Progression Together

An evaluation of a model of personalised residential care developed by Together for Mental Wellbeing

Mental Health Foundation

together FOR MENTAL WELLBEING

This report is the culmination of a three-year independent evaluation of the impact of Progression Together, a model of personalised support in a residential setting by the charity Together for Mental Wellbeing. The project was funded by the Department of Health.

March 2016

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Executive Summary

In 2009, Together for Mental Wellbeing (Together) began to transform some of its residential services for people with complex mental health needs into personalised accommodation-based support that uses self-directed support to progressively move individuals towards independence. After a consultation process with service users and other stakeholders, Together named this model of residential support 'Progression Together'. The Mental Health Foundation conducted a three-year evaluation of the Progression Together model between 2013 and 2016.

The evaluation assessed whether Progression Together is an effective model of local step-down provision, which moves people with complex needs from hospitals or secure environments into the community, with a focus on the following outcomes:

- Improvements in mental wellbeing and functional living skills.
- Engagement in local community.
- Increased incidence of self-directed support.
- Achievement of self-directed goals.
- Increased independence and move-on rates.
- Improved cost efficiency and productivity of Progression Together services compared to traditional statutory residential service approaches.

A mixed-method approach was used to collect data, using a longitudinal approach to assess the impact of Progression Together on the outcomes listed above. Quantitative and qualitative data in the form of questionnaires and in-depth interviews were collected at three time points: baseline (T1), nine-month follow-up (T2) and 18-month follow-up (T3). In addition to this data, a staff consultation and cost-comparison analysis of Progression Together services in relation to comparable support delivery in the local area were conducted in Year 3.

Findings

Wellbeing

Statistically significant increases in wellbeing were found between T1 and T2 and T1 and T3 time points. In addition, significance was associated only with those participants who had entered a service post-transformation to Progression Together.

Lifestyle

Statistically significant increases were observed on 'overall health' scores and on the subscales of 'general health' and 'social life' between T1 and T2, and nearing significance for T1 and T3 follow-up.

Goals

In terms of goal achievement, mixed outcomes were observed at T2 and T3; however, it's difficult to draw any comparisons between achievement at follow-up as the sample of individuals who achieved goals at T2 and T3 was not the same.

Participant experiences

The qualitative interviews identified the aspects of Progression Together that clients highly valued and revealed which elements were integral to the model. On the whole, the experience of living in a Progression Together service was deemed very positive, and staff were highly regarded and valued for the practical and emotional support they provided.

Staff consultation

Staff expressed clear benefits of the model, as well as some challenges regarding implementing the model when working with external agencies. There appeared to be some variability in staff attitudes towards some elements of the model, which influenced the manner in which it is implemented in some services.

Cost-comparison analysis

Where Together runs a fully occupied residential service providing self-directed support, it is possible to do so at a reduced cost compared with the statutory, private/voluntary sector and NHS hospital equivalent available in the region. However, where the Progression Together service provides higher levels of one-to-one and self-directed support based on the higher level of need of residents, Together services cost more than the statutory equivalent and voluntary and independent support services. However, they cost less than secure NHS mental health services.

Recommendations

Evaluating the Progression Together model – which is innovative in its delivery of support and draws on a personalised approach to people who have complex needs – posed some challenges to the evaluation.

The following recommendations reflect the challenges below:

- Variation in the implementation of elements of the Progression Together model across services.
- External factors, such as the commissioning environment, which resulted in some Progression Together services losing their contract mid-evaluation.
- Measuring the outcomes and impact of the model for those individuals who are less engaged or whose mental health problem impedes their ability to demonstrate increased independence or incidences of self-directed support.

1. **Progression Together approach**
   We recommend that Together continues to learn from the development of this approach to determine which 'core' and 'flexi' elements are integral to the model and whether it is appropriate for all of the clients they support. There is a need to embed other elements of personalisation into the model, since not all residents are fond of using recovery vouchers. In addition, Together would benefit from co-producing these elements alongside their service users to determine what is useful or meaningful to them in their progression.

2. **Dissemination of the Progression Together model**
   We recommend increased training and communication of the Progression Together model and its use among staff, particularly those working frontline in supporting clients in order to ensure consistency in the implementation of the model.

3. **Cost–benefit analysis (CBA)**
   We recommend that further investment in research is needed to incorporate measures that allow for CBA. Further investment is also needed to quantify the wider savings to other services, such as the criminal justice system.

4. **Development of an evaluation approach**
   We recommend that Together develops future evaluation approaches of the model to understand the following: i) the longer term operation in order to further measure progress beyond Stage 3 of the model after a client has moved on into the community; and ii) the number of clients who return to their services.

1. Introduction

1.1 Background

The Mental Health Foundation was commissioned by Together to undertake an independent evaluation of their model, Progression Together. This is the final report on a three-year evaluation that aims to establish Progression Together as an effective model of personalised residential care for people with complex needs, including those with forensic histories. The model provides a pathway from hospitals/secure settings to independent accommodation within the local community, using a personalised approach, which gives individuals control over the mental health support they receive. This self-directed support is designed to help individuals eventually transition into independent living in the community.

The outcomes related to this project include mental health and wellbeing, progress towards achievement of personal goals, independent living, and reintegration into society. The evaluation tracks residents' journeys throughout the course of their residency and beyond (if they have moved on to independent living in the community).

1.2 Funding context

Health and social care services are under increasing scrutiny. The primary focus of this scrutiny has historically been around inspections for compliance and quality, but current economic circumstances and new models of both commissioning and delivery are starting to give greater emphasis to service outcomes and value for money. Funding models for health and social care in mental health have not, however, been developed with this in mind: payment by results has not been applied to mental health as it has to other health areas. Most funding for mental health services is still focused on activity or given as a block fund rather than focusing on outcomes, but work is currently underway to try to establish adequate ways to fund both effective services and promising innovations.

In general, the funding climate for Together's services can be described in the following way. Some contracts have block funding, which means that Together is paid a lump sum to provide a service against a specification. These are generally the older contracts and most are being renegotiated to other types of contracts at present. Some Together services are funded on the basis of the number of hours delivered, or by the number of people supported. A small number of services is spot funded – that is, bought on an individual basis as required by the commissioner/purchaser.

Additionally, some services are funded by individuals through direct payments or personal budgets, and some places are self-funded, though these are few.

Together has developed progressive approaches to delivering mental health services and has led the way in developing personalised residential support services where they have taken on new contracts, as is the case for Progression Together services. These new models provide opportunities for progression and development and start to challenge previously rigid boundaries between staff and service users. This is not unique to Together, but peer-support roles in the NHS have not been established long enough for there to be a reliable cost evaluation of the statutory approach to peer support, and it is therefore not possible to make direct cost comparisons between the peer support provided by Together and that provided by the NHS. In Together's services, service users have the option to choose to work with someone with similar experiences to them, and who shares their experiences and learning with them, in order to support their progress to move on in a way that a member of staff may not be able to do.

1.3 Overview of Progression Together

Progression Together is an innovative, personalised residential service for individuals with complex needs, including those with forensic backgrounds. The service aims to provide a clear path of progression from 24-hour residential support to independent living in the community. This is accomplished through the use of self-directed support, which enables individuals to have more choice and control over the type of support they receive in their recovery. The model consists of both 'core' and 'flexi' elements, which include peer support, psychological therapies, and a recovery voucher system whereby individuals use vouchers to plan and book specific activities or time with staff to meet goals within their recovery plans. This approach aims to prepare individuals to progress towards their personal goals, use personal budgets, and ultimately move on to independent living.

The model unfolds in three stages over a two-and-a-half-year timeframe. Stage 1 (between 0 and 12–18 months) is an intensive phase of recovery and support within a residential care environment. Initially, the majority of support is delivered in house and, over time, the staff gradually supports individuals to engage with community-based services. Stage 2 (between 6 and 12 months) helps individuals to prepare for independence, which includes identifying suitable move-on accommodation and targeted work towards addressing the needs, fears, risks and goals associated with moving. Stage 3 is support provided to

individuals once they have moved on to independent living. Support is provided up to six weeks post-move; however, there is flexibility to provide longer term support if needed.

1.4 Evaluation aims and objectives

The evaluation aims to assess whether Progression Together is an effective model of local step-down provision of mental health support for people with complex needs to move on from hospitals and secure settings into the community.

The main outcomes of this evaluation are:

- Improvements in mental wellbeing and functional living skills.
- Engagement in the local community.
- Increased incidence of self-directed support.
- Achievement of self-directed goals.
- Increased independence and move-on rates.
- Improved cost efficiency and productivity of Progression Together services compared to traditional statutory residential service approaches.

2. Method

The evaluation adopted a mixed-method approach to collect both quantitative and qualitative data. To assess the impact of Progression Together on the outcomes listed above, data were collected using a longitudinal approach to assess the impact of Progression Together on improved mental health and wellbeing, progress with personal goals, progress into independent living, and reintegration into society through engagement in activity in the community. Data were collected at three time points: baseline (T1), nine-month follow-up (T2) and 18-month follow-up (T3).

Participants were asked to complete a questionnaire at T1, which involved describing basic demographic information about themselves (i.e. age, sex, ethnicity, etc.). The form was designed by the evaluation team in order to understand the characteristics of the sample involved in the evaluation (see Appendix 1). Both quantitative and qualitative data in the form of questionnaires and in-depth interviews were collected at T1, T2 and T3.

A cost-comparison analysis was carried out in Year 3 of the evaluation and used a cost-comparison methodology with two of the five evaluation sites. Desktop searches and liaison with the service managers and accountants were used for data collection. Alternative service provision was identified based on an expert opinion consultation. The cost-comparison analysis covered the periods of 2013/2014 and 2014/2015, as this coincided with the years of the overall evaluation. Comparative data was unavailable from the Personal Social Services Research Unit (PSSRU) for 2015/2016.

2.1 Setting

Five sites were used as part of the evaluation, selected from an original total of nine sites that were using the Progression Together model. Two sites were removed from the evaluation during the evaluation period, as these were deemed unsuitable for evaluating the model due to the high percentage of long-term clients and service-changing processes. Of the sites that participated in the evaluation, Kelvin Grove is the longest running Progression Together service – having transformed in 2009 – followed by York Road, which transformed in 2012. The remaining sites, Cliddesden Road, Kirtling House and Snowdon, all transformed to the Progression Together model in 2013.

2.2 Design

The evaluation aimed to recruit 60 people across Together's Progression Together services. Residents were provided with an information sheet describing what their participation would entail, and consent forms were collected by the Progression Together Development Manager. A total of 65 Progression Together residents consented to take part in the evaluation. Of these, eight were residents at a

site that subsequently lost its delivery contract; five were deemed unsuitable for the evaluation due to the severity of their symptoms or their length of service use; five declined to participate at the point of data collection; and one had already moved out of the service at the point of baseline data collection.

Thus, while there was a good level of interest in the evaluation, overall recruitment was slower than expected. The baseline data collection period was also extended to accommodate issues relating to the retendering processes or staff changes. The original recruitment target was revised to 45 participants following a review of the Year 1 data collection. Of the nine services that were originally involved in the evaluation, only five remained suitable in Year 3 and were able to be included in the evaluation.

This report examines the experiences of 36 people using Progression Together services across five sites, as seen in Table 1.

2.3 Measures

Wellbeing was originally assessed using the **Warwick-Edinburgh Mental Wellbeing Scale** (WEMWBS).[1] WEMWBS is a 14-item scale of mental wellbeing covering subjective wellbeing and psychological functioning, in which all items are worded positively and address aspects of positive mental health. The scale is scored by taking the summation of all item responses, which are scored

Table 1. Evaluation sites and numbers of participants

Name of service	Numbers of evaluation participants	Numbers of participants who completed T1	Numbers of participants who have been followed up at T1 and T2	Numbers of participants who have been followed up at T1, T2 and T3
Cliddesden Road	7	7	5	1
Kelvin Grove	10	10	8	6
Kirtling House	6	7	4	3
Snowdon	3	3	2	1
York Road	10	10	8	7
TOTAL	**36***	**37**	**27**	**18**

*One participant withdrew from the evaluation at T2

1. Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S. & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. Health and Quality of Life Outcomes, 5 (1), 63.

on a five-point Likert scale. The minimum score is 14 and the maximum is 70, with higher scores corresponding to higher mental wellbeing (see Appendix 1).

During the data collection phase, the evaluation team perceived the questionnaire as being too long for some participants, and others had difficulty in understanding some of the items; thus, the questionnaire was substituted for the **Short Warwick-Edinburgh Mental Wellbeing Scale** (SWEMWBS).[2] This is a shorter version of the WEMWBS and uses only seven of the 14 statements. The minimum score is 7 and the maximum is 35. Similar to the WEMWBS, higher scores correspond to higher mental wellbeing (see Appendix 1).

Functional living skills were assessed using the **Health-Promoting Lifestyle Profile II** (HPLP II).[3] This is a 54-item scale answered using a four-point Likert scale, comprising six subscales (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management). The overall score (health-promoting lifestyle) is the mean of all the answers, and the six subscale scores are the mean of the responses to each subscale's items. The minimum score is 1 and the maximum is 4, with higher scores corresponding to a greater health-promoting lifestyle (see Appendix 2).

Progress in goal achievement was assessed using the **Goal Attainment Scaling** (GAS).[4] At baseline (T1), participants were asked to identify three goals to work towards in the following nine-month period. They were then asked to rate these goals in terms of their perceived importance ('not at all', 'a little', 'moderately', or 'very') and difficulty ('not at all', 'a little', 'moderately', or 'very'). These goals were then revisited at T2 (nine months) to assess whether or not the goals had been achieved, and to find out to what degree. Identifying goals was repeated again at T2 before measuring a final rating of goal attainment at T3 (18 months) (see Appendix 3).

2.4 Procedure

Quantitative data were collected in the form of questionnaires administered at T1, T2 and T3. Qualitative data were collected through face-to-face interviews with participants at T2 and T3 follow-ups. A staff consultation was added in the final evaluation year in order to understand how the model was operating. Details on the methodology and procedure for the staff consultation can be found under the findings of the staff consultation section later on in this report.

For the methodology of the cost-comparison analysis, please refer to the findings of the cost analysis further on in this report.

2. Stewart-Brown, S., Tennant, A., Tennant, R., Platt, S., Parkinson, J. & Weich, S. (2009). Internal Construct Validity of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS): A Rasch analysis using data from the Scottish Health Education Population Survey. Health and Quality of Life Outcomes, 7(15).
3. Walker, S. N., Sechrist, K. R. & Pender, N. J. (1987). The Health-Promoting Lifestyle Profile: Development and psychometric characteristics. Nursing Research, 36(2), 76-81.
4. Turner-Stokes, L. (2009). Goal Attainment Scaling (GAS) in Rehabilitation: A practical guide. Clinical Rehabilitation, 23(4), 362-370.

2.5 Site profiles

Table 2 provides details of the evaluation site characteristics. It includes a summary of the provision of support offered, the availability of peer support, the use of the recovery voucher system, the staffing structure, the occupancy, and the funding method as of September 2015.

