The Living Well Network

Living Well Network Hub

Year Two Evaluation Report

December 2017

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The Living Well Network

Foreword

This report has been agreed and ratified by the Provider Alliance Group (PAG) consisting of: Thames Reach, South London and Maudsley NHS Foundation Trust, Lambeth Council, Certitude, Clapham SPMS, Lambeth Clinical Commissioning Group, First Step Trust

The year two evaluation report was considered and discussed with members of the PAG on 26th October 2017. The report was well received by the PAG and members were greatly encouraged by the continued progress of the Living Well Network (LWN) Hub, particularly in relation to the culture change that the evaluation was able to clearly evidence, with 91% of Hub staff strongly agreeing or agreeing that the Hub has moved from a traditional model of mental health and as a result of this mental health care is more integrated within the local community. Clearly staff felt that they were engaging with a coproduction approach and more able to support people in the context of their communities. The PAG particularly noted that staff reported having a different quality of conversation with service users, being encouraged to focus primarily on what mattered to the person rather than engaging in a standard, less personal, long assessment.

Additionally, the PAG was heartened by the strides taken in year two in reducing barriers to people accessing the Hub by having no eligibility thresholds and in adapting processes to meet higher demand. This was seen as a significant advancement in developing a preventative approach with an important focus on assisting people to access the services that best suited their needs. The increase in self-referrals to 10% of introductions to the Hub was viewed very positively with a wish to see this percentage figure increase further.

PAG members were also acutely aware that there is more to do to meet changing demands and to ensure that all Lambeth citizens with mental health needs receive the holistic, community-based, choice driven services they need and deserve. In particular, the PAG meeting noted that the Hub's rapid borough-wide expansion and ease-of-access approach had led to challenges in communicating how the service can help and in responding to the many demands on its service. As a result, satisfaction among people using the Hub had fallen in year two in comparison with year one, though overall people still positively rated their satisfaction with the Hub. The PAG was confident, particularly as a consequence of the introduction of more management capacity, that satisfaction figures would improve in year three.

The PAG requested that the LWN Evaluation Board develop a year three evaluation framework. The PAG noted in particular the need to further improve data collection in relation to ethnicity and reasons for accessing the Hub. The PAG also asked that attention be given to the collection of data from neighbouring boroughs to enable further comparison and to evidencing, where possible, the impact of the Hub on the wider system delivering mental health services.

Finally, the group reiterated its support for the work of the Hub as it enters a new phase which will include the need to deliver services in a more effective and integrated way with primary care. PAG members were appreciative of the commitment and enthusiasm of those on the evaluation group and asked that regular updates be circulated to them and a final year three report presented at the point when the Guy's and St Thomas' Charity funding comes to an end in late 2018.

Executive summary

Key findings:

- The Hub has increased access to mental health support in primary care, in year two offering support to 5,677 people. This does not take into account the informal follow up support given by Hub staff, which suggests that there are an additional group of people who need and benefit from ongoing brief support to help them to stay well. In our original vision we hoped we would support 1,500 people by year three.
- In comparison to the financial year 2013/14, the Hub has contributed to:
  - The reduction in the numbers of referrals to the Assessment and Liaison service (A&L) by 31% in year two against a target of 25% by year three.
  - The reduction of referrals to secondary care teams by 25%. Secondary care teams are defined as all community mental health teams (CMHTs), specialist services (for example early intervention and crisis services) etc. CMHT's offer people with serious mental illness (e.g. schizophrenia) specialist treatment and support under a multidisciplinary team led by a psychiatrist, with people having a named worker, usually a care coordinator.
  - The reduction of caseloads of long term care co-ordination by 27% (against a year two target of 40%).
- As envisaged in the original Collaborative aim, a wide range of clinical and social care support is offered by the Hub and in turn people are making introductions for a broad range of social and clinical reasons.
- Self-introduction has increased from 4% in year one to 10% in year two
- The average (mean) cost per person introduced to the Hub was £103 (as analysed between 1st march and 30th June 2017). When compared to national reference costs, this suggests that for many people the Hub is likely to provide a comparatively low cost (and high volume) means of freeing up resources in the local secondary care Assessment and Liaison services.
- There is evidence that there is improvement in outcomes of the people who access the Hub and largely people are satisfied with what the Hub has to offer.
- The satisfaction of people who have been supported by the Hub may have been lower in year two than in year one. However, people who have been supported by the Hub provide mainly positive feedback, describing the Hub's support as effective and as having made a helpful difference to their lives.
- 91% of Hub staff agree that the service has moved away from a traditional model of mental health and as a result of this mental health care is more integrated within the local community. The same percentage felt empowered to be part of service development.
- Stakeholders who work with the Hub gave mixed feedback.

Recommendations centre upon:

- The need to more clearly communicate the Hub's remit and purpose in order to foster shared expectations amongst stakeholders.
- Making changes to improve the collection of some demographic data, in particular data on ethnicity.
- The need to increase completion of self-reported impairment scales. The findings show that the Hub may be reducing people's self-reported impairment; however, the difference between pre and post Hub impairment scores was small and not statistically significant. Recommendations centre upon assessment after a longer period of time in order to assess if sustainable change occurred.
- The need to more fully understand differences in culture and practice between the three locality teams that operate as part of the Hub – so as to ensure cross learning within the Hub itself.

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List of abbreviations

A&E – accident and emergency
A&L – Assessment and Liaison service
CCG – clinical commissioning group
CIS – Centre for Implementation Science
CSQ – client satisfaction questionnaire
DXS – an IT system linked to EMIS
EMIS – an electronic patient record system in Lambeth
ePJS – electronic patient journey system (in South London and Maudsley NHS Foundation Trust)
GP – general practitioner
GP+ – an enhanced model of support in primary care for people discharged from secondary care
GST – Guy's and St. Thomas'
IAPT – Improving Access to Psychological Therapies team
IPTT – Integrated Psychological Therapy Team
KCL – King's College London
KHE – King's Health Economics
KIS – King's Improvement Science
LWN – Living Well Network
MI – Maudsley International
NHS – National Health Service
PAG – Provider Alliance Group
SLaM – South London and Maudsley NHS Foundation Trust
WASAS – Work and social adjustment scale

SECTION ONE: Background to the year two evaluation and introduction to the evaluation team

The Lambeth Living Well Network (LWN) Hub opened on 26th June 2015. A pre-requisite of the funding was "an evaluation programme to assess the impact of the Hub and develop the evidence base of community based provision for mental health care" (from original funding application to Guy's and St. Thomas' (GST) Charity). The year one evaluation was carried out by members of King's Health Economics (KHE) at King's College London (KCL) and the findings were incorporated into the report to the GST Charity for the period July 2015 – June 2016. The evaluation programme was reviewed at the end of the first year and KHE members suggested that it may be advantageous to involve other colleagues experienced in review/evaluation work in London (and further afield).

Having reviewed a draft evaluation specification and associated documentation, it was proposed to develop a partnership between the Centre for Implementation Science (CIS), King's Improvement Science (KIS), Maudsley International (MI) and King's Health Economics (KHE) - each of these groups is physically based within the Health Service and Population Research Department at the Institute of Psychiatry, Psychology and Neuroscience, King's College London (KCL). This brought together a small evaluation team comprising members with a range of skills and research expertise.

This new evaluation team developed proposals for the year two evaluation in collaboration with LWN Hub staff. Evaluation workshops were held with LWN Hub staff members in January 2017 in order to discuss the purpose of the evaluation, provide training, and receive feedback. An evaluation group involving representatives of LWN Hub staff (including peer support workers / people with lived experience) and KCL colleagues met monthly, starting in December 2016. A key focus for the KCL evaluation team has been to provide support and training on evaluation methods and analysis, therefore strengthening the skills of LWN Hub staff and building capacity within the Hub.

The evaluation group has also been supported by an evaluation board comprising senior representatives of the Lambeth Living Well Collaborative, including the Provider Alliance Group Director and the Assistant Director of Integrated Commissioning (Adult Mental Health) NHS Lambeth Clinical Commissioning Group and London Borough of Lambeth. The evaluation group and evaluation board have overseen the development and delivery of the work plan and the production of this year two evaluation report.

The underpinning evaluation methodology for this review is sometimes referred to as 'embedded' evaluation whereby the researchers work closely with the service to develop and carry out the evaluation activities together. This approach can facilitate the review team developing a deep understanding of the service context and having opportunities to reflect openly on challenges and ideas for improvements. It is noteworthy that this style of evaluation appeared to be particularly effective for this year two evaluation and the Hub are to be commended for the level of openness to external scrutiny they demonstrated during the evaluation process.

This report presents the context of the service and discusses data collected during the year July 2016 – June 2017, the LWN Hub's second year, and where relevant makes comparisons to the previous year.

SECTION TWO: Context and background to the Living Well Network Hub

In June 2010, Lambeth Clinical Commissioning Group (CCG) established the Living Well Collaborative ('the Collaborative') with users of services, carers, statutory organisations across secondary care, primary care and commissioning, voluntary sector agencies and public health. This was a shared platform to begin a journey towards meaningful and sustainable whole system transformation of mental health services that would radically improve the recovery outcomes of those with mental health needs in Lambeth.

As a result, three Big Outcomes were formed, namely to support people to:

1. Recover and stay well, and experience improved quality of life and physical and mental health
2. Make their own choices to achieve their personal goals and experience self-determination and autonomy
3. Participate on an equal footing in daily life, specifically:
   - To connect with others, family, friends and neighbours
   - To give in the community i.e. via community activities, peer support or volunteering
   - To be included, particularly in relation to education, employment and stable housing
   - To participate on an equal footing in society to access mainstream services such as housing and employment, thereby reducing stigma

There was a commitment from members to achieve this via a co-productive approach as defined in Figure 1. A key principle of this approach is supporting individuals to identify and grow their own skills and assets and to use the resources they have, including neighbours, family and agencies they are in contact with, to have a 'good life'.

Figure 1: A co-production approach

After a series of stakeholder consultation events where experiences of users were described and financial investment explained, it was recognised that significant investment was placed with a low number of people with severe problems at extremely high cost. Stakeholders felt this did not give enough emphasis to early intervention or supporting people in their health when they had a 'wobbly day'. Secondary care mental health services, to manage an increasing demand and reduction of investment, would further ration who could be seen, thereby increasing their threshold so only those with the most complex needs could be supported. This

resulted in people deteriorating before they could access help. These services were also very much clinically led, when many of the problems people reported experiencing concerned practical issues which affected their mental health; such as housing, employment and social isolation.

The Collaborative journey and progress to date

In November 2013, a Provider Alliance Group (PAG) was established to co-ordinate a response. This informal group consisted of leaders from the Collaborative organisations, namely: Thames Reach, Certitude, First Step Trust (voluntary sector led organisations), South London and Maudsley NHS Foundation Trust (SLaM), Lambeth Council, Lambeth Commissioning and Clapham SPMS (GP Service). Together, a bid was made to Guy's and St. Thomas' (GST) Charity. This was envisaged to be the first bid of a three year programme with the CCG mainstreaming the service as impact was made on secondary care activity.

