Commissioning for Mental Health Outcomes in the North West

Final Report

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Contents

1 Background and aims

The North West Mental Health Improvement Programme (NW MHIP) and the National Mental Health Development Unit (NMHDU) have been working with commissioners in the North West of England to form the *North West Commissioning for Outcomes Project*. The project was established with the following three aims:

1. to provide commissioners with tools to commission for clear outcomes;
2. to enable providers to clearly articulate outcomes for their service users that result from their service interventions; and
3. to learn lessons about the process of agreeing and gathering robust, meaningful evidence of clear outcomes for service users.

The project drew upon the theoretical *Social Inclusion Outcomes Framework* (SIOF) that was published in 2009 and has attempted to apply this in-service delivery practice.[1]

A key facet of the project has been the process of providers and commissioners agreeing outcome areas of the SIOF and signing off how data would be collected in a manner that was robust, verifiable and acceptable to commissioners, without the need to sustain a 'cottage industry' around data collection.

2 Process

The project commenced in Autumn 2009 and ran until the end of March 2011 (18 months). The project enlisted commissioners from across the North West who were interested in developing their commissioning expertise in this area.

Each commissioner agreed to work to develop SIOF areas with NHS and third sector providers that could be embedded in future contracts and linked to local or regional Commissioning for Quality and Innovation (CQUIN) payments.

Support to the project was provided by the Mental Health Improvement Programme through Catherine Webster (lead for Cumbria and Lancashire), Colin Vose (lead for Cheshire and Merseyside), Tony Ryan (lead for Greater Manchester) and Margaret Oats from the National Mental Health Development Unit (NMHDU) along with coordination from Ian Fairbrother (MHIP project lead and formerly through Simon Rippon). Support was delivered to sites throughout the North West with sites consisting of both commissioners and their provider partners.

A series of regional events supplemented the on-site support and took place between autumn 2009 and October 2010. These brought together commissioners and providers to share learning about progress and problem solve issues that were creating difficulties for sites.

This report represents the progress achieved over the course of the project.

[1] http://www.socialinclusion.org.uk/publications/Broadened_Social_Inclusion_Outcomes_Framework.pdf

The 10 areas involved in the project were:

- Cumbria
- Halton
- Knowsley
- Lancashire
- Salford
- Stockport
- St Helens
- Warrington
- Wigan
- Wirral

They covered 11 Local Authorities and Primary Care Trusts with a total of 16 provider services successfully completing the project.

3 Developing outcome measures and differentiating between outcome and process measures

The Social Inclusion Outcomes Framework (SIOF)[2] was developed as a tool that could be applied to mental health services promoting social inclusion. However, several of the 'outcomes' the SIOF describes are in fact 'process measures' as they count interventions, support mechanisms or tasks that might be put in place by the service to support the user. In many cases it is assumed these processes will lead to desirable outcomes, which may be what often happens. Yet, helpful as these process measures are, they only go so far.

For example, setting up an appointment with a dietician for someone who has a weight problem is a very helpful process on the way to achieving a healthy weight. However, in itself, it does not demonstrate that it has achieved anything for the service user. A true outcome measure (or 'hard' outcome) would be one that describes the effects of such a process or intervention, in this case weight loss. A 'sustainable outcome measure' would be weight loss that is maintained over a period of time and which is healthier that the previous weight at the start of the interventions.

The SIOF was used throughout the North West Commissioning for Outcomes Project to stimulate thinking across participating sites and helped them to describe clear outcomes in many areas of the SIOF. A list of the areas of social inclusion covered in the SIOF are provided below in Table 1.

User outcomes	• Community participation • Social networks • Employment • Education and training • Physical heath • Mental wellbeing • Independent living • Personalisation and choice
Service outcomes	• User satisfaction • User involvement • Diversity

[2] http://www.socialinclusion.org.uk/publications/Broadened_Social_Inclusion_Outcomes_Framework.pdf

Table 1: Social Inclusion Outcome Framework areas

Participants in the project aimed to clearly differentiate between 'process measures' and 'outcome measures'. Within the outcome measures there is further differentiation between 'hard' and 'sustainable' outcomes. Being able to describe (and ultimately count) both the 'outcomes' and 'processes', allows the service to adjust their 'processes' if they are not delivering the 'outcomes' they agree with their commissioners.

4 Project participants and outcome areas

An overview of commissioners, providers, service type and outcome areas are provided below. The Appendices contain the contact details of providers and commissioners for any readers who wish to liaise and learn more about specific projects. An overview is provided below.

Commissioner	Provider	Service Type	Outcome Area
Stockport LA	Stockport Day Centre	Mental Health Day Service	• Social Networks • Mental Wellbeing
Stockport LA and Tameside LA	Stockport & District Mind	Crisis Accommodation & Home Support Service	• Social Networks • Mental Wellbeing
Ashton, Leigh & Wigan PCT	Making Space (Ashwood Court)	Independent hospital: Rehabilitation	• Physical Health • Independent Living
	Alternative Futures (Fir Trees Independent Hospital)	Independent hospital: Rehabilitation	• Mental Wellbeing • Independent Living
	Making Space	Employment Service	• Employment
	Spinning World (PSS: Liverpool Personal Service Society)	Asylum seeker support service	• Mental Wellbeing
	Richmond Fellowship (Rueben's Court)	Supported accommodation	• Physical Health • Independent Living
Salford PCT	Turning Point (Pendlebury House)	Independent Hospital: Rehabilitation	• Physical Health • Independent Living
	Greater Manchester West NHS Foundation Trust (Bramley Street)	In-patient rehabilitation unit (community based)	• Independent Living
	Greater Manchester West NHS Foundation Trust (Prescott House CMHT, Salford)	Community Mental Health Team	• Physical Health
Halton & St. Helens PCT	St Helens Mind	Social Inclusion	• Social Networks • Mental Wellbeing

Commissioner	Provider	Service Type	Outcome Area
Wirral PCT	Advocacy in Wirral	Computerised Cognitive Behavioural Therapy	• Education & training
	Wirral Community Development BME / Wirral Change	Community Development Worker Service	• Education & training
Warrington PCT	Alternative Futures (Lea Court)	Independent Hospital: Rehabilitation	• Physical health • Mental Wellbeing not provided • Independent Living
Lancashire PCTs	Lancashire Care NHS Foundation Trust	Step 4 community services	• Physical health • User satisfaction
Cumbria	Croftlands Trust	Community Participation Service	• Community Participation

5 Findings

Most of the commissioners and providers who commenced the project were able to complete it and deliver data for outcome areas of the SIOF as they had agreed. Where providers were unable to complete the project it was primarily due to their data collection systems not being sufficiently flexible to accommodate the work of the project. NHS Trusts found this more difficult to accommodate than third sector organisations. This is likely due to the fact that their information technology infrastructure can be particularly complex and expensive to amend.

Key issues as they relate to the outcome areas

A summary of the key findings in each of the outcome areas is provided below. Within the Appendices greater detail is given for each service and their outcome areas. In many cases, figures may appear low, and there are four reasons why this may be so. Firstly, the project took place as a developmental initiative with people learning about the process throughout. Secondly, some services' data was gathered partway through the year and any data gathered from earlier months may not have been as robust as we would have liked. Thirdly, there is a lag between achieving the outcomes and demonstrating they were sustained, often of six months. There were many instances where the six-months' deadline for achieving a sustainable outcome occurred after the 31st March 2011. Finally, it should be acknowledged that achieving outcomes in several of the areas is actually very difficult; although this should provide an even greater reason to attempt to achieve meaningful user outcomes in these areas.

Some of the service outcome templates presented in the Appendices also include a brief case study in order to give a rounder sense of progress to readers. In these case studies, pseudonyms have been used to ensure service user confidentiality and maintain anonymity. A small number of the qualitative studies are also included in the section below, summarising the outcome areas.

Mental wellbeing (five services)

There was a range of ways in which mental wellbeing could be measured which was identified across the participating sites (use of the Recovery Star[3], use of new coping strategies, self report and use of CORE – Clinical Outcomes Research and Evaluation)[4]. The numbers and proportions of people achieving the agreed outcome measures were variable but all services were able to show some positive impacts. Crucially, there were significant proportions of those who achieved the outcome, who went on to sustain this over a six-months period.

A number of reasons exist for some people not achieving the six-months outcome. The main one, as indicated above, is the time lag between achieving the outcome and the date of the six-months follow up being outside the period of data collection (as was the case in many of these outcome areas).
A second reason behind the variability was the range of different client groups worked with: people using day services, crisis services, rehabilitation services and asylum seeker services. Each of these clients groups will have had different needs and this may explain some of the variations. Nevertheless, it is apparent that mental wellbeing outcomes could be measured, achieved and sustained.

Mental Wellbeing Case Study: Stockport Crisis Accommodation & Home Support Service

> *Susan was diagnosed with bi-polar disorder as well as self-diagnosing as having adult Attention Deficit Hyperactivity Disorder (ADHD). Her symptoms caused her continuously to miss vital appointments and payments and had led to breaches of tenancy for not paying rent on time and allowing rubbish to collect in her garden. She had previously self-harmed and used negative coping mechanisms such as excessive drug and alcohol misuse. When Susan was referred into the service she was feeling very depressed and anxious, stating that she was finding it increasingly difficult just to get by with day-to-day living. In order to cope, she had been camping in the woods at a time when temperatures were below freezing. Susan was offered temporary accommodation but stated she would prefer practical and emotional support whilst remaining in her own home.*
>
> *After an initial couple of visits in which the assessment was conducted and Susan got to know the Crisis Accommodation and Home Support Service (CAHSS) worker, the recovery star was completed with her. She scored a low overall score of 32 out of a possible 100, with her worst areas being in 'Living Skills', 'Responsibilities' and 'Work'. On the basis of Susan's needs, a series of short, medium and long term goals were devised with her. In the short term, Susan was helped with developing immediate coping skills for managing her day-to-day life; implementing calendars and organisers for time and home management and setting up direct debits for her finances. Medium term goals looked at how she*

[3] Recovery Star: http://www.mhpf.org.uk/recoveryStar.asp
[4] CORE: http://www.coreims.co.uk/

could make positive life changes. A referral was made to a drugs support agency for her cannabis dependency and she was encouraged to take part in various social drop-ins, classes and therapy sessions. The longer-term goals looked at her future and her aim of becoming a volunteer, and she was helped to apply to become a volunteer at a local centre. Leisure activities were undertaken with Susan such as going with her on walks and taking her to the gym. More practical interventions were also offered such as introducing her to a solicitor in order to challenge a recent decision made by the NHS, and referring her to a housing support agency in order for her to potentially be re-housed.

Throughout the intervention, Susan was encouraged to learn new skills and problem-solving techniques in order to encourage her independence. Over time, this clearly increased her confidence and self-esteem as she engaged further with peer support networks at local centres. Susan also developed new coping strategies and as she increased using strategies such as meditation, deep breathing and exercise, she decided to stop using cannabis all together. By the end of the intervention it was clear that Susan had new confidence and higher well-being and had even achieved her aim of becoming a volunteer, supporting other people with mental health problems. On the final score of the recovery star, Susan had gone from 32 up to 55, indicating positive improvements in all aspects of her life.

Social networks (three services)

A day service, crisis service and social inclusion service all took up the challenge of seeking to improve service users' social networks. Having robust social networks can provide resilience for people's mental health, improve their self esteem and feelings of inclusion. An extraordinarily wide range of ways of evidencing success was used across just three services. These included tools developed outside the project such as the *Inclusion Web* [5], *Recovery Star* areas 'social networking' and 'relationships' [6], the *Wellbeing Outcomes Star* [7] and the *Eco Mapping Tool* [8]. Also, a bespoke service data recording system was further refined to capture outcomes specific data for this project, the *Case Outcome Recording System* (CORS) [9]. These tools were supplemented with a range of other methods including reviews, notes between users and key workers, contact notes, specific one-to-one sessions to examine outcomes, and feedback from other sources of evidence (e.g. support groups three months after discharge – with prior approval from users to make contact). As with other outcome areas the achieved outcomes and sustained outcomes varied across the services, probably for the same reasons as previously expressed.

Physical health (five services)

[5] Inclusion Web: www.ndti.org.uk/what-we-do/community-inclusion/the-inclusion-web/
[6] Recovery Star: http://www.mhpf.org.uk/recoveryStar.asp
[7] Wellbeing Outcomes Star: http://www.outcomesstar.org.uk/well-being-star/
[8] Eco-mapping tool: http://hdi.uky.edu/SF/Libraries/NECTC_Rearch_Spotlights/Using_Eco-Mapping_as_a_Research_Tool.sflb.ashx
[9] Case outcome recording system (CORS): www.go-gravitas.co.uk/

This area proved the most difficult to deliver outcomes and sustained outcomes. In most cases this is likely to be due to the client group concerned having particularly poor health. It is well established that long term users of mental health services experiences poorer physical health than most other groups. Yet, despite these difficulties, the services were able to show some outcomes. They all reported that the focus on physical outcomes had significantly restructured what they offered in terms of interventions. It also provided a clear focus on an area that has often been neglected in mental health.

Physical Health: Lancashire Care Case Study

> *David is currently being supported by the Recovery Team. On his initial physical health assessment his BMI was 50.3. He reported that he had tried over the years to reduce his weight but for one reason or another had not managed to do so. His physical health check also highlighted his heavy drinking and poor diet, both of which contributed to his weight issues. David was initially referred to weight management and a dietician where advice was given. He has not drunk alcohol since Christmas, is eating a fat free diet, taking regular exercise (walking) and has been given Xenical to assist him. His weight is now steadily dropping and he has lost half a stone in the last month.*

Independent living (six services)

Each of the services that looked to demonstrate outcomes in this area were rehabilitation services, although the principles of what they did could easily be applied to any service that seeks to move people on to more independent living. The services were able to produce reasonably impressive outcomes, given the low numbers of people in the services, and this outcome area has proved one of the easiest to measure and report on. It could easily be applied to the use of out-of-area placements and linked to a CQUIN measure to ensure focus is given to a client group who are sometimes known to have difficulties in attaining greater independence from services. Such an approach would provide greater focus than is sometimes given by Care Programme Approach (CPA) Care Coordinators and area of origin services.

Independent Living Case Study: Fir Trees (Independent Hospital)

> *Prior to Miss A being admitted to the service (a mental health rehabilitation facility) there had been on-going problems in maintaining her stability as she presented as generally chaotic and distressed with unpredictable behaviours, as a result of past experiences and mental health needs. During her nine months stay within the service, she progressed well. Initially problems occurred with engaging with staff and commencing the rehabilitation programme. However, we worked together in identifying each area of need. We spent time together working on areas of early warning signs, relapse prevention, developing alternative and effective coping strategies and a staying-well plan, alongside increasing confidence in her abilities to manage general domestic and daily living activities, e.g. cooking, shopping etc. Miss A achieved her goal of moving to independent accommodation with planned support from community staff/services. Contact with her care co-ordinator has confirmed that Miss A has successfully maintained this tenancy since discharge and has continued to utilise her staying-well plan and coping strategies developed at our service.*

Community participation (two services)

Two services looked at outcomes relating to community participation and proved that clear outcomes could be described, measured and appropriate data collected. The tool of choice was the Recovery Star but this was supplemented by using reviews with service users and contact with other services when the person had moved on from the participating service.

Community Participation: Case study (Making Space day services Wigan and Leigh)

> *Mr H has a diagnosis of schizophrenia and currently lives in supported residential accommodation. He was referred by the Community Mental Health Team to the day centre which he attends four days a week. When he first arrived he made minimal communication with others within the day centre and had little confidence using public transport. When completing his Personal Development Plan one of his main goals was to make friends and be able to trust them to go on outdoor activities. We agreed that the photography session was the perfect session to help Mr H build on his confidence. The session is run by the group, who pick a place of interest to visit, e.g. Manchester or Liverpool, and then travel by using public transport to take pictures. Mr H was closely monitored and within a short time we noticed he would ask about the next session and then discuss this within the group. Mr H now makes full use of public transport and is confident enough to ask at the bus station for travel information if needed. Mr H now attends a day centre in another town and in his spare time likes to go out locally and take pictures that interest him with his own camera.*

User satisfaction (one service)

This proved to be a difficult area to articulate outcomes and gather them in a robust and meaningful way. Several services initially intended to work on this outcome area but were not able to do so for a range of reasons including existing users' satisfaction tools not being sufficiently robust, many tools being qualitative rather than quantitative and therefore there were difficulties in aggregating information. Finally, some services simply found the process of gathering the data too difficult, especially for the sustainable outcomes. Nevertheless, one organisation was able to provide some data.

Volunteering, employment and training (three services)

Three services looked at employment, volunteering and training as their outcome areas and were able to demonstrate good outcomes from its work. The lower number of sustainable outcomes in one service was primarily likened to the time-lag between achieving the initial outcomes and the follow up period lying outside the end date of this project. Simple measures were used to verify success including the use of monitoring support logs, reviews with users, evaluation sheets, contract monitoring reporting arrangements, post placement support and subsequent contact with users and the employing organisation.

Volunteering, Education and Training Case Study: (written by the client)

I attended BtB after attending an appointment with my GP. I had suffered a nervous breakdown and was suffering with severe anxiety and depression, having lost my job due to pressure at work. I was totally unable to cope with day-to-day living and had moved back in with my parents. I felt totally ashamed, had lost all self-confidence, felt a complete failure and couldn't see any future for me. I had had feelings about being better off dead, although I had not acted on these.

I was at a stage in my life where I was desperate to grasp any help that was available to me to help me function again. I chose to undertake the BtB sessions in a group, in an attempt to recommence engaging with other people again, as I had become totally isolated as a result of my illness. The thought of meeting other people scared me, but I also felt that I would perhaps be able to relate to others in similar situations to my own.

My first session went well and was useful and educational. Afterwards, one of the Clinical Helpers took me to one side and talked to me about my problems. It felt good to talk to someone who was not involved in my situation and who was friendly and non-judgemental. The Clinical Helper asked me if, in time, I would consider volunteering at Advocacy in Wirral, helping to update the BtB database. I had always worked in offices before and so took up the offer, partly to attempt to fill my day and to give me some routine and partly as it seemed like a good idea and might aid my recovery. I continued with the BtB course and found that, after four or five sessions, a 'light-bulb' had come on in my head and I could begin to deal with and rationalise what had happened to me, without totally blaming myself and beating myself up as much. I had learnt different techniques to identify thinking errors that I was making and to address those errors and return to a more rational state of mind. I completed the BtB course, feeling much better than when I had originally attended and began my recovery by increasing the amount of hours I was volunteering for Advocacy.

I was then asked if I would be prepared to be a Clinical Helper for new BtB clients. This made sense to me, as I had undertaken the course, found it very beneficial and also wanted to 'give something back' and to help others. I continued this for some months, until I found myself volunteering five days a week, both with BtB and also on the PCAL project within Advocacy. I subsequently joined the PCAL team on a six month paid placement through the Future Jobs Fund scheme on a part time basis and continued to assist with BtB clients as a volunteer. Once the placement ended, I continued to volunteer with Advocacy until October 2010, when I was fortunate to be offered a full time position with the PCAL project, where I remain today, being very happy in a job that I love.

I will always be so grateful and give such credit to BtB, as it helped me to put my life back together again and returned me to good mental health and to paid employment, after such a bleak and miserable period of my life.

Once I had finished the BtB programme, I felt that I was back in control of my life, much less anxious and depressed and ready to face the future with confidence and hope. This led to a return to paid employment in due course.

I still use techniques that I learnt in BtB to tackle any day-to-day problems that I encounter. I am back in control of my life and in good mental health and the future now looks great for me. Thanks to all at BtB for the invaluable work and support that they provide.

6 Caveats

It is important to recognise this work was very developmental. The figures reported as achieved for each outcome by providers will have been against a backdrop of learning about the process of articulating outcomes (as opposed to processes) in a concrete and meaningful way, setting up data collection systems and training in-house staff to gather the data. For several services, undertaking these tasks occurred after the start of the year of data collection. Also, by their very nature, the sustainable outcomes are always going to appear lower than the initial outcome, as a period of time is required to determine sustainability - in most cases six months. Consequently, any outcomes achieved after 1st October will not have been assessed for sustainability as the six-months follow-up date will have been after 1st April.

In order to give a rounder picture to the sustainable outcomes, a number of services have also provided vignette case studies that provide a qualitative aspect to understanding the outcomes that have been achieved by service users with the support of providers.

7 Lessons learned

As the project was very developmental we sought to learn lessons about the process and how sites implemented their projects. To this aim we invited participants (commissioners, providers and the support team – the authors of this report) to provide structured feedback on their experiences. These are detailed below to aid others who wish to undertake similar work.

Feedback for the social inclusion outcome framework project: NHS North West

Feedback was received from the Mental Health Improvement Team, four commissioners and nine pilot site teams:

- Ashwood Court
- Fir Trees
- Making Space
- PSS Wigan
- SPARC
- CASS Stockport
- Pendlebury House
- Cumbria (Croftlands)
- Richmond Fellowship

It should be noted that, unfortunately, no NHS based pilot teams provided feedback for the project.

Conditions for success

Local ownership

- Getting staff on board.
- Getting service users involved.
- Getting managers on board.
- Aligning the project within existing systems.
- Regular project team meetings to reflect, review and problem solve – including commissioners.
- Share progress and encourage learning between teams or sites.
- Finding funding and resources.
- Find a Champion for each tool that you apply to promote use and provide and develop the evidence base.
- Exploit local enthusiasm to ensure high levels of engagement.

Defining outcomes and measurements

- Understand the difference between a process and an outcome.
- Understand how to measure outcomes in a useful and therapeutic way, whilst being sensitive to service users' needs.
- Keep things general – avoid indicators based on rare events.
- Agree how often / at which points the measures will be applied.
- Apply parameters to the project – test and review before rolling out across the organisation.
- Test measurement systems and support with staff training.
- Set realistic challenges – reducing BMI may not be achievable – maintaining current weight might be more effective.
- Address any staff anxieties about what the measures mean in relation to their own performance.
- Commissioners need to be closely involved: to set reporting systems, to support the data collection team and to drive forward the SIOF agenda.
- Understand and coordinate the outcomes framework within the wider policy context.
- Embed the principle of outcomes so it becomes second nature.
- Strengthen the focus and purpose of Recovery and Independence.

Implementation

- See this as opportunities to challenge and inform service users.
- Integrate tools into assessment processes, care planning and general working practice.
- Work towards a 'conversational' approach with clients ("Motivational Interviewing").
- Make sure staff have training in any specific measurement skills (e.g. BMI) and appropriate equipment.

- Encourage staff to develop their skills and interests.
- Encourage service users to lead development of groups or activities.
- Be creative.

Data collection

- Early development and testing of templates for collecting measurements.
- Keep things as simple and consistent as possible.
- Embed data collection into the organisation's recording systems.
- Understand and address reasons for non-completion of measurement tool at agreed points.
- Share the data collection and progress reports with other stakeholders.
- Outcome measures (soft, hard and sustainable) to be inserted into relevant service contracts, tenders and other broad contexts such as CQUIN and Payment by Results (PbR).
- Indicators to be clear and quantifiable and to support service quality 'stretch'.
- Use contractual levers to sustain recording.

Who to involve

- Service users.
- Nursing and support staff, including volunteers and students.
- Operational management.
- Senior management.
- Data analysts.
- Administrators.
- Commissioners (Health and Local Authority).
- Data collection system providers.
- Community Mental Health Team.
- General Practitioners / NHS.
- Third Sector Forum members.
- Training and Development Team.
- Practice and Quality Team.
- Contracts Team.

Feedback and future

- Arrange stakeholder events to share experiences and discuss wider roll out of approach.
- Use the information collected to feedback into the system – including to clients.
- Recognise the value of the service provided.
- Feed successes back into the team.
- Include information about outcomes within referral information so that future service users are aware from the start of any placement.
- Embed the philosophy in staff supervision and appraisals.

- This approach can inform the commissioning processes of the future.

Significant challenges

Engagement

- It needs organisational commitment to work – it can be "too difficult" at times and easy to drop out of if those above you aren't supporting and performance managing. It needs consistent development support to keep it going, keep people to task and hold a strategic overview.
- Organisational change processes distract people. Staff and service users may be resistant to change – seeing this initiative as "just more paperwork". Find ways to support staff training and the amount of quality time that needs to be spent with participating clients.
- Not all clients will be ready, willing or able to engage in the project or in measuring progress over time. This may especially apply if you are contacting them when they are out of your service. Learn to be pragmatic about the "inaccuracy" of some of the information that you will be given.
- For clients that choose to engage, you will have to find cost effective and locally available activities to offer them.

Data collection

- For many organisations, teams or individuals this will be their first experience of systematic data collection. Developing routine, familiarity and confidence takes time; expect a slow start.
- Voluntary sector organisations are better at capturing data than the NHS,
- Learn how best to collect the data – and agree how to cope with updates to the data collection system or changes in your staffing. Things will change as your understanding of your project evolves. Develop a Project Manager / Champion role to support this.
- Be flexible with your aims – for example a client is unlikely to shift between BMI groupings within a six month period – yet may lose a considerable amount of weight.
- Find a method that motivates staff and service users – e.g. a percentage reduction.
- Challenge and resolve attempts to frame the data in a way that casts a 'good light' on performance, and agree how you will record inputs for your commissioners in a way that you both find meaningful.

Service implications

- A focus upon outcome measurement may result in core elements of the service becoming at risk. Payment for outcomes may lead to people being pressured to move on quickly and reduce the quality of your work in the future,

8 Conclusions

The North West Commissioning for Outcomes Project gathered information about clear and concrete outcomes for service users across a wide area of service types between 1st April 2010 and 31st March 2011. It required a significant amount of set-up work by commissioners, providers and MHIP support in advance of the April 2010 of start-up and throughout the year it was running.

Commissioners and providers felt the project was particularly helpful in assisting them to articulate direct benefits to service users from services rather than simply "looking after people". Services were able to evidence effectiveness, not just in achieving outcomes with users but also doing this sustainably.

Many services underwent transformations in the way they offered their services, as a result of having to consider the end point of what was to be achieved and then seeking a pathway to that point. In some cases this challenged previous ways of working for services. As a consequence, many services reported they were clearer about what was expected of them, more focused in their interventions, staff were more satisfied and motivated about their work, and the service users had a better understanding of what they could achieve when using the service. The project generated a great deal of creativity, both in terms of describing outcomes that were important to service users and also in finding ways of evidencing that they had been achieved and sustained.

Participating commissioners intend to utilise this approach within future contracting arrangements with providers, partly because the systems are now in place to do this, but also because there is a potential menu of outcome templates from which commissioners can draw upon for such purposes (see Appendices).

Additionally, several provider organisations are seeking to roll out the use of outcomes from this project to other services in their organisation. The templates provided below (in the Appendices) could be used as they stand, or could be further refined and developed. They can also serve to stimulate thinking in other areas of social inclusion; there is no requirement to stick solely to the areas that have been the focus of this project.

Finally, whilst this work has taken place in the field of mental health there is no reason why this approach could not work for commissioners and providers in other fields - for example, those with learning disabilities, older adults, physical disabilities, substance and alcohol misuse, and for any group that may experience social exclusion.

9 Acknowledgements

The project team are very grateful to all those who have participated in this project and helped to make it a success. In particular, we would like to acknowledge all the efforts of providers and commissioners who devoted time, effort and intellect to the process. Without their support this project would not have come to such a valuable conclusion.

Appendices

Appendix 1: Outcomes project checklist – what needs to be in place measure outcomes

Outcomes project checklist	Achieved	Set to be achieved	Not achieved
Key ownership issues			
Are the staff team on board for the project? (Do they know what will be involved? What will be their roles?)			
Are users of the service (or former users) able to help describe outcomes the service should be delivering to them?			
Are senior mangers of the organisation supportive? (Do they understand what is needed? How to help to overcome barriers? The implications of the project, including any cost implications?)			
Is ownership shared with the whole team rather than an individual?			
Defining outcomes and measurements			
Does everyone understand the difference between a process measure and an outcome measure?			
Are the measures you intend to use clearly articulated, meaningful and measurable?			
Do you have robust ways of measuring your process and outcome measures? (Including what will be measured, by whom, when and how this will be recorded.)			
Are there any copyright or licensing issues related to measurement tools that need to be resolved?			
Are the measures you intend to use auditable and verifiable if required by commissioners?			
Have staff had the chance to discuss any anxieties about what the measures mean in relation to their own performance?			
Have commissioners been involved in agreeing the outcomes and how they will be measured?			
Implementation			
Are process and outcomes measures embedded into everyday activity so it does not add unduly to paperwork?			
Has the need for specific training on interventions (processes) or data collection (evidence) been met?			
Are there opportunities for all to learn about the implementation processes as time goes by?			
Data collection			
Is there an opportunity to pilot the process and outcome measures in the service?			
Has the data collection been embedded into the organisation's recording systems?			
Does data collection comply with local Information Governance Standards?			

Is there a mechanism in place for reporting back to data providers?			
Are there opportunities to address reasons for non-completion data collection at agreed points?			
Do staff have the opportunity to review and celebrate success (along with service users)?			
Commissioning for outcomes			
Have commissioners been actively involved in agreeing the outcomes and how they will be measured?			
Have outcome measures (soft, hard and sustainable) been included in relevant service contracts, tenders and other broad contexts such as CQUIN and Payment by Results (PbR)?			
Is the service able to change on the basis of what it learns?			
Have times been set aside to review progress against outcomes between providers and commissioners?			

Mental Wellbeing

Mental Wellbeing

Service name	Stockport Progress And Recovery Centre (SPARC)
Type of service	Mental health day service
Project lead for the service	Lynn Barrett
Contact details	E: lynn@stockportdaycentre.org.uk T: 0161 429 9744
Commissioner(s)	Nick Dixon
Commissioner contact details	T: 0161 474 4742 E: nick.dixon@stockport.gov.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Improved quality of life, confidence and self-esteem for people with mental health problems.	Number of people supported to develop and begin using new coping strategies: **29**	Number of people with an improved score on the managing mental health arm of the Recovery Star.	**6/10**	Number of people who sustain a score over 5, or improve on it over 6 months.	**4/6**	Recovery Star. Frequency counts.
	Number of people supported to make changes leading to enhanced confidence and self-esteem: **29**	Number of people with an improved score on self-esteem scale.	**5/10**	Number of people who sustain a score over 5, or improve on it over 6 months.	**5/7**	Self-esteem ladder of the recovery star. Frequency counts.

	Number of people supported to make changes leading to a reduction in mental distress: **29**	Number of people with an improved score on a wellbeing scale.	**6/10**	Number of people who sustain a score over 42 or improve on it over 6 months.	**Six month follow on stage not reached by end of project.**	Warwick-Edinburgh wellbeing scale.

Process measures for the service to achieve the 'hard' outcomes	
Number and proportion of members of the Women's Group who complete baseline measures	**12/20**
Number of new referrals who, six weeks after commencing at the Centre, complete baseline measures	**7/12**
Number of relevant one-to-one sessions delivered	**29/102**
Number of relevant group work activities delivered	**2**
Number of reviews completed at three months after baseline measures taken	**10**

Mental Wellbeing

Service name	Stockport & District Mind CAHSS Team
Type of service	Crisis Accommodation & Home Support Service (CAHSS)
Project leads for the service	Gill Walsh
Contact details	E: gill.hall@cahss.org.uk T: 07974824540
Commissioners	Nick Dixon (Stockport) Dave Wilson (Tameside)
Commissioner contact details	E: nick.dixon@stockport.gov.uk E: dave.wilson1@tameside.gov.uk

Intended outcomes	Key outcome indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Improved quality of life, confidence and self esteem for people with mental health problems.	Number of people supported to develop and begin using new coping strategies.	Number of people using new coping strategies to manage their mental wellbeing at the point of discharge from the service. Number of people using less negative coping strategies to manage their mental wellbeing at the point of exit from service.	**22/24** **22/24**	Number of people returning to the service within six months of discharge, Number of people on exit and three months after referral onto wellbeing groups, who maintain or improve, on their Recovery Star scores.	**3/24** **21/24**	Re-admission rates. Frequency counts of positive and negative coping methods on entry and exit from the service. Recovery Star in the domains for 'managing mental health'. One-to one sessions.

Intended outcomes	Key outcome indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
	Number of people supported to make changes leading to enhanced self confidence & self esteem.	Number of people with enhanced confidence and self esteem at the point of exit from the service.	**20/24**	Number of people returning to the service within six months. Number of people with maintained or enhanced confidence and self esteem scores, three months after accessing support groups.	**3/24**	
Increased ability to manage own mental distress for people with mental health problems.	Number of people supported to develop a recovery plan.	Number of people using a support plan.	**24/24**	Number of people returning to the service within six months.	**3/24**	Number of people with a completed recovery plan on exit from the service.

Mental Wellbeing Case Study

Susan was diagnosed with bipolar disorder, as well as self-diagnosing as having adult Attention Deficit Hyperactivity Disorder (ADHD). Her symptoms caused her to continuously miss vital appointments and payments and had led to breaches of tenancy for not paying rent on time and allowing rubbish to collect in her garden. She had previously self-harmed and used negative coping mechanisms such as excessive drug and alcohol misuse. When Susan was referred into the service she was feeling very depressed and anxious, stating that she was finding it increasingly difficult just to get by with day-to-day living. In order to cope, she had been camping in the woods at a time when temperatures were below freezing. Susan was offered temporary accommodation but stated she would prefer practical and emotional support whilst remaining in her own home.

After an initial couple of visits in which the assessment was conducted and Susan got to know the CAHSS worker, the recovery star was completed with her. She scored a low overall score of 32 out of a possible 100, with her worst areas being in 'Living Skills', 'Responsibilities' and 'Work'. On the basis of Susan's needs, a series of short, medium and long-term goals were devised with her. In the short term, Susan was helped with developing immediate coping skills for managing her day-to-day life; implementing calendars and organisers for time and home management and setting up direct debits for her finances. Medium term goals looked at how she could make positive life changes. A referral was made to a drugs support agency for her cannabis dependency and she was encouraged to take part in various social drop-ins, classes and therapy sessions. The longer-term goals looked at her future and her aim of becoming a volunteer and she was helped to apply to become a volunteer at a local centre. Leisure activities were undertaken with Susan such as going with her on walks and taking her to the gym. More practical interventions were also offered such as introducing her to a solicitor in order to challenge a recent decision made by the NHS, and referring her to a housing support agency in order, potentially, for her to be re-housed.

Throughout the intervention, Susan was encouraged to learn new skills and problem-solving techniques to encourage her independence. Over time, this clearly increased her confidence and self-esteem as she engaged further with peer support networks at local centres. Susan also developed new coping strategies and as she increased the use of techniques such as meditation, deep breathing and exercise, she decided to stop using cannabis altogether. By the end of the intervention it was clear that Susan had new confidence and higher well-being, and had even achieved her aim of becoming a volunteer, supporting other people with mental health problems. On the final score of the recovery star, Susan had gone from 32 up to 55, indicating positive improvements in all aspects of her life.

Mental Wellbeing

Service name	Fir Trees Independent Hospital
Type of service	Independent Hospital
Project leads for the service	Kim Cooke
Contact details	Office 01942 864627 / Mobile: 07738 329019
Commissioner(s)	Peter Harrison E: peter.harrison@alwpct.nhs.uk
Commissioner contact details	Bryan House, Ashton, Leigh and Wigan PCT

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Improved quality of life, confidence and self-esteem for people with mental health problems.	Number of people who develop and begin using new coping strategies.	Number of people who have started to use specific coping strategies.	**13 / 16**	Number of people using effective coping strategies over a six month period.	**7 / 13**	Collated by Named Nurse in monthly care reviews – evidenced in care plan.
Increased ability to manage own mental distress for people with mental health problems.	Number of people supported to decrease their reliance on mental health services.	Number of people who have completed a staying well /recovery action plan.	**12 / 16**			Completion of a staying well / recovery action plan. Collated by Named Nurse in monthly care reviews.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
		Number of people who have been referred to a less intensive service.	**5 / 16**	Number of people who have moved on to a less intensive service.	**3 / 5**	Completion of each of the stages of the programme, and using our discharge criteria to measure level of independence. Collated by Named Nurse in monthly care reviews - evidenced in care plan. Follow up call to Care coordinator six months post-discharge for update on sustainability.
				Number of people who remain in that less intensive service for a 6 month period.	**3 / 3**	

Mental Wellbeing

Service name	St Helens MIND
Type of service	Social Inclusion
Project leads for the service	Jean Garlick
Contact details	E: sthelmind@yahoo.com T: 01744 677058
Commissioner(s)	Erica Crisp
Commissioner contact details	E: Erica.Crisp@hsthpct.nhs.uk T: 01928 593495

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increased hope for the future leading to increased self-reliance and resilience and increased connections with people they trust.	Number of people who have increased hope about the future and have increased connections with people they trust and increased self-reliance and resilience.	Number of people who have expressed increased self-reliance and hope about the future and have increased connections with those they trust, after six months.	**6/31**	Number of people who have sustained their self-reliance and feelings of hope about the future and have increased connections with people they trust, after 12 months.	**0/31 No data available**	Frequency counts. Review with users and key workers. Well-being Outcomes Star.
Improved quality of life, confidence and self-esteem for people with mental health	Number of people supported to make changes leading to enhanced confidence and self-	Number of people making changes that lead to enhanced confidence and self esteem after six	**5/31**	Number of people maintaining changes that have led to sustained enhanced confidence and self-	**0/31 No data available**	Frequency counts. Review with user

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
problems.	esteem.	months.		esteem after 12 months.		and key worker. Well-being Outcomes Star

Mental Wellbeing

Service name	Spinning World (NHS ALW)
Type of service	Psychological Therapies for traumatised asylum seekers
Project leads for the service	Lynn Learman
Contact details	E: lynn.learman@pss.org.uk T:0151 702 5580
Commissioner(s)	Peter Harrison
Commissioner contact details	peter.harrison@alwpct.nhs.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Ability to participate in CORE assessment (Client Outcomes Research Evaluation).	Number of people who are able to complete CORE assessments.	Completed form.	**11/22**	Number of people who continue to participate in the CORE questionnaire at six week intervals.	**8/22**	Number of people who are engaged by the service and whose mental health and trauma is therefore being monitored.
Reduction in CORE score by 20%.	Number of people who reduce their score by 20% = casement.	The number of people who completed CORE and achieve reduction of 20%.	**9/20**	Number of people who sustained a reduced outcome of 20% after a 6-month period.	**2/20**	Number of people who are engaged by the service and whose score has reduced by 20%.

Process measures for the service to achieve the 'hard' outcomes
Number of referrals received per month.
Number of appointment letters sent/ Interpreters booked.
Number of clients attending for assessment.
Number of assessments completed/ clients engaged therapeutically to continue
Number of specific therapeutic interventions used.
Number of ongoing clients.

NB: total number of clients = 43. The highest score for CORE is 40.13 clients were deemed too traumatised to participate and their score would have exceeded the maximum outcome baseline of 40. So all data based on the 30 clients deemed clinically suitable. Some of this number are clients who have not been involved with the service long enough to achieve a sustainable outcome.

Case study mental wellbeing: Spinning World

A is a 29 year old male asylum seeker who self referred after being told about the service by his GP. There have been 28 sessions to date and reviews have been undertaken regularly using a CORE 10 Questionnaire. In our initial meetings the client identified a number of key issues. These included social isolation, sleep disturbance and coping with difficult memories. Sleep disturbance and the traumatic experiences that led him to seek asylum constantly recur in our work. These have been explored over a number of sessions allowing him to process and understand his experiences from a cognitive, emotional, physical and behavioural perspective. The main emphasis of the work undertaken has been listening to A bearing witness to his experience. Over the course of a month A completed both a 'Thought Record' and a 'Mood Diary'. This allowed him to identify and clarify the times of day and situations that were hardest for him. In the following sessions we reviewed what the exercises had been like to do and what / how A felt. Within the space of four weeks A reported an overall improvement in how he felt which was reflected in his CORE score. Using the PSS information sheet on trauma, which was translated into his own language, we also discussed how trauma can affect the body. Over a period of approximately two months we ended each session with a relaxation exercise. This began in session one where we had to reduce A's hyper arousal state. From that we built in breathing and relaxation elements that helped A develop a sense of control. A has spoken about experiences in his homeland, especially the loss of his family. This was linked to some creative arts therapy exercises designed to help express emotion. However, A's emotional and psychological wellbeing has been impacted upon by the asylum process and the everyday practical struggles he has had to face. During the time we have been working together his asylum claim has been refused. This means that he is not entitled to accommodation or any money for subsistence from the Border Agency. As a result he has had

nowhere to sleep and no money for food and he is now destitute. Despite this, we have worked on reducing his sense of social isolation. A is now very active in his local church and supports the church youth group. He is determined to give back something to the community that is helping him. He survives by sleeping on friends' sofas on an ad hoc basis. He also does some voluntary work. Despite these considerable difficulties A's psychological health has improved. This improvement has been sustained over eight months.

Social Networks

Social Networks

Service name	Stockport Progress And Recovery Centre (SPARC)
Type of service	Mental health day service
Project lead for the service	Lynn Barrett
Contact details	E: lynn@stockportdaycentre.org.uk T: 0161 429 9744
Commissioner(s)	Nick Dixon
Commissioner contact details	T: 0161 474 4742 E: nick.dixon@stockport.gov.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increase in the size and range of social networks for people with mental health problems.	Number of people supported to develop positive new relationships/ friendships: **29**	Number of individuals who increase the number of people in their social network.	**5/10**	Number of people who sustain new friendships for six months.	**Six month follow on stage not reached by end of project**	Inclusion web. Case Outcome Recording System (CORS) (www.go-gravitas.org.uk) Contact Notes, Individual Reviews.
	Number of people supported to access new social settings: **29**	Number of people who increase the range of people in their social networks (i.e. friends in different places/groups).	**5/10**	Number of people who sustain their increased range of social networks after six months.	**Six month follow on stage not reached by end of project**	As above.

Process measures for the service to achieve the 'hard' outcomes	
Number and proportion of members of the Women's Group who complete baseline measures.	**12/20**
Number of new referrals who, six weeks after commencing at the Centre, complete baseline measures.	**7/12**
Number of relevant one-to-one sessions delivered.	**29/102**
Number of relevant group work activities delivered.	**2**
Number of reviews completed at three months after baseline measures taken.	**10**

Social Networks

Service name	Stockport & District Mind CAHSS Team
Type of service	Crisis Accommodation & Home Support Service
Project leads for the service	Gill Walsh
Contact details	E: gill.hall@cahss.org.uk T: 07974824540
Commissioners	Nick Dixon (Stockport) Dave Wilson (Tameside)
Commissioner contact details	E: nick.dixon@stockport.gov.uk E: dave.wilson1@tameside .gov.uk

Intended Outcomes	**Key outcome Indicators**	**Examples of Hard outcomes**	**Outcomes Delivered (number/ total cases possible)**	**Sustainable outcomes**	**Outcomes Delivered (number/ total cases possible)**	**Measures**
Increase the size and range of social networks for people with mental health problems.	Number of people supported to strengthen existing relationships with friends or family.	Number of people who have maintained or improved their scores on the recovery star areas of (i) social networks and (ii) relationships between admission and exit.	**22/24**	Number of people who have maintained or improved their scores on the recovery star areas of (i) social networks and (ii) relationships between exit and three months later for people who have accessed wellbeing groups.	**21/24**	Recover Star areas 'social networking' and 'relationships'. Eco mapping tool. one-to-one sessions
Increase the size and range of social networks for people with	Number of people supported to begin accessing peer support or self-	Number of people accessing wellbeing groups or peer support at the point of discharge from the	**12/24**	Number of people continuing to access wellness groups and peer support after three months.	**11/24**	Feedback from support groups at three months from discharge.

Intended Outcomes	Key outcome Indicators	Examples of Hard outcomes	Outcomes Delivered (number/ total cases possible)	Sustainable outcomes	Outcomes Delivered (number/ total cases possible)	Measures
mental health problems.	help groups.	service.				
Increase the size and range of social networks for people with mental health problems.	Number of people enabled to begin giving support to others.	Number of people accessing volunteer training at the point of discharge from the service.	**7/24**	Number of people continuing to give support to others after three months after discharge.	**6/24**	Feedback from volunteer organisations at three months after discharge.

Social Networks

Service name	St Helens MIND
Type of service	Social Inclusion
Project leads for the service	Jean Garlick
Contact details	E: sthelmind@yahoo.com T: 01744 677058
Commissioner(s)	Erica Crisp
Commissioner contact details	E: Erica.Crisp@hsthpct.nhs.uk T: 01928 593495

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increase in the size and range of social networks for people with mental health problems.	Number of people supported to make changes that lead to increased access to social networks.	Number of people making changes that lead to increased access to social networks after six months.	**8/31**	Number of people reporting sustained improvement in access to social networks after 12 months.	**No data for 12 month period yet**	Frequency counts. Review with user and key workers. Wellbeing Outcomes Star.

Physical Health

Physical health

Service name	Ashwood Court (Making Space)
Type of service	Independent hospital - rehabilitations
Project leads for the service	Joel Zinyemba / Gill Connor
Contact details	E: joel.zinyemba@makingspace.co.uk T: 01942 713065
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk T: 01942 481 669

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures used / evidence
Improved physical health for people with mental health problems.	Number of people who begin regular physical activity/exercise.	Number and proportion of adults with a BMI index that identifies them as unhealthy (i.e. overweight (BMI 25 - 30) or obese (BMI over 30)) who decrease their BMI towards the healthy range (BMI - 18.5 - 25). Or underweight (BMI ≤18.5) who increase their BMI to within the healthy range.	**4/7**	The number of people who reduce their BMI by five points or to a lower grouping and maintain this for six months.	**0/4**	BMI measure.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures used / evidence
	Number of people who begin accessing support relating to their physical health.	Number and proportion of adults with a BMI index that identifies them as 'overweight' or 'obese' who move down a BMI category.	**2/5**		**2/5**	BMI measure.
		The number of people with Cholesterol levels higher than 5mmol/L who reduce their levels to 5mmol/L or less.	**2/4**	The number of people who reduce their cholesterol levels to 5mmol/L or less and sustain this for six months.	**1/2**	Cholesterol level.

Process measures for the service to achieve the 'hard' outcomes
Number of people who make positive changes to their diet or lifestyle leading to sustained health benefit.
Number of people with mental health problems taking regular exercise.
Number of people who make changes leading to a reduction in physical health symptoms.

Physical Health

Service Name	Prescott House
Type of Service	Community mental health team
Project Leads for the Service	Tara McGinley (Advanced Practitioner)
Contact Details	T: 0161-702-9368 E: Tara.McGinley@gmw.nhs.uk
Commissioner(s)	Tony Marlow
Commissioner Contact Details	E: Tony.Marlow@salford.nhs.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of Hard Outcomes**	**Outcomes Delivered**	**Sustainable Outcomes**	**Outcomes Delivered**	**Measures**
Improved physical health for people with mental health problems particularly focusing on reducing risk of developing metabolic disorders.	Patients to achieve a healthy BMI score. Patients to achieve a healthy cholesterol level. Patients to have annual health checks,	Reduction in BMI levels to a more healthy measure. Reduction in cholesterol levels to a more healthy measure using the following measures: Und'weight < 18.5 Normal 18.5-24.9 O'weight 25-29.9 Obesity 30 or 30+. Evidence of physical health care needs being	**9/19** **8/19** **19/19**	Number of patients who maintain either a reduction in their BMI score or maintain a BMI within a healthy range. Number of patients who maintain a reduction in their cholesterol level or maintain a healthy cholesterol level. Number of patients who engage in annual health care	**11/19** **13/19** **19/19**	The number of patients who have their physical health care needs assessed and met within the primary health care setting, or where unable do this, secondary care services provide this service to meet such needs.

Intended Outcomes	Key Outcome Indicators	Examples of Hard Outcomes	Outcomes Delivered	Sustainable Outcomes	Outcomes Delivered	Measures
	preferably within primary health care setting, or in secondary care setting if necessary.	identified and addressed in care plans within CPA.		check within the primary health care setting or attend such checks within secondary care.		

