The Living Well Network Hub Report

July 2015 – December 2015

Written by:

Sue Field PAG Programme Director

Emma Willing PAG Programme Manager

Contents

Executive Summary

The Living Well Network (LWN) was formed in 2012 to improve health outcomes for people with mental health needs. The aim is to support people in their recovery, recognising their strengths and support them to build sustainable relationships in their local community. As part of the LWN the Hub was formed in 2013 and became a new place for people to get support for their mental health and access more specialist support. Guys and St Thomas' Charity funding enabled the Hub services to be extended to the whole of Lambeth in July 2015.

The LWN offers a radically different way of integrated working between primary care, secondary care services (the South London and Maudsley NHS Foundation Trust SLaM), Lambeth Council and voluntary sector agencies. This represented the first phase of moving from a 'clinically led' system based on crisis care to one that supported the management of mental health and the wider determinants of health, such as housing and community connections. It aimed to be more preventative in nature, where more people would be supported to prevent deterioration of health.

This report summarises the Hubs' first six months of operation as a borough wide service.

In its first six months, the Hub has:

- Offered 1056 people personalized support. The Hub initially proposed it would support 800 people in its first year
- Reduced the amount of referrals to secondary care by 32%
- Reduced the caseloads in the Community Mental Health Teams by 25%. This is against a target of a 10% reduction (160 people) in year one.
- Supported 70 people to be discharged from secondary care with the help of a newly developed medication management service and GP+
- Started to change the culture and develop the LWN staff to work differently as well as influencing and training partners, notably providing mental health awareness training to 308 work coaches at the Job Centre Plus (JCP)

Key challenges are described in the Hub's mobilisation, notably difficulties in staff recruitment, and developing a model of peer support.

Key recommendations focus upon:

- Sustaining the Hub and continuing to impact the wider system
- working with GPs in a more systematic way to support people
- the need to increase our connections with local communities and networks to encourage more people to self-introduce to get support more quickly

The next phase of the LWN will be to further develop this integrated working, and develop a wider alliance incorporating all existing Local Authority and CCG commissioned services. This will bring the network together towards a preventative model of care, enable the system to work together in a co-productive way.

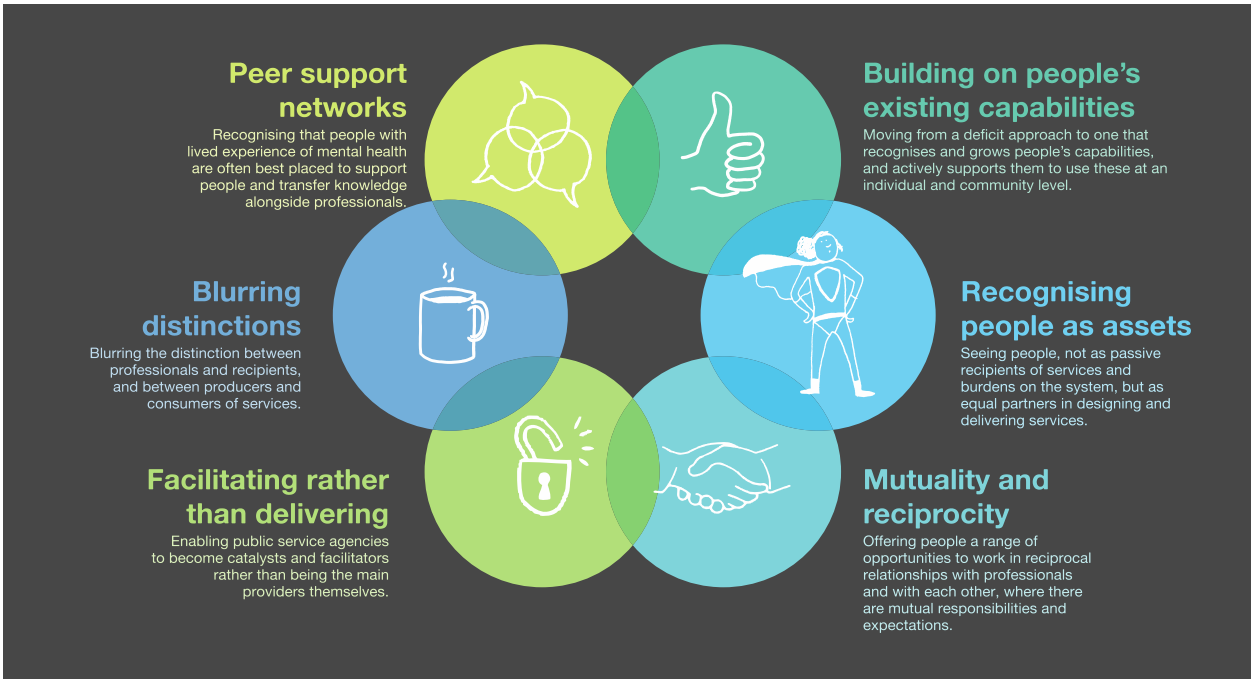
Section 1 – Introduction and purpose of the report

1.1 Background

The Living Well Network (LWN) Hub opened in North Lambeth on 18th November 2013, accepting introductions from North Lambeth GP's. The purpose was to:

- Support people to recover from mental ill health and stay well
- Support people to make their own choices and achieve their personal goals
- Participate on an equal footing in daily life
- Support more people in primary care and ensure access to secondary care only when appropriate, thereby reducing the numbers of people unnecessarily being referred.
- Together with the Living Well Network (LWN), offer an integrated model of Assessment, Action and Planning (AAP), offering a community engagement re-ablement approach that includes clinical, social and peer support

It was developed by the Living Well Collaborative after extensive discussion with local stakeholders across the voluntary and statutory sector, but particularly people with lived experience of mental health services and their carers. A co-productive approach was taken in developing these discussions and in determining how the Hub should operate on a day to day basis. These are outlined in the figure below.



This culminated in 5 key organisations coming together to form the Provider Alliance Group (PAG) who operationalized the Hub, these organisations are:

- Two voluntary sector organisations, Certitude and Thames Reach
- Clapham Family Practice (CFP), a local GP practice
- London Borough of Lambeth (LBL) and
- South London and Maudsley NHS Foundation Trust (SLaM), the local secondary care mental health trust who provide specialist support for people

The Hub sought to operate in a wider network of support formed by existing commissioned mainstream and voluntary sector services, in the context of the person's own community including their family and friends. Its key aim was to help people identify their skills and assets and the support they could draw upon in the network when experiencing a 'wobbly' day. A 'wobbly' day means when people are finding things more difficult than usual.

After significant success, the Hub received additional funding from Guys and St Thomas (GSTC) Charity in May 2015 to extend the Hub borough wide.

The borough-wide Hub was officially launched on 29th June 2015, a key difference being that people could introduce themselves to the Hub (self-introduction) when they felt they needed support for their mental health. Other key changes took place during this time, notably the Hub staffing structure changed to reflect the three GP localities that had been set up in primary care, the Community Incentive Scheme, a service supporting discharge from secondary care was renamed the GP+ team and the location of the Hub moved from Elmfield House in Stockwell to Job Centre Plus (JCP) in Streatham. This is further discussed in Section Four.

1.2 Purpose of the Report

The purpose of this report is to demonstrate the progress and impact of the Hub on the wider landscape of Lambeth and against the milestones that have been agreed with GSTC. This includes the activity of the Hub and the outcomes of the GP+ team to date. The journey of culture change within the Hub, the evaluation process and the relationships that the Hub is building as part of the wider Living Well Network are also discussed.

Most importantly the report gives feedback from people who have used the Hub, this is in the form of stories, compliments and complaints that the Hub has received and can be found in the appendices.

The report concludes with the next steps for the Hub and how these could be achieved.

Section 2 – Living Well Network Hub Activity

2.1 Overview of remit

As stated, the Hub opened borough wide on 29th June 2015. It is the front door to all mental health services in Lambeth with the exception of the following services:

- Lambeth Talking Therapies Service (IAPT)
- Lambeth Early Intervention -LEO
- Tertiary Services – Specialist Mental Health interventions

The services above all accept referrals from the GP's directly (via the CCG for Tertiary services) or self-referral (IAPT). The Hub will accept introductions for these services and make onward referrals if needed.

The Hub receives introductions from GP's, other health care professionals, housing officers, work coaches and LWN agencies if they have a Lambeth address and/or a Lambeth GP and are between the ages of 18-65. In July 2015, the Hub started to accept introductions from people themselves.

The Hub will make onward referral to secondary care (SLaM) if this is appropriate or if the person needs a crisis response. This may be on receipt of the introduction, or at any time during the period when the person is being supported by the Hub. The SLaM staff working in the Hub facilitate this onward referral.

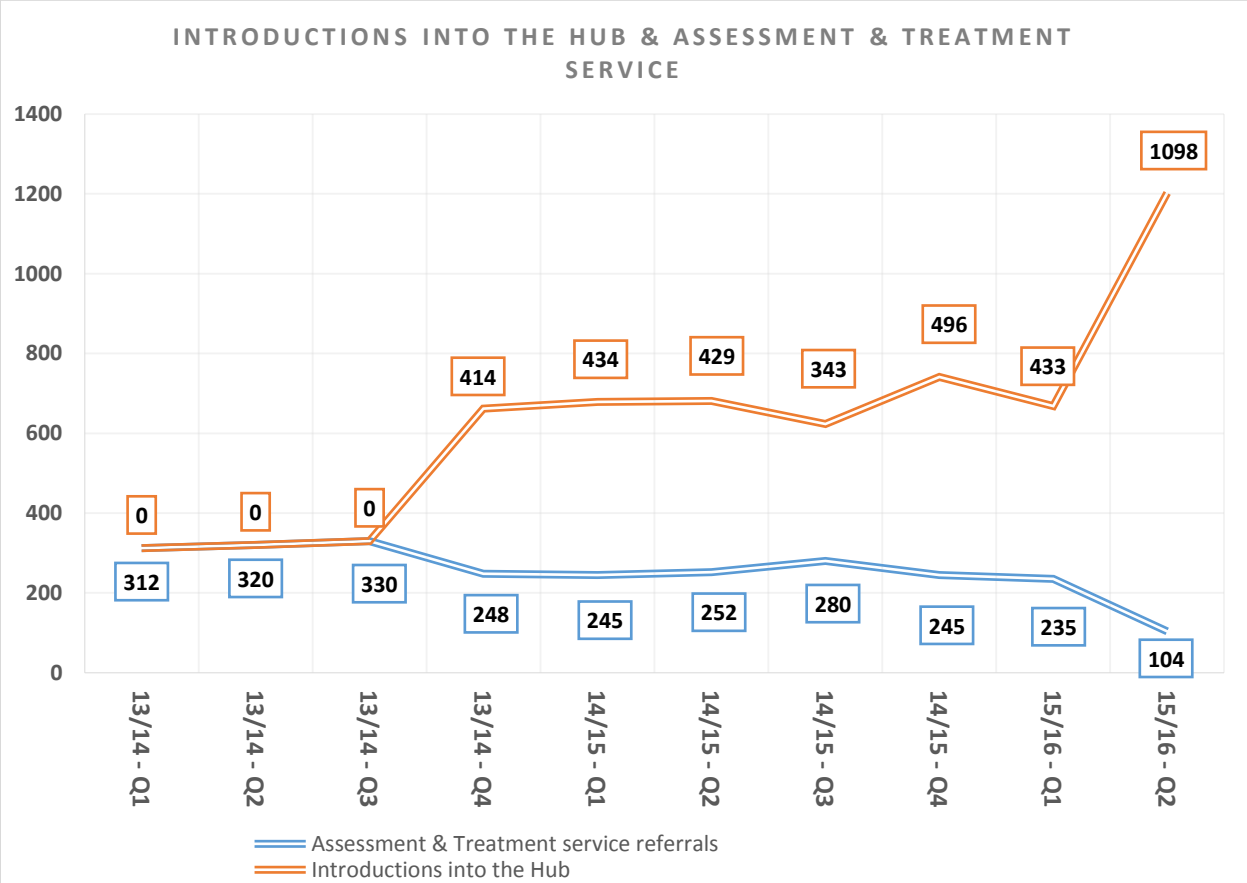
2.2 Activity Overview

The Hub has received 1,877 introductions since it opened borough wide in July. Graph One shows the introductions since the North Hub opened in November 2013 and the referrals made to secondary care teams over the same time frame. As part of the GSTC bid the Hub aimed to provide personalised support to 800 people in year one. This has been achieved in the first six months as the Hub have worked with 1056 people. Many of these people have been signposted to other services such as talking therapies or another service within the Network. Some of the people have received face to face interventions and support over a 12-week period. The Hub will be able to give a more detailed breakdown of the level of support offered in the annual report in July 2016.

