ImROC
Implementing Recovery through Organisational Change

A joint initiative from

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

Briefing

6. The Team Recovery Implementation Plan: a framework for creating recovery-focused services

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INTRODUCTION

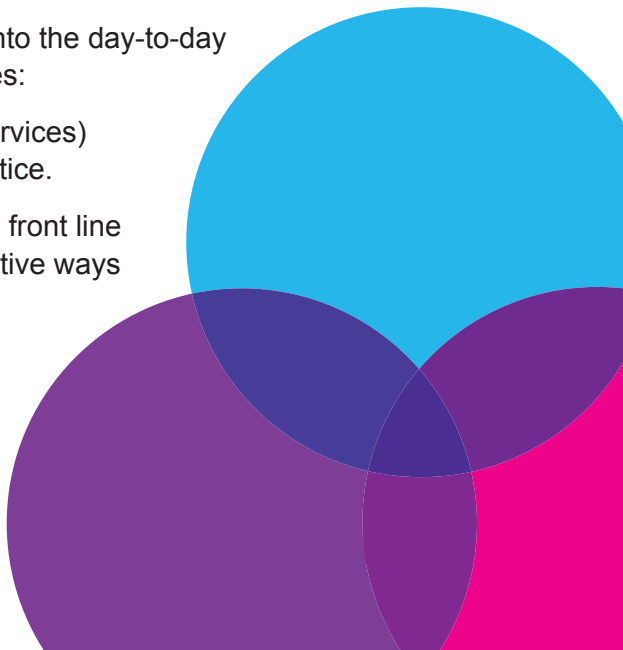
Creating more recovery-focused services requires a change in culture and practice at every level of the organisation (Shepherd *et al.*, 2010). In modern mental health services, the basic building block is the multidisciplinary team, whether in a hospital ward or in the community.

Supporting recovery through working with the whole team is at the centre of the processes of organisational change and a necessary complement to changing the attitudes and behaviour of front-line staff (Whiteley *et al.*, 2009).

The 'Team Recovery Implementation Plan' (TRIP) was initially developed by Julie Repper and her colleagues in Nottingham and is a tried and tested instrument designed to assist with this goal. This paper describes the instrument and its practical use in a variety of settings.

Successfully embedding recovery ideas and practice into the day-to-day work of individual teams requires two parallel processes:

1. Empowering teams (their staff and people using services) to translate abstract ideas about recovery into practice.
2. Utilising the skills and resources of everyone at the front line (staff and people using services) to develop innovative ways of promoting recovery and recovery environments.



The creativity of front line staff can often be stifled by competing demands and directions coming from the top which are not aligned with recovery priorities. Similarly, the skills of people using the services are often underused and undervalued. They are seldom asked what they want staff to do or how they want services to support them, thus excluding them from having a meaningful influence on service design. And they are often not recognised as having a direct role in service delivery.

We are missing a trick here. By bringing together all the creativity and skills of staff and people using services, in both the design and delivery of innovative, recovery-focused services, we double our assets and make 'co-production' a reality at a grass-roots level.

What is co-production?

"Co-production ... promotes equal partnership between service workers and those intended to benefit from their services – pooling different kinds of knowledge and skill, and working together... designing and delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours." (New Economics Foundation, 2011)

But there is no one way of 'doing' co-production. It consists of a set of underpinning principles (Cahn, 2004; Boyle *et al.*, 2010; Nesta, 2012). These are identified below:

- Recognising people as assets: building on all the strengths within the team/service by utilising both the expertise of using/providing services and the other skills, resources and networks that they can bring.
- Mutuality and reciprocity: breaking down barriers, blurring roles, valuing what everyone brings, and enabling staff and people using services to share responsibility for both design and delivery.
- Extending the resource base by engaging peer, personal and professional networks: to build knowledge, and work together to design, deliver and support change.
- Team/services as catalysts for change rather than the creator of change: enabling people to lead their own recovery journey and empowering them to develop a range of resources in peer networks and communities to support these journeys.

The TRIP is based on these ideas and is designed to provide a framework to assist teams to co-produce services that will enhance the experience of people using them and so better facilitate their recovery.

THE TEAM RECOVERY IMPLEMENTATION PLAN (TRIP)

Initially developed by Julie Repper and her colleagues at Nottinghamshire Healthcare NHS Trust, the TRIP has been refined through use in the full range of adult mental health services. The aim of TRIP is not to provide a formal assessment device but to initiate a process of discussion, reflection, innovation and development within a team. It is not designed to provide comparison between teams, but to enable teams to co-produce, co-deliver and co-review of actions plans in an ongoing process. It is therefore not a management device: it is an heuristic tool to promote collaborative service development.

The instrument (see Appendix)

The TRIP comprises four key elements:

1. An overview of all the resources that exist within the team ('identifying assets').
2. A tool for benchmarking progress in recovery-focused practice.
3. A list of the top three priorities for action agreed by everyone involved, together with action plans for future developments.
4. A method for systematic review and resetting of goals.

All these elements are 'co-produced' by staff and service users working together. The intention of TRIP is to initiate a process to support a recovery-oriented way of working within the team, based on a shared responsibility for reviewing practice, agreeing areas for development and delivering change. Our experience of using TRIP within at least 15 organisations (statutory and voluntary) has taught us that it is the process of using TRIP, rather than TRIP in and of itself, that is most critical.

The process

1. An overview of all the resources that exist within the team ('identifying assets'). All staff will have mental health experience and training that will, hopefully, be useful; but they will also have 'hidden talents' – e.g. skills and interests in music, sport, cooking, gardening, languages, etc.; lived experience of trauma; an understanding of their own and others' mental health problems; contacts with a range of communities and organisations. This process of asset finding and building among people using the service can involve all the available staff and residents for inpatient wards, but for community teams (with far larger numbers) it may be necessary to use representatives of people using the services who can reflect their diverse views. But it is important to identify and to use this total list of assets and resources to help support the recovery of people being looked after by the team.

2. A tool for benchmarking progress in recovery-focused practice. The TRIP provides a series of 'good practice' statements drawn from *Recovery Self Assessment (RSA) – Provider Version* (O'Connell *et al.*, 2005) and *10 Key Organisational Challenges* (SCMH, 2010). These tools invite staff and people using services to consider what the team has already achieved in each area and what remains to be addressed. The benchmarking tool provides a framework for generating these discussions, but it should not limit them. The process involves everyone in discussions about these benchmarking statements and it is useful to rate each on a five point scale to help when deciding upon the importance of each area for future work. Examples of some TRIP benchmarking statements are given in Box 1.

3. A list of the top three priorities for action agreed by everyone involved, together with action plans for future developments. Clearly, it is not possible for a team to do everything at once - a maximum of around three priorities appears to be realistic. These do not have to be the 'worst' areas: quick wins have an important role both in demonstrating achievement and cementing the co-production process. It can also be helpful to think about the twin dimensions of impact and ease of implementation and strike a balance between the two. At least one member of staff and one person using the service should then share responsibility for their implementation. The targets for action must be specific, measurable, achievable, realistic and timely (SMART); identifying what can be achieved by when and how progress will be measured.

4. A method for systematic review and resetting of goals. Finally, the team needs to establish forums for reviewing progress, providing support and problem-solving, and holding the joint leads accountable for their actions. Part of an existing meeting like a ward community meeting or a team business meeting can be designated to deliver this function as long as it routinely includes people using the service. Alternatively a new, specific meeting can be created. An annual review beginning again with reviewing assets and benchmarking can then be undertaken to complete the cycle. This gives an opportunity to celebrate success, review priorities and agree new action plans.

Making co-production work

Too often nowadays, those working in and using front-line mental health services experience decisions being foisted on them from on high and there is a risk that organisation-wide enthusiasm for recovery-focused transformation of services may result in yet another set of top-down prescriptions that only serve to reinforce the feelings of disempowerment among both staff and people using services. For co-production to be really effective it is therefore essential that staff at all levels, together with the people using the service, are involved in the process on an equal footing. There must be an opportunity for everyone to discuss their different perspectives about what the team is doing and arrive at a consensus about the current situation and possible directions for development.

Our experience suggests that staff often feel uncomfortable about having open, equal discussions. Too often they feel they must not 'wash their dirty linen in public', and can be defensive when people using services do not appear to understand the constraints and demands under which they have to operate. Staff also sometimes assume that it is their job to sort everything out and fear that these open discussions will lead to demands that they cannot meet. This may stem from traditional approaches to user involvement which have asked people using services what they want with little honest information about the external imperatives and constraints that exist (e.g. externally imposed targets and regulations).

By contrast, the TRIP allows staff and people using the service to come together in a different way: to identify progress, to understand each other's perspectives and constraints, to seek solutions together, and to share responsibility for implementing actions. This is a different way of working together: it is not 'us' involving 'them', it is asking how can we work together. These discussions are often helped by the presence of an external facilitator – either from another team, a local manager, or an external expert - to promote dialogue and mutual understanding. They should not be seen as a one-off exercise.

Whole team recovery away-days can be a productive way of co-producing a team plan. We have successfully run recovery away-days, which include people using services, in a wide range of services: from wards in special hospitals and forensic services, through acute wards, rehabilitation services, early intervention and crisis services and

Box 1: Examples of TRIP benchmarking statements

- We help people build and/or keep existing roles, relationships and connections with neighbourhoods and communities of their choice.
- We encourage people to make their own choices and decisions and support them even if we do not agree with them.
- We develop care/support plans and write notes in collaboration with service users focusing on their personal recovery plans and clearly stating plans for meeting their recovery goals.
- We work with service users to understand their perspective on 'risk', negotiate an agreed safety plan and share responsibility for safety (e.g. what the person can do, what staff can do to help).
- We involve significant others in care planning if so desired and use their expertise and insights (e.g. family and friends, peer support workers, advocates, other service providers).
- We provide examples of real success stories, life story books, DVDs, posters, for people to see what is possible and to inspire their hope.
- We offer everyone in our service access to recovery education where ideas about recovery and personal plans can be developed with others including peers who have moved on.
- We support the wellbeing of staff (e.g. wellbeing plans, supervision and appraisal including personal reflections and wellbeing).

community teams. As indicated earlier, for inpatient wards these can involve all staff and residents; for community teams it may be necessary to use representatives of people using the services who can reflect the diverse views of people using the team's services. In some teams, people have been asked to give individual responses to the benchmarks, these can then be collated to help prioritise areas for action; others have used community meetings or team business meetings (with people using the service present) as part of the benchmarking process. Whichever method is used, it is important that people come together to agree priority actions and develop implementation plans.

The process of co-production continues through development and implementation of action plans: the joint leads need to agree who will do what by when and what other expertise (available within, or to, the team) they will draw upon. Responsibility for implementation should then not rest with the staff lead alone, but be shared with a service user lead. Their roles may be different, based on their skills and resources, but they are equally important.

It is important that the development of recovery-focused practice is a live part of the day-to-day work of the team. This is best achieved by a regular forum at which the joint leads report progress and seek the advice and assistance of their colleagues and their networks/contacts. For example, community and team meetings have been used to discuss one priority/action plan per week on a rolling programme.

EXAMPLES OF THE TRIP IN ACTION

The priorities and action plans of teams have included a wide range of targets:

- Developing personal recovery goals as part of care plans and/or introducing Wellness Recovery Action Plans / personal recovery plans.
- Reviewing team / ward policies, e.g. risk assessment and management.
- Including people using services on staff interview panels.
- Agreeing on shared entries in notes and people having copies of their own session notes. People writing their own summaries and reports for review meetings.
- Improving the ward/team environment, including positive images and hopeful messages about the possibilities of life with a mental health problem, for example making a 'Hope and recovery – what it means to me' pin board.
- Developing a team/ward recovery library, including anthologies of recovery stories.
- Creating information packs (that include recovery stories and 'things I know now that I wish I had known then' tips).
- Co-producing directories of resources, sometimes with 'trip advisor' style ratings.
- Introducing carer recovery and wellbeing packs.

Box 2: Changes brought about through using the TRIP

At Nottinghamshire Healthcare NHS Trust, B2 acute admission ward in Bassetlaw began to use TRIP in 2008. By 2012, the average benchmarking rating had increased from 1.7 to 3.8. Over the four years of their use, action plans had resulted in many important changes including:

- The development of a self-help library and a visiting 'living library' of people (instead of books) who could recount their personal experience of recovery.
- Implementation of personal recovery plans for all.
- The local MIND group running a social group on the ward.
- Co-production of a carers' leaflet and introducing a separate TRIP action plan with families and friends.
- A 'Hope board' of inspiring messages from people using the service.
- People using services and staff who took on joint lead roles were provided with a tailored programme of supervision, training and development.
- Introduction of protected time for staff to ensure more contact with people using the service.
- Increasing peer input on the ward, including the introduction of a Peer Support Worker.
- Introducing an evaluation of 'levels of coercion' using the scale developed by Szmuckler & Appelbaum (2008).

- Creating links with community resources and facilities (e.g. open days). Inviting external organisations and agencies to run events.
- Involving others within the mental health service to provide seminars and activities, for example, spirituality and mental health discussions for staff and service users.
- Developing buddy/mentoring systems.
- Introducing peer support workers and volunteers. Facilitating peer networks.
- Co-producing and co-delivering 'safe dating' and other courses in conjunction with recovery colleges.
- Celebrating moving on and 'graduation' from the team or ward with parties, good luck cards etc.
- Inviting former service users back to share their experience of the benefits and challenges of moving on.