The aim was to develop a new collective experience with a new partnership between voluntary and statutory services and the person experiencing mental health needs and their community. A collective 'leap of faith' was made to:

- Manage demand differently, remove eligibility criteria and empower people to self-introduce to services to support easy access
- Change access points in the system so that more people are supported and seen by a more diverse staffing group in primary care, which included not only clinicians but voluntary sector staff and peers, and empowering GPs in their knowledge of mental health
- Support the development of a 'Living Well Network' of the communities and services that support people prior to a formal statutory response, thereby building resilience

This would involve the need for a significant culture shift from everyone in the system, towards a more personalised approach where the person was in control of their health. The key targets set within the first year were:

- Divert 800 people in year one and 1500 people each year by year three to be supported via a new enhanced primary and community based 'networked' offer, outside of secondary mental health care
- Reduce the number of people managed within the Assessment and Liaison teams in secondary care (traditionally the first point of contact) by 160 people (10%) in year one, with the aim of achieving a reduction of 25% by year three
- Reduce the number of people receiving long term care coordination by secondary care teams, achieving a reduction of 50% within three years

The following prototypes were identified to achieve this:

1. **The development of a North Lambeth Living Well Network Hub to reduce the flow into secondary care:** This was to become the new integrated front door to secondary mental health care and be able to work with people for up to a 12 week period in the areas that affected their mental health. GPs in North Lambeth were no longer able to refer directly to secondary care mental health teams. The Hub was comprised of a partnership of:

- Lambeth Council (social care staff)
- SLaM (psychiatry, clinical nurse specialists, occupational therapy)
- Thames Reach, Certitude, Look Ahead, One Support (voluntary sector organisations - support workers and expertise in housing, benefits, engagement)

- Mosaic Clubhouse (support people with lived experience to work as members of staff in the Hub to enable them to gain experience to gain work opportunities in the community)
- Clapham SPMS GP Practice (administration, management and nursing/occupational therapy staff)

The envisaged model of operation is illustrated in Appendix A, and outlines how a new way of working interfaces with a greater community response.

2. A community incentive scheme to increase the flow out of secondary care: This 'GP+' scheme would incentivise GPs to work with people with enhanced needs outside of the General Medical Services contract. It was estimated that there were 300 people who were 'stuck' in secondary care because there was not enough support to sustain their recovery in primary care. There were also some people that repeatedly visited their GP because they needed additional support but did not meet the eligibility criteria of secondary care. These groups of people often revolved around the system. Within this prototype, GPs would receive an incentive payment to see people every three months. People would also be supported by voluntary sector staff in the Hub; for example, with help in taking medication at home if necessary. Although some findings are described in this report, a separate evaluation has taken place for this part of the service.

3. A workforce culture change programme to support people to think and behave differently: 'Living Well Labs' were developed where people using the service were encouraged to tell their stories of their experience of the Hub, so that staff could reflect on their actions in the context of co-production principles as described in Figure 1.

Year one results

In year one, the Hub far exceeded the targets set.

- Referrals to secondary care were reduced by 43%. The SLaM caseload was reduced by 25%
- Waiting times in community mental health teams in secondary care were significantly reduced from one month to one week, on average. This was achieved by offering rapid clinical assessment and screening in the Hub and by only referring those who need specialist intervention to secondary care, thereby creating capacity in secondary care teams to see people more quickly
- In total, the Hub offered support to over 4000 people with evidence starting to show improvements in people's well-being via validated measures

Year two aims (July 2016 - June 2017)

As a result of this significant achievement, in year two the LWN were again successful with a second bid to the GST charity and were able to secure additional pick-up funding to support mainstreaming of the service from the CCG. This enabled the LWN Hub to be extended borough wide.

In year two, the key aims were to:

- Sustain the progress of year one
- Learn from the success of the Hub, and test whether a similar staffing mix and approach could be used to support discharge and improve recovery outcomes with people supported via the psychosis teams – the community mental health teams that supported people with severe mental illness
- Further capacity-build community organisations to support people with mental health needs via a Local Area Co-ordination Approach. Staff from the Hub would be supported to work with community organisations to make connections and to provide training in mental health

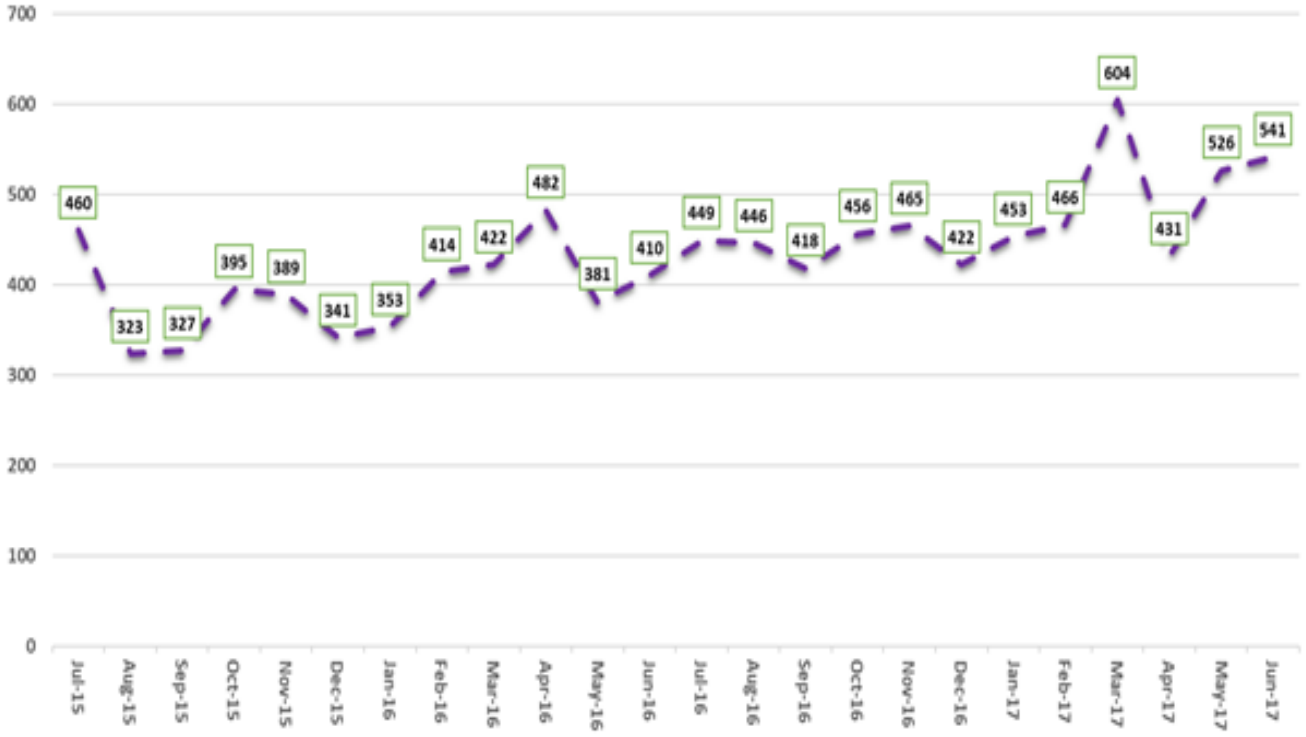
SECTION THREE: Year two evaluation findings

Access to the Hub and support provided

Number of people supported by the Hub

The Hub received 5,677 introductions in the period July 2016 to June 2017, an average of 473 introductions per month. The average number of introductions to the Hub has increased by 21% compared to the previous year (there were an average of 392 introductions per month in the year July 2015 to June 2016). The Hub is providing support to a large and increasing number of Lambeth residents.

Figure 2: Number of introductions to the Hub each month (July 2015 – June 2017)



Sources of introduction to the Hub

Table 1 (overleaf) outlines the sources of introduction to the Hub. During the Hub's second year, most people (55%) were introduced to the Hub by their GP. All GP practices in Lambeth made introductions. The police made a significant number of introductions (12%), and an increasing number of people are introducing themselves to the Hub (10% of all introductions, up from 4% of all introductions in 2015-2016). Being able to self-refer is a unique and innovative aspect of the Hub and it is promising to see that an increasing number of people are introducing themselves. The 'other' category in Table 1, which also accounts for 10% of introductions, comprises a variety of sources, for example: sister, neighbour, relative, solicitor, Home Office.

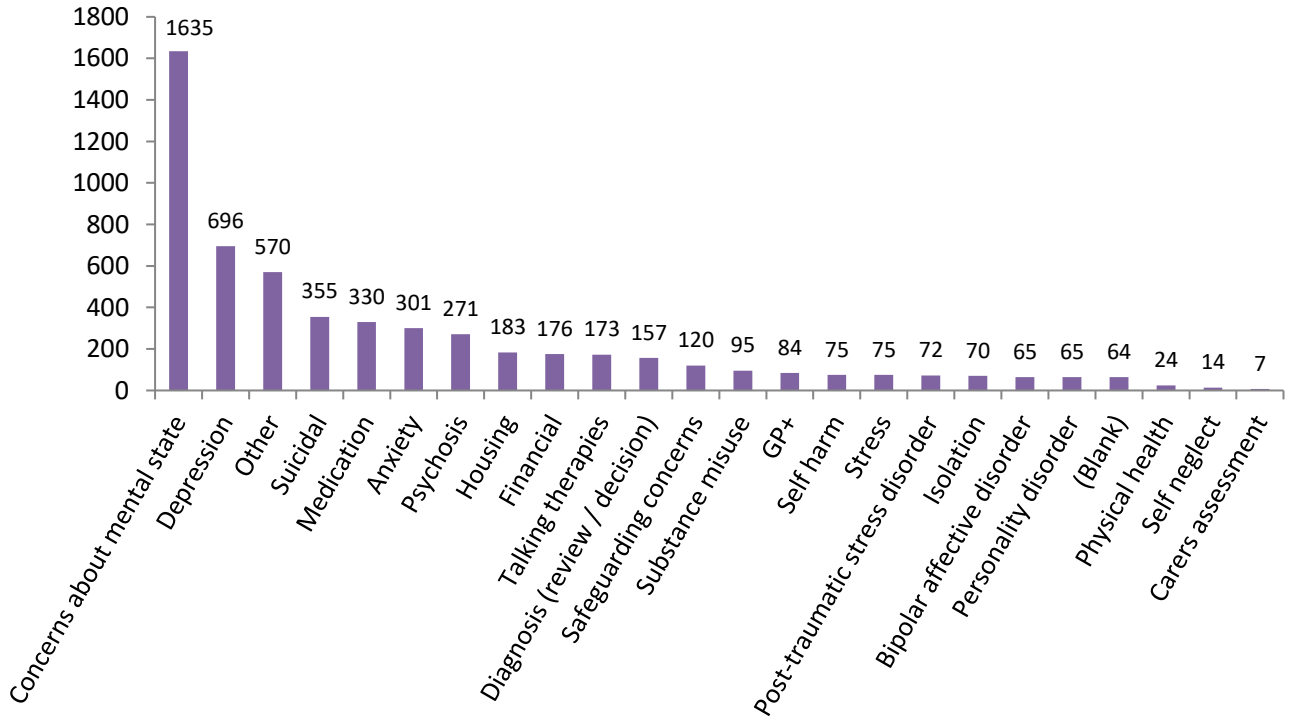
Table 1: Sources of introduction to the Hub (July 2016 – June 2017)

Source of introductions	Number of introductions	Percentage (%)
General Practitioner (GP)	3,141	55.3%
Police	667	11.7%
Other	546	9.6%
Self-referral	545	9.6%
Improved Access to Psychological Therapy (IAPT)	461	8.1%
South London and Maudsley (SLaM)	96	1.7%
Local Authority	96	1.7%
Accident and Emergency (A&E)	38	0.7%
Not known	33	0.6%
Living Well Network (LWN) agency	27	0.5%
Job Centre	14	0.2%
Integrated Psychological Therapy Team (IPTT)	13	0.2%
TOTAL	**5,677**	**100%**

Reasons for introduction to the Hub

Figure 3 demonstrates the wide range of reasons underpinning introduction to the Hub. This shows that a key aim of the service - provision of a broad variety of support - is being met.

Figure 3: Main reason for introduction (July 2016 – June 2017)



Going forward, the way that data is collected to document reason for introduction will be improved to allow multiple reasons for introduction to be recorded and to provide greater detail to describe the range of social and clinical support being sought by people.

Support provided following introduction

People receive different types of support once they have been introduced to the Hub, depending on their need. Broadly speaking, the Hub aims to support people with both their mental health needs and the social factors that can help people to stay well / increase their recovery. These are described in Appendix B.

Table 2: Proportion of people receiving each type of support from the Hub in year one compared to year two

	Percentage (%) of people		
	Year one 2015/16	Year two 2016/17	% change
15 minute conversation	3%	10%	+7%
Phoned	5%	10%	+5%
Assessed	37%	12%	-25%
Intervention	7%	24%	+17%
Not closed when data extracted	25%	14%	-11%
Not suitable for Hub support	23%	31%	+8%

A 15 minute conversation (also known as an initial conversation) is the first step for people to identify their assets and the priorities they want support with. From this conversation, they can then decide the best course of action. This may be information and onward introduction to another service or a longer conversation or support from 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 person introducing them to the Hub thinks they want.

Phone calls also provide brief, focussed support and potentially signposting to other services.

Where there is initial clinical concern or a person has complex social needs, the Hub carries out specialist assessments to ensure people get the right support. 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.

Interventions involve providing a person with support from the Hub for a period of up to 12 weeks (without the person being signposted elsewhere). Interventions include having appointments with the Hub consultant psychiatrist where a change of medication may be advised or receiving support from a senior practitioner for more practical issues.

Compared to the year 2015/2016, the Hub has seen increases in the proportion of 15 minute conversations, and initial phone calls, and notably an increase in the number of interventions provided. The Hub's work has changed in its second year – more intensive support is being offered to a greater number of people. The reduction in the number of people assessed may be due to people being seen sooner and then signposted to other services where applicable. This data was reflected back to staff who felt that there was an additional group of people who would regularly contact the person who supported them for ongoing advice and reassurance, but this additional input was not recorded.

In year two, 31% of the introductions received were considered by a clinician but the Hub 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 years, or they did not respond to the Hub's contact, despite the Hub calling and writing to them (i.e. they did not opt in to receive Hub support).

Key messages

- The Hub has been successful in supporting more people each year. In year two the Hub received an average of 473 introductions each month – an increase of 21% compared to year one.
- All Lambeth GPs are introducing people to the Hub and self-introduction is increasing.
- A wide range of support is offered by the Hub and people are being introduced for a broad range of social and clinical reasons.
- More people are receiving interventions than in year one, and more intensive support is being offered to a greater number of people.

Learning points

- Our categories in relation to reasons for introduction remain too clinical and do not take into account the multiple complex reasons why people would access the service. They also do not take into account more 'informal' ongoing brief support to help people stay well that staff report giving. They are therefore not fully reflective of the intervention we give. We will review this in year three.

Demographics

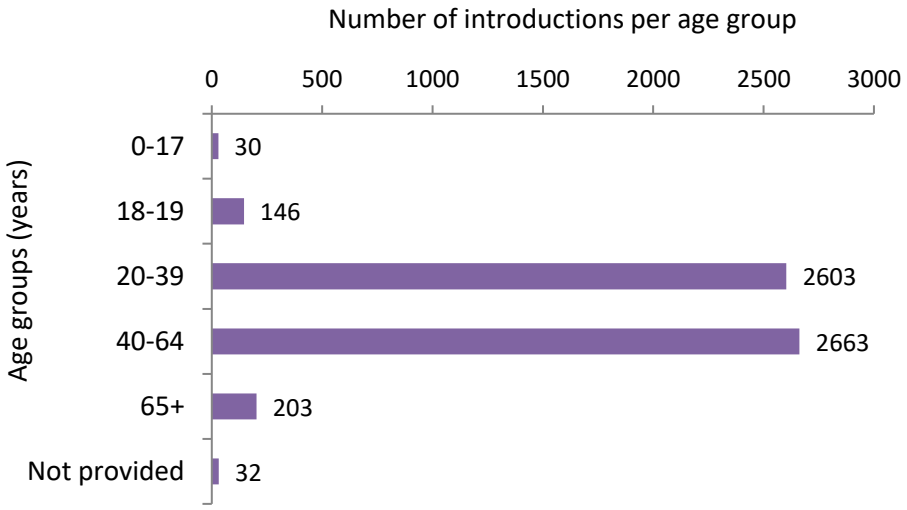
Age

Lambeth has a relatively young age profile with 68% of the population being aged between 20 and 64 years (Lambeth State of the Borough report 2016).

National statistics suggest that working age people are twice as likely to have symptoms of a common mental disorder compared to people aged 65 and over (Psychiatric Morbidity Survey, 2016).

The Hub is an adult service for people aged 18 – 64 years (with some discretion around the boundaries). Completeness of age data held by the Hub was very good – age was 'not provided' for a small minority of people (0.6%).

Figure 4: Age of people introduced to the Hub (July 2016 – June 2017)



Gender

There are roughly equal numbers of male and female residents in Lambeth (Lambeth State of the Borough report 2016).

Nationally, 19% of women and 12% of men report symptoms of a common mental disorder (Psychiatric Morbidity Survey, 2016). Broadly in line with this national picture of need, in the year July 2016 – June 2017, the Hub was accessed by a higher number of females (52%) than males (46%). The Hub supported a small number of transgender people in its second year (0.1%).

The Hub has a high completion rate for recording gender, though 2% of people have their gender recorded as 'did not disclose'. Of these people, it is unclear how many were asked and chose not to disclose and how many were not asked.

The Hub are in the process of updating the way that gender is recorded, for example giving people a free text option to specify their gender.

Table 3: Gender of people introduced to the Hub (July 2016 – June 2017)

Recorded gender	Percentage (%)
Female	52%
Male	46%
Did not disclose	2%
Trans-female	<0.1%
Trans-male	<0.1%
TOTAL	100%

Ethnicity

Around 55% of the Lambeth population are white (around 40% have a white British or Irish background). Around 30% of the Lambeth population are black and around 8% of the Lambeth population are Asian, including Chinese (Lambeth State of the Borough report, 2016).

National data show that people from black and minority ethnic groups living in the UK are more likely to experience problems with their mental health, though these problems may more often go unreported and untreated in comparison to white people (Mental Health Foundation, 2017).

Unfortunately, we do not have ethnicity data for 40% of the people who were supported by the Hub between July 2016 and June 2017. In 22% of cases, ethnicity is recorded as 'not provided'. A further 17% are recorded as 'unknown' and an additional 1% as 'other ethnic group'. This means that improving the completeness of ethnicity data is an important recommendation going forward.

When looking at the ethnicity data that we do have, 47% of people accessing the Hub are white (38% white British or Irish), 35% are black (11.6% black Caribbean, 11.6% black African, 10% black British, 1.7% any other black background), and 6.7% are Asian or Asian British (see Table 4).

Table 4: Ethnicity of people introduced to the Hub (July 2016 – June 2017)

Recorded ethnicity	Percentage (%)	Percentage (%) with unknown / missing data excluded
White	28%	46.6%
White British	22%	36.7%
Any other white background	5%	8.3%
Irish	1%	1.7%
Black	21%	35.0%
Black Caribbean	*7%*	11.6%
Black African	*7%*	11.6%
Black British	*6%*	10%
Any other black background	*1%*	1.7%
Mixed / multiple ethnic groups	5%	8.3%
Asian / Asian British	4%	6.7%
Portuguese	1%	1.7%
Latin American	1%	1.7%
Missing data	40%	-
Not provided	*22%*	
Unknown	*17%*	
Other ethnic group	*1%*	
TOTAL	100%	100%

Other demographic information

The Hub has rich demographic detail recoded within each person's case notes; for example, information about sexuality, disability, housing, employment status and financial situation. However, it is currently not possible to systematically extract and present this data.

Key messages

- The Hub will make changes to improve the collection of some demographic data, in particular data on ethnicity.

References

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Mental Health Foundation (2017) Fundamental facts about mental health 2016. Available from: https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016 Accessed 08.09.17

Psychiatric Morbidity Survey (2016) Available from: http://content.digital.nhs.uk/catalogue/PUB21748 Accessed 08.09.17

Impact on wider service use

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 Liaison (A&L) services at South London and Maudsley NHS Foundation Trust (which was the previous front door to secondary care mental health support).

Figure 5: Number of introductions to the Hub and number of introductions to the A&L Team

Figure 5 shows the numbers of people being introduced to the Hub and the number of referrals to A&L. On average, the Hub refers 40 people per month to A&L services. In year one this was 33. We have therefore seen an average of an additional seven people referred per month. This has affected our overall percentage reduction of referrals into secondary care.

From SLaM contract information, A&L receives 67 referrals per month, in year one this was 50. This suggests that A&L are receiving an increased number of referrals from other sources; however, despite this, from the 2013/14 baseline there has been a reduction in referrals to A&L services of 31%.

The overall reduction in referrals to secondary care teams is 25% since the Hub commenced (compared to 2013/14). Secondary care teams are defined as all community mental health teams, specialist services etc.

Compared to the financial year 13/14, caseloads have reduced by 27% in the financial year 16/17. However, community mental health teams that are supporting those with psychosis have seen a reduction of 30%. A large factor in this has been the SLaM redesign programme – a secondary care initiative which enables care co-ordinators to work more intensively with a smaller caseload to reduce the use of acute care. Cross-borough comparisons on the number of secondary care referrals would help to further establish the impact that the Hub may be having on wider service use.

Key messages

- There is evidence that the Hub has reduced referrals into secondary care mental health services, although other unknown factors may have also contributed to this reduction.
- The Hub is supporting more people than were previously being supported by secondary care Assessment and Liaison services.

Health economics analysis

The health economics analysis focussed on the following:

- Assessing the cost of support delivered by the Hub.
- An examination of variation in support offered and cost.

Methods and data

The economic analysis used information recorded by Hub staff on individual actions (or "activities") and the duration of actions completed by Hub staff in managing people attending the Hub. Data extracted related to people introduced to the Hub who were either signposted or received the full Hub intervention with formal closure between the period 1st March and 30th June 2017. This left a sample of 369 people. We excluded people aged under 16 and over 65 years, people on the GP+ scheme and people who had an outcome of *"screened and not suitable."*

Hub activity was costed by applying unit costs for Hub staff time which were developed specifically by the King's team using financial data provided from the Hub management team.

A "health warning"

As we have used data from a selected period of time, it may not be representative of the case-mix or patterns of resource use for the entire period since the Hub was introduced in Lambeth. So the results we present should be seen as exploratory, and we have recommended that in any future evaluative work that we extend the health economic analysis to cover a wider period.

Cost of Hub support

- The average (mean) cost per person introduced to the Hub was £103. This includes people who were either signposted to another service after initial meetings and assessments (281 people out of the 369 included in the health economic analysis) and those who went on to receive a "full intervention" from Hub staff (88 out of 369 people). A full intervention is where people who have accessed the Hub continue on to receive full support from the Hub without being signposted elsewhere. An intervention can vary from 1-6 contacts, 7-12 contacts or 12+ contacts. Receiving an intervention implies the person requires a higher level of support, for example, having appointments with the Hub consultant psychiatrist where a change of medication may be advised or receiving support from a senior practitioner for more practical issues.
- Table 5 compares the average cost per person introduced to the Hub with published national reference costs for initial assessments across a range of mental health service clusters (https://www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016).
- Table 5 demonstrates that the Hub can offer a comparatively lower cost (and high volume) approach to reducing the inflow of people into secondary care who might not require that level of support. The cost per person for up to three quarters of the cases we analysed was no more than £138 per person, which is below the average initial assessment Reference Cost reported for lower severity mental health clusters (£258).
- We would add a note of caution when making these comparisons. Firstly, NHS Reference Costs are calculated in a different way to the costs we report for the Hub. This means that reported differences could partly reflect measurement methodology. Secondly, these comparisons provide only a partial

assessment of whether the Hub can be viewed as offering a better alternative to Assessment and Liaison teams. This would require additional evidence that the Hub delivers comparable, or better, outcomes (in terms of functioning and quality of life) for people over time compared to what would have been the case if they had been received by secondary services instead. It would also require a full assessment of the impact of the Hub on resource use across the entire network of services who provide support to people.

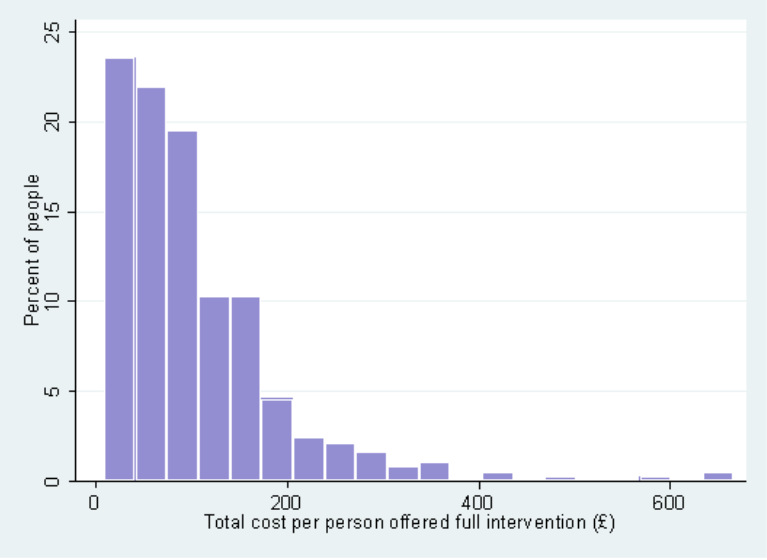
Table 5: Cost of the Hub compared to assessment delivered by secondary care services

	Average	Bottom Quartile	Top Quartile
LWN Hub	£103	£43	£138
Mental Health Clusters: Initial Assessment			
Common mental health problems (low severity)	£258	£156	£320
Common mental health problems (low severity, greater need)	£278	£176	£365
Non-psychotic (moderate severity)	£270	£163	£366
Non-psychotic (very severe)	£372	£209	£433
			2015/2016 prices

Variation in levels of support and cost

Figure 6 shows that, for people who received full support (rather than being signposted elsewhere), their individual costs varied widely. This pattern of resource use has been widely observed across mental health services in numerous economic evaluations: a high percentage of service caseloads generating relatively low costs and a small percentage generating high costs in terms of staff time and other resources. In an efficient and responsive service, we would expect wide variation given that different people will present with varying needs and severity and complexity of problems presented. Some of this variation could also reflect differing levels of engagement among people with similar levels of need, an issue we have not managed to explore here.

Figure 6: Variation in cost per person for people receiving full Hub intervention



- Older people were more likely to receive a full intervention from Hub staff, while the most costly 25% of people who went on to receive a full intervention (as defined earlier) were more than 10 years older on average than people in least costly 25%. This suggests that the Hub is responsive to age-associated needs in the way it allocates its resources. Due to incomplete data we were unable to examine whether resources also followed increasing levels of functional disability (as measured through the WASAS).
- The level of support received was also found to be associated with factors that might not reflect differences in the type and complexity of needs that different people present with. Women were more than twice as likely to be offered full support from Hub staff compared to men and people managed through the South East locality were over two and a half times as likely to receive full support compared to people managed through the North and South West localities. These results could not be explained by differences in age or reasons for main referral between men and women and between people managed by different teams. This may warrant further investigation in any further evaluative work in order to establish whether service improvements could be made.

Key messages

- For many people the Hub is likely to provide a comparatively low cost (and high volume) means of freeing up resources in the local secondary care Assessment and Liaison services.

Learning points

- It is recommended that the analysis of activity data on the In-Form system is extended to cover a much longer period. This would help mitigate problems with incomplete data for certain variables and their relationship with support offered and costs (particularly WASAS and ethnicity). It would also support exploration as to whether Hub support and costs differ according to factors that might not be necessarily associated with individual needs.
- The wider system impact of the Hub may be evaluated using data on secondary care referrals and other measures of service activity where available. We particularly recommend an examination of trends in activity sourced from GP practices in both Lambeth and other boroughs (Lewisham, Southwark and Croydon) where the Hub does not operate. This will provide a more robust opportunity for assessing changing patterns of service use that are attributable to the Hub as opposed to wider pre-existing trends.
- Cultural differences between localities in the Hub should be examined. It is important culturally to reflect on differing practices in order to examine effect on cost.

Feedback from people who have been supported by the Hub

Work and Social Adjustment Scale

The Work and Social Adjustment Scale (WASAS) has been used by the Hub as a validated measure of the needs of people and as a way of determining any self-reported change in impairment following contact with the Hub. The WASAS should usually be completed twice: at introduction (pre-WASAS) and at closure (post-WASAS); however, people attending a single 15 minute conversation do not need to complete the WASAS twice – a change in impairment would not be expected in such a short space of time. We aimed for at least 200 completed pairs.

The WASAS comprises five measures of impairment; relating to work, home management, social leisure activities, private leisure activities and close relationships. These measures are ranked from 0 (no impairment) to 8 (very severely impaired) and are aggregated to find a total WASAS score between 0 and 40, which can be grouped into three clinical categories:

1. Score < 10 (0-9): Subclinical populations
2. Score 10-20: Significant functional impairment but less severe clinical symptomatology
3. Score > 20 (21-40): Moderately severe or worse psychopathology

Allocation to one of these three groups acts as a guide to understand the health of a person, not as a clinical diagnosis. The Hub intends to see a lower score in people's self-reported impairment following Hub support.

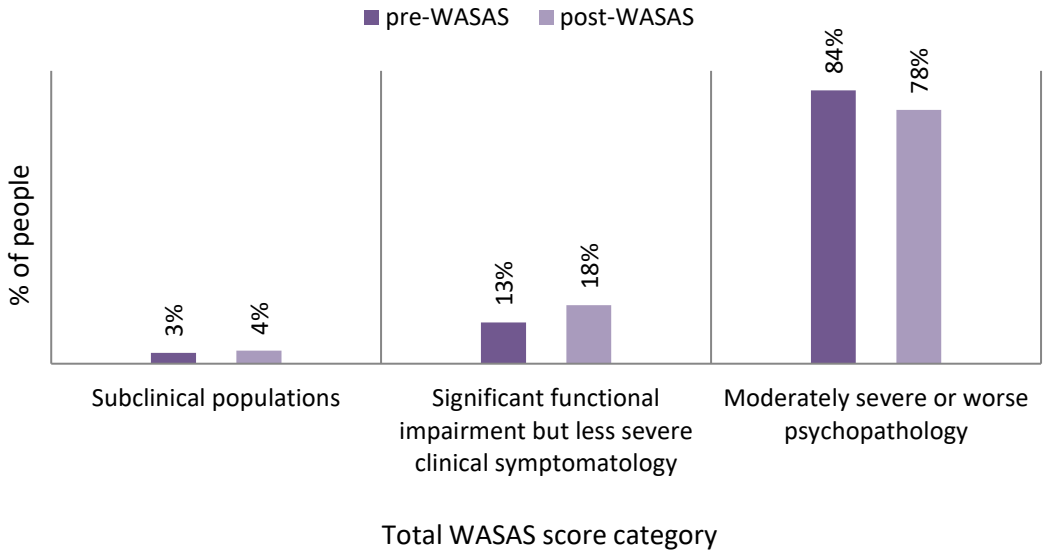
Method

We tested for statistically significant differences between pre-WASAS and post-WASAS scores. Data were analysed for the period July 2016 - June 2017; 157 people had pre and post WASAS scores recorded. We excluded data if one or more of the five components of the WASAS were missing leaving 150 cases for inclusion in the analysis. It should be noted this represents a very low proportion of people introduced in the period July 2016 to June 2017 who went on to receive Hub support after the 15 minute conversation.

Findings

- The average (mean) total WASAS score reduced on closure to 28.6 compared to an average (mean) score at introduction of 28.9. However, this change is small and no statistically significant difference between pre and post Hub WASAS scores was found overall. This finding is possibly due to having too few cases in the analysis to meet robust statistical requirements (i.e. if more cases were included, it may be that even a small difference would be statistically significant).
- Over half of people reported a total impairment score of 31 or higher at introduction compared to a total score of 30 at closure, implying people are reporting a fall in severity of impairment at closure (though this change is not statistically significant).
- Figure 7 compares the proportion of people in each clinical category pre and post support from the Hub. It illustrates that some people shift down clinical categories after receiving support from the Hub. This suggests that people with more severe problems are improving and reporting relatively lower impairment. It also shows that most people accessing the Hub report moderately severe or worse psychopathology.

Figure 7: The proportion of people in each WASAS clinical category, pre and post Hub support



Key messages

- The Hub may be reducing people's self-reported impairment; however, the difference between pre and post Hub WASAS scores was small and not statistically significant.

Learning points

- It must be noted that no large change between pre and post Hub scores can be expected when the post Hub WASAS is reported immediately after closure. This is because people may only receive Hub support for a period of days or weeks which is not likely to be long enough to see a change in impairment. We would suggest completing the post-Hub WASAS again three to six months after receiving Hub support to appropriately measure longer-term effects of Hub support on a person's impairment. We also recommend considering use of alternative measures in year three.
- Year two has highlighted successful efforts in raising the number of completed paired WASAS scores (136 in 2015/16 to 150 in 2016/17) but this is still only a small proportion of total introductions to the Hub for that period. Further efforts to collect paired WASAS scores from a large group of people are therefore necessary to provide a more robust analysis.

Personal stories

Background

Your Story is an ongoing project which involves inviting people to talk freely about the story of their involvement with the Hub. This can include their background, their problems, the activities that they enjoy, how the Hub supported them and their experiences with the Hub, their lives after leaving the Hub, and their aspirations for the future. The interviews are conducted by the Hub's Peer Support Workers, who either audio-record or take notes on the narrative in order to produce a transcript of the story.

Your Story gives people who have been supported by the Hub a voice in ongoing service development, by providing user-created knowledge and insights which give the Hub as an organisation material to reflect upon so as to develop and improve their practice. It also gives an opportunity to identify and celebrate the positive outcomes that their support helps people to achieve.

In the interests of brevity, quotes from the transcripts which illustrate the findings are presented in Appendix C. Numbers in parentheses below refer to specific quotes in Appendix C which relate to each finding. No real names are used in attributing the source of quotes.

Fourteen transcripts of Your Story interviews collected between September 2016 and May 2017 were examined by the Peer Support Workers and a senior researcher to develop themes.

Before Hub involvement

The stories are characterised by lengthy histories of mental health problems, social isolation, and social problems such as homelessness, or domestic or homophobic abuse. Some also reported challenging chronic physical health problems which compound their distress (1, 2). Negative experiences with mental health and other services are another common feature of the stories. They were often seen as dismissive and ineffective (3, 4, 5).

Experience of the Hub's support

The stories are mainly very positive about the Hub's support. Hub staff were typically seen as flexible and understanding, with good interpersonal and listening skills and a strong ability to build rapport (6, 7, 8). One much-appreciated aspect of the Hub's support was that it felt unhurried, with people being given time to describe and explore their problems (9, 10). Other stories were appreciative of the workers' efforts to address practical and general welfare problems, rather than just concentrating on symptoms (11, 12, 13).

However, one person in particular did not feel that the Hub supported him particularly well (14), another felt uncomfortable in the venue where he was seen (15), and two people did not feel that their expectations about the help that they should receive were met (16, 17).

The main problem that was identified concerned poor communication. Some people related some uncertainty about the nature of the Hub's services, and some were not told that the Hub would be contacting them (18, 19). Problems with communication between the Hub and other services, and between the Hub and the people who use it were also mentioned (20, 21, 22).

Most of those interviewed described the outcomes of the support that they received from the Hub positively (23, 24). Specific benefits of the Hub's support included gaining insight into problems and developing practical coping skills (25). The general emotional support that the Hub provided was also valued (26). People can re-introduce themselves to the Hub if they need further support in the future, which some found reassuring (27).

Opportunities for improvement

The stories suggest two areas for improvement. The first is communication.

GPs are the largest single source of introduction to the Hub. There are also a high number of people who are introduced, who are not informed of their referral, for example via the police if there is concern in relation to someone's mental health. It may also be the case that, as a relatively new and different service, stakeholders do not understand the remit, what is offered or the role of the Hub, and therefore cannot explain this to the people they introduce. Expectations of what should be offered, or what traditionally has been offered, have a significant bearing on satisfaction with the service.

This suggests we need to be clearer on what we offer and how we work.

People also wanted to be more informed as to the progress of onward referrals to other agencies. This is sometimes outside of the Hub's control (i.e. not being able to reduce waiting times for other services). Furthermore, the Hub does not have the capacity to 'chase' referrals unless these have been made to secondary care. A judgement call has to be made by the Hub staff member as to the assertiveness of what is required in order to keep people informed.

We need to be better at communicating this involvement to the person, and be clear on how the person can pursue this information, seeking support if necessary.

The second related point concerns the length of time that people can be supported. Given the complex nature of the needs that are often presented, a 12 week period may feel too brief for some people. It is therefore important to be clear from the beginning that the period of support that is offered is limited, what is likely that can be achieved during it, and that the service's door remains open should they need help in the future. It should also be remembered that the Hub's key aim of using community resources to support people is likely to be a huge cultural shift for people who expect the Hub to take over responsibility for addressing their problems, because their expectations have been moulded by their previous experience of services.

We need to think about how we work with community networks and how we communicate this as a recovery tool for people.

Key messages

- Almost all those interviewed reported positive experiences. Hub staff were mainly described as skilled, caring, and acting quickly and effectively to address the problems that had brought people to the Hub. People felt reassured by the fact that they could contact the Hub again should the need arise in the future.

Learning points

- We need to review how we market the service and explain clearly what is on offer. We also need to make sure staff are able to communicate this in a systematic way.
- The Hub needs to support stakeholders to ensure that they have told people that they have been introduced to the Hub.
- The Hub needs to ensure that people know how to pursue referrals that have been made to other services so that they are more able to take control of the process themselves or communicate clearly what they will do to support the person. They also need to communicate this back to the referrer when appropriate (e.g. the GP).

Structured interviews

Background

As in the year one evaluation, the structured interviews collected data concerning sociodemographic and clinical variables in a sample of people who had been supported by the Hub, as well as on other service use, amount of contact with the Hub, what problems were presented, how these were addressed and what the outcomes were, service satisfaction, and suggestions for how the Hub's service could be improved.

Participants

Hub records were used to identify people whose cases had been closed between January 1st and March 31st 2017, and who had given their consent to be contacted for the evaluation. People were included in the sampling frame if their outcome codes indicated that they had received an assessment, a 15-minute conversation, or an intervention, and a sample of 93 participants was randomly selected from the 570 people in the sampling frame. The people in the sample were contacted either by telephone, email, or letter (with an enclosed self-addressed envelope for their reply). If they were interested in participating a convenient time and date was agreed upon to conduct the interview. Of the 67 people who were successfully contacted, 20 were unable to participate because of health problems, work or other commitments. Nine people declined participation, or failed to attend for two scheduled interviews, and were deemed as having effectively declined. A total of 38 people out of a possible 47 were therefore interviewed, giving a response rate of just under 81%.

Findings

- In terms of age and ethnicity the sample was comparable with the population of Lambeth as a whole. However, nearly two-thirds of those interviewed were female, which may reflect a gender bias in willingness to participate.
- Two-thirds of the sample had a diagnosis of either depression or depression with anxiety, 12% were diagnosed with a psychotic disorder, and 5% had no history of treatment for a mental disorder.
- 58% only had one contact with a Hub staff member. Participants had an average of three contacts with a Hub staff member before involvement was closed.
- 44% did not know where they would have looked to for support with their problems if the Hub had not been available.
- 55% in the year two evaluation sought help for just one problem, compared to 16% in year one. This probably reflects sampling bias in year one where Hub staff asked people to participate, while in year two people were randomly selected.
- While people in the sample who had had more than one contact with the Hub made higher ratings of effectiveness and satisfaction with the Hub's support than those who had only one contact, these differences were not found to be statistically significant, probably because of the small sample size.
- The only or single most important problem that those interviewed sought help with was referral for psychiatric or psychological assessment and/or treatment (26% of the sample). This was followed by problems with daytime activity and structure / social isolation, accessing benefits / help with benefit forms / help with benefits problems, general emotional support, and information about services, emergency contacts, and helplines, each of which was indicated by 11% of those interviewed.

- Most people agreed that the help that they had received from the Hub had been effective, and that they had been well supported by Hub staff.
- 10% of people noted that their outcomes were actually 'much worse' following Hub involvement – this was 2% at the end of year one. Again, this probably reflects sampling bias in year one. All other ratings were quite similar for both years.

Figure 8: "The support was effective – it made a difference"

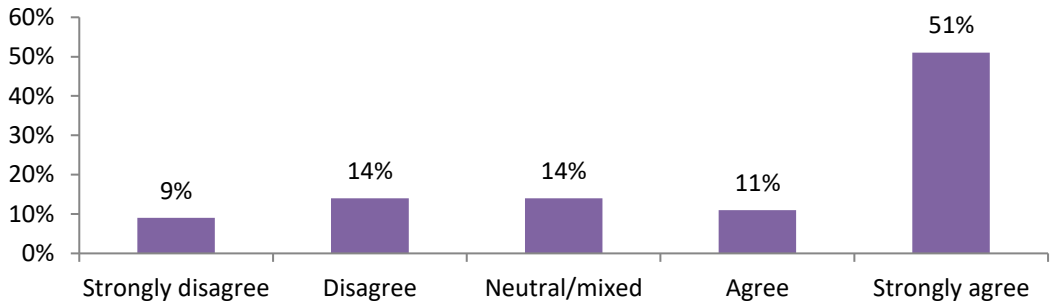
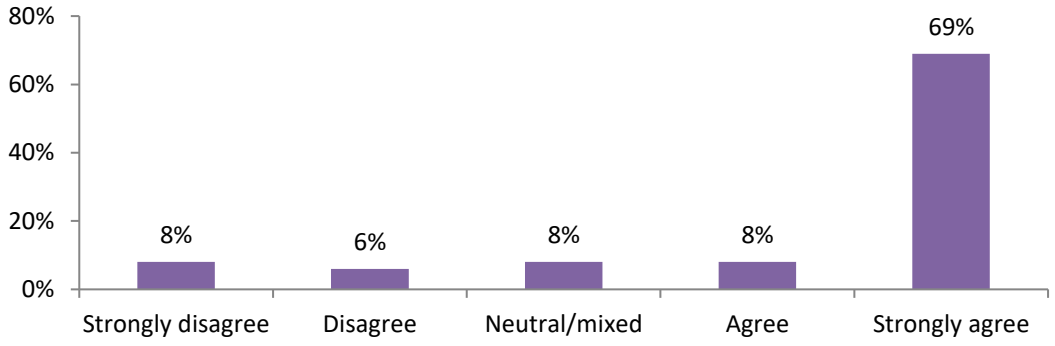
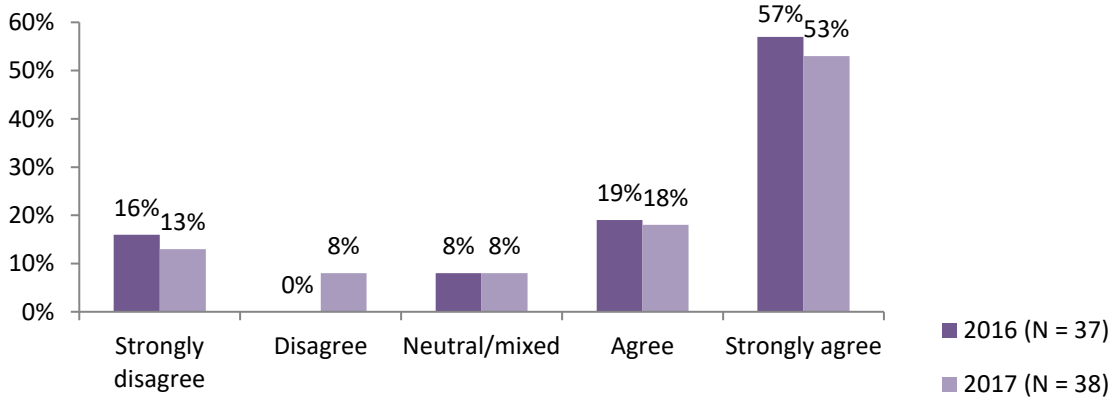


Figure 9: "I felt well supported by my Hub worker"



- No statistically significant difference was found between ratings of overall satisfaction for the year one and year two evaluations, with over 70% of the year one and year two samples agreeing or strongly agreeing that they were satisfied with the support they had received.

Figure 10: "I am satisfied with the support I had from the Hub" – year one and year two comparison



- Most participants would be happy to receive the Hub's support again, and would recommend the Hub to others (79% and 73% respectively agreeing or strongly agreeing).

- People who were satisfied with the Hub's support most frequently mentioned that services that they had been introduced to by the Hub had supported them in ways that met their needs. Almost as frequently mentioned was their feeling well supported by Hub staff, and improved sense of mental wellbeing as a result of this support, especially in time of crisis.
- People who had experienced improvement in their only or single most important problem were eight times more likely to be satisfied with the Hub's support than those who have experienced no change or worsening in their problem.
- Prior to Hub involvement, over half of the year two structured survey interview sample saw their GP at least once a month. After closure, seven people reported an increased frequency of GP visits, while five reported a decreased frequency. When the saved GP consultations were subtracted from the increased number of GP consultations, there was a net increase of 107 anticipated GP consultations over the coming year, with half of this attributed to worsening physical health. The increase in mental health-related GP visits for each of these seven people amounts to just over one extra consultation every two months. It is possible that because these people were actually more likely to visit their GP at an early stage, their problems were less likely to deteriorate, making intervention by specialist services less likely.

Opportunities for improvement

- The principal area where dissatisfaction was expressed (by comparatively few participants) lay in delays in receiving help from services that they had been introduced to by the Hub, and not being informed about the progress of these referrals.
- Less commonly reported sources of dissatisfaction included not receiving the kinds of help which were expected, or advice being given that did not take account of their preferences or capabilities.

Key messages

- Most people rated satisfaction and effectiveness very highly, and no statistically significant differences were observed between the year one and year two comparisons.
- Dissatisfaction was sometimes attributable to delays in onward referrals made by the Hub to other agencies.

Client Satisfaction Questionnaire

The Client Satisfaction Questionnaire (CSQ) is a validated questionnaire increasingly used in mental health services to provide an efficient and comprehensive measure of client satisfaction. It is sent to people after closure to gain their perspective on their satisfaction with the service received. The CSQ comprises eight questions. The main differences between the CSQ and the structured interviews are that the CSQ seeks brief feedback on satisfaction and does so anonymously, whereas the structured interviews are administered face-to-face or over the phone (confidentially) and seek detailed feedback on the support received, wider service use, and suggestions for improvement in addition to satisfaction.

Method

In year two, the CSQ was distributed to every person who had been closed by the Hub who had supplied an email address using a link to an online questionnaire with individuals having a one month window to respond. In total, 212 questionnaires were returned, of which 139 were complete (the 73 incomplete questionnaires were removed from the analysis). This is an improvement from year one, where distribution by post and email resulted in 101 completed questionnaires. Year two data were analysed and compared to year one data.

Year two findings

- Over half of people who responded rated the quality of the service offered by the Hub as excellent (30%) or good (29%) compared to those reporting the quality was fair (13%) or poor (28%).
- 60% reported that they definitely (32%) or generally (28%) received the kind of service that they wanted.
- 65% of people definitely would (38%) or think they would (27%) return to the Hub if they were to seek help again.
- 49% of people reported that none of their needs (27%) or only a few of their needs (22%) had been met, with one person stating *"it seems there isn't actually any consistent care given with regard to mental health."*

Yearly comparison

Between year one and year two, the proportion of people who definitely would or think they would recommend the Hub service to a friend fell by 26%. The proportion of people reporting excellent or good quality of service reduced by 25% during this period. 24% less people reported the Hub effectively dealing with their problems and fewer people would return to the Hub service, a decrease of 23% over the two years. The proportion of people reporting high satisfaction rates for overall service satisfaction fell by 26% between year one and year two.

The fall in satisfaction in year two may be due to the Hub opening the service to a much wider group of people and offering a greater number of short appointments through the introduction of 15 minute conversations. As the questionnaire was anonymous, we do not have access to data that would enable us to examine any differences in either the characteristics of people or the amount of support provided by the Hub in people who responded in year one compared to year two.

Table 6: Proportion of positive responses to client satisfaction questionnaire in year one and year two

Question	Year one: 2015/16 response	Year two: 2016/17 response	% change
How would you rate the quality of service you have received? *(proportion answering excellent or good)*	79%	59%	-25%
Did you get the kind of service you wanted? *(proportion answering yes definitely or yes generally)*	78%	60%	-23%
To what extent has our programme met your needs? *(proportion answering almost all needs met or most needs met)*	60%	50%	-17%
If a friend were in need of similar help, would you recommend our programme to him or her? *(proportion answering yes definitely or yes I think so)*	87%	64%	-26%
How satisfied are you with the amount of help you have received? *(proportion answering very satisfied or mostly satisfied)*	68%	58%	-15%
Has the support you received helped you to deal more effectively with your problems? *(proportion answering a great deal or yes somewhat)*	80%	61%	-24%
In an overall, general sense, how satisfied are you with the service you have received? *(proportion answering very satisfied or mostly satisfied)*	80%	59%	-26%
If you were to seek help again, would you come back to our programme? *(proportion answering yes definitely or yes I think so)*	84%	65%	-23%

GP+ service Client Satisfaction Questionnaire

In April 2017, a client satisfaction questionnaire was sent out to 190 people who had been supported by the GP+ service. Questionnaires were returned by 28 people (a 15% return rate).

- 85% of people reported definitely (46%) or generally (39%) receiving the service that they wanted.
- 15% reported that they definitely did not (4%) or did not really (11%) receive the service they wanted or expected.
- 23% wanted to be seen more often, 19% wanted more support with their benefits and finance, 19% greater support with their medication, 12% more input to support social isolation, 11% more help with housing.
- 85% of people felt their needs had been met, 11% reported that only a few of their needs had been met and 4% that none of their needs being met.
- 74% of people felt the GP+ scheme had supported them to work more closely with their GP in their health issues. 22% reported not really, and 4% definitely not. 81% reported general satisfaction with the service, 4% were mildly satisfied or indifferent, and 15% quite dissatisfied.

Key messages

- People generally rated their satisfaction with the Hub positively; however in comparison to year one, satisfaction rates appear to have dropped. This might be explained by the Hub offering a service to a far greater number of people with more varied and complicated needs, and due to the increase in the number of people offered very short term support via the introduction of 15 minute conversations. Additionally, Hub staff have worked with higher caseloads of people during the second year, which could potentially have impacted upon people's reported satisfaction with the service. As described, people's expectations and the way referrers inform people about the service may also have had an impact.
- When the Hub expanded from covering the North of Lambeth in year one, to borough wide in year two, we recruited more front line staff but did not increase management numbers. We also expanded very quickly. This was originally to ensure consistency of approach. From September 2017 we have increased management capacity to ensure front line staff receive more support and also to think more creatively about managing demand in each locality. We will evaluate the impact of this in year three.

Learning points

- The CSQ could be distributed at more regular time intervals. In year one and year two, the CSQ has been sporadically distributed, therefore comparisons between both years may not be measuring the same points of time each year and the demographics of people who completed the CSQ in year one may not match those of year two.
- Year two has been successful in increasing the response rate of completed CSQs (from 101 in 2015/16 to 139 in 2016/17), but to reduce waste and increase completed CSQs, further efforts could be made to ensure all questions within the CSQ are answered fully and not left incomplete.

The Talking Shop

The Talking Shop is a weekly discussion session for a group of invited people who have been receiving Hub support. It was set up in August 2016 by a former Hub Peer Support Worker and continues to be run by Peer Support Workers. The discussion sessions are loose-structured and informal and designed to be driven by attendees. Peer Support Workers are there to facilitate the group, make sure the venue is ready and provide refreshments. They help to guide discussion so that everyone in the group gets a chance to speak and ensure nobody is contributing too much or too little. The Peer Support Workers usually start the sessions by asking each person 'how was your week?' and discussion flows from there.

During June 2017, the Hub's Peer Support Workers conducted an evaluation of the Talking Shop and produced a full report of the findings. A brief summary of the findings is presented here.

Findings

- A questionnaire designed to collect feedback on the Talking Shop was completed by 13 people.
- The Talking Shop is viewed very positively. 83% definitely would or probably would recommend it to others. 58% indicated that their mental health has improved as a result of the Talking Shop.
- The Talking Shop is enjoyable, confidence building, and reduces people's sense of isolation. People particularly liked:

  "Being able to meet new people and realising I'm not alone in the way I'm feeling. Also, listening and getting different views to different situations."

  "That I receive respect as a person who has some emotional problems, to talk to people, and improve confidence to talk and become more mentally well."

  "Meeting people and knowing that we all experience different issues and I am not alone."

Recommendations

- The recommendations for improvement made by respondents are now being implemented by the Peer Support Workers. For example: plans are in place to invite a greater number of young adults to attend, the session time has been extended to two hours, the venue has been changed and herbal teas are now provided.

Key messages

- A group discussion session known as the Talking Shop has been set up and is led by Peer Support Workers.
- The Peer Support Workers carried out an evaluation of the Talking Shop.
- People who have attended the Talking Shop provide very positive feedback on their experience of the sessions and many of the respondents reported that it has improved their mental health.

Feedback from Hub staff

Background

As stated in section two, the Hub is staffed by people with lived experience, workers from the voluntary sector (support workers, administrators) as well as clinicians, occupational therapists, a psychiatrist, social workers and nurses.

Moving away from clinically focussed crisis support and towards a co-production approach has required a change in culture for staff. During its inception, The Living Well Network co-produced a 'ways of working' diagram that displays the main principles associated with working innovatively in the Living Well Network in comparison to working in traditional mental health services (see Appendix A). These agreed 'ways of working' formed the basis of questionnaires that were circulated to Hub staff in May 2016 (year one) and May 2017 (year two).

Development of the year two 'ways of working questionnaire' was overseen by the evaluation group. It was decided that administering an anonymous paper questionnaire at the start or end of staff meetings would be a good way to encourage participation. The majority of the questions were multiple choice; for example, asking respondents to indicate their level of agreement or disagreement with principles from the ways of working diagram. Free text questions were also included so that respondents could provide additional detail.

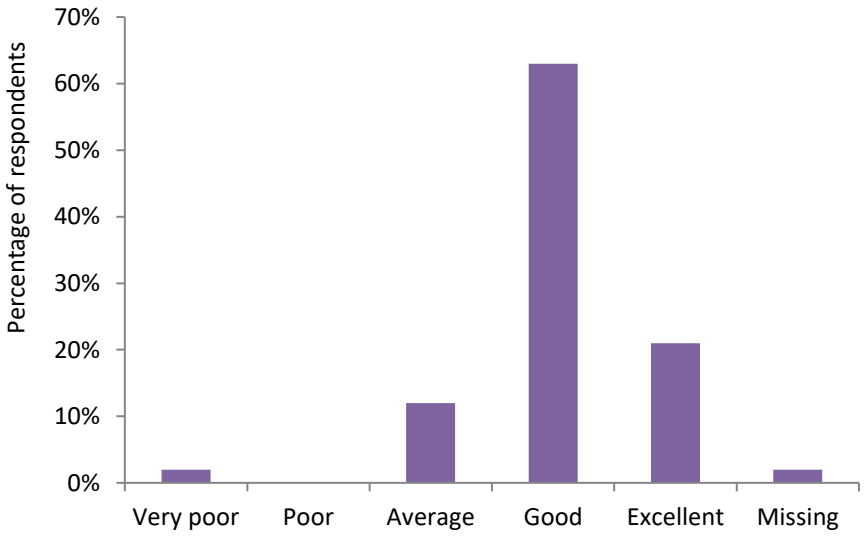
Participants

The year two ways of working questionnaire was completed by 43 members of Hub staff (the vast majority of staff members) covering all teams and professional groups. Hub staff reported that the questionnaire was quick and easy to complete.

Overall experience

Hub staff rate their overall experience of working at the Living Well Network Hub very highly.

Figure 11: Overall, how would you rate your experience of working at the Living Well Network Hub?



Contribution to service improvement

91% of staff agreed or strongly agreed that they actively contribute to service improvement. The remaining 9% of staff were neutral (no respondents disagreed or strongly disagreed). The majority of staff felt that they are given permission to try new things even when they might fail (70% agreed or strongly agreed), and felt that the LWN Hub is reflective and learns from experience in order to continuously improve the service delivered (93% agreed or strongly agreed). This illustrates that staff feel that they are working within a culture that actively supports service improvement.

A different model of service delivery

91% agreed or strongly agreed that the Hub has moved away from a traditional model of mental health and as a result of this mental health care is more integrated within the local community (the remaining 9% were neutral). Similarly, 84% agreed or strongly agreed that the Hub makes mental health care less institutional and that the relationship between people who access support from the Hub and Hub staff is more equal. These findings suggest that Hub staff feel that they are working in a new way and that the Hub offers a different model of service delivery.

Offering personalised support

70% of staff agreed or strongly agreed that it is difficult to ensure that the support offered by the Hub is time-limited (e.g. a maximum of 12 weeks of support). Around a third of respondents (37%) agreed or strongly agreed that due to the pressures of their everyday work, they sometimes see people as 'cases' rather than as individual people. 51% indicated that they feel their colleagues sometimes see people as 'cases' rather than as individual people. Only 20% of staff agreed or strongly agreed that they do not have enough time for dialogue (i.e. enough time to spend talking to and listening to people and discussing thoughts, ideas and plans). This feedback is slightly more mixed - staff members within the evaluation group suggest that high workloads can make it more difficult to offer personalised support.

Co-production

84% agreed or strongly agreed that co-production (i.e. putting people who have experience of the service at the heart of planning, delivering and evaluating the service) is the basis or foundation of the Hub's approach (the remainder were neutral) and 49% agreed or strongly believed that all Hub staff have this belief (37% were neutral and 12% disagreed).

Safeguarding

88% agreed or strongly agreed that they see safeguarding as part of their day-to-day responsibilities at work, the remaining 12% were neutral.

The Living Well Network

79% agreed or strongly agreed that people who receive support from the Hub are easily able to access support from other organisations in the Living Well Network and the broader community. However, contrastingly, 49% agreed or strongly agreed that it is difficult for people to move between primary and secondary care services to access the mental health support they need, when they need it (33% disagreed or strongly disagreed, the remainder were neutral).

Key positives

Key positives listed by Hub staff in free text comments include: team work / team spirit; colleagues who are supportive / friendly / co-operative / committed / hard working / enthusiastic / passionate / motivated / caring; supportive management; making a difference to people's lives; providing a broad offer of support; reaching people where they live; seeing people as people / taking a person-centred approach / offering personalised support; working with a diverse group of people; working innovatively; flexible working; working with colleagues from different organisations / from different backgrounds / working collaboratively; personal development / learning new skills; the Hub is constantly growing and developing / dynamic / adapting.

Key challenges

Key challenges listed by Hub staff in free text comments include: shortage of staff / turnover of staff / short term contracts; high caseloads / high workloads; lack of staff support; completing support needs within the 12 week time limit; not having access to ePJS [the electronic patient record system in secondary care]; laptops being slow or heavy; co-ordination and communication between different organisations / transferring people to community mental health teams / referring people to secondary care when they are unwell; lack of engagement from people.

Key messages

- The very positive feedback from Hub staff demonstrates that staff report working according to the 'ways of working' model within the Living Well Network Hub and suggests that staff view this new way of working favourably.
- It is notable that almost half of the staff reported that it was difficult to facilitate people to move from primary to secondary care when needed. On further investigation, staff reported that accessing the secondary care talking therapy service in SLaM was the most difficult. They cite that many people waited up to a year before receiving treatment. The length of time taken to gain acceptance into specialist services was also seen as a difficulty. Referral into Assessment and Liaison is seen as less difficult but the Hub do support those with complex mental health problems including people who hoard. Staff report that despite identifying that longer term intensive psychological intervention is required for some people who hoard, this is not available in current secondary care services.
- Other key challenges relate to short-term staff contracts and high demand for the service. From mid-2017, permanent contracts were being offered by some voluntary sector organisations to support staff to feel more secure. It is the intention that incrementally, those posts funded via GST are picked up by mainstream funding each year.

Feedback from wider stakeholders

Background

The Living Well Network is described as being "a community of providers, support agencies, statutory organisations and people who are all working together to support the citizens of Lambeth to live well". The Hub is the central point of this network and therefore works in close collaboration with a wide range of stakeholders in Lambeth, including GPs, secondary care services, and voluntary and community services.

The evaluation group developed an electronic questionnaire to assess the perceptions and experiences of stakeholders who work with the Hub. The questionnaire was designed so that an appropriate set of questions were presented dependent on whether the respondent had: only ever introduced people to the Hub; only ever received introductions from the Hub; or had both introduced people to the Hub and received introductions from the Hub. The electronic questionnaire was emailed out by a member of the King's evaluation team to 80 stakeholder organisations / services / key individuals working within organisations in Lambeth that work closely with the Hub.

Participants

Feedback was received from 39 respondents, including GPs (15), IAPT staff (13), Adult Social Care staff (5), other organisations (4), and affiliation undisclosed (2).

Due to the distribution method used it is not possible to calculate a response rate; however, it is important to note that the number that responded represents a low proportion of all relevant stakeholders, and so the views of the respondents may not be representative.

A total of 11 respondents stated that they had only ever introduced people to the Hub. 27 respondents stated that they had both introduced people to the Hub, and received introductions from the Hub. One respondent indicated that their service had only ever received introductions from the Hub.

Of the respondents that have made introductions to the Hub, one respondent indicated that they introduce fewer than one person per month on average, four respondents introduce between one and five people in a typical month, three respondents introduce between six and 10 people in a typical month, one respondent introduces between 11 and 20 people per month, nine respondents introduce more than 20 people per month, and seven people did not know how many introductions their service made in a typical month.

Reasons for introducing people to the Hub

Respondents indicated that they had introduced people to the Hub for a very wide variety of reasons (which may co-occur), in line with the wide range of support provided by the Hub (see Figure 12).

Figure 12: Reasons for introducing people to the Hub

Agencies that receive introductions from the Hub

Respondents who indicated that they receive introductions from the Hub were asked whether there were any common reasons why their service might sometimes be unable to help people. The following themes were suggested in free text answers:

- The person has had psychological therapy before and it didn't work
- Refusal to engage
- Capacity (type of capacity e.g. mental capacity or workload capacity unspecified)
- Person does not meet mild / moderate severity / psychosis / substance misuse is main problem / bipolar / complex needs / social or environmental situation means it is not the best time for therapy / risk too high
- Bureaucratic red tape

Respondents who indicated that they receive introductions from the Hub were asked whether the Hub is well informed about what their service offers. 42% of respondents agreed or strongly agreed that the Hub was well informed about what their service offered. 47% were neutral. 11% disagreed and no respondents strongly disagreed.

Strengths of the Hub

Synthesis of respondents' feedback suggests that some stakeholders think the Hub is particularly good at:

- General support with mental health
- Offering diverse support - *"the idea of a service that can support people with many things is great"*
- Signposting to other services
- Giving information on debt / housing
- Social support
- Assessments (including psychiatric / psychological assessments)
- Psychiatric or psychological treatment
- Counselling
- Helping with social isolation
- Safeguarding - *"excellent safeguarding from concern to conclusion", "positive experiences with child protection lead"*

In particular, respondents suggested that the Hub had made a unique contribution towards mental health service provision in Lambeth by:

- Offering holistic and inclusive support / specialist support / diverse support / more than just mental health support / taking a multi-disciplinary approach
- Offering a single point of access / easy access / self-referral

One respondent stated that the Hub "*has become an essential service*".

Opportunities for improvement

Synthesis of respondents' feedback suggests that some stakeholders feel the Hub does less well with the following:

- Informing services about what the Hub offers - "*I only thought it directed referrals to the psychiatry team I did not know about the other services you offered*"
- Risk - *"there needs to be a focus on the introductory meetings and how risk is managed"*
- Response to urgent referrals - *"I often have to chase urgent referrals to see if they are actioned and they have not been"*
- Being easily able to make contact with the Hub to raise concerns
- Access to psychiatric or psychological assessment - *"More vulnerable patients in need of more intensive therapy seem to have difficulty receiving this"*
- Following up with people after initial contact and making sure people know what support they can expect from the Hub

- Informing services about what the Hub did and what the outcomes were when the Hub closes their involvement with people
- Physical environment - *"clients find it very difficult to speak about suicidal thoughts in a crowded room"*
- No service for housebound patients

When asked what the Hub could do to improve the quality of the service it offers, suggestions were made in the following areas:

Access to the Hub: Faster response to first introductions; provide additional drop-in sessions and let people know about any changes to drop in sessions.

Managing risk: Effective, reliable triage; fast response to referrals for risk stabilisation; quickly pass on urgent referrals to appropriate secondary care services, offer prompt follow-up.

Communication: Better communication with services and the people that access the Hub in describing the service offered and how the Hub will work with individual people; answer phones and respond to voicemails; make multiple attempts to phone people who are not responding; provide a website with a detailed service specification to improve knowledge about the service offered.

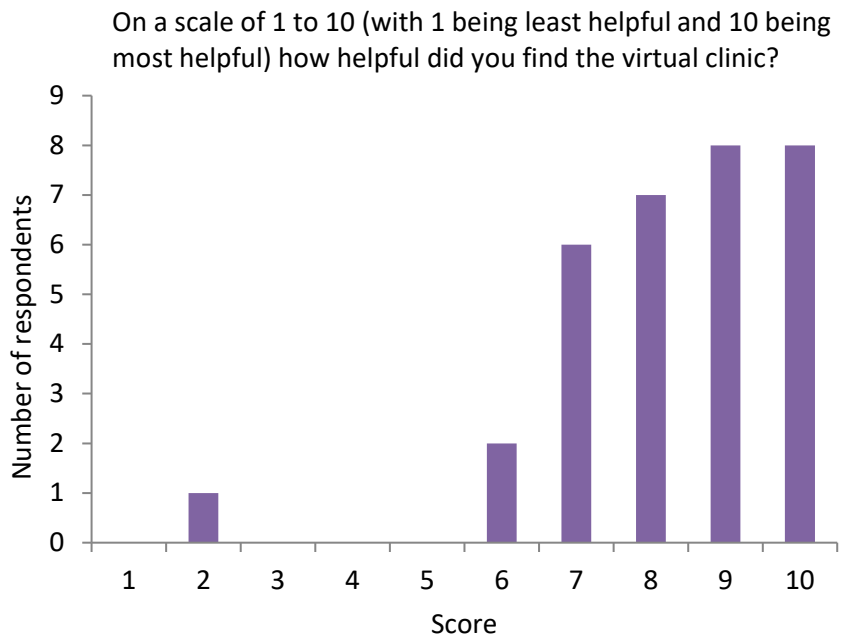
Staffing: Additional staffing leading to a reduction in individual staff members' caseloads, staff training (type of training unspecified).

Electronic information systems: Access to ePJS (the patient record system within South London and Maudsley NHS Foundation Trust) to improve information sharing; access to the local care record and EMIS (information system used by Lambeth adult social care) to improve information sharing; listing services offered by the Hub on DXS forms which GPs can tick and email to the Hub.

Stakeholder feedback on the GP+ Virtual Clinics

Virtual clinics are led by the Hub Psychiatrist and give the opportunity for GP practice staff to discuss people they are concerned about, and ask for advice in relation to clinical support, medication or referral pathways. To date, the Hub has facilitated 49 virtual clinics. So far, 32 GPs have provided feedback after their virtual clinic session. Figure 13 illustrates how helpful each GP practice found the clinic with an average (mean) rating of 8 out of 10.

Figure 13: Overall rating of GP+ Virtual Clinic



GP practice staff were also asked what the most and least helpful element of the virtual clinic was. Many GP surgeries reported that they valued specialist advice, an update on the people they support, discussion around pathways into care and the opportunity to network. However, 3 GPs reported that actions agreed during a virtual clinic were not followed up by secondary care / Hub staff.

The most popular training requested by GP practice staff was around medication management and introduction (7 GPs). GPs also requested training in regards to the interdependencies of physical and mental health, substance misuse, how to support people with personality disorder and suicidal ideation. The need for a greater understanding of service configuration was also a common theme (4 practices).

Key messages

- The number of responses is low, and are limited as they do not reflect the many agency interfaces in which the Hub operates.
- It is notable that some of the strengths highlighted by stakeholders were identified as clear areas for improvement by others and vice versa, demonstrating that a range of perceptions are held by stakeholders who work with the Hub and there is no single consensus.
- However, the theme of better communicating what the Hub offers is noted. Some of the comments relate to services not offered by the Hub (i.e. therapy) which again highlights the importance of clearly specifying what the Hub can do.

SECTION FOUR: Reflections and recommendations

Reflections from Hub Peer Support Workers

"As a mental health service user myself, being a part of the evaluation with the King's team has been great. They have been keen to work with me and get my opinions and their support has definitely increased my confidence. It also showed that they are willing to listen to both service users and staff to extract data with which to evaluate the Hub."

"I have really enjoyed being able to be part of the evaluation and development of the service and work alongside the King's team and management of the Hub. It has given me more confidence in my own abilities as a researcher and I'm enjoying being able to help make a difference to how the LWN Hub operates and help individuals".

Selected reflections from the King's evaluation team

"My experience of working on the Living Well Network Hub year two evaluation has been very rewarding. From the get-go, the Hub team have been very warm and welcoming, enabling me to attend meetings and shadow daily practice…Producing work together has given this work an even greater importance because it has compromised of everyone's views and take on ways to improve the service the Hub offers."

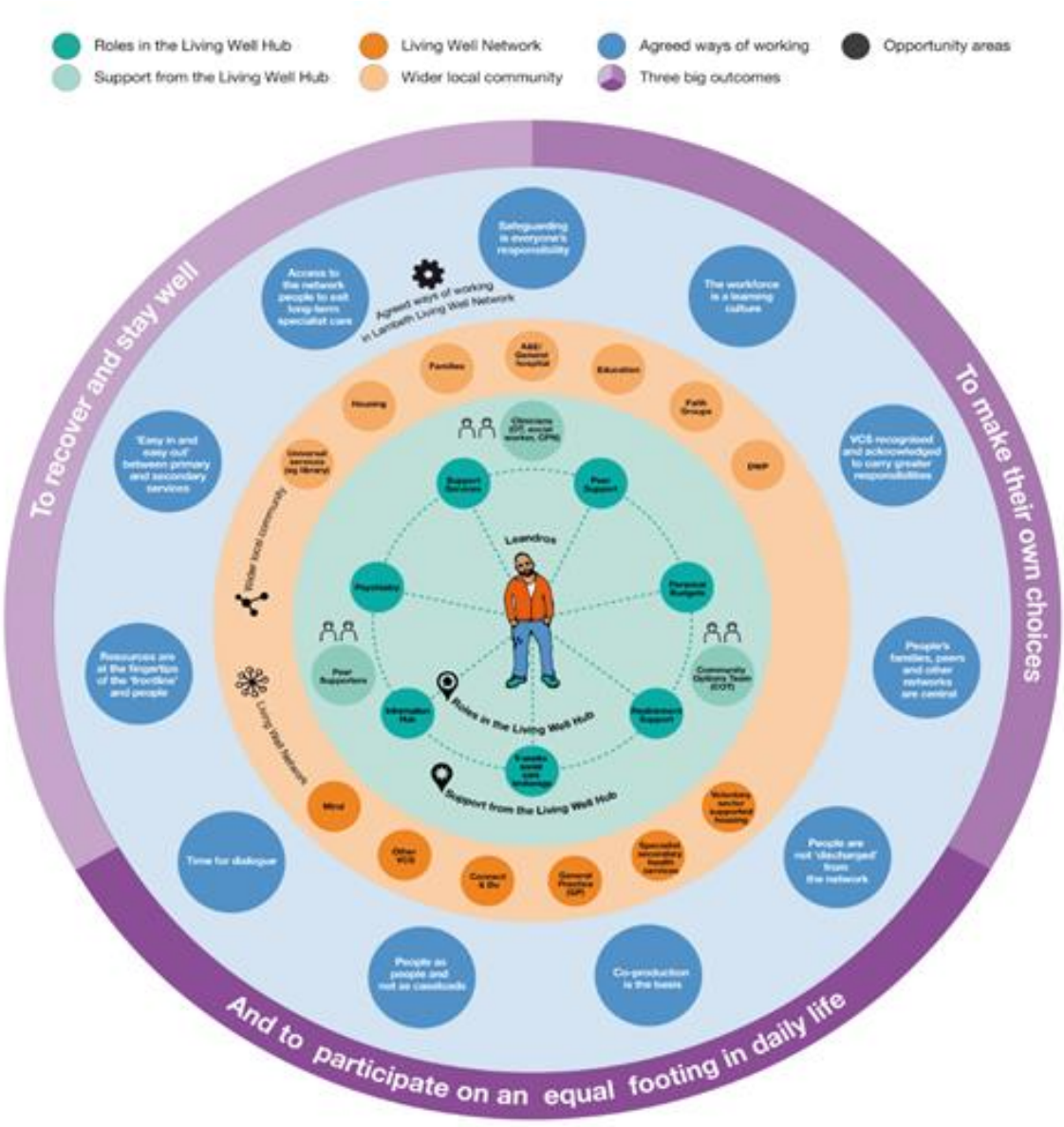
"The LWN Hub states that it is driven by the principles of co-production; from my experience, this statement is completely genuine and has been evident in the evaluation work. The level of engagement from busy staff members has been brilliant. Staff appear to support one another, and are clearly committed and passionate about helping to improve the mental wellbeing of Lambeth residents."

Summary recommendations for future evaluation work

- Efforts should be continued to encourage improved recording of information about people who access the Hub and their contact with the Hub.
- It will be possible to do more in the future in terms of looking at changes in trends over time (e.g. are patterns of service use changing, is the case load composition changing, are WASAS scores changing over time, do staff report a change in ways of working).
- There would be great value in assessing whether it would be feasible for cross-borough comparators to be included in the evaluation that might be used to assess key outcomes against what might have happened in the absence of the Hub (e.g. changing patterns of secondary care service use).
- It would be helpful to explore whether longer term follow-up of resource use and other outcomes beyond closure would be possible.
- Three different methods have been used to look at satisfaction and experience of people who have received support from the Hub. In the future, this could be condensed.
- Future work with wider stakeholders may benefit from in depth qualitative data collection, for example via focus groups.

Appendices

Appendix A: The Living Well Network Map



Appendix B: Support offered by the Living Well Network Hub

The Hub offers the following types of social intervention:

- Assessment for eligibility for care and support under the Care Act 2014
- Ensuring people are safe using the safeguarding process
- 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
- Employment support to remain in or access employment
- Support to involve people more in their local community or in an activity of their choice to reduce social isolation

The Hub offers the following types of clinical support:

- Clinical assessment/a mental state examination
- Medications advice
- Mindfulness techniques
- Mental Health Education
- 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

Appendix C: Personal stories - sample quotes illustrating findings

No real names are used in attributing the source of quotes.

Before Hub involvement

1. *My partner was an alcoholic; she physically assaulted me if I didn't buy her a drink. She got nicked for domestic abuse.* Bill.
2. *Mum beat me so much she knocked my tooth out when I was three.* Reena.
3. [A mental health service] *put me on talking therapy with a stupid woman and it didn't work.* Ernie.
4. [My GP was] *intent on getting me back to work, without any support or help whatsoever.* Bob.
5. *I've been engaging with services for years and my experience has been very negative*. Jane.

Experience of the Hub's support

6. *We would meet at my home or in the park. I preferred that to going to a hospital or the Hub itself. I probably wouldn't have gone otherwise as I was barely leaving the house at the time.* […]. *I was always able to text or email my support worker – I had a proper point of contact.* […] *The relationship with my support worker was good, the element of trust was better with the Hub.* Ernie.
7. *She was very kind and understanding and she listened which was the most important thing.* Reena.
8. *They just listened and formulated where we go next with things. It was only after five years that there was an intervention* […] *I was quite relieved that finally someone understood where I was coming from. It was positive, a change in direction, they realised what was going on with my situation.* Bob.
9. *Most GPs you've got 10 minutes and they're trying to shut you out of the door. It's chalk and cheese compared to the Hub.* Bill.
10. [The Hub staff member was] *really nice, there was no pressure; I could just talk about what I wanted to.* Rachel.
11. *She helped me to look for a free painting class and a managing pain clinic.* Angela.
12. [The Living Well Network Hub] *did in two weeks what others had been trying to do for two-and-a-half years.* Bill.
13. [My support worker] *listened to me and gave information and advice. She also helped me with my benefits […] She got in touch with the housing officer on my behalf and she came with the housing officer to my flat to take down my concerns.* […] *When she said she would do something she actually did it, which was really important to me.* Reena.
14. *I was told by my support worker to motivate myself. But how do I self-motivate myself when I have a lack of motivation? He wasn't listening to me and was dismissive.* […] *My support worker was dismissive of what I was saying. I felt as though he was rushing me through the sessions, because each one had a limited time slot. He kept cutting me short when in conversation.* Alan.
15. *It was a difficult environment to come into.* […] *The biggest concern I had was that the appointment was in a public space, which was too exposed. I didn't want to discuss previous suicide attempts and/or my borderline personality disorder in such a public space. I just didn't want to open up there.* Jerry.
16. *I just cancelled an appointment I had at the Hub. If I don't see a psychiatrist, there's no point.* Alan.
17. *I was disappointed that there was a waiting list* […] *for DBT* [dialectical behaviour therapy]. […] *I felt like, if I can't get a referral for DBT* [from the Hub]*, what's the point?* Jerry.
18. *I still* [after speaking with a Hub staff member] *wasn't sure what the appointment was for.* Harleen.
19. *I wasn't expecting to hear from the Living Well Network Hub – didn't know who they were and I literally just got an appointment.* Rachel.

20. *The co-ordination between the GP and the Hub needs to improve.* Bob.
21. *I didn't hear from anyone in between meetings with Hub staff, which made me feel left in limbo.* Amy.
22. *I was closed* [two months before the interview], *but I didn't realise I was closed until I was told of the Your Story interview today.* No one at the Hub had informed me of this. Jerry.

Outcomes

23. *I would not criticise the Living Well Network at all. They were reactive and pro-active, and got things sorted at great speed.* Bill.
24. [The Hub] *provided good support for getting me back on track and dealing with the relevant services needed to obtain a better way of life.* Jane.
25. *First couple of appointments were confirming what I did and didn't have. Then it was talking about how it could have come about, what worked, what didn't.* […] *I have better understanding of potential reasons why I have* [mental health problems] – *how I could help my condition and this helped me to accept it.* Rachel.
26. *It has been helpful, especially when I have been upset.* Dan.
27. *I have the impression that if I needed help, I can just call them as I have the support worker's number even though I am not at the Hub anymore.* Andy.