2.3 Introductions Received

Graph One outlines the numbers of people per quarter introduced to the Hub and the numbers referred to the assessment and treatment (A&T) teams (now called the Mood, Anxiety and Personality (MAP) assessment and liaison (A & L) teams or MAP treatment teams). This is shown for both the North and the South Lambeth Teams. Referrals to the A&T teams include all those onward referrals made by the Hub, as well as other referral sources, namely from the psychiatric in patient wards to carry out 7 day follow up and transfers of care within SLAM and from other mental health trusts.

Graph One – Referrals to the Hub and A&T teams in SLaM



Data Source: SLaM activity provided to Lambeth Clinical Commissioning Group (CCG) and salesforce for introductions to the Hub

The drop in referrals to secondary care is evident from Quarter 3 (Nov) 2013/14 when the North Hub opened. This was maintained throughout the time that the North Hub was operational. The Hub was then expanded to the whole borough in Quarter 2 (July) 2015/16 and it can be seen that there was another further drop in referrals received by the MAP A & L teams. In Quarter 2 2013/14, prior to the Hub starting, Assessments and Treatment Teams received a total of 330 referrals in quarter 2 2015/16, with the Hub working borough wide they received a total of 104 referrals, representing a 32% decrease. SLaM have also reported that as well as receiving a smaller number of referrals, they are also appropriate for their services. This means that SLaM are providing a specialist service to those who need it at a time they need it, this contributes to a more efficient and effective service for people when they need specialist services.

The Hub has therefore made an immediate impact since it opened borough wide and it hopes to maintain this impact on the secondary care referrals and further reduce this still over the next year.

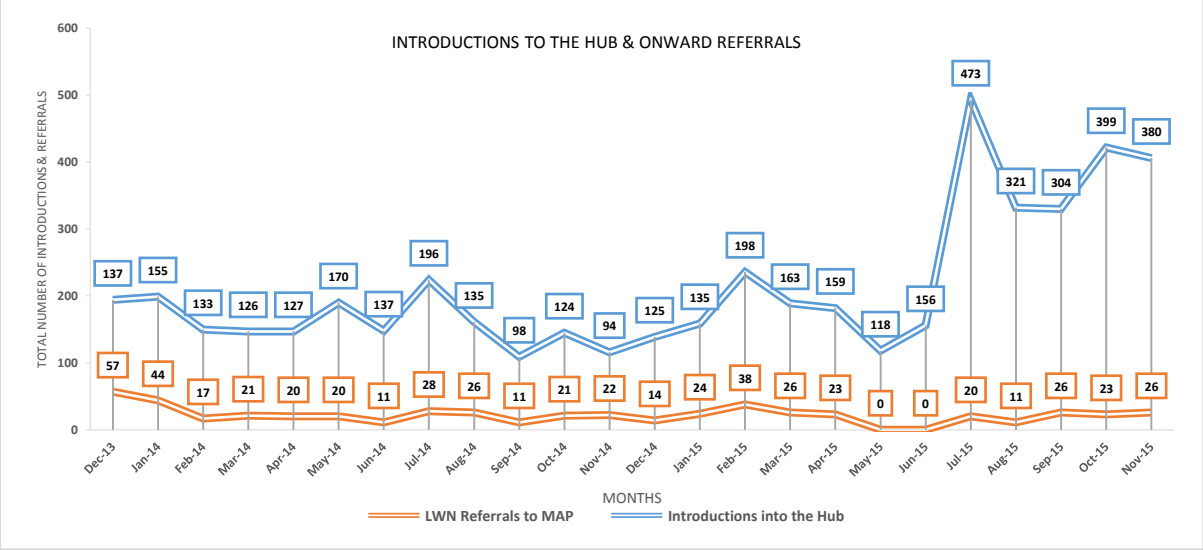
2.4 Referrals to Secondary Care

2.4.1: Referrals to MAP Assessment and Liaison Teams

The above activity is further broken down in Graph Two which highlights the numbers of people introduced to the Hub who have been referred on to the MAP A&L Team.

These figures have been confirmed with SLaM Head of Pathways for MAP and show that the Hub has maintained a reduction in referrals into secondary care throughout the borough. One of the aims of the GSTC bid was to demonstrate a reduction in the referrals into secondary care. Through the work of the Hub this reduction has been achieved.

Graph Two – Numbers of Onward referrals to MAP teams from the Hub



Please note that there is missing data (referrals into MAP) from May and June 2015 due to change of data collection
473 introductions received in July includes some introductions received at the end of June due to induction week and launch of borough wide Hub.
Data Source: SLaM activity provided to Lambeth (CCG) and salesforce for the Hub introductions

2.4.2: Referrals from the Hub to all community secondary care services.

Chart One shows all the referrals the Hub have made into secondary care, as the Hub can make direct referrals to the following Lambeth teams:

- MAP A&L Team (shown in the graph above)

- Psychosis Promoting Recovery Teams
- Specialist Teams such as Lambeth Early Onset (LEO) Team, Integrated Psychological Treatment Team (IPTT), Eating Disorder Outpatients and Attention Deficit Hyperactivity Disorder (ADHD) service.

Prior to the borough wide Hub, the Hub made referrals into these secondary care teams but these were not reported in the annual report 2014-15. The 2014-15 annual report only reported the referrals the North Hub made into the MAP team, but the Hub made a small number of referrals into the other teams. The Hub now has more sophisticated data collection tools and is able to demonstrate which secondary care team onward referrals are made too. Some of the referrals made to MAP are forwarded onto the Promoting Recovery and Specialist teams after the intervention from MAP, this is because of the need for further specialist assessment or because a more urgent response is needed to the referral.

Chart One: Total number of referrals made to secondary care from the Hub.

	MAP	Promoting Recovery	Specialist	Total referrals into secondary care
July 2015	20	7	5	32
August 2015	11	0	6	17
September 2015	26	3	9	38
October 2015	23	1	14	38
November 2015	26	5	6	40

Data Source: Salesforce Inform

From these numbers it is evident that the amount of people needing support from secondary care is relatively low on a monthly basis. On average 33 people per month are referred to secondary care. Often support can be offered within primary care, especially some clinical and social support, which will reduce the numbers of people being referred to secondary care unnecessarily and impact on the assessment team in secondary care.

2.5 SLaM Community Mental Health Teams Caseloads

Chart Two shows the total caseload numbers for Lambeth SLaM Community teams since 2013. This includes the Assertive Outreach, outpatients, MAP assessment and treatment teams and Promoting Recovery (Psychosis) teams, these are referred to collectively as Community Mental Health Teams (CMHT's).

Chart Two: Community Mental Health Team caseloads.

	13/14	14/15	15/16
Q1	2331	2173	1887
Q2	2342	2050	1768
Q3	2372	2056	
Q4	2175	2054	

Key
No hub
N hub
Hub

Hub Q2 vs no hub Q2 **-25%**

N hub Q2 vs no hub Q2 **-12%**

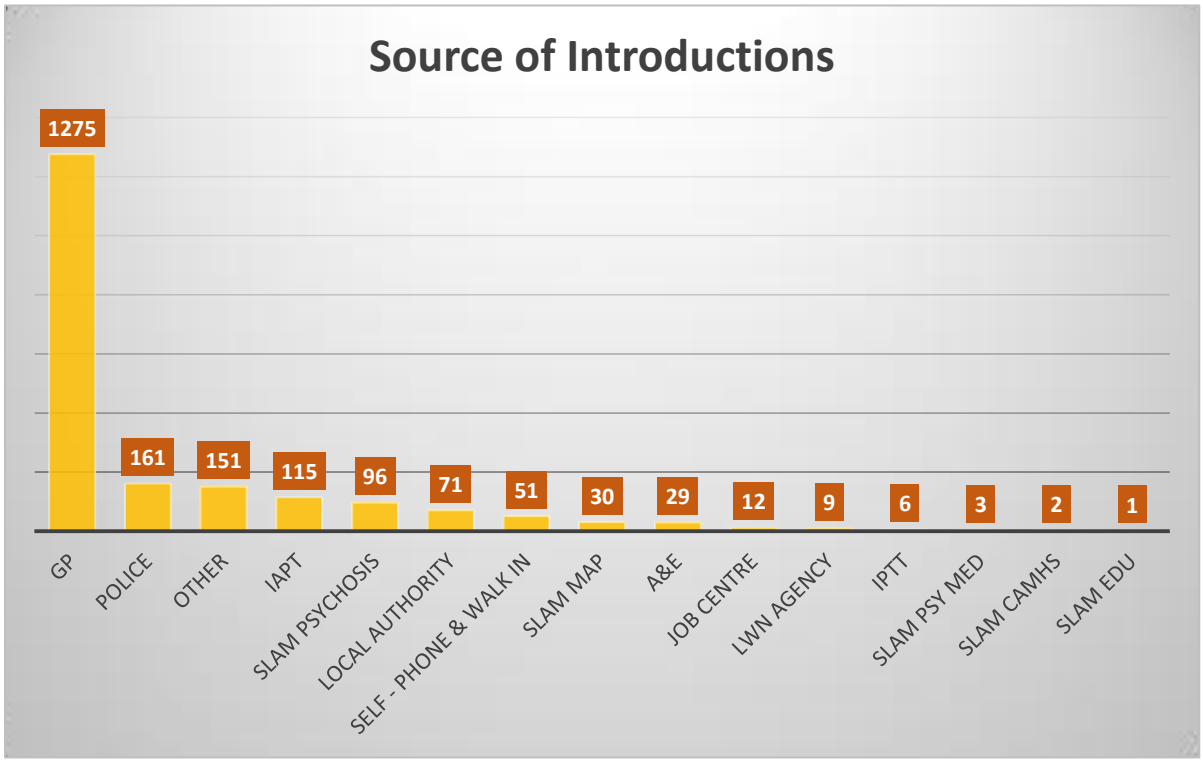
Data Source: SLaM activity provided to Lambeth CCG

The application to GSTC discusses the expectation that the Hub along with other changes across the mental health system in Lambeth would achieve a 25% reduction in caseloads by 2018. The Hub is pleased to show that there has been a 25% reduction in caseloads since it commenced in North Lambeth. However, it is important to recognise that there is a whole system change taking place in Lambeth and our partners in the Lambeth Collaborative, SLaM has also successfully implemented the Adult Mental Health Model in Lambeth. The adult mental health model is a step change programme in SLaM to solving a number of pressures within SLaM. Both these change programmes aim to reduce caseloads in secondary care and this objective has been achieved in the past 2 years.