Service	Summary of current provision	Peer support	Use of recovery voucher system	Funding method	Staffing structure	Occupancy
Cliddesden Road	Opened in 1996. Transformed into a Progression Together service in 2013. Works with people with complex mental health needs, including personality disorders, dual diagnosis, and people from forensic backgrounds. Support planning includes Recovery Star.[5] Offers support with mental health and crisis management, medication, daily living skills, and budgeting. Group work is conducted on areas such as Food and Mood, Aromatherapy, and Anxiety Management.	X	X	Block funded by 5 Hampshire Clinical Commissioning Groups (CCGs).	1 FT Project Manager; 1 FT Senior Recovery Worker; 4.6 Recovery Workers; In-house Psychologist and Occupational Therapist; 1 Peer Support Coordinator.	7 beds (mixed male/female, 18+).
Kelvin Grove	Opened in 1990. Transformed into a Progression Together service in 2009. Works with people with complex mental health needs, dual diagnosis, learning disability, and forensic backgrounds. Service demonstrates a lot of throughput	No peer support at present.	Recovery vouchers were introduced but not successfully embedded.	Block contract and partly spot purchased. Jointly funded by the local authority and the CCG.	1 Project Manager; 2 FT Senior Social Care Workers; 4 FT and 1 PT Social Care Worker;	12 beds (mixed male/female, 18+).

	and supports individuals to move on within 3 months to 2 years of stay. Uses Recovery Star, Stay Well Plan 3, and 3 Hardest Things.[6] Offers support with mental health management, medication, daily living skills, support to reach aspirations – including employment – and equips people with skills to move to independent living and sustain community tenancies.				1 Activities Coordinator.	
Kirtling House	Opened in 1996. Transformed into a Progression Together service in 2013. Works with people with complex mental health needs, personality disorders, and forensic backgrounds. Uses Recovery Star. Offers support with mental health and crisis management, medication, daily living skills, and budgeting. Group work on areas including cooking skills, relaxation, and anxiety management.	No peer support at present.	Recovery vouchers were introduced but not successfully embedded.	Block funded by the North East Hampshire and Farnham CCG.	1 Project Manager; 1 Senior Recovery Worker; 4 Recovery Workers.	7 beds and 1 crisis bed (mixed male/ female18+).
York Road	Opened in 1955. Transformed into a Progression Together service in 2012. High support service working with clients from secure hospitals/ forensic services. Takes referrals from all over England. Uses Recovery Star.	No peer support currently.	Recovery vouchers were introduced but not successfully embedded.	Spot purchased.	1 Project Manager; 1 Deputy Project Manager; 9 Support Workers.	14 beds (male only, 18+).

5. A tool for people using services to enable them to measure their own recovery progress usually completed with the help of mental health workers or others. The 's ten areas covering the main aspects of people's lives, including living skills, relationships, work, identity and self-esteem.
6. A tool used with people with low motivation and engagement levels. It supports individuals to identify the three things they find the hardest to complete and breaks these down into more manageable steps.

Figure 1 illustrates the distribution of the evaluation sample according to the service. Almost one third of the sample (n=10/36) was engaged with services at York Road and Kelvin Grove, each accounting for 28% of the sample (n=10). Kirtling House accounted for 17% of the sample (n=6), and Cliddesden Road accounted for 20% (n=7) of the sample. The Snowdon site accounted for the smallest sample, with 8% (n=3) of the total number of participants.

Figure 2 displays the level of completion of data collection across T1, T2 and T3. Of this sample, a total of 36 participants took part in the evaluation at baseline. During follow-up, 75% of the sample (n=27) completed the evaluation at T2, and 50% completed it at T3 (n=18).

2.6 Participant characteristics

Of the 36 participants that took part in the evaluation, 83.3% (n=30) were male and 16.7% (n=6) were female. The mean age of participants was 39 (SD=10.13), with the youngest participant aged 19 years and the oldest aged 59 years. The majority of the participants reported their ethnicity as British (72.2%, n=23). The majority of the sample did not have children, with only 30.6% (n=10) reporting having children.

Just over 30% of participants (31.4%, n=11) reported having a disability, with disabilities reported to include learning difficulties and hearing and vision impairments. The majority of the participants reported that they were unemployed (90.6%, n=29), and few were involved in volunteering (9.4%, n=3) at T1.

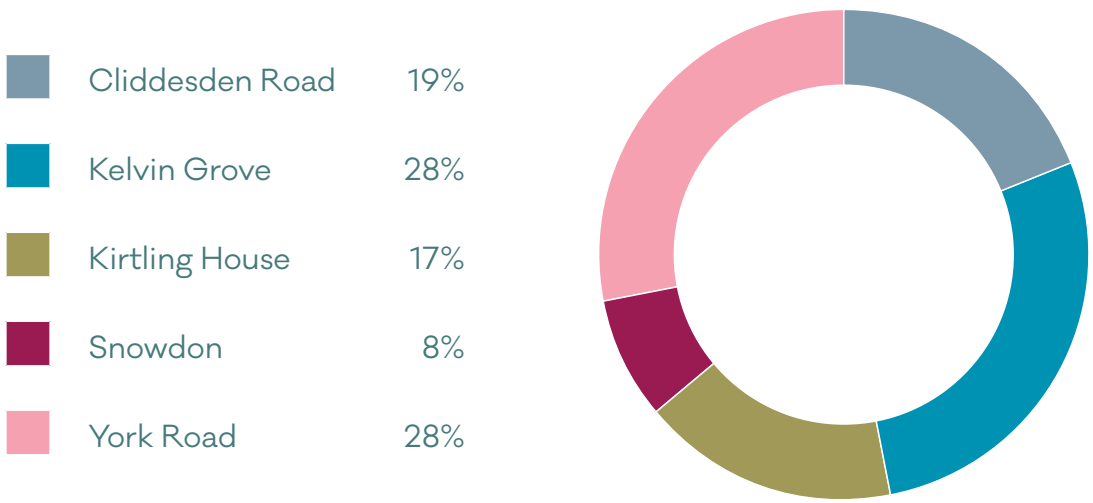


Figure 1. Breakdown of sample according to site of service attended

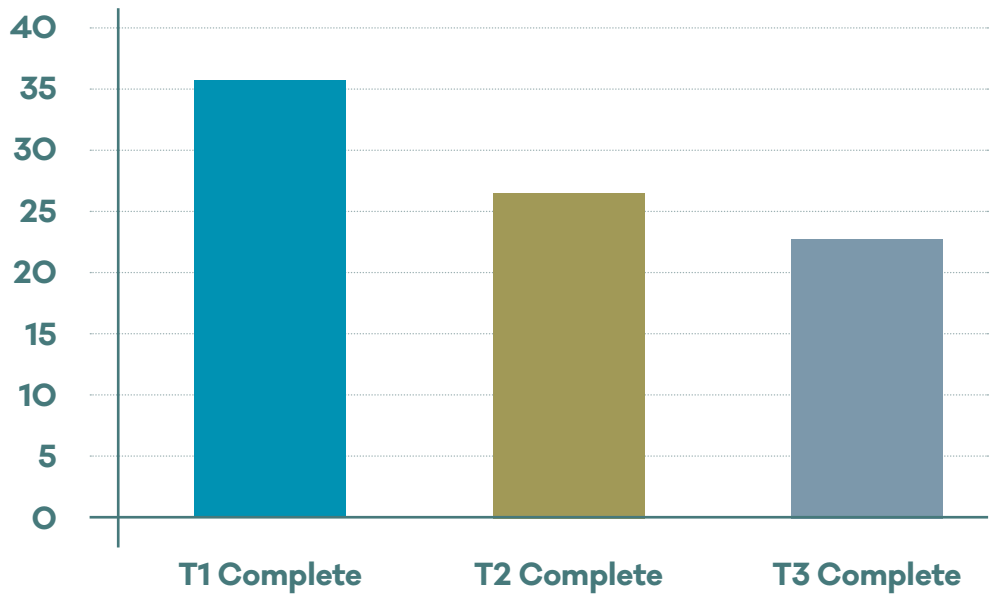


Figure 2. Participant follow-up completion rates

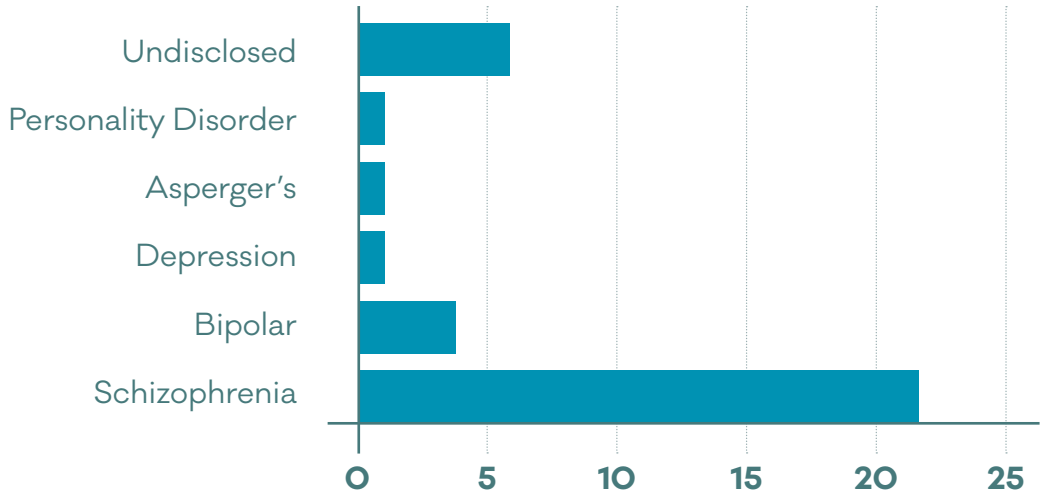
The majority (75%, n=27) of the sample reported having either 'good' or 'quite good' reading and writing skills, and 25% (n=9) reported having 'poor' reading and writing skills.

Diagnosis

Figure 3 provides an overview of the primary diagnoses that were reported by participants. The most frequently reported primary diagnosis was cited as schizophrenia (62.9%, n=21). Bipolar disorder was cited as a primary diagnosis by 11.4% (n=4) of the sample. Depression, Asperger's syndrome and personality disorder were each cited by 2.9% of the sample (n=1) as a primary diagnosis. Six participants (17.1%) did not disclose a primary diagnosis. Almost a third of participants (27.3%, n=11) reported having a comorbid diagnosis.

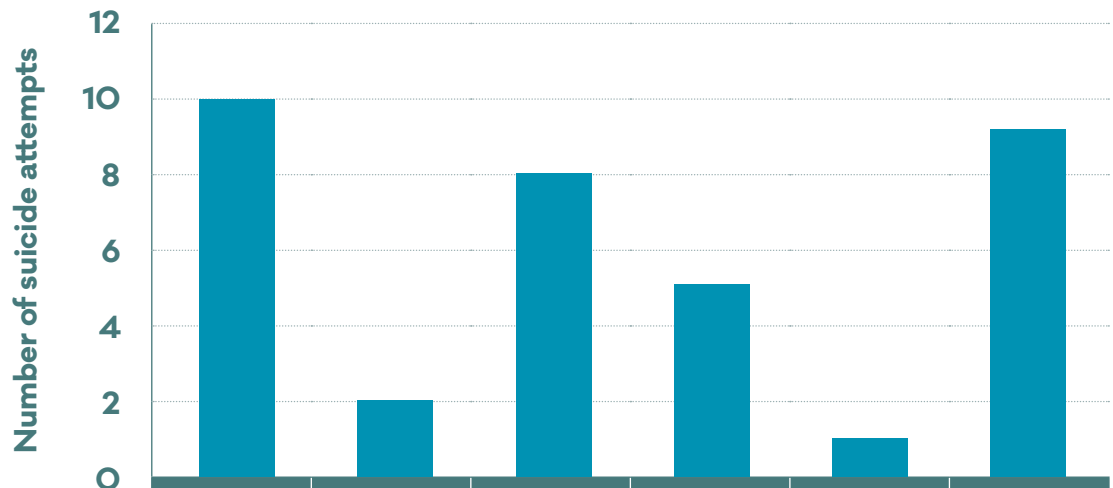
In addition to their diagnosis, 82.5% (n=28) reported having episodes of depression. Episodes of depression were reported as ongoing by 17.6% (n=6) of the sample, with a further 6.3% (n=2) reporting having experienced 10 or more episodes of depression. A high proportion of participants did not report how frequently these episodes occurred (35.3%, n=12).

Just over 40% of the sample (41.9%, n=13) reported having experienced episodes of mania, with 3% (n=1) reporting these episodes as ongoing and 6.1% (n=2) having experienced 10 or more episodes of mania. 15% of the sample (n=5) did not report the frequency of their experience.



	Schizophrenia	Bipolar	Depression	Asperger's	Personality Disorder	Undisclosed
Series 1	22	4	1	1	1	6

Figure 3. Participants by primary diagnosis



	None	One	Between two and five	More than five	Over 100	Missing
Series 1	10	2	8	5	1	9

Figure 4. Number of suicide attempts

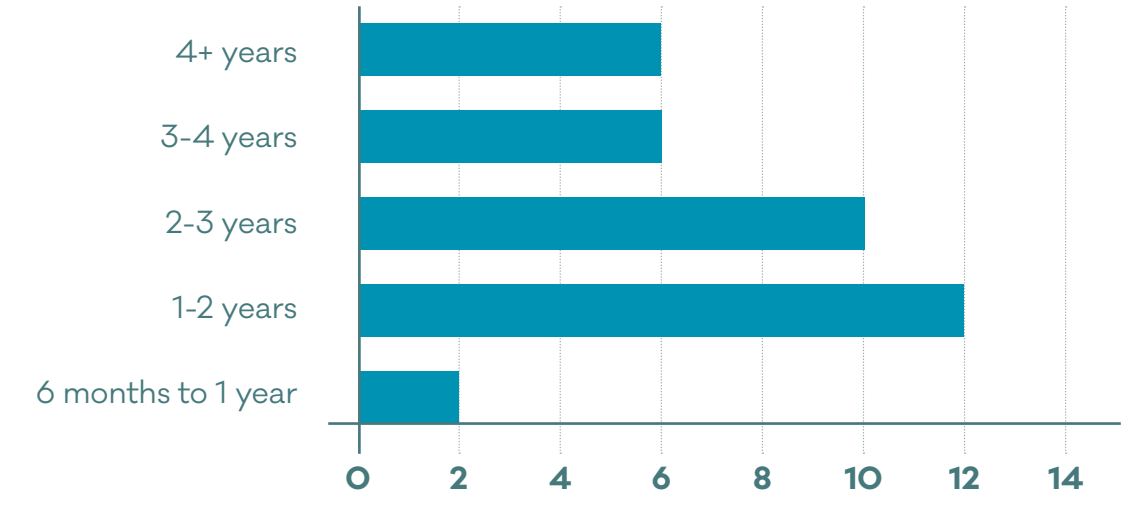
The majority of the sample (73.5%, n=25) reported that they had experienced episodes of psychosis. Of the sample, 17.6% (n=6) reported episodes of psychosis as an ongoing issue for them, with a further 2.9% (n=1) reporting having experienced over 10 episodes of psychosis. 15% of the sample (n=5) did not report the frequency of their psychotic episodes. All participants within the sample (n=36) reported taking medication for their diagnoses.

Over half of the sample (52.9%, n=18) reported that they had a family member, or members, who had a suspected or diagnosed mental illness. Multiple family members suspected or diagnosed with a mental illness was the most common response reported by participants (16.7%, n=6).

Over half of the sample reported having attempted suicide (59.4%, n=19). Figure 4 displays the number of suicide attempts reported by participants within the sample. Of the sample, 5.6% (n=2) reported having attempted suicide once, while almost a quarter of the sample reported having attempted suicide more than five times (16.7%, n=6). One participant reported having attempted suicide more than 1,000 times.

Service use

At the time of data collection, the majority of the participants (61.1%, n=22) had been residents within the service for between one and three years. Few participants (5.6%, n=2) had been residents for less than a year, with 16.6% of the sample (n=6) having been residents within services for over four



	6 months to 1 year	1-2 years	2-3 years	3-4 years	4+ years
Series 1	2	12	10	6	6

Figure 5. Length of residence in the Progression Together service

years. Figure 5 provides a summary of participants' length of residence within services, broken down by year.

Just over a quarter (27.8%, n=10) of these participants had been admitted into the service before it was transformed into a Progression Together service.

At follow-up, just under half of the sample had been fully discharged from the service into independent living or supported accommodation (41.7%, n=15). Of those participants who had been discharged from services, the length of time spent within the service ranged from eight months to 60 months (five years). Across all five services, the average length of stay before discharge was 30 months (two-and-a-half years). A full breakdown of discharge rates according to service is outlined in Appendix 5.

Two participants (5.6%) were in the process of being discharged, and were waiting for accommodation to become available. The remaining 19 participants (52.8%) had not been discharged, with one of these participants (2.8%) having been hospitalised during the course of the evaluation.[7] A breakdown of discharge rates by service entry date is outlined in Table 3 below.

Whether participants were residents before the service transformation had no significant impact on the discharge rates ($p>0.05$).[8]

Table 3. Discharge rates of participants who entered services pre- and post-service transformation

Resident before service transformed into a Progression Together service	Discharge rates		
Yes	**Discharged**	n=4	40%
	Not discharged	n=6	60%
No	**Discharged**	n=13	50%
	Not discharged	n=13	50%

7. No difference in discharge rates based on length of residence.
8. Note in discussion: many services were using some elements of the model and its therapeutic style pre-transformation; therefore, these participants may have received the benefits of the model before transformation.

Support services used

Participants were asked about the perceived levels of support they received from the service psychiatrist, community practice nurse (CPN) and social worker, with Figures 6, 7 and 8 displaying the level of support perceived by participants from these services respectively.

Over half of the sample was regularly being supported by a psychiatrist (53.1%, n=17), with just over a third having contact with a psychiatrist when needed (33.6%, n=11). Of the sample, 13.3% (n=4) reported that they never received support from a psychiatrist or had never been offered this level of support.

Almost three quarters of the participants reported that they had received support from a CPN regularly (61.9%, n=13), or when they needed this level of support (14.3%, n=3), while 23.8% (n=5) of the participants reported that they never used this form of support or had never been offered it.

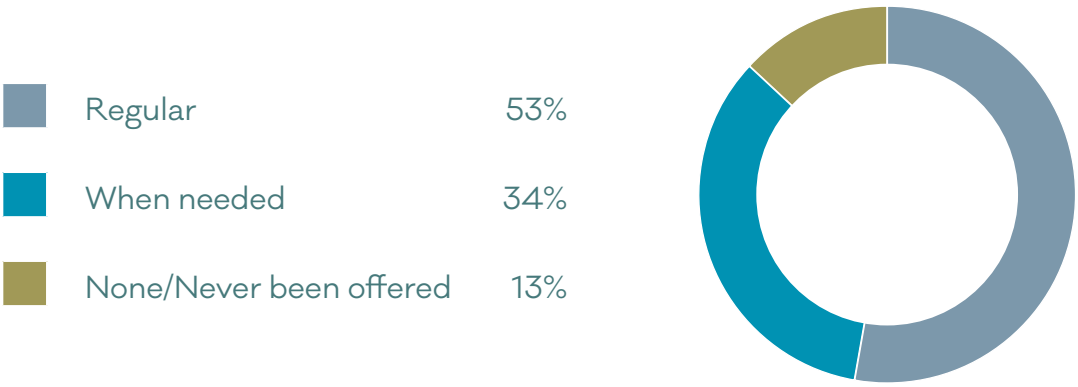


Figure 6. Level of perceived support from the psychiatrist

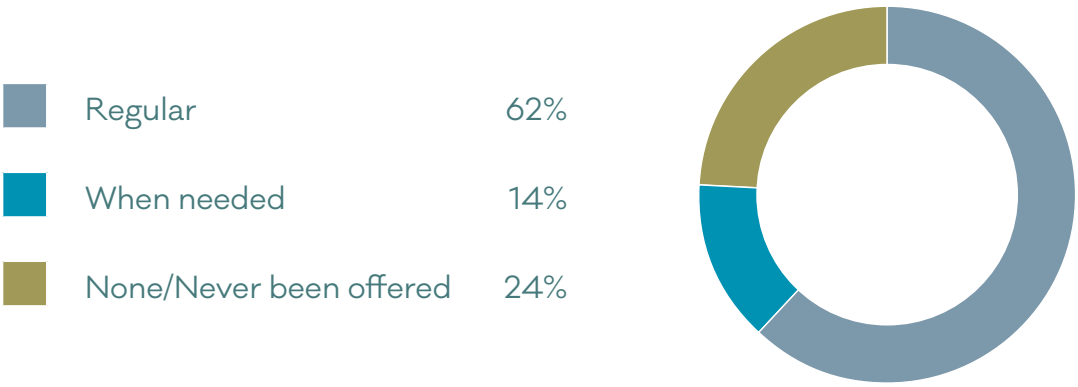


Figure 7. Level of perceived support from the CPN

The majority of participants reported having regular support from a social worker (36%, n=9), or having support from the social worker when necessary or required (28%, n=7), while a high proportion of participants noted that they never used or were not offered this type of support (36%, n=9).

Parents were the most common sources of social support for participants (66.7%, n=24), followed by friends (65.6%, n=21). Of those participants with children, 60% (n=18) cited their children as a source of support, 57.7% (n=15) cited their peers as support, and 50% (n=17) referred to other sources as support.

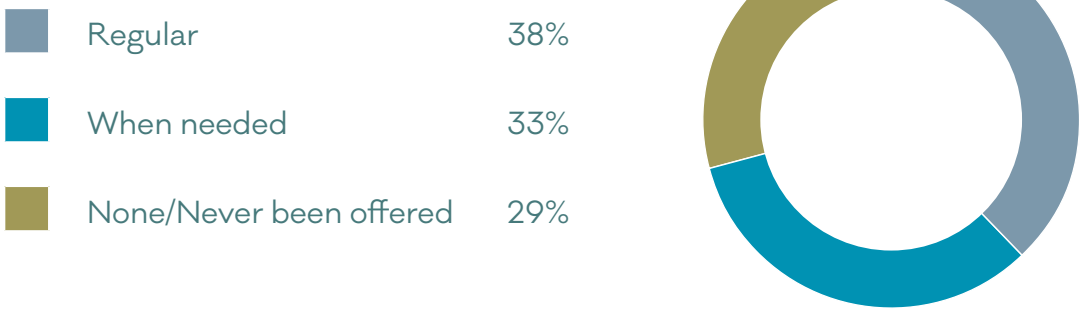


Figure 8. Level of perceived support from the social worker

2.7 Data analysis

Quantitative data analysis

Hard-copy questionnaire data were input by a member of the evaluation team. Participants' personal details were anonymised and each participant was provided with a unique ID code linked to all responses on the questionnaires.

Quantitative data were stored and analysed using Statistical Package for Social Sciences (SPSS) for Windows. The primary outcomes were wellbeing (measured by WEMWBS), lifestyle activities (measured by HPLP II) and goal attainment (measured by GAS). Trends and descriptive statistics for demographic and characteristic analyses were conducted using the SPSS frequencies and crosstabs analysis functions.

Missing item data were coded within the dataset as '99' to ensure that these items would not skew the results. Where participants missed a single item on a questionnaire, mean scores were computed to allow valid overall scores to be calculated. However, where a participant had missed three or more item responses, all scores for that measure were scored as missing.

When statistical analyses were conducted, 'exclude cases listwise' was selected to ensure that the results were not skewed by missing data.

Due to the small sample size and violation of statistical assumptions, the non-parametric Mann–Whitney U and Kruskal–Wallis tests were used for testing the differences between groups (i.e. pre-transformation and post-transformation of a service). Non-parametric Wilcoxon matched pairs signed-rank tests were used on wellbeing data and lifestyle data to ascertain the significance of changes in wellbeing and lifestyle outcomes.

Qualitative data analysis

Qualitative data were analysed thematically and in relation to aspects of the Progression Together model across its three stages. Themes were noted as they arose from the data and corresponded to aspects of the model. This was unsurprising, as the interview schedules (T1, T2 and T3) had been designed to capture these important aspects (see Appendix 6). Interview transcripts were coded in accordance with the Progression Together model framework. The framework was subsequently refined with similar themes grouped together, and sub-themes were created.

3. Findings

3.1 Quantitative data

3.1.1 Wellbeing

For the entire sample (n=36), mental wellbeing scores ranged from a low of 17 to a high of 30, with an average mean score of 22.9 (SE=0.740). These scores increased at T2 (n=27) to a mean score of 26.67 (SE=0.872), with a score range from 21 to 35. Wellbeing scores continued to increase at T3 (n=18) to 27.17 (SE=1.011). The progressive increases in wellbeing scores can be seen in Figure 9.

Using a Wilcoxon ranks test, the differences between wellbeing scores at data collection time points were explored. The results show that the mean mental wellbeing scores increased significantly between T1 and T2, from 23.89 to 26.37 ($Z=-3.189$, $p<0.001$) respectively. This increase in wellbeing was sustained and even increased significantly at T3 (M=27.17) compared to T1 scores ($Z=-2.869$, $p<0.01$). While the mean wellbeing scores rose from T2 to T3 (26.67 to 27.17 respectively), this was not a significant increase ($Z=-0.762$, $p=0.446$).

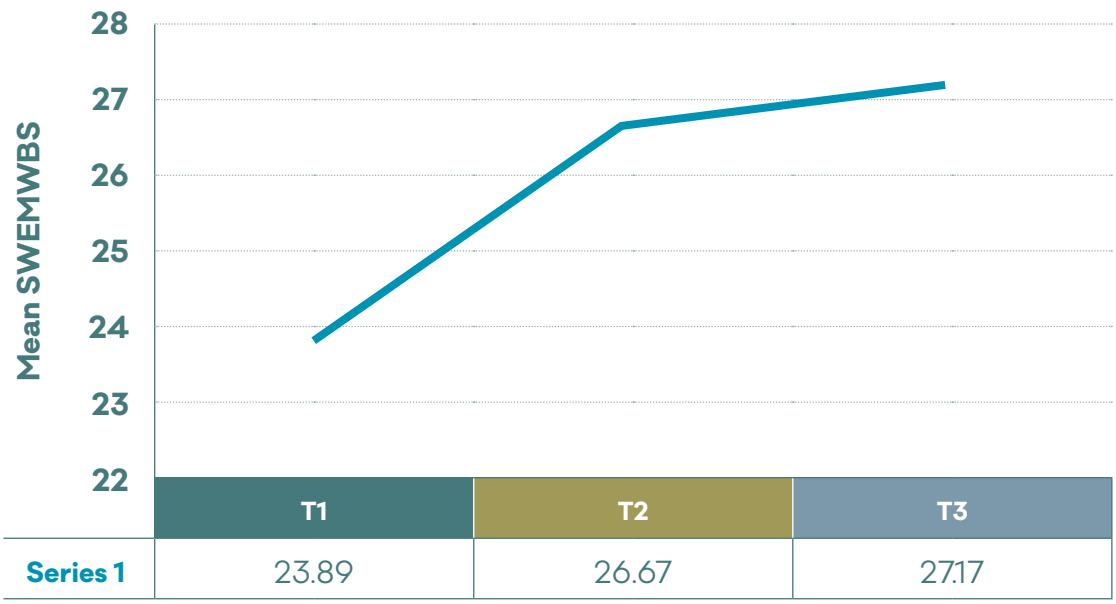
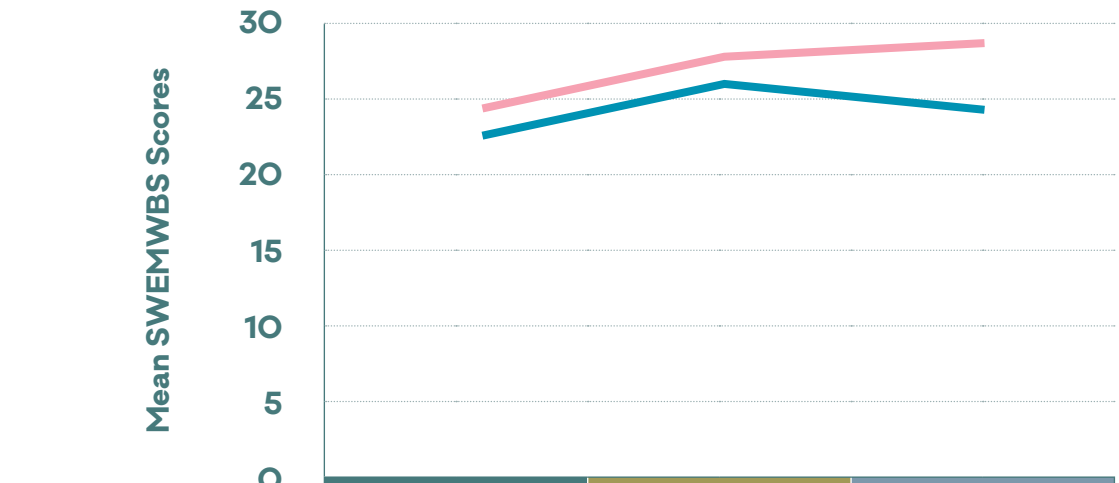


Figure 9. Mean wellbeing scores across T1, T2 and T3



	T1	T2	T3
Pre-transformation	22.51	25.17	24.67
Post-transformation	24.15	27.42	28.42

Figure 10. Mean wellbeing scores across T1, T2 and T3 according to service entry point

This difference in wellbeing scores was re-examined to explore whether admission pre-or post-implementation of the Progression Together model had an impact, with the analysis re-examining scores across T1, T2 and T3 according to the service entry point as displayed in Figure 10. Participants admitted post-transformation to a Progression Together service followed the overall trend of mental wellbeing scores – that is, increased wellbeing scores maintained at T3. In contrast, those admitted to a service pre-transformation had slightly lower mental wellbeing scores for all three time points, and appear to have had a slight decrease in mean mental wellbeing scores at T3. Those who were in the service post-transformation were found to have a significant increase in wellbeing scores ($Z=-2.496$, $p<0.05$). In contrast, for those who were in services pre-transformation there was no significant increase in wellbeing scores from T1 to T2 or T3 ($p=0.141$). However, caution should be exercised when interpreting these results, as this may be due to small sample sizes and therefore warrants further attention within future work.

Findings from the Kruskal–Wallis test showed results nearing significance between mental wellbeing scores for those who had been discharged from

services and those who had not been discharged (p=0.073), with those who had been discharged from services having significantly higher overall mental wellbeing scores (M=31.00, SE=1.673) than those who had not been discharged (M=26.00, SD=1.128). The lack of significance may be a result of the small sample size, and further attention within future work is needed.

3.1.2 Lifestyle

As outlined in Figure 11, the overall health-promoting lifestyle scores followed the same pattern as the mental wellbeing scores, with the mean scores increasing significantly from T1 (n=31, M=2.53, SD=0.38) and T2 follow-up (n=27, M=2.77, SD=0.34): Z=-2.731, p<0.05. This increase was sustained at T3 (n=17, M=2.79, SD=0.43), though it was not significantly higher than the T1 or T2 scores (p>0.05).

The Wilcoxon signed ranks test results showed that the mean difference between T1 and T3 was approaching significance (p=0.078); this may be partially explained by the loss in sample size between T1 and T3 follow-up.

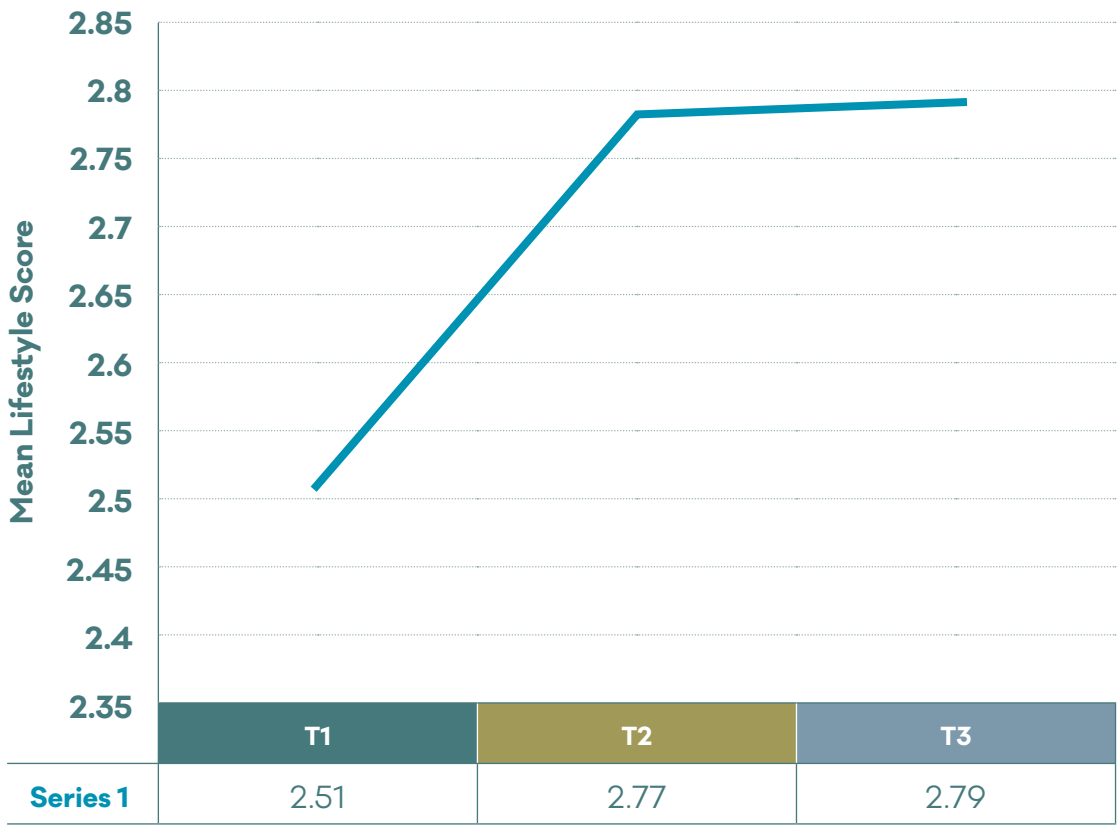


Figure 11. Lifestyle scores across T1, T2 and T3

Table 4: Health-promoting subscale scores across T1, T2 and T3

	T1	T2	T3
General health	2.4	2.7	2.6
Exercise	2.4	2.7	2.7
Food	2.2	2.4	2.5
Social life	2.7	2.9	2.9
Dealing with health professionals	2.7	2.9	2.9
Finding meaning	2.7	2.9	3.0

Each of the six subscales were examined, and the results showed that, for all six subscales, the mean scores were found to have increased between T1 and T2, and were found to have remained around the same level or increased further at T3. A breakdown of health-promoting subscales across T1, T2 and T3 is displayed in Table 4.

Analysis of the subscale scores found a significant increase in general health scores from T1 to T2 ($Z=-2.845$, $p<0.05$), and nearing significance for T1 and T3 scores ($p=0.08$). This trend was the same for social life scores between T1 and T2 ($Z=-1.964$, $p<0.05$), with T1 and T3 scores nearing significance ($p=0.066$). The low sample size and considerable drop in participant numbers at T3 may help to explain why the scores for T3 comparisons only near significance. No significant differences were found between the scores for the subscales of exercise, food, dealing with health professionals or finding meaning.

On examining the differences between groups, significant differences were found in HPLP II scores and subscale scores between those participants who had been discharged and those who had not been discharged. As one would expect, those who had been discharged had significantly higher scores for the exercise, food, social life and dealing with health professionals subscales ($p<0.05$).

Overall, the health-promoting lifestyle scores were found to be significantly higher in those who had been discharged from services ($n=5$, $M=3.59$, $SD=0.238$) than those who had not ($n=10$, $M=3.16$, $SD=0.299$). This increase in health-promoting lifestyle skills provides evidence that those leaving the model are more positively equipped for independent or supported living within the community.

3.1.3 Employment, volunteering and education

Within the sample (n=18), engagement with employment, education and volunteering was recorded in order to see whether participants were more engaged in these factors of life as they progressed through the model. Results within this section are based on the overall sample that completed all three time points. An overview of the changing levels of engagement in employment, volunteering and education has been provided in Figure 12.

The results show that, at baseline (T1), three participants were engaged with employment (16.7%). These figures were found to reduce, with no participants reporting being in employment at T2 follow-up. Figures at T3 returned to two participants being in employment (11.1%). These changes in employment status did not show significant differences between T1, T2 or T3 ($p>0.05$).

Levels of engagement with volunteering activities were found to remain consistent across the three data collection time points, with no significant changes being found between T1 (11.1%, n=3), T2 (16.7%, n=3) and T3 (22.2%, n=4). Three participants (16.7%) indicated at T2 that they would like to engage with volunteering; however, this did not

Figure 12. Engagement in employment, volunteering and education at T1, T2 and T3

translate into a significant increase in volunteering activity at T3.

At T2, education and/or training levels showed that only 11.1% (n=3) of participants in the sample were engaged with these activities; however, a further 7.4% (n=2) indicated that they would like to engage with education or training but were unable to do so due to costs or other difficulties. At T3, there was found to be a significant increase in levels of engagement with education and/or training, increasing to 44.4% (n=8): Z=-2.000, p<0.05.

3.1.4 Goal attainment

Goal setting and attainment

Participants' goals can be broadly categorised into seven overarching themes:

- Physical health and wellbeing.
- Mental health and wellbeing.
- Social support, family and community.
- Creative interests and hobbies.
- Employment, education and volunteering.
- Housing, legal and budgeting.
- Life skills and personal development.

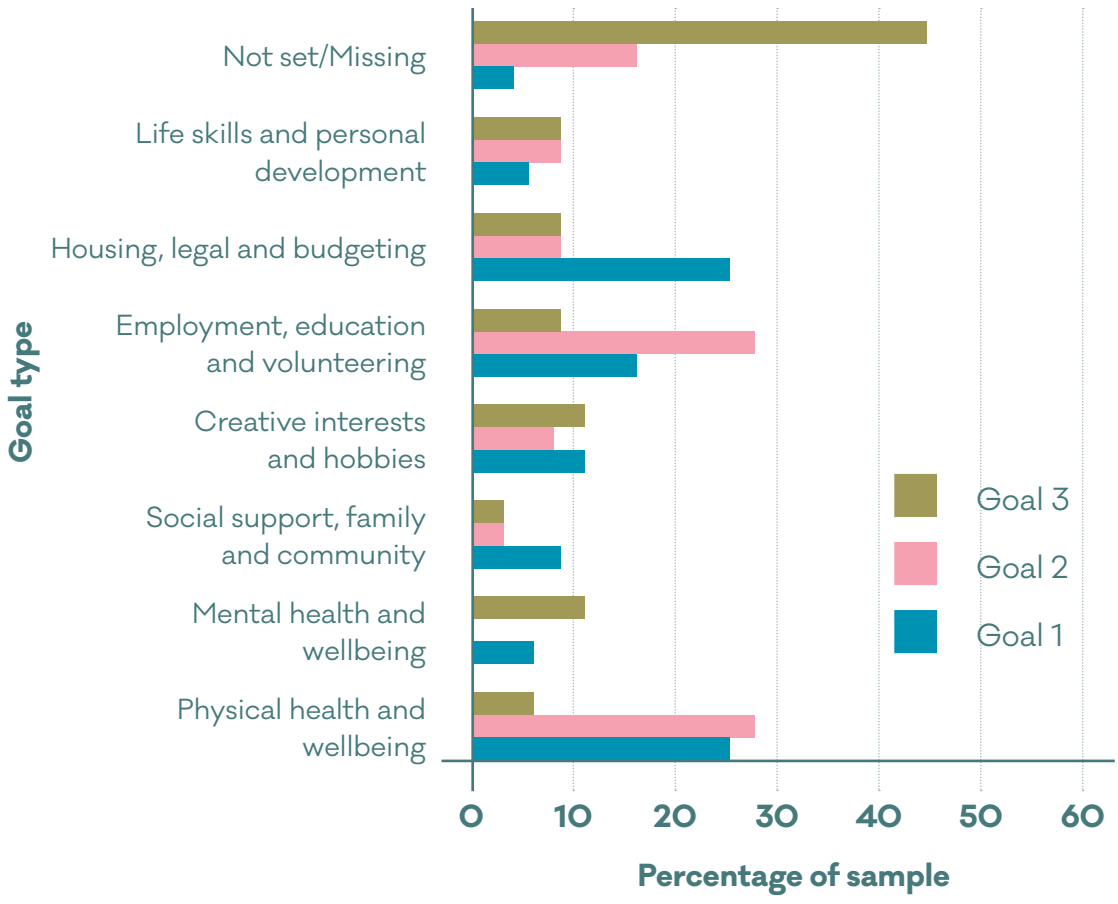


Figure 13. T1 goals by type

Goal setting at T1

Common goal types selected by participants at T1 have been outlined in Figure 13. The most common goals identified by participants at T1 were physical health and wellbeing goals, such as to lose weight and exercise more. A quarter of participants (25%, n=6) set this type of goal for Goals 1 and 2 at T1.

Goal 1

The most common goals identified by participants at T1 were physical health and wellbeing, and housing, legal and budgeting goals, with 25% (n=9) of the sample each setting these types of goals for Goal 1.

Of those who set a Goal 1 (n=25), 96% (n=24) reported that they felt this to be 'very' or 'moderately' important, while only 4% (n=1) reported that the goal was only 'a little' important or 'not at all' important. The majority of the sample (72%, n=18) perceived that achieving the goal would be 'very' or 'moderately' difficult, while 30.8% (n=8) perceived the goal to be 'a little' or 'not at all' difficult to achieve.

Goal 2

The most common goals identified by participants at T1 were physical health and wellbeing, and employment, education and volunteering goals. Just over a quarter of the sample (27.8%, n=10) set this type of goal for Goals 1 and 2 respectively.

For those who set a Goal 2 (n=20), 95% (n=19) reported that they felt this to be 'very' or 'moderately' important, while only 5% (n=1) reported that the goal was only 'a little' important or 'not at all' important. More than half of the sample (65%, n=13) perceived that achieving the goal would be 'very' or 'moderately' difficult, while 38.1% (n=8) perceived the goal to be 'a little' or 'not at all' difficult to achieve.

Goal 3

Goal setting dropped considerably for Goal 3, with 46.2% (n=12) of the sample not setting a third goal. Creative interests and hobbies, and mental health and wellbeing goals were found to be the most popular type of goal for Goal 3, with 11.1% (n=4) of the sample setting these types of goals.

For those who set a Goal 3 (n=15), 100% reported that they felt this to be 'very' or 'moderately' important. Most of the sample (73.4%, n=11) perceived that achieving the goal would be 'very' or 'moderately' difficult, while 26.7% (n=4) perceived the goal to be 'a little' or 'not at all' difficult to achieve. There was no significant difference between the level of goal importance or the perceived difficulty for Goals 1, 2 and 3.

Achieving goals at T2 follow-up

When goals were revisited at T2, 36% (n=9) of the sample reported that they had achieved their Goal 1, and 68% (n=17) did not achieve their Goal 1. Of the 17 participants who did not achieve their goal, seven (41.3%) reported that they were in the process of doing so and reported that the goal was 'not quite achieved'. One participant noted that they had attempted their goal; however, it had been too difficult and therefore they stopped. Of those who had achieved their goal (n=9), 44.4% (n=4) found it to be as difficult to achieve as expected, 44.4% (n=4) found that

they had achieved it 'a little better than expected', and only one participant (11.1%) found that they had achieved their goal 'a lot better than expected'.

For Goal 2 (set at T1), 22 participants revisited their success in achieving this goal at T2. A total of 19.2% (n=5) of the sample achieved their Goal 2. Most of the sample (60%, n=3) reported that they had found it as difficult as expected, while 20% (n=1) reported finding it a little better than expected, and 20% (n=1) found it a lot better than expected. Of the 65.9% (n=17) who reported having not achieved this goal, six participants (35.3%) reported that they had 'not quite achieved' the goal, but were in the planning process of doing so or were progressing towards achieving the goal. 15% (n=4) of the sample did not provide updates on their baseline goal attainment.

Sixteen participants provided feedback on the attainment of their third goal, with 43.8% (n=7) of these participants reporting having achieved this goal. Of those who achieved this goal, 42.9% (n=3) reported they found this as difficult as expected, with 14.3% (n=1) reporting it as being 'a little better than expected', and 42.9% (n=3) reporting that they found it 'a lot better than expected'. Of the 56.3% (n=9) of the sample who reported that they did not achieve this goal, 33.3% (n=3) reported that they had 'not quite achieved' the goal, but were progressing with it.

Goal setting at T2

Figure 14 outlines the distribution of the types of goals set at T2. It should be noted that, at T2 goal setting, 18 participants actively set goals.

There was a shift in the focus of goal types set from T1 to T2, with the most common goal type set at this time point changing from physical health and wellbeing to goals related to housing, legal and budgeting goals. Almost twenty per cent of the participants (19.4%, n=5) set their goals under this theme as their first goal, and 16.7% (n=6) set this as their second goal. Housing, legal and budgeting goals were also popular first goals at this time point, with 19.4% (n=7) of the participants choosing goals within this theme. Goal 3 setting saw a considerable decline, with only 16 participants setting a goal at this point. Mental health and wellbeing was found to be the most popular type for this third goal, with 11.5% (n=4) of the sample choosing goals within this theme.

Of those who set a Goal 1 (n=18), 94.5% (n=17) reported that they felt this to be 'very' or 'moderately' important, while 5.6% (n=1) reported that the goal was only 'a little' important or 'not at all' important. Just over half of the sample (55.6%, n=10) perceived that achieving the goal would be 'very' or 'moderately' difficult, while 44.4% (n=8) perceived the goal to be 'a little' or 'not at all' difficult to achieve.

For those who set a Goal 2 (n=17), 94.1% (n=16) reported that they felt this to be 'very' or 'moderately' important, while only 5.9% (n=1) reported that the goal was only 'a little' important or 'not at all' important. The majority of the participants (64.7%, n=11) perceived that achieving the goal would be 'very' or 'moderately' difficult, while 35.3% (n=6) perceived the goal to be 'a little' or 'not at all' difficult to achieve.

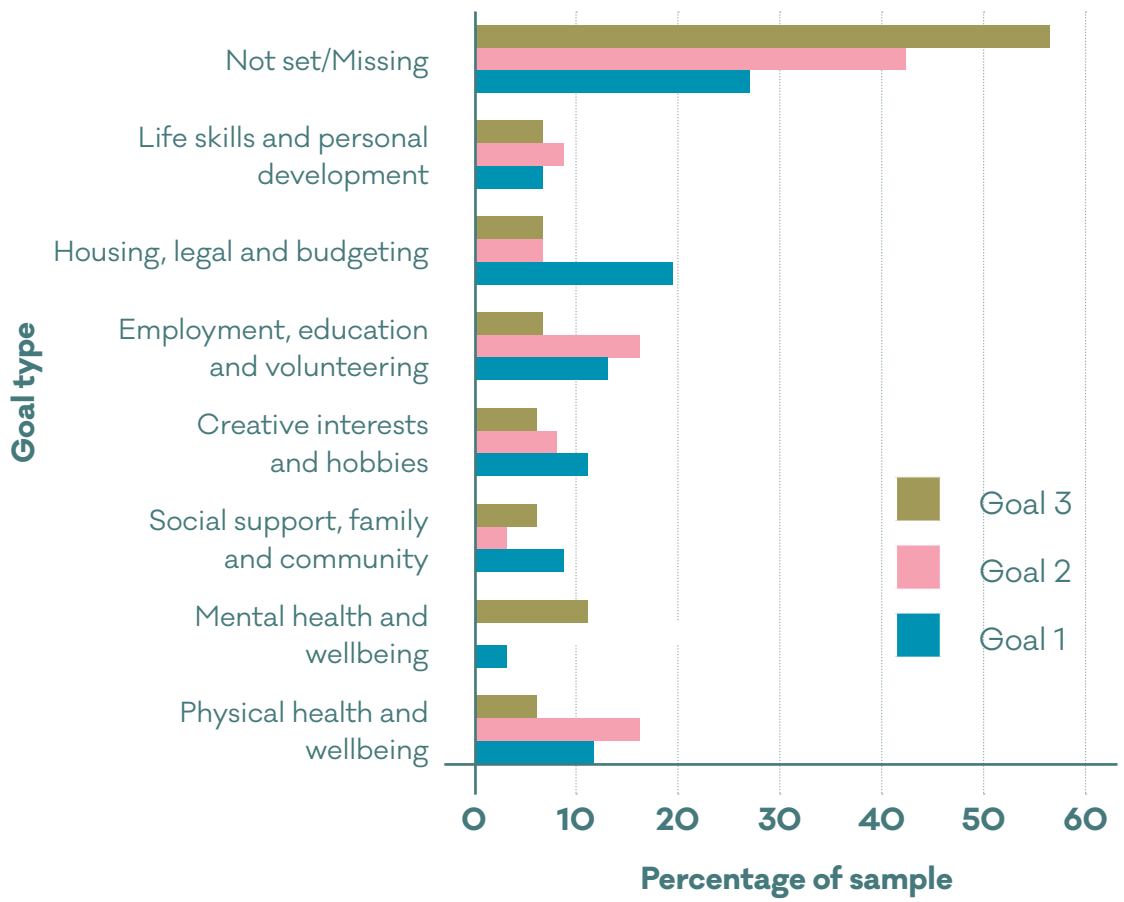


Figure 14. T2 goals by type

For those who set a Goal 3 (n=11), 100% reported that they felt this to be 'very' or 'moderately' important. Over 60% of this sample (63.7%, n=7) perceived that achieving the goal would be 'very' or 'moderately' difficult, while 36.4% (n=4) perceived the goal to be a 'little' or 'not at all' difficult to achieve.

There were no significant differences in the level of importance or the perceived difficulty between Goals 1, 2 and 3 at T2 follow-up.

Achieving goals at T3 follow-up

Goals set at T2 were revisited at T3 to see if participants had achieved them. For Goal 1, 14 participants revisited this goal, with 21.4% (n=3) of these participants having achieved their goal. All three of these participants reported that they found this goal 'a little better than expected'. Of the 78.6% (n=11) of the sample who did not achieve T2 Goal 1, 36.4% (n=4) reported the goal as 'not quite' achieved, but that they were progressing and working on this goal. One participant (9.1%) reported that they were 'nowhere near achieving' the goal.

A total of 13 participants reported follow-up data for T2 Goal 2. The majority of the sample (69.2%, n=9) reported having achieved this goal, with 22.2% (n=2) of these participants having found the difficulty of achieving the goal 'as expected'. Almost half (44.4%, n=4) of the participants found it 'a little better than expected' and 11.1% (n=1) found it 'a lot better than expected'. Two participants' (22.2%) data were missing for this follow-up. Of the 30.8% (n=4) of the sample who reported that they did not achieve this goal, one person reported that they had 'not quite achieved' the goal but were making progress, while one noted that they were 'nowhere near achieving' the goal.

Ten participants provided follow-up data for T2 Goal 3. 40% of this sample (n=4) achieved this goal, with 25% reporting that this was 'as expected' and 25% reporting it as being 'a lot better than expected'; data from the remaining two participants were recorded as missing. Of the 60% (n=6) who reported not having achieved this goal, 33.3% (n=2) reported that they had 'not quite achieved' this goal and 16.6% (n=1) reported that things were 'worse than before'.

3.1.5 Cost analysis

Currently, there are no data available in cost estimates, such as by the PSSRU, which further makes determining cost savings a challenge. Despite the lack of information available, the evaluation has included an economic analysis of the Progression Together model that shows the differences in costings of services delivered by Together, and statutory and voluntary sectors.

In the years 2013/2014 and 2014/2015, both York Road and Kelvin Grove services were compared to local-authority care homes, voluntary, private and independent sector care homes, and NHS secure settings. These comparator settings were used to provide an insight into the costs of alternative places for residents living in York Road and Kelvin Grove. It was also done to give the reader as much information and as much of a perspective as possible, since the staff consultation provided limited information on the services these residents would have gone to if Together services were unavailable.

Establishing service costs

Costs were measured at 2013/2014 and 2014/2015 prices. Unit costs for health and social care services were sourced from the PSSRU Unit Costs of Health and Social Care 2014 and 2015 (Curtis, 2014; Curtis and Burns, 2015). Cost data was only compared for 2013/2014 and 2014/2015 because data for the period 2015/2016 had not been published by the PSSRU at the time of this report. Unit prices per resident are reported on both a weekly and yearly basis in this report; the yearly figures can be used for further insight on costs over a longer period of time.

We have used the most recent reliable data for comparable statutory services available at the PSSRU. In addition to this data, we carried out an expert consultation of staff working in Together's services. This consultation comprised operational managers, as well as clinicians working in Together's services. Experts were asked to provide a 'best alternative' service in the local authority that clients would have gone to

if the Progression Together service were unavailable. The data available indicate that the majority of clients would have gone to local-authority care homes, voluntary sector supported housing, or secure NHS services in the region. It was decided that all cost categories that reflected these services should be included. Thus, the comparison groups chosen were local-authority care homes, voluntary, independent and private care homes, and secure NHS settings. Figure 15 shows alternative service provision informed by expert opinion for York Road and Kelvin Grove.

A London multiplier was used for PSSRU cost comparisons to York Road, as this service falls within the Greater London Authority region. As Kelvin Grove bed prices varied, average prices were taken over the course of the year.

Descriptive service details support, staffing and occupancy rates

Staffing and occupancy figures were provided by both York Road and Kelvin Grove for 2013/2014 and 2014/2015. However, data on support delivered were only available for 2015 and can be found in Table 5. It is clear from these tables that York Road has more staff members employed at the service and delivers higher levels of one-to-one and self-directed support per month compared to Kelvin Grove. York Road also operates with a lower occupancy rate compared to Kelvin Grove.

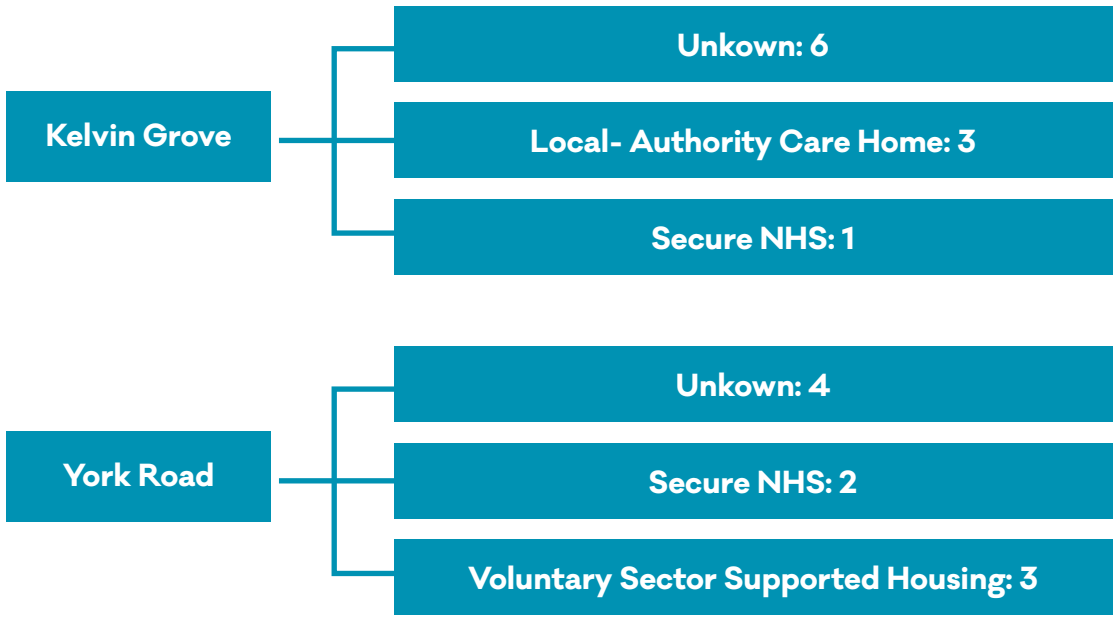


Figure 15. Alternative service provisions informed by expert staff opinion for York Road and Kelvin Grove

Table 5. Support provision breakdown of Kelvin Grove and York Road in 2015

Service support activities	Kelvin Grove (activities delivered per month in 2015)	York Road (activities delivered per month in 2015)
Group activity	32 hours	30 hours
One-to-one support	240 hours	Between 336 and 1,568 hours
Self-directed support	25 hours (on average per month)	93 hours (on average per month)

Table 6. Staffing structure for York Road and Kelvin Grove services for 2013/2014 and 2014/2015

Staffing structure	Kelvin Grove	York Road
Project Manager	1 FT	1 FT
Deputy Project Manager	0	1 FT
Support Workers	0	9 FT
Senior Social Care Workers	2 FT	0
Social Care Workers	4 FT and 1 PT	0
Total staff (FTE)	**7.5**	**11**

Table 7. Occupancy rates for Kelvin Grove and York Road for 2013/2014, 2014/2015 and 2015/2016

	Capacity	2013/2014	2014/2015	2015/2016
Kelvin Grove	12	98.4%	99.4%	96.24% (up to October 2015)
York Road	14	84.34%	77.74%	83.41% (up to October 2015)

Together cost breakdowns for Kelvin Grove and York Road

Together cost breakdowns (i.e. staff, property, staff learning and development, etc.) per week for each service can be found in Appendix 7.

Together cost comparisons

Table 8. Cost comparisons for each service per week for 2013/2014

Service	Together	Local authority	Voluntary, private and independent sector	NHS secure mental health service	Cost difference: Together vs statutory	Cost difference: Together vs voluntary, private and independent sector	Cost difference: Together vs NHS secure mental health service
York Road	£906.50	£1,322.18	£832.54	£3,759.00	-£416.00	£74.00	-£2,852.50
Kelvin Grove	£730.69	£1,419.90	£745.90	£3,759.00	-£689.21	-£15.21	-£3,028.31

Table 9. Cost comparisons for each service per annum for 2013/2014

Service	Together	Local authority	Voluntary, private and independent sector	NHS secure mental health service	Cost difference: Together vs statutory	Cost difference: Together vs voluntary, private and independent sector	Cost difference: Together vs NHS secure mental health service
York Road	£10,878.00	£15,866.16	£9,990.48	£45,108.00	-£4,988.00	£888.00	-£34,230.00
Kelvin Grove	£8,768.28	£17,038.80	£8,950.80	£45,108.00	-£8,270.52	-£182.52	-£36,339.72

Table 10. Cost comparisons for each service per week for 2014/2015

Service	Together	Local authority	Voluntary, private and independent sector	NHS secure mental health service	Cost difference: Together vs statutory	Cost difference: Together vs voluntary, private and independent sector	Cost difference: Together vs NHS secure mental health service
York Road	£1,066.59	£937.90	£889.20	£3,647.00	£128.69	£177.39	-£2,580.41
Kelvin Grove	£681.22	£894.40	£776.40	£3,647.00	-£213.18	-£95.18	-£2,965.78

Table 11. Cost comparisons for each service per annum for 2014/2015

Service	Together	Local authority	Voluntary, private and independent sector	NHS secure mental health service	Cost difference: Together vs statutory	Cost difference: Together vs voluntary, private and independent sector	Cost difference: Together vs NHS secure mental health service
York Road	£55,462.68	£48,770.80	£46,238.40	£189,644.00	£6,691.88	£9,224.28	-£134,181.32
Kelvin Grove	£35,423.44	£46,508.80	£40,372.80	£189,644.00	-£11,085.36	-£4,949.36	-£154,220.56

Findings

Cost-comparison analysis

The analysis indicates that in both 2013/2014 and 2014/2015, Together services were running at a lower cost compared to secure NHS mental health units. This analysis also shows that staff costs are the largest component by a significant margin for both York Road and Kelvin Grove, even where services are based in a fixed physical location. The office and administrative costs are a relatively small component of the overall costs.

York Road had a higher cost compared to Kelvin Grove for both 2013/2014 and 2014/2015, with the cost per resident per week increasing over time. Kelvin Grove showed a decrease in weekly cost from 2013 to 2015. The reason for this can be largely attributed to a reduction in staff costs.

For 2013/2014, York Road had a higher weekly cost compared to voluntary, independent and private sector care homes, with a difference of £137.00. However, the service was less costly compared to local-authority care homes, with a difference of £416.00, and with a difference of £2,852.50 compared to NHS secure services.

Kelvin Grove was less costly than York Road, with this difference mainly attributed to lower staff costs and also fewer members of staff. The comparison showed that Kelvin Grove had a substantially lower unit price compared to local-authority care homes and NHS secure services. Kelvin Grove's unit price was most equivalent to that of the unit price of voluntary, private and independent sector care homes, with a difference of £15.21 in favour of Together services.

For 2014/2015, the costs per unit per week decreased for local-authority care homes compared to 2013/2014. For example, for Kelvin Grove, the comparable unit price decreased from £1,419.90 to £894.40, with a decrease in reported local-authority expenditure of £504.00 causing the large shift in costs. Voluntary, private and independent sector care home unit prices were slightly higher for 2014/2015, with an increase of £30.60.

This evaluation shows that Kelvin Grove Together services have lower unit costs compared to statutory, and voluntary, private and independent sector services. York Road has higher staffing levels compared to Kelvin Grove, which is the main reason for higher costs. Additional analysis has shown that the increased staffing levels at York Road are due to differing needs related to the population caseload, which, in turn, requires an increased level of support, including the use of night workers for York Road residents. However, when compared to NHS secure mental health services – a main route of referral for residents in York Road – the service unit price cost is lower.

The NHS secure comparator is useful to compare with costs for York Road services, considering the higher risk of these clients and because clients from York Road are mainly referred from secure NHS services. In addition, since York Road had a lower occupancy rate, it could be presumed that, if York Road were to operate at full capacity, there may be a lower average cost per

participant; however, further information on staffing and caseload is needed to draw any definitive conclusions.

Limitations

The comparison groups used for statutory, and voluntary, private and independent sectors can comprise services with differing levels of support and slightly different caseloads; thus, this may reflect a very heterogeneous comparison group, limiting the usefulness of the comparison. Any inferences drawn from this comparison may be limited by the fact that the analysis cannot guarantee whether 'like for like' is being compared.

As alternative service provision data was largely missing, expert opinion from staff informed the decision to include statutory care home, NHS, and voluntary organisation comparison figures. This analysis can be informative, but further data is required.

The cost analysis could only cover a two-year timeframe rather than the three years, as data for 2015/2016 was not available in the PSSRU dataset. Future analysis would benefit from covering a longer timeframe.

Data on support activities delivered has only been collected since January 2015; thus, the research team was unable to compare the data to any support activities on offer in previous periods.

Lastly, the economic evaluation did not include benefit and outcome data. Issues relating to data collection limited the undertaking of a sufficient CBA; however, further findings from the evaluation can give an indication of quality of service.

3.2 Qualitative data

This section explores the experiences of 18 individuals engaged in Progression Together who have been followed up at three time points (T1, T2 and T3), and nine individuals who completed T1 and T2 follow-up only. A total of 27 individuals participated in in-depth

Table 12. Numbers of qualitative evaluation participants by service

Service	Number of participants
Cliddesden Road	5
Kelvin Grove	8
Kirtling House	4
Snowdon	2
York Road	8

interviews across the five evaluation sites. Table 12 shows the numbers of evaluation participants for each site.

At T3 follow-up, one participant had moved out of Cliddesden Road service, and three participants had moved out of Kelvin Grove service.[9] Participants who had been discharged either moved on to independent or less-supported accommodation.

3.2.1 Participants' experience of Progression Together

Flexible staff support that is tailored to each individual

The support that clients receive from staff was unanimously considered to be a key element of the Progression Together model, facilitating individuals to progress in their recovery. The majority of participants (n=26/27) rated staff support very highly and it would appear that it was this aspect of the model that made the Progression Together service a successful one.

> ***"Everything was top notch when I was here. They had answers for everything, so I was bewildered how good this place was."*** PTO2

One participant described their relationship with staff as 'adequate'. However, they later changed their opinion at T3 follow-up, and spoke of appreciating 'all the things that staff did for residents'. A number of participants commented on how the type of support they received from staff at a Progression Together service differed from other types of mental health support they had received in the past (e.g. at hospitals).

> ***"You've got your own freedom. You can come and go out whenever you want. They [hospitals] put you on all these sections and stuff, don't they? At the hospital you have to abide by them."*** PTO2

Overall, participants described how staff tried their best to meet their needs and, in most cases, the staff was able to provide the support or information they were looking for.

> ***"Nine out of 10 times they really calm me down loads and pretty much solve the problem, so that kind of support is really good."*** PT64

Staff support can range from the practical (e.g. helping clients remember to take their medication, financial planning and budgeting, moving out, etc.) to the more emotional and social in nature, where staff will provide residents with a listening ear or more intensive one-to-one support, if necessary. Additionally, the 24-hour support helped some individuals to better manage their mental health, as the knowledge that someone was there served as a 'safety net' during difficult periods.

> ***"I am very happy to be here. It is really good. There are staff here 24 hours a day. A lot of times in the evening about 9 o'clock I get quite***

9. These participants represent a smaller proportion of those mentioned earlier in the report under the Service Use section who had been discharged by T3.

depressed. It's nice to know there is someone there that I can go and talk to if I feel really, really bad or low... I guess because I have got all this support behind me and where I am living, I guess it does make me more confident and it's kind of like there is a safety net there. I still feel like a nervous wreck, but I also feel I am in a much, much better place than I was three or four months ago." PT64

"They help me with cooking because I self-cater[...] It is good support; I have got my key worker, X, and he makes me laugh. If I have got any troubles I go to him. At the beginning it was sorting out benefits and work: gradually getting there." PT62

"It helped me come out of my shell. I feel a better person from being h ere and then moving on, you know? I feel more confident in myself." PT16

"It's a stressful thing, isn't it, moving? But it was a bit less stressful than what I thought it was going to be." PTO2

Staff support, while flexible to meet the varied needs of clients, also appeared to remain relatively consistent over the 18-month period of the evaluation. Across all five services, no one reported feeling that the support they originally had received decreased over time.

"There is always support because it depends where you are at, sort of, mentally as to what you need, but it is always quite flexible[...] They put things in place when they need to and they don't need to be there when not." PT66

Additionally, it is this constant that seems to help individuals develop emotional resilience, a stronger sense of self, and the confidence to begin to feel more capable of engaging with the community again and achieving things.

"Helped me a lot with my confidence and self-esteem: getting to know people, getting that connection[...] I am more motivated to do things." PT18

"The support shows me that I am, you know, worth something really, because I was very low." PTO2

It was also observed that, for some participants, it was this support that, over time, helped them learn to cope better themselves and ultimately led them to need less support from others involved in their care.

"I have got a lot of confidence. I don't know why – I think it is that they are friendly here. I have sort of been going out a lot, whereas I never used to." PT59

They train everyone to be able to live by themselves... You know, train you up and then move. You're capable to do things yourself. PT16

Progress towards self-management

All participants (n=27) reported at T3 at least some aspect of being able to manage themselves and their lives better. Markers of improvement in independent living skills included

learning new skills (e.g. cooking), or engaging in a new routine (e.g. cleaning).

> ***"I cooked myself last week[...] Fish and beans last week – last Saturday. I cooked them fishcakes and sweetcorn on Saturday."*** PT10

> ***"I've become a bit more independent at home. Gaining independence on going on my own down to town to do shopping. Showering by myself. And cooking. Cooking simple meals or cooking a meal by myself."*** PT08

> ***"Order for living[...] It does help. Wash clothes, shopping, cooking independently."*** PT04

Beyond practical living skills, individuals also shared how they had also progressed emotionally while living in a Progression Together service.

> ***"I have got a lot better at resolving problems and talking about them, and actually opening up and talking to other people and approaching other people."*** PT60

> ***"It's given me a bit more confidence."*** PT24

Engagement in the community

Progression Together services encourage participants as part of their progression through the model to step out into the community and use facilities in the local area. Often, the first step may be to use local mental health resources, such as a day resource centre, before moving on to other community activities, including attending training and courses. Participants described that this can be a useful stepping stone towards greater independence.

> ***"On a Tuesday I go to a place called The Stables... Gardening, kitchen work, craft: various things."*** PT11

> ***"I just volunteer... Marie Curie... I hang clothes, I go on the till, I steam: a bit of everything really."*** PT18

> ***"I drive. I've got a car ... We've got a friend that lives in Reading and sometimes we go and visit her."*** PT24

Other participants mentioned going to the local cinema, leisure centre, church, or library. Participants are able to discover things that they like to do and have the freedom to explore these activities.

> ***"When I can – when I am inspired – I do a lot of painting, 'cause I'm an artist as well. So, yeah, I like[....] When I'm mentally inspired, yeah, I can do art in my room."*** PT16

> ***"I've created a mental health dating website which... is live at the moment, so I'm just waiting to promote it a little bit. I've got some fliers printed out, so I'm gonna take some down[...] There's, sort of, mental health places in Woking. I'm gonna give them some leaflets – maybe get some interest in that."*** PT24

Peer support

Use of peer support in services at T3 follow-up varied between services and individuals with each service. Two of the five services had adopted peer-support workers; these were Kirtling House and

Cliddesden Road. It would appear that, while the majority of the participants were familiar with the concept of peer support, only a small minority were interested in and received peer support from a trained peer-support worker. Those who did receive peer support found it to be helpful and an insightful experience.

> ***"I think it's brilliant – it is learning from others, what they have done before, and it's learning from them, isn't it?"*** PTO6

> ***"It helps to share how we're feeling. Some people, like peer-support workers, have gone through mental health problems themselves, so it helps to relate and talk and get support from them and stuff."*** PTO8

A number of participants (n=6) were not familiar with the concept of peer support, although, when an explanation was given by the researcher, the majority was not interested in receiving this type of support. Most of the participants, however, were familiar with the concept but were not interested in using it.

> ***"You can do it, but I don't."*** PTO7

Use of recovery vouchers

Regarding the use of recovery vouchers in services, there seems to be little uptake, with only a minority of the participants reporting that they knew what they were and even fewer reporting having used them. Those who had used them had done so in the past and, it would appear, had stopped using them at T3 follow-up.

Those participants who had used the recovery vouchers found them useful; however, most of the participants felt that it wasn't necessary and said that, if they did want more individual one-to-one time with a staff member, all they would need to do is ask.

> ***"I went for dinner with the boss[...] They [the recovery vouchers] were good, yeah, you got to know people a bit better."*** PT18

> ***"I went to the Isle of Wight. And I had extreme anxiety... but I did it. And I thought that was good. When I came back, in the end... I thought it was brilliant... A little bit of the recovery focus [sic] is to pay for staff to take us out."*** PT24

Goal setting

Use of goal setting across services varied between individuals and within services. Some participants had identified goals through the Recovery Star approach and were working towards achieving them. Some individuals had not identified goals they were working towards throughout the course of the evaluation, and others found the prospect of identifying goals a challenge for them. These mixed views on goal setting are shown below.

> ***"[It's a] challenge for some individuals with identifying goals and taking steps to progress towards achieving them. I understood what it means, but I don't know how to set the actual goal, y'know?"*** PTO2

> ***"I don't like looking towards the future. It's kind of a big no no with me, so it's more of a case of 'how am***

I helped now?' rather than looking forward." PT66

"They do the Recovery Star, which is like having a look at, like, where we are with our illness, but that was actually quite a good eye opener." PT64

"There aren't negatives. It's quite helpful because you can see how much you've progressed every time you do a Recovery Star. And I've come really far." PT18

Some participants did not find the Recovery Star approach helpful, while others found that their mental health condition, such as anxiety, made it difficult for them to achieve their goals. Goal setting and monitoring seems to be an area that could warrant some further development. While some individuals had no problem using the Recovery Star approach, others might have benefited from more support with identifying some small goals to start working towards.

Improvements

One criticism reported by a few individuals concerned the responsibilities given to residents while they lived in the Progression Together service. Some felt there were not enough responsibilities for residents and that this impacted their feelings of independence.

There's not much responsibility here[...] So where do I start? Everything's done for us. It's not really like real life is it, really? PT16

It should be noted, however, that these individuals felt ready to move on from the service into independent accommodation and they were frustrated with waiting for accommodation options to become available. At T3, these individuals had moved out of the services and the same individual shared that, overall, their experience was 'very good actually – they taught me a lot of things when I moved out of hospital. They taught me how to cook properly... just to keep up my hygiene – you know what I mean?'

3.2.2 Staff consultation

Method

Facilitated by the Progression Together Operation and Development Manager, 10 staff (seven females, three males) across five Progression Together services were identified and consented to participate in semi-structured interviews. Job functions included frontline staff (six), service managers (four) and strategic management (one).

Procedure

The interview schedule comprised nine questions and covered areas such as participants' involvement in and understanding of the Progression Together model, implementation of the Progression Together model, strengths and challenges, and collaboration with other services. Interviews ranged between 10 and 30 minutes in length.

Data analyses

Qualitative data were analysed thematically. Nine themes were identified and subsequently organised under three overarching themes: i) model design; ii) implementation; and iii) the change process.

Results from the staff consultation

Model design

Support

All participants spoke of the Progression Together model as one of support, helping the client to get to certain 'goalposts' leading to the overall objective of independent living. Several participants spoke of the assessment process as a means of determining the 'right fit' between client and staff, which reflects the supportive role adopted by staff. Peer support was referred to by three participants as a vital part of the process, which highlighted the positive impact of clients engaging with someone with shared experiences. One Peer Support Practice Manager emphasised the value of peer-support coordinators as a means of having an effective peer-support programme:

> ***"[...] something like a peer-support coordinator role is really important [...] I think that there are other services that are trying to go by the model but they don't have a peer support coordinator [...] I hope that it is part of the model as well: just as much a part of the model as all the other types of support."*** ST1

Goals

Participants stressed the role of setting and achieving goals as an important element in helping clients to move on. This reflects the general understanding of the model as fostering a progressive, 'step-down' process of recovery and independence. Identifying and working towards incremental goals was portrayed as an important means by which clients are enabled to attain their ultimate goal.

> ***"So, from the word go, we are having the discussions about move on – so, at every recovery meeting, 'how-is-it-going?' meeting, move on is discussed, and move on, basically throughout the time service users are here, is broken down into goals. [...] So move on is basically broken down into smaller, more achievable goals service users can work towards."*** ST2

> ***"I am aware that it is a move-on strategy, so it is about setting goals with service users so that they can then re-enter the community."*** ST5

Client-directed model

The Progression Together model, as one that is client directed, with staff providing support in the process, was a central theme that appeared to be a guiding principle in the model's implementation. Staff considered this to be a strength of the model, as it ensures an individualised approach and also provides a means of empowering clients with the support available.

> ***"Most of it is directed by the service users. My role is just, sort of, not do what they want me to, but support them in the ways that they need and suggest new ways that we can do things that I think would help them with their support, and see what they think about it."*** ST6

> ***"[...] the help provided is being designed individually for everyone and that clients are being in charge of their own recovery. [...] It really***

empowers them and it gives them... I guess, for them to see that there are things they can do for themselves and they are able to do it." ST4

Some staff felt that unmotivated clients are less inclined to identify goals, thus making it a challenge to identify progress through the model and ultimately their readiness to move on.

"[L]ack of motivation is a difficult thing sometimes within the model, but mainly it is because it is quite difficult to then show progress or things that you are doing with the individual." ST8

"Sometimes people are going to be unwell. That is life, I think, and so, as much as you want Progression Together to work (and it does work), [...] it is not always going to work with everyone" ST3

Though acknowledging the challenges posed by an unmotivated client, some staff suggested that it can be overcome, leading to successful progression through the model.

"Some people don't like to talk about move-on plans at the start, whereas some people are very focused as soon as they get here and want to say that, within a year, they want to be in [their] own flat, whereas some people are a bit more like 'oh don't talk to me about the future at the moment'. I work with a lady I keywork who is a bit like that and she refuses to talk about the future, so it is kind of all very much at a slow pace. It was, sort of, quite a big thing to get her on a housing register because she didn't want to do that for a long time because it meant thinking about the future." ST6

"Not everybody fits it[the model] and people work at a different pace. Some people don't want to go through it, but, again, it works because we do work with people at their own pace. Some people do relapse, but that is fine too – we just have to get back on track, but, as I said, not all service users are able to work to that model as well as others maybe because there are older clients we have got at X that would struggle a little bit more. We still, wherever we can, try to empower people and try and get them to lead their care." ST7

It appears that, with appropriate support, those clients lacking motivation are able to progress through the model – albeit at a slower pace than those who do not have this difficulty.

Implementation

Flexibility and tailoring

Taking an individualised rather than a 'one-size-fits-all' approach was presented as a strength of the model that increases the chances of clients successfully moving on.

"I think that the model is really individualised, so I don't think it is a one mould fits all at all. Basically, the model is there for sort of guidance, and service users are able to basically cater it to their needs." ST2

Participants suggested that this built-in flexibility means the manner in which the model is applied to individual cases varies from person to person, and may even change during the course of treatment for a single client. This flexibility reflects a harmony between the model as one that is client directed and also features in the way that it is implemented.

> ***"Also, I think it is really flexible so that, you know, it is forever changing. [...] you are able to adapt it so that, in a month's time if it is reviewed, it can be changed again"*** ST2

External influence

Three members of staff from different Progression Together services made reference to instances in which external agencies have the potential to impede clients' progress and impose limits on the model's flexibility. Examples identified the impact of the Ministry of Justice in cases of ex-offenders, as well as other barriers to move on from the Community Mental Health Team whose role it is to identify suitable housing for residents.

> ***"So the model itself is very, very resident-, per-person-centred support. It very much comes from the wishes and goals set by the resident rather than what is set by the outside system. Whereas sometimes we have to juggle that. A resident may well come out of [forensic] hospital after 20 years and think they can move straight into a flat, and, based on the support model, you might think that is where you set the goal, but in reality it is the Ministry of Justice's take on this [...] It is not to say that the final goal isn't to move into a flat, but just that, in reality, it is going to take much longer."*** ST9

> ***"When I work with CMHT [community mental health team] they often really struggle to find suitable projects and placements, or move-on settings for residents who are ready. We have got a resident right now who is ready and the CMHT is just stuck for finding somewhere for him to move to, and he has been here seven years."*** ST5

> ***"[...] with regards to moving on and housing, we have had problems with, you know, even if somebody is ready to move on there is no housing solution out there, so that becomes a bit disheartening for people."*** ST10

Some staff suggested that there was a lack of synchronicity between outcomes under the Progression Together model and outcomes of external agencies, which has the potential to undermine the individual's progress. Similarly, there is the suggestion that the client-directed nature of Progression Together is somewhat incompatible with the operations of some external agencies, whose activities are directed by other factors that do not necessarily consider the client's goals to be paramount.

One service's approach suggests that reduced client autonomy may be necessary in forensic settings, which the model should reflect. For other services, it may be more a matter of 'multi-agency staff being on board with that [Progression Together] model' (ST5) to minimise delays in clients' progress.

Stage 3 (six-week follow-up)

Only four participants mentioned follow-up as part of their operations, and only one of those participants referred to follow-up as part of the Progression Together model: 'I think it is nicer now that they have sort of, a bit more of a follow-up at the end – six weeks' (ST6).

This suggests that there are instances in which Stage 3 is not being recognised as part of the model and is therefore not being actively implemented, or implementation may not be according to the Progression Together guidelines.

> ***"[...] they move out and they move on and we lose contact with them, so sometimes I feel it is difficult to follow up, but it is probably more for you than for us to actually capture. If we say two years or so, it might be difficult to follow up certain cases."*** ST4

Paperwork

Several participants made reference to the paperwork that accompanies the model, citing the volume and the language used as creating a barrier for some clients. Some recognised the need for the paperwork as a useful means of monitoring clients' progress – a benefit, particularly for those clients who find it difficult to remember goals or where they are in the change process.

The language of some documents, however, was considered by some to be 'quite advanced for some of the service users to understand' (ST2), leading some clients to refuse completing the paperwork.

The change process

Training

There was a mixture of opinion regarding whether the model is easy to use. On one hand, it was described as 'quite a simple model' (ST8) and as 'a very clear pathway' (ST7). On the other hand, some described a sense of 'confusion around it, especially at the beginning [of its implementation]' (ST4).

These comments suggest that there may still be the matter of change management to address, particularly in relation to training and communication of the use of the model among staff who have not been appointed as the service's champion/lead:

> ***"I know quite a bit about the Progression model just because I am the named person to be involved in the Progression Together model for X and I have quite recently taken that on. I think maybe I know a little bit more about it than the rest of the team. We had a sort of discussion about it recently [...] and it did feel that the staff team as a whole [...] understood the model, but they couldn't see why it was particularly new or particularly revolutionary or particularly different to things they had been doing anyway."*** ST9

> ***The issue has been acknowledged by those in strategic management: 'there were some difficulties there with regards to staff actually accepting the new way of working. But it's a challenge and a real experience with any kind of change'*** ST10

Staff buy-in

Implementation of all Progression Together components seemed to be associated with the degree to which staff and clients have bought into the model. Comments from staff revealed a mixture of attitudes towards the model, with some acknowledging its value, regardless of its resemblance to pre-existing operations.

> ***"I think this model has been around for a long time anyway, it's just pinning it down isn't it really? I think Together has done that for a long time, but maybe not as a model in a sense, in the strict terms.***
>
> ***[...] I think because it is more formally structured now and that is what we are expected to do, so that's the way that we work, and it wasn't official before in a sense. It is much more... formalised now, more pinned down."*** ST8

Other participants shared a slightly negative view of the model, as they could identify little to no difference with how they had always been operating.

> ***"I would like to say that, since we joined the model, the way we work hasn't actually changed that much; it is pretty much as we worked before anyway."*** ST4
>
> ***"[...] it does feel like it is not really being done, I mean the style of work we do at X in the end probably matches up quite well with the Progression model anyway because that is how X is set up, but when the staff team is spoken to about the Progression model there is this sort of note of cynicism and scepticism in, like, it is an obvious way of working and it is just wrapped up in something made more important than it really is, and therefore [...] this slight air of cynicism comes in, so it makes it hard to talk about it I think sometimes in the group because people roll their eyes a little bit and say 'oh, so what we have been doing for however long?"*** ST9

The extent to which this 'nothing new' viewpoint has been influencing implementation is unclear. However, from one service, it would appear that the model is being implemented only so far as it is compatible with existing site operations – that is, where an element (e.g. recovery vouchers) is considered irrelevant to a service, and where relevance is measured against pre-existing operations, the 'new' element is less likely to be implemented.

> ***"As soon as I started working here, we have used the recovery voucher system, which is kind of pretty much another way of using self-directive support, so we used to work a lot with recovery vouchers."*** ST6
>
> ***"Maybe even more elements of this model could be implemented for services like Your Way, where people actually live in their own accommodation and they only meet with the staff every now and then to discuss what is happening. We work this way anyway and the staff is here anyway, so certain elements like recovery vouchers for us do not really work. We don't use them because they didn't work in here."*** ST4

4. Discussion

Wellbeing

Progression Together provides valuable person-centred support for people with a diagnosed mental health problem living in residential care. Across all services, average wellbeing at baseline (T1) for participants was found to be 22.9. This score is lower than the average wellbeing found in the general population of 26.25[10] (Craig and Mindell, 2012). However, after engaging in support from the Progression Together service, significant increases in wellbeing scores from T1 and T2 follow-up were observed, and from T1 and T3 follow-up. Wellbeing increased to 26.67 and to 27.17 respectively. While wellbeing continued to increase from T2 to T3, this rise was not significant. Regardless, wellbeing at T3 was higher than the average wellbeing found in the general population. Additionally, statistically significant findings in wellbeing were obtained despite the relatively small number of follow-up participants.

Given greater numbers of response at T3, it could very well be that findings would also be statistically significant between T2 and T3 as opposed to nearing significance. It should also be noted that significance on wellbeing scores was observed only among those who had been admitted to a Progression Together service post-transformation, which would indicate that it was the Progression Together model that was the catalyst for increasing wellbeing in the sample.

Health-promoting lifestyle activity

Mean scores for health-promoting lifestyle activities improved overall and followed a similar pattern to the wellbeing scores of the participants at T1, T2 and T3. Significant increases were also observed on the subscales of general health and social life, with scores reaching significance between T1 and T2 and nearing significance for T1 and T3 follow-up. The small sample size and considerable drop in participants at T3 may help to explain why scores for T3 comparisons were only able to near significance; however, it is still promising and demonstrates the positive impact that the Progression Together model has overall.

Patterns of goal setting and achievement

Physical health and wellbeing was the most frequently identified first goal at T1, and first goals were rated to be 'very' or 'moderately' important for the majority of the participants.

10. This figure was calculated based on the WEMWBS 14-item scale, which has a total score of 70. The SWEMWBS is based on seven items of the WEMWBS scale. As no normative data is currently available on the SWEMWBS, we have halved the score to create a normative score of 26.25 for SWEMWBS.

Education, employment and training, and physical health and wellbeing were the most frequently reported Goal 2 at T1, and creative interest and hobbies and mental health and wellbeing were the most frequently identified Goal 3 at T1. Goal types at T2 shifted from those set at T1, with participants identifying employment, education and volunteering as their Goal 1, housing, legal and budgeting as Goal 2, and creative interests and hobbies remained as their third goal. At T1, the goal types identified complement the findings observed on wellbeing and the health-promoting lifestyle activity measure, which indicates that health and wellbeing are a priority and are important for participants.

In terms of goal achievement, mixed outcomes were observed at T2 and T3. The percentage of participants who achieved Goal 1 at T2 was 36% and, at T3, it was 20%. For Goal 2, 19% achieved this goal at T2, and 69% at T3. For Goal 3, 42% achieved this goal at T2, and 40% at T3. It's difficult to draw any comparisons between the two time points, as the samples of the individuals who achieved goals were not the same – for example, not all participants would have identified a Goal 3.

Additionally, among those who did not achieve their goals, for many, this was 'not quite achieved' and they were still progressing towards their goal but at a slower pace. This could suggest an area for improvement within goal setting for these individuals to break down larger goals into smaller steps so that progress could be captured.

Participants' experiences

On the whole, the experience of using Progression Together was very positive. Staff and peer supporters were highly regarded and valued in terms of the practical and emotional support they provided. For some, this support enabled participants to move forward with their lives and to pursue work and training activities, or even to move on to independent living or less-supported accommodation. Building emotional resilience and increasing confidence were other important gains for participants as they progressed through the stages of the Progression Together model. In general, few participants had suggestions for improvement with Progression Together services and, on the whole, the majority expressed that they felt the service and the support they received was excellent.

Staff consultation

Discussions with staff from Together's services revealed a general interpretation of the Progression Together model as one providing client-directed support geared towards achieving specific client goals, ultimately progressing to independent living. While there was unanimous agreement that the model meets its objectives, concerns were expressed regarding the extent of its applicability to certain types of clients (e.g. the unmotivated), given the model's emphasis on progression as a client-led, self-directed process. Clear advantages of the model were identified, as well as challenges with collaboration between Progression Together services and external agencies. As with any

change process, there appeared to be some variability in attitudes towards some elements of the model, which has influenced the manner in which it is being implemented in some services.

Cost-comparison analysis

The preliminary economic analyses suggest that Together can offer services to clients at a lower cost than local authority, voluntary, independent and private, and NHS settings. However, this is only the case for one service – namely Kelvin Grove and not York Road. The difference in costs can be attributed to a different caseload and higher staff costs for the client group at York Road.

When compared to NHS secure units, York Road does seem to provide a less costly alternative. A decision to allocate a client to a service, however, is not solely based on cost; thus, also taking into account the quality of support, York Road may be a suitable service for some clients, as this service not only boasts lower unit prices than NHS secure mental health service provision but it also offers a high number of hours of one-to-one support.

The results of this work are only indicative of an actual cost saving, as there is a lack of information available on further outcomes – including criminal justice, employment and savings – elsewhere. Cost–benefit data need to become an integral part of service provision, and these facets of an evaluation need to be prioritised in commissioning practices.

Limitations and factors that affected the evaluation

Limitations and factors that impacted the study are listed below.

- Some of the original evaluation sites were found not to be suitable for evaluation, and some sites lost their Progression Together contract during the course of the evaluation, which impacted the recruitment and engagement of participants.
- A smaller sample expressed interest in engagement at T1 and these numbers decreased further due to attrition occurring at T2 and T3.
- Not all residents living in the services were new to the Progression Together service. Some had been living in the service before it was transformed. This can somewhat confound the data, making it difficult to determine whether or not the model was the contributing factor that led to positive outcomes for participants. However, where possible in the analysis, we have grouped participants into pre- and post-transformation to distinguish where benefit can be noted.
- One challenge for the evaluation was measuring the impact of the model for those clients who struggled with demonstrating evidence of self-directed support or increased independence during the timeframe of the evaluation.
- Not all of the evaluation sites had embedded the aspects of peer support or self-directed support, as evidenced through the use of recovery vouchers, so the model could look different between different

services and this posed a challenge when capturing this information.

- Goal data collected on participants using GAS were not very reliable or meaningful in the end. The numbers of participants completing GAS at T2 and T3 decreased significantly over time. This outcome poses the question of whether using GAS was the most appropriate assessment tool and whether participants would have benefited from an alternative measure of progress towards achieving goals. This was raised in discussions between Together and the Mental Health Foundation at the end of Year 2; however, due to the proximity of this to the end of the evaluation, it was not possible to change measures. The design of the study would have benefited from piloting measures with a small group of residents. Participants may have also benefited from an introduction on how to set goals that can be monitored throughout the course of the evaluation, as some goals that participants set were too large and presented as a difficulty to achieving them during the timeframe of the evaluation. Additionally, some participants were already working towards different goals with their support workers and it may have been useful to collect goal data with participants' key workers, to align goals or break down larger goals into smaller ones.
- The evaluation did not capture information on participants' readiness to move on, but only on those who had been discharged at T3 follow-up.
- The evaluation also did not capture any data on numbers of residents who may return to a Progression Together service, which emphasises the need for studies to be set up for a longer period of time to monitor them at least 12 months after being discharged.

5. Conclusions

The evaluation highlights the Progression Together model as an encouraging approach to working with people with complex needs in an integrated residential care setting. The evaluation shows significant positive findings in relation to improvements in mental wellbeing and health-promoting lifestyle activity, particularly for those clients who entered the service post-transformation into a Progression Together service.

In general, participants were positive about the Progression Together model and appreciative of the support they received from staff. Nearly half of all participants (n=15/36) during the course of the evaluation were discharged into the community with the support of Progression Together staff.

On the whole, staff working in Progression Together services described the model as providing the right type of support; however, differences were observed among staff in terms of the overall understanding of the model and the difference of Progression Together services and services' pre-transformation operations.

Where Together is running a fully occupied residential service that provides self-directed support, it is possible to do so at a reduced cost to the statutory, private/voluntary sector and NHS hospital equivalents available in the region. Where the Progression Together service provides higher levels of one-to-one and self-directed support, as reflected in heightened staff costs, the Together services cost more that the statutory equivalent and voluntary and independent support services. However, they cost less than secure NHS mental health services.

6. Recommendations

Evaluating the Progression Together model – which is innovative in its delivery of support and draws on a personalised approach to people who have complex needs – posed some challenges to the evaluation.

The following recommendations reflect the challenges below:

- Variation in the implementation of elements of the Progression Together model across services.
- External factors, such as the commissioning environment, which resulted in some Progression Together services losing their contract mid-evaluation.
- Measuring the outcomes and impact of the model for those individuals who are less engaged or whose mental health problem impedes their ability to demonstrate increased independence or incidences of self-directed support.

1. **Progression Together approach:** We recommend that Together continues to learn from the development of this approach to determine which 'core' and 'flexi' elements are integral to the model and whether it is appropriate for all of the clients they support. There is a need to embed other elements of personalisation into the model, since not all residents are fond of using recovery vouchers. In addition, Together would benefit from co-producing these elements alongside their service users to determine what is useful or meaningful to them in their progression.

2. **Dissemination of the Progression Together model:** We recommend increased training and communication of the Progression Together model and its use among staff, particularly those working frontline in supporting clients in order to ensure consistency in the implementation of the model.

3. **Cost–benefit analysis (CBA):** We recommend that further investment in research is needed to incorporate measures that allow for CBA. Further investment is also needed to quantify the wider savings to other services, such as the criminal justice system.

4. **Development of an evaluation approach:** We recommend that Together develops future evaluation approaches of the model to understand the following: i) the longer term operation in order to further measure progress beyond Stage 3 of the model after a client has moved on into the community; and ii) the number of clients who return to their services.

7. References

Craig, R. & Mindell, J. (eds), (2013), *Health Survey for England 2012*. London: The Health and Social Care Information Centre.

Curtis, L. (2014), Unit Costs of Health and Social Care 2014, Personal Social Services Research Unit at the University of Kent, Canterbury.

Curtis, L. & Burns, A., (2015), Unit Costs of Health and Social Care 2015, Personal Social Services Research Unit at the University of Kent, Canterbury.

8. Appendices

Appendix 1 – Baseline characteristics

To understand how effective the service at [name of service] has been, we need to gather some information from the people who receive it. The information that you share in this form is confidential and will be stored securely at the Mental Health Foundation's (MHF's) London office for evaluation purposes only.

You can choose to answer all, some, or none of the questions below – the choice is yours.

You will be identified only by your participant number; all information remains anonymous. This number will be used to compare your responses over time. You will only have to complete this form once.

We hope that this questionnaire should take no longer than 10–15 minutes to complete.

Contact Details

Name (please print): _____

Name of Service: _____ Today's Date: _____

Home Phone: _____ Mobile: _____

Email: _____

How would you prefer us to contact you: Phone ☐ Email ☐ Post ☐

About You

1. Are you: Male ☐ Female ☐
2. How old are you? _____ What is your Date of Birth? _____
3. Do you have any children? Yes ☐ No ☐
   If yes, please tell us their ages: _____
4. Are you currently employed? Yes ☐ No ☐
5. Are you currently doing voluntary work? Yes ☐ No ☐
6. Do you consider yourself to have a physical disability? Yes ☐ No ☐
   If yes, what is your disability? _____

7. How would you describe your reading and writing skills?

Good ☐ Quite Good ☐ Poor ☐

8. What is your ethnic group? Choose one option that best describes your ethnic group or background:

White

☐ English/Welsh/Scottish/ Northern Irish/British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Any other White background (please specify) _____

Asian/Asian British

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Any other Asian background (please specify) _____

Mixed/Multiple ethnic groups

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed/Multiple ethnic groups (please specify) _____

Black/African/Caribbean/Black British

☐ African
☐ Caribbean
☐ Any other Black/African/ Caribbean background (please specify) _____

Other ethnic group

☐ Any other ethnic group (please specify) _____

9. Do you have the support of:

Partner: Yes ☐ No ☐ N/A ☐ Parents: Yes ☐ No ☐ N/A ☐
Children: Yes ☐ No ☐ N/A ☐ Friends: Yes ☐ No ☐ N/A ☐
Peers: Yes ☐ No ☐ N/A ☐ Other: Yes ☐ No ☐ N/A ☐

10. Have you been given a psychiatric diagnosis? Yes ☐ No ☐ Don't know ☐

11. What is your main diagnosis? _____

12. What other diagnoses have you been given?

_____

13. Do you accept these diagnoses? Yes ☐ No ☐ Don't know ☐

14. How old were you when you first became aware of your condition? _____

15. How old were you when you were first diagnosed? _____

16. Have you experienced episodes of:

Depression: Yes ☐ No ☐ How many times? _____

Mania: Yes ☐ No ☐ How many times? _____

Psychosis: Yes ☐ No ☐ How many times? _____

17. Has anyone in your family ever had a suspected or diagnosed mental illness?

Yes ☐ No ☐

What was their relationship to you? _____

18. Are you currently taking medication for your mental health?

Yes ☐ No ☐

If yes, what medication are you taking?

_____

_____

19. Would you be prepared to take part in more detailed research?

Yes ☐ No ☐

20. If someone helped you to complete this form, please tell us who:

_____

_____

_____

By completing this form, I understand that I give my explicit consent under the Data Protection Act 1998 for the MHF to retain this information for up to one year after the end of the evaluation.

Next, you will be asked to complete a form aimed at evaluating the effectiveness of the service at [name of service]. For further information regarding the evaluation, please contact X.

Thank you for taking the time to complete this questionnaire.

Appendix 2 – Wellbeing

Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS)

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last two weeks.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been feeling interested in other people					
I've had energy to spare					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling good about myself					
I've been feeling close to other people					
I've been feeling confident					
I've been able to make up my own mind about things					
I've been feeling loved					
I've been interested in new things					
I've been feeling cheerful					

Do you have any other comments you would like to make?

Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS)

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last two weeks.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

Do you have any other comments you would like to make?

Appendix 3 – Health-promoting lifestyle activity

Health-Promoting Lifestyle Profile II (HPLP II)

Instructions: To help us to understand more about you, please fill in this questionnaire.

Please read the list of health-related actions below and circle the answer closest to what you do.

Key:
N = never
S = sometimes
O = often
A = always

General health					
1.	I get enough sleep for my needs	N	S	O	**A**
2.	I make time for myself	N	S	O	**A**
3.	I seek out information on TV or in books and magazines about improving my health	N	S	O	**A**
4.	I take time to relax each day	N	S	O	**A**
5.	I concentrate on pleasant thoughts before going to sleep	N	S	O	**A**
6.	I inspect my body for physical changes/warning signs	N	S	O	**A**
7.	I balance my time between work (including voluntary work) and leisure.	N	S	O	**A**
8.	I try to manage my day so as not to become overtired	N	S	O	**A**

Exercise					
1.	I take part in some kind of physical exercise	N	S	O	**A**
2.	I exercise for 20 minutes at least 3 times a week	N	S	O	**A**
3.	I take part in leisure activities that include movement	N	S	O	**A**
4.	I do stretching exercises at least 3 times a week	N	S	O	**A**
5.	I get exercise during daily activities (such as walking)	N	S	O	**A**

Food					
1.	I eat breakfast	N	S	O	**A**
2.	I choose a low fat diet	N	S	O	**A**
3.	I keep sugary foods to a minimum	N	S	O	**A**
4.	I drink one litre or more of water a day	N	S	O	**A**
5.	I eat at least 5 portions of fruit and vegetables a day	N	S	O	**A**
6.	I read labels on food packaging to find out what the food contains	N	S	O	**A**
7.	I eat three meals or five snacks a day	N	S	O	**A**

Social life					
1.	I give other people praise for their achievements	N	S	O	**A**
2.	I maintain worthwhile and enjoyable relationships with others	N	S	O	**A**
3.	I spend time with close friends or family	N	S	O	**A**
4.	I find it easy to show love and warmth towards others	N	S	O	**A**
5.	I get support from people who care about me	N	S	O	**A**
6.	I discuss my problems and concerns with people close to me	N	S	O	**A**
7.	I talk to others to settle arguments or conflicts	N	S	O	**A**

Dealing with health professionals					
1.	I discuss my health problems and concerns with health professionals	N	S	O	**A**
2.	When I don't understand what health professionals tell me I ask them questions	N	S	O	**A**
3.	When I am unsure about advice my doctor or other healthcare provider gives me I ask for a second opinion	N	S	O	**A**
4.	I seek help with my emotional or health problems when necessary	N	S	O	**A**
5.	I report any unusual signs or symptoms to a doctor or another health professional	N	S	O	**A**

Finding meaning					
1.	I feel I am making changes for the good in my life	N	S	O	**A**
2.	I believe that my life has meaning or worth	N	S	O	**A**
3.	I accept things in life that I cannot change	N	S	O	**A**
4.	I look forward to the future	N	S	O	**A**
5.	I feel content and at peace with myself	N	S	O	**A**
6.	I work towards my long-term goals in life	N	S	O	**A**
7.	I find each day interesting and challenging	N	S	O	**A**
8.	I am aware of what is most important to me in life	N	S	O	**A**
9.	I feel spiritually connected	N	S	O	**A**
10.	I look forward to new experiences and challenges	N	S	O	**A**

Appendix 4 – Goals

Goal Attainment Scale (GAS)

What are your goals?	How important is this goal?	How difficult is this goal for you?
Goal 1	☐ None at all ☐ A little ☐ Moderately ☐ Very	☐ None at all ☐ A little ☐ Moderately ☐ Very
Goal 2	☐ None at all ☐ A little ☐ Moderately ☐ Very	☐ None at all ☐ A little ☐ Moderately ☐ Very
Goal 3	☐ None at all ☐ A little ☐ Moderately ☐ Very	☐ None at all ☐ A little ☐ Moderately ☐ Very

GAS Outcomes

What were your goals?	Achieved?	If Yes	If No
Goal 1	☐ Yes ☐ No		
Goal 2	☐ Yes ☐ No		
Goal 3	☐ Yes ☐ No		

Appendix 5 – Average length of residence in each service

As outlined in Figure 15, of the participants who were discharged, the average length of stay between admission and discharge varied between service sites. Participants discharged from the Cliddesden Road service (n=2) had the shortest length of service use (12 months), with a range between 9–14 months. The Snowdon service had a similar length of stay (13 months); however, this site only accounted for one participant being discharged.

Of the six participants discharged from the Kelvin Grove service, the length of stay ranged from 8–50 months, with an average overall length of stay of 27.3 months. For those discharged from the York Road site (n=6), the length of stay ranged from 29–80 months, with an overall average of 48.8 months from admission to discharge date.

Participants at the Kirtling House site had the highest average length of stay within the service, at 52 months, with a range of 44–60 months. This result may, however, be skewed, as there were only two participants within this sample who had been discharged from the service.

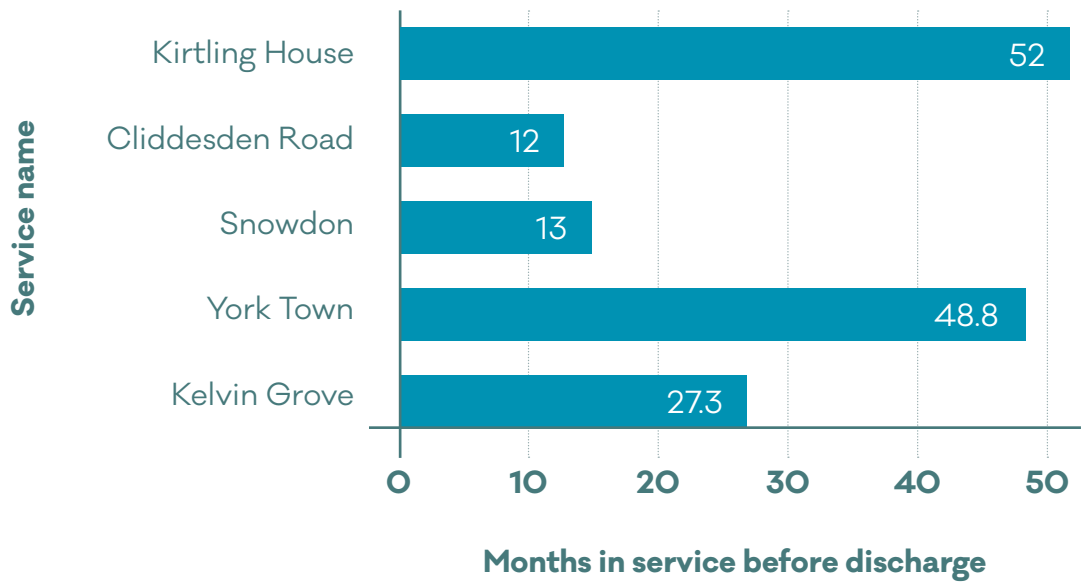


Figure 15. Average length of residence before discharge by service.

Appendix 6 – Interview schedules

Interview schedule: nine-month follow-up

The Mental Health Foundation is independently evaluating Together's X service. We want to identify what is working well and what could be improved in the future. You may remember speaking with me/my colleague approximately nine months ago. By keeping in touch with you over time, we can assess whether the service has been helpful to you.

If you agree, I'd like to record our conversation. Everything that you tell me will be kept strictly confidential, and any information that you give me will be stored anonymously.

If you wish to stop the discussion at any point, then please feel free to do so. You can also withdraw from participating in this evaluation at any point. This will not affect the service you receive from X.

Finally, if you have any questions or concerns about this research during or after our discussion, please do let me know.

Can you tell me a bit about the support you currently receive here at X?

What types of support do you receive? How long have you been receiving this support?

Has this changed at all since our last conversation?

In what ways do you think living here at X has helped you?

What works well?

What changes have you noticed in your day-to-day life? (E.g. started a course, joined a group, developed a new interest/hobby.)

Have you learnt any new skills?

Do you choose what type of support you receive? Can you tell me about this?

What has been positive about this approach? What has been negative?

Can you tell me about your experience of using recovery vouchers?

How have you used these vouchers? Are they linked to your personal goals?

What is different about this approach? Positives/negatives

Do you receive support from services outside of X? (E.g. alcohol or substance misuse, support groups, day centre.)

Do you use any facilities in the community? (E.g. leisure centre, library.)

In the past nine months, have you been hospitalised for your mental health?

How many times? For how long?

Are you currently:

Employed?

Volunteering?

In education/training?

Are you familiar with the term 'peer support'? Peer support is where other people who have experienced similar issues offer insight and understanding and can draw on their own experience to help. Have you received peer support while at X?

How has this impacted on your wellbeing?

In what ways is peer support different to other support you may have received? Can you give me an example?

Do you think you have gained any new skills as a result of peer support? Can you give me an example?

How are others involved in the support you receive (family, friends, carers, etc.)?

Has this changed since you started receiving support from X?

Do you feel there are any areas of the service that could be improved?

Is there anything you would change about X? Could you give me an example?

We would like you to revisit the goals you set yourself when you spoke with us nine months ago. We can remind you of these if you have forgotten them.

[Administer GAS Outcomes]

Again, we would like you to identify three goals that you would like to achieve in the next nine months. Once you have identified each goal, please rate the importance of achieving this goal to you by using the scale below.

We will ask you to return to these goals in nine months' time to reflect on your progress.

[Administer GAS]

We probably haven't been able to cover every aspect of your experience of being a resident at X in this interview. Is there anything you'd like to add?

Is there anything that you would like to ask? Thank you for taking part in this interview.

Interview schedule: 18-month follow-up

The Mental Health Foundation is independently evaluating Together's [name of service] service. We want to identify what is working well and what could be improved in the future. You may remember speaking with me or my colleague approximately nine months ago. By keeping in touch with you over time, we can assess whether the service has been helpful to you.

If you agree, I'd like to record our conversation to ensure accuracy of reporting. Everything that you tell me will be kept strictly confidential, and any information that you give me will be stored anonymously with no names or identities revealed.

If you wish to stop the discussion at any point, then please feel free to do so. You can also withdraw from participating in this evaluation at any point. This will not affect the service you receive from [name of service].

Finally, if you have any questions or concerns about this research during or after our discussion, please do let me know. Your feedback is really important to us.

If the resident has moved out of [name of service]:

Can you tell me about the process of moving on from [name of service]?

How was this planned?

How did you decide what would be suitable move-on accommodation?

What factors did you consider?

Were you supported with this process?

Did you have any worries/concerns? How was this managed?

All residents:

Can you tell me about your experience of living at [name of service]?

What do you think of the support? Has the type of support you receive changed at all since our last conversation?

Do you choose what type of support you receive? Can you tell me about this? (Positives/negatives.)

What do you think of the accommodation/environment?

How would you describe your relationship with staff?

How would you describe your relationship with other residents?

Has living at [name of service] had an impact on your life?

What works well?

How has it affected your wellbeing? (Developing coping strategies, self-management of medication, etc.)

Since living at [name of service], what changes have you noticed personally in your day-to-day life? (E.g. started volunteering, extended your social network, developed an interest or hobby, etc.)

Have you learnt any new skills? Can you give me an example?

Has living at [name of service] impacted on your future plans and ambitions? (E.g. independent living, employment, etc.)

Are you currently:

- Employed?
- Volunteering?
- In education/training?

Has the support you have received impacted on your personal goals? How has it done this?

We would like you to revisit the goals you set yourself when you spoke with us nine months ago. We can remind you of these if you have forgotten them.

[Administer GAS Outcomes]

Do you receive support from services outside of [name of service]? (E.g. resource centre drop-in, alcohol or substance misuse, etc.)

Do you use any facilities in the community? (E.g. leisure centre, library, etc.)

In the past nine months, have you been hospitalised for your mental health?

Are you familiar with the term 'peer support'? Peer support is where other people who have experienced similar issues offer insight and understanding and can use their own experience to help you. Have you received peer support while at [name of service]?

How has this impacted on your wellbeing?

In what ways is peer support different to other support you may have received? Can you give me an example?

Do you think you have gained any new skills as a result of peer support? Can you give me an example?

How are others involved in the support you receive (family, friends, carers, etc.)?

Has this changed since you started receiving support from [name of service]?

How has the support you have received from [name of service] compared to other support you have received for your wellbeing?

Is there anything you would change about [name of service]? Can you give me an example?

What would you improve about the service?

We probably haven't been able to cover every aspect of your experience of being a resident at [name of service] in this interview. Is there anything you'd like to add?

Finally, is there anything that you would like to ask?

Thank you for taking part in this interview.

Appendix 7 – Together cost breakdowns for Kelvin Grove and York Road

Table 13. Budget breakdown per week for Kelvin Grove service between 2013 and 2015

	2013/2014	2014/2015	Description
Staff costs	£477.04	£392.60	Includes on-costs and ODM allocation
Property costs	£42.14	£49.72	Includes building maintenance and insurance
Service user welfare expenses	£43.43	£58.50	Includes catering costs
Service charges	£54.62	£59.78	Service contracts, repairs and renewals, utilities, rates, cleaning materials, and garden maintenance
Staff learning and development	£15.64	£12.22	Includes in-house and externally provided courses
Office expenses	£17.98	£16.92	Includes telephone, postage, stationery, and IT
Voids/bad debts	£2.69	£20.00	Voids and bad debts at 14% and 3% respectively
Management charges	£77.16	£71.47	HR Department, Finance Department, and Senior Management Team
Total gross weekly unit cost (per participant)	**£730.69**	**£681.22**	

Table 14. Budget breakdown per week for York Road service between 2013 and 2015

	2013/2014	2014/2015	Description (similar to table on previous page)
Staff costs	£525.54	£508.22	Includes on-costs and ODM allocation
Property costs	£88.56	£89.06	Includes building maintenance and insurance
Service user welfare expenses	£27.02	£34.65	Includes catering costs
Service charges	£45.29	£66.57	Service contracts, repairs and renewals, utilities, rates, cleaning materials, and garden maintenance
Staff learning and development	£20.74	£20.26	Includes in-house and externally provided courses
Office expenses	£38.06	£28.81	Includes telephone, postage, stationery, and IT
Voids/bad debts	£71.62	£229.31	Voids and bad debts at 14% and 3% respectively
Management charges	£89.66	£89.71	HR Department, Finance Department, and Senior Management Team
Total gross weekly unit cost (per participant)	**£906.50**	**£1,066.59**	

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