Physical health

Service name	Lea Court
Type of service	Independent Hospital
Project leads for the service	Laura Sheldon
Contact details	T: 01925 243577 E: Laura.Sheldon@alternativefuturesgroup.org.uk
Commissioner(s)	Margi Butler
Commissioner contact details	E: Margi.Butler@warrington-pct.nhs.uk T: 01925 843792

Intended Outcomes	Key Outcome Indicators	Examples of Hard Outcomes	Outcomes Delivered	Sustainable Outcomes	Outcomes Delivered	Measures
Improved physical health for people with mental health problems.	Number of people supported to begin accessing support relating to their physical health.	The number of people who have increased their knowledge and awareness of where to get health advice, information and support.	**9/12**	The number of people who have accessed services for advice, information and support over a six month period.	**4/12**	Completion and use of Rethink Health Action Plan. Collated by Named Nurse in monthly care reviews evidenced in care plan (advice given or signposted).
	Number of people who previously did not participate in any form of physical activity/exercise but have now increased physical activity or	Number of people who begin regular physical activity /exercise.	**5/10**	Number of people who have continued to participate in physical activity/exercise for six months.	**4/10**	Completion and use of Rethink Health Action Plan. Collated by Named Nurse in monthly care

Intended Outcomes	Key Outcome Indicators	Examples of Hard Outcomes	Outcomes Delivered	Sustainable Outcomes	Outcomes Delivered	Measures
	exercise.					reviews evidenced in care plan.
Improved physical health for people with mental health problems.	Number of people supported to begin accessing support relating to their physical health.	The number of people who have increased their knowledge and awareness of where to get health advice, information and support.	**9/12**	The number of people who have accessed services for advice, information and support over a six month period.	**4/12**	Completion and use of Rethink Health Action Plan. Collated by Named Nurse in monthly care reviews evidenced in care plan (advice given or signposted).

Physical health

Service name	Lancashire Care NHS Foundation Trust
Type of service	Community Mental Health Teams
Project leads for the service	Lorna McGlynn and Frances McKinney
Contact details	E: Lorna.McGlynn@Lancashirecare.nhs.uk M: 07507857461 E: Frances.McKinney@lancashirecare.nhs.uk M: 07507847633
Commissioner(s)	Tracey Callaghan Hayes
Commissioner contact details	E: Tracey.Callaghan-Hayes@bwd.nhs.uk T: 01254 282232

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Improved physical health for people with mental health problems.	Number of people supported to begin accessing support relating to their physical health	Number and proportion of adults with a BMI index that identifies them as unhealthy (i.e. overweight (BMI 25-30) or obese (BMI over 30) who	**48/299**	Number of people who are classed as 'overweight' reducing their BMI to a lower grouping within a 6 month period and sustaining this at next	**0** (NB: 16 / 48 people who accepted support have lost weight.)	Initial completion of comprehensive Rethink 'health check'. Subsequent actions/referrals to improve access to

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
	Number of people supported to begin regular physical activity/exercise.	decrease their BMI towards the healthy range (BMI - 18.5 - 25).	**18/46**	measurement.	**This sustainable data will be available in June 2011**	physical health support & uptake. BMI measurement six monthly- recorded on team spreadsheet and care plan

Physical Health: Lancashire Care Case Study

David is currently being supported by the Recovery Team. On his initial physical health assessment his BMI was 50.3. He reported that he had tried over the years to reduce his weight but for one reason or another had not managed to do so. His physical health check also highlighted his heavy drinking and poor diet, both of which contributed to his weight issues. David was initially referred to weight management and a dietician where advice was given. He has not drunk alcohol since Christmas, is eating a fat free diet, taking regular exercise (walking) and has been given Xenical to assist him. His weight is now steadily dropping and has lost half a stone in the last month.

Physical health

Service name	Rueben's Court (Richmond Fellowship)
Type of service	Supported accommodation
Project leads for the service	Marie Wilcock & Paul Graham
Contact details	E: Marie.Wilcock@RichmondFellowship.org.uk T: 01942 260547
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Improved physical health for people with mental health problems.	Number of people who take regular physical activity/exercise. Number of people who begin regular physical activity/exercise.	Increased regular exercise.	**4/32**	Number of people who sustain taking regular physical activity/exercise.	**16/32**	Daily Exercise Log. Service Health & Wellbeing Questionnaires. Reviews. Recovery Journey progressions notes.
	Number of people with a BMI index identified as unhealthy who	BMI index decreases.	**3/8 (NB: Commenced**	Reduction or sustained BMI figure.	**Unknown due to six month target date**	Service Health & Wellbeing Questionnaires.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
	decrease BMI towards a healthy range.		**project on 7th month)**		**not reached within project timescales**	Reviews – evidence spreadsheet. Recovery Journey progressions notes.
	Number of people who address substance misuse issues.	Increase of addressing issues.	**3/4**	Number of people who start to, or continue to address substance misuse issues through intervention.	**2/4**	Recovery Journey progressions notes. Engagement with local Drug/Alcohol Service. Compliance with medication records (Methadone /Antebuse).

Physical Health Case Study: Rueben's Court, Richmond Fellowship

D had a Mental Health diagnosis when she moved in. She had a mental and behavioural disorder due to substance misuse. She had a history of drug-induced psychosis and was admitted to hospital due to a suicide attempt using prescribed medication, on 10.4.2006 until 2.5.2006.

She had a close relationship with her mum, aunty and daughter when she moved into her Rueben's Court flat. D's mother had custody of her daughter. D visited her family a few times a week and would stay with her aunt. D also had a partner, with whom she would stay over the weekends. Her partner was a stabilising influence on D. Staff worked with D on her addiction to illicit and prescribed drugs whilst she was living in the scheme, supporting her to use Browns Street Drugs Counselling Centre. With support, Client D arranged appointments with a diazepam reduction counsellor. She attended these appointments on and off.

D started some voluntary work at a local charity shop where she worked and enjoyed it for a period of approximately two months.

D began to disengage with the support I was offering and frequently missed key working sessions following a new relationship with another service user in the scheme. On 18.7.2010 D said she felt she would like to take the next step and move to Floating Support. She was appointed a new social worker, JB, on 2.8.2010 to provide support with finding the right accommodation. D found a flat with Brookfield's Supported Housing. D viewed her flat with support on 21.9.2010, and on 14.10.2010 handed in her tenancy with four weeks notice. Met with Brookfield's manager, who told D that her move-in date will be around the middle of December 2010. She successfully moved on 16.12.2010.

Physical Health

Service name	Pendlebury House (Turning Point)
Type of service	Independent Hospital - rehabilitation
Project lead for the service	Bill Friend
Contact details	E: bill.friend@turning-point.co.uk T: 0161 728 6710
Commissioner(s)	Tony Marlow
Commissioner contact details	E: Tony.Marlow@salford.nhs.uk T: 0161 282 4800

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Service Users with a BMI index that identifies them as un healthy (i.e. overweight BMI 25-30) or obese (BMI over 30 will be assisted in attempting to reduce this towards the healthy range (BMI 18.5-25).	Service users with a BMI index that identifies that they are over weight or obese who move down a BMI category.	Number of service users who reduce their BMI down a category.	**2 / 13**	Number of service users who are categorized as overweight or above who reduce their BMI by five points or to a lower grouping and maintain this for six months.	**2 /13**	Frequency counts of monthly BMI measures.

Process measures for Pendlebury House to achieve the 'hard' outcomes
Number of Service Users engaging with dietary interventions.
Number of Service Users who have been referred to a dietician.
How many periods of exercise have Service Users spent exercising each week.
Number of Service Users who are registered with a GP.
Number of Service Users who are have Cholesterol levels above the 'normal' range and have agree to have their levels monitored.
Number of Service Users who have been offered smoking cessation advice and education.
Number of Service Users who have had an annual health check with the practice nurse.

Physical health

Service name	Bramley Street GMW
Type of service	Salford Rehabilitation
Project lead for the service	Tom Haslam/Colin Galaska
Contact details	E: thomas.haslam@gmw.nhs.uk E: colin.galaska@gmw.nhs.uk T: 0161 708 2788
Commissioner(s)	Tony Marlow
Commissioner contact details	E: Tony.Marlow@salford.nhs.uk T: 0161 282 4800

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
For all service users to have access to Physical Heath Care and treatment	Number of service users accessed physical health care /treatment.	Are registered with a GP. Are registered with a dentist. Have had a 'physical' in last 12 months.	**9/12** **4/12** **8/12**	Have had GP appointment in last month. Attended dental appointment in last six months. Have had optician appointment in last six months. Have been referred to a Specialist in last six months.	**10/12** **10/12** **1/12** **3/12**	ICIS (Trist IT system). Advanced nurse practitioner feedback. GP surgery.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Waist circumference and BMI to be reduced.	Number of service users deemed to be overweight.	Number of service users whose waist circumference and BMI has reduced.	**3/12**	Monthly weights. Waist circumference. BMI reduced after two months.	**12/12** **2/12**	ICIS Care Plans. Tape measure scales. Weight chart.
For Service Users to give up or reduce smoking.	Have attempted to give up smoking.	Have been prescribed nicotine replacement.	**3/12**	Who continue to stop smoking over a period of three months.	**0/12**	ICIS Care Plans.
Regular exercise.	Increase their exercise to two 20mins episodes a week.	Independently to build exercise into their routine.	**3/12**	Attend eight exercise sessions in three months.	**2/12**	ICIS Care-Planned.
Have been given verbal/written advice about screening.	Service uses to give consent to be tested.	Have had blood tests for diabetes Type 2 and blood tests for high cholesterol.	**9/12**	Service users that have diabetes diagnosed and receiving treatment.	**9/12**	ICIS Care-Planned. ICIS Care-Planned.

Independent Living

Independent Living

Service name	Ashwood Court (Making Space)
Type of service	Independent hospital - rehabilitations
Project leads for the service	Joel Zinyemba / Gill Connor/
Contact details	E: joel.zinyemba@makingspace.co.uk T: 01942 713065
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk T: 01942 481 669

Intended Outcomes	**Key Outcome Indicators**	**Outcomes delivered (number / total cases possible)**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible**	**Sustainable outcomes**	**Measures**
Increased number of people with mental health problems living in independent accommodation.	Number of people who move to more independent accommodation.	**7/15**	Number of people who move from an independent hospital to a care home with nursing (for example)or from a care home with nursing to supported accommodation (see typology of services below).	**5/7**	Number of people who move to a lower level of support and remain there for a six month period.	Follow up call to Care Coordinator and/or 'current service provider' six months post-discharge, for update on sustainability.

Intended Outcomes	Key Outcome Indicators	Outcomes delivered (number / total cases possible)	Examples of hard outcomes	Outcomes delivered (number / total cases possible	Sustainable outcomes	Measures
	Number of people who effectively manage their own finances.	**8/10**	The number of people who begin to manage their own finances without support.	**7/10**	The number of people who manage their own finances without support over a fixed period of time (e.g. six months) without acquiring debt problems, who previously could not manage their own finances effectively.	Recovery Star review sessions, priority area 8. Monthly Rehabilitation Care Plan Reviews. Follow up call to Care Coordinator where patient was discharged before end of six month period.

Hierarchical typology of services leading to greater independence
High Secure.
Medium Secure.
Low Secure.
Psychiatric Intensive Care Unit.
Acute in-patient ward.
Independent hospital rehabilitation unit / NHS in-patient rehabilitation unit.
Care home with nursing.
Care home.
Supported accommodation with staff on site.
Supported accommodation with staff off site.
Own tenancy with routine CMHT / AOT support.
Own tenancy with no secondary care services support.

Independent Living

Service name	Fir Trees Independent Hospital
Type of service	Independent Hospital
Project leads for the service	Kim Cooke
Contact details	Office 01942 864627 / Mobile: 07738 329019
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk

Intended outcomes	**Key outcome indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increased number of people with mental health problems living in independent accommodation.	Number of people who move to more independent accommodation.	Number of people who completed the rehabilitation programme and have been referred to a less intensive service.	**5 / 16**	Number of people who move from current level of care provision to a less dependent service (see hierarchical list of services).	**3 / 5**	Completion of each of the stages of the programme, and using our discharge criteria to measure level of independence collated by named nurse in monthly care reviews - evidenced in care plan.
				Number of people who remain in that less intensive service for a six month period.	**3 / 3**	Follow up call to care co-ordinator six months post-discharge for update on sustainability.

Intended outcomes	Key outcome indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Increased number of people with mental health problems receiving appropriate financial advice.	Number of people supported to effectively manage their own finances.	The number of people who begin to manage their own finances without support.	**2 / 10**	The number of people who manage their own finances without support over six months.	**1 / 2**	Evidenced in budget plans and collated in monthly care reviews by named nurse.

Independent Living Case Study: Fir Trees (Independent Hospital)

Prior to Miss A being admitted to the service (a mental health rehabilitation facility) there had been on-going problems in maintaining her stability as she presented as generally chaotic and distressed with unpredictable behaviours as a result of past experiences and mental health needs. During her nine months stay within the service, she progressed well. Initially, problems occurred with engaging with staff and commencing the rehabilitation programme. However, we worked together in identifying each area of need. We spent time together working on areas of early warning signs, relapse prevention, developing alternative and effective coping strategies and a staying well plan, alongside increasing confidence in her abilities to manage general domestic and daily living activities - e.g. cooking, shopping, etc. Miss A achieved her goal of moving to independent accommodation with planned support from community staff/services. Contact with her care co-ordinator has confirmed that Miss A has successfully maintained this tenancy since discharge and has continued to utilise her staying well plan and coping strategies developed at our service.

Mr B experienced a similar chaotic presentation with a long history of placements failing. This usually resulted in return to acute and/or secure services. However he quickly engaged well with staff and participated in the programme. Education about his illness, and how this affected him, was a key factor in developing a level of insight to promote understanding and agree future plans, some of which related to developing his abilities within social and domestic environments. Mr B was discharged to a supported living tenancy within 11 months and he has maintained his independence since. A six-month follow-up with his care co-ordinator confirmed that he continues to manage his day-to-day life well. Mr B has also visited the service and informed us that he remains very happy.

Independent Living

Service name	Lea Court (Alternative Futures)
Type of service	Independent Hospital
Project leads for the service	Laura Sheldon
Contact details	T: 01925 243577 E: Laura.Sheldon@alternativefuturesgroup.org.uk
Commissioner(s)	Margi Butler
Commissioner contact details	E: Margi.Butler@warrington-pct.nhs.uk T: 01925 843792

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Increased number of people with mental health problems living in independent accommodation.	Number of people who move to more independent accommodation.	Number of people who completed the rehabilitation programme and have been referred to a less intensive service.	**6/12**	Number of people who move from current level of care provision to a less dependent service.	**3/12**	Completion of each of the stages of the programme.
		Number of people who move from current level of care provision to a less dependent service (see hierarchical list of services).	**2/6**	Number of people who remain in that less intensive service for a six month period.	**2/6**	Follow up call to Care co-ordinator six months post discharge for update on sustainability.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Increased number of people with mental health problems receiving appropriate benefits/financial advice.	Number of people supported to effectively manage their own finances.	The number of people who begin to manage their own finances without support.	**0/12**	The number of people who manage their own finances without support over a fixed period of time (e.g. six months).	**0/12**	Evidenced in budget plans and collated in monthly care reviews by named nurse.

Independent Living

Service name	Rueben's Court (Richmond Fellowship)
Type of service	Leigh Supported Accommodation
Project leads for the service	Marie Wilcock & Paul Graham
Contact details	T: 01942 260547 E: Marie.Wilcock@RichmondFellowship.org.uk
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increased number of people with mental health problems living in independent accommodation.	Number of people to more independent accommodation.	Number of people who move through the service from 24-hour support/ Supported Housing/Floating Support to greater independence.	**4/18**	Number of people who move from supported housing to greater independence and sustain over six months.	**5/18**	Number of people who are continuing in their accommodation and are still in contact with the service or via care co-ordinator.
	Number of people who complete the rehabilitation programme and have been referred to a less intensive service.	The number of people who complete the rehabilitation programme and are referred to a less intensive service.	**2/18**	The number of who people complete the rehabilitation programme and are referred to a less intensive service and sustain over six months.	**2/18**	Number of people who are continuing in their accommodation and are still in contact with the service or via care co-ordinator.

Independent Living Case Study: Rueben's Court, Richmond Fellowship

Client C initially moved into our Community Resettlement Scheme in November 2008 when the service first opened. He had been living with his mum after coming out of hospital. Whilst living with his mum he tended to live in his bedroom and did not go out much. It was reported to us that Client C had to move out of his mum's house due to her planning to move to Spain and he would be made homeless, although he had other family within the area there was nobody else he could live with.

Client C quickly demonstrated that he had the necessary skills to live a full and independent life. He was compliant with medication, able to manage his own finances on a day-to-day basis, pay his bills on time and keep himself and his flat in a clean and presentable state. He also took on the responsibility for looking after a cat, which he did very adequately. His mental health remained stable during his placement, with one minor relapse which resulted in a slight increase in medication but no hospital admission. We would describe him as being a model tenant during his placement. He became involved in house activities, going on trips, engaging in weekly support sessions, and attending house meetings.

Client C was considered to be doing so well that after 14 months of a 24-month placement he wanted to move out from the Community Resettlement Scheme into our more independent Supported Housing Scheme, where he currently lives. Client C's mental health has remained stable with no relapse, he is engaging in social activities, has built up a social network of friends, and he continues to manage his finances and daily activities with little support from staff. He continues to be fully compliant with his medication and attends all his outpatient appointments. He is currently looking to move out from the Supported Housing Scheme into his own flat and to disengage from Richmond Fellowship support. This has been supported by Richmond Fellowship, his Care Coordinator and Consultant, although he will still remain under the local Community Mental Health Team.

Independent Living

Service name	Pendlebury House (Turning Point)
Type of service	Independent Hospital - rehabilitation
Project lead for the service	Bill Friend
Contact details	E: bill.friend@turning-point.co.uk T: 0161 728 6710
Commissioner(s)	Tony Marlow
Commissioner contact details	E: Tony.Marlow@salford.nhs.uk T: 0161 282 4800

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number/ total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
To increase the number of people with severe and enduring mental health needs living in independent accommodation.	Number of people who move to more independent accommodation.	Number of people who move from Pendlebury House to a more independent area of living within the described hierarchy.	**3 / 13**	The Service user moves to a more independent service and sustains this move for six months.	**3 / 13**	Report provided by care coordinator on service users' lives, and no return or readmission to acute in-patient areas. Frequency counts of service users who "step down" from Pendlebury House.
	Number of people who effectively manage their own medication.	Number of people who begin to manage their own	**5 /13**	That the service user following a stepped programme	**0 / 10**	That service user is compliant with medication and with no increase in side-

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number/ total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
		medication without staff support.		successfully manages own medication for a period of three months, with minimum checks (weekly) by staff.		effects or symptoms for a period of three months, accepting that random checks (weekly) are made by staff to confirm this. Frequency counts of service users who meet these criteria for three months.

Process measures for Pendlebury House to achieve the 'hard' outcomes
Number of service users accessing the easy to read medication guide.
Number of service users who have accepted information files about their medication in their bedroom.
Number of service users shopping and preparing a meal for themselves once per week.
Number of service users shopping and preparing a meal for themselves three times or more during the week.
Number of service users shopping and preparing a meal for themselves independently.
Number of service users who take part in preparing their CPA / review meeting.
Number of service users who attend their CPA / review meeting.
Number of service users who have been referred to other services and have taken part in referral assessments.

Case Study: Pendlebury House

David was admitted to Pendlebury House in 2008 from an acute in-patient setting. He has a diagnosis of Treatment Resistant Schizophrenia and was detained on Section 3 of the Mental Health Act 1983 when he came to the service. David presented as being

inappropriate towards others, and he appeared to experience a variety of positive symptoms. David lacked insight into his symptoms and behaviour, and therefore was non concordant with his medication as he believed that he did not need to take it. This belief was reinforced within his family who struggled to accept his diagnosis. Initially, David refused to have an active role in his care and refused participate in any aspect of rehabilitation including any activities of daily living.

Throughout the last three years the team at Pendlebury House have regularly met to discuss how best to support David. We have done this through regular Team Meetings, a Multi-Disciplinary Team (MDT), Care Programme Approach (CPAs), and formulation meetings with the Clinical Psychologist. David was allocated a Key Worker (RMN) and two co-workers who have been responsible for overseeing his care and having regular one-to-one meetings to discuss his individual needs and future goals. All goals, support needs and outcomes have then been documented within the Arrow Toolkit and The Recovery Star, communicated effectively to ensure that David has continuity from staff. With David's permission his key worker has also regularly liaised with his family, who regularly attend his CPAs and the bi-monthly family events at Pendlebury House.

To encourage engagement with treatment and support, staff have been clear and consistent when supporting David, having direct goal-orientated support plans. Staff have also been consistent at reinforcing boundaries with David, whilst giving him as much control as possible in decisions about his life. The strong focus on promoting independence and involvement at Pendlebury House has also been effective in assisting David to build and maintain therapeutic relationships with the staff. Although David was initially reluctant to engage with his care, as time has progressed he has slowly become more involved in discussing his goals, risks and needs. David currently engages well with The Recovery Star and Arrow Toolkit. As David gradually built a therapeutic relationship with staff, he became more involved with the rehab structure and has slowly become more independent.

David is now an informal service user and he appears to trust professionals within the mental health system. David recognises the importance of taking medication to maintain good mental health, and through attending in-house therapeutic groups, engaging with the Recovery Star and one-to-one meetings with his key worker, co-workers and the clinical psychologist, he has gained valuable insights into his diagnosis, symptoms and behaviour. Through exploring his hopes and aspirations, he now has a positive attitude towards his recovery, becoming more independent, building relationships with others and about his future. He has recently been accepted to a supported flat, and he is currently waiting to hear if his funding has been approved.

Independent Living

Service name	Bramley Street GMW
Type of service	Salford Rehabilitation
Project lead for the service	Tom Haslam / Colin Galaska
Contact details	E: thomas.haslam@gmw.nhs.uk colin.galaska@gmw.nhs.uk T: 0161 708 2788
Commissioner(s)	Tony Marlow
Commissioner contact details	E: Tony.Marlow@salford.nhs.uk T: 0161 282 4800

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
To increase the number of people with severe and enduring mental health needs who are living in independent accommodation.	Number of people who move to more independent accommodation.	Number of people who move from Bramley Street to a more independent area of living within the described hierarchy.	**7/12**	Number of Service Users who move to a lower level of support and remain there for a six month period.	**7/12**	Follow up by unit staff and monitored through CPAs and Reviews Information gained from ICIS bed management section.
To increase the number of people who go onto self-medication.	Number of people who effectively manage their own medication.	Number of people who started Self Medication Stage 1.	**3/12**	The number of service users that have increased a stage in self-	**9/12**	All service users have Self-Medication Assessment and

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
				medication.		Self-Medication Care Plans documented on ICIS.
Have progressed to individual shopping and cooking.	Have progressed to individual shopping and cooking.	Do not need staff support to complete menu planning. Have been given healthy diet information.	**9/12**	Still continued to cook individually after three months.	**6/12**	Care Plans ICIS CQC monitoring.
Service users to use public transport independently.	Service users applied for bus passes.	To use public transport independently.	**4/12**	Service users continued to use public transport independently.	**10/12**	Staff support and observation S.I.O.F.
Service users to manage their finances independently.	Service users referred and received support from Welfare Rights.	Collect monies independently from Post Office, bank and finance bodies.	**12/12**	Continued to collect monies independently.	**8/12**	Care-Planned and MANCAS Assessments. CPA Discharge planning.
All service users to participate in activity in the community.	All service uses to have a weekly activity programme.	Section 17 escorted leave and Section 17 unescorted leave and "Informal" status.	**12/12**	Have a weekly structure after 3 months. Who have become Informal. Who remain	**12/12** **3/12** **1/12**	Care-Planned and MANCAS Assessments. CPA Discharge planning.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
				Informal after 6 months.		MHRT.
All service users to participate in activity in the community.	Have completed a activity interest questionnaire. Given information of educational opportunities. Assessments done by STR Network.	Number of service users that have attended educational activity.	**5/12**	Service users who have continued to attend educational activities over three months.	**5/12**	Care-Planned and MANCAS Assessments. CPA Discharge planning.
Service users who participate in leisure activities.	Plan leisure activity with staff. Attend leisure activity with support. Attend leisure activity without support (independently).	Number of service users attending leisure activities with support. Number of service users attending leisure activities without support.	**9/12** **3/12**	Service uses who have continued to attend leisure activities with support over 3 months. Service users who have continued to attend leisure activities without support over three months.	**6/12** **6/12**	Care-Planned and MANCAS Assessments CPA. Care-Planned and MANCAS Assessments CPA.
Number of service users who attend to their daily living skills independently.	Requires support to shower and bathe.	Number of service users who attend to their Activities of Daily Living	**4/12**	Service users who continue to attend to ADLs over a six-month period.	**3/12**	Care-Planned and MANCAS Assessments CPA

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
	Clothes shop with staff support. Clean room weekly.	(ADLs) with support.				

Independent Living Case Study: Bramley Street

A is a 44 year old single female with a diagnosis of paranoid schizophrenia. She is presently waiting to move into 24-hour supported accommodation. She is a warm, sociable and assertive individual who has a lot to offer society and who states she is looking forward to the future. A is a very different person compared to three years ago, when Bramley Street staff first met her.

A first entered our service aged 41 with no diagnosis. She was discovered by the police, squatting in a flat she did not own. She was very distressed and was brought into hospital. She reported daily commanding and derogatory visual and auditory hallucinations. She had no insight into her mental ill health and wanted to return to her flat.

She did not initially trust the acute mental health team who were offering to give her support and because she wanted to return to this flat was placed on section 2 MHA. Acute care services initiated anti-psychotic medication but a number of key issues remained unchanged. These included social isolation, poor sleep patterns, lack of trust with her carers, and poor insight into her condition. In addition, she was homeless. She was then accepted by Bramley Street who began to address these issues with her.

We assessed her needs with her, from her perspective as well as from ours, and devised a plan with her that was based upon safety, holistic assessment, and one which focused initially on her strengths and hopes for the future. This was to increase her level of hope for the future. We carried out a weekly "Activity Plan" with her, which included a plan to shop once a week, with staff in the community, for food and personal items, and also bathing days and menu planning; help with budgeting; and social outings. Her social isolation remained an issue but we observed her growing fond of the two cats at Bramley Street. We used this as a motivator for her to "come

out of her shell" and gave her the "supported" responsibility to feed these cats daily. She now came out of her room unprompted to feed these cats. This was her first step in seeing and meeting her peers.

Within this therapeutic relationship, we carried out a kitchen assessment with her, and soon supported her to cook her own meals in her kitchen. Her familiarity with staff grew from this, and this facilitated familiarity and trust, making it easier for us to challenge, probe and introduce new ways of being for / with her.

We began to carry out more one-to-one sessions with her and found her insight remained poor. These sessions proved invaluable because she would never volunteer information without prompting. Regular one-to-one sessions with staff she trusted facilitated better understanding of her problems. These therapeutic relationships helped facilitate use of new anti-psychotic medication, and her daily hallucinations began to diminish as her insight and medication compliance began to increase.

She began to develop her own social group with peers. She spends more time in communal areas and takes part in social outings with staff and peers and now shops by herself. She is also interested in her appearance. Her progress enabled us to refer her to 24-hour supported accommodation.

Community Participation

Community Participation

Service name	Making Space
Type of service	Day Centres (Wigan and Leighl)
Project leads for the service	Liam Brown
Contact details	Liam.brown@makingspace.co.uk
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Increased number of people with mental health problems volunteering in a mainstream setting.	Number of people supported to begin volunteering in mainstream organisations.	Number of people supported to begin volunteering in mainstream organisations.	**6/6**	Number of people supported to sustain regular volunteering for six months.	**0/6**	Recovery Star. Reviews. Post-support. Contact with organisation.
Increased number of people with mental health problems participating in, or engaging with, local community activities.	Number of people supported to take up a new or develop an existing / dormant leisure pursuit.	Number of people supported to take up a new (or develop an existing/dormant) leisure pursuit.	**22/22**	Number of people supported to sustain regular leisure pursuits for six months.	**4/22**	Recovery Star. Reviews. Post-support. Contact with organisation.

Process measures for the service to achieve the 'hard' outcomes
Number of people given information about volunteering and leisure opportunities.
Number of people supported to make enquiries about volunteering.
Number of people supported to make enquiries about leisure pursuits.
Number of people supported to apply for volunteering.
Number of people supported to apply for leisure pursuits.
Number of people supported to access volunteering.
Number of people supported to access leisure pursuits.
Number of people reporting a positive change on the recovery star.

Community Participation: Case study

Mr H has a diagnosis of schizophrenia and currently lives in supported residential accommodation. He was referred by the Community Mental Health Team to the day centre, which he attends four days a week. When he first arrived he made minimal communication with others within the day centre and had little confidence using public transport. When completing his Personal Development Plan one of his main goals was to make friends and be able to trust them to go on outdoor activities. We agreed that the photography session was the perfect session to help Mr H build on his confidence. The session is run by the group who pick a place of interest to visit, e.g. Manchester or Liverpool and then travel by using public transport to take pictures. Mr H was closely monitored and within a short time we noticed he would ask about the next session and then discuss this within the group. Mr H now makes full use of public transport and is confident enough to ask at the bus station for travel information if needed Mr H now attends a day centre in another town and in his spare time likes to go out locally and take pictures that interest him with his own camera.

Community Participation

Service name	Croftlands Trust Community Bridge Building Service (Carlisle, Copeland and Barrow)
Type of service	Community Participation and Wellbeing Service
Project leads for the service	Chris Graham
Contact details	director@croftlands.org
Commissioner(s)	Bill Colmer
Commissioner contact details	bill.colmer@cumbriacc.gov.uk

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increased number of people with mental health problems volunteering in a mainstream setting	Number of people supported to begin volunteering in mainstream organisations.	Number of people supported to begin volunteering in mainstream organisations.	**25/90**	Number of people supported to sustain regular volunteering for six months.	**19/25**	Recovery star Reviews Post support Contact with organisation

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Increased number of people with mental health problems participating in, or engaging with, local community sport exercise activities.	Number of people supported to take up a new (or develop an existing/dormant) sport & exercise pursuit.	Number of people supported to take up a new (or develop an existing/dormant) sport and exercise pursuit.	**33/90**	Number of people supported to sustain regular sport and exercise pursuits for six months.	**22/33**	Recovery Star. Reviews. Post support. Contact with organisation.
Increased number of people with mental health problems participating in or engaging with local community education activities.	Number of people supported to take up a new (or develop an existing/dormant) education pursuit.	Number of people supported to take up a new (or develop an existing/dormant) education pursuit.	**21/90**	Number of people supported to sustain regular education pursuits for six months.	**18/21**	Recovery Star. Reviews. Post support. Contact with organisation.
Increased number of people with mental health problems participating in, or engaging with, local community	Number of people supported to take up a new (or develop an existing/dormant) leisure pursuit.	Number of people supported to take up a new (or develop an existing/dormant) leisure pursuit.	**33/90**	Number of people supported to sustain regular leisure pursuits for six months.	**19/33**	Recovery Star. Reviews. Post support.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
leisure activities.						Contact with organisation.
Increased number of people with mental health problems participating in, or engaging with, local community faith activities.	Number of people supported to take up a new (or develop an existing/dormant) faith pursuit.	Number of people supported to take up a new (or develop an existing/dormant) faith pursuit.	**9/90**	Number of people supported to sustain regular faith pursuits for 6 months.	**4/9**	Recovery Star. Reviews. Post support. Contact with organisation.
Increased number of people with mental health problems participating in, or engaging with, local community work activities.	Number of people supported to take up a new (or develop an existing/dormant) work pursuit.	Number of people supported to take up a new (or develop an existing/dormant) work pursuit.	**5/90**	Number of people supported to sustain regular work pursuits for six months.	**5/5**	Recovery Star. Reviews. Post support. Contact with organisation.

User satisfaction

Service User Satisfaction

Service name	Lancashire Care NHS Foundation Trust
Type of service	Community Mental Health Teams
Project leads for the service	Lorna McGlynn and Frances McKinney
Contact details	E: Lorna.McGlynn@Lancashirecare.nhs.uk M: 07507857461 E: Frances.McKinney@lancashirecare.nhs.uk M: 07507847633
Commissioner(s)	Tracey Callaghan Hayes
Commissioner contact details	E: Tracey.Callaghan-Hayes@bwd.nhs.uk T: 01254 282232

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures**
Increased levels of satisfaction of service users with the delivery and outcomes of the service.	Proportion of service users expressing that the service helps them engage with their local community.	Proportion of people reporting an improvement on their social inclusion needs pertinent domains identified by them from the 10 domains (points) of the Recovery Star.	**39/90 (43.3%)**	Proportion of people having improved domain score(s) sustained over a six month period.	**Six month follow up period not completed by the end of March 2011**	Recovery Star. Qualitative service user stories.

	Proportion of service users expressing that the service helps them manage their mental health needs.	Proportion of people having an improved score on the "Managing Mental Health" domain/point of the Recovery Star.	**38/89 (42.7%)**	Proportion of people having improved "Managing Mental Health" domain score(s) sustained over a six month period.	**Six month follow up period not completed by the end of March 2011**	

Process measures for the service to achieve the 'hard' outcomes
Proportion of service users who move down stepped care model of care.
Proportion of service users with improved Health of the Nation Outcome Scores (HoNOS).
Proportion of service users who have obtained or returned to work.
Proportion of service users with a Wellbeing Recovery Action Plan (WRAP).

User Satisfaction: Case Study

Vicky is in her thirties and has been in Mental Health Services for approximately 20 years in various parts of the UK. During this time Vicky has been given several different diagnoses, resulting in her having seen numerous professionals who have prescribed different treatment programmes, none of which Vicky feels have fully met her needs. She reported she had commenced a second course of Cognitive Behavioural Therapy (CBT) around the same time that her care coordinator introduced her to the Recovery Star.

Vicky felt that this second course of CBT was far more successful, and she attributes this wholly to the Recovery Star, which she said had helped her to identify goals for the therapy and to focus upon the areas of her life where she needed support. The Recovery Star worked as a very useful took for engagement. Vicky told us that she had always struggled to explain the impact of her mental health problems on her life to her friends and family. This had caused particular problems in her relationship with her mother. However, using the Recovery Star had enabled her to communicate these needs so that her family could understand how they could assist in her recovery. Vicky now has a much better relationship with her mother, and she is satisfied with the support she has received from the service.

Vicky is currently studying for a degree in Health & Social Care at a local university.

Education, training, volunteering and employment

Employment

Service name	Making Space
Type of service	Employment Service
Project leads for the service	Gill Fairhurst
Contact details	E: Gill.fairhurst@makingspace.co.uk
Commissioner(s)	Peter Harrison
Commissioner contact details	E: Peter.Harrison@alwpct.nhs.uk

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures
Increased number of people with a mental health problem accessing voluntary/work placement within the community (i.e. non-mental health).	Number of people who begin volunteering in mainstream organisations (i.e. non-mental health).	Number of people supported to begin volunteering in mainstream organisations (non-mental health).	**12/20**	Number of people supported to sustain regular volunteering for six months.	**2/20**	Monitoring support logs. Reviews. Evaluation Sheets. Post support. Contact with organisation.
Increased number of people with a mental health problem entering and/or retaining full time employment (16+hours per week) or part time employment (less than 16 hours per week).	Number of people who gain employment either full time or part time.	Number of people supported to gain employment either full time or part time.	**2/20**	Number of people supported to sustain employment for six months.	**1/20**	

Process measures for the service to achieve the 'hard' outcomes
Number of people supported to attend and complete employability modules, e.g., interview technique, team building, completing an application form.
Number of people supported to complete a C.V.
Number of people supported to access advice about employment issues.
Number of people supported to do an in-work benefit calculation.
Number of people supported to access voluntary work.
Number of people supported to access a job broker or employment support service.
Number of people supported to apply for employment.
Number of people supported to attend a job interview.
Number of people supported to begin paid employment (full or part-time).

Employment Case Study: Making Space Employment Service, Wigan

Mr G was referred from a local rehab unit to attend the Wigan Workshop to help with training and work opportunities. He had a diagnosis of depression/anxiety. His assessment at the workshop showed that Mr G needed help in basic work skills, i.e., attendance and time keeping. He began at the workshop attending two days per week and began to learn the manufacture of curtains, which built up his confidence. His attendance was closely monitored and was good, and his punctuality was excellent. He received support from staff and was noted to have a very positive attitude. Mr G was referred to Supported Employment who helped to find him a work placement in a supermarket in Bolton as a cleaner. There were no problems with the placement and it was monitored closely by contact with staff at Supported Employment. Mr G was subsequently employed by the supermarket on a permanent part-time basis.

Volunteering, education and training

Service name	Wirral Change
Type of service	BME Community Development Worker, Mental Health.
Project lead for the service	Clint Agard Sabra Ahmed
Contact details	clint@wirralchange.org.uk robert@wirralchange.org.uk sabra@wirralchange.org.uk T: 0151 666 2725
Commissioner(s)	Barbara Edwards
Commissioner contact details	E: Barbara.edwards2@wirral.nhs.uk T: 0151 651 3907

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures used / evidence**
Increase the number of people with mental health problems accessing volunteering opportunities.	Number of people who begin volunteering.	Number of people who enter volunteer programmes.	**10/43**	Number of people who remain for six months or more in volunteering or who access employment or training as a direct result of volunteering.	**8/43**	NHS Contract Monitoring Report. Contract data report. Case study 1.
Increased number of people with mental health problems accessing	Number of people who begin a mainstream	Number of people who begin a mainstream	**15/43**	Number of people who are ongoing with mainstream education or training	**15/43**	NHS Contract Monitoring Report.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures used / evidence
education and training opportunities.	education or training course.	education or training course.		course.		Contract data report. Wirral Change client support/follow-up process.
Increased number of people with mental health problems attaining qualifications.	Number of people who complete a mainstream education or training course.	Number of people who start to complete a mainstream education or training course.	**15/43**	Number of people who complete a mainstream education or training course.	**15/43**	NHS Contract Monitoring Report. Contract data report. Wirral Change client support /follow-up process.

Volunteering, education and training: Case Study 1

An Asian female, aged 26 years-old, self-referred to Wirral Change to see the Community Development Worker (CDW). At the first meeting with the CDW, the client shared a lot of personal issues and declared that she had mental health issues that affected her confidence and self-esteem. The CDW, working closely with the BME Employment Team at Wirral Change, agreed an action point with the client, which was to volunteer at Wirral Change at the English for Speakers of Other Languages (ESOL class), to help and support non-English speakers.

The client was very nervous and unsure but with the CDW's support, she was able to achieve the task and build a good relationship with the ESOL tutor and students. In time, the client started to build up her confidence and feel important. The CDW kept regular meetings with the client to see her development in the voluntary placement. The client was very happy with what she was doing and decided that she would like to continue this kind of work as a professional because she feels it has given her a lot of confidence, and that seeing the outcome of her effort and support is priceless.

The CDW spoke to other agencies and Wirral Change to see what support they could give the client in achieving her goal. Wirral Change financially supported her to go on a Preparing to Teach in the Lifelong Learning Sector (PETTL) course. The client completed the course and from the volunteer position she was offered a permanent position as an ESOL teacher. The CDW at Wirral Change and other agencies worked to support this client to achieve her goals and build her confidence. This support took about eight months from start to finish.

Volunteering, education and training: Case Study

A young Eastern European male was referred to the service by Birkenhead Jobcentre Plus. The CDW met with the client and discussed current issues and problems. The client scored 6 on PHQ2 which gave an indication of a possible mental health problem. The CDW advised the client to visit his GP if he continued to feel low. The CDW then ascertained that the young man was living alone and had few friends, he was unemployed and his written English was not very good. The CDW was able to establish a relationship of trust with the young man and encouraged him to enrol for English for Speakers of Other Languages (ESOL) classes at the local college. The young man did enrol at college and completed the ESOL course. In her role the CDW ensures that all clients who enrol for ESOL complete the course. This is part of the client plan and there is regular contact with the client (face-to-face / phone / text to check their progress and to provide ongoing support).

During the client's time at college he developed new friendships and became involved in social activities. The young man is now in settled accommodation, and has developed lasting friendships. The ESOL course enabled him to write a good standard of job application and in the last month he has been successful in his application to enter a local apprenticeship scheme.

Volunteering, education and training

Service name	Advocacy in Wirral
Type of service	Beating the Blues (Computerised Cognitive Behavioural Therapy)
Project lead for the service	Chris Shaw
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Commissioner(s)	Barbara Edwards
Commissioner contact details	E: Barbara.edwards2@wirral.nhs.uk T: 0151 651 3907

Intended Outcomes	**Key Outcome Indicators**	**Examples of hard outcomes**	**Outcomes delivered (number / total cases possible)**	**Sustainable outcomes**	**Outcomes delivered (number / total cases possible)**	**Measures used / evidence**
Increase the number of people with mental health problems accessing volunteering opportunities.	Number of people who begin volunteering.	Number of people who enter volunteer programmes.	**29 / 86**	Number of people who remain for six months or more in volunteering or access employment or training, as a direct result of volunteering.	**29 / 29**	Contacted clients via email and telephone and via questionnaires.
Increased number of people with mental health problems accessing education and training opportunities.	Number of people who begin a mainstream education or training course.	Number of people who begin a mainstream education or training course.	**22 /86**	Number of people who complete a mainstream education or training course.	**16/16**	Contacted clients via email and telephone and via questionnaires.

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Outcomes delivered (number / total cases possible)	Sustainable outcomes	Outcomes delivered (number / total cases possible)	Measures used / evidence
Increased number of people who have begun to access peer support or self-help groups.	Number of people supported to begin accessing peer support or self-help groups since using Beating the Blues.	Number of people who access self-help groups such as women's group, positive mental health group etc.	**28 / 86**	Number of people who have accessed self-help groups since completing Beating the Blues, and have sustained participation over a minimum of three months.	**28 / 28**	Contacted clients via email and telephone and via questionnaires.
Increased number of people who have accessed social groups.	Number of people who have accessed social groups or social activities since completing Beating the Blues.	Number of people who access groups such as gym, swimming, walking, bike riding etc...	**52 / 86**	Number of people who have accessed social groups or social activities since completing Beating the Blues and have sustained participation over a minimum of three months.	**52 / 52**	Contacted clients via email and telephone and via questionnaires.
Increased number of people who have begun to take interest in a variety of hobbies.	Number of people who have started a variety of different hobbies.	Number of people who take up hobbies such as the arts, writing, poetry etc.	**28 / 86**	Number of people who are partaking in hobbies since completing Beating the Blues and have sustained participation over a three-month period.	**28 / 28**	Contacted clients via email and telephone and via questionnaires.

Volunteering, Education and Training Case Study 1: A

Background
The client was referred to Beating the Blues (BtB) by her GP suffering with anxiety and depression. This was due to the client losing her job and a breakdown of her relationship. Client had been having suicidal thoughts for two months prior to starting the Beating the Blues sessions. Client said that she had felt she could 'no longer cope' with her situation and felt it would be better if she 'wasn't here'.

BtB Progress
Throughout the programme this client made a profound improvement and became able to manage the pressures she faced in her day-to-day life. The client managed to begin sorting out her personal issues and becoming more assertive; something she felt she couldn't have done before commencing the programme. The client also became able to manage her anxiety and depression by using the techniques she had learned while attending the BtB sessions, including challenging her inner beliefs and recognising negative automatic thoughts that had been troubling her for some time. The use of these techniques have vastly improved the client's wellbeing and helped boost her confidence. The new skills have allowed the client to maintain a manageable control over both her anxiety and depression.

Outcomes
On completion of the BtB programme this client felt that she had gained full control of her life and was able to manage both her anxiety and depression.

- Client is now a volunteer on the BtB programme.
- Client is actively looking for work.
- Client has taken up self confidence classes and is looking into further education (social work).

Summary
This client has benefitted greatly from the BtB programme and, as shown above, has been able to achieve her goals in her personal and professional life with the help of the techniques learned via the BtB programme.

	GAD 7	PHQ 9
Session 1	21	25
Session 8	0	2

Volunteering, Education and Training Case Study 2: B

Background
The client was referred to BtB by his GP suffering with anxiety and depression. There was no actual trigger but the client had suffered from anxiety and depression for a number of years and as he got older the anxiety and depression became progressively worse. B had difficulties with leaving the house and was unable to do so without the accompaniment of either his parents or his STR worker. B also suffered with panic attacks which had a negative impact on his anxiety and depression which left him living in isolation for months prior to starting the programme.

BtB Progress
Throughout the eight sessions this client made a vast improvement and became able to manage the difficulties he faced in his life on a daily basis. The client became able to leave the house and to use public transport, things the client had been unable to do for a year prior to the programme. He was able to manage his anxiety, depression and panic attacks by using techniques he had learnt whilst attending the BtB sessions. This included using breathing techniques and catching his hot thoughts before they became problematic. The use of these techniques has improved the client's wellbeing and boosted his self-esteem.

Outcomes
On completion of the programme the client felt that he had done a complete "180" degree turnaround and had become able to manage both his anxiety and depression.

- Client is actively at college gaining English and Mathematics certificate.
- Client has joined the gym.
- Client has become involved in a relationship.
- Client is actively looking for full time work.

Summary
This client has benefitted greatly from the BtB programme and, as shown above, has been able to achieve his goals in his personal and professional life with the help of techniques learned via the BtB programme.

	GAD 7	PHQ 9
Session 1	24	21
Session 8	0	0

Volunteering, Education and Training Case Study 3: C (written by the client)

Background

I attended BtB after attending an appointment with my GP. I had suffered a nervous breakdown and was suffering with severe anxiety and depression, having lost my job due to pressure at work. I was totally unable to cope with day-to-day living and had moved back in with my parents. I felt totally ashamed, had lost all self-confidence, felt a complete failure and couldn't see any future for me. I had had feelings about being better off dead, although I had not acted on these.

BtB Progress and beyond

I was at a stage in my life where I was desperate to grasp any help that was available to me to help me function again. I chose to undertake the BtB sessions in a group, in an attempt to recommence engaging with other people again, as I had become totally isolated as a result of my illness. The thought of meeting other people scared me, but I also felt that I would perhaps be able to relate to others in similar situations to my own.

My first session went well and was useful and educational. Afterwards, one of the Clinical Helpers took me to one side and talked to me about my problems. It felt good to talk to someone who was not involved in my situation and who was friendly and non-judgemental. The Clinical Helper asked me if, in time, I would consider volunteering at Advocacy in Wirral, helping to update the BtB database. I had always worked in offices before and so took up the offer, partly to attempt to fill my day and to give me some routine, and partly as it seemed like a good idea and might aid my recovery. I continued with the BtB course and found that, after four or five sessions, a 'light-bulb' had come on in my head and I could begin to deal with and rationalise what had happened to me, without totally blaming myself and beating myself up as much. I had learnt different techniques to identify thinking errors that I was making and to address those errors and return to a more rational state of mind. I completed the BtB course, feeling much better than when I had originally attended and began my recovery by increasing the amount of hours I was volunteering for Advocacy.

I was then asked if I would be prepared to be a Clinical Helper for new BtB clients. This made sense to me, as I had undertaken the course, found it very beneficial and also wanted to 'give something back' and to help others. I continued this for some months, until I found myself volunteering five days a week, both with BtB and also on the PCAL project within Advocacy. I subsequently joined the PCAL team on a six month paid placement through the Future Jobs Fund scheme on a part-time basis, and I continued to assist with BtB clients as a volunteer. Once the placement ended, I continued to volunteer with Advocacy until October 2010, when I was fortunate to be offered a full-time position with the PCAL project, where I remain today, being very happy in a job that I love.

I will always be so grateful and give such credit to BtB, as it helped me to put my life back together again and returned me to good mental health and to paid employment, after such a bleak and miserable period of my life.

Outcomes
Once I had finished the BtB programme, I felt that I was back in control of my life, much less anxious and depressed and ready to face the future with confidence and hope. This led to a return to paid employment in due course.

Summary
I still use techniques that I learnt in BtB to tackle any day-to-day problems that I encounter. I am back in control of my life and in good mental health and the future now looks great for me. Thanks to all at BtB for the invaluable work and support that they provide.