ImROC
Implementing Recovery through Organisational Change

A joint initiative from
Centre for Mental Health
Mental Health Network NHS Confederation

Team Recovery Implementation Plan

Team:

Date:

Nottinghamshire Healthcare NHS Trust

TEAM INFORMATION

Role / 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,	5 4 3 2 1		

medication…) and give them information to help them make their choice.			
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 I 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 I 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 I year, what do you want to have achieved?		
How will you achieve this? What will you do?		
Actions	Who	By when