not all pilot sites. In these sites it is clear that its items were meaningful to those populations. As can be seen from the feedback reported before and below, some of the items of ERFS were not meaningful for some pilot sites and the participants at these sites could not respond to these items with meaningful replies. These items do not, therefore, provide a valid indication of recovery at these sites.

108 ERFS questionnaires were analysed from 8 pilot sites, but not all were fully completed. The questionnaire asks participants to consider 20 qualities of recovery services and rate the extent to which they are present in the services they use. This is done on a five point scale – ‘always’, ‘often’, ‘sometimes’, ‘rarely’ or ‘never’ present. A score of 0 indicates that participants consider that a quality is never present in the service and a score of 4 indicates that it always is.

Diagram 1 shows the combined average score for the 5 highest and 5 lowest scoring questions



This would appear to show that services performed best overall in response to statement 4: *Staff seem to hold hope for me* and least well for statement 10: *I have a say in how this service is run*. However, it is important to remember that this information cannot be taken as a direct commentary on service provision. Personal responses are as much a commentary on the individual participant and their circumstance at that time. This introduces many variables and much ‘noise’ in the data.

²⁵ Dinniss, S., Roberts, G., Hubbard, C., Hounsell, J. & Webb, R. (2007) User-led assessment of a recovery service using DREEM. *Psychiatric Bulletin*, 31, 124–127.

Not all items of the ERFS were meaningful to participants in every pilot site. The overall score from ERFS had better validity in some services than others. It would not therefore be helpful to use the overall ERFS scores for either comparisons between services or to monitor changes in the overall performance of all services. This feature of our data does not simply reflect a difficulty with the ERFS; instead it reflects a more fundamental issue. The most appropriate manifestation of recovery values in services will be different in different circumstances. It was predicted from the outset that people using particular network services would find it difficult to apply some questions to the support they use. This was borne out by the number of ‘not applicable’ or similar comments written on questionnaires and further implied by the number of questions which were left blank, this varied from site to site.

Of the questionnaires returned, there was only one person who declined the ‘how well is life working out for you?’ questionnaire throughout. Therefore virtually all participants who responded completed at least some items at each stage. A much higher percentage of respondents at each stage completed the all questions in ‘how well is life working out for you?’ than they did in ERFS. Taken along with participants’ qualitative feedback, this would seem to indicate a higher degree of relevance of the former and several difficulties with the latter. This is shown in the table below.

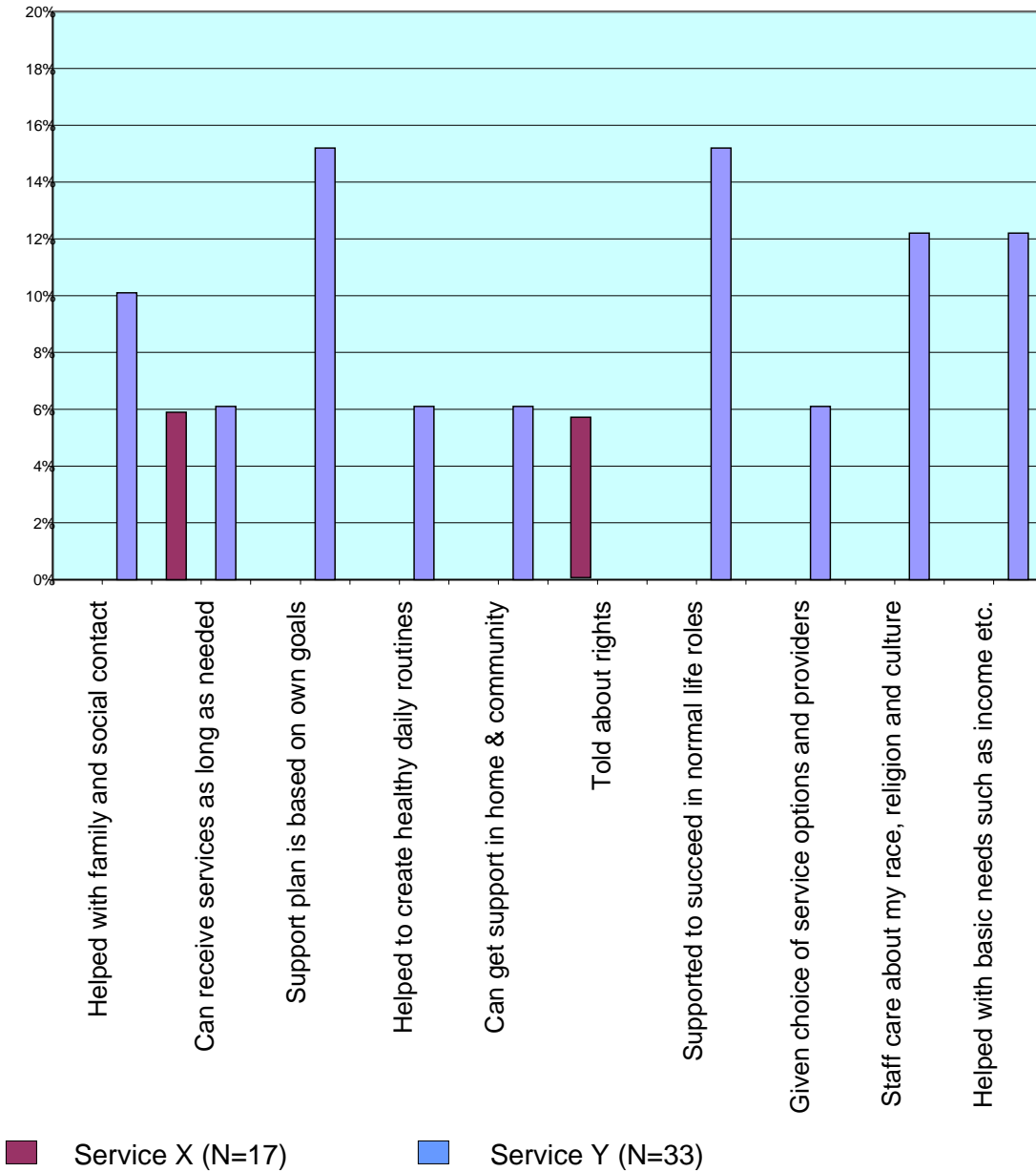
	How well is life?			ERFS
	Stage 1	Stage 2	Stage 3	
Number of people answering some or all questions	264	187	112	108
Percentage of people who answered all questions	97%	95%	85%	58%

Diagram 2 on the next page shows the percentage of ‘not applicable’ or blank responses for the 10 questions in which they most commonly appeared for pilot site X (which had the least missing data) and Y (which had the most). The issue of relevance might be connected to the provenance of the tool as a product of consumer experience of mental health services in the United States (predominantly inpatient and accommodation based services)²⁶. It is not surprising that some of the content does not fit well with the life experiences and expectations of people who use resources within the wellbeing and access function, or people who use (for example) the networks of mutual support. However, pilot sites X and Y are at the same end of the service spectrum and broadly fit the provenance of the tool – both work with people who have significant and sometimes long standing mental health problems so another explanation is required.

