The Living Well Network Hub Report

July 2015 – June 2016

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Contents

Executive Summary

Lambeth Living Well Network (LWN) Hub was extended to become a borough wide service in July 2015, after considerable success in working in the north of the borough. This was supported by funding from the Guys and St Thomas's Charity (GSTC) and Lambeth Clinical Commissioning Group(CCG)

In the past year the Hub has supported people in primary care with an enhanced offer to reduce the use of secondary care and improve outcomes. In its first year the Hub has:

- Offered over 4000 people support
- Reduced referrals into the previous secondary care entry point - MAP Assessment and Liaison Team by 43%
- Reduced referrals into all community secondary care teams by 29%
- Supported the Adult Mental Health redesign to reduce caseloads by 25% in the past three years
- Contributed to a broader system wide change of the 'flow' of people accessing and receiving support
- Demonstrated that people are satisfied with support the Hub has offered, that this support meets some of their needs and helps them deal with their problems more efficiently.
- Made significant progress in changing the culture of the workforce
- Change how the Hub staff are structured further reflecting the primary care localities and moving the Hub out into the local communities to offer initial conversations to people. Initial Conversations are brief face to face discussions with a member of Hub staff to identify the priorities people want to achieve to improve their mental health

The report concludes with recommendations for the following year. This are:

1. To review the resources in the Hub, GP+ and wider LWN to build on the learning made in year one by offering more timely, personalised support that is asset based. Developing the idea of the Hub completing specialist assessments to ensure people get the right support, without needing multiple assessments each time they need a new service
2. To further develop culture change concentrating on:
   - Extending the locations and frequency of days that initial conversations are held
   -Starting a prototype integrating voluntary sector staff within a community mental health team
   -The role of peers across the network

-Developing our asset based approach in the local communities including relationships with stakeholders.
-Working with socially excluded and minority communities
-Consolidating learning and develop process to support people with social care needs in primary care

3. Continuing our evaluation to ensure we can evidence the impact we are having

Section One - Introduction and Purpose of the Report

This report outlines the activity and key achievements of the Living Well Network (LWN) Hub in its first year of being a borough wide service.

The key aims of the LWN is to provide a network of services that support people in their community to achieve the three big outcomes of the Lambeth Collaborative. These are to ensure people recover and stay well, make their own choices and fully participate in everyday life on an equal footing. There are three transformation programmes in Lambeth happening over a three- year period. More details can be found on the website at www.lambethcollaborative.org.uk

The LWN Hub is at the centre of the network providing the 'front door' to mental health support in Lambeth. The Hub accepts introductions from GP's, healthcare professionals and self-introduction for people who feel they need support to achieve or maintain a 'good life' The Hub offers a personalised support plan to people in primary care using the assets of the person, the network and their local community. The Hub has been developed using the principles of coproduction and this is still one of the main foundations. The aim is for this new primary care service to offer people more choice, support people much earlier, when they feel they need support and change the culture of mental health service delivery in Lambeth.

The Hub is formed of a partnership of five organisations, South London and Maudsley NHS Foundation Trust (SLaM), Certitude, Thames Reach, Clapham Family Practice and London Borough of Lambeth. Staff work in three 'locality' teams which are in line with the GP practices local care network structure, teams are integrated and include voluntary sector support workers and peers with lived experience working alongside Occupational Therapists, Nurses, Doctors and social workers to give the person the best opportunity of achieving their goals. There is also a GP+ team who support people to be discharged from secondary care back to primary care to be supported by the LWN.

Lambeth CCG and GST Charity currently fund the Hub and the key aims of it are to

- Offer people personalised support

In the initial application for funding from GST Charity we stated we wanted to support 800 people in year one with a more personalised support package using a reablement approach. A reablement approach encourages people to use the skills they have or develop new skills to live an independent life.

- Reduce the flow into secondary care

We wanted to reduce the number of people being referred in the assessment and treatment teams by 10% in year one and by 25% in year 3

- Increase the flow out of secondary care

We wanted to reduce the numbers of people being care coordinated in secondary care by 50% at the end of year 3. We wanted to support 300 people on the GP+ Scheme

- Demonstrate the impact of creating a new service offer (the Hub) for individuals but also the wider system

We wanted to show that people can access a different offer when they want and in a place they find more convenient, we wanted to support people to improve their quality of life by achieving the big three outcomes. We wanted an accessible service that it did not have 'eligibility criteria' and we hoped that this would reduce the need for secondary care and costly crisis interventions.

- Change the culture of the workforce

We wanted to work differently with people, using an asset based approach and building people's networks and connections in a way that supported them to achieve a good life. We wanted to move away from clinically focused crisis support and offer an easy in easy out approach that people could access when they were having a wobbly day. This would require a change in culture for staff, people in Lambeth and other stakeholders such as GP's.