2.6 Sources of Introduction

The Hub receives introductions from a variety of different sources. Graph Three shows the range of sources and the numbers the Hub receive.

Graph Three: Sources of introduction



This shows the source of introductions since July 2015.

The Hub is still receiving high numbers of introductions from GP's. The Hub has received referrals from 98% of Lambeth GP practices since opening borough wide. There has been a very small number of people who have introduced themselves and the Hub would like to see this number increase further over the next 6 months. The Hub believe that this can be achieved by spending time in the community, visiting organisations and meeting with local people to advertise the service.

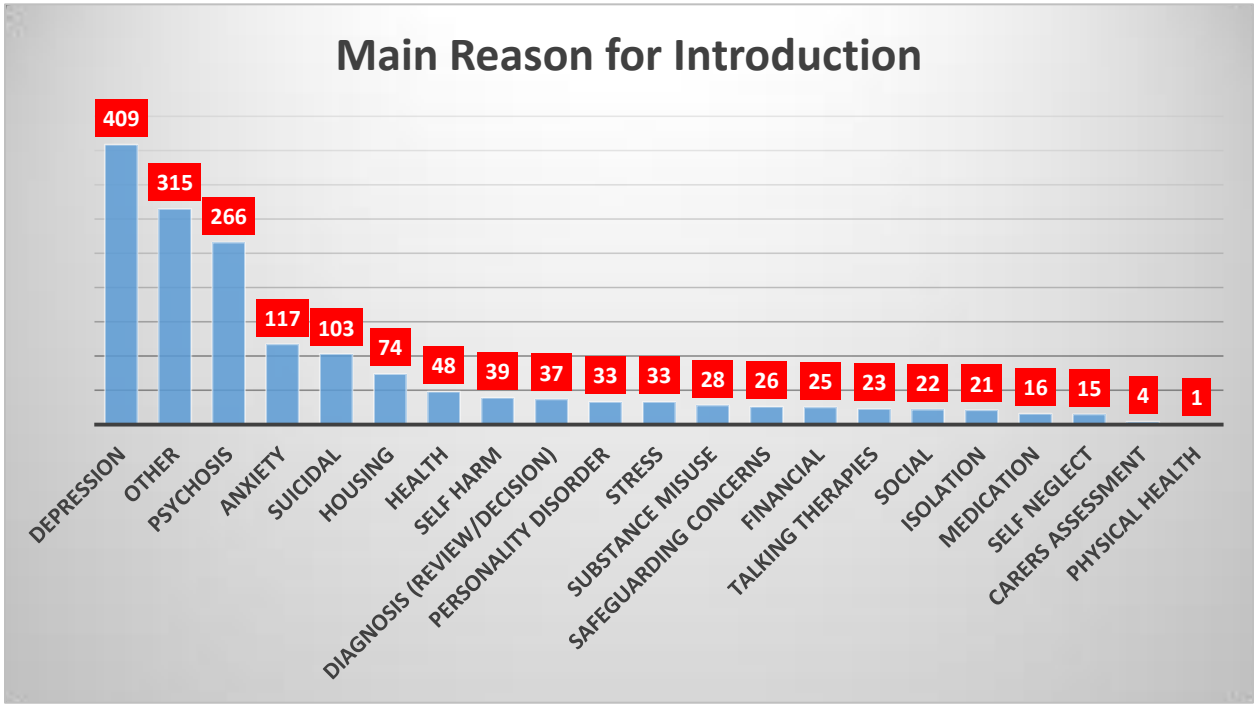
The Hub received some introductions from SLaM MAP A&L and treatment teams, Psychosis promoting recovery teams, Integrated Psychological Therapy Team (IPTT), Child and Adult Mental Health Services (CAMHS) and the Eating Disorder Unit (EDU). These are generally for people who no longer need the specialist support of that service but need some ongoing support and we will work with people to ensure that the discharge from secondary care back to being effectively linked to their GP is successful.

2.7 Reasons for Introduction

Graph Four shows the main reason why someone is introduced to the Hub. The Hub often works with people for different reasons than is originally stated or for a variety of different reasons. However, for the purposes of Graph Four, the main reason on the introduction form is shown. Over 1000 of the introductions we have received are for clinical reasons. However, on further investigation other social

issues emerge which directly impacts upon a person's mental health. The Hub is pleased to be able to receive introductions where there are safeguarding concerns as this is a new development for the Hub since it opened borough wide. They are able to do this due to the presence of LBL Social Workers in the Hub. Previously the Hub would have made an onward referral into secondary care when an introduction indicated safeguarding concerns. The Hub have also negotiated with LBL that the Hub can offer Functional Assessment of Care Environment (FACE) to assess people for social care needs and all staff in the Hub have received training on this. The Hub are also beginning to receive introductions for carers who would like support to stay well. The 'other' column includes bi polar affective disorder, when a combination of reasons are given or it is not clear why the person needs support in the introduction.

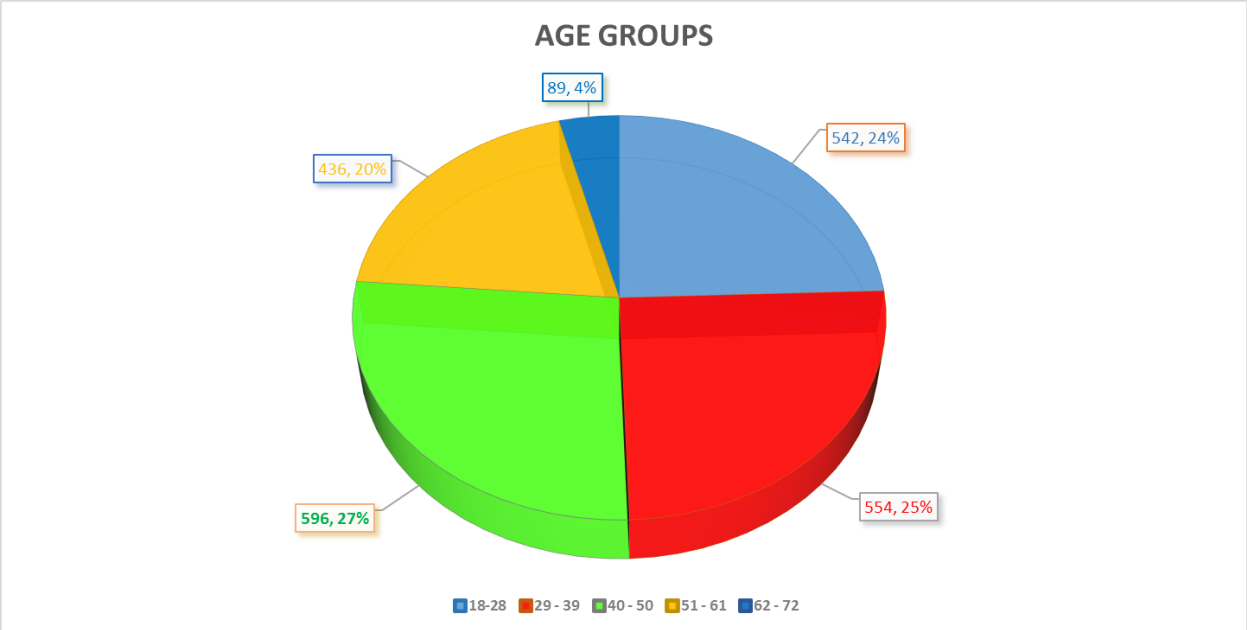
Graph Four: Main Reason for Introduction to the Hub



2.8 Demographics of the people introduced to the Hub

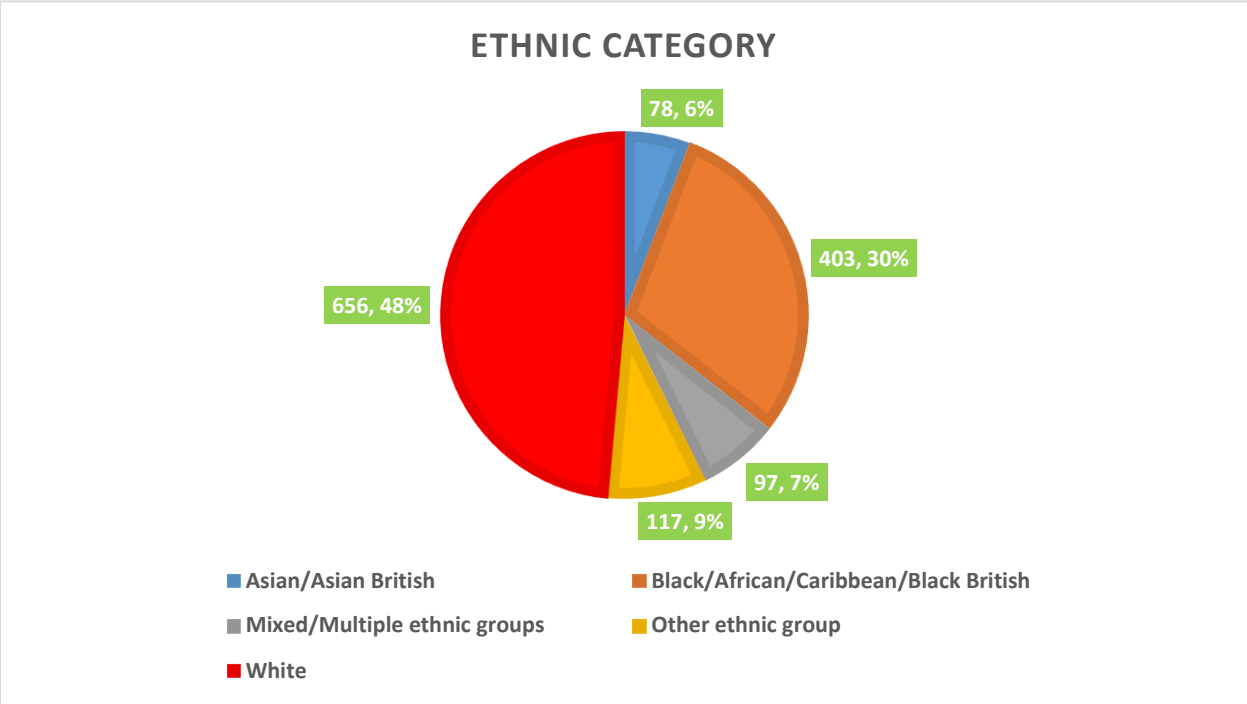
Graph Five highlights the range of ages of the introductions received since July 2015. We have on occasion received introductions for people who are over 65 and where possible we will have a conversation with the person to see what their needs are and then make an onward referral.