Some practical examples of using the TRIP are shown in Box 2.

Nottinghamshire Healthcare Trust has used the TRIP as a means of enabling all clinical teams to work with the people using their services to identify their own, recovery focused priorities and to develop their own ways of addressing them. All teams are included in the transformation of the organisation and they each now annually benchmark their practice against the TRIP statements, progressively working towards their own recovery priorities. In this way the process can drive practice throughout the whole organisation.

While it is neither helpful nor accurate to compare teams in terms of the scores they award themselves, it has been helpful to aggregate data collected from teams across the Trust to identify the recovery focused practices that are considered to be most and least well developed. For example, 'supporting family and friends' seemed well developed; while 'collaborative note writing' was not. This exercise also identified recruiting peer workers as the most powerful innovation in driving change within teams (see Repper, 2013).

Central and North West London Foundation Trust have extended the use of TRIP beyond individual teams by using it as the basis for a recovery quality target (CQUIN). Teams were required to complete a TRIP and identify three team priorities which were then collated across service lines and progress monitored by commissioners. This moved away from the usual uniform target expected across all services, towards an individually tailored target developed by front-line staff and service users thus ensuring local relevance and ownership within an overarching, recovery focused framework.

Box 3: Using the TRIP in West London

At West London Mental Health NHS Trust, the Aurora Ward (a female forensic admission ward) began to use TRIP in 2011. Their initial action plan, supplemented by a range of other initiatives deriving from their weekly progress reviews in community meetings between 2011 and 2012, included:

- The collection of recovery stories,
- The co-production of 'ward house rules',
- Communal meals,
- The marking of beginnings and endings: welcome meetings and parties when someone was moving on,
- Recovery sessions,
- Ward round self-reporting.

The impact of these, and the process of joint working between staff and residents that it promoted, improved the experience of the ward for everyone. Between 2011 and 2012:

- Incidents of self-injury fell from 39 to 8,
- Hours spent in seclusion fell from 987 to 483,
- The number of residents who moved on increased from 3 to 14,
- Staff sickness absence decreased from 10.4 To 4.66,
- Physical assaults of staff by patients decreased from 34 to 27.

CONCLUSION

Recovery is founded on the narratives of lived experience and these frequently emphasise the importance – for good or ill – of relationships at the front-line. Indeed, the need to change the nature of day-to-day interactions and relationships is the first of the ImROC programme's *10 Key Organisational Challenges*. But such changes cannot be achieved by training alone – they require local ownership, co-production, the involvement of staff and line managers, and a culture of innovation that can harness expertise and creativity across the organisation in order to create an environment in which all can grow and flourish. As Patricia Deegan noted nearly 20 years ago, "We are learning that the environment around people must change if we are to be expected to grow into the fullness of the person who, like a small seed, is waiting to emerge from within each of us … How do we create hope filled, humanised environments and relationships in which people can grow?" (Deegan, 1996).

But services cannot make people recover. Neither can service directors make the work of their staff recovery-focused. What they can do is to nurture the wealth of knowledge, resourcefulness and ingenuity that exists among front-line staff and people using services and empower them to co-create their own solutions. Recovery is about recognising and building on these strengths and possibilities and the creation of recovery-focused services can only be achieved by valuing the assets and ingenuity of all, whatever their formal 'position' in service hierarchies. The TRIP provides a framework that capitalises on the resources of people using services and the staff they see on a day-to-day basis in order to co-produce the fertile environment in which both can grow.

The TRIP is most effective when it is used in the context of an organisation that is committed to creating a recovery-focused culture. There needs to be an overarching recovery strategy, supported by training and awareness-raising for staff, people using services and those close to them. Within this context, the TRIP becomes the way in which individual teams can make recovery a reality at the front-line. However, it can only be one element in the strategy for organisational change.

The 'Team Recovery Implementation Plan' is reproduced in the Appendix and can be downloaded from www.imroc.org/resources.

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Advances in recovery-focused practice arise from collaborative partnerships between individuals and organisations. The ImROC briefing papers draw upon this work. Each paper is written by those members of the project team best placed lead on the topic, together with contributions from others.

In this case, we particularly wish to acknowledge the contribution of those whose work on the co-production of care using instruments like the Team Recovery Implementation Plan (TRIP) has inspired and informed the field. Thanks for the support of the many clinical teams who have tried, tested and developed the tool in Nottinghamshire Health NHS Trust, and particularly the leadership of Beverley Johnson and Simon Barnitt.

APPENDIX

The Team Recovery Implementation Plan

You can download an editable word version of this plan from www.imroc.org/media/publications.

Team Recovery Implementation Plan

Team:

Date:

TEAM INFORMATION

Role or function of the team	
Number of people served by the team	
Average length of stay within the team	
Staff in the team	

Resources to support recovery in the team

Staff with special skills, interests, experience, knowledge, contacts that might be used to make the service offered more recovery-focused
People using the service with special skills, experience, knowledge, contacts that might be used to make the service offered more recovery-focused
Any other resources available to the team (links with other agencies/community organisations, relatives, friends ...)

BENCHMARKING RECOVERY APPROACH

Criteria	Extent implemented (5 - fully, 1 - not at all)	Examples of implementation	How important is it that we work on this?
We help people build and/or keep existing roles, relationships and connections with neighbourhoods and communities of their choice.	5 4 3 2 1		
We are knowledgeable about resources and opportunities in the local community.	5 4 3 2 1		
We support local community facilities to understand mental distress and accommodate people with mental health challenges (e.g. in relation to individuals who are going back into education, employment or leisure activities).	5 4 3 2 1		
We have an effective system for involving and informing family and friends (e.g. ways of identifying carers and keeping them informed, offering assessment and involving in reviews where appropriate).	5 4 3 2 1		
We involve significant others in care planning if so desired and use their expertise and insights (e.g. family and friends, peer support workers, advocates, other service providers).	5 4 3 2 1		
We offer all people using our service a personal recovery plan/WRAP and help them to develop their personal recovery plan.	5 4 3 2 1		
We develop care/support plans and write notes in collaboration with service users focusing on their personal recovery plans and clearly stating plans for meeting their recovery goals.	5 4 3 2 1		
People have their own copies of session and progress notes, as well as their care plans, for their own record.	5 4 3 2 1		

We encourage people to make their own choices and decisions and support them even if we do not agree with them.	5 4 3 2 1		
We give information and promote choice rather than using threats, bribes or coercion to influence a person, and only use force as a very last resort.	5 4 3 2 1		
We are prepared to take risks and try new things – and encourage service users to do the same.	5 4 3 2 1		
We work with service users to understand their perspective on 'risk', negotiate an agreed safety plan and share responsibility for safety (e.g. what the person can do, what staff can do to help).	5 4 3 2 1		
We encourage everyone to develop an advanced directive/crisis plan and help them to reach an agreement about this with all relevant people (Care Co-ordinator, Psychiatrist, GP, family).	5 4 3 2 1		
We provide examples of real success stories, life story books, DVDs, posters, for people to see what is possible and to inspire their hope.	5 4 3 2 1		
We have clear systems for linking people with peers who can serve as role models (e.g. through contact with local user run groups).	5 4 3 2 1		
We have a system for identifying and celebrating progress towards self-defined recovery defined goals.	5 4 3 2 1		
We offer everyone in our service access to recovery education where ideas about recovery and personal plans can be developed with others including peers who have moved on.	5 4 3 2 1		

We provide opportunities for service users, family members and staff to learn about recovery.	5 4 3 2 1		
We offer (or signpost to) a variety of therapeutic interventions from which service users can choose (psychological therapies, complimentary therapies, medication…) and give them information to help them make their choice.	5 4 3 2 1		
We involve service users in recruitment, training and service development through routine involvement in decision making forums.	5 4 3 2 1		
We encourage staff to prioritise service users' recovery rather than administrative and bureaucratic jobs.	5 4 3 2 1		
All staff receive regular supervision and this is focused on recovery based practice (e.g. using the SCMH *Ten Top Tips for Recovery*).	5 4 3 2 1		
We support the well-being of staff (e.g. well-being plans, supervision and appraisal including personal reflections and well-being).	5 4 3 2 1		

What are your top three priorities for development?

1	
2	
3	

ACTION PLAN

Priority 1: Area for development		
At the end of the year, what do you want to have achieved?		
How will you achieve this? What will you do?		
Actions	Who	By when

ACTION PLAN

Priority 2: Area for development		
At the end of the year, what do you want to have achieved?		
How will you achieve this? What will you do?		
Actions	Who	By when

ACTION PLAN

Priority 3: Area for development		
At the end of the year, what do you want to have achieved?		
How will you achieve this? What will you do?		
Actions	Who	By when

The Team Recovery Implementation Plan

This briefing paper has been produced for the Implementing Recovery through Organisational Change programme, a joint initiative from the Centre for Mental Health and the NHS Confederation's Mental Health Network.

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For more information on the current work of ImROC, please visit **www.imroc.org**.

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