This annual report builds on the six-month report which can be found on the collaborative website or as an appendix at the end of the report

Section Two: Meeting the Key Aims

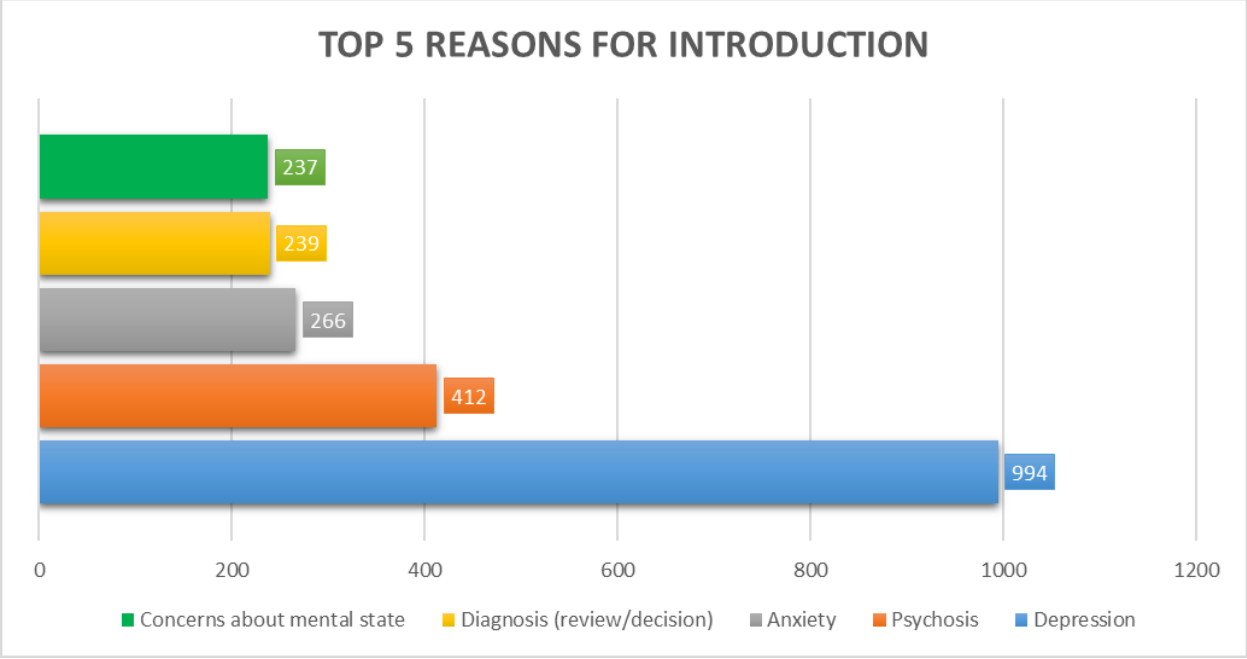
This section looks at how we have managed against the key aims set out in section One.

Section 2.1 - Offer people personalised support

The Hub has received 4708 introductions since it opened borough wide in July. This is an average of 392 introductions per month. All of these introductions are considered by a member of the Hub team and if appropriate contacted via phone, letter or in more recent months, invited for an initial conversation which is discussed in section three.

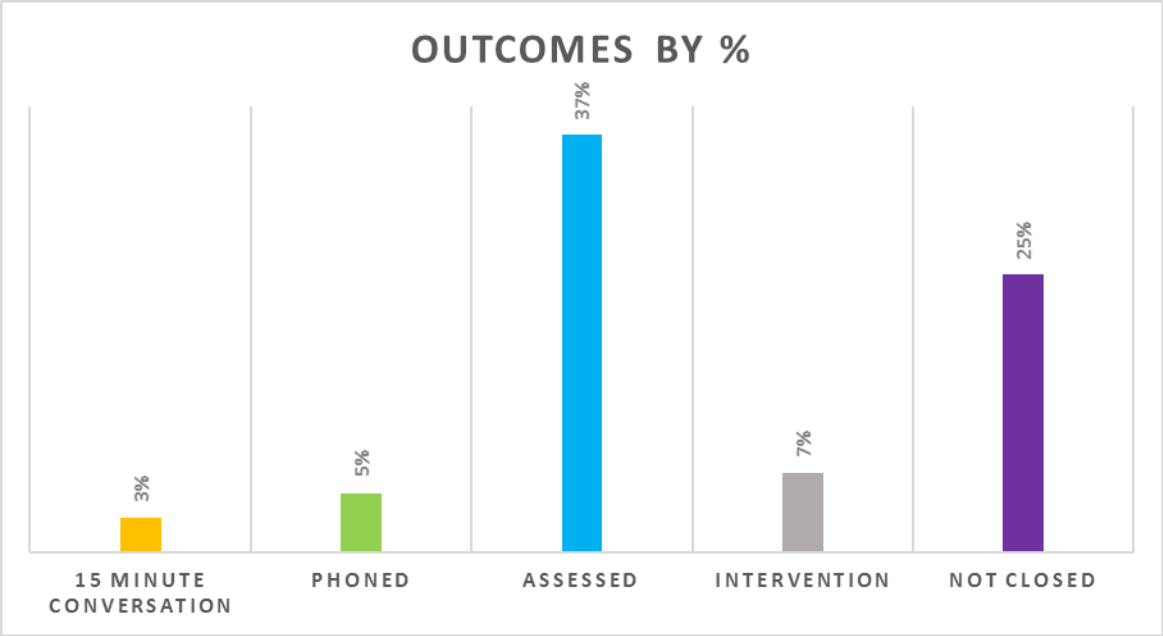
The majority of people are introduced by their GP. Graph One shows the main reason for introduction is depression although this isn't always a clinical diagnosis. The majority of introductions are between the ages of 20-64 (93%). We receive an even representation of males and females. The ethnicity of people introduced into the Hub are White (30% against a Lambeth population of 40%) followed by 18% of Black (African, Carribbean or Black British) people (compared to 25% of the Lambeth population). A more in depth breakdown of demographic information can be found in the Appendix.