Graph Five: Age groups of people introduced to the Hub



The Hub receives equal amounts of introductions for males and females.
Graph Six shows the introductions based on ethnicity.

Graph Six: Percentage of introductions per ethnicity



This information has only been collated on 57% of the people introduced to the Hub. The Hub have had some challenges collecting this data and have not been able to collect this for all of the introductions (43% missing data). This is for a number of reasons, either because people making the introduction do not complete the data required, the person does not wish to engage or the staff member does not ask. Further discussion with the GPs is taking place to improve this reporting and an evaluation workshop took place with staff to stress the importance of gathering this information. Lambeth Council's document 'The State of the Borough 2014' reports that:

'Around 40% of Lambeth's population is White with a UK background. White people make up 59% of the population. Around 40% of Lambeth residents are White British or Irish. 15% of the population are from other White backgrounds – around 47,000 people. About two thirds of these people are from Europe outside the UK & Ireland,8% are from central and south America, 4% from north America and the Caribbean, and 8% from Australasia.

Black people make up a quarter of the population (25%). Lambeth's largest non-white ethnic group is black African (11.5%), followed by black Caribbean (9.8%). Only 7.8% of Lambeth residents are from Asian backgrounds (including Chinese)' This is taken from the executive summary. Graph Six shows a slightly higher population of black people being introduced to the Hub than the general population in Lambeth and a slightly lower population of white people.

2.9 GP+ Activity

The GP+ team is part of the Hub. The purpose of the GP+ team is to identify people who would benefit from discharge from secondary care with some additional support so that they can be supported in primary care. In the GSTC bid it stated that the GP+ team would support 200 people to be discharged from secondary care and support an additional 100 people who were currently in primary care. Table One demonstrates that 78 people have benefited from working with the GP+ team. There have been considerable additional referrals and assessments completed. A key learning point is that often people have ongoing social situations that impact on their mental health, such as outstanding issues with housing which can lead to instability. It is important that people feel settled in the move from secondary care and hence the GP+ team have altered how they
work with people to facilitate this. This is described further in the next section

The chart also highlights that on occasion the GP+ are waiting for available appointments from the GP in order to enable access.

Table One: No's of introductions to the GP+ service

	Since April 2014
Introductions received:	**392**
from CMHT	366
from GP	26
Assessed and Taken on:	**78**
Discharged from the Scheme	6
Not taken on:	**167**
Not suitable for GP+ at time of assessment	58
Discharged directly to GP	35
Refused support from GP+	14
CMHT more appropriate at time of assessment	44
Low Intensity Team more appropriate	7
GP+ not needed	7
Death	2

Assessed and to be review at later date:	**55**

Section 3: GP+ and Medication Management

3.1 GP+ Team

As highlighted in the above figures, there has not been the expected uptake of the service. The GP+ team have supported 28% of the 200 people it hoped to support. The GP+ team has had a number of challenges over the past six months. Among these has been staffing issues including the team leader being on three month's sick leave. The team has been making better progress together to move people from SLaM caseloads to the GP+ team in recent months, but the numbers are yet to reflect this.

Identifying people who would benefit from the GP+ team support has mainly been through in-reaching to CMHTs to speak to individual care co-ordinators about suitability. This remains difficult as care co-ordinators have fed back that they see discharging people via the GP+ team as more work intensive than discharging directly to a GP. Some GPs have fed back that they are dissatisfied with some clients being discharged directly to them without the GP+ team being considered and the GP+ team plan to redress this balance by attending each CMHT's discharge meetings on a more regular basis to be better aware of, and where appropriate involved in, the discharge planning of more SLaM clients. They have also agreed to reduce the work expected from CMHTs to a minimum requirement and will reiterate to care co-ordinators the benefits of clients who may require additional support being considered for the GP+ team.

Many of the people assessed by the GP+ team have not been suitable due to having pieces of work related to a discharge plan outstanding such as the Care Programme Approach (CPA) or placement/care package review. This means that the process of being identified as suitable for the scheme and moving onto the scheme can be delayed.

Communication with GPs has been difficult and inconsistent since the GP+ team started. This was all done via the GP+ team leader and some surgeries have specified different preferences for how the GP+ team should communicate with them. There have been times when it has taken repeated calls and emails to garner a response to request for a GPs views on whether a person is suitable for the scheme. The GP+ have learned that face to face meetings at the GP surgery have been the best way to complete transfers, and this is what the team now aims to do for each person moved onto the scheme. There are still delays and difficulties setting up these meetings as double appointments often need to be booked in by a GP or practice manager as some reception staff are unable to do this.

The GP+ team is gradually building better relationships with GP surgeries through improving communication, and GP+ team staff and locality leads are attending practice meetings. Once a surgery has people on the scheme, it becomes easier to link with the correct individuals to communicate about further potential discharges. Over the coming months, the GP+ team leader will prioritise on improving these relationships with surgeries as new staff take on more of the clinical work and in-reaching to CMHTs.

Feedback from clients on the GP+ team has overall been positive. People are allocated a lead nurse, but are aware that the team works on a shared basis. This means that any GP+ team nurse will be able to respond to them quickly if the lead nurse is unavailable. 23 people to date have made use of the additional support available via the Hub support workers, Peer Support or Look Ahead Medication Management Team (see below) offer either as part of preparing for discharge, to put support in place to reduce risk of relapse, or to explore opportunities available within Lambeth and the Collaborative that will positively impact on functioning or wellbeing.

There are a small number of people with the GP+ team that are seen more frequently than every 3 months as originally anticipated. Despite this, it has been felt that they remain more suitable to be supported in primary care than through the CMHT due to the relative stability of symptoms, persistent nature of symptoms and level of input they receive from GP surgeries.

3.2 Medication Management Team

As part of the GSTC application there is a provision for a medication management service which is provided by Look Ahead, a local voluntary sector provider. This service was initially to be used to support people to regularly take their medication as part of their discharge plan from secondary care. This included different ways of supporting people with their medication including practicing the new arrangements to collect their medication from their GP, ensuring they take their medication regularly,

offering support to ensure they understood why they were taking medication and helping the person to build relationships with their local pharmacies.

The service did not receive any referrals and Look Ahead, along with the Hub and GP+ team looked at other ways of promoting the service. They are now accepting referrals from secondary care for people who may need support regarding their medication but also now seek to address social issues that are outstanding and may otherwise be preventing their discharge from secondary care. The GSTC application stated that the service would support 100 people.

There are currently five people being supported by the service, four people who have been referred and assessed but not taken on and an additional 20 people identified as needing a referral with information provided by secondary care. The Hub expect that with this change of remit, usage will quickly increase.

Section 4: Hub Location and Service Delivery Issues

4.1 Central base and new locality-focused arrangements

From June 2015 the Hub has been based on the 3rd floor of a building in Streatham above the local Job Centre Plus (JCP). This space is provided free of charge by the Department of Work and Pensions (DWP). It is an excellent location that is accessible for those people who want to meet staff in this part of Lambeth and offers rooms where confidential meetings can take place. The proximity to the JCP has also enabled the Hub to provide training and support to JCP staff so that they have a better understanding of mental health and the impact this can have for people.

As part of opening of the new central base and the extension of the Hub service across the whole of the borough, a plan was implemented through which local agencies, the public, GPs and other stakeholders were informed of the new address and that the Hub would henceforth be able to accept introductions from all Lambeth GPs and from residents of Lambeth who wanted to introduce themselves. There are plans to further market the Hub so that more people will become aware of it. This will include staff

attending local events, spending time in community locations and the wider circulation of information through leaflets, the website and social media.

There was some misunderstanding concerning why the Hub central base was moving to a JCP building with some local community groups believing, erroneously, that the Hub would be part of a programme of mandatory engagement by people with mental health issues who would risk losing entitlement to benefit if they didn't accept support from the Hub. At the launch of the Hub some protesters disrupted the event. Members from the PAG have since meet with one of the local community groups involved to explain that the services provided through the Hub are optional and focus on the needs of the person using the service and are not mandatory or linked with enforcement.

4.2 Staffing Structure

Importantly, the services offered by the Hub are provided across the borough, at places that best meet the needs and preferences of the people using the service. The model of service delivery has changed to reflect the creation of GP localities and the Hub staffing model mirrors this with three locality teams now in operation.

The initial Hub service comprised:

- The Community Options Team (COT),
- Primary Care Support Service (PASS),
- Triage Team
- Community Incentive Scheme (CIS) – now the GP Plus Team.

There has been further integration of these teams to create the new structure of a single borough-wide Hub and members from the COT and PASS teams form part of each of the locality teams. The Triage team is now part of an Introductions Team which explores all new introductions to the Hub. The new staffing structure was agreed following feedback from individuals and organisations that are part of the wider Living Well Network.

The Introductions Team comprises:

- 6 x Clinical Expert Practitioners from SLaM
- 2 x Lead Workers from Thames Reach
- 2 x Peer Interns from Certitude
- 1 x Consultant Psychiatrist from SLaM
- 1 x Practitioner Manager from LBL

Each of the Locality Teams is formed of:

- 1 x Senior Practitioner from Thames Reach
- 1x Lead Worker from Thames Reach

- 3 x Support Workers from Thames Reach and Certitude
- 1 x Peer Intern from Certitude
- 1x Social Worker from LBL
- 1x OT from the Clapham Family Practice.

The GP+ Team is staffed by:

- 1 x Team Leader
- 3 x Nurses

The administration team has:

- 3 x Admin Support Workers
- 3 x Transitional Employment Placements (TEP)

(The Peer Interns and TEP are discussed in Section 5.2.5)

4.3 Recruitment and retention issues

One of the milestones agreed as part of the GST Charity bid was to have 80% of staff recruited by September. This milestone was initially met but some staff have since left the Hub bringing the staff complement to just below the 80% level. Despite managing to create a strong Hub work-force that has successfully delivered on many of the objectives agreed at the point when the Hub was rolled out across Lambeth, there have been issues around staff recruitment and retention.

The primary cause for this staffing situation is the short-term nature of the current funding. The instability that arises from this means that very competent people who are enthusiastic about the work of the Hub are sometimes understandably reluctant to commitment themselves when the employment contract or secondment opportunity is short-term.

There have been significant delays in the recruitment of clinical staff and the Hub opened with only 42% of clinical staff in post. The first Consultant Psychiatrist left to work away from London and they were replaced, but this change in personnel had an impact on the development of the role and on engagement with the culture change element of the Hub. Recruitment and retention continues to be an issue, though the Hub has now recruited all the clinical staff required and they are due to start in the coming months.

Since opening, the Hub have received high volumes of work which requires clinical support and with limited staffing this has had an impact on the length of time people have had to wait. Project Managers have had to undertake more clinical work that expected and this has had repercussions regarding their other responsibilities. Nonetheless, waiting times have still generally been shorter than the wait for Assessment and Treatment services under the previous operating model. Additionally, reliance on high

levels of agency staff has increased staffing costs and impacted on our ability to support and grow sustainable culture change.