Practitioners from site Y reported in their feedback that participation in the pilot added little to their practice because they already did ‘comprehensive support planning’ yet 15% of respondents at that site felt that the statements *my treatment or support plan is based on my own goals* and *I am supported to succeed in normal life roles such as worker, student and tenant* were not relevant to them in the service they use. This could indicate that people are not as involved in their support planning as claimed or, given the lack of enthusiasm for the pilot amongst staff at this site, it might be explained by the attitudes to and understanding of the questionnaire referred to before (see 4.5). This illustrates that the data cannot provide the answers but is a good starting point for further discussion.

²⁶ Assessing the recovery commitment of your mental health service: a user’s guide for the Developing Recovery Enhancing Environments Measure (DREEM) Priscilla Ridgway, MSW Allan Press, Ph.D. UK Version I (2004)

Diagram 2 the percentage of 'not applicable' or blank responses in sites X and Y



Associated with this is the importance that participants place on each quality or feature of recovery supportive services. Two pilot sites with previous experience of using the service evaluation sub section of DREEM felt that the simplification of the measure had taken some of the richness out of the tool. DREEM not only asks for an evaluation of each service quality but also asks the person to indicate how important this quality is for them which ERFs does not do.

This point was also illustrated in the information from other sites. Staying with the example of statement 10: *I have a say in how services are run*: this is an area which has rightly received much attention within mental health services and a low score could naturally be seen as something of concern. However, in the site which provides psychological interventions in primary care settings more than one participant made a comment along the lines of *why would I want to?*

Use of data – an example

While the data cannot be used as a definitive statement on the performance of the service, two pilot sites provide an illustration of how the information generated might be of value. The teams at Russell Clinic²⁷ and Cypress²⁸ had both used the service evaluation sub section of DREEM in the past. These two sites share some features of service provision in that they both provide intensive recovery support in an inpatient setting.

These two sites identified similar areas where participants did not consider the service supported them well. One of these was attention to and support for spiritual needs. Both sites went on to look at how practitioners could be encouraged to explore this area with the people they work with and what additional support could be provided by (for example) the chaplaincy.

It was useful for the teams to see how people's perceptions changed over time and in response to changes made but both sites treated this information with caution, relying mostly on the subsequent discussions with the people who had completed the questionnaire.

5.5 Discussion

The Devon approach to the measurement of outcomes incorporates three key components into a single framework: service evaluation against agreed standards; personal outcomes for recovery and wellbeing and the individual experience of using services. None of these tells the full story and none can be substituted for another. A consumer rated evaluation of the experience of using services is essential to complete the framework.

We need to be clear about the purpose and function of such a measure and maintain a clear distinction between tools which are deployed as supports for personal recovery such as *how well is life working out for you?* and those which are intended to gather information for the practitioner, service or agency.

The evaluation should go beyond the more familiar 'satisfaction' surveys to capture the person's view of how well services support recovery and wellbeing.²⁹ The need is for a tool which allows each person to reflect on the experience of the service being used and for practitioners to understand how the service they provide is experienced.

The purpose of *how well is life working out for you?* is to be a support for personal recovery and practice development but ERFS has a service evaluation function – albeit with caveats. The data generated from ERFS can usefully contribute to this function within, but not beyond, the service in which it is generated.

Results from such a tool will carry implications for action for practitioner, team and service development. Successive measures over time can be used as a way of recording shifts in personal experience and mapping practice and service development.

²⁷ Dinniss, S., Roberts, G., Hubbard, C., Hounsell, J. & Webb, R. (2007) User-led assessment of a recovery service using DREEM. *Psychiatric Bulletin*, 31, 124–127.

²⁸ www.community-care-trust.co.uk

²⁹ For a discussion of this see: Recovery and Independent Living Professional Expert Group (R&IL PEG) Advisory Paper No: 2: Briefing paper on the setting of standards and measurement of outcomes for the Mental Health and Wellbeing Networks of Devon and Torbay January 2008

The collection and analysis of data consumes time and resources. Several pilot sites expressed concerns about their capacity to collect and analyse data without the support of the project. Embedding recovery service evaluations into routine audit and reporting schedules will have resource implications which will vary from provider to provider. Services which support small numbers of people should not find it unduly challenging to conduct (for example) a six monthly evaluation survey involving all those using the service. Those with greater numbers might have to use a sampling process and, as with all such exercises, the larger the sample: the better the information.

The pilot identified problems with the application of ERFS which related to the content and language. Although it was considered easy to use, it is clear that the pilot has not given a universal endorsement of this measure.

If implemented across the networks some services would need to adapt the content for their particular circumstances. This would be problematic if the intention was to use the information gained to compare or 'rank' services against each other but the commissioners have made it clear that this is not the case:

Individual recovery journeys are likely to be unique and influenced by a range of determinants. This is why the focus is being placed on evidence of process and practice and their linkages to recovery outcomes rather than creating a recovery league table approach.³⁰

Adaptation of the measure is not necessarily problematic if it is being used at a team or service level to support improvement rather than arrive at a definitive statement on the adequacy or otherwise of provision.

We should not ignore the requirement for providers to produce performance information about social inclusion indicators such as: employment, education, housing, healthy lifestyles and social and community engagement. The reasons for basing neither personal outcomes measurement nor the evaluation of service experience on externally defined indicators are discussed in section 4.2. Pilot sites reported a tension between the two approaches and also the difficulties of responding to multiple demands for information.

If network services are going to adapt ERFS there could be a pragmatic benefit to combining these two distinct functions. For example: question 13. *I am supported to succeed in normal life roles such as worker, student, and tenant* could be combined with factual information on the person's employment, educational and housing status which could be collated and mapped over time. The principle benefit would be that this would ensure that social inclusion indicators are not conflated with personal outcomes for recovery. One pilot site has already adapted ERFS in this way and incorporated a combined measure into their contract monitoring and review process.³¹

The steering group considered doing further work on ERFS to modify the language, and the categories of questions. It was agreed that this would be better done when more services are involved in the implementation. At the outset of the pilot several pilot site leads identified elements that were 'not applicable' to their services but revised this opinion in the light of feedback from their participants. This demonstrates the importance of working with people using particular services in any adaptation of ERFS. It is also recommended that this should feed into a network-wide learning process.

³⁰ Devon Joint Commissioning Manager Adult Mental Health. LIT report. September 2008

³¹ For more information contact info@community-care-trust.co.uk

In addition to the issues of content, the pilot identified key questions about the process of using such tools:

Should such measures be incorporated into clinical or support time if the principal direct benefit is to the practitioner or service rather than to the individual? Providers should consider how and when this type of evaluation should take place. As a minimum standard, extra time should be allocated either within a support session or separately to prevent it encroaching on the person's support needs.

Would it be more comfortable for the individual to express their views to someone who is not also their main support provider? And would the responses be less influenced by reluctance to give 'negative' feedback directly to the person concerned (and the person with whom an effective relationship has to be maintained). Previous experience of using DREEM in one pilot site has identified the value of people other than staff administering service evaluation questionnaires.³²

Providers should consider who should conduct the evaluation and what opportunities and benefits there may be for this to be done by people who have the experience of using services.

The pilot identified resource implications for embedding ERFS into routine service monitoring and reporting. It is legitimate to require commissioned services to demonstrate that such measures are in place but also that such a requirement is proportional to providers' capacity to meet it. For this reason, it is recommended that service evaluation be negotiated and defined within the contract monitoring and review process.

Recommendations

- All service specifications should incorporate a requirement to evaluate the experience of using recovery services by the people who use them.
- Commissioners, providers and contract managers should agree an annual cycle of service development planning which incorporates the evaluation of the experience of using services.
- ERFS should be offered to providers with the invitation to work with people who use their services to adapt it as necessary for particular service delivery or adopt an alternative tool which fulfils the same function.
- Providers should, where appropriate, consult with the people who use their services about how to conduct this evaluation. This should include a consideration of the benefits of employing people who have experience of using services to conduct the evaluation.
- Providers and contract managers should receive training in the purpose and application of evaluation measures
- The continuing development of the measure, choice of alternative tools and the learning from wider implementation should be supported and monitored.

³² Dinniss, S., Roberts, G., Hubbard, C., Hounsell, J. & Webb, R. (2007) User-led assessment of a recovery service using DREEM. *Psychiatric Bulletin*, 31, 124–127.

6. Core standards for the mental health and wellbeing networks

“Service providers aim to provide a good service. But how do we know if we are, and how do those who pay for such services know what they are getting? Extensive work in Devon has led to broad and inclusive endorsement of 10 core standards for recovery oriented services.³³ Taken collectively these form a framework for what a ‘good service’ should look like and how it should behave.”³⁴

The 10 standards were developed locally through the process described in section 1. This process drew on the considerable information already available about service evaluation and what matters to people about the resources they use. This included:

- The growing literature of consumer opinion and research into what constitutes recovery supportive services. This includes local, national and international viewpoints with some of the most developed work coming from the same sources that informed the outcomes element of the project³⁵.
- National policy and guidance for social inclusion, diversity and the reduction of stigma and discrimination³⁶ together with local intentions for their implementation.³⁷
- The LIT vision for the mental health and wellbeing networks as expressed in strategic plans, policy implementation guides, contractual standards and service specifications.
- The statutory quality standards which providers are required to meet.

The intention is that the standards will be applied to all commissioned services within the mental health and wellbeing networks. The audit of compliance with, or progress towards, the standards should take account of the diversity of service provision across the three network functions and specialist services. These services respond to different needs and are provided by teams and organisations in the statutory, private and third sectors.

The published standards are broad statements which are designed to have wide applicability but do not give the detail necessary for audit. The aim of the pilot was to develop and test a tool for self evaluation which could be externally validated and used for a variety of purposes:

- To provide a description of the attitudes, behaviours and processes people who use services and their supporters can expect to experience – and a means of holding the system to account for delivering these.
- To support team and service review and development and inform managers and service planners about service improvement priorities.
- To inform the contract monitoring and review of commissioned services, using shared language and expectations to promote equity and transparency.
- To give commissioners an understanding of how a service is performing overall and what the focus of service improvement or investment should be.
- To support public confidence in the services commissioned on their behalf.

³³ The recovery guide to values, principles, practices and standards: Devon Partnership Trust, Devon and Torbay LIT, Devon Joint Commissioners August 2008.

³⁴ G Roberts: Measuring recovery: Discussion paper - standards and outcomes steering group

³⁵ DREEM: Developing Recovery Enhancing Environments Measure; Yale Programme for Recovery and Community Health. Cited in R&IL PEG Advisory Paper No 2

³⁶ Delivering Race Equality in Mental Health services: (DoH 2005)

³⁷ A.Moores. Social inclusion; recovery and the networks. Devon and Torbay LIT September 2007

6.1 Process

The intention was that each pilot site would look in detail at one randomly allocated standard in the context of their service. They would describe the service features which would need to be in place to meet the standard and the evidence they would provide to demonstrate that it was met. The purpose was not to rate or score the site but to describe *how* it could assess itself against the standard and identify areas for improvement. Sites would be encouraged to collaborate, not compete and to draw on outside expertise and support. It was anticipated that relevant information would already be available from other monitoring and inspection processes.

At the beginning of August, pilot site leads were allocated a standard and asked to prepare a description of its application in their service and of the evidence they would provide for self evaluation (not to collect the evidence itself). This was to be submitted in October and be reviewed by a small group of their peers and other steering group members to establish if the self evaluation could be externally verified.

The project lead had an initial meeting to clarify the task and begin to generate ideas with most, but not all, pilot site leads. Four pilot sites did a considerable amount of work and consultation to arrive at the description of the standard as applied to their service. Two pilot sites also supplied an outline of their supporting evidence.

By October it became clear that many pilot sites were struggling with capacity for this work and that it would not be completed in line with the project plan. It was agreed to adopt the following revised process and this was subsequently achieved:

- The project lead would draft an evaluation framework which would incorporate the work done by the pilot sites to date and the discussions that had taken place.
- This framework would be circulated and presented to a variety of interests for comment and feedback. This would be done as opportunity presented itself but target audiences included DPT Clinical team Leaders, Community Development Workers, contract managers, commissioners, pilot sites and other teams.
- The project lead would redraft the evaluation framework in the light of feedback thus obtained and circulate to pilot sites and commissioning interests for final comment.
- The steering group and pilot site leads would identify the range of quality assurance measures currently applicable to commissioned services. The project lead would invite other interests to review this and add any relevant measures not identified.
- The project lead would identify the contribution each standard could make to the monitoring of a selection of external quality assurance measures commonly applied in the networks^{38 39 40}. These would be cross referenced to make it clear to future users of the framework that self evaluation can and should incorporate information already routinely collected. It would also show that the self evaluation could be a useful tool for services wishing to demonstrate compliance with external quality assurance measures.

³⁸ Standards for Better Health: Department of health 2004

³⁹ Supporting People Quality Assessment Framework: Office of the Deputy Prime Minister 2003.

⁴⁰ National Minimum Standards for care homes, independent hospitals, adult placements and day services/opportunities.

6.2 Discussion

The project target of producing a detailed self evaluation framework for the standards was met. This is attached at appendix 1. There was broad consensus to the content of the framework and its applicability in a range of service settings. All the comments received were incorporated into the final draft and there were no outstanding or unresolved issues with the content. There was no feedback from pilot sites or elsewhere to indicate that the framework contained unreasonable or unrealistic expectations for service providers.

The practical application of the standards was only partially tested for the reasons given above. The framework was presented to a group of clinical team leaders⁴¹ and was also used as the basis for a team review in two services⁴². The comments made were that it was a workable tool which provided a welcome clarity about what recovery based services look like in practice. No negative feedback was received. This feedback is less comprehensive than was hoped for but provides an indication of how the framework might be received by those responsible for its application.

It was not possible to confirm that self evaluation could be externally verified for the reasons given above. The cross referencing with existing quality assurance measures indicates that that it could be but further work is needed to demonstrate that the whole self evaluation could be externally verified and to consider who should carry this out and in what context.

Recommendations

- The 10 core network standards should be incorporated into all mental health and wellbeing service specifications.⁴³
- Commissioners, providers and contract managers should agree an annual cycle of service development planning which is based on the audit and reporting of standards
- The self evaluation framework should be offered to providers and contract managers as a tool for auditing progress towards meeting the standards.
- Providers and contract managers should receive training in the purpose and application of the self evaluation framework.

⁴¹ Recovery and Independent Living Clinical team Leader support and development group

⁴² St Maur and Granvue residential recovery and community support services (CCT)

⁴³ For information about the incorporation of the 10 standards into the standard NHS and local authority contracts contact: info@community-care-trust.co.uk

APPENDICES

6. I have privacy, time and space to think about myself and my life

| _____ |
Not at all moderately completely

7. I have roles and responsibilities which are valued by others

| _____ |
Not at all moderately completely

8. I have opportunities in my life to use my personal strengths, skills and talents

| _____ |
Not at all moderately completely

9. I feel of equal value to others

| _____ |
Not at all moderately completely

10. I have a sense of meaning and purpose in life and feel hopeful about my future.

| _____ |
Not at all moderately completely

Additional questions

11. How well do these questions cover the important areas of your life?

| _____ |
Not at all moderately completely

12. What other important area of life would you like to include?

13. And how well is that working out for you?

| _____ |
Not at all moderately completely

Appendix 2

ELEMENTS OF A RECOVERY FACILITATING SYSTEM (ERFS)

Thinking about the service or project you are using at present, please indicate which of the following choices is most true for you. Please answer all of the items

		Always	Often	Sometimes	Rarely	Never
1	I am treated as a whole person (with a body, mind, social and spiritual life)					
2	I am helped to create healthy daily routines					
3	I am treated as a person who can learn. Grow and change					
4	Staff seem to hold hope for me					
5	I am helped to see and use my own strengths					
6	Staff care about my race, religion and culture					
7	My treatment and support plan is based on my own goals					
8	Staff treat me as a full partner in decision making					
9	I am taught how to cope with and manage my mental health problems					
10	I have a say in how this service is run					
11	I can get support in my home and community					
12	I am helped with my basic needs such as income, housing, and transport					
13	I am supported to succeed in normal life roles such as worker, student, and tenant.					
14	I am told about my rights and how to uphold them					
15	I am helped to create and maintain family and social contact					
16	This service employs people who are positive role models who I can learn from					
17	All the services I receive are well coordinated					
18	I am given choice among good service options / providers					
19	Staff share information clearly and openly					
20	I can receive services for as long as I need them					

Appendix 3

10 Core Network Standards

The 10 core standards for the mental health and wellbeing networks aim to describe the features and qualities of a 'good recovery supportive service'. This framework offers a tool for the self evaluation of progress towards meeting the standards by teams and services.

Many network providers will be subject to other quality assurance frameworks and policy guidance which are specific to the type of service they provide. The intention is, wherever possible, to avoid duplication and unnecessary bureaucracy by using the same information / evidence to support evaluation against network and other standards. To support this, examples are given of how the 10 core standards can be supportive of some of the other quality assurance measures which are most commonly applicable. This is intended as illustration and is not comprehensive, all services and teams could usefully consider how this framework fits with other measures required of their particular service.

The quality assurance frameworks referred to in the final column are:

S4BH	Standards for Better Health: Department of health 2004 (updated 2006). The core and developmental standards covering NHS health care provided for NHS patients in England.
SPQAF	Supporting People Quality Assessment Framework: Office of the Deputy Prime Minister 2003.
NMS (C)	Commission for Social Care Inspection: National Minimum Standards for care homes for adults (18-65) in compliance with the Care Standards Act 2000. Regulation of Care Homes 2003.
NMS (H)	Healthcare Commission: National Minimum Standards for private and independent healthcare providers in compliance with the Care Standards Act 2000
NMS (AP)	Commission for social care inspection: National Minimum Standards for Adult Placement Schemes in compliance with the Care Standards Act 2000.Regulation of Adult Placement Schemes 2004
NMS (DS)	Care services Improvement Partnership/ Integrated Care Network: National Minimum Day Services / Opportunities Standards 2007

The numbers and letters refer to the relevant standards within these frameworks.

Network core standards

Standard 1. The Recovery Approach		
All staff have a knowledge of the recovery approach and the significance of social inclusion and are competent in using recovery skills and qualities appropriate to their work role.		
The provider can describe:	Features	Supports QAF:
<p>The approach taken by the service to promote the mental health and wellbeing, recovery and social inclusion of the people who look to it for support</p>	<ul style="list-style-type: none"> ➤ A statement of purpose (operational policy, vision statement, or equivalent) which describes how the service will: <ul style="list-style-type: none"> • Engage with each individual in a respectful and empowering relationship. • Support each person to identify their needs and aspirations in those areas which give common value to human life such as financial security, employment, education, accommodation, relationships and social engagement. • Work towards outcomes which are individually defined and inclusive of aspirations for employment, education, relationships and other quality of life and social inclusion indicators. • Support each person to meet their needs through the use of the resources available to them and wherever possible through use of resources available to the general population • Increase individual empowerment and control over important life choices. • Promote mental health awareness and self management skills through education and supported experience. • Increase individual participation in community and civic life. 	<p>S4BH C5 D5 D9 C10 C11 D11</p> <p>SPQAF C1.3 S3.1 S3.2 S4.3</p> <p>NMS(C) 1 3 8 32 34 35</p>
<p>How the service recruits people with the appropriate knowledge skills and attitudes</p>	<ul style="list-style-type: none"> ➤ A recruitment policy or statement which includes: <ul style="list-style-type: none"> • Advertising, application forms, job descriptions and person specifications which are: consistent with the statement of purpose; clearly identify the aims and ethos of the organisation; and identify the post holder's contribution to the recovery and self management of people who use the service. • Selection processes such as application forms, short listing criteria, reference proforma and interview questions which are explicitly based on the knowledge, skills and attitudes required for the delivery of recovery based services. • The involvement of people with lived experience of recovery in the process of recruitment (including job design, person specifications, advertising and interviewing) • Advertising and selection processes which encourage and support applications from people who have a lived experience of recovery and diverse life experience. • Relevant mandatory selection and vetting procedures such as CRB, POVA, professional registration and affiliation, and others as appropriate. • A monitored probationary period during which the suitability of the applicant can be assessed in practice and the review of which includes feedback from people who look to the service for support. 	<p>NMS(H) C8 C9 C10 M5 M6 M11</p> <p>NMS(AP) 2.3 7.1 8.1 8.2 8.4 8.5 9.1 9.2</p>

<p>How the service trains staff in the recovery competencies (knowledge, skills and attitudes) necessary for their work.</p>	<ul style="list-style-type: none"> ➤ A statement of the knowledge, skills and attitudes required for the delivery of the service which includes those which are common to all staff and those which are role specific. This might make reference to established national and international recovery competency frameworks such as those developed in New Zealand and by CSIP or the local integration of recovery competencies into the Knowledge and Skills Framework (KSF) ➤ A training and development plan or statement which includes: <ul style="list-style-type: none"> • Well structured induction and foundation training which incorporates: recovery awareness; the importance of partnership in the support relationship; recovery outcomes; the principles and techniques of self management using frameworks such as the Wellness Recovery Action Planning (WRAP); and, where appropriate, foundation Support, Time and Recovery (STR) training. • The development of self awareness in staff and an understanding of the impact of personal attitudes on recovery and the experience of using services – particularly in relation to hope and aspiration. • The development of good ‘customer relations’ skills and of the standards of communication and behaviour that people can expect from staff. • Exposure to personal stories of recovery and also of the experience of using services • An understanding of the range of responses (care, treatment, education, social and leisure activities, the creative arts etc) which people have found helpful to their recovery. • Developing an awareness of the importance of having meaning and purpose in life to individual recovery and quality of life. • Ongoing training for the development of recovery practice which is based on performance appraisal which includes feedback from people who look to the service for support. • Ongoing training and development to meet the fidelity criteria of specific roles such as Support, Time and Recovery (STR) workers and other professional CPD requirements. • Training for specific or ‘specialist’ aspects of delivering recovery supportive services such as vocational reablement, return to education, the self management of unhelpful coping responses or living with extraordinary experiences such as hearing voices. • The delivery of training by, or in conjunction with, people with lived experience of recovery. ➤ A description of how the provider ensures that personal, team and organisation training plans are responsive to the needs and preferences of the people who look to the service for support and how they are evaluated for their impact on the experience of using services. 	<p>NMS(DS)</p> <p>1 3 16</p>
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Standard 2. Recovery Outcome Evaluation

All services have a regular cycle of measuring recovery outcomes embedded into routine practice which is used to inform progressive practice and service improvement

The provider can describe:	Features	Supports QAF:
<p>The approach taken to defining and measuring the personal recovery outcomes of the people who look to the service for support.</p>	<ul style="list-style-type: none"> ➤ A description of how the service reviews with each person their satisfaction with their situation and quality of life, the changes they wish to make, the desired outcomes of such changes and whether the person considers these outcomes have been achieved. This should make reference to the needs we share in common for our mental health and wellbeing: <ul style="list-style-type: none"> • A safe and homelike living environment • The opportunity to give and receive appreciation and attention • A sense of independence and control over important decisions • Someone to trust and turn to for help • Mutual (give and take) relationships • Privacy, time and space to reflect about oneself and one's life • The opportunity to hold roles and responsibilities which are valued by others • Being able to use our strengths and talents • Feeling valued by others • Challenges to stretch us and help us grow • A sense of meaning and purpose in life. ➤ A description of how the service captures the service user perspective of how well it supports recovery and wellbeing. This would include service user evaluation of indicators of recovery supportive services such as: <ul style="list-style-type: none"> • Having a support plan based on personal goals • Having a say in how the service is run • Being treated as a whole person (with a body, mind, social and spiritual life) • Being helped to create healthy daily routines • Being taught how to cope with and manage mental health problems • Being helped to create and maintain family and social contact • Being supported to succeed in normal life roles such as worker, parent or tenant. 	<p>S4BH D4 C5 D8</p> <p>SPQAF C1.1 S4.2</p> <p>NMS (H) C5 C7 C6 M4 M13</p> <p>NMS(DS) 4</p>
<p>How this is used to inform and guide the practice of staff.</p>	<ul style="list-style-type: none"> ➤ A description of how outcomes measures are used to improve the way staff relate to and understand the needs of the people they support and to tailor their practice / responses to individual need. This will include through supervision and appraisal. 	
<p>How this is used to inform service improvement and development.</p>	<ul style="list-style-type: none"> ➤ A description of how the information is used in service and policy reviews, training and development, team evaluations and organisational development plans. 	

Standard 3. Coherent and Effective Service Configuration

Services are constructed on recovery principles and delivered by teams that are managed and led so as to be coherent and effective contributors to the overall network.

The provider can describe:	Features	Supports QAF:
<p>How the work of staff is organised and led to ensure that they are able to respond to the needs and preferences of those they support.</p>	<ul style="list-style-type: none"> ➤ A description of a management and leadership culture which enables staff to promote the recovery and empowerment of those they support through: <ul style="list-style-type: none"> • Clarity of purpose which is based on the recovery outcomes of the people who look to the service for support. • Clear lines of accountability and authority • High standards for the performance of staff • High expectations for the quality of life those who use services can be supported to achieve or maintain. • Arrangements for both formal and day to day supervision and support of staff • Employment and management practices which are based on recovery principles, such as supporting wellbeing in the workplace, maintaining the work-life balance, personal responsibility for conduct, seeking support and raising concerns and 'no blame' learning from untoward incidents. • Safety and risk management policies which support positive risk taking as an important component of self management and personal autonomy. ➤ A description of daily working practice and / or caseload management which is demonstrably based on recovery principles and includes: <ul style="list-style-type: none"> • A negotiation of support which is based on need rather than 'what the service does'. • Flexible work allocation in response to changing need and personal preference. • Provision for the person to exercise choice over the support provided and who provides it. • Team working hours which are responsive to need and choice • Daily routines which are flexible and which limit collective or group activities to those where there is a clear reason for or benefit in doing so. ➤ A description of how the service monitors the delivery of support and how this informs service improvement. 	<p>S4BH</p> <p style="padding-left: 20px;">D2 D4 C5 C6 D9 D11 C16</p> <p>SPQAF</p> <p style="padding-left: 20px;">C1.1 S1.1 S1.3 S1.4 S2.2 S3.1 S3.2 S4.1 S4.2</p> <p>NMS (C)</p> <p style="padding-left: 20px;">4 8 33</p> <p>NMS (H)</p> <p style="padding-left: 20px;">C1 C7 M2 M20</p> <p>NMS(AP)</p> <p style="padding-left: 20px;">3.3 6.1 6.3 9.4</p>

<p>How the service provided is integrated with the care treatment and support provided by other services</p>	<p>➤ A description of how the service ensures that people receive the supports and responses they need and that these work together to achieve individual recovery outcomes regardless of where in the networks they are provided or by which organisation or service. This may include:</p> <ul style="list-style-type: none"> • Personal recovery plans held by the person using the service and incorporating all elements of care, treatment and support – including contingency plans for times of difficulty. Or care plans which clearly identify the role the service plays in the overall care package. • Support for people to manage and coordinate their own packages of care through the use of direct payments • Strong links with local services, including specialist mental health, vocational, educational and other support services. • Agreed referral and access routes which are well communicated to relevant service providers • Joint assessments, planning and reviews • The responsibility to inform relevant others of changes in the person's health and circumstances and when the service is no longer available. • Arrangements for continuity of contact when the person's circumstances change for example, during hospital or respite admissions. • Arrangements to ensure smooth transitions between services and continuity of support until the new support relationship is established • Procedures for alerting other care providers (including families and other supporters) in the case of unplanned withdrawal or unavailability of services. • Information for families and other supporters about sources of information, help and support 	<p>NMS(DS) 1 3 18</p>
<p>The information available to service users, their supporters and colleagues in other services about the service, what it can offer, who is eligible to make use of it and how they can gain access to it.</p>	<p>➤ Readily accessible information which includes details of:</p> <ul style="list-style-type: none"> • The purpose of the service and what a person could expect to achieve through making use of it. • A description of the service including where, at what times and by whom it is delivered • Who the service is available for including any eligibility criteria. • Any particular groups of people or areas of need that the service aims to work with. • How people can get access to the service • Provision for additional support in gaining access to and using the service and where this is available from. • Contact details and response times for enquiries. • Provision for the information to be available in other languages and formats. 	

Standard 4. Network Partnership Relationships

Network partnership relations are characterised by good communication, clarity, consistency and respect.

The provider can describe:	Features	Supports QAF:
<p>How the service ensures that high standards of communication are maintained.</p>	<ul style="list-style-type: none"> ➤ A communication policy or statement which includes: <ul style="list-style-type: none"> • A requirement in job descriptions, code of conduct or similar that staff will conduct all communication with courtesy and respect and in a timely manner. • The training given to staff about the responsibility to provide accurate information to colleagues in other support settings. • A confidentiality policy which is clear about the circumstances in which personal information will be shared; with whom and what control the service user can exercise over this. • Regular liaison with partner organisations to review the effectiveness of inter-service communication. 	<p>S4BH C6 C22</p> <p>SPQAF S2.1</p> <p>NMS (H) M3 M20</p>
<p>How the service contributes to and is informed by the development of the mental health and wellbeing networks.</p>	<ul style="list-style-type: none"> ➤ A description of how the service and its staff contribute to the development of the mental health networks and how it meets the requirement to keep up to date with the opportunities available to service users. For example: <ul style="list-style-type: none"> • Contributing to strategic planning groups and consultation exercises. • Participating in local planning groups • Providing or sharing training with other services • The sharing of information and good practice through networks such as Recovery Devon, the Support, Time and Recovery (STR) network, service user and carer networks • Joint working or partnership arrangements • The co-location of staff • Ensuring that information about other services and resources is readily available to service users. 	<p>NMS(AP) 3.5 3.6</p> <p>NMS(DS) 4 18</p>
<p>How the service ensures that it works effectively with other network agencies in the provision of care and support.</p>	<ul style="list-style-type: none"> ➤ An explicit commitment to partnership working which is communicated to all staff, is monitored, and includes an undertaking to: <ul style="list-style-type: none"> • Conduct all business with openness and transparency and in keeping with contract governance arrangements and, where applicable, Compact guidelines. • Discuss with partners the impact of any proposed service changes and take into account the effect they will have on other services. • Be aware of and respect the referral and operating criteria of partner services • Provide accurate information to service users, families and other supporters about the opportunities other services provide. • Obtain the agreement of other service providers before including them in care or contingency plans. • Share good practice and new initiatives in mental health and wellbeing • Share the learning from untoward incidents and near misses. 	

Standard 5. Staff and Service Performance

All practitioners, teams and services are subject to regular performance review to ensure that staff are safe, appropriately qualified and equipped, and that they are supervised and supported in the requirement to deliver recovery based practice.

The provider can describe:	Features	Supports QAF:
<p>How the service ensures that staff are clear about their roles and responsibilities.</p>	<p>➤ A description of how staff are made aware of their roles and responsibilities for the delivery of recovery based practice which may include:</p> <ul style="list-style-type: none"> • Service statements of purpose and outcomes • Pre employment information about the service and the post holder’s role in supporting the recovery of those who use the service. • Job descriptions and person specifications which are based on the requirement to deliver recovery supportive practice and are regularly reviewed. • Induction, training and development which incorporates the fidelity criteria for specific roles • The responsibility of staff to identify where they are not clear about what is expected of them and to seek advice • Operating policies which define roles, responsibilities and personal accountability for practice • Team or service planning which considers the wellbeing (ie effectiveness) of the team and each person’s responsibility to contribute to that. 	<p>S4BH</p> <p style="padding-left: 40px;">D4 C5 D5 C11</p> <p>SPQAF</p> <p style="padding-left: 40px;">S4.1 S4.2 S4.3</p> <p>NMS (C)</p> <p style="padding-left: 40px;">31 32</p>
<p>How the service supervises staff and monitors their performance in recovery based practice</p>	<p>➤ A supervision, appraisal and performance policy or statement which includes:</p> <ul style="list-style-type: none"> • Supportive and robust line management arrangements. • Regular supervision of all staff by supervisors who are appropriately trained in recovery focused supervision • Regular appraisal which is based on the knowledge, skills and attitudes required for recovery based practice. • The responsibility of staff to maintain competency and seek support or additional training when appropriate. • The arrangements in place to address poor performance and to ensure that the service is delivered by staff who are competent to do so. 	<p>NMS (H)</p> <p style="padding-left: 40px;">C7 C8 C11</p> <p>NMS(AP)</p> <p style="padding-left: 40px;">9.2 9.3 9.4 10.8</p>
<p>How team or service performance is reviewed.</p>	<p>➤ A description of how teams or services regularly review their performance in delivering recovery outcomes which may include:</p> <ul style="list-style-type: none"> • The achievement of the aims and objectives in the statement of purpose • The achievement of recovery outcomes as described by those who use the service • The satisfaction with services as expressed by service users, their supporters and colleagues in other services. • Performance against contractual targets – activity and outcomes • The wellbeing of the team and its capacity to deliver recovery based practice • The involvement in service reviews of people with a lived experience of recovery, people who use the service, and those who support them. 	

Standard 6. The experience of networks

There is excellent 'customer care' such that services are experienced as supportive of individual recovery as well as receptive to personal preferences and diverse need.

The provider can describe:	Features	Supports QAF:
<p>How the service ensures that it is responsive to the diverse needs and preferences of those it supports.</p>	<ul style="list-style-type: none"> ➤ A description of an assessment process which: <ul style="list-style-type: none"> • Is collaborative and, if they choose, include the person's family and other supporters. • Is 'whole person' taking into account all mental health and wellbeing needs. • Focuses on the person's strengths, resources and proven coping skills and strategies. • Considers the person's family life and social and economic situation • Considers the person's legal situation (eg refugee, asylum seeking status) • Considers spiritual and cultural needs • Considers gender related issues • Addresses language and communication barriers • Asks people about their preferences for how their needs might be met. 	<p>S4BH D8 D9 D10 C13</p> <p>SPQAF C1.1 C1.2 S1.2 S1.3 S3.2 S4.2</p>
	<ul style="list-style-type: none"> ➤ A description of personal support planning and review which is: <ul style="list-style-type: none"> • Developed collaboratively with the person and any others they wish to be involved. • Uses a recovery and self management framework such as WRAP • Strengths based, building on the person's potential for self management. • Pays attention to all aspects of the person's life and needs including the support needed to retain or gain employment, training and education. • Is based on personal need and preference rather than on 'what the service does'. • Focus on the individual's goals and aspirations. • Identifies the desired outcomes and the responses needed to achieve them. • Encourages Self Directed Support including the option of Direct Payments • Considers the support the person needs to maintain their safety. 	<p>NMS (C) 1 3 6 7 11 15 16 18</p> <p>NMS (H) C2 C3 C4 C6 C7</p>
<p>How the service works with families and other supporters and recognises the importance of family and relationships to recovery</p>	<ul style="list-style-type: none"> ➤ A description of how the service recognises the importance of family and supports the individual to maintain key relationships. This may include: <ul style="list-style-type: none"> • Ensuring the privacy to maintain personal and intimate relationships • Welcoming the participation of families and supporters both in support planning and in activities of support. • Providing information and support to enable families and other supporters to identify and meet their own needs. • Supporting people to maintain and fulfil their own caring responsibilities, including parental responsibilities • Providing mental health and emotional wellbeing information and education to the family as a unit. • Providing support for people to re-establish fractured family relationships. 	<p>M1 M11 M12 M13 M14 M20 M25 M27</p> <p>NMS(AP) 1.1 1.3 1.4</p>

<p>The arrangements in place to ensure that services are consistently and reliably delivered in accordance with individual need and personal preference.</p>	<p>➤ A description of how the service monitors the delivery of the supports identified in personal recovery plans. This might include:</p> <ul style="list-style-type: none"> • Detailed caseload reviews to establish if the supports provided are consistent with the needs and preferences expressed in the personal plan. • Making contact with people who choose to disengage with the service to find out the reasons for this. • The monitoring of support activities for individual variation and choice. • Monitoring the balance of individual and group activities. • Provision for continuity of service in the absence of staff (eg holidays and sickness) • Monitoring of missed appointments and cancelled activities. • Providing a contact point for use by service users and carers in the case of staff not attending appointments or activities. • Reviewing working patterns with staff to ensure that they are flexible and responsive to changing need and preference. • The collection of activity and outcome data as specified within contracts. • The involvement of people who use the service in contract monitoring and review. 	<p>2.1 3.1 3.2 3.5 4.1 4.2 4.3 5.5 6.1 6.2 10.3</p> <p>NMS(DS) 4 5 6 7 9 16 20</p>
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Standard 7. Satisfaction

There is a high level of satisfaction from those who use the services to support their recovery, their families and other supporters, and providers of related services. The general public have confidence in the services provided to their communities

The provider can describe:	Features	Supports QAF:
<p>How it measures the satisfaction with service provision of those who look to it for support, their families and other supporters, and colleagues in related services</p>	<p>➤ A description of how satisfaction with services from the various perspectives is measured. This might include:</p> <ul style="list-style-type: none"> • Periodic satisfaction questionnaires targeted at the relevant interests • The use of advisory or focus groups • The use of peer interviewing and other forms of service user led satisfaction measures. • The recording of suggestions, concerns and plaudits • Exit interviews • Encouraging articles from people who use services in newsletters / websites etc • Monitoring and following up unplanned disengagement from services • Agreements for service user and carer participation workers or others hold 'surgeries' collect and report service user feedback. 	<p>S4BH D8 D11 C14 C17</p> <p>SPQAF S1.2 S2.3 S4.1 S4.2</p> <p>NMS (C) 8 22</p>

<p>How this information is used to inform service improvement and development.</p> <p>The systems in place to respond to concerns from whatever source.</p>	<ul style="list-style-type: none"> ➤ A description of how information about service satisfaction is used to inform: <ul style="list-style-type: none"> • Reflective supervision and appraisal • Team reviews • Organisational reviews and planning • Annual and governance reports • Contract monitoring and review ➤ Where the organisation is large enough, a description of the role of the senior member of staff or director who is responsible for monitoring satisfaction with services and maintaining a programme of continuous service improvement. ➤ A description of comprehensive arrangements for registering and responding to concerns which will include: <ul style="list-style-type: none"> • A culture which is open and responsive to feedback • A formal complaints procedure • The availability of advocacy support to raise concerns • Responsibility for responding to concerns resting with a named individual • The involvement of people who use the service in the investigation and resolution of complaints and concern. 	<p>NMS (H)</p> <p>C4</p> <p>C6</p> <p>C14</p> <p>C15</p> <p>NMS(AP)</p> <p>1.6</p> <p>6.1</p> <p>10.6</p> <p>NMS(DS)</p> <p>16</p> <p>17</p>
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Standard 8. Social Inclusion

All services demonstrate socially inclusive practice which is supportive of people living ordinary lives in ordinary settings and considers in particular people’s needs for accommodation, occupation, education, personal relationships, money and participation in community activities

The provider can describe:	Features	Supports QAF:
<p>How it supports the people who use the service to engage with everyday life in ordinary settings.</p>	<ul style="list-style-type: none"> ➤ A description of service delivery which: <ul style="list-style-type: none"> • Carries out most of its activities in locations available to the general public. • Provides flexible and where necessary, intensive support for people to access community opportunities and engage in activities with the general population. • Limits the number of segregated and /or group activities to those with clear purpose and benefit. • Has strong links with local organisations. • Collaborates with education, supported employment, arts and leisure providers to offer taster courses, concessionary rates and other encouragements for participation. • Promotes schemes which encourage participation such as prescriptions for learning, exercise on prescription and arts on prescription. • Provides individual support to people to progress from segregated mental health education, vocational and leisure activities to mainstream opportunities 	<p>SPQAF</p> <p>C1.1</p> <p>S1.3</p> <p>S3.2</p> <p>NMS ©</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>19</p>

<p>How the service supports people to meet their aspirations for work, education or other meaningful occupation.</p>	<p>➤ A description of how educational and occupational needs and aspirations are identified and incorporated into personal recovery plans. . This may include providing support to engage with :</p> <ul style="list-style-type: none"> • Activities which increase confidence and interpersonal skills. • Mainstream educational opportunities by helping with travel and enrolment and support in or outside the classroom. • Educational taster and trial sessions. • Specialist vocational services • Volunteering opportunities • Pre vocational training to enhance work related confidence and skills. • <i>Pathways to Work</i> providers for personal vocational advisors, condition management programmes and individual work focused action plans. • Supporting participation in schemes such as time banks which enable people to contribute their skills and time to others and form mutually beneficial connections. 	<p>NMS(AP) 1.2 4.4 4.5 4.7</p> <p>NMS(DS) 11 12 15 18 19</p>
<p>How the service supports people to achieve and keep the accommodation of their choice and have sufficient income to meet their needs.</p>	<p>➤ A description of how the service supports people to meet the need for a safe and comfortable home environment and sufficient income to meet basic needs. This may include:</p> <ul style="list-style-type: none"> • Providing support with day to day living and household management activities • Providing intensive support to people at risk of losing their home. • Working with housing services to identify and meet housing and support 	
<p>How the service supports people to maintain good physical health,</p>	<p>➤ A description of how the service promotes healthy lifestyles and access to physical healthcare. This may include:</p> <ul style="list-style-type: none"> • Encouraging the inclusion of healthy living and diet and exercise regimes into personal recovery plans. • Ensuring that each person is registered with a GP, including the homeless and those in temporary accommodation. • Ensuring that access to primary care services is maintained during periods of transition such as discharge from inpatient or residential care or movement within supported housing provision. • Supporting people to have regular physical health checks and in particular that all people with longer term mental health problems have access to regular health checks and that the uptake of these is monitored. • Working with public health colleagues to engage people in health promotion activities which will include; diet and nutrition; smoking cessation; sexual health; exercise regimes; medication advice. • Supporting people to make use of targeted health screening programmes for at risk groups which will include mammograms, cervical screening and testicular screening. • Ensuring that people have the appropriate support to maintain adequate nutrition, personal hygiene and environmental safety. • Supporting people to take medication at home, seeking advice and communicating concerns to colleagues in primary care or specialist mental health services. 	

Standard 9. Building mental wellbeing

All service users are supported to develop skills and strategies to achieve and maintain wellbeing and develop resilience to stressful life experiences. Service providers and practitioners are similarly encouraged and supported to develop their health and wellbeing.

The provider can describe:	Features	Supports QAF:
<p>The approach taken to strengthening the emotional wellbeing and resilience of those who use the service.</p>	<p>➤ A description of the approach used to encourage emotional wellbeing and equip people with the skills and resilience to live well in the face of difficulties. This might include:</p> <ul style="list-style-type: none"> • An approach which emphasises personal responsibility for wellbeing and the control that we can take over our responses to difficult life events. • The use of a self management and wellness framework such as Wellness Recovery Action Plans (WRAP) as the basis for all support planning. • Groups and classes which help people to learn positive strategies for dealing with stressful experiences. • Promoting engagement with peer-led training and support for managing mental health problems such as bi-polar disorder, depression or for living with extraordinary experiences (such as 'hearing voices' groups) • Support to self manage unhelpful coping responses such as overuse of alcohol or illicit drug use. • Attention to physical health as an important contributing factor in emotional wellbeing. • Staff who model self management and positive responses to challenging situations. 	<p>S4BH D13 C23</p> <p>SPQAF C1.1 S1.3 S4.3</p> <p>NMS (C) 17</p> <p>NMS(AP) 1.4 4.7</p> <p>NMS(DS) 12</p>
<p>How the approach to wellbeing is applied and modelled to the wellbeing of staff.</p>	<p>➤ A description of how the service applies a consistent approach to wellbeing in its management and support of its staff. For example:</p> <ul style="list-style-type: none"> • A culture which promotes self awareness amongst staff and an understanding that the needs and challenges faced by people who use the services are common to us all. • Attendance and sickness policies which are based on personal responsibility for self management and organisational responsiveness to difficulties. • Training and support for staff to manage their health in the workplace. • Debriefing after difficult events and recognition of the impact these can have on staff. 	

Standard 10. Challenging stigma and discrimination

All services are able to engage with and effectively respond to issues of prejudice, stigma and discrimination.

The provider can describe:	Features	Supports QAF:
<p>The approach taken to challenge and reduce the discrimination experienced by people with mental health problems</p>	<ul style="list-style-type: none"> ➤ A description of the approach the service takes to minimizing the effect of negative attitude towards mental health problems and those who experience them. This may include: <ul style="list-style-type: none"> • Maintaining a culture of high expectation for and of people who use the service, challenging practice which limits aspirations and standards for people who experience mental health problems. • Maintaining a high level of awareness of the subtle aspects of stigma and discrimination in all forms of communication • Delivering services in places which are open to the general public, encouraging better interaction and understanding and not reinforcing a perception of stigma through segregation. • Making positive connections with community organisations, employers and leisure providers to promote positive attitudes towards mental health and increase emotional literacy. • Promoting activities, such as sports, which bring together people with and without defined mental health problems – to support both physical health and encourage better interaction and understanding • Providing advocacy and support for people to access resources and opportunities in their local communities. Supporting access to information, advocacy and legal advice for the enforcement of the rights of people with mental health problems under the Disability Discrimination Act 1995. 	<p>S4BH C7 C8 C18</p> <p>SPQAF S1.3 C1.4 S4.3</p> <p>NMS (H) M15 M26</p> <p>NMS(DS) 3 8 10 13</p>
<p>How the service seeks to engage with under-represented groups.</p>	<ul style="list-style-type: none"> ➤ A description of how the service identifies and meets the needs of under-represented, diverse and potentially stigmatized groups. This may include: <ul style="list-style-type: none"> • Ensuring that the service is easily accessible to the identified ethnic minority groups in each local area by: providing services in culturally sensitive environments; connections with faith and religious groups; access to interpreters or translation facilities • Connections with organisations and groups for other people who might be discriminated against for reason of age, gender, sexual orientation or disability. • The promotion of services and provision of outreach to diverse communities and groups 	
<p>How the service promotes inclusive and non stigmatising practice.</p>	<ul style="list-style-type: none"> ➤ A description of recruitment, training and employment practices which promote Inclusivity and sensitivity to diverse need. These may include: <ul style="list-style-type: none"> • Anti discrimination training for all staff which is delivered by trainers with lived experience from various Black and Minority Ethnic community groups, and also from Community Development Workers • The impact of culture and Belief in terms of working effectively with people from various ethnic backgrounds. • Inclusive recruitment and selection procedures. • The employment of people with lived experience throughout the workforce, including supervisory staff and practitioners. 	

Appendix 4

Pilot sites

	Service	Pilot site lead
1	ARC counselling	Catherine Davies
2	Community Care Trust : Cypress Recovery services (independent hospital)	Eilis Rainsford
3	Community Care Trust: Torbay and Rural Teignbridge Women's Networks	Caroline Riggs
4	Devon Partnership Trust: Exeter Recovery and Rehabilitation team	Cath Kean / Susan Crowe
5	Devon Partnership Trust: Exeter Recovery and independent living community team	Shaun Crean
6	Devon Partnership Trust: Dart ward Langdon Hospital: forensic services	David Brunskill
7	Devon Partnership Trust: North Devon assertive outreach team	Doug Mclynn
8	Devon Partnership Trust: North Devon Link Centres. Community network services	Russ Drayton
9	Devon Partnership Trust: Harbourne Unit. Older adults services:	Neville Todd
10	Devon Partnership Trust : Russell Clinic, rehabilitation and recovery inpatient unit	Rachel Webb
11	Guinness Trust: Spurfield House: residential care	Primrose Bond
12	MIND: Housing support Exeter	Leah Allen
13	Pluss: vocational enablement services	Tom Bromwich
14	Primary care mental health practitioners – West Devon (Devon Primary Care Trust and independent practitioners)	Kevin Dudman
15	Rethink: Riverside project (housing support)	Karen Sullivan / Kevin Whitty
16	Young Devon : counselling, psychotherapy and housing support	Keith Coulston

Steering group members:

All pilot site leads

David Cooke	Trainer with lived experience
Laurie Davidson	DPT practice development manager
Rohan Davidson	Community Care Trust (South Devon) Ltd - Project administrator
Sarah Frazer	DPT Assistant Director of Organisational Development
Sue Gubb	Devon Supporting People. Service Review & Development Officer.
Ian Harrison	DPT Director of projects
Nick Hopkinson	DPT Assistant Director of Information Management & Technology
Sarah Leach	DPT Recovery Lead
Ann Iley	DPT Research and Development Team
Sally Lloyd-Tomlins	DPT Clinical effectiveness lead
Glenn Roberts	DPT Consultant Psychiatrist (rehabilitation and recovery)
Anne Sawyer	DPT Director of Corporate Development and Performance
James Wooldridge	Trainer with lived experience

Alison Moores (Project Lead)

March 2009