Graph One: Top 5 Reasons for introduction to the Hub



We estimated we would support 800 people with a reablement approach of up to 12 weeks using the assets of the network, the person's own resources and their local communities.

We have offered differing levels of support to the 4708 introductions. Graph Two shows the type of support offered to people following their introductions. In Section three we discuss a change of the Hub Structure and service delivery that impacts on the type of support offered from initial telephone calls to face to face conversations.



Graph Two: Outcome of Hub introduction

Many people received brief, focused support that involves a conversation over the phone or face to face leading to advice, information or signposting to other services, others required a fuller assessment period and some received up to 12 weeks of reablement. A fuller assessment is usually because of initial clinical concerns but can also be because of a complex social need. It has been our experience that many of the clinical assessments have identified a social issue that is having an impact on the person and their clinical presentation. It is becoming clear that there are also some people that may require more than the 12 weeks of reablement support and whilst we are able to be flexible in offering more time, this is an issue that we need to consider over the next year.

23% of the introductions we received were considered by a clinician but we did not work with them because:

They did not have a Lambeth Address and/or a Lambeth GP

They were under the age of 18 or over the age of 65

They were already known to a SLaM services and working with them

They did not respond to our contact, despite us calling and writing to them (they did not opt in)

A summary of the types of support offered in the Hub are:

- Clinical assessment/a mental state examination
- Medications advice
- Mindfulness techniques
- Mental Health Education
- Accessing personal health budgets
- Urgent housing support and advocacy to prevent housing evictions, manage tenancy and arrears, or other housing related issues
- Benefits advice and support to attend appeals or complete forms
- Diagnosis of a mental health problem
- Advice around accessing specialist services and treatment
- Education and self-help techniques to support people to self-manage depression, psychosis, personality disorder
- Assessment for onward referrals to specialist services such as psychological treatment or the attention deficit hyperactivity disorder team
- Practical support to help someone clear their house out or get better bedding
- Employment support to remain in or get employment
- Emotional support
- Support to be involved more in their local community or an activity of their choice to reduce social isolation
- Assessment for eligibility for care and support under the Care Act 2014
- Ensuring people are safe using the safeguarding process

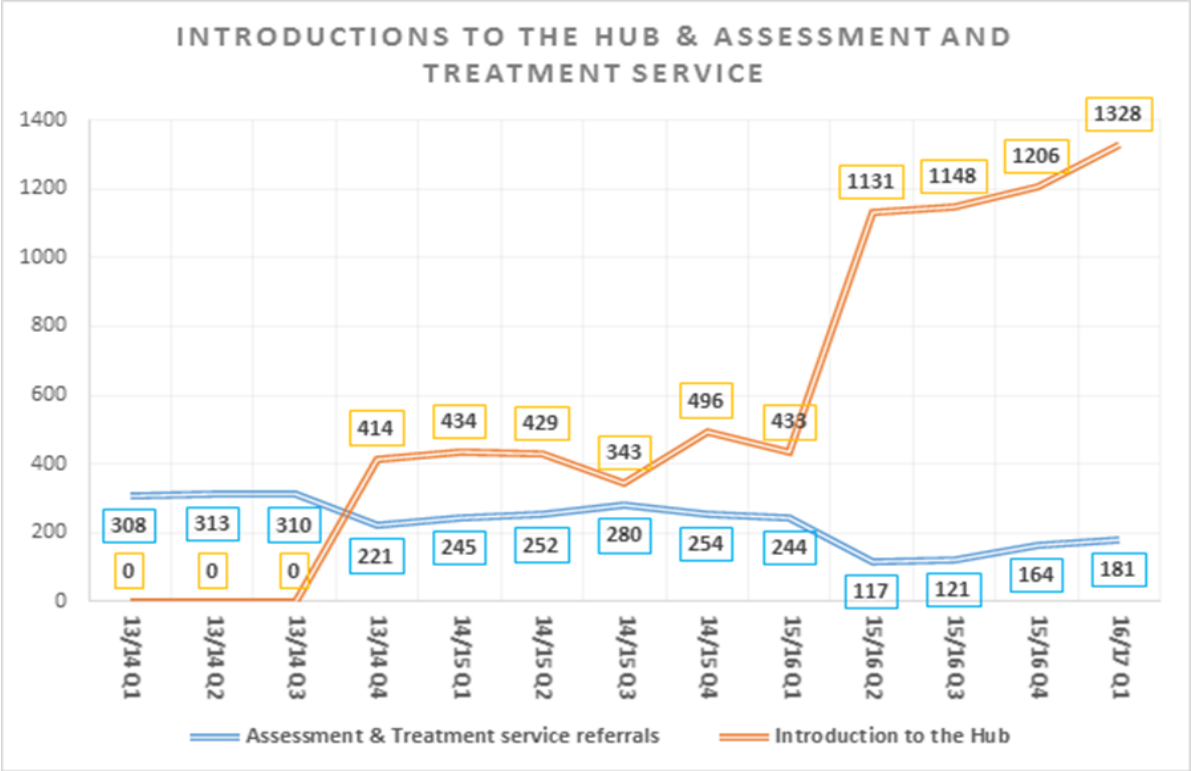
Section 2.2 - Reducing the flow into secondary care

One of the aims of the Hub is to reduce the flow into secondary care, by reducing the numbers of people being referred into the Assessment and Treatment Team (this was the previous front door to secondary care mental health support).