An extremely positive development has been the recruitment of a Social Worker Practitioner Manager to support the Hub in how it can provide social care and meet statutory requirements in primary care. Previously the Hub teams referred people with social care or safeguarding needs to secondary care. The introduction of the Care Act 2014 has changed some local authority responsibilities and this needed to be considered. The Practitioner Manager has offered considerable training and process development and the Hub is now accepting safeguarding alerts, requests for judicial reviews and social care assessments.

The issue of staff stability is one of the major challenges for the next stage of development as without changes in this area the establishment of a culture of support and stability will be hampered, as will the ability to grow sustainable relationships with GPs and people who may return when they need help.

Section Five: Culture Change

The Hub represents a different way of operating and its development has had an impact on the wider Living Well Network - the collaboration of agencies, individuals and organisations that collectively seek to provide services to support people with their mental health in Lambeth. The Hub is one part of a wider change in the way that services are being facilitated across Lambeth. For services to be more effective and offered in a more personalised and holistic way, a major culture change is required.

The Hub has been instrumental in pioneering these developments and has achieved significant culture change, enabling people to receive support for their mental health earlier and to be offered support with a greater emphasis on choice and personal control. This has been achieved through the commitment, skills and knowledge the talented workforce within the Hub and support from the wide range of stakeholders that forms the Living Well Network.

5.1 How the Hub approach is different

5.1.1 Working together - a multi-disciplinary approach

The Hub has built a structure to facilitate each organisation working together in a way that has not been achieved before. Clinicians work alongside support workers from the voluntary sector and peers (people who have themselves experienced using mental health services) supporting a person to achieve their own outcomes in a personalised manner, rather than through a 'one size fits all' approach. Previously, if people reported many issues in which they needed support, they would have been referred to multiple services, mostly in different locations. Often, this would have taken time, meant that information and assessments would need to be repeated and resulted in interventions not being aligned and effective.

The Hub has extended this approach outside of the parameters of the Hub in jointly working with the wider Living Well Network. The Hub assists people to grow their own network of support. Staff encourage people to seek help earlier, equipping them with the knowledge of how to gain support through accessing community resources including those that are not based on professional services or interventions. The Hub also focusses on the assets that people bring with them to the Hub, the personal qualities, strengths and skills they can offer, and help them develop these so that they can become more resilient and able to engage in a good life on an equal footing.

Having social care staff in the teams has meant that safeguarding (support to ensure that vulnerable people are safe from neglect, abuse and exploitation) is everyone's concern. All staff have been empowered to raise alerts and complete assessments that can enable social care packages of support to be introduced at a much earlier time. It is the first time that social workers have been in a primary care mental health setting in Lambeth and they are able to offer additional expertise and support to people to further enhance their well-being in a holistic and personalised way.

Social care resources have also supported the Hub to reduce referrals into secondary care as previously safeguarding concerns and judicial reviews would have required the person to be passed onto secondary care, even if the mental health needs could have been supported in primary care.

5.1.2 'Having a conversation' and offering support earlier

The Hub doesn't simply offer clinical interventions and the assessments are about understanding all the areas people want support with and using their assets to achieve these goals. Staff have a conversation with people rather than completing an assessment. This is a wider, more informal approach to ascertaining how people can be supported and learning from the development of the North Hub has encouraged the teams to offer a 'conversation' to everyone who is introduced to the Hub if they want it.

The Hub wants people to recognise when they are having a 'wobbly' day and need support as early as possible. It wants to move away from an approach whereby people feel that they cannot get help until the point arises when they are at 'crisis' point. The Hub does not discharge people from the Network. People can come back at any time and as many times as they need support and this flexible approach is sometimes described as 'easy in easy out'. This will take a considerable culture shift in the wider

community to make them aware of the support they can receive from the Living Well Network, that they have permission to seek help at an early point and should take responsibility for their health.

The Hub wants people to understand that their good health is not simply the absence of illness. It is about their social situation, their relationships, home environment, work-life and community. All this needs professionals to change how they work with people. The Hub want people to introduce themselves earlier and have brief, focused support that enables them to utilise their network of support. Appendix A looks at some people's experiences of the Hub and how it has supported them.

The Living Well Network has developed an initiative called the Living Well Lab. It gives staff the opportunity to explore people's experiences of using the Hub and it uses the themes and learning from these stories to further develop themselves and the service. The Living Well Lab is facilitated by the Innovation Unit. The Peer Interns working within the Hub are going to receive support from the Innovation Unit to interview people to obtain their stories to use in the Lab. These stories will also be used as part of the evaluation of the Hub. Two stories developed through the Lab can be seen in Appendix A and concentrate on the theme of relationships.

The Labs explored the opportunities within the stories. The first opportunity was how the relationships the Hub has with local GPs could deliver more and needed improving. The second opportunity was to further extend the reach of the Hub so that more people are aware of what it does and how people can access it. The Hub hope that the Labs will become an integral part of the culture change giving everyone an opportunity to offer feedback and a space to test ideas.

5.1.3 Changing working practice through Information Technology

The Hub has needed a completely new Information Technology (IT) infrastructure to support it. The North Hub staff were documenting records for the support offered on three different recording systems, making communication difficult between the agencies working in the North Hub. The IT in place was office based and did not facilitate staff mobility, thereby resulting in people needing to come to the Hub to receive support rather than being met at a place of their own choosing.

A significant upgrade in IT infrastructure and linked training has meant that the Hub now has a mobile, IT literate work force who use smart phones, laptop computers and a new recording system called Inform that is used by all staff in the Hub and enables an Analyst who supports the work to provide more in depth data to inform the work and delivery priorities. This represents a significant shift in culture. All staff now work on laptop computers and can work from anywhere in the borough. The Hub encourages staff to be out in their locality, finding space to work and to meet people in a timely and efficient way at places that are convenient.

A number of issues have needed to be tackled such as accessing shared drives, ensuring everyone has access to appropriate systems and agreement over issues of information governance and sharing information. Policies are being developed to further support this and the Hub is also going to ensure that teams outside of the Hub have access to its recording system. If, for example, someone presents to A& E it will then be possible to see what support the Hub is offering or could offer.

5.2 Working towards wider culture change

The application to the GSTC committed the Hub to ensuring culture change that extended to the wider Living Well Network as well the Hub. The following section notes some of the challenges and areas where further progress is required in the area of changing culture.

5.2.1 GP engagement

Impressively, 98% of GPs are making introductions to the Hub when they feel they need support for their patients. GP's have been introducing people much earlier than previously when the only option was to refer to SLaM. This is because the Hub allows introductions to be made earlier, when the person is having a 'wobbly' day and not when they are at or near 'crisis point'. The high volume of introductions from GPs and the small numbers of people the Hub has referred onto secondary care indicates that there has been a change in approach.

However, some GP's are still unsure of what the Hub can do and the system change vision of the Living Well Network. The Hub would like to be based in GP practices more regularly, offering even earlier support and awareness to further promote self-introduction and raise awareness of what the Hub can do to support people. The Hub want to be able to support and enable GPs so that they can explain to people what the Hub and wider Living Well Network can offer. The Hub needs to engage more with GP's and build stronger relationships with them. This has been challenging due to time restraints and understanding how all of the different practices operate.

5.2.2 Staff Engagement

Staff recruited prior to July 2015 were part of an induction supported by the Innovation Unit, the Induction looked at the history of the Living Well Network, the idea of a networked approached of support and re-aliment, the principles of coproduction and the vision and outcomes expected from the Hub. Some staff have found it complex operating in a co-productive environment requiring a different approach to using both the assets of colleagues and of the people coming to the Hub. Whilst good progress has been made it will take longer for new working practices to become accepted and developed and it has not been helped that there has been a turnover of staff, as described in the preceding chapter.

The higher than expected turnover of staff and the delay's in recruitment has made it challenging to continually repeat the induction and training for new staff joining the teams though there is now a

better understanding of the importance of the induction process and the Hub will be addressing this with the arrival of staff in the future.

The Hub staff have been working in a challenging and at times uncertain environment whilst changes have been implemented and they have shown commendable commitment and resilience. They have had to work with new colleagues, and learn about new processes and organizations. They have continued to very effectively support people on a daily basis and have individually and collectively made a positive impact on the lives of people receiving mental health services in Lambeth that has exceeded expectations.

Questionnaires to staff have been developed to ask them how they feel about working in the Hub and to ascertain the extent of culture change that has taken place. However, due to time restraints, these have not been completed and therefore the results will form part of the annual report for 2015-16.

5.2.4 Training

The Hub are embarking on a programme of solution focused therapy training for all the staff working within the Hub as part of a culture change programme. The Hub want staff to enable people to focus on solutions rather than their problems and also ensure that they provide brief, solution focused interventions to people as our part of our model of support.

The Hub also feel staff need more support to deliver change and are considering training for managers of the locality teams so that they can further support the culture change within the Hub locality teams, and with respect to the relationship with GPs and local communities. The Hub will constantly assess and reflect on how it can facilitate services and be flexible in the way this is done.

5.2.5 Peer Support

The Hub initially set out to develop a peer support network. However, this was reviewed and it was decided that Certitude's Peer Support Network Hub was too similar service. Instead, the Hub is currently developing a peer internship through which people who have recently experienced problems with their mental health can apply for a peer intern role as part of their recovery. They will be supported to work in the Hub where they can learn new skills undertake training and in doing so increase confidence and self-esteem. As positive role models who have experienced using mental health services the Hub are confident that the peer interns will make a big impact. This would be a short term role to enable the person to move onto meaningful employment. It is hoped that they will work with people on a one to one basis as well as bringing up-to- date knowledge and information regarding other peer support networks across the borough into the Hub. As the Hub recruit the additional four peer interns the role is likely to further support the introductions and locality teams.

The Hub also have three Transitional Employment Posts (TEPs) in the Hub. These are facilitated and supported by Mosaic Clubhouse and are a six month 'work' placement for people who are experiencing mental health difficulties, or have in the past. These roles have mainly focused on administration tasks.

However, one of people in this role talks to people who have completed their support from the Hub to find out how they are doing and how they felt about the service provided by the Hub. This is completed as a telephone call six weeks after the person has been closed. One of the people in a TEP with the Hub has gone on to gain full time employment with the Hub.

The Hub is also exploring other ways that peer support can be incorporated into the daily work. The Hub would like to offer groups to people who are experiencing similar issues so that they can meet up and discuss these together.

Section Six: Evaluation

As part of the GSTC bid the Hub is required to consider how it can evaluate the impact that it is having on people's lives, the wider mental health system and the cost impact. This is being completed in different ways

6.1 Evaluation Framework

An Evaluation Framework has been developed by the Evaluation Board. The evaluation board is a regular meeting involving representatives from the CCG, public health, Institute of Psychiatry, Psychology and NeuroSciences (IOPPN) and the PAG. This looks at all the aims and outcomes from the GSTC application and adds them into a framework that looks at how these aims and outcomes can be measured and what data is required to support this.

6.2 Institute of Psychiatry, Psychology and Neurosciences (IOPPN)

As part of the Evaluation Board, it was recognised that specialist support would be needed to interview people who have used the Hub and analyse these interviews to look at themes and assess if the Hub is achieving its reported aims and outcomes. The IOPPN is being funded to support the Hub to complete interviews and questionnaires and to analyse these.

