

## Recovery Pathway Standards

No.	Standard	Examples	Our Evidence	RAG Rating
1	A clear pathway is identified with the service user on admission that looks at the services they are likely to need on the pathway into the community	Visual pathway Pathway mapping tool Individual pathway documents My Shared Pathway		<input type="text"/>
2	Care plans are written with the service user and the MDT together and include the following areas (as appropriate): <ul style="list-style-type: none"> <li>• My Mental Health Recovery</li> <li>• Getting Insight</li> <li>• Stopping my Problem Behaviours</li> <li>• Recovery from Drugs and Alcohol</li> <li>• Making Feasible Plans</li> <li>• Staying Healthy</li> <li>• My Life Skills (including technology)</li> <li>• My Relationships</li> <li>• Positive Behaviour Support Plans</li> <li>• Advanced Directives</li> </ul>	Care plan audit Evidence of collaboration Evidence of reviews being collaborative Recovery Star Psychology Formulation		<input type="text"/>
3	Service Users choices are taken into account when selecting medication, therapies and activities, and are acted upon as far as possible	MDT and CPA minutes Notes of discussions Service users views recorded, Involvement evident in discussions and planning		<input type="text"/>
4	It is made clear to service users which outcomes they must achieve to progress to the next step on their pathway	MDT and CPA minutes Care plans linked to outcomes Service user questionnaire		<input type="text"/>
5	There is a clear connection between planned activities and the Recovery Goals of service users	Activity planners link in to Recovery goals My Outcome plans and progress		<input type="text"/>
6	The MDT regularly talks with the service user about their expected length of stay as well as looking at any obstacles to moving forward	MDT audit Regular recording of conversations about LoS Discharge plans in place CPA Goals		<input type="text"/>
7	Service users can meet their MDT care team at least once every 2 weeks to review their care, outcomes plan and progress	MDT Rota's MDT minutes		<input type="text"/>
8	Service users have a CPA within the first three months of admission and as a minimum every 6 months after that to review outcomes plans and progress	CPA Rota's CPA minutes		<input type="text"/>
9	Service user plans include individual outcomes and interventions in the following areas: (as relevant) <ul style="list-style-type: none"> <li>• Health awareness</li> <li>• Weight management</li> <li>• Smoking</li> <li>• Diet and nutrition</li> <li>• Exercise</li> <li>• Any service user specific items</li> </ul>	Health care plans Health action plans Specific care plans around these areas in place		<input type="text"/>
10	The team provides information, signposting and encouragement to service users to access local organisations for peer support and social engagement such as: <ul style="list-style-type: none"> <li>• Voluntary organisations;</li> <li>• Community centres;</li> <li>• Local religious/cultural groups;</li> <li>• Peer support networks;</li> <li>• Recovery colleges</li> </ul>	Individual care plan Clear information is available on local organisations including peer support that can be accessed within the hospital. Evidence that these are supported by the service, are available and are included in section 17 leave opportunities.		<input type="text"/>
<b>Average Score for the area</b>				<input type="text"/>

RAG Rating	
5 Green	Fabulous!
4 Green Amber	↓
3 Amber	Functional!
2 Amber Red	↓
1 Red	Action!

## Recovery Pathway Action Plan

No.	Standard	Our Actions	RAG Rating
1	A clear pathway is identified with the service user on admission that looks at the services they are likely to need on the pathway into the community		
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3	Service Users choices are taken into account when selecting medication, therapies and activities, and are acted upon as far as possible		
4	It is made clear to service users which outcomes they must achieve to progress to the next step on their pathway		
5	There is a clear connection between planned activities and the Recovery Goals of service users		
6	The MDT regularly talks with the service user about their expected length of stay as well as looking at any obstacles to moving forward		
7	Service users can meet their MDT care team at least once every 2 weeks to review their care, outcomes plan and progress		
8	Service users have a CPA within the first three months of admission and as a minimum every 6 months after that to review outcomes plans and progress		
9	Service user plans include individual outcomes and interventions in the following areas: (as relevant) <ul style="list-style-type: none"> <li>• Health awareness</li> <li>• Weight management</li> <li>• Smoking</li> <li>• Diet and nutrition</li> <li>• Exercise</li> <li>• Any service user specific items</li> </ul>		
10	The team provides information, signposting and encouragement to service users to access local organisations for peer support and social engagement such as: <ul style="list-style-type: none"> <li>• Voluntary organisations;</li> <li>• Community centres;</li> <li>• Local religious/cultural groups;</li> <li>• Peer support networks;</li> <li>• Recovery colleges</li> </ul>		