Graph Three shows the numbers of people being referred into A&T since November 2013 when the initial North Hub opened.

Since the Hub opened borough wide in July 2015 there has been a 43% reduction in the numbers of people being referred into the assessment and liaison (A&L this has replaced the A&T teams) team. We aimed to reduce the referrals into A&T by 25% in the first year and we

have exceeded this, demonstrating that many people can successfully be supported with brief focused support rather than needing a specialist service.



Graph Three: Introduction and Referrals made into the Hub and the A&T team for the past 2 years

Data from Lambeth CCG and Salesforce Inform

We have recruited three social workers in the Hub who are able to complete statutory social care work. They support staff to identify safeguarding concerns and complete the necessary processes for this, as well as supporting staff to complete social care assessments in line with the Care Act 2014. Previously this work would have been referred to A&T teams, even if the person's mental health needs did not require a secondary care treatment. This has further reduced the referrals into secondary care. Specifically, the social workers have:

Completed 13 urgent judicial reviews requiring assessment of the person's social care needs due to their mental health

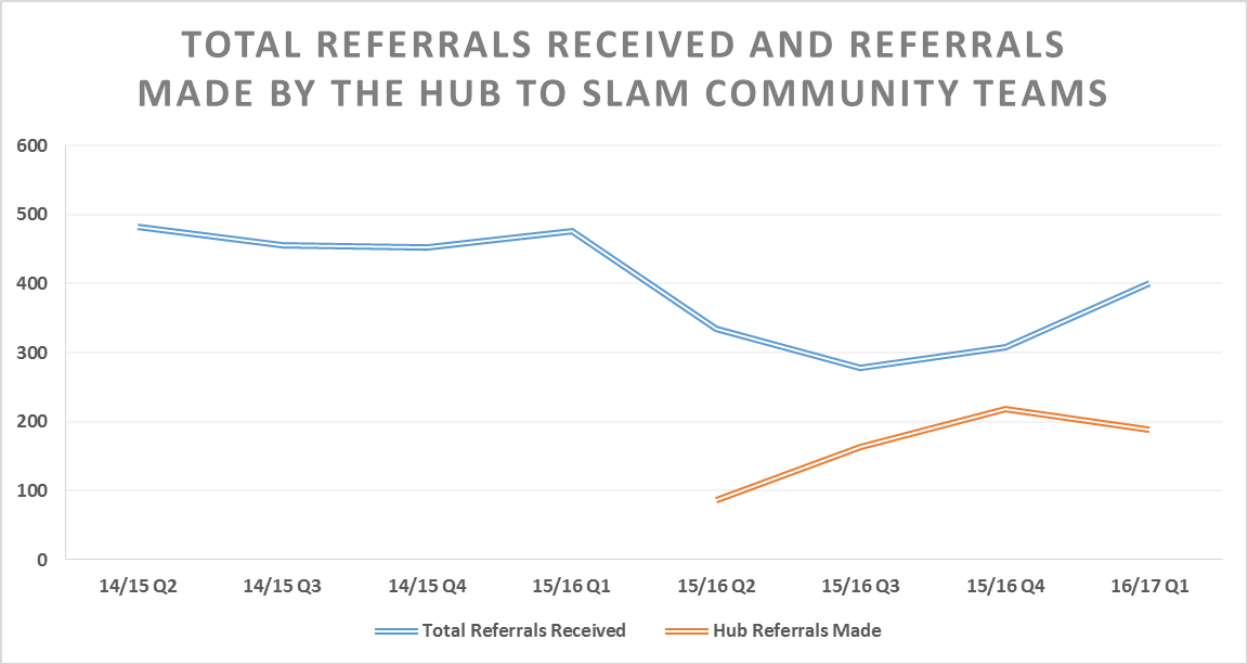
Supported the Hub to raise 92 safeguarding alerts via training and support of all the Hub staff and then gone on to investigate and plan how to maintain someone safely in the community.

Made ten referrals onto children and young person's services

There has also been a 29% reduction of all referrals into SLaM Community Teams (Assessment and Liaison (A&L), treatment, assertive outreach, promoting recovery, outpatients, Integrated Psychological Therapy Teams, (IPTT) and Lambeth Early Onset (LEO)*) in the past year since the borough wide Hub began. This can be seen below in graph four. This graph shows the numbers of referrals that the Hub have made to those teams in the past year.

*assertive outreach and outpatients team no longer exist, IPTT and LEO we have grouped as specialist teams

Graph Four: Total referrals received by secondary care and onward referrals made by the Hub



14% of the people introduced to the Hub go on to need a specialist secondary care service. As a result of this reduction of referrals to secondary care and learning derived in year one we feel we could further reduce the referrals into secondary care. We believe that identifying the need for a specialist service and making an assessment in the Hub could mean a more seamless service, preventing delays and reducing the need for multiple assessments in different services creating further savings and efficiencies.

We have made significant progress in supporting people in a timely manner. Prior to the Hub, assessments were taking place in specialist SLaM services (A&T team). The outcome of the assessments in SLaM were similar to that of the Hub's (people being signposted or given information and then discharged) but people were often wait up to 28 days for a routine assessment, although the referral would be triaged quickly to ascertain urgency and need. Both

the triaging and the assessment process were completed clinician. The Hub have reduced the time taken for people to be seen in the past year, and in June 2016 people were waiting on average 12 days to be contacted and offered an initial conversation 'slot' and it is hoped that this will further be reduced to five working days by the end of year two. If the Hub receives urgent introductions, they will contact the person the same day and ascertain when the person needs to be seen. If someone does need to be seen on the same day and this isn't possible in the Hub we would ensure the person got that support in SLaM through the A&L team or an accident and emergency department. In section three we discuss how any member of the Hub team can meet with someone during an initial conversation to ascertain their hopes and needs, which is more cost effective than always being seen by a clinician. One the days that the Hub are holding initial conversation day's people can just 'drop in' so they can be seen on the same day. Our experience is that receiving information from support workers and peers can be useful for people.

We believe that the Hub has demonstrated that the analysis and rationale of the Lambeth Collaborative and the first GST charity application for funding were right - that by investing resources further 'up stream' and giving primary care a more robust network of support this would reduce referrals into an overstretched secondary care system. We need to sustain and further improve this work within the Hub and seek support across the system to do this so that the changes made can become mainstreamed at the point when the GST Charity funding comes to an end.

The Hub have been able to offer a front door to mental health support that is not just focused on clinical intervention as the initial conversations are held with any practitioner from the Hub (peer interns, social workers, Occupational Therapists, nurses, support workers) and offers a broader range of intervention. This has reduced the referrals into A&T by 43% as well as contributing to a reduction in overall referrals to secondary care by 25%. Many people have a 'clinical' reason for introduction but this is often identified by the person and the Hub staff through the initial conversation and further assessment as not always being the persons

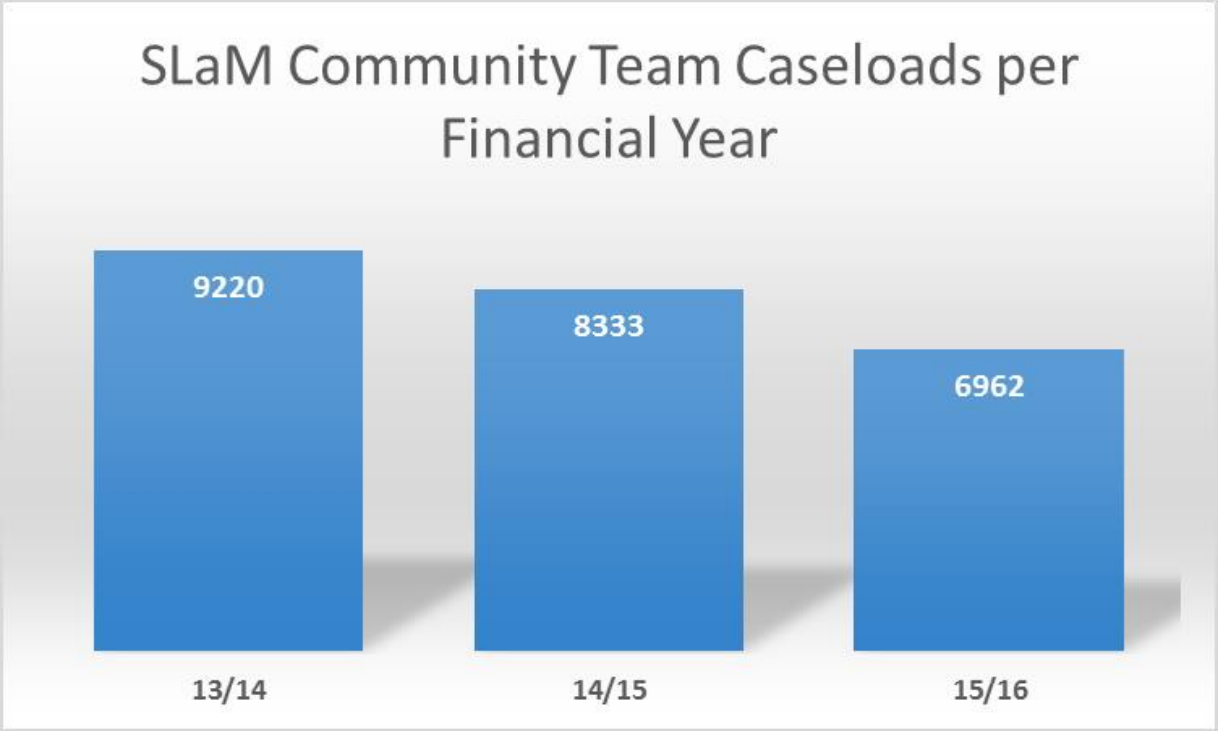
The Hub has received more introductions per month in the past year than A&L did prior to the Hub, indicating that people are responding to the change in services by introducing people who would not have received any service previously thereby potentially preventing crisis response at a later date. We also believe that this indicates that people are responding to a model of preventative, early intervention health care.