6.3 Quantitative Data

SLaM are providing data as part of the evaluation. This has been complex as the evaluation requires data from different Clinical Academic Groups (CAG's) and the Hub have requested some data from SLaM that they do not ordinarily provide as part of their reporting mechanisms. This has been communicated and the Hub is hoping to resolve these issues in time for the full year evaluation.

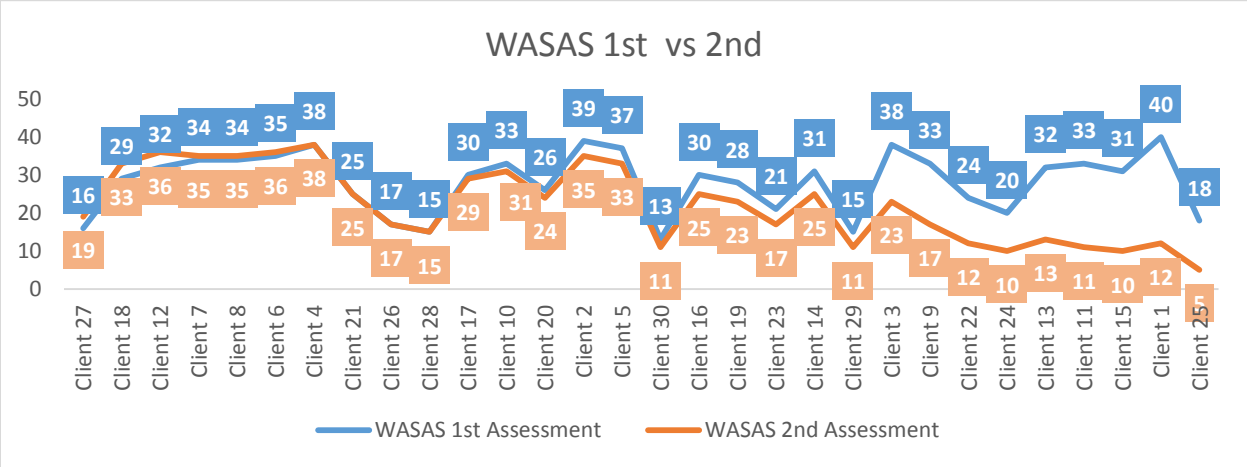
6.4 Work and Social Adjustment Scale (WASAS) Scores

The WASAS is a self-reported outcome measure that looks at how someone's problems impact on five areas of their life. This is scored between 0 (not impaired) to 8 (severely impaired). The five areas are:

- Home Management
- Ability to Work
- Social leisure activities
- Private leisure activities
- Close Relationships

When the Hub first meets someone they complete a WASAS and at the end of the period of support the person completes another WASAS and the scores are compared. The Hub has found this challenging to collect two WASAS scores as either staff forget to ask people to complete at one or both opportunities, people do not want to complete one or two WASAS forms, people disengage from the Hub when they no longer need support and there is not an opportunity to get two scores. The Hub has collected a total of 344 WASAS scores, of those there is a sample of 30 paired scores. The Hub hope to focus on this so that they can collect more 'paired' scores for the twelve-month report.

Graph Seven: WASAS pre and post scores



Graph Seven shows a sample of 30 people who have completed the 'pre' Hub support (first) WASAS and a 'post' Hub support. The scores are the total of the five self-rated areas and the maximum score is 40. As Graph Seven shows there is a 21% decrease in pre and post WASAS scores, indicating that people self-rated an improvement following support from the Hub.

6.5 Initial Themes and Comments from the 6 week follow up call

A task that the person in the Transitional Employment Post (TEP) is given is to call people approximately six weeks after they have been discharged from the Hub. Three key questions are asked over the phone; these are:

Q1: How are you?

Q2: How did you find the support you received from the Hub?

Q3: Are you using any services the Hub recommended? If so which ones?

They also ask if the person would be happy to be contacted again for a more in depth interview.

The TEP has made 260 calls since the Hub started these follow up calls in October 2015. Many of the people called did not answer, however there have been 17 responses. The Hub will be using this information as part of the evaluation of how people felt using the service and more detailed analysis will be presented in the annual report.

Below are some of the comments documented:

Qu. 2 'it was fine, really good support. There are different options available. It took a while for me to get seen by the Hub, but once I was everything went quickly'

Qu. 3 'Yes, I am using the work academy (Thames Reach). It was really good'

Qu. 3 'Yes I am; I go to Mosaic Clubhouse'

Qu. 2 'I found it very supportive indeed. They listened to me, they were able to help me in all aspects of opportunity that I asked'

Qu. 2 'It was ok, I didn't get any support, I just was called on the phone and spoke to someone'

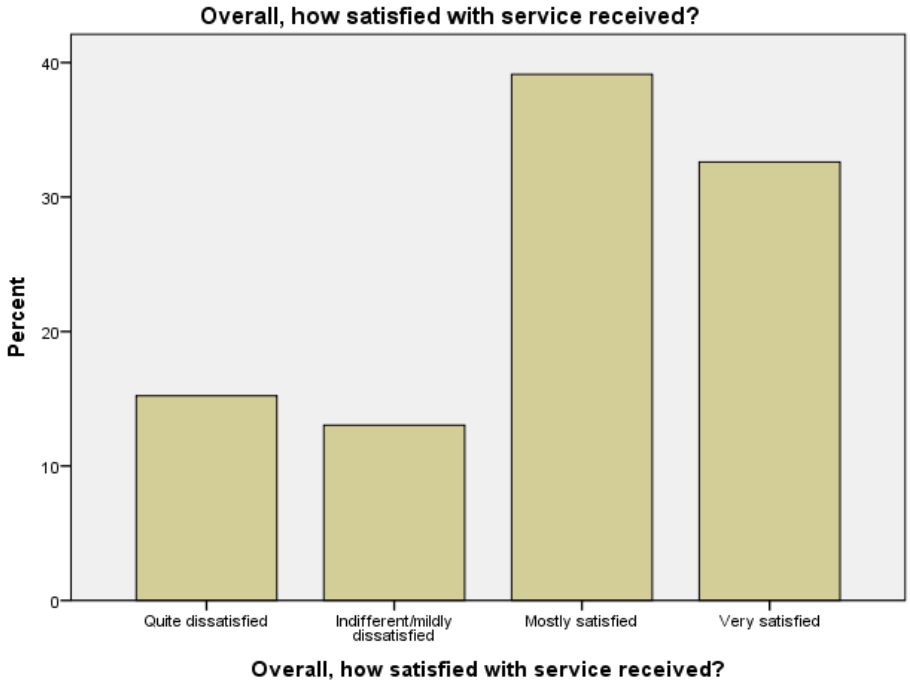
Qu. 2 'It was good, but I didn't get to see them that much. They offered me counselling but I can get that through my doctors'

Qu. 2 'The support was helpful, they helped me find jobs and helped me get into mental health services'

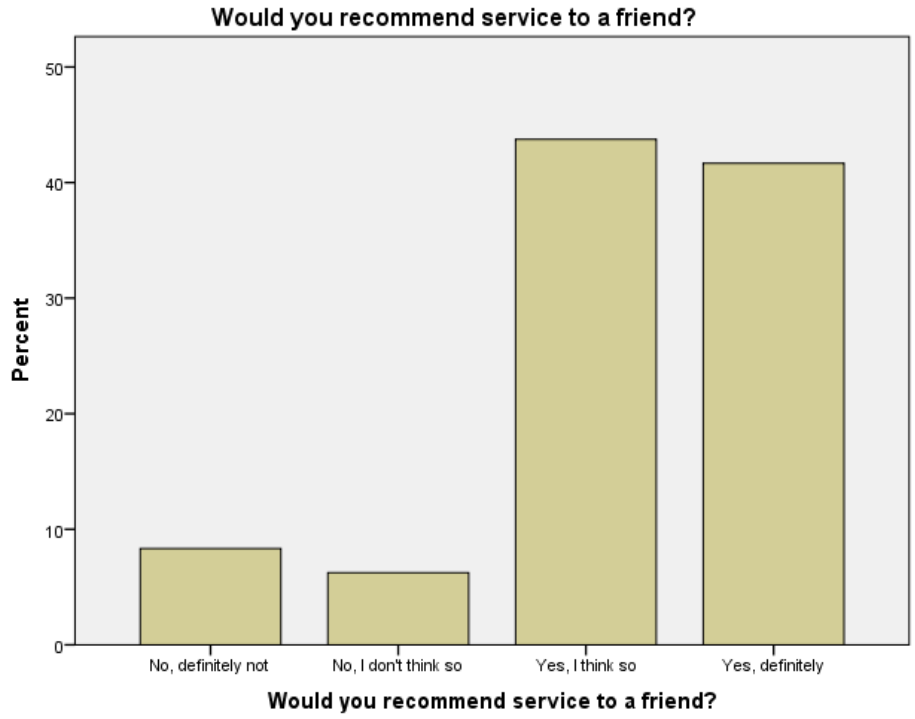
6.6 Initial Feedback from the client satisfaction questionnaire

Client Satisfaction Questionnaires (CSQ) were sent to 400 people who had been closed to the Hub asking them a set of questions regarding how 'satisfied' they were with the Hub service. 48 people have since returned these questionnaires and graph eight and nine show the responses to this. Overall, the PAG feel this is positive feedback, and this questionnaire will need to be sent to more people to get a wider range of people to respond. It is hoped that by the end of the first year the Hub would have responses from approximately 10% of people who have used the Hub.

Graph Eight: Response to how satisfied people were with the service, overall



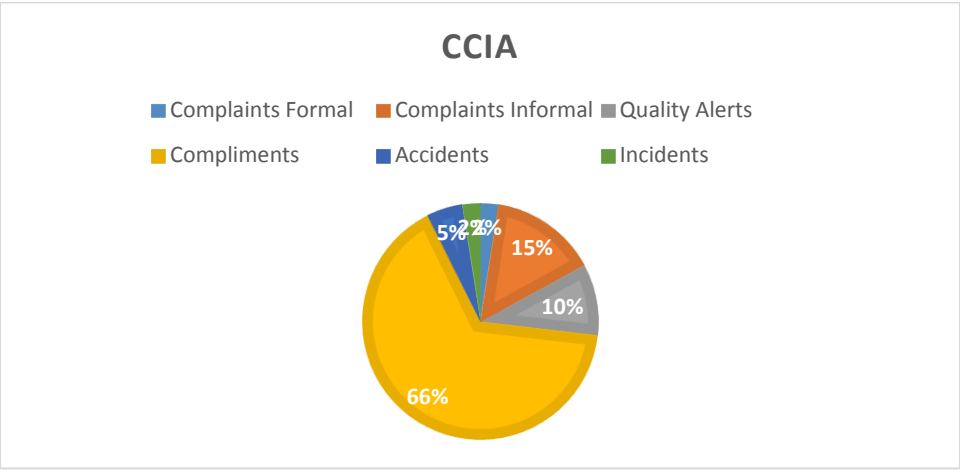
Graph Nine: 'Would you recommend the service to a friend?'



6.7 Complaints and Quality Alerts

Graph Ten shows the percentages of Complaints, Compliments, Incidents and Accidents (CCIA) since July 2015.

