Bristol Community Rehabilitation Service

Service Evaluation - Year One

Bristol Mental Health community rehabilitation service

Authorship and acknowledgements

This evaluation was commissioned by Paul Flood, Second Step Director of Services, as part of service requirements. Chris Kinston, Senior Operations Manager, and Damian Taylor, Clinical Lead, contributed to the evaluation design and final report. The evaluation process was overseen by the Service Board. The evaluation was produced with the help of the staff team, service users, and the members of the Service User Forum. A wide range of community services assisted in consultation and feedback.

The evaluation was conducted and written by Hannah Frenken.

Bristol Mental Health community rehabilitation service

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Executive Summary

The Community Rehabilitation Service became operational on 1st April 2015 as part of the newly commissioned Bristol Mental Health Service. The service is delivered as a partnership between Second Step, Avon and Wiltshire Mental Health Partnership Trust (AWP) and Missing Link. The service provides intensive intervention and support for up to twelve months for people with long term mental health problems and complex needs to support service users in working towards their recovery goals and increasing independence. The development of a new partnership service provides both exciting opportunities and a range of challenges.

Community Rehabilitation Service Evaluation

The rationale for this report is to illustrate and evaluate the work that has been done in the first year of service using a formative approach. The aim is to gather information and understand strengths and weaknesses in order to inform improvement and learning, touching on outcomes and quality but focusing on the ways in which the service has developed and established itself. Three key areas will be evaluated: partnership working within the organisation and within Bristol Mental Health; service quality and indicators of service user outcomes; and development within the service.

Partnership working will be addressed from two perspectives. As a service formed of NHS and Voluntary sector organisations, the extent to which a cohesive identity and working practice has been established will be explored from the perspective of the staff team. The extent to which the service has worked collaboratively within the wider Bristol Mental Health system will also be assessed, based on partner feedback and evidence of joint working. Service outcomes and quality will be described in terms of indicators of outcomes and case examples. This evaluation is based on data from the first 12 months of activity (1st April 2015 to 31st March 2016) and therefore evaluation of outcomes against service aims will be feasible in future evaluation reports when service users have completed their work with the service. Lastly, the service's approach to development will be reviewed and evaluated under a model of new service development.

This work will form a baseline for evaluations of the service in Year Two onwards, when the framework will undergo further development. The findings from this and future evaluations will tie into system-wide evaluation of Bristol Mental Health. The full report and summary will be made widely available within Second Step as well as feeding back to the service board, commissioners and System Leadership team.

Methods

The evaluation is based on a mixed-methods approach. Data were sourced from in-house statistics, electronic patient records, staff and partner surveys and service user feedback. Outcomes of reports from the Care Quality Commission (CQC) and Quality Indicator for Rehabilitative Care (QuIRC) were also included. Qualitative data has been presented in full or analysed using thematic content analysis.

The evaluator was employed by Second Step solely for the purpose of the evaluation, and had previously worked within the service. External consultation around the development of the evaluation framework was sought from specialists in AWP, the Bristol CCG and Bristol Mental Health System Lead. The evaluation project was registered through AWP.

Findings

1a The new partnership has been an opportunity for staff from different backgrounds to share expertise, ideas and learn from each other. However, confusion around policies and responsibilities has been a challenge in the first year of delivery. Staff felt proud to be part of the service which they said delivered a high standard of support. A clear theme in the feedback was the open culture of learning from colleagues and supportive team. However some staff found the new partnership challenging due to lack of clarity around roles and lines of responsibility. Clarity and leadership in organisational policy and procedure was also raised as an area for improvement in the staff feedback. Recommended actions:

- Ensure clarity around policies and procedures
- Ensure that roles and responsibilities of staff in different roles are clear to the whole team
- Ensure clarity around supervision procedure for staff from different agencies
- Ensure clarity around HR procedures regarding sickness and absence, and ensure that these are followed
- Consider whether there is a need to improve communication within the team to reassure staff that policies and procedures are being followed
- Consider whether periodic whole-team meetings are an option for sharing perspectives and discussing solutions to challenges together

1b Key partner services in Bristol Mental Health have found the service efficient, helpful and effective. Communication has been good, and the service has linked up with a variety of agencies to work together with service users. Efforts were made to engage with partner services in the first six months to publicise the service, its referral criteria and build relationships. Patterns of referrals to the service were made appropriately and in line with expectations according to the service referral criteria. One issue was raised by a partner service manager around arrangements for care coordination of service users at Wellbridge House. Recommended actions:

- Ensure good communication with key partner services continues
- Continue to develop the understanding of service criteria among main referring services
- Implement monitoring of time spent on extended assessments for referrals not taken on. Use this to form a benchmark for how long an effective assessment period should be to make best use of staff resources
- Implement monitoring of support provided to referrals not taken on to better capture the work being done with this group
- Improve clarity of criteria for handover of care coordination for service users residing at Wellbridge House. This should be discussed by the team management and clear guidance developed

2 The inspection of Wellbridge House by the CQC rated the service as "good", and the QuIRC assessment rated Wellbridge House as scoring at the national average on seven domains of care. Audit of outcome indicators found care plans were holistic and consistent, addressing goals in mental and physical wellbeing and social inclusion. Service users were able to access a range of social and therapeutic activities, including psychological interventions from a psychologist, or from staff trained by psychologists in a range of approaches. All service users taking medication had regular medication reviews, and were encouraged to manage their medication independently. All service users who moved on from the service retained their accommodation or moved on to more independent accommodation, apart from one service user who was discharged back to inpatient services due to deterioration in mental health.

The service's approach to capturing the work done is an area for attention. Use of outcome measures should be reviewed to ensure a consistent approach. One complaint was made against the service and this led to an action to make the duty system more robust when dealing with staff absence. Recommended actions:

- Monitor the proportion of service users who maintain their accommodation after discharge by implementing a follow-up procedure for service users who have been discharged
- Develop clear procedures for recording of physical health monitoring, interventions and outcomes
- Ensure consistent recording of social functioning and inclusion including employment and housing status
- Establish a procedure for use of outcome measures across the service. Incorporate feedback from staff at Wellbridge House to revise the procedure for collecting outcome data that was piloted in Year One and ensure that structures are in place to support staff to follow the procedure
- Ensure there is a clear procedure for documenting crisis plans on RiO
- Implement regular audit of care plans to ensure quality and compliance
- Review and implement relevant recommendations generated by the QuIRC assessment

3 **The service has taken a pragmatic approach to development over the first 12 months. The team have worked together to develop and improve the services provided while keeping the overarching vision of the service intact.** Formal development activities took place 6 months into the year. These were team meetings dedicated to working towards a better shared understanding of roles and responsibilities in the team, and reflecting on the identity of Wellbridge House. A significant amount of attention has been directed toward Wellbridge House as it has worked hard to create an environment that differentiates itself from a ward while providing interventions and upholding its duty of care. Learning from experience of delivering the service has been evidently applied, and the team have implemented changes accordingly.

The overwhelming majority of staff asked in a survey said they had contributed to the service development in some way, and were able to give examples relating to policy and procedure. Feedback was in line with staff experiences of working in the new partnership team; sharing ideas has been encouraged and ownership of projects has been distributed throughout the team. Staff suggested that more focused management time could help ideas for service development to be implemented. Looking at the clarity of management roles and responsibilities in this area is recommended. Recommended actions:

- Improve access to RiO data to inform areas for development
- Consider implementing whole team development meetings to continue whole-team participation in development work
- Maintain learning and sharing culture by reviewing support structures available to staff. Consider an approach which best suits the service and incorporates some formal structure to help guide a systematic process. Implementing a model will ensure the range of factors at each stage are considered and provide a framework for evaluating the progress of the service's development.

1. Service Activity Overview

Service referrals and caseload statistics

This section describes the demographic characteristics of the caseload in Year One. The service aimed to work with 100 service users by the end of March 2016. Table 1 breaks down the referrals made to the service by the Community Team and Wellbridge House. 163 referrals were made to the service in the first year, with 83 individuals being taken on to the caseload.

Table 1. Service referral and caseload descriptive statistics

	Total referrals	Community Team	Wellbridge House
Taken on	83	70	13
Sex (% male)	64%	61%	62%
Age (M, SD)*	43.4, 12.9	45, 12.5	34.8, 12.1
Days on caseload (Med)		299	283
(Range)		42 - 365	2 - 365
Not taken on	80	61	19
Sex (% male)	71%	70%	74%
Age (M, SD)	42.8, 12.1	43, 12.5	41.9, 10.1
Total referrals	163	131	32
Sex (% male)	67%	66%	75%
Age (M, SD)	43.3, 12.3	44.2, 12.5	38.6, 11.2

**M = Mean, SD = Standard Deviation, Med = Median*

Service access

The Black or Minority Ethnic (BME) population refers to all ethnicity groups with the exception of all White groups. In 2016 the BME population made up 16% of Bristol's population[1]. The definition "Non-White British" can also be used to describe all groups except White British, including the Eastern European population. In 2016 this group made up 22% of Bristol's population.

Figure 1 shows a breakdown of BME groups represented in the caseload in Year One, and the total proportion of White and Non-White British service users on the caseload. The same breakdown is presented in Figure 2 for all referrals not taken on to the caseload.

21% of the caseload was categorised as Non-White British in Year One, indicating that the caseload was representative of the Bristol population in 2016. 15% of referrals not taken on were categorised as Non-White British. However, 35% of referrals not taken on had missing entries or recorded ethnicity "unknown". With the exclusion of missing or unknown data, the proportion of Non-White British referrals not taken on was 23%. As a minority of records on the caseload were unknown or missing, this suggests that the team update this information for cases coming into the service.

[1] The Population of Bristol: July 2016. (2016). *Bristol City Council*

In Year Two, BME data of the Community Rehabilitation caseload should be contrasted with the BME representation in Bristol Mental Health as a whole.

Referrals taken on

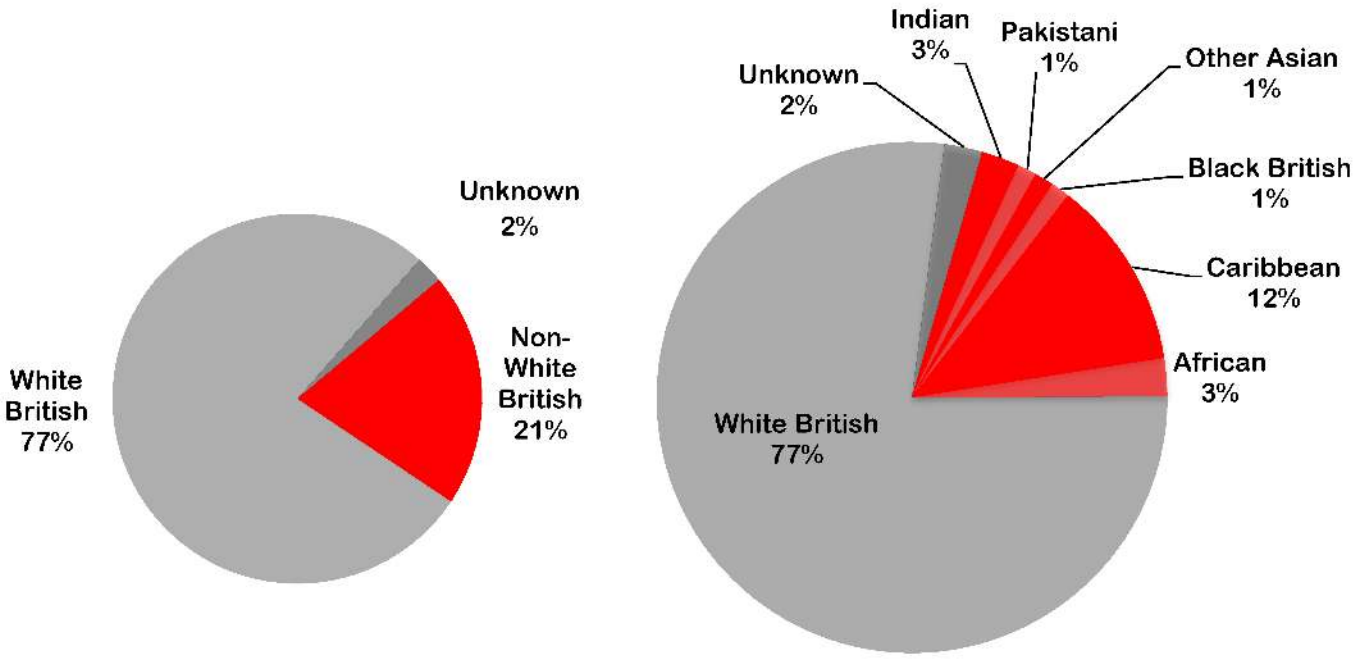


Figure 1. Caseload by ethnic group

Referrals not taken on

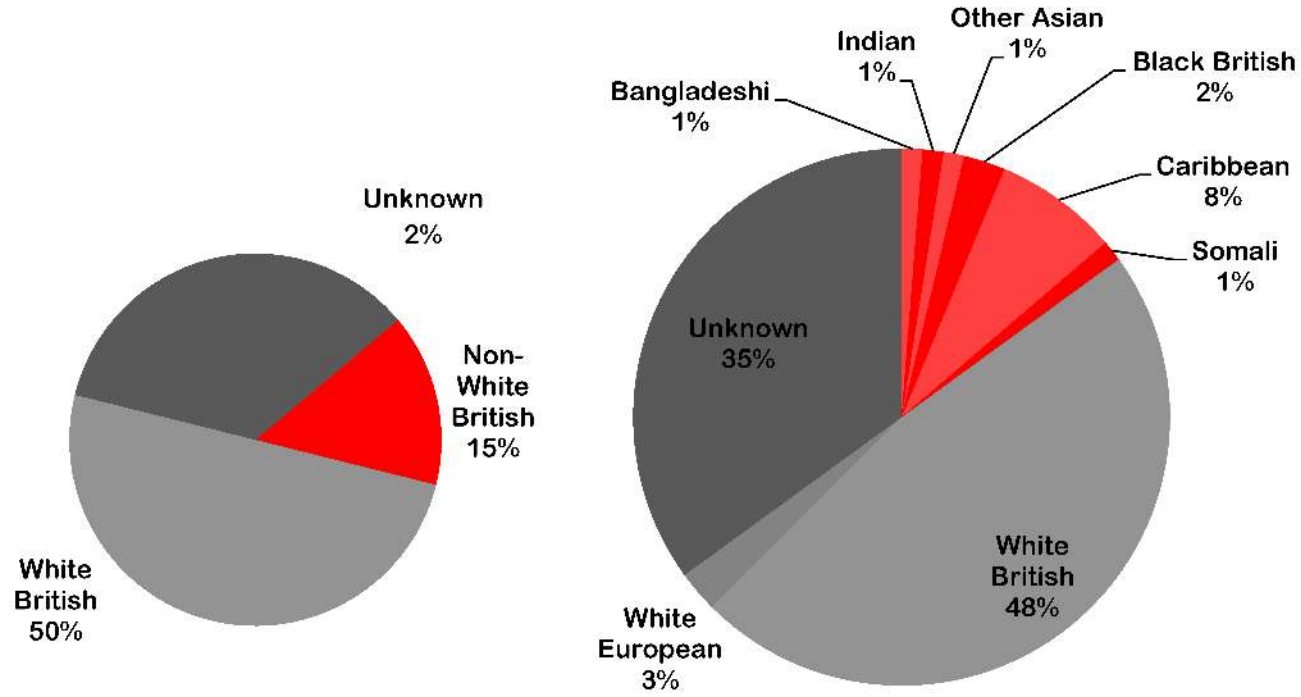


Figure 2. Referrals not taken on by ethnic group

2. Partnership working

Partnership working between the NHS and the Voluntary sector is a central focus of current policy in the UK[2], and holds the potential to provide service users with a wide range of expertise in collaboration. Achieving good partnership working will be an on-going process of learning, development and engagement with other services, though identifying strengths and weaknesses in partnership working at this stage is pertinent. Good practice can be recognised and cultivated, and challenges can be addressed early.

Second Step is the lead contractor of the service, sub-contracting clinical input from AWP and specialist women's mental health input from Missing Link. As a new partnership between Second Step, AWP and Missing Link, the Community Rehabilitation service has needed to establish a cohesive service staffed by different agencies, each with their own policies, culture and identity. The service has also needed to function effectively within a new network of partner services under Bristol Mental Health.

At this early stage of the service lifespan the key areas to be explored around partnership working will be:

i) Reflecting on how the three agencies have worked together as one; what has the experience been of staff so far, what positives have been achieved and what challenges are there that may be addressed?

ii) How the service has worked in partnership with others in the locality, especially Bristol Mental Health services. Are referrals in line with expectations, what examples are there of engagement and good joint working, and what kind of experiences have key partner services had of the Community Rehabilitations service?

Partnership working within the Bristol Community Rehabilitation Service

All staff from AWP, Second Step, and Missing Link were invited to complete an online questionnaire anonymously. Items on the questionnaire were chosen based on themes in the literature found to be important to staff experiences of partnership working in mental health services[3]. A small group of staff were consulted about the questionnaire content and based on their feedback the items were revised to open-ended questions about successes and challenges of the partnership as it was considered to be shorter and more manageable for busy staff. Thematic content analysis of survey feedback generated themes, summarised below.

"What do you think has been positive about working in the new partnership?"

[2] Department of Health (2004a) Making Partnership Work for Patients, Carers and Service Users: A Strategic Agreement between the Department of Health, the NHS and the Voluntary and Community Sector. *Department of Health*.

[3] Larkin, C., & Callaghan, P. (2005). Professionals' perceptions of interprofessional working in community mental health teams. *Journal of Interprofessional Care*, *19*, 4, 338-346.

Supportive and collaborative team

Good multidisciplinary teamwork was highlighted by several staff as a key factor in providing a high quality service. “Supportive staff and supervision”, “varied experience and training” of the team, and “working together to provide personalised support for each client” were recurring comments. “Most of the team work well together in times of crisis and we pull together well”, “it has been positive that people have been respectful to one another and in my experience, appreciate what each individual has to offer”.

High quality service

Voluntary and statuary sector collaborations are advantaged in having greater flexibility over their operational processes than statuary services, particularly in this case where the Voluntary sector agency is the lead[4], affording them room to implement new and innovative ways of working. This was reflected in staff experiences of working in the partnership: “different experiences, an environment that is more open to trying new/different approaches”, “I have found this very enriching. It has brought a very person centred emphasis which is worked out in a way that can be quite refreshing”. The feedback suggested that the team cultivated new ways of thinking and was an “interesting dynamic of differing approaches”, “breaking down stereotypes of ‘how the other service/ organisation works’”. Overall there was a strong sense of pride in the feedback: “the whole service has a very positive impact on the clients that we work with and I personally feel very lucky to be part of this team and am proud of the service we generally give to our clients”, “although there are a number of teething problems with the service we have done some excellent clinical work with service users”.

Learning opportunities

“Working with different agencies in the team has been really good. I have enjoyed learning from my colleagues and feel that all of our skills and experiences together means we can offer a more holistic and meaningful service, and that feels good! It has been a long time since I have been able to feel proud of the service I am part of!” Many staff felt a strength of the partnership lay in the diverse skill set of team members and the opportunity to learn from one another: “learning from different members of staff with different skill sets”, “how they might do things differently and then combining the two ideas”. This culture of sharing skills and knowledge extended beyond professional expertise to knowledge of local services in both sectors: “It has been invaluable in terms of learning about the variety of avenues of support that exist in the area”, “better links with other services, better understanding of how everything fits together”.

“What have the challenges been of working in the new partnership?”

Processes and policies

“Bringing together different working practices, policies, documentation… developing a team culture that encompasses the working practices of three organisations in the partnership”. Several staff felt that a key challenge for the service was bringing together the documentation of the agencies and establishing a clear set of policies fitting the identity of the service. **“**Getting to grips with using the same systems has been a challenge and I feel this is still a work in progress. Staff do not have the time to duplicate work and would much rather be giving this time to service users”, “Ideally you would just use one organisations recording/ clinical documentation”. Confusion about which agency’s paperwork and policies should be used for which purpose was a clear theme in the feedback. This

[4] Tait, L., & Shah, S. (2007). Partnership working: a policy with promise for mental healthcare. *Advances in Psychiatric Treatment*, *13*, 4, 261-271.

was also linked to management challenges: “I think it can also be a challenge line managing someone from a different organisation as policies vary between organisations”.

Leadership and management

Linking in with confusion around processes and policies was a feeling that policies were not consistently applied: “Lack of … clear leadership to ensure all relevant policies and practices are adhered to”, “I feel there should be more involvement from management ensuring staff are following procedures and general service delivery expectations”. This was especially relevant for the management of staff sickness leading to absence from work, team meetings and duty cover. Implications for pressures on staff as well as service users were noted: “Our clients should be the main focus… missed appointments due to sickness/absence and duty call not being covered is not helpful to the service or clients”. The issue was related to supporting the service delivery rather than clinical support. Staff expressed that the service could benefit from more accessible operational management.

Role clarity

One of the biggest challenges facing a new partnership organisation is reaching a shared understanding of the roles and responsibilities of different professionals within it[2] and this was clear in the survey responses. “The base culture / principles from which we all work creates a disparity, which makes it more challenging”, “organisations can have different expectations, standards and priorities”. The feedback suggested that staff understood their own role, but felt their role or expertise was sometimes misunderstood by colleagues. This related to professional differences: “People from different backgrounds have been taught to work in different ways – sometimes hard for everyone to understand others’ ways of working”, “lack of respect/ understanding of professional roles… rather than the understanding that we all have equally useful but different skills”. It also referred to differences between staff working in the accommodation and community-based branch of the service: “some people working in the community… do not always understand the challenges faced by working in a 24 hour environment”.

The feedback from this survey is in line with the findings of studies into staff experiences of working in community mental health partnerships[2,3,5]. Developing agreed policies is a well-documented challenge. This does not suggest that confusion around policies or lines of accountability are inherent to partnership working, but suggests that some lack of clarity is to be expected during the initial development phase of a new partnership. The service was established quickly and was obliged to open before many of the policies were finalised. Policies and procedures have been developed over time based on learning through practice and team debate and reflection. This was a complex but important process in ensuring that the service maintained the values and identity of Second Step as the lead agency. However, the frustration experienced by staff when a clear process is not in place is evident in the feedback and should be acknowledged. A review of the support staff are given around the policy framework may be necessary, and the consistency of sickness protocol should be explored.

Some staff felt their role had been misunderstood by their colleagues. A lack of recognition of specialist skills, specific responsibilities and also the different challenges faced by professionals in different roles was considered a key challenge of the partnership. Clear role identity can be difficult to achieve[3], but is important to avoid misunderstanding responsibilities and ways of working. Regular

[5] Aldridge, N. (2005). *Communities in Control: The New Third Sector Agenda for Public Sector Reform*. Social Market Foundation.

team meetings and multi-agency training are evidence-based ways of improving role clarity[6,7]. It is not clear from the feedback what staff believe would improve this situation, and there was no trend in the feedback coming from Voluntary sector or NHS employees. Both the community and accommodation elements of the service currently meet weekly and the senior / care-co-ordinators across the service meet monthly. One solution may be to hold whole-team meetings as a forum for sharing perspectives between different professionals. Clarifications of policies and procedures may also increase staff sense of role identity and delineate lines of responsibility more effectively.

Importantly, the overall message was that service users received a high quality service that staff were proud to be a part of. The feedback suggests that the service has cultivated an atmosphere of sharing knowledge, collaboration and learning. Staff have supported one another to deliver services to a high standard making use of their diverse skill set, and have highlighted a level of respect for the different professionals in the team and the expertise they bring. This is reassuring in light of the role ambiguity felt by some staff. The next step will be to ensure that the concerns raised by staff in this survey begin to be addressed, so this culture of mutual respect and openness to new approaches can be maintained.

Recommendations

- Ensure clarity around policies and procedures
- Ensure that roles and responsibilities of staff are clear to the whole team
- Ensure clarity around supervision procedure for staff from different agencies
- Ensure clarity around HR procedures regarding sickness and absence, and ensure that these are followed
- Consider whether there is a need to improve communication with the team to reassure staff that policies and procedures are being followed
- Consider whether whole-team development meetings are an option for sharing perspectives and discussing solutions to challenges together

Partnership working within Bristol Mental Health

Bristol Mental Health comprises 14 services provided by 18 different organisations. Partnership working of the Community Rehabilitation service within Bristol Mental Health was assessed using a variety of data including: referral statistics; feedback from service managers across the partnership; evidence of joint working; and engagement with other services to raise awareness about the service.

[6] Secker, J. & Hill, K. (2001) Broadening the partnerships: experiences of working across community agencies. *Journal of Interprofessional Care*, 15, 341–350.

[7] Fowler, P., Hannigan, B. & Northway, R. (2000) Community nurses and social workers learning together: a report of an interprofessional education initiative in South Wales. *Health and Social Care in the Community*, 8, 186–191.

Engagement

The service has documented outreach work that was done in the first three months of the service opening. This involved: providing information booklets and posters about the service and Bristol Mental Health; providing referral criteria and referral forms; talking to a contact or to the team about the service including information about Wellbridge House and the community team; exchanging contact details with relevant people in the team; advising who to contact in future for guidance or to discuss referrals. Where possible a presentation about the service was given.

GP practices

Of 30 practices contacted by the service, 10 practices allowed members of the Community Rehabilitation team to attend their team meeting and other practices asked that information be left with their receptionist. It is worth noting that in an evaluation conducted by Bristol Mental Health in which 30 GP mental health leads responded[8], 77% rated their knowledge of the Community Rehabilitation service as less than 5 on a scale of 0 – 10. As this was a newly developed service it had contact with service users from a relatively small number of GP practices. This will have increased over the year GP awareness should be re-evaluated in Year Two.

Bristol Mental Health services

All Bristol Mental Health services were contacted at least once. A Bristol Mental Health Clinical Leads meeting and Operations Management meeting were attended regularly by the Clinical Lead and Senior Operations Manager. Through these meeting they were able to raise awareness of the service to other Bristol Mental Health leads. Allocated members of the team maintained contact with key partners including inpatient units and the Assessment and Recovery teams. For example, weekly ward management meetings at Callington Road hospital were attended for the first 6 months of service.

Voluntary sector and community organisations

The service reached out to over 40 voluntary or community-based organisations as part of their initial outreach work. This included wellbeing services (Off the Record, Missing Link, Rethink, Mind, LGBT Health Forum), housing and homelessness services (St Mungo's, The Maples, Shelter), advisory/ advocacy services (Avon and Bristol Law Centre, Citizen's Advice Bureau, Talking Money) and community centres and faith groups.

Social Services

The Senior Operations Manager gave presentations about the service to North, Central and South Adult complex intervention Social Work teams, and attended a Bristol's Homeless Agencies meeting.

[8] Soodeen, D. (2016). Bristol Mental Health: GP Survey Feedback Report. *Unpublished manuscript*

Referrals

"*We believe that services should be joined up so that, whoever you contact in Bristol Mental Health, you are put in touch with the right person to help you*"
Bristol Mental Health website[9]

Referrals were summarized to give an indication of how "joined up" the service has been with other services in the network. Referrals were broken down by referral source and assessment outcome to highlight any services which submit a high proportion of unsuccessful referrals, and to provide an indicator of the extent to which service users were put in touch with "the right person".

Referral data from community organisations outside of the Bristol Mental Health network were also included, such as GPs and prison services, due to their important role in signposting individuals into the services. Figures 2 and 3 describe the total number of referrals and proportion of referrals taken on and not taken on per service for Bristol Mental Health and non- Bristol Mental Health services respectively.

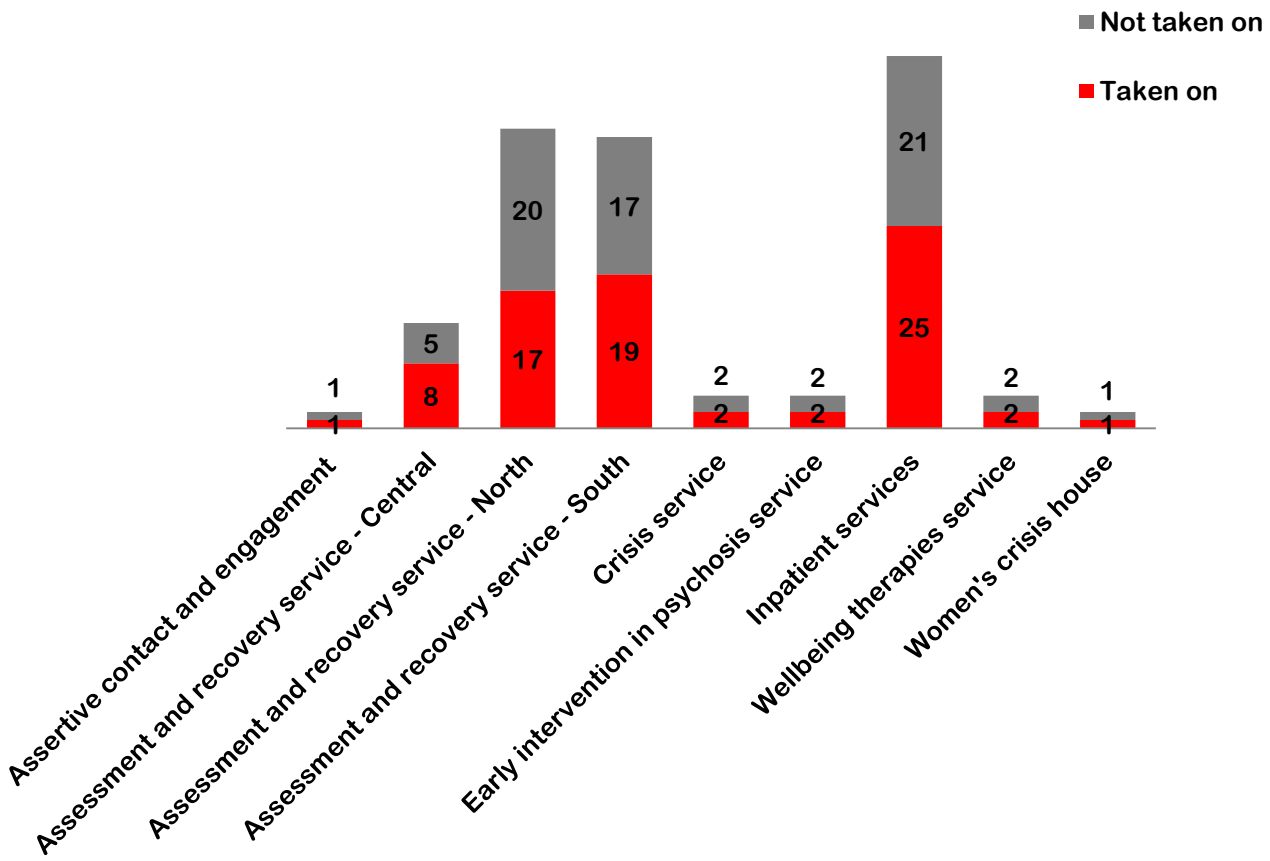


Figure 3. Total number of referrals to the Community Rehabilitation service from each service within Bristol Mental Health between 1st April 2015 and 31st March 2016

[9] Bristol Mental Health: Our Values. (2014). Retrieved from http://bristolmentalhealth.org/who-we-are/our-values/

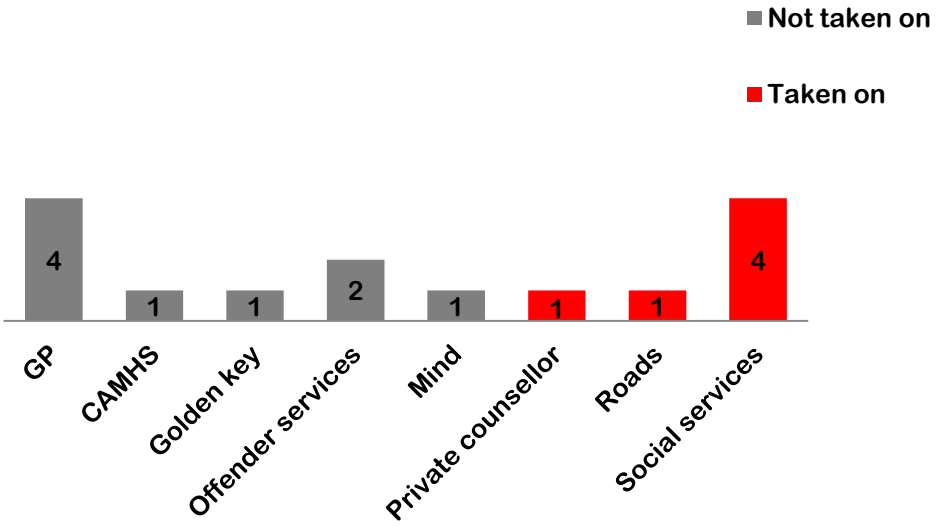


Figure 4. Total number of referrals to the Community Rehabilitation service from non-Bristol Mental Health services between 1st April 2015 and 31st March 2016

Of the total referrals received by the Community Rehabilitation service in Year One, 89% were submitted by Bristol Mental Health services. 78% of these referrals were for community-based rather than accommodation-based services. 58% of referrals made by Bristol Mental Health services were taken on to the caseload. The pattern of referrals is in line with what would be expected based on the referral criteria (Appendix 2), with most referrals being made by Assessment and Recovery and Inpatient services. Across services the proportion of referrals being taken on to not taken on is consistent, suggesting there are no obvious gaps in understanding about referral criteria.

There are a number of reasons why referrals made to the service may not lead to being taken on. Monitoring these may highlight gaps in understanding about the service or its referral procedure in partner services. The service started recording detailed reasons for why people were not taken on by the service shortly after opening. This information was available for 62 of the 80 people not taken on. The existing records were grouped into eight categories to describe the most common reasons for referrals not being taken on.

Table 2. Reasons for referrals not taken on to the service

	Wellbridge House	Community Team
Difficulty engaging in assessment process	1	14
Referral requires lower-intensity support	1	5
Referral requires higher-intensity support	4	2
Unknown	2	7
Moved out of area	1	2
Needs met by other service	4	7
Risk too high	2	1
Declined service	5	4

The most frequent reasons for referrals not being taken on include service users not engaging in the assessment process or declining the service following assessment. The service offers extended assessment to people who find it difficult to engage in the assessment process. If people decline to engage with the service they would be unlikely to benefit from a time limited intervention focused on recovery goals.

The audit also shows a trend toward individuals with support needs that are too high being referred to Wellbridge House, while almost a third (29%) of referrals declined by the Community Team were because the needs were not sufficient to require input or were being adequately met by another service. This may reflect a misunderstanding about the referral criteria or service provision, though proportionately this is not a prevalent issue: 61% of referrals to the service overall were declined due to external factors including service user declining service, not engaging with assessment process, moving away or already being seen by another service.

While the service has tracked where referrals not taken on are referred on to, work done by the service during this transition is more difficult to quantify. Staff were asked to provide examples of work done with individuals who were not taken on but still received support from the service to move them on to the right service, or who liaised with other services to form a plan. One example is described in Box 1.

Box 1. Supporting referrals not taken on to access appropriate support

A service user was referred to the Community Rehabilitation Service due to concerns about his mental health which were exacerbated by not taking prescribed medication and illicit substance use. There were also concerns about his vulnerability and behaviour toward other service users at his current supported accommodation.

As part of the assessment process a Community Rehabilitation team worker met with the manager of his accommodation service and discussed the referral with the service user's social worker. He also reviewed his previous RiO notes and discussed the referral with his care coordinator.

He then met the service user for assessment. It was clear following the assessment and liaison with the professionals working with the service user that he would not currently engage with the Community Rehabilitation Team. However, the team worker offered a number of suggestions to support the service user's current team, such as providing tools to help them work on identifying interests and goals together. The meetings with him and his current and previous workers enabled a clearer assessment of his current mental health needs and risks. It also led to a clearer plan about current interventions and future re-referral to services.

Joint working

To illustrate the service's partnership working in practice, staff were asked to come forward with examples of joint working they had been involved with in Year One, outlined in Box 2. An example of how joint working has been instrumental to the set-up phase of the service was provided by the service's Nurse Prescriber. The opening of Wellbridge House saw a new group of individuals with mental health needs requiring GP services. The Nurse Prescriber made the local practice aware of the new service, contacting the Mental Health lead who agreed to bring Wellbridge House to the practice's team meeting agenda. A GP was then allocated to work with all Wellbridge House service users, who discussed every service user with the Nurse Prescriber to decide how they could best work together. The two professionals communicated directly on an on-going basis.

This relationship later proved instrumental in meeting the needs of complex clients at Wellbridge House, such as a frequent attender distressed by health anxiety who was allocated a weekly slot with this GP, helping to contain his anxiety and manage his use of emergency services. "Willingness to collaborate and to go the extra mile" was felt by the Nurse Prescriber to be the driving factor in this joint work.

Box 2. Joint working in the Community Rehabilitation service

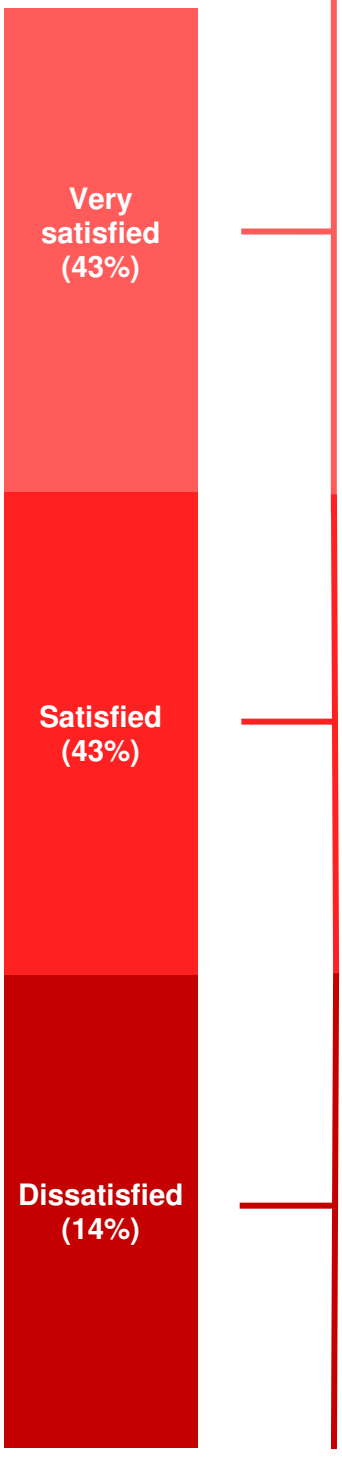
Staff were asked to come forward with examples of joint working they had been involved with since the start of the service:

- An occupational therapist and recovery navigator worked with the Men's Crisis House for 4 weeks to support a service user's transition back to his own flat. This involved developing daily living skills as well as supporting him to attend Bristol Active Life Project (BALP) for regular exercise classes and the Bristol Drugs Project for 1:1 support, relapse prevention courses and group therapy. A key role of the Community Rehabilitation service was also to liaise between each of the services which were involved in the service user's support to ensure a complementary approach.
- The Community Rehabilitation service has joint worked to support people through transition. For example, the service worked with Places for People for 3 months as an extended handover period.
- As the service has developed, initiatives have been set up with the support of outside agencies. A weekly walking group was set up by Community Rehabilitation staff with help from BALP: two Recovery Navigators were trained for 6 months, meeting the BALP coordinator every 6 weeks for guidance before the group was active.
- When a service user was in conflict with a neighbour who was receiving support from Missing Link, the Community Rehabilitation service was able to allocate a Missing Link worker from the team to liaise and resolve the issue, working alongside the woman's housing support officer.
- Supporting service users to access other services has been a key role for the Community Rehabilitation service. One example was given of a service user with challenging behaviour who was banned from the Life Recovery group. A member of staff advocated on behalf of the service user which enabled her to re-join the group.

Feedback from partner services

A questionnaire was emailed to contacts at 16 services in Bristol Mental Health and 10 community services who have worked with the service in Year One. After 2 rounds of questionnaire distribution 7 responses were received.

How satisfied are you with how the community rehabilitation service has worked with your service in the last 12 months?



How has the service worked well or how could it work better with your service?

"They have taken the right kinds of people on their caseload and have worked intensively with them, which has benefitted the service users a great deal. I'm not sure it could be any better. Communication between teams has been great. My experience has been very positive and I am glad the service is there"

"Interface with team, joint working for complex clients, developing crisis and contingency plans for service users. The service has been working well and might help if we have some joint reflective practice for complex cases of people who use the service to ensure joint learning"

"Working really well with someone in the residential setting in helping him become more independent and learn life skills. Excellent timely assessment, able to give advice when not for the service. Always polite and helpful"

"Very good links with clinical director who has kept our service informed about developments and we have looked to do some joint work … around training, etc. [Would like to see] continued good communication"

"…willing to work with service users who have rehabilitation needs. In some cases declined to work with service users when not motivated to change to continue their recovery journey. It is my concern that these service users feel rejection. I wonder if the referring team and the Rehab Team could work on a plan to move service users to a position of positive change. Even if service users do not choose to change, then they can feel somewhat more empowered"

"Wellbridge is adequate in meeting service user's needs, especially service users presenting with complex and long term mental health needs. Service users are well supported to achieve independence and the team works closely with carers and GPs. It would be helpful if the team take over care coordination for service users where the care pathway has been identified. This was the frustrating part. Decisions about care coordination seemed inconsistent and sometimes reasons … appeared incongruent with what was already being provided for the service user"

The service has done a great deal of collaborative work with partner and non-Bristol Mental Health organisations during its first year. Engagement with a wide range of services during the first months was carefully considered, with allocated staff attending the meetings from key referrers for up to six months and maintaining regular contact. Good on-going communication with partner services has formed productive working relationships, reflected in the feedback of partner services. Partner services have found the service helpful, effective and supportive in joint working. One partner service found arrangements for transfer of care-coordination to be confusing. This has since been acknowledged by the service and will be reviewed again in Year Two. Examples of joint working show the service as an active participant in developing new initiatives, such as the BALP walking group, as well as providing a supportive and complementary service to other services, and ensuring that individuals who are referred but not taken on to the service are directed toward the most appropriate service for their needs.

Recommendations

- Ensure good communication with key partner services continues
- Continue to develop the understanding of service criteria among main referring services
- Implement monitoring of time spent on extended assessments for referrals not taken on. Use this to form a benchmark for how long an effective assessment period should be to make best use of staff resources.
- Implement monitoring of support provided to referrals not taken on to better capture the work being done
- Work with other BMH service to agree processes for the transfer of care coordination to the Community Rehabilitation Service. .

3. Service Outcomes, Process and Quality

Service user outcomes and the processes in place to promote outcomes are key indicators of service quality[10]. At this stage, the focus will be on evaluating the processes supporting recovery and outcomes. Comprehensive evaluation of service user outcomes will become viable when more service users have completed their work with the team, and should be a focus of future evaluations.

A mixed methods approach was used to form a broader picture of service outcomes, process and quality: descriptive data was gathered on discharges and move-on; a snapshot of process indicators for a sample of current service users was gathered from RiO; and service user outcomes were described in more detail using case examples. Data on complaints and incidents are reported, and details of in-house and external service quality assessments are summarised.

Discharge and move-on

Between April 1st 2015 and March 31st 2016, 9 service users were discharged from the service. One person died while under the care of the team. The cause of death was found to be a known physical health problem.

Table 3. Summary of reasons for discharge and move-on data

Reason for discharge	***n***
Completed rehabilitation programme	3
Disengaged with service	2
Deterioration in mental health	3
Moved out of area	1
Move-on accommodation type	
Retained private accommodation	2
Returned to supported accommodation placement	5
Moved on to more independent accommodation	1
Returned to inpatient service	1
Referral source	
Assessment and recovery services	7
Inpatient services	2
Service referred on to	
Assessment and recovery services	5
Community rehabilitation service*	3
Inpatient services	1

**Service users completing programme at Wellbridge House and continuing support in community with the service*

[10] Killaspy, H., Marston, L., Omar, R. Z., Green, N., Harrison, I., Lean, M., Holloway, F., Craig, T., Leavey, G., & King, M. (2013). Service quality and clinical outcomes: an example from mental health rehabilitation services in England. *The British Journal of Psychiatry, 202*, 28-34.

All but one service user retained their accommodation or moved on to more independent accommodation after being discharged from the service; one service user moved from Wellbridge House to accommodation with stepped down support. One service user was discharged back to inpatient services after 2 days at Wellbridge House due to deterioration in mental health.

Box 3. Supporting transition from inpatient services through Wellbridge House to independent community living

Two service users taken on to Wellbridge House from local inpatient services moved on to accommodation with lower-intensity support after a period of 10-12 months with the service. One returned to their flat with a support package from the community team and adult social care. Another moved in to supported mental health accommodation in the community.

Both service users experienced multiple crises while at Wellbridge House, but were able to manage this with a high level of support from the team, avoid a hospital re-admission and ultimately move on to more independent housing. This was achieved through: thoughtful use of staff by allocating Recovery Navigators on alternating basis to give 1:1 support 24 hours a day; regular clinical supervision for advice and support including out of hours through on-call access; a consistent approach documented in regularly maintained crisis plans to ensure all staff including agency workers were informed; medication consultation with psychiatrist and nurse prescriber and use of PRN. The support was tailored to the needs of each individual on an on-going basis.

One service user experienced a series of psychotic episodes and paranoid delusions which became more severe as he prepared to be discharged back to his flat. Due to the complexity of the service user's mental and physical health needs, intensive support was needed to facilitate move-on back to his flat and avoid residential care, which he wished to do but which presented certain risks. By making use of the multidisciplinary skills in the team, it was possible for him to manage his crises without hospital admission and achieve the best possible outcome: to move back into his flat in the community.

Recovery navigators were given regular clinical guidance, for example through use of grounding techniques, and had access to 24 hour on-call advice from senior staff where necessary. They liaised with local police who allocated an officer to visit the site as the service user had been contacting the police. During the run up to his discharge they supported him to reconnect with friends who would visit him when he began visits to his flat, a key source of motivation and reassurance for him. They also played a key role in advocating for the service user when he faced losing his flat over concerns from the housing provider about the length of time the flat had been uninhabited. Having secured his flat, appropriate adaptions were made to meet his physical needs, facilitated by an occupational therapist. His medication was overseen by the nurse prescriber and psychiatrist, including PRN which he self-managed. Wellbridge House staff provided overnight telephone support during overnight visits to help the service user manage his distress more independently.

Over time the service user reached a period of stability and was discharged to the community branch of the service. By securing a social care package alongside, he was able to receive a high intensity of community support and maintain his accommodation in the community.

Outcome and process indicators

A random sample of 20 service users was selected from the community team caseload. All service users who had received support from Wellbridge House were included in the evaluation with the exception of one service user who was discharged from the service within two days due to deterioration in mental health. The total sample was 32 service users, approximately 20% of the caseload. The audit was based on information recorded in social inclusion assessments, care plans, clinical documentation, CPA review notes and key-word searches in progress notes on RiO. Key process indicators were chosen based on the literature[11,12], discussion with clinical lead, and availability of data. Case examples that illustrate how outcomes have been achieved with individual service users are presented alongside.

Social inclusion

"I'm very happy with the service I have had. It's really helped me get back on track and lead a normal life again. My coordinator is very supportive and is excellent because of all the things he has set up for me. One of the best things he set up is my work at fairshare which I go to twice a week. This has given me lots of confidence and experience ready for when I take on full paid work. I really enjoy my trips out with him, I can really talk to him about things that are going through my mind. He listens and we discuss my thoughts. I would like to thank everyone who has been involved in my recovery. Excellent service."

Table 4. Key process indicators relating to social inclusion outcomes

Key Indicators	**Wellbridge House** ***n = 12*** ***n***	**Community Team** ***n = 20*** ***n***	**Total %**
Occupation			
employed	0	1	3%
unemployed	6	6	38%
seeking work	0	6	19%
long term sick	4	6	31%
retired	0	1	3%
volunteering	2	3	16%
in education or training	2	0	6%
not recorded	4	0	13%
Housing			
settled (owned or rented accommodation)	3	17	63%
not settled (temporary accommodation)	9	3	38%
Care planning			
occupational care plan	6	13	59%
housing or move-on accommodation care plan	12	7	59%
Hospital admissions			
No. admissions to hospital	1	0	3%

[11] Parkinson, J. (2007). Establishing a core set of national, sustainable mental health indicators for adults in Scotland: FinReport. *NHS Health Scotland*.

Nationally the prevalence of unemployment among people experiencing mental health problems is 67%[12], and this is likely to be significantly higher among users of secondary care services. Of the total sample, 91% were not in paid employment. 16% of the sample were volunteering and 6% were engaged in education. 52% of service users who were not engaged in an occupation had a care planned pathway towards obtaining voluntary, educational or professional occupation. All remaining service users who did not have an occupational care plan had care planned goals relating to mental health issues that precluded occupational goals, such as building confidence to be in public spaces using graded exposure or supported visits to the community.

All service users who were not living in settled accommodation or appropriate accommodation had housing care plans. Audit of move-on and occupational care plans showed evidence of joint working with agencies outside of Bristol Mental Health. Box 3 illustrates how the service has worked to promote social inclusion with two service users.

Box 4. Promoting social inclusion

Case example A

Getting into paid work and returning to college were priorities for one service user who came to Wellbridge House from inpatient services. After leaving hospital and moving into Wellbridge House she resumed her part-time job and began a college course. This was unmanageable for her at that time due to a number of factors, including a relationship which was an on-going trigger for distress, and medication which made it difficult for her to wake up on time to attend classes.
Over several months staff worked intensively with the service user on her goals. When her mental wellbeing declined, a coping mechanism was to apply to courses or voluntary work in high volumes. Staff liaised with local colleges who were concerned about this, and she was given a contact for career advice. Staff helped her to manage her applications by learning other coping strategies and offering regular 1:1 support each day to contain discussions about educational goals or practice interview skills. The service user often searched out new opportunities with staff support, and was signposted to the Employment Service on a number of occasions. A review of the service user's medication both improved her mental health and reduced her drowsiness.

By reaching a point of stability, helping to manage expectations about what was achievable at that time and supporting application and interview preparation, the service user obtained voluntary work in line with her career goal to be a nurse. Alongside this, she began a pre-access course which would enable her to do further study in future. She has maintained this successfully to date.

At the end of the service a support package was secured with Keystones Housing with the help of her social care team. Before being admitted to hospital the service user had lived in her family home and was motivated to find a more independent housing solution. Keystones does not provide an on site waking night team, so was a step down in support from Wellbridge House. This was carefully managed as the service user had frequently sought support from the night team in the past. Wellbridge House night staff offered continued out of hours telephone support in addition to the Keystones out of hours phone line, and a familiar member of the team continues to meet weekly with her in the community.

[12] Mental Health Taskforce (2016). The Five Year Forward View For Mental Health. *NHS England.*

Case example B

One service user was re-admitted to hospital on a Section 2 four months into his stay at Wellbridge House. This was due to a relapse associated with not taking his medication. With careful management of his medication and risk, he was able to return to Wellbridge House for the last two weeks of the section period and remain out of hospital for the duration of his stay at Wellbridge.

This example reflects how the aims of the service have been put into practice. Wellbridge House aims to be a safe space to foster stability and security, avoiding institutionalisation: "Interventions should involve self-management strategies" ... "promoting independence and autonomy" (Appendix 1).

One of the ways this translates into practice is through the management of medication and positive risk taking. Service users are encouraged to manage their medication with support, the appropriate level of support being reviewed on an on-going basis. This service user had no historical risk of not taking his medication , and was encouraged to manage his medication himself with box checks from staff. When he returned to Wellbridge House from his section he began a medication care plan which would

Mental health and wellbeing

"I've been using mental health services for most of my life. This is the first time where I've felt that the focus has been on me and my wellbeing, not just around crisis. I've never felt listened to or respected before but now I feel not only respected and listened to, but that my opinion is valued. For the first time ever I feel hope for the future, that my mental illness isn't just something to be managed but something I can live with. My support team are excellent and I can't rate them highly enough. I wish this service was more widely available for other service users."

Table 5. Key process indicators relating to mental health and wellbeing outcomes

	Wellbridge House *n = 12*	**Community Team** *n = 20*	**Total** %
Key indicators	***n***	***n***	
Care planning			
crisis plan	12	20	100%
mental health care plan	12	20	100%
Interventions			
psychological intervention with psychologist	4	7	34%
low-level psychological intervention	8	14	69%
access to peer worker	12	12	75%
Outcome measures			
outcome tool completed at least once	10	7	53%

All service users had a care plan that related to the management of mental health symptoms. This included planned interventions and support to access other services for specialist counselling. Where service users were not willing to engage with mental health interventions, care plans included guidance for staff such as staff-facing formulations. All service users had crisis plans. There was variation in the documentation of crisis plans with some recorded as a care plan, others recorded under crisis management in RiO and others uploaded to clinical documentation.

The team includes a part-time psychologist and full-time clinical lead psychologist. The psychologists have provided interventions including cognitive behavioural based interventions, compassion focussed therapy and integrative psychological therapy. In addition to delivering therapeutic interventions the psychologists attend weekly clinical meetings and advise staff on psychologically-informed therapeutic interventions they can deliver. This has included relaxation techniques, mindfulness, and graded exposure work. They have also provided formulation based team supervision.

A programme of training has been delivered to staff by the psychologists to supplement core training and develop understanding of mental health issues such as anxiety, psychosis and trauma. This included training on different conceptualisations of mental health, such as the compassionate mind approach. The team have also been trained to use psychological formulation as a model of developing the most suitable treatment approach with service users. This is in line with the service aims to provide services on the basis of individual needs, strengths and life experiences (Appendix 1).

The use of validated outcome measures was not consistent across the service. At Wellbridge House, 83% of service users had completed at least one outcome measure, either the CORE-OM[13] or the Warwick Edinburgh Mental Wellbeing Scale[14] (WEMWBS). 25% of service users at Wellbridge House had completed more than one outcome measure. A smaller proportion of service users sampled from the community team had completed an outcome measure, with 35% completing at least one outcome measure in Year One.

The discrepancy in use of outcome measures between Wellbridge House and the community team may be accounted for by a procedure being piloted in Wellbridge House prior to implementation across the service. The pilot asked staff to complete both the CORE-OM and WEMWBS with service users when joining the service and every 3 months thereafter. As a minimum, service users were to complete the tools at the start and end of contact with the service. Together the CORE-OM and WEMWBS should take around 15-20 minutes to complete.

Rationale for use of both measures was to produce a fuller picture of wellbeing, as each measure taps into different aspects of wellbeing and risk, and as a pragmatic approach to delayed confirmation of a system-wide protocol. Progress notes showed that the reason for service users not completing measures in the pilot's first cycle was due to declining to participate. However it was not clear whether this was the reason for completion tailing off over time. Some staff reported that they found the questions on the CORE-OM difficult to ask, and also reported that service users had found the CORE-OM particularly negative ("can't you ask me some happier questions?"). No issues were raised with the WEMWBS.

Bristol Mental Health now recommends WEMWBS as a minimum. At this stage it is appropriate to review the pilot in more detail taking staff experiences into account and implementing an achievable procedure across the whole service. As part of this process any ethical considerations around use of the tools should be addressed, namely whether service users have found them distressing and whether staff feel competent in debriefing service users after using the tool. The added value of using CORE-OM or alternatives may also be reviewed in light of this.

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[13] Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K. & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE–OM: towards practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology, 69*, 2, 184–196.

[14] Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., et al., (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation. *Health and Quality of life Outcomes*, *5*, 1, 1.

"Having my peer worker's support made me feel a lot more relaxed about actually getting through the door, where as I probably would have bottled out. When they shared in the meeting I found it really helpful as I found I could identify with what she said and gave me confidence to make me believe that I will get to the stage where I can share and believe that recovery is possible. As in she has been where I am now and achieved so much in her recovery which gave me a lot of hope."

The service employs 5 peer recovery navigators with 2 allocated to Wellbridge House. Access to peer workers was good according to the audited sample with 75% of service users working with peer workers in the first year. Box 4 describes an example of how working with peer navigators has impacted on the wellbeing of service users.

Box 5. The role of peer work in supporting mental wellbeing

Case example A

"A service user was referred to the service with a history of mood instability and anxiety. She was particularly worried about experiencing panic attacks. Specific goals on referral included working on social inclusion and to eventually be able to return to work.

A senior recovery navigator, recovery navigator and myself as a peer recovery navigator were assigned to work with the service user. Initially the service user entered into a program of gradual exposure to leaving her house with one of the team, then eventually on her own. She graded each activity according to the amount of anxiety she experienced, aimed at reducing her panic attacks while out in the community. As a peer worker, I disclosed information about my own experiences if I believed this would be helpful to the service user, for example, how I overcome the temptation to avoid anxiety provoking situations, which may only serve to prolong the problem in the long-term.

Over a period of ten months the service user moved from finding it almost impossible to leave her house to travelling abroad on a holiday with her husband. She expressed an interest in the peer role, particularly recognising the sense of hope this role may bring, and has recently attended a 'Peer Mentoring' training course with a view to eventually finding employment as a peer worker herself." – Peer Recovery Navigator

Case example B

"This service user was unable to access community activities that she had previously attended regularly due to increasing anxiety. She wanted to start accessing her local gym, with weight loss being one of her goals when initially coming into the service.
At first we began to form a trusting relationship by having coffee and looking into activities together. When she began attending a slimming class independently she found it extremely difficult being around other people and lost confidence as she struggled to follow the programme.

I began to support her to the classes, and with a lot of encouragement she was able to participate in the classes regularly. Together we worked on developing realistic targets for her weight loss, and over time her confidence grew as she met her goals. Another achievement was starting aqua aerobics.

I shared with the service user that I couldn't swim, and my fear of water helped her to relate her anxieties about attending classes. We attended the aqua aerobics class together, arriving early so she wouldn't feel overwhelmed. At times she needed a lot of encouragement to continue, and I supported her using deep breathing exercises and reassurance. Over time I encouraged her to attend the swimming classes independently, and now she is attending the groups on her own.

She has been able to use the relaxation exercises to help manage her anxiety and access more exercise groups and volunteering. She has now lost 4 stone, and works as a volunteer in two placements." – Peer Recovery Navigator

Physical health and wellbeing

"I'm more than grateful for the support I receive. From my point of view they go over and aboard what I expect. The nurse has been helpful with support on my medication. My peer worker has supported me with my physical needs and has come to swimming sessions and slimming world. They have both escorted me regarding training courses etc."

"I find it useful that they come to talk to me and talk through medication. Having my depot injection with the nurse, exploring courses and community activities give me somebody to talk to. Stops stress of too many letters."

Physical health is inextricably linked with mental health. People with a long-standing mental health problem are at significantly greater risk of smoking, problematic alcohol use, obesity, diabetes and heart disease[15]. Addressing health inequalities among individuals with mental health problems remains a key agenda for mental health services[16] as part of a holistic approach that addresses factors underlying health inequalities, including social relationships, access to good housing, employment and resilience. Ensuring health monitoring through annual health checks with GPs is an important part of this.

Care planning for physical health and medication was consistent across both branches of the service. 91% of the sample had a physical health care plan that related to specific health goals or attending annual health checks with the GP. All service users who were taking medication had a medication care plan and medical reviews with either the nurse prescriber or psychiatrist. Around half of the sample had been supported to access some form of physical exercise or sport, and one third received support with diet or nutrition. These interventions were tailored to specific health needs of the service users, addressing goals such as weight loss, fitness, social engagement and management of physical conditions such as diabetes or Phenylketonuria (PKU).

[15] Hardy, S., & Thomas, B. (2012). Physical and mental health comorbidity: policy and practice implications. *Journal of Mental Health Nursing. 21*, 3, 289-298.
[16] Glasper, A. (2016). Improving the physical health of people with mental health problems. *British Journal of Nursing*, *25*, 12, 696-697.

Table 6. Key process indicators relating to physical health and wellbeing outcomes

	Wellbridge House *n = 12*	Community Team *n = 20*	Total %
Key indicators	***n***	***n***	
Care planning			
physical health	10	19	91%
Medication	11	20	97%
Interventions			
dietary/ nutritional support	3	8	34%
exercise / sports	5	10	47%
occupational therapy	4	7	34%
medication review	11	20	97%

Box 6. Multidisciplinary support for physical and mental health

"When we started working with this service user she was moving from hospital to temporary accommodation as her home was unfit to move into to. Her home was unsafe due to extreme hoarding which had built up over years of deteriorating mental health. Her home had fallen into disrepair with no hot water or heating and she was overwhelmed by the amount of work to be undertaken. Her mental health issues were compounded by complex physical health problems including diabetes and mobility issues which put her at risks of falls. Working alongside WE Care and Repair we were able find funding to fix both the heating and hot water and undertook a huge decluttering exercise so that the radiators and boiler could be reached. The bedroom, bathroom, kitchen and lounge previously unusable now function for purpose. Communication with the service user's two sons was important for maintaining direction and focus with the decluttering. One of the sons also had mental health issues and we were able to give him information and signpost him to relevant services.

The occupational therapist recommended a number of adaptations to be carried out which enabled her to safely access her bedroom upstairs and wash independently with confidence. By working in a multidisciplinary approach we were able to support her with many of the areas in her life which were contributing to high anxiety. For example, high anxiety provoked the service user to stock pile her medication and led to a lot of confusion and distress when reordering. She met with the nurse prescriber who was able to simplify her medication and organise a dosette box collection. We also supported her to manage her debts with the help of North Bristol Advice Service and wrote off a significant amount of debt. Finally she was referred to a dietician at Callington Road Hospital who was able to offer on-going support with cooking and creating diabetic friendly meals and meal planner.

The service user received psychological support from our clinical psychologist which helped to address her low self-esteem, lack of confidence and self-criticism which prevented her from taking steps towards her recovery. We then helped her to build coping mechanisms including using a Mindful Basket which contains items to distract and soothe when experiencing anxiety. Workers benefitted from reflective practice meetings with service psychologists to ascertain best working approach. From this workers were able to support and encourage her to take ownership over her own decisions and rebuild her confidence. Although initially very reluctant to re-engage with her community she has built the confidence to attend a chair aerobics class in her local area. Since being back home she reports "feeling more herself and more decisive about coping with issues independently"."
- Recovery Navigator

Complaints

Two complaints were received in Year One. One complaint was made regarding a visit which was not cancelled or covered when a worker was off sick. This prompted a review of the duty desk procedure for covering meetings and contacting service users, and no further complaints regarding cancelled visits have been received.

A second complaint was received from a service user who was unhappy that the service could not be extended after 12 months. This was addressed by the service manager and the complaint was withdrawn by the service user.

Incidents

Table 7. Breakdown of incidents reported in Year One

Risk rating	Category	Frequency
High	Unexpected death (natural causes)	1
Moderate	Personal injury	1
	Self-harm	2
Low	Medication	1
	Mental health	1
	Property damage or theft	2
	Security incident	1
	Self-harm / overdose	1
Very Low	HR / staffing	1
	Medication	2
	Mental health	1
	Physical health	1
	Property damage or theft	1
	Verbal abuse	1
	Verbal aggression	1
Total		**18**

Service Quality: QuIRC results for Wellbridge House

The Quality Indicator for Rehabilitative Care (QuIRC) is an online toolkit which assesses the living conditions, care and human rights of people with long term mental health problems in psychiatric and social care units[17]. QuIRC assesses the provision of care across seven domains considered most important for recovery (living/built environment; therapeutic environment; treatments and interventions; self-management and autonomy; social interface; human rights; Recovery-based practice). Although the tool is staff-rated it has been validated against service user views, and has been found to be positively associated with service user experience[18].

[17] Killaspy, H., White, S., Wright, C., Taylor, T. L., Turton, P., Schützwohl, M., et al. (2011). The development of the Quality Indicator for Rehabilitative Care (QuIRC): a measure of best practice for facilities for people with longer term mental health problems. *BMC Psychiatry*, *11*, 1, 1.

[18] Killaspy, H., White, S., Wright, C., Taylor, T. L., Turton, P., Kallert, T., et al. (2012). Quality of longer term mental health facilities in Europe: validation of the quality indicator for rehabilitative care against service users' views. *PLoS One*, *7*, 6, e38070.

The tool produces a report with scores on each of the seven domains assessed, alongside the national average score for comparison. The QuIRC assessment of Wellbridge House was completed by the Clinical Lead with assistance from staff at Wellbridge House.

Table 8. QuIRC scores on seven domains of care

Domain	Wellbridge House score (%)	Average for similar unit (%)
Living environment	75	66
Therapeutic environment	61	66
Treatments and interventions	59	59
Self-management and autonomy	71	68
Social interface	55	59
Human rights	73	74
Recovery based practice	68	65

The report produces a series of recommendations for boosting percentage scores on each of the seven domains. These recommendations are not specific to the unit but are a generic list to help prompt thought and action planning. The full report is available on request. Table 8 describes the results for Wellbridge House against the national benchmark. Wellbridge House scored at or above average on living environment, treatments and interventions, self-management, human rights and autonomy and recovery-based practice. The following sections scored marginally below national average:

Therapeutic environment

This refers to therapeutic culture, including staffing, supervision, attitudes of staff and promotion of service user activities. Some recommended areas for development are already in place, such as providing tailored co-produced care planning and facilitating family involvement. The following recommendations may be explored:

- Reducing staff turn-over
- Reducing use of “bank”/ temporary staff
- Ensuring training opportunities for staff
- Ensuring adequate staff supervision

Social interface

This refers to the extent that service users participate in community activities and interact with individuals outside of the facility. Recommendations involve promoting access to community groups, or occupational activities. As the audit found, 59% of the sample had an occupational care plan and the remainder were working on goals related to improving mental health issues that prevented access to public/ community resources. This will continue to be a key part of facilitating meaningful community engagement with service users. In this way, the quantity of service users with a community link or occupation may not be the most appropriate measure of social interface, as it does not take into account the diverse range of mental health issues and access issues faced by service users of the Community Rehabilitation service. Care planning around supporting access to the community at different levels of engagement appropriate to the needs and wishes of the service user should continue.

Service Quality: CQC Inspection Results for Wellbridge House

On March 24th 2016 two inspectors from the Care Quality Commission visited the Wellbridge House site unannounced to observe the care and support provided, talk to staff and service users, and look at the care records of two service users. A number of different records relating to how the service was managed were also inspected. Six service users, five support staff and the registered manager were spoken to by the inspectors.

The inspection was conducted as part of the regulatory function of the CQC, assessing whether the service met regulations under the Health and Social Care Act 2008, assessing the overall service quality and to rate the service under the Care Act 2014. This inspection was focused on the Second Step registration for the regulated activity of 'personal care'. The delivery of other CQC regulated activities including 'treatment' was not included as this falls under the separate AWP trust wide registration.

The full report is available on request. In summary, some key findings were that people felt safe with the staff who worked with them, that staff knew how to keep people safe and recognise abuse, and that systems were in place to protect people from the potential risks from staff. Staff knew about the Mental Capacity Act 2005 and knew how to protect the rights of service users.

There were enough staff to meet the needs of service users and the service was effective; staff had a good understanding of service user mental health needs, and could provide support effectively. They were aware that the service aim was to provide person-centred care that focused on the service user's individual needs. Service users were supported with their diet and nutrition, to meet with GPs and specialist healthcare professionals. Service users felt supported by the team who had a caring approach, were treated with respect and their independence was encouraged. Service users were involved in care planning, and staff were competent in supporting service users in the ways they preferred.

Service users made choices about their care and knew how to make their views known. This included awareness of the complaints procedure. Service users were supported in line with what had been jointly agreed upon in their care plans, and were able to access a range of social and therapeutic activities. Service and support quality was checked to ensure it was of a good standard. As part of this process, service users were asked for their views. Staff said they felt supported by the manager, who they could speak to at any time about anything.

Recommendations

At this stage there is not sufficient data to report on service user outcomes based on standardised outcome measures. However, audit of the processes in place to promote rehabilitation show that care plans incorporating social inclusion, mental and physical health were in place as part of a holistic program, in line with service aims and evidence-based practice. Future evaluations will be better placed to establish the outcomes and impact of this work.

In order to facilitate future evaluation the following processes should be established:

- Monitor the proportion of service users who maintain their accommodation after discharge by Implementing a follow-up procedure for service users who have been discharged
- Develop clear procedures for recording of physical health monitoring, interventions and out-comes
- Ensure consistent recording of social functioning and social inclusion including employment and housing status
- Establish a clear procedure for use of outcome measures across the service. Incorporate feed-back from staff at Wellbridge House to revise the pilot procedure and ensure that structures are in place to support staff to follow the procedure
- Ensure there is a clear procedure for documenting crisis plans on RiO, particularly where they are recorded on RiO
- Review and implement recommendations generated by the QuIRC assessment

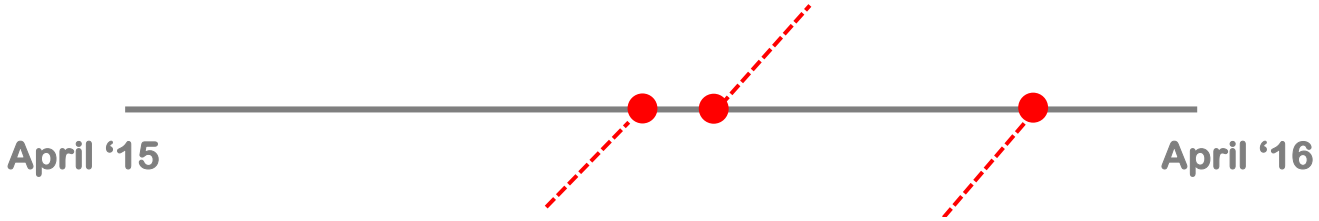
4. Service Development

A key factor common to services that successfully meet their aims is their approach to learning, evaluation and improvement[19]. Feedback from staff has suggested the organisation promotes a culture of sharing ideas and perspectives. This section will explore how ideas are implemented, whether developments undergo systematic review, and what structures are in place to support this process.

Evaluation of the service is expected to be completed annually. In Year One the cycle of reflection and development may be considered to be in its first stage and itself under development. The purpose of this evaluation is to highlight where the strengths and weaknesses have been so far to inform a future approach. Evidence of development work will be based on documentation, outcomes, staff and service user feedback. This will be applied to a model of new service development as a basis for recommendations.

Timeline of events

Whole Service Development Meeting
November 2015
This event focused on role clarity within the service. Each role was explored through a series of group activites, presentations and discussions to promote shared understanding. Ways in which the two branches of the service could work more closely to avoid fragmenting was also discussed.



Wellbridge House Development Meeting
October 2015
Six months into the service, staff of Wellbridge House met with the clinical lead and service manager to reflect together on the successes and challenges they had experienced. Workgroups were formed to lead projects addressing areas for development

Wellbridge House Forumulation
February 2016
A series of meetings were led by a psychologist and occupational therapist from the team. Staff discussed their hopes for the service and were encouraged to think about how it would look in an ideal scenario. The formulation its outcomes are presented in Figure 5

[19] Bardsley, M., Steventon, A., Smith, J., & Dixon, J. (2013). Evaluating integrated and community-based care. *London: Nuffield Trust*.

Wellbridge House

The vision described for Wellbridge House at the opening of the service was an accommodation service providing a high level of multidisciplinary support, leaning away from a ward-based model and toward an innovative supported housing model. The novel approach of this branch of the service has therefore attracted most of the development work. Negotiating the balance between intervention and independence has been on-going, underpinning conversations about values, policy and delivery.

Two clear themes undelie the topics discussed for development:

i) Upholding duty of care while avoiding an institutional atmosphere
For example, how can a visitor policy accommodate the needs of service users to spend time with visitors privately while managing risk appropriately? Many policies at Wellbridge House have been developed over the first 12 months, tailored to help the service meet this balance. This includes the use of communal space, alcohol consumption and health and safety checks on bedrooms.

ii) Reaching the right level of intervention
On opening, the service trialled an approach modelled more closely on supported housing services than ward-based rehabilitation. This focused on individual support and the individual's rights and freedoms. This has been modified based on experiences of staff and the responses of service users. A good example of this is the revision of the timetable of activities offered. Initailly this programme was minimal with a view to setting the service apart from a more structured approachs. Over time this was reviewed to provide more daily structure and motivation for service users who were struggling to engage and maintain sleep patterns. Other examples include the writing of a residency agreement and welcome pack for service users, and taking a more assertive approach to move-on.

The developments have aimed to retain the original values of the service, but have adapted to the needs of service users and to support staff in delivery. The team formulation describes the thought processes contributing to key developments in the first year and is summarised in Figure 5 alongside the outcomes of the work.

Formal development meetings to supplement weekly team meetings and clinical supervision show a comittment from the service to make use of learning and implement change. The use of psychologically informed frameworks such as reflective practice and formulation alligns with the social model on which the service was based. Staff from all levels were invited to participate in the development meetings with cover arranged to allow the maximum number of staff to attend. The documentation of the meeting shows that development projects were shared across the team in small workgroups, distributing ownership and making use of the wide skill set available in the team.

What is less clear from the documentation is what process was followed after the workgroups were allocated and whether expectations were outlined in terms of timeframes and outcomes. For a small number of groups there is no evidence of any outcome to date. Implementing a process for on-going service development to a degree of formality suitable for the service could be considered to support projects and ensure work is systematic.

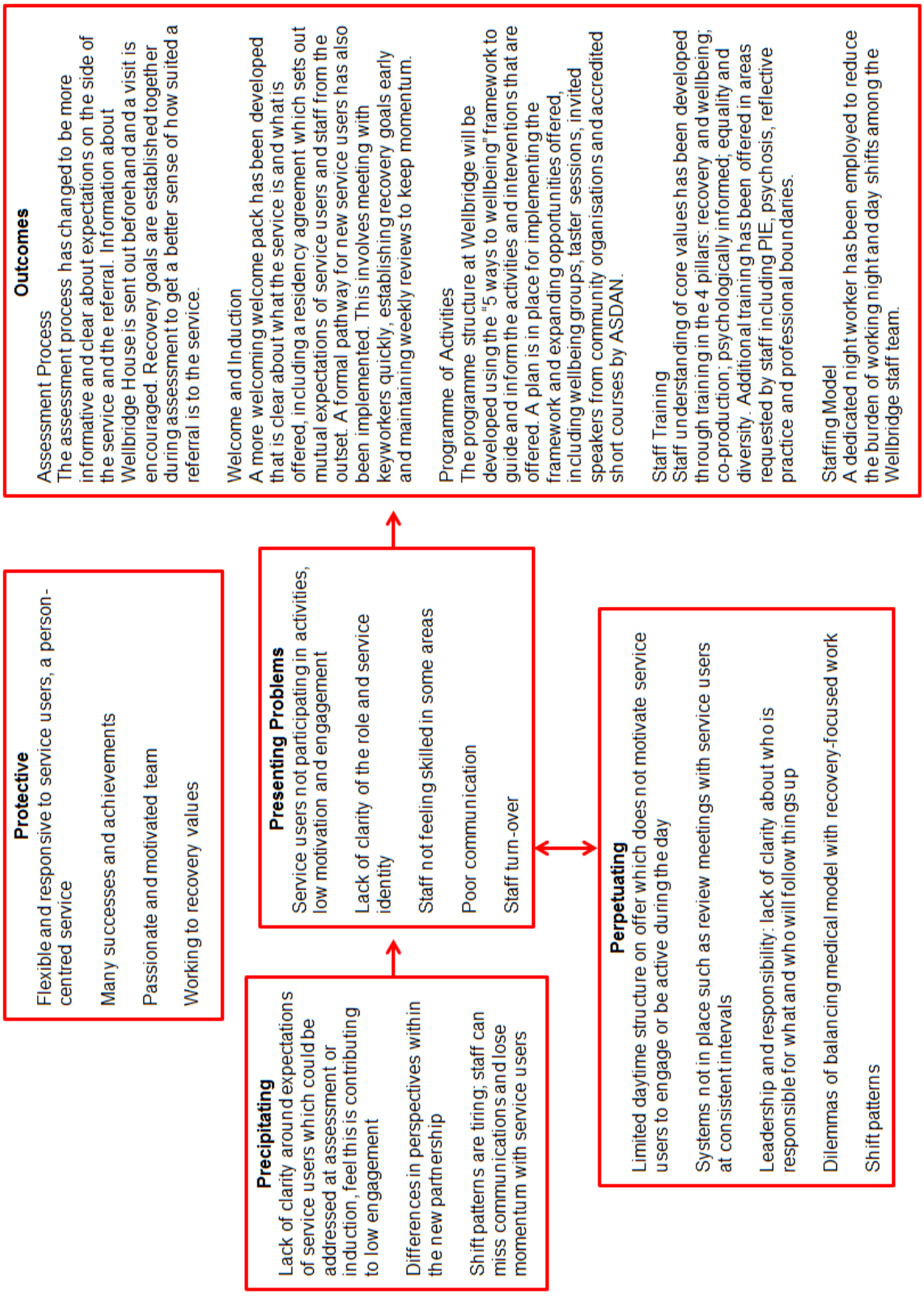


Figure 5. Wellbridge House team formulation

Staff experiences of contributing to service development

Staff were asked for their reflections on whether they felt they had been able to contribute to the development of the service in the first 12 months and any barriers they had experienced. 13 out of 14 respondents to the survey said they had been able to contribute to the service. Themes were highlighted in the survey responses, summarised below.

"Could you give any examples of how you have been able to contribute to the development of the service?"

Contributing to decisions about service delivery

"I feel I have been able to share my expertise and perspective with others. This has helped to develop understanding of certain issues such as the role of medication and managing risk". Contributing to decision-making by sharing knowledge and perspectives was a broad theme in the feedback. Specifically, staff said they made "suggestions about how we manage the discharge of people and define recovery goals", were involved in "shaping roles" and choices about paperwork and policy. Comments resonated with the feedback from staff around their experience of working in the new partnership, that the environment was collaborative and provided opportunities for open communication and sharing of ideas: "…talk about grievances of things that are not going too well openly and amicably with colleagues", "I feel that if things are not working well then I let managers know so things can be rectified. I have shared my opinion at meetings and development days which have been taken on board".

Contributing to development of service initiatives

A second theme emerged around staff feeling that there were opportunities for them to build initiatives into the service. For example, "helping to contribute to the development of the carers' service and the support offered to carers, friends and families. Thinking about how we can incorporate family work into our service" and having input to therapeutic sessions. "I am involved in and set up a group to ensure we meet one of our CQUINs"… "giving ideas in sessions about how to improve the service".

"What are the barriers to service development?"

Structures to support change

According to the survey, staff felt that while there were a lot of ideas for service development, the support structures in place to implement change could be improved. This was related to leadership on decision-making. "I feel we have been in danger or tackling too many issues at once… during a development day a number of work groups were initiated to look at different areas… I think each group needs very clear leadership, a clear timeframe for completion and clear expectations". "There are a lot of meetings/ work groups with good ideas generated but sometimes the ideas take a long time/ forgotten to be implemented", "it is often unclear if a decision is made, and if so, how we are going to take this forward".

Shift patterns

Staff working at Wellbridge House commented on the problems associated with working on rota: "it's hard for a consistent message to be passed around. The whole team rarely meet to discuss issues / ideas due to the rota".

Overall the feedback indicates that staff felt they had been involved in the development of the service during the first year, were included in decision-making and were able to contribute their expertise or knowledge to developing initiatives. In line with feedback from staff about the experience of working in the new partnership, there appears to be a lively culture of sharing ideas and a shared responsibility for developing the service. However, this open hierarchy has at times been problematic in terms of project management. A number of staff noted that while a lot of ideas for development and improvement arise, outcomes have not materialised due to real or perceived lack of support from a senior member of staff. Staff suggested that it would be helpful to support staff to implement their ideas by making management decisions promptly, formulating clear action plans for taking ideas forward and providing clear expectations and time frames for team projects are mentioned in the feedback as strategies that would help improve the situation. The staffing rota at Wellbridge House was also highlighted as an issue because meetings could not always be attended and opportunities to contribute could be missed. A dedicated night worker is a new addition and will increase the number of day shifts worked by the core team. The impact of this should be reviewed in a future evaluation.

Service user and carer involvement

Wellbridge House community meeting

Weekly meetings are held at the house and all service users are encouraged to attend. Staff and service users share the positive and challenging experiences of the previous week. Service users can use this meeting to plan the coming week and make suggestions for group activities they would like to do. The meeting has also been used as a forum to take proposed changes to the service, discuss the proposal together and give feedback which is relayed to seniors at team meetings. An example of this is the development of a policy around use of communal spaces at night.

Service user development groups

Service users have acted as representatives in development groups for two major projects. The new build project has involved 2 service users, who attended co-production meetings every month. Another service user has attended the development group for the “Joining the Dots” project which is an initiative to enable service users to use and add to their RiO files through an accessible interface.

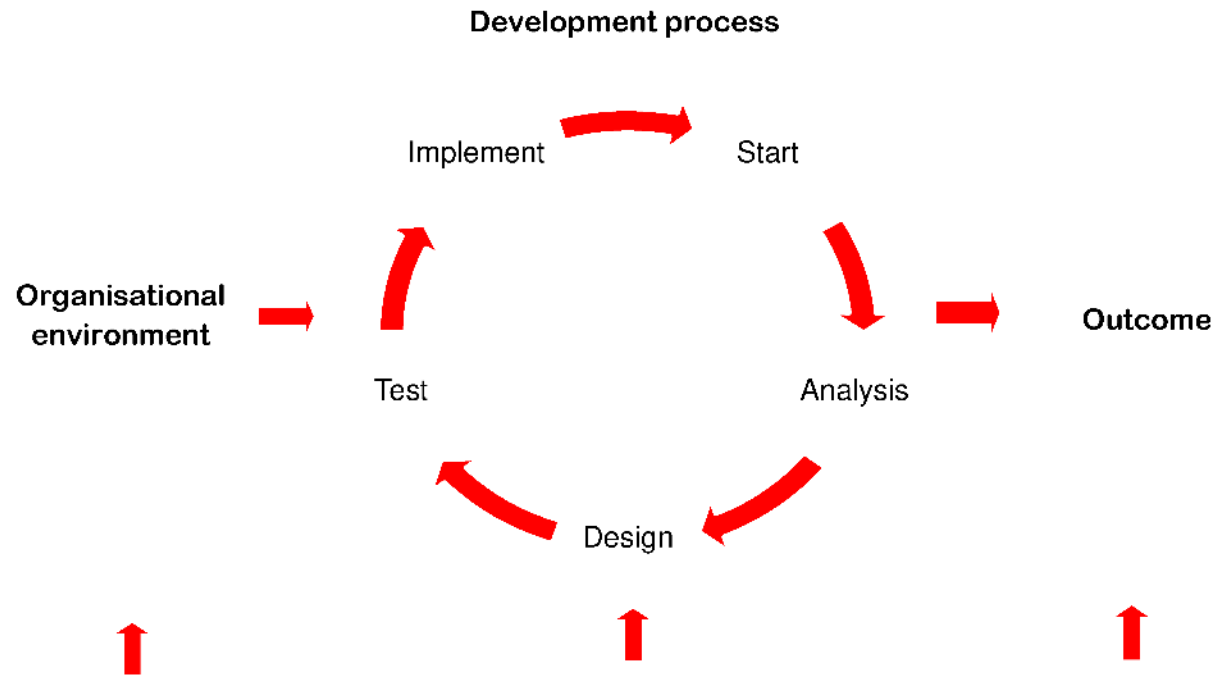
Involvement initiatives

A service user forum specifically for the Community Rehabilitation Service has been set up and will be used as a space to share ideas about service improvement. Work is underway to develop a carer forum with 3 staff leading a project to find out whether there is a demand for a service specific forum for carers, and if so, whether this would play a supportive function or focus on service improvement and consultation. This is being carried out under the 4PI national involvement standards framework.

Service development framework

The model presented is based on a systematic review of resarch into successful service development across different sectors[20]. Guidelines are given on the areas a service should attend to in order to meet service aims. This could be a framework to guide a development process annually, or more broadly throughout the service lifespan.

The focus at this stage should be the antecedents and process elements to the model. By satisfying the factors at each of these stages, the end product is more likely to be "successful", generically defined here as a service which meets the needs of service users, has a good level of staff expertise and competency, and produces tangible evidence of outcomes. Each section of this report has looked to the groundwork done to build the service in the first year, and at the processes which have supported this work. Applying this evidence to the model will highlight where the strengths and weaknesses have been.



Organisational environment factors

- Learning culture
- Sharing knowledge
- Service user-led culture
- Supportive culture
- Technology

Development process factors

- Employee involvement and expertise
- Appropriate level of formalization
- Service user and carer involvement
- Cross-functional involvement
- Strong visible support from management
- Process quality

End product

- Unique service that meets the needs of service users
- Working relationships with service users
- Employee expertise
- Tangible evidence of outcomes and success generated

[20] Posselt, T., & Förstl, K. (2011). Success Factors in New Service Development: a Literature Review. *Productivity of Services Next Gen-Beyond Output/Input. Fraunhofer Center for Applied Research and Supply Chain Service, Germany.*

Antecedents

A learning culture has been defined as one allowing experimentation of ideas, facilitated by feedback and questioning from managers, with processes in place to encourage and sustain learning among employees[21]. There is a strong theme in the feedback from staff that the service encourages this kind of sharing and use of initiative. Some processes are in place to facilitate this, such as formal development meetings. However, feedback from staff and available documentation on outcomes of development work suggests more support is needed from senior staff to implement new ideas. Ensuring that staff feel supported in their endeavours will be important to maintaining the service culture of enthusiasm for contributing ideas and sharing knowledge. This feeds into process and is discussed further below.

There is evidence for a service-user led culture in service delivery: care plans have been invdividually tailored; service user meetings at Wellbridge House have informed policy; and the Joining the Dots project will soon allow service users to use and update their own records on a regular basis. Co-production in service development projects has also taken place, and the service user forum will be an avenue for increasing participation in future.

Using technology to better track outcomes and service activity is a key area for improvement. RiO is a comprehensive tool for keeping service user records and is used across the service. Accessing RiO will be essential in basing improvement projects in accurate data. Using RiO records as the main data source also shares responsibility for data quality throughout the service rather than on administrative staff and reduces errors associated with manual data entry.

Process

Employee involvement and expertise is good. Project work groups have involved staff across the service making use of the multidisciplinary skill set in the team and there is recognition among the staff of the specialist knoweldge brought to the team by staff in different roles or employed by different agencies. Cross-functional involvement in this context refers to the involvement of others from outside the team who may contribute toward the service in some way. Joint-working is an example of this, for instance partnering with BALP to initiate a walking group within the service. The involvement of service users is also well-documented, and initiatives are in place to increase participation of service users and carers in the service.

A next step for the service will be to consider what an appropriate level of formalisation is for the service in terms of its development strategy. This should be a concrete tool to support the team to conduct work systematically, provide a benchmark for measuring process adherence and quality, and guide senior staff on their role in overseeing that the process is maintained. This could be the addition of project management to the supervision agenda, allocation of project champions or formation of a development committee. Defining the role of senior staff in supporting development work might begin by exploring the needs of the team in more detail to ensure they are appropriately addressed.

[21] De Brentani, U. (2001). Innovative versus incremental new business services. Different keys for achieving success. *Industrial Marketing Management, 21*, 231-241.

Recommendations

- Improve access to RiO data to inform areas for development

- Consider implementing development meetings and team formulation annually to continue whole-team participation in development work

- Maintain learning and sharing culture by increasing support structures available to staff. Consider an approach which best suits the service, but incorporates some formal structure to help guide a systematic process. Implementing the model will ensure the range of factors at each stage are considered, and will be a validate it as a framework for evaluating the progress of the service's development.

5. Conclusion

In parallel to operating at a high standard, the Community Rehabilitation Service has worked hard along several lines to build the service in its first 12 months. The evaluation has focused on characteristics of the service which are known to be challenging to establish, such as cohesion of a multi-agency team and good partnership working. The evidence for good service outcomes and quality has also been assessed, and learning and service development processes have been evaluated.

The findings suggest that the service has developed strong working relationships with partner agencies, delivering a holistic and joined-up service by encouraging joint working. The experience of working in a partnership between the NHS and Voluntary sector has been positive for many of the staff. Sharing ideas with and learning from colleagues with diverse professional backgrounds and expertise was a key theme in feedback. In terms of future development, the feedback indicates that it will be important to ensure clarity and consistency around policies and procedures.

An audit of outcome indicators suggested a high standard of support was delivered in Year One in line with the service aims. To ensure a consistent approach to collection and recording of outcome data, outcome measures used in the service and care plan documentation should be reviewed. This will enable a more comprehensive assessment of service user outcomes in Year Two.

The service has shown a commitment to reflecting on progress and using this learning to improve. Whole team meetings have been facilitated to address development issues under psychologically-informed models. Staff reported an inclusive approach and most felt they had contributed to service policy or procedure in some way. A barrier to development perceived by staff was a lack of support or project ownership to ensure follow through on development initiatives. Suggestions to improve this process included introducing time frames or clearer expectations for project outcomes. Deciding on an approach to development work that fits the service in terms of formality and management is recommended.

Overall this report highlights a number of significant achievements in the first year of the Community Rehabilitation Service, with many examples of success and good practice. The next task will be to develop the evaluation framework for Year Two onwards with expertise from outside of the service. Incorporating the recommendations highlighted in this report alongside increasing collection of qualitative data from service users and carers will stand the service in good stead to maintain a learning culture and build on the vast gains made so far.

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Bristol Mental Health community rehabilitation service

The Community Rehabilitation Service works with people with long-term mental health and complex needs. It focuses on helping people achieve their goals and aspirations and gain the skills and confidence to live as independently as possible.

The Community Rehabilitation Service is part of Bristol Mental Health.

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