Section 2.3 - Increasing the flow out of secondary care

In the GST charity bid another target set was to reduce the numbers of people receiving care coordination by 50% by year 3. Since April 2013 and in partnership with the Adult Mental

Health Redesign in SLaM there has been a reduction of the community team's caseloads of 25%.

Graph Five: Caseloads of SLaM Community Teams



This is an important achievement, demonstrating the success of both redesign programmes in ensuring the system works together to achieve change. However further change is required if we are to achieve another 25% reduction.

The GP+ Team have also supported this target. (See Story in Appendix five) The GP+ team have supported 129 people to date. 118 of these people have been discharged directly from secondary care, where many were being care coordinated. This falls short of our target of 200 people being discharged from secondary care.

We also had a target of supporting 100 people from primary care to prevent referral back into secondary care and we have supported eleven people who were identified by their GP as needing additional support from the team. We suspect the number of introductions from GPs for this service is lower than predicted as people who meet the criteria for GP+ are being seen and supported by the Hub's 12 week reablement offer.

To date we have worked with 43% of the 300 people targeted and we will achieve this target in year two. We want to review the GP+ team to consider the skill mix and function in year two. We have learnt that whilst many people no longer need specialist clinical support they have complex social needs that require more input than the GP+ was initially designed to offer when seeing someone every three months. We have two opportunities to reduce caseloads in year two, the first is through the development of the CMHT prototype, funded by GST charity. This will give us an even better understanding of what the network can offer people who have longer term needs. The second is to consider the role of social care in discharging people who remain in secondary care solely because of their long term social care needs.

Section 2.4 - Demonstrating the impact of creating a different offer (LWN Hub) for individuals but also the wider system

To evidence the impact of the LWN Hub we have used four methods of evaluation:

- Client Satisfaction Questionnaire (CSQ) – this is a brief questionnaire people can complete themselves. We have sent this out to over 700 people in the past year and asked them to complete it. We have received 101 responses, (see appendix for questionnaire and results). The results show that many of the people who responded to the questionnaire were satisfied with the quality of the service they received (79%). 89% of people felt that the Hub was able to meet some or almost all of their needs and 79% of people felt that the support they received helped them to deal with their problems more effectively. We feel this shows that people are generally happy with the type of and quality of support that the Hub is offering. It also recognises that the Hub does not meet all of the needs of an individual all of the time. Those people who were satisfied with the Hub all reported a positive impact on their life.
- A face to face survey conducted by a researcher from the Institute of Psychiatry, Psychology and NeuroSciences (IOPPN) interviewed 39 people using an agreed set of questions (see appendix for analysis of this). Overall, the results from this survey showed the excellent strengths of the Hub. People were receiving support for a wide range of issues. 64% of people felt better after the support from the Hub. The Survey also gave us a greater understanding of why people were satisfied with the Hub and reasons why they were not. Some people were dissatisfied with the time taken to get support, so we have worked hard to reduce the waiting time in the year. People interviewed overall felt more supported by the Hub than other services they had received or were receiving support from.

- Ethnography. This involved the Innovation Unit and peers spending time collecting stories from people who had used the service to gain an in-depth understanding of what the service was like for them and also the impact it had on their lives. We have collected five stories and synthesized these into presentations which can be found in the appendix. These stories are important as they have all been used in the Living Well Lab, a bi monthly workshop for all Hub staff. In the lab the staff spend time looking at the story to better understand what the experience was like for the person and to identify ideas and prototypes that could further improve the service experience for people in the future. This is an important part of our service development.
- Work and Social Adjustment Scale (WASAS) is a simple, well-used measure asking people to rate their 'impairment' using 5 areas. These are: home management, ability to Work, social leisure activities, private leisure activities and close relationships. We have collected 136 paired WASAS. The measure and results can also be found in the appendix. Statistical analysis found that there was a significantly lower score in the WASAS completed after the Hub support, demonstrating people rated their 'impairment' lower or less after Hub support.

Overall we are pleased with the results of this feedback regarding people's experience, we believe this is a really positive start and indicates that we are doing the right thing for the majority of people in terms of the model of support, however, we need to continue to improve our services and the feedback we receive is always considered as part of the ongoing development of the service. We would also like to get feedback from more people and we aim to improve this in the next year.

The reduction of referrals to and caseloads in SLaM has demonstrated that people do not always need specialist support and working with people in the Hub and primary care using networks in local communities can have an impact on people. It could also save money and support SLaM to work with people who benefit the most from their specialist clinical expertise.

We would like to offer more people the opportunity to give their feedback so in year two we will be identifying and improving the way we ask people for their feedback, especially using technology more to continue the evaluation as part of year two.

Section 2.5 - Changing the culture of the workforce

Whilst changing culture is a challenging and ongoing process we feel that we have made great progress in year one and we are keen to continue this in year two. The main changes to culture are:

- Asking GP's to make introductions to the Hub rather than secondary care to give people an opportunity to be supported in primary care. All the GP's have made introductions to the Hub and we would like to ask them their views on the Hub and the impact it has made to their work in year two. We believe we have made an impact for them as previously people would need to have a diagnosis or require urgent support because they were already unwell could make a referral. The Hub has no thresholds and we want people to come to us when they are beginning to find life difficult We have also introduced the idea that people can introduce themselves when they need support rather than going to their GP.
- That the Hub is based in an unusual location, which is a different space to traditional mental health services. The Job Centre Plus has given us the opportunity to work in a different environment which is instrumental in how people view services. We recognise that we need to work in places within the local community, that people may not normally identify as support settings, this enable us to reach people who may not access traditional mental health services.
- Changing the language we use supports people, including staff, to think differently. Instead of referrals we have introductions, we do not discharge people from the Hub, we close their support and they can come back at any time and be made to feel welcome. We want this change in language to feel less clinical and more empowering for people.
- Integrating the organisations in the Hub has meant that they work much more closely together. The voluntary sector have a significant presence in the Hub, leading and managing the other professionals within the locality teams. Having different organisations working in the Hub brings opportunities to challenge 'norms' such as levels of risk taking and encourages the use of different services within the local community
- Providing mental health training to over 350 people who work with people in Lambeth. These are work coaches within the Job Centre and Housing Support Officers in Lambeth Housing. This has been an opportunity for us to build links with other organisations and also to challenge how people think about their mental health. It is also supporting one of the recommendations of the Lambeth Black Health and Well Being Commission Report 'From Surviving to Thriving'
- Enabling staff to work in the local communities by providing IT equipment that enables them to work in people's homes, cafes and other places, staff have laptops and access to the internet wherever they go, so that they can work more efficiently

- Having a social care presence in primary care has allowed us to support the identification of people's social care and safeguarding needs with their GP and this, enables people to live safely and independently in their local communities. Supporting people earlier in primary care supports the Local Authority to meet some of the requirements of the Care Act 2015 to provide preventative social care.
- Supporting people to meet their goals by giving 29 personal health budgets in the past year. A small one-off payment has enabled people to support their health and recovery by, for example, attending a course, buying equipment, have a specialist assessment or receiving ongoing support past the Hub's 12 weeks. (See Story in appendix five)
- Asking people what they want, not basing our interventions on what a professional has written on the introduction., We are really interested in what people identify as their priorities and working with them on these
- Providing information to people who access the service. People often do not receive information about self-management of symptoms, where they can access other services or even who they may be meeting. The Hub has been providing client held information and records to everyone who we meet for a face to face assessment. We also have information and photos about the practitioners who work in the service displayed in the team base
- Having peers within the workforce. The Hub has five part-time members of staff who are on a transitional employment placement (TEP) and three supported employment places (admin assistants) supporting the administration of the Hub and three peer interns. These are all people who have a lived experience of using mental health services. Some of the peers will also be supported to develop researcher skills so that they can listen to people's stories and understand why they came to the Hub and how the Hub impacted on them. This stories will be used to develop the service in year two.

We would like to focus on how we can have truly asset based conversations with people in their local communities and develop a model that explains this simply to people. As we extend the network into the CMHT we also have a further opportunity to continue the work regarding our workforce culture change. We have asked staff to complete a questionnaire called 'ways of working' and this can be found in the appendix. However, it shows that staff feel they have changed how they work because of the integration of teams in the Hub and changing the concept of discharging people, so that they can always come back to the Hub in the future. We still have a long way to go to change culture but we have made a considerable start.

Section Three – Developments Since the Six-Month Report

When the borough wide Hub opened in July 2015, we decided to work within a team structure of an introductions team (six clinical expert practitioners from SLaM and two support workers from Thames Reach, three locality teams (with professionals from all organisations) and the GP+ team (nurses). However, this structure did not work well and lead to a delay in responding to introductions in a timely manner, it also felt overwhelming for staff.

The Hub wanted to foster an approach that offered a different response from secondary care at the point of entry into mental health services and we realized that it was often the stresses and strains of everyday life that led to an introduction to the Hub along with some clinical symptoms. An initial conversation with someone was a way of considering people's circumstances and clinical symptoms in a more holistic way.

We have changed the structure of the Hub so that there are three locality teams and a GP+ Team. Introductions are given to one of the Locality Teams based on the GP practice. The locality teams now have the clinical expert practitioners within them. The Hub Coordinator, psychiatrist, peer interns and Practitioner Manager from social care work across all three teams providing further specialist support when needed. The GP+ works as a separate team.

This change has further helped with integrating the different assets of all the organisations and professionals working in the Hub and has supported us to manage the demand, we are now able to see people much quicker and in the last month we have be able to contact people within an average of 12 days.

<u>Section 3.1 - Initial Conversations</u>

The initial conversation day started in March 2016 and involved a locality team from the Hub being in a community space one day a week and offering an initial '15-minute conversation' to

people who are introduced to the Hub. An initial conversation is similar to a GP consultation and is the first step for people to identify their assets and the priorities they want support with. From this conversation they can then decide what is the best course of action. This may be information and onward introduction to another service or a longer conversation or support with a specific member of the Hub. This change has enabled the Hub to manage work flow more efficiently and also to ensure that we are offering people the service that they want, not what the referrer thinks they want. Currently this is offered by appointment only and is in the following places:

- St Luke's Hub (North Locality) on a Tuesday
- Connect and Do Space (SE Locality) on a Tuesday
- Clapham Methodist Church (SW Locality) on the Thursday

We are hoping to expand this service so that people can 'drop in' when they need support. We want to have a presence in more venues, more regularly for people to attend in year two. We believe this will support Lambeth CCG to meet the recommendation made in the 'Surviving to Thriving' Report of having mental health support accessible to people in local community settings.

Section 3.2 - Identifying the need to grow the LWN

During the course of the year we have received over 4500 introductions and are starting to identify areas of support with that traditional mental health services have not been able to offer. This is because we are seeing a 'different' group of people who are often struggling to maintain their mental health and wellbeing rather than being formally diagnosed as mentally ill. We have made onward introductions to many of the LWN agencies such as Certitude, Mosaic Clubhouse, The Employment Academy, Every Pound Counts and IAPT.

Prior to year one we made links with the Job Centre Plus (JCP) which has enabled us to be based in a different location and learn more about the support they offer people and the challenges they face. The relationship between the Hub and the JCP has continued to grow and they have given us valuable advice about the benefits system and the number of people they work with that access mental health services and their relationship with these services. We also believe it is really important to increase our ability to support people regarding employment, and we have been exploring opportunities to do this, using Thames Reach Employment Academy and the local authority programmes. The Local Authority also recognise the importance of employment on people's health and wellbeing and are looking at how this can be further improved in Lambeth. They have created a link-working service as part of the Lambeth Works team, which staff in the LWN Hub can make onward referral to, to enable them to get specialist support to gain employment.

We have also begun to build links with Lambeth Housing as we know that having suitable housing is an important part of people's well-being and one of the reasons people present to services. We would like to better understand problems people have with housing so that we can develop solutions together with Housing providers and the local authority. There are examples of the different types of housing problems that people are experiencing in Lambeth, in appendix five, and whilst we have links with 'No Second Night out', Street Link and the START team, all of which are services that seek to support people avoid or escape homelessness. We also need more housing specialists who can advise and advocate for people regarding eviction, housing rights, entitlement and tenancy and this needs to be considered with the development of the network.

We would like to further support the reduction and duplication of assessments in different services and have agreed to start a pilot which will enable a clinician from LEO to spend a year in the Hub, supporting us to identify people who may be experiencing their first episode of psychosis and need access to specialist services for assessment and treatment in line with government targets. We believe that we can expand the front door further - extending the Hub offer to others, which we feel with further reduce the fragmentation and make it easier still for people to get the right type of support quickly. We would like to improve our relationships with local A&E departments and out of hour's services such as 111 (the NHS non-emergency support line), so that people can access the right service at the right time. We are now on the 111 service menu, so people can be introduced to us from 111 if they ring outside of working hours.

We want to improve our links to local community services and resources. We know that there is a wealth of resource in local communities that are not linked to mental health services, that can offer support, activities and reduce social isolation. We want to be able to work with these services so that we can support them to understand the importance of wellbeing and when and where they can get help if they are worried about people, and linking people with these community resources if they express an interest in them. This is a really important part of year two.

We need to further build our relationships with our GP's, and we would like to do this by regularly attending their practices to offer support and maintain good relationships with them. We want to be part of the Locality Care Networks and support them to develop, our managers are already attending these meetings regularly. We are developing mental health virtual clinics which will give GP's the opportunity to have a conversation with mental health specialists from the Hub and secondary care to discuss their concerns and help develop the GP's skills and understanding.

Section Four - Recommendations and Conclusions

The Hub has made significant progress in enabling more people to receive support. This has meant that some people who are likely to have entered mental health services in crisis at a later date have not done so. This has contributed significantly to the management the demand in secondary care, and in discharging people out of secondary care.

As a result of learning to date from staff and user feedback, we have identified some recommendations which we hope will further contribute to the Big Three outcomes of recovery, choice and participation, reducing the flow into and out of secondary care and culture change. These are:

1. To review the resources in the Hub, GP+ and wider LWN to build on the learning made in year one by offering more timely, personalised support that is asset based. Developing the idea of the Hub completing specialist assessments to ensure people get the right support, without needing duplicate assessments each time they need a new health or social care service and result in seamless service with less fragmentation in the wider system
2. To further develop culture change concentrating on:
   - Extending the locations and frequency of days that initial conversations are held
   - Starting a prototype integrating voluntary sector staff within a community mental health team
   - The role of peers across the network

- Developing our asset based approach in the local communities including relationships with more stakeholders
- Working with socially excluded and minority communities to engage with them with the LWN and Hub so that they know where to get support when they need to
- Consolidating learning and develop process to support people with social care needs in primary care this will include partnership working around prevention, safeguarding support plans, social care assessments, reviewing and managing personal budgets for people who require ongoing packages of care

3. To continue and further develop our evaluation to ensure we can evidence the impact we are having
4. To consider the scope to make savings within secondary care as outlined in the original GST Charity bid

The LWN Hub has had a positive impact in its first year as a borough wide service, supporting a broader system wide change outlined by the Lambeth Collaborative. It has achieved many of its targets outlined in the GSTC bid for year one and continues to learn and develop to support the citizens of Lambeth to lead a 'good life'.