Graph Ten: % of Complaints, Compliments, Incidents and Accidents



Complaints and Quality Alerts have mainly been regarding the delay in accessing services from the Hub. This has been in part due to staff shortages and volume of workload when the Hub first opened borough

wide. There have also been complaints made to the Hub regarding miscommunication of onward referral. This means that when the Hub have forwarded a referral to another service the Hub did not communicate this onward referral to the referrer. A total of 11 complaints were received by the Hub, this included quality alerts raised by GP's to the CCG.

6.8 Compliments

The Hub have received 27 formal compliments and these have been recorded on Inform. Two examples can be seen in the appendices.

6.9 Time Frames for Evaluation

Table Two shows the time frame for other areas of evaluation

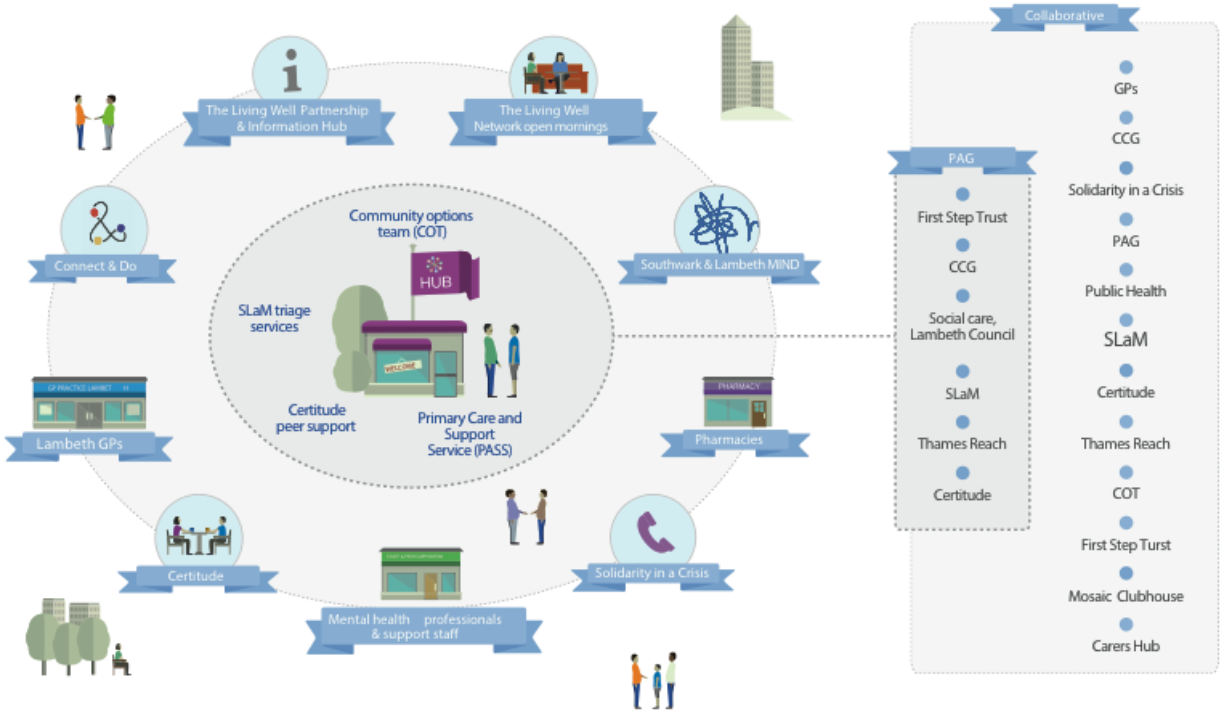
Table Two: Evaluation Timetable

Task/ Type of Evaluation	Date to be completed
Interviews with 60 people who have used the Hub	To start in January and be completed in May 2016
To analyse interviews	June 2016
Questionnaires to be completed by staff	February 2016 and May 2016
Postal Client Satisfaction Questionnaires to be sent to an additional 600 people and results presented	June 2016
Collate and present the complaints and compliments received over the first year of the Hub	June 2016
To collect 300 paired WASAS scores	June 2016
To hold an additional 3 Labs in February, March and May	Innovation Unit to provide a synthesis of this work for June 2016
The Living Well Network Annual Report 2015-16 to be completed	July 2016

Section 7: The Living Well Network

The Hub is part of a whole system change called The Living Well Network which is a network of organisations and providers who are all working together to improve the outcomes for people with mental health problems. Some of these organisations provide staff to work in the Hub and other organisations support people to recover, stay well and make choices and can be accessed independently of the Hub or the Hub can make an onward introduction to.

The Living Well Network



7.1 Mosaic and the Living Well Partnership

Mosaic Clubhouse is based in Brixton and offers peer support, employment and training opportunities to people in Lambeth who want support with their mental health. They also offer a drop in service called the information hub which provides information to people who want to know what services are available in Lambeth. They have offered peer support on average to 304 people per month, through workshops, the information hub and enablement.

They also host the evening sanctuary which is a peer led space for people to come in the evenings between 18:00 and 02:00 when they are experiencing a crisis or are distressed. This service opened in May 2015 and initially was open for two nights per week, there are plans to extend this to four nights a week in April 2016. This service has supported nineteen people.

On the Last Thursday of each month the Living Well Partnership hosts an open morning. This is an opportunity for providers to have a stall to show what they offer to all those who attend. It is open to members of the public and users of services, staff across the Network who are encouraged to attend as part of their induction and other Network providers.

7.2 Certitude

Certitude provide a number of services that offer support to people. These include the peer support network based at Railton Road. This offers workshops and groups such as the women's group, drop in coffee mornings and yoga. Connect and Do is an online social networking tool which supports people to connect to other people and their local community.

Certitude also provide the 'Solidarity in a Crisis' service which is a peer led service providing out of hours' emotional support over the phone and in person. This operates every weekday evening between 18:00 and midnight and at weekends from midday 12 noon until midnight. They have received on average 64 calls per month.

Activity data taken from CCG Mental health integrated dashboard Jul-Nov 2015.

The Hub also signposts and makes onward referrals to other services such as Lambeth Council's Every Pound Counts which provides benefit advice or Lambeth talking therapies who provide psychological treatment, the awareness centre for counselling and Spires for people who are experiencing homelessness.

7.3 Job Centre Plus (JCP)

The Hub has been working with the JCP to build relationships. This has involved the Hub providing mental health awareness training to 308 work coaches within the JCP. As the two organisations are so close in terms of physical space the Hub have also encouraged the work coaches to ask people to come 'up' to the Hub if they are worried about someone or if the person themselves feel they need support.

The Hub have also offered two group sessions with the JCP to people who have recently started claiming Employment Support Allowance (ESA). The JCP invite people to attend for an hour to find out what support is on offer. The Hub gives a presentation regarding what they can do and offer to people.

The Hub is also looking at the numbers of 'fit/sick' notes written in Lambeth that are received in Streatham JCP to explore with GP's if there is any other support that can be offered to people at an earlier time.

The Hub also hopes that working with the JCP may offer more opportunities for people with mental health needs to gain meaningful employment.

The work of the Hub in relation to JCP is focused on raising awareness amongst JCP staff of mental health and that of the customers using the JCP. This also includes offering the services of the Living Well Network and making available this support to people. The Hub is not engaged in any support work linked to mandatory requirements associated with receiving benefits.

7.4 Housing

The Hub has started to build relationships with Lambeth Housing. The Hub has offered mental health awareness training to housing officers across Lambeth and this will take place in the next three months. As part of building this relationship the Hub are looking at staff being based in the Housing Offices on a regular basis so that people in the local communities get to know the staff from the Hub and build relationships and gain more awareness of mental health and how to get support earlier. The Hub hopes that working with Lambeth Housing and other housing providers will be an opportunity to engage people who would not normal get support or feel marginalized in the wider community.

7.5 Social Care

The relationship between Social Care and the Hub has been invaluable over the past 6 months. Both organisations have worked hard to understand each other's role and responsibilities. Social care has facilitated training to staff on safeguarding responsibilities and when to raise safeguarding alerts. All members of staff in the Hub can now complete a safeguarding alert and inform the Practitioner Manager and Hub Coordinator of their concerns. If these concerns need further investigation these can also be made in the Hub. Previously the voluntary sector organisations would raise this through the Initial Contact Centre in social care and the clinicians would pass the referral onto secondary care.

The Hub staff have also been offered training to use the FACE package of tools. This is a tool that assesses someone's eligibility for social care needs and if they are eligible a support and recovery plan is completed using the format provided. Hub Staff have been given this training and are completing FACE assessments when appropriate and on one occasion have secured an emergency package of care for someone who has been assessed in the Hub to support their personal care needs and to support the safeguarding enquiry. Both organisations hope that this will continue so that people are able to access social care to support their mental health at the earliest possible opportunity and to further support the re-ablement and recovery of that person in the best way possible.

7.6 Personal Health Budget (PHB)

Personal health budgets were introduced by the NHS to help people manage their care and support in a way that suits them whilst giving more choice and control (personalisation). A PHB is a one off payment to support identified health and wellbeing needs, planned and agreed between the person and staff in the Hub. The PHB can be spent on items/services that will improve a person's wellbeing and support

their recovery. People can use a PHB for a wide range of items and services, including therapies, personal care and equipment.

The Hub have approved 25 personal health budgets since April 2015. These PHB's have been spent on things including bicycles, laptops, gym membership, course fee, items for the home, removal costs, self-help books, a dyslexia assessment, yoga and musical instruments. A story of the impact of a PHB can be found in the Appendices.

Section 8: Next Steps

8.1 Consolidation and improvement

Over the next six months there is a lot of work still to be done regarding the change of culture and building relationships with GP's and local communities. The Hub needs time to consolidate the vast amounts of knowledge it has gained and support staff to do this.

8.2 Alliance Contract

In December 2015 Lambeth CCG held a meeting to discuss the possibility of an alliance contract with the providers in Lambeth Mental Health Services. This alliance would be similar to that of the Integrated Personalised Support Alliance (IPSA) and would eventually become one alliance contract from October 2016. More information about the IPSA can be found at lambethcollaborative.org.uk

An alliance contract sits above the existing contracts with the Local Authority and CCG and brings together two or more organisations to work together in a way that is agreed to achieve a common goal. The CCG is discussing the possibility of all its commissioned voluntary sector providers forming an alliance. They key outcomes of this contract will be those of the Collaborative, namely:

- To recover and stay well
- To Support people to make their own choices
- To Support people to participate on an equal footing

The CCG is proposing that, depending on negotiation, the Alliance Contract for the LWN start in April 2016.

8.3 GSTC and CCG Funding

The initial GST application was to fund the Hub to became borough wide and further reduce the referrals and workload in secondary care. This report has demonstrated that the Hub is making a significant impact.

It was originally envisaged that the Hub would ask for support over a three-year period, returning annually as learning developed and it identified what support was needed for the following year. The CCG would also agree a sliding scale of investment in the Network and away from secondary care during the same time period.

Section 9: Summary and Conclusions

9.1 Conclusions

The Living Well Network Hub has been operational in the North of Lambeth since November 2013 and opened borough wide in July 2016. The Hub uses the principles of coproduction to work with people and coproduction is considered in the development of the service.

The activity from the Hub demonstrates an immediate and significant impact on mental health services in Lambeth. It is now the front door to mental health services in Lambeth and offers self introduction.

There have been considerable challenges in the past 6 months which have been discussed in the report. These are:

- Staff recruitment
- Peer Support
- Engagement with Lambeth GP's
- GP+ and Look Ahead Medication Management Team
- Collecting data from people in particular ethnicity and paired WASAS's

The findings from this report in relation to the outcomes documented in the GST bid are that the Hub have:

- Offered 1056 people personalized support since we opened and accepted 1877 introductions from a variety of referrers. As part of our aim the Hub wanted to divert 1500 people a year to be supported via a new primary and community 'Networked' offer provided by primary care, the voluntary and community sector, social care, volunteers and peers (in year one the target is 800 people).

- Reduced the caseloads in secondary care: This report shows a reduction in the caseloads in Community Mental Health Teams of 25% since 2013. It stated in the bid that these would be reduced by 10% (160 people) in year one, with the ambition to increase this to 25% (400 people) over year three. As there has been a 25% reduction in caseloads across Lambeth since the Hub went borough wide the year three target has been achieved in the first six months. This is in part due to the Hub but also significant changes across the whole system including SLaM's Adult Mental Health (AMH) model.

- Reduced the referrals into secondary care: There has been a 32% reduction in the amount of referrals secondary care receive since the opening of the borough wide Hub.

- Begun to increase the flow out of secondary care: in the GST bid it was documented that this would be by supporting 300 people with enhanced mental health needs funded by a Community Incentive Scheme. This is now called the GP+ Team and has received 298 referrals from CMHT's and 22 from GP's. The GP+ have worked with nearly 70 people.

- Developed a Medication management service to support people at home: the aim is to support 100 people within the GP+ Team to manage their medications outside of secondary care. The Hub have made considerable efforts to ensure this service is utilised in primary care and they are currently working with 5 people. This has now been modified to support a greater number of people.

The Hub have also started to:

- Change the culture: The Hub aims to deliver a workforce culture change programme to 200 people each year. The Hub are working with 35 staff members, offered mental health awareness training to 308 work coaches at the JCP and members of the CCG

- Sustain the Hub: The Hub has been developed and implemented borough wide and a plan to evaluate the Hub in order to evidence their effectiveness and ensure long-term funding has been made and begun.

9.2 Recommendations

Throughout this report there have been key areas of success and key challenges and the PAG would like to make some recommendations for the Hub to explore over the next six months.

- It is really important that the marketing of the Hub as a service to support people with their mental health continues and grows. *The Hub need to advertise its role in the local community and ensure that all the people of Lambeth have an awareness of it and that they can self introduce when they need support.* This includes working with people who often feel excluded or isolated when discussing their mental health and people may not have equal opportunities to access support. *It is hoped that over the next six months the amount of people self introducing to the Hub will increase significantly*.

- Whilst the Hub has been an immediate impact on the referrals into secondary care and working with people earlier to support their mental health than previously, there is still some confusion

in primary care and amongst GP's regarding the Hub's role and the vision of working with people in a networked, personalized way*. The PAG recommend that the Hub further engage with GP's, meeting with them, offering sessions in their practices and being more accessible to them in the next six months. This would also involve promoting self introduction to people within the GP practice*. This would improve the care and support offered to the person and enable a quicker recovery potentially.

- The Hub need to continue to work with secondary care to refer people onto them when they need more specialist, urgent care*. Whilst the Hub have had a significant impact on the referrals into secondary care, this needs to continue in the next six months to demonstrate that that this model of working is sustainable*

- The Hub need to recruit committed, experienced staff across all the organisations. This has been challenging and very time consuming, and the Hub still do not have a full complement of staff. Despite this, the Hub are working hard to ensure people receive the right levels of support at the right time and in a timely manner. However, this has led to deficits in other important areas such as building links with the local communities, advertising the service, working with GP's, training and culture change. The Hub have also relied on agency staff which have increased costs and impacted on team development. *Moving forward there needs to be a wider discussion about how recruitment can be further supported through secondments, longer contract terms, terms and conditions of mental health clinicians in primary care.*

- When the Hub recruits new staff there needs to be more careful consideration of their induction. Previously this has been very organic and has been peer led. The Hub will *develop an induction structure and programme for all new staff regardless of their role and organisation and this will be implemented by February 2016*. This will address some of the challenges the Hub has had in the past six months.

- The staff at the Hub have been working very hard to support individual people when they are introduced to the Hub; they have all have to work with new colleagues. They have had to learn to use new IT systems. For some staff this has been a significant change in culture in itself. The staff have all made an incredible impact on the mental health landscape in Lambeth already and this needs to be sustained and developed. The PAG recommend that *staff spend more time in their local community, building relationships with individuals, organisations and peers to continue and develop the networked approach, to spread wider understanding of mental health and all the support available to them through the Living Well Network.*

- The Hub will continue to offer mental health awareness training to organisations across Lambeth and is committed to doing this with Lambeth Housing already. *There is a commitment to train staff in the Hub to use solution focussed therapy in the next 3 months.* The Living Well Lab is a bi monthly workshop which all staff from the Hub and the wider network can attend to give people an opportunity to hear about stories of people who have used the Network and look at these stories in depth to see if there is an opportunity for learning and development for the network. There are another three planned which will be facilitated by the Innovation Unit.

- The Living Well Network will take forward the GSTC bid for the next year, to further consolidate the work of the Hub and explore new and exciting opportunities.

Appendix A: Stories and Compliments

A:1 Kemi's Compliment

'Kemi fed back today that they liked how the Hub was 'reaching out to people' which they felt was 'important' for their own mental health. They stated that the Hub's way of working with them 'suits me very much'. Kemi stated they appreciated the information provided in the Wellbeing Pack and found this useful. Kemi also thanked staff for having sent a letter feeding back to them after the initial assessment visit and agreed with the letter's description of the initial visit. Kemi also stated they appreciated staff's verbal feedback today regarding changes to their mental state observed from the previous visit.

On a further visit they commented positively on the way that the Hub allows individuals to be re-referred at any time for support with any additional needs that may arise, therefore individuals are not left feeling 'alone' or without support. This followed a discussion regarding the service user wishing to hold off on accessing support for various things at present and being encouraged to ask for a re-referral from their GP in the future when needed.' (compliment written by a staff member 4th September 2015)'

A:2 Murat's Compliment

This is an email from Murat who is under the GP+ team and needed some additional support from the wider Hub. He also received a personal health budget to buy a computer.

'Firstly I would like to give my apologies for taking so long to write this e mail. My name is Murat and I was working with Alice. I was lucky enough to be able to apply for a grant to help me in my education and to start to look for work. I have now had my pro surface three for a number of weeks and although it's strange working with a different type of computer and software I am slowly beginning to understand it.

I am sincerely grateful for all the help and support that Alice was able to offer and it's sad that we had all few sessions together due to outside time restraints. I found her to be extremely supportive and completely understanding of me and the issues that I face. It's not easy to accept some help sometimes, especially from a 44-year old guy, but she knew this and understood some of the other health issues that I face.

That being said I now face another challenge to find work, I have updated my CV (on my new surface pro, thanks again), and have enclosed it for your pursuer. I am not sure if Alice can help me again.

The difficulties are that I have lost a few years in using my experience and I have found it hard to get back on the job ladder. I feel I am not ready to work full time just yet and do not want to go into senior management again. I am hoping that I could go back into client work.

I have had an extensive and rewarding career, that has allowed me to undertake all sorts of interesting work. But with a 6 year break it's difficult to get back out there. I want to use my sign language if I can. But also my counselling skills, I might be a bit rusty but just need to find opportunities to get back on track

Anyway thank you very much for assisting me in getting this grant and for Alice's hard work.

I am still working with Laura who is amazing and a breath of fresh air. It's a real joy to work with both experienced professionals'

Murat has since gone onto gain part time employment.

A:3 Mohammed's story

When we first started working with Mohammed it was a somewhat difficult situation. Mohammed had been introduced to us by his GP at the insistence of his sisters. Mohammed had moved back into the family home after his depressive symptoms got worse. He was finding it difficult to leave home, do much with his free time and was also finding it difficult to meet people.

Mohammed was very quiet and reserved when we first met him and was clearly struggling to manage tense family dynamics. He appeared to be trying to please his sisters by agreeing that he should move out, but didn't appear to be articulating what it was that he wanted out of life.

Mohammed needed to identify what support he needed and what he wanted to achieve a good life for him. One of the things we needed to do was to manage expectations, so that Mohammed knew that our role was to help him decide what he wanted to get out of life and what he wanted to work towards. We had to emphasis to Mohammed's family that our role wasn't to help Mohammed to move out, particularly if this was not what he wanted. It involved building a relationship with Mohammed and his family, visiting him on a number of occasions to encourage him to build trust in us, and to draw out what it was that Mohammed wanted to achieve.

Mohammed was suffering from depressive symptoms that we identified during our early conversations, however as a Hub team we felt that a clinical intervention maybe needed by that we needed to support Mohammed to identify what he wanted first. Mohammed identified after several meetings that he wanted to meet new people, leave home more and work towards fulfilling his ambition to start paid employment again.

We accompanied Mohammed to start going to Mosaic Clubhouse. Before we started working with Mohammed he was isolating himself at home, and wasn't going out much, because of his anxiety and worries about meeting new people. By meeting Mohammed regularly and building up a rapport and trust with him, we were able to work with Mohammed on a graded exposure programme to support him going out, to the point where he felt able to go to a new and unfamiliar service, like Mosaic, with our support.

After supporting Mohammed to go to Mosaic for an initial meeting, Mohammed had the confidence to start going to Mosaic by himself. He has started to attend Math's and IT Classes at Mosaic, to help him develop his basic skills and to help increase his chances of finding paid work. Mohammed has also started to see a specialist Employment Adviser at Mosaic with a view to him starting a paid work placement (possibly a TEP Placement).

It was a challenge to manage the different expectations that Mohammed's family had about our service. We had to explain that our role was to support Mohammed in what he wanted to achieve. We had to balance this with listening to and respecting the views of Mohammed's family as we didn't want to create a situation where our intervention negatively impacted on Mohammed's close relationship with his family. We also had to work hard to show Mohammed's family that he had a right to pursue his own interests and ambitions. These dynamics had to be managed sensitively so that we could work collaboratively with Mohammed and his family.

Initially Mohammed's family were insistent that he should go back to his flat in Brixton and they were unhappy that we wouldn't support him to do this, because he didn't want to move out of his family home at the time of the Hub's support. By working closely with Mohammed and supporting him achieve some positive outcomes, Mohammed's mood lifted and there was a noticeable difference in him this gave the family hope that Mohammed may be able to have a different live than he was currently living and they became to see the benefit of us working together.

Towards the end of our support journey with Mohammed, he said that he wanted to try and move out of Brixton so he could move more closely to his family in Peckham (without having to live with them in the family home). We advised him on the Housing Registration forms he would need to complete to start the moving process. Mohammed filled in the forms independently with help from his sister and this has enabled them to become closer.

A:4 Sally's Story

When the Hub first started working with Sally she was very distressed, upset and tearful. She appeared to be experiencing some particularly raw emotions and needed a lot of time and space to be able to articulate how she was feeling. Sally had experienