

## **North West Mental Health Improvement Programme**

A collaborative development programme between the NHS, Social Care, the Third Sector and Users and Carers to improve mental health across the North West

# **Commissioning for Mental Health Outcomes in the North West**

## **Working Paper 2**

**July 2010**

**Dr Tony Ryan  
Margaret Oates**

## Background

The North West Mental Health Improvement Programme (NW MHIP) and the National Mental Health Development Unit (NMH DU) have been working with commissioners to form North West Commissioning for Outcomes Project. The project was established to provide commissioners with tools to commission for clear outcomes and enable their providers to clearly articulate the outcomes for service users that result from their service interventions.

The project commenced in Autumn 2009 and enlisted commissioners from across the North West who were interested in developing their commissioning expertise in this area.

The project draws heavily upon the Social Inclusion Outcomes Framework (SIOF) that was published in 2009 and attempts to apply this in commissioning practice and service delivery.<sup>1</sup>

It was intended that by 1<sup>st</sup> April 2010 providers would have agreed the outcome areas of the SIOF with commissioners and have signed off how data would be collected in a manner that was robust, verifiable and acceptable to commissioners without the need to sustain a ‘cottage industry’ around data collection.

Support to the project to date has been provided by the Mental Health Improvement Programme through Ian Fairbrother (MHIP project lead) Catherine Webster (lead for Cumbria and Lancashire), Colin Vose (lead for Cheshire and Merseyside), Tony Ryan (lead for Greater Manchester) and Margaret Oats from the National Mental Health Development Unit (NMH DU),

The project intends to deliver achievable outcomes over the next 12 months to March 2011. That is, we will have learned about the process of agreeing and gathering robust and meaningful evidence on achieving outcomes and we will have learned about how effective services are in delivering the agreed outcomes.

Each commissioner has agreed to work to develop SIOF areas with NHS and third sector providers that could be embedded in future contracts and linked to local or regional CQUIN payments. Areas involved in the project are:

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

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<sup>1</sup> [http://www.socialinclusion.org.uk/publications/Broadened\\_Social\\_Inclusion\\_Outcomes\\_Framework.pdf](http://www.socialinclusion.org.uk/publications/Broadened_Social_Inclusion_Outcomes_Framework.pdf)

To date regional meetings with commissioners have identified (in no particular order):

- Commissioners are looking at implementing aspects of the SIOF in a range of ways.
- Differentiating between outcomes and processes has been difficult.
- The ability to gather evidence of processes and outcomes is variable across providers.
- Some area of the SIOF may not be measurable.
- Some commissioners are further ahead than others; the same is true of providers. This is largely related to time pressures and support available to the commissioner and their provider services.
- Significant fieldwork is necessary to establish the SIOF in localities.

A series of regional events took place between autumn 2009 and March 2010. These brought together commissioners and providers to share learning, learn more about progress in at least two areas in detail, clarify how the project will move forward from this point and agree support needs to March 2011.

This working paper represents the progress achieved in determining outcomes with SIOF areas for many of the commissioners and their providers to July 2010. Further areas are likely to be added in the future as commissioners and providers not detailed in this document develop their thinking and agree processes and outcomes they wish to measure.

Consequently this paper should be seen as work in progress and not the definitive word on commissioning for outcomes. It is intended that it can be used by services and commissioners who are not currently participating in the project to inform their thinking. The contact details for services and commissioners participating have been included here to enable providers to share their experiences during the period of the project.

A further learning event is being organised for autumn 2010 that will review progress in respect of gathering data on processes and outcomes.

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## Developing ‘hard’ outcome measures and differentiating between outcome and process measures

The Social Inclusion Outcomes Framework (SIOF)<sup>2</sup> was developed as a tool that could be applied to mental health services promoting social inclusion. Many of the ‘outcomes’ the SIOF describes are in fact ‘process measures’ as they count interventions, support mechanisms or tasks that might be put in place by the service to support the user. They also assume these processes will lead to desirable outcomes. In many cases this may be in fact what happens. Yet, helpful as these process measures are, they only go so far. For example, setting up an appointment with a dietician for someone who has a weight problem is a very helpful process on the way to achieving a healthy weight. However, in itself it does not demonstrate that it has achieved anything for the service user. A true outcome measure (or ‘hard’ outcome) would be one that describes the effects of such an intervention, in this case weight loss. A ‘sustainable outcome measure’ would be weight loss that is maintained over a period of time and which is healthier than previously.

Detailed below are outcomes that have been developed by providers and commissioners in the North West which they have agreed to work with over the next year. They aim to clearly differentiate between ‘process measures’ and ‘outcome measures’. Within the outcome measures there is further differentiation between ‘hard’ and ‘sustainable’ outcomes. Being able to describe (and ultimately count) both the ‘outcomes’ and ‘processes’ allows the service to adjust their ‘processes’ if they are not delivering the ‘outcomes’ they agree with their commissioners. There are also examples of outcomes from the SIOF that could be used but are not currently being applied in this project in Appendix 1.

Updates of this paper will be produced as appropriate over the next year as we explore how the SIOF as applied in practice. MHIP support for the project until March 2011 is being provided by:

- Ian Fairbrother (Co-ordination) ([ian.fairbrother@ntlworld.com](mailto:ian.fairbrother@ntlworld.com))
- Catherine Webster (Lancashire and Cumbria) ([catherinewebster1@me.com](mailto:catherinewebster1@me.com))
- Colin Vose (Merseyside and Cheshire) ([colin.vose@knowsley.nhs.uk](mailto:colin.vose@knowsley.nhs.uk))
- Tony Ryan (Greater Manchester) ([info@tonyryan.org](mailto:info@tonyryan.org))
- Margaret Oats (general regional support from NMH DU) ([margaret.oates@nmhdu.org.uk](mailto:margaret.oates@nmhdu.org.uk))

Feel free to liaise with your sub-regional support lead to discuss any issues associated with this project. Also feel free to contact participating sites to share learning experiences. A list by site is provided overleaf with a breakdown of the participants by SIOF area after this.

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<sup>2</sup> [http://www.socialinclusion.org.uk/publications/Broadened\\_Social\\_Inclusion\\_Outcomes\\_Framework.pdf](http://www.socialinclusion.org.uk/publications/Broadened_Social_Inclusion_Outcomes_Framework.pdf)

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## Project participants and outcome areas

Commissioner	Provider	Service Type	Outcome Area
Stockport LA	Stockport Day Centre	Mental health Day Service	1. Social Networks 2. Mental Wellbeing
	Stockport & District Mind CAHSS	Crisis Accommodation & Home Support Service	1. Social Networks 2. Mental Wellbeing
	Pennine Care NHS Foundation Trust	Community Mental Health Teams	1. Personalisation & Choice
Ashton, Leigh & Wigan PCT	Ashwood Court: Making Space	Independent hospital: Rehabilitation	1. Physical Health 2. Independent Living
	Fir Trees Independent Hospital: Alternative Futures	Mental Health Rehabilitation	1. Mental Wellbeing 2. Independent Living
	Leigh acute in-patient wards and community services: 5 Boroughs Partnership FT	Acute Mental Health	1. Service User Satisfaction 2. Mental Wellbeing
Salford PCT	Pendlebury House: Turning Point	Independent Hospital: Rehabilitation	1. Physical Health 2. Independent Living
	Bramley Street: Greater Manchester West NHS Foundation Trust	In-patient rehabilitation unit (community based)	1. Independent Living
	Prescott House CMHT Salford; Greater Manchester West NHS Foundation Trust	Community Mental Health Teams	1. Physical Health
	Salford CMHTs / AOT - Out of areas treatments (OATS) in Independent Hospitals: Greater Manchester West NHS Foundation Trust	Community Mental Health Teams	1. Independent Living
Halton & St. Helens PCT	St Helens Mind	Social Inclusion	1. Community Participation 2. Social Networks 3. Mental Wellbeing
Wirral PCT	Advocacy in Wirral	Computerised Cognitive Behavioural Therapy	1. Education & training
	Wirral Community Development BME / Wirral Change	Community Development Worker Service	1. Education & training
Warrington PCT	Lea Court (Alternative Futures)	Independent Hospital: Rehabilitation	1. Physical health 2. Mental Wellbeing 3. Independent Living
Blackburn with Darwen PCT (for all Lancashire PCTs)	Lancashire Care NHS Foundation Trust	Step 4 community services	1. Physical health 2. User satisfaction 3. Mental Wellbeing

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## **Mental Wellbeing**

### **North West Mental Health Improvement Programme**

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## Mental Wellbeing

<b>Service name</b>	Fir Trees Independent Hospital (Alternative Futures)
<b>Type of service</b>	Mental Health Rehabilitation
<b>Project lead for the service</b>	Kim Cooke Registered Manager with Tracy Latimer Deputy manager
<b>Contact details</b>	E: <a href="mailto:Kim.Cooke@alternativefuturesgroup.org.uk">Kim.Cooke@alternativefuturesgroup.org.uk</a> T: 01942 866010 /01942
<b>Commissioner(s)</b>	Nigel O’Gorman
<b>Commissioner contact details</b>	E: Nigel.O’Gorman@alwpct.nhs.uk T: 01942 48(1669)

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved quality of life, confidence and self-esteem for people with mental health problems	Number of people who develop and begin using new coping strategies.	Number of people who have started to use specific coping strategies	Number of people using effective coping strategies over a six month period	Collated by Named Nurse in monthly care reviews and evidenced in care plan.
Increased ability to manage own mental distress for people with mental health problems	Number of people supported to decrease their reliance on mental health services	Number of people who have completed a staying well /recovery action plan (coping with setbacks and staying well).  Number of people who have been referred to a less intensive service.	Number of people who have moved on to a less intensive service.	Completion of a staying well /recovery action plan. Completion of each of the stages of the programme and using our discharge criteria to measure level of independence. Collated by Named Nurse in monthly care reviews and evidenced in care plan.

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## Mental Wellbeing

<b>Service name</b>	Leigh acute in-patient wards and community services (5 Boroughs Partnership Foundation Trust)
<b>Type of service</b>	Acute mental health
<b>Project lead for the service</b>	Chris Molyneux
<b>Contact details</b>	E: <a href="mailto:Chris.Molyneux@5bp.nhs.uk">Chris.Molyneux@5bp.nhs.uk</a> T: 01942 264822
<b>Commissioner(s)</b>	Nigel O’Gorman
<b>Commissioner contact details</b>	E: Nigel.O’Gorman@alwpct.nhs.uk T: 01942 48(1669)

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved quality of life, confidence and self-esteem for people with mental health problems.	Number of people supported to develop and begin using new coping strategies.	Number of people with a reduction in their HONOS score on discharge.	Number of people who after 6 months have maintained their reduced HONOS score.	
Increased ability to manage own mental health and distress for people with mental health problems	Number of people supported to decrease their reliance on mental health services	Number of people who have moved on from the in-patient service to a mental health service that is less intensive.	Number of people who have been supported in a less intensive service (than in-patient care) for six months continuously.	

Process measures for the service to achieve the ‘hard’ outcomes
Number of people supported to make changes leading to a reduction in mental distress, HONOS score reduction on discharge.
Number of people supported to develop a Wellness Recovery Action Plan (WRAP).
Number of people using their Wellness Recovery Action Plan (WRAP) six months after discharge.
Number of people identified as utilizing new coping strategies as identified in their care plan (based on a random sample of 10% of anticipated admissions (N = 180)).
Number of people identified on discharge as moving to a less intensive service.
Number of people re admitted to hospital within a 6 month period.
Each ward will maintain a record of everyone admitted, discharged and followed up at six months using the above measures.

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## Mental Wellbeing

<b>Service name</b>	Stockport day centre
<b>Type of service</b>	Mental health day service
<b>Project lead for the service</b>	Lynn Barrett
<b>Contact details</b>	E: <a href="mailto:lynn@stockportdaycentre.org.uk">lynn@stockportdaycentre.org.uk</a> T: 0161 429 9744
<b>Commissioner(s)</b>	Nick Dixon
<b>Commissioner contact details</b>	T: 0161 474 4742 E: <a href="mailto:nick.dixon@stockport.gov.uk">nick.dixon@stockport.gov.uk</a>

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved quality of life, confidence and self-esteem for people with mental health problems.	Number of people supported to develop and begin using new coping strategies.	Number of people with an improved score on the managing mental health arm of the Recovery Star	Number of people who sustain a score over 5 or improve on it over 6 months.	Recovery Star. Frequency counts.
	Number of people supported to make changes leading to enhanced confidence and self-esteem.	Number of people with an improved score on self-esteem scale.	Number of people who sustain a score over 5 or improve on it over 6 months.	Self-esteem ladder of the recovery star. Frequency counts.
	Number of people supported to make changes leading to a reduction in mental distress.	Number of people with an improved score on a wellbeing scale.	Number of people who sustain a score over 42 or improve on it over 6 months.	Warwick-Edinburgh wellbeing scale.

Process measures for the service to achieve the 'hard' outcomes
Number and proportion of members of the Women's Group who complete baseline measures
Number of new referrals who, six weeks after commencing at the Centre, complete baseline measures
Number of relevant 1-1 sessions delivered
Number of relevant group work activities delivered
Number of reviews completed at 3 months after baseline measures taken

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## Mental Wellbeing

<b>Service name</b>	Stockport & District Mind CAHSS (and various support groups within the care pathway)
<b>Type of service</b>	Crisis Accommodation & Home Support Service
<b>Project lead for the service</b>	Gill Walsh
<b>Contact details</b>	E: <a href="mailto:Gill.hall@cahss.org.uk">Gill.hall@cahss.org.uk</a> T: 0161 336 7231
<b>Commissioner(s)</b>	Nick Dixon (Stockport) Dave Wilson (Tameside)
<b>Commissioner contact details</b>	E: <a href="mailto:nick.dixon@stockport.gov.uk">nick.dixon@stockport.gov.uk</a> E: <a href="mailto:dave.wilson1@tameside.gov.uk">dave.wilson1@tameside.gov.uk</a>

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved quality of life, confidence and self esteem for people with mental health problems	Number of people supported to develop and begin using new coping strategies	Number of people using new positive coping strategies to manage their mental wellbeing at the point of discharge from the service  Number of people using less negative coping strategies to manage their mental wellbeing at the point of discharge from the service	Number of people returning to the service within six months of discharge  Number of people at discharge and at three months after discharge (if referred to (i) ‘Thrivers’, (ii) Anger Management Group or (iii) Confidence Group who maintain or improve on their Recovery Star scores from admission to discharge and to three months after discharge	Readmission rates  Frequency counts of negative & positive coping methods at admission and discharge from the service  Recovery Star in the domains for ‘managing mental health’  1:1 sessions  Timely reviews
	Number of people supported to	Number of people with enhanced confidence and	Number of people returning to the service within 6	Measurement on WEMWBS scale

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	make changes leading to enhanced confidence & self esteem	self esteem at the point of discharge from the service	months Number of people with maintained or enhanced confidence and self esteem scores three months after accessing support groups	Recovery Star in the for 'identify and self esteem'  1:1 sessions  Group work activities  Timely reviews
Increased ability to manage own mental distress for people with mental health problems	Number of people supported to develop a recovery plan  Number of people supported to decrease their reliance on mental health services	Number of people using a recovery plan  Number of people referred by Crisis Teams who are supported to disengage from secondary care	Number of people returning to the service within six months  Number of people returning to the service within six months	Number of people with a completed recovery plan on discharge from service  Frequency counts of people referred by CRHTs and discharged out of secondary care

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## Mental Wellbeing

<b>Service name</b>	Lea Court (Alternative Futures)
<b>Type of service</b>	Independent Hospital – Rehabilitation
<b>Project lead for the service</b>	Terry Keegan
<b>Contact details</b>	E: <a href="mailto:Terry.Keegan@alternativefuturesgroup.org.uk">Terry.Keegan@alternativefuturesgroup.org.uk</a> T: 01925 243577
<b>Commissioner(s)</b>	Margi Butler
<b>Commissioner contact details</b>	E: <a href="mailto:Margi.Butler@warrington-pct.nhs.uk">Margi.Butler@warrington-pct.nhs.uk</a> T: 01925 843792

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved quality of life, confidence and self-esteem for people with mental health problems	Number of people who develop and begin using new coping strategies.	Number of people who have started to use specific coping strategies	Number of people using effective coping strategies over a six month period	Collated by Named Nurse in monthly care reviews and evidenced in care plan.
Increased ability to manage own mental distress for people with mental health problems	Number of people supported to decrease their reliance on mental health services	Number of people who have completed a staying well /recovery action plan (coping with setbacks and staying well) Number of people who have been referred to a less intensive service	Number of people who have moved on to a less intensive service.	Completion of a staying well /recovery action plan. Completion of each of the stages of the programme and using our discharge criteria to measure level of independence. Collated by Named Nurse in monthly care reviews and evidenced in care plan.

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## **Independent living**

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## Independent living

<b>Service name</b>	Fir Trees Independent Hospital (Alternative Futures)
<b>Type of service</b>	Mental Health Rehabilitation
<b>Project lead for the service</b>	Kim Cooke Registered Manager with Tracy Latimer Deputy manager
<b>Contact details</b>	E: <a href="mailto:Kim.Cooke@alternativefuturesgroup.org.uk">Kim.Cooke@alternativefuturesgroup.org.uk</a> T: 01942 866010 /01942
<b>Commissioner(s)</b>	Nigel O’Gorman
<b>Commissioner contact details</b>	E: Nigel.O’Gorman@alwpct.nhs.uk T: 01942 48(1669)

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased number of people with mental health problems living in independent accommodation	Number of people who move to more independent accommodation	Number of people who completed the rehabilitation programme and have been referred to a less intensive service.	Number of people who move from current level of care provision to a less dependent service ( see hierarchical list of services)	Completion of each of the stages of the programme using our discharge criteria to measure level of independence. Collated by Named Nurse in monthly care reviews and evidenced in care plan.
Increased number of people with mental health problems receiving appropriate benefits/financial advice	Number of people supported to effectively manage their own finances	Number of people who begin to manage their own finances without support	Number of people who manage their own finances without support over a fixed period of time (e.g. 6 months)	Evidenced in budget plans and collated in monthly care reviews by Named Nurse

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## Independent Living

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

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
To increase the number of people with severe and enduring mental health needs living in independent accommodation	Number of people who move to more independent accommodation	Number of people who move from Pendlebury Hospital to a more independent area of living within the described hierarchy	That service user moves to a more independent service and sustains this move for six months	Report provided by care coordinator on service users living and no return or readmission to acute inpatient areas  Frequency counts of users who “step down” from Pendlebury House
	Number of people who effectively manage their own medication	Number of people who begin to manage their own medication without staff support	That service user following a stepped programme successfully manages own medication for a period of three months with minimum checks (weekly) by staff	That service user is compliant with medication and with no increase in side effects or symptoms for a period of three months accepting that random checks (weekly) are made by staff to confirm this  Frequency counts of service users who meet this criteria for three months.

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## Independent Living

<b>Service name</b>	Ashwood Court (Making Space)
<b>Type of service</b>	Independent hospital - rehabilitations
<b>Project leads for the service</b>	Gill Connor/Joel Zinyemba
<b>Contact details</b>	E: <a href="mailto:Gill.Connor@makingspace.co.uk">Gill.Connor@makingspace.co.uk</a> T: 01942 713065
<b>Commissioner(s)</b>	Nigel O’Gorman
<b>Commissioner contact details</b>	E: Nigel.O’Gorman@alwpct.nhs.uk T: 01942 48(1669)

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased number of people with mental health problems living in independent accommodation.	Number of people to more independent accommodation.	Number of people who move from Independent Hospital to greater independence	Number of people who move from Independent Hospital to greater independence	On discharge accommodation moved to, logged and follow up call to care coordinator six months later to ascertain sustainability.
	Number of people who effectively manage their own finances.	The number of people who begin to manage their own finances without support.	The number of people who manage their own finances without support over a fixed period of time.	Number of people who now have a bank account when they did not have one when admitted.

Process measures for the service to achieve the ‘hard’ outcomes
Number of people who move to more suitable (but not more independent) housing.
Number of people who address and reduce a debt problem.
Number of people who open a bank account or savings scheme
Number of people who develop new skills for independent living (e.g. cooking, shopping)
Number of people who access advice regarding their finances, benefits or debts. (cab)
Number of people who begin leaving the house and/or using public transport independently.

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## Independent Living

<b>Service name</b>	Lea Court (Alternative Futures)
<b>Type of service</b>	Independent Hospital – Rehabilitation
<b>Project lead for the service</b>	Terry Keegan
<b>Contact details</b>	E: <a href="mailto:Terry.Keegan@alternativefuturesgroup.org.uk">Terry.Keegan@alternativefuturesgroup.org.uk</a> T: 01925 243577
<b>Commissioner(s)</b>	Margi Butler
<b>Commissioner contact details</b>	E: <a href="mailto:Margi.Butler@warrington-pct.nhs.uk">Margi.Butler@warrington-pct.nhs.uk</a> T: 01925 843792

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased number of people with mental health problems living in independent accommodation	Number of people who move to more independent accommodation	Number of people who completed the rehabilitation programme and have been referred to a less intensive service.	Number of people who move from current level of care provision to a less dependent service (see hierarchical list of services).	Completion of each of the stages of the programme and using our discharge criteria to measure level of independence. Collated by Named nurse in monthly care reviews and evidenced in care plan.
Increased number of people with mental health problems receiving appropriate benefits/financial advice	Number of people supported to effectively manage their own finances	The number of people who begin to manage their own finances without support.	The number of people who manage their own finances without support over a fixed period of time (e.g. 6 months).	Evidenced in budget plans and collated in monthly care reviews by Named Nurse.

Hierarchical typology of services leading to greater independence
High Secure
Medium Secure
Low Secure
Psychiatric Intensive Care Unit
Acute in-patient ward

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Independent hospital rehabilitation unit / NHS in-patient rehabilitation unit (Lea Court)
Care home with nursing
Care home
Supported accommodation with staff on site
Supported accommodation with staff off site
Own tenancy with routine CMHT / AOT support
Own tenancy with no secondary care services support

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## Independent living

<b>Service name</b>	Bramley Street (Greater Manchester West NHS Foundation Trust)
<b>Type of service</b>	In-patient rehabilitation unit (community based)
<b>Project lead for the service</b>	Paula Solomon
<b>Contact details</b>	E: <a href="mailto:Paula.Solomon@gmw.nhs.uk">Paula.Solomon@gmw.nhs.uk</a> T: 0161 772 3708
<b>Commissioner(s)</b>	Tony Marlow
<b>Commissioner contact details</b>	E: <a href="mailto:Tony.Marlow@salford.nhs.uk">Tony.Marlow@salford.nhs.uk</a> T: 0161 282 4800

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased number of people with mental health problems living in independent accommodation.	Number of people who move to more independent accommodation.	Number of people who move from e.g. an Independent Hospital to a Care Home with Nursing or e.g. from a care home with nursing to supported accommodation (see typology of services below)	Number of people who move to a lower level of support and remain there for a six month period	Report provided by care coordinator on service users living and no return or readmission to acute inpatient areas  Frequency counts of users who “step down” from Bramley Street
	Number of people who effectively manage their own finances.	The number of people who begin to manage their own finances without support	The number of people who manage their own finances without support over a fixed period of time (e.g. six months)	Report provided by care coordinator at six months post discharge

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			without acquiring debt problems who previously could not manage their own finances effectively	Frequency counts of service users who meet this criteria
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<b>Process measures for the service to achieve the ‘hard’ outcomes</b>
Number of people with a CPA Review that identifies their needs in relation to promoting independence
Number of CPA reviews that set targets with dates that promote movement towards step down
Number of people who move to more suitable (but not more independent) housing.
Number of people who address and reduce a debt problem.
Number of people who open a bank account or savings scheme
Number of people who develop new skills for independent living (e.g. cooking, shopping)
Number of people who access advice regarding their finances, benefits or debts.
Number of people who begin leaving the house and/or using public transport independently.
Number of people who manage relationships with neighbours.
Number of people who resolve issues with their landlord.
Number of people in OATS independent hospitals with a CPA Care Coordinator

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

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## Independent living

<b>Service name</b>	Salford CMHT Care coordinators of people placed in out of areas treatments (OATS) in Independent Hospitals (Greater Manchester West NHS Foundation Trust)
<b>Type of service</b>	Community Mental Health Teams
<b>Project lead for the service</b>	Simon Johns
<b>Contact details</b>	E: <a href="mailto:Simon.Johns@gmw.nhs.uk">Simon.Johns@gmw.nhs.uk</a> T: 0161 772 3699
<b>Commissioner(s)</b>	Tony Marlow
<b>Commissioner contact details</b>	E: <a href="mailto:Tony.Marlow@salford.nhs.uk">Tony.Marlow@salford.nhs.uk</a> T: 0161 282 4800

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased number of people with mental health problems living in independent accommodation.	Number of people who move to more independent accommodation.	Number of people who move from an Independent Hospital to low level of support (see typology of services below)	Number of people who move to a lower level of support and remain there for a six month period	Report provided by care coordinator on service users living and no return or readmission to acute inpatient areas  Frequency counts of users who “step down” from OATS
	Number of people who effectively manage their own finances.	The number of people who begin to manage their own finances without support	The number of people who manage their own finances without support over a fixed period of time (e.g. six months) without	Report provided by care coordinator at six months post discharge

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			acquiring debt problems who previously could not manage their own finances effectively	Frequency counts of service users who meet this criteria
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<b>Process measures for the service to achieve the ‘hard’ outcomes</b>
Number of people in OATS independent hospitals with a CPA Care Coordinator
Number of people with a CPA Review that identifies their needs in relation to promoting independence
Number of CPA reviews that set targets with dates that promote movement towards step down
Number of people who address and reduce a debt problem.
Number of people who open a bank account or savings scheme
Number of people who develop new skills for independent living (e.g. cooking, shopping)
Number of people who access advice regarding their finances, benefits or debts.
Number of people who begin leaving the house and/or using public transport independently.
Number of people who manage relationships with neighbours.
Number of people who resolve issues with their landlord.

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

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## **Service User Satisfaction**

### **North West Mental Health Improvement Programme**

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## Service User Satisfaction

<b>Service name</b>	Leigh acute in-patient wards and community services (5 Boroughs Partnership Foundation Trust)
<b>Type of service</b>	Acute mental health
<b>Project lead for the service</b>	Chris Molyneux
<b>Contact details</b>	E: <a href="mailto:Chris.Molyneux@5bp.nhs.uk">Chris.Molyneux@5bp.nhs.uk</a> T: 01942 264822
<b>Commissioner(s)</b>	Nigel O’Gorman
<b>Commissioner contact details</b>	E: Nigel.O’Gorman@alwpct.nhs.uk T: 01942 48(1669)

Client group: All people who have been admitted to in-patient services  
 Services involved: In-patient wards and community teams

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased levels of satisfaction of service users with the delivery and outcomes of the service.	Proportion of service users admitted to hospital expressing that the hospital and community service enables them to achieve their personal goals.	Number of service users expressing that the service provides them with a high level of care  Number of service users expressing that the service provides them with support to manage their mental health needs.(via discharge questionnaire)	Number of service users, who 6 months after discharge, are still expressing that the service provides them with a high level of care.  Number of service users, who 6 months after discharge, are still expressing that the service provides them with support to manage their mental health needs. (via questionnaire).	Number of people completing service user satisfaction survey, who give the service a “good/excellent” rating in the user satisfaction questionnaire at (i) discharge and (ii) six months after discharge.

Process measures for the service to achieve the ‘hard’ outcomes
Number of people given a satisfaction questionnaire prior to discharge.
Number of completed questionnaire returned to staff prior to discharge.
Number of people completing a service user satisfaction survey. (A 60% return rate expected has been set by the Trust for in-patient services)
Number of people, whose care has been transferred to a community mental health team on discharge, who complete the service users’ satisfaction survey six months after discharge.

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## Service User Satisfaction / Mental Wellbeing

<b>Service name</b>	Lancashire Care NHS Foundation Trust
<b>Type of service</b>	Adult Mental Health, Step 4 Community Services
<b>Project lead for the service</b>	Simon Pierce / Frances McKinney
<b>Contact details</b>	E: <a href="mailto:Simon.Pierce@lancashirecare.nhs.uk">Simon.Pierce@lancashirecare.nhs.uk</a> / <a href="mailto:Frances.McKinney@lancashirecare.nhs.uk">Frances.McKinney@lancashirecare.nhs.uk</a> T: 01282 657117 / 07507847633
<b>Commissioner(s)</b>	Tracey Callaghan-Hayes
<b>Commissioner contact details</b>	E: <a href="mailto:Tracey.Callaghan-Hayes@wvl.nhs.uk">Tracey.Callaghan-Hayes@wvl.nhs.uk</a> T: 01254 282232

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased levels of satisfaction of service users with the delivery and outcomes of the service. (Close correlation with mental wellbeing and ability to manage their own mental health and improvement in individual goals)	Proportion of service users expressing that the service enables them to achieve their personal goals	Proportion of people reporting an improvement on their social inclusion domains (identified by service users) from 10 domains (points) of the Recovery Star.	Proportion of people having improved domain score(s) sustained over a 6 month period.	Utilising Recovery Star with service users in 3 CMHTs at regular intervals. (150 of the most recent on caseload) Baseline completed.
	Proportion of service users expressing that the service helps them manage their mental health needs	Proportion of people having an improved score on the “Managing Mental health” domain/point of the Recovery Star	Proportion of people having improved “Managing Mental health” domain score(s) sustained over a 6 month period.	Health of the Nation Outcome Scale (HONOS) scores to be measured and reported  Service users moving through the ‘steps’ of care  Qualitative service user stories to be completed

Process measures for the service to achieve the ‘hard’ outcomes
Proportion of Service Users who move down stepped care model of care
Proportion of Service Users with improved HoNOS scores
Collection of qualitative ‘stories’ from service users

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## **Social Networks**

### **North West Mental Health Improvement Programme**

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A collaborative development programme between the NHS, Social Care, the Third Sector and Users and Carers to improve mental health across the North West

## Social Networks

<b>Service name</b>	Stockport day centre
<b>Type of service</b>	Mental health day service
<b>Project lead for the service</b>	Lynn Barrett
<b>Contact details</b>	E: <a href="mailto:lynn@stockportdaycentre.org.uk">lynn@stockportdaycentre.org.uk</a> T: 0161 429 9744
<b>Commissioner(s)</b>	Nick Dixon
<b>Commissioner contact details</b>	T: 0161 474 4742 E: <a href="mailto:nick.dixon@stockport.gov.uk">nick.dixon@stockport.gov.uk</a>

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increase in the size and range of social networks for people with mental health problems	Number of people supported to develop positive new relationships/ friendships	Number of individuals who increase the number of people in their social network.	Number of people who sustain new friendships for 6 months.	Inclusion web. Case Outcome Recording System (CORS) ( <a href="http://go-gravitas.org.uk">go-gravitas.org.uk</a> ) Contact Notes, Individual Reviews, Recovery Star.
	Number of people supported to access new social settings.	Number of people who increase the range of people in their social networks (i.e. friends in different places/groups.)	Number of people who sustain their increased range of social networks after 6 months.	As above.
	Number of people supported to begin accessing peer support or self-help groups.	Numbers of people who access peer support or self-help groups.	Number of people who continue to access peer support or self-help groups after 6 months (if they still need to.)	CORS. Frequency counts.

<b>Process measures for the service to achieve the 'hard' outcomes</b>
Number and proportion of members of the Women's Group who complete baseline measures
Number of new referrals who, six weeks after commencing at the Centre, complete baseline measures
Number of relevant 1-1 sessions delivered
Number of relevant group work activities delivered
Number of reviews completed at 3 months after baseline measures taken

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## Social networks

<b>Service name</b>	Stockport & District Mind CAHSS (and various support groups within the care pathway)
<b>Type of service</b>	Crisis Accommodation & Home Support Service
<b>Project lead for the service</b>	Gill Walsh
<b>Contact details</b>	E: <a href="mailto:Gill.hall@cahss.org.uk">Gill.hall@cahss.org.uk</a> T: 0161 336 7231
<b>Commissioner(s)</b>	Nick Dixon (Stockport) Dave Wilson (Tameside)
<b>Commissioner contact details</b>	E: <a href="mailto:nick.dixon@stockport.gov.uk">nick.dixon@stockport.gov.uk</a> E: <a href="mailto:dave.wilson1@tameside.gov.uk">dave.wilson1@tameside.gov.uk</a>

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increase the size and range of social networks for people with mental health problems	Number of people supported to strengthen existing relationships with friends or family	Number of people who have maintained or improved their scores on the Recover Star areas of (i) social networks and (ii) relationships between admission and discharge	Number of people who have maintained or improved their scores on the Recovery Star areas of (i) social networks and (ii) relationships between discharge and three months later (for people who have accessed (i) Thrivers, (ii) Anger Management Group or (iii) Confidence Group	Recovery Star areas 'social networking' and 'relationships'  Eco-mapping tool  1:1 sessions  Timely reviews
Increase the size and range of social networks for people with mental health problems	Number of people supported to begin accessing peer support or self help groups	Number of people accessing wellbeing groups or peer support at the point of discharge from the service	Number of people continuing to access wellness groups and peer support after three months	Feedback from support groups at three months after discharge

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Increase the size and range of social networks for people with mental health problems	Number of people enabled to begin giving support to others	Number of people accessing volunteer training at the point of discharge from the service	Number of people continuing to give support to others after three months after discharge	Feedback from volunteer organizations at three months after discharge
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## North West Mental Health Improvement Programme

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## **Community Participation, Social Networks and Mental Well-being**

### **North West Mental Health Improvement Programme**

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A collaborative development programme between the NHS, Social Care, the Third Sector and Users and Carers to improve mental health across the North West

## Community Participation, Social Networks and Mental Well-being

<b>Service name</b>	St Helens Mind
<b>Type of service</b>	Social Inclusion
<b>Project lead for the service</b>	Jean Garlick
<b>Contact details</b>	E: <a href="mailto:sthelmind@yahoo.com">sthelmind@yahoo.com</a> T: 01744 677058
<b>Commissioner(s)</b>	Erica Crisp
<b>Commissioner contact details</b>	E: <a href="mailto:Erica.Crisp@hsthpcnhs.uk">Erica.Crisp@hsthpcnhs.uk</a> T: 01928 593495

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increase number of people with mental health problems participating in or engaging with local community activities	Number of people supported to take up a new or develop an existing / dormant leisure pursuit	Number of people who have taken up a new or develop an existing / dormant leisure pursuit	Number of people supported to sustain pursuit of new or existing dormant/existing leisure activity for six months	Frequency counts  Review with users and key workers
Increase in the size and range of social networks for people with mental health problems	Number of people supported to begin accessing peer support or self-help groups	Number of people accessing peer support or self-help groups on a monthly basis	Number of people maintaining access to peer support or self-help groups for six months	Frequency counts  Review with user and key workers  Well-being Outcomes Star
Improved quality of life, confidence and self-esteem for people with mental health problems	Number of people supported to make changes leading to enhanced confidence and self-esteem	Number of people making changes that lead to enhanced confidence and self-esteem	Number of people maintaining changes that have led to enhanced confidence and self-esteem for a period of six months	Frequency counts  Review with user and key worker  Well-being Outcomes Star

Process Outcomes
Number of people provided with information about accessing local community activities
Number of people meeting with a 'befriender' on a regular basis
Number of people reporting at least one positive change on the well-being star

### North West Mental Health Improvement Programme

A collaborative development programme between the NHS, Social Care, the Third Sector and Users and Carers to improve mental health across the North West

## **Personalisation and Choice**

### **North West Mental Health Improvement Programme**

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A collaborative development programme between the NHS, Social Care, the Third Sector and Users and Carers to improve mental health across the North West

## Personalisation and Choice

<b>Service name</b>	Pennine Care NHS Foundation Trust
<b>Type of service</b>	Community Mental Health Teams
<b>Project lead for the service</b>	Richard Spearing
<b>Contact details</b>	E: <a href="mailto:richard.spearing@penninecare.nhs.uk">richard.spearing@penninecare.nhs.uk</a> T: 0161 604 3752
<b>Commissioner(s)</b>	Nick Dixon
<b>Commissioner contact details</b>	T: 0161 474 4742 E: <a href="mailto:nick.dixon@stockport.gov.uk">nick.dixon@stockport.gov.uk</a>

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Increased number of people with mental health problems controlling their own support	Number of people supported to begin accessing direct payments or individual budgets	Number of people supported to begin accessing direct payments or individual budgets	Number of people supported to using accessing direct payments or individual budgets for a six month period	Frequency counts
Increased number of people with mental health problems in receipt of direct payments or individual budgets	Number of people supported to become more actively involved in decision making regarding their support	Number of people stating they are more actively involved in decision making regarding their support	Number of people supported to using accessing direct payments or individual budgets for a six month period without the support of a mental health professional	Frequency counts

Process measures for the service to achieve the ‘hard’ outcomes
Number of people supported to begin using direct payments to fund daytime activity or community participation
Number of people supported to assert their needs with a health or social care provider
Number of people supported to access exercise, arts or books on prescription

## North West Mental Health Improvement Programme

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## **Physical Health**

### **North West Mental Health Improvement Programme**

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## Physical Health

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

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Service Users with a BMI index that identifies them as un healthy (i.e. overweight BMI 25-30) or obese (BMI over 30) will be assisted in attempting to reduce this towards the healthy range (BMI 18.5-25)	Service users with a BMI index that identifies that they are over weight or obese who move down a BMI category	Number of service users who reduce their BMI down a category	Number of service users who are categorized as overweight who reduce their BMI by 5 points or to a lower grouping and maintain this for 6 months	Frequency counts of monthly BMI measures

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## Physical Health

<b>Service name</b>	Ashwood Court (Making Space)
<b>Type of service</b>	Independent hospital - rehabilitations
<b>Project leads for the service</b>	Gill Connor/Joel Zinyemba
<b>Contact details</b>	E: <a href="mailto:Gill.Connor@makingspace.co.uk">Gill.Connor@makingspace.co.uk</a> T: 01942 713065
<b>Commissioner(s)</b>	Nigel O’Gorman
<b>Commissioner contact details</b>	E: Nigel.O’Gorman@alwpct.nhs.uk T: 01942 48(1669)

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures used / evidence
Improved physical health for people with mental health problems	Number of people who begin regular physical activity/exercise.	Number and proportion of adults with a BMI index that identifies them as unhealthy (i.e. overweight (BMI 25 - 30) or obese (BMI over 30)) who decrease their BMI towards the healthy range (BMI - 18.5 - 25).	The number of people who reduce their BMI by 5 points or to a lower grouping and maintain this for six months	BMI measure
	Number of people who begin accessing support relating to their physical health.	Number and proportion of adults with a BMI index that identifies them as 'overweight' or 'obese' who move down a BMI category		BMI measure
		The number of people with Cholesterol levels higher than 5mmol/L who reduce their levels to 5mmol/L or less	The number of people who reduce their cholesterol levels to 5mmol/L or less and sustain this for six months	Cholesterol level

Process measures for the service to achieve the ‘hard’ outcomes
Number of people who access health promotion activities such as smoking cessation.
Number of people with mental health problems taking regular exercise.
Number of people who make changes leading to a reduction in physical health symptoms.

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## Physical health

<b>Service name</b>	Lea Court (Alternative Futures)
<b>Type of service</b>	Independent Hospital – Rehabilitation
<b>Project lead for the service</b>	Terry Keegan
<b>Contact details</b>	E: <a href="mailto:Terry.Keegan@alternativefuturesgroup.org.uk">Terry.Keegan@alternativefuturesgroup.org.uk</a> T: 01925 243577
<b>Commissioner(s)</b>	Margi Butler
<b>Commissioner contact details</b>	E: <a href="mailto:Margi.Butler@warrington-pct.nhs.uk">Margi.Butler@warrington-pct.nhs.uk</a> T: 01925 843792

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved physical health for people with mental health problems.	Number of people supported to begin accessing support relating to their physical health.	The number of people who have increased their knowledge and awareness of where to get health advise, information and support Number of people with a BMI index that identifies them as unhealthy i.e. overweight or obese .and who decrease their BMI towards a healthy range.	The number of people who have accessed services for advise, information and support over a 6 month period, and number of people with a BMI index that identifies them as “overweight” or “obese” who move down a BMI category and maintain this for a six month period.	Completion and use of Rethink Health Action Plan. Collated by Named Nurse in monthly care reviews evidenced in care plan.
	Number of people who begin regular physical activity /exercise	Number of people who previously did not participate in any form of physical activity/exercise but have now increased physical activity or exercise.	Number of people who have continued to participate in physical activity/exercise for 6 months.	Completion and use of Rethink Health Action Plan. Collated by Named Nurse in monthly care reviews and evidenced in care plan.

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## Physical health

<b>Service name</b>	Prescott House CMHT, Salford (Greater Manchester West NHS Foundation Trust)
<b>Type of service</b>	Community Mental Health Team
<b>Project lead for the service</b>	Simon Johns
<b>Contact details</b>	E: <a href="mailto:Simon.Johns@gmw.nhs.uk">Simon.Johns@gmw.nhs.uk</a> T: 0161 772 3699
<b>Commissioner(s)</b>	Tony Marlow
<b>Commissioner contact details</b>	E: <a href="mailto:Tony.Marlow@salford.nhs.uk">Tony.Marlow@salford.nhs.uk</a> T: 0161 282 4800

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures used / evidence
Improved physical health for people with mental health problems	Number of people who begin regular physical activity/exercise.	Number and proportion of adults with a BMI index that identifies them as unhealthy (i.e. overweight (BMI 25 - 30) or obese (BMI over 30)) who decrease their BMI towards the healthy range (BMI - 18.5 - 25).	The number of people who reduce their BMI by 5 points or to a lower grouping and maintain this for six months	BMI measure
	Number of people who begin accessing support relating to their physical health.	Number and proportion of adults with a BMI index that identifies them as 'overweight' or 'obese' who move down a BMI category		BMI measure
		The number of people with Cholesterol levels higher than 5mmol/L who reduce their levels to 5mmol/L or less	The number of people who reduce their cholesterol levels to 5 mmol/L or less and sustain this for six months	Cholesterol level

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**Process measures for the service to achieve the ‘hard’ outcomes**

Number of people on the CMHT caseload (and proportion of total caseload) who have BMI measured at baseline
Number of people on the CMHT caseload (and proportion of total caseload) who have Cholesterol measured at baseline
Number of people who access health promotion activities such as smoking cessation.
Number of people who make positive changes to their diet or lifestyle leading to sustained health benefit.
Number of people with mental health problems taking regular exercise.
Number of people who make changes leading to a reduction in physical health symptoms.
Number of people who address substance misuse issues.
Number of people on the CMHT caseload (and proportion of total caseload) who have BMI measured at six months who have been identified as overweight / obese
Number of people on the CMHT caseload (and proportion of total caseload) who have Cholesterol measured at six months who have been identified as having levels in excess of 5mmol/L

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## Physical health

<b>Service name</b>	Lancashire Care NHS Foundation Trust
<b>Type of service</b>	Mental Health
<b>Project lead for the service</b>	Lorna McGlynn
<b>Contact details</b>	E: <a href="mailto:Lorna.McGlynn@Lancashirecare.nhs.uk">Lorna.McGlynn@Lancashirecare.nhs.uk</a> T: 07507857461
<b>Commissioner(s)</b>	Tracey Callaghan-Hayes
<b>Commissioner contact details</b>	E: <a href="mailto:Tracey.Callaghan-Hayes@wwl.nhs.uk">Tracey.Callaghan-Hayes@wwl.nhs.uk</a> T: 01254 282232

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures
Improved physical health for people with mental health problems	Number of people supported to begin accessing support relating to their physical health	Number and proportion of adults with a BMI index that identifies them as unhealthy (i.e. overweight (BMI 25-30) or obese (BMI over 30) who decrease their BMI towards the healthy range (BMI - 18.5 -25).	Number of people who are classed as 'overweight' reducing their BMI to a lower grouping within a 6 month period and sustaining this at next measurement	Initial completion of comprehensive Rethink 'health check'  Subsequent actions/referrals to improve access to physical health support & uptake  BMI measurement 6 monthly-recorded on team spreadsheet and care plan
	Number of people supported to begin regular physical activity/exercise			
<b>Process measures for the service to achieve the 'hard' outcomes</b>				
Number of people who access health promotion activities such as uptake of weight loss class or 'exercise on prescription'.				
Number of people who make positive changes to their diet or lifestyle leading to sustained health benefit.				
Number of people with mental health problems taking regular exercise.				

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## **Volunteering, education and training**

### **North West Mental Health Improvement Programme**

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## Volunteering, education and training

<b>Service name</b>	Advocacy in Wirral
<b>Type of service</b>	Beating the Blues (Computerised Cognitive Behavioural Therapy)
<b>Project lead for the service</b>	Chris Shaw
<b>Contact details</b>	E: <a href="mailto:chris.shaw@aiw.org.uk">chris.shaw@aiw.org.uk</a> T: 0151 650 1530
<b>Commissioner(s)</b>	Barbara Edwards
<b>Commissioner contact details</b>	E: <a href="mailto:Barbara.edwards2@wirral.nhs.uk">Barbara.edwards2@wirral.nhs.uk</a> T: 0151 651 3907

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures used / evidence
Increase the number of people with mental health problems accessing volunteering opportunities	Number of people who begin volunteering	Number of people who enter volunteer programmes	Number of people who remain for 6 months or more in volunteering or access employment or training as a direct result of volunteering	Frequency counts Follow up phone calls Case studies
Increased number of people with mental health problems accessing education and training opportunities	Number of people who begin a mainstream education or training course	Number of people who begin a mainstream education or training course	Number of people who complete a mainstream education or training course	Frequency counts Follow up phone calls with users, link workers Case studies
Increased number of people with mental health problems attaining qualifications	Number of people who complete a mainstream education or training course	Number of people who to complete a mainstream education or training course	Number of people who complete a mainstream education or training course	Frequency counts Follow up phone calls with users, link workers Case studies

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<b>Process measures for the service to achieve the ‘hard’ outcomes</b>
Number of people who enter volunteer activities/programmes
Number of people who apply for a mainstream education or training course
Number of people who attend an interview or information session for a course
Number of people who identify funding for an education or training course
Number of people who obtain a qualification (state level)
Number of people who maintain/retain an education or training course through a crisis period
Number of people who begin a discrete (mental health only) education or training course

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## Volunteering, education and training

<b>Service name</b>	Wirral Community Development Black & Minority Ethnic /Mental Health (Wirral Change)
<b>Type of service</b>	Community Development Worker Service
<b>Project lead for the service</b>	Clint Agard
<b>Contact details</b>	T: 0151 650 5428 E: <a href="mailto:clint@wirralchange.org.uk">clint@wirralchange.org.uk</a> or <a href="mailto:rob@wirralchange.org.uk">rob@wirralchange.org.uk</a>
<b>Commissioner(s)</b>	Barbara Edwards
<b>Commissioner contact details</b>	E: <a href="mailto:Barbara.edwards2@wirral.nhs.uk">Barbara.edwards2@wirral.nhs.uk</a> T: 0151 651 3907

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures used / evidence
Increase the number of people with mental health problems accessing volunteering opportunities	Number of people who begin volunteering	Number of people who enter volunteer programmes	Number of people who remain for 6 months or more in volunteering or access employment or training as a direct result of volunteering	Frequency counts  Follow up phone calls  Case studies
Increased number of people with mental health problems accessing education and training opportunities	Number of people who begin a mainstream education or training course	Number of people who begin a mainstream education or training course	Number of people who complete a mainstream education or training course	Frequency counts  Follow up phone calls with users, link workers  Case studies
Increased number of people with mental health problems attaining qualifications	Number of people who complete a mainstream education or training course	Number of people who to complete a mainstream education or training course	Number of people who complete a mainstream education or training course	Frequency counts  Follow up phone calls with users, link workers  Case studies

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<b>Process measures for the service to achieve the ‘hard’ outcomes</b>
Number of people who enter volunteer activities/programmes
Number of people who apply for a mainstream education or training course
Number of people who attend an interview or information session for a course
Number of people who identify funding for an education or training course
Number of people who obtain a qualification (state level)
Number of people who maintain/retain an education or training course through a crisis period
Number of people who begin a discrete (mental health only) education or training course

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## Appendix 1 – Further examples of possible outcomes and processes

### Education and training

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures used / evidence
Increased number of people with mental health problems accessing education and training opportunities	Number of people who begin a mainstream education or training course	Number of people who begin a mainstream education or training course	Number of people who complete a mainstream education or training course	Frequency counts  Follow up phone calls with users, key-workers or CPA CCs
Increased number of people with mental health problems attaining qualifications	Number of people who complete a mainstream education or training course	Number of people who to complete a mainstream education or training course	Number of people who complete a mainstream education or training course	Frequency counts  Follow up phone calls with users, key-workers or CPA CCs

Process measures for the service to achieve the ‘hard’ outcomes
Number of people who apply for a mainstream education or training course
Number of people who attend an interview or information session for a course
Number of people who identify funding for an education or training course
Number of people who obtain a qualification (state level)
Number of people who maintain/retain an education or training course through a crisis period
Number of people who begin a discrete (mental health only) education or training course

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## Personalisation and choice

Intended Outcomes	Key Outcome Indicators	Examples of hard outcomes	Sustainable outcomes	Measures used / evidence
Increased number of people with mental health problems controlling their own support	Number of who begin accessing direct payments or individual budgets	Number of people supported to begin accessing direct payments or individual budgets	Number of people supported to using accessing direct payments or individual budgets for a six month period	Frequency counts  Follow up phone calls with users, key-workers or CPA CCs
Increased number of people with mental health problems in receipt of direct payments or individual budgets	Number of people who become more actively involved in decision making regarding their support	Number of people stating they are more actively involved in decision making regarding their support	Number of people supported to using accessing direct payments or individual budgets for a six month period without the support of a mental health professional	Frequency counts  Follow up phone calls with users, key-workers or CPA CCs

Process measures for the service to achieve the 'hard' outcomes
Number of people who begin using direct payments to fund daytime activity or community participation
Number of people who assert their needs with a health or social care provider
Number of people who access exercise, arts or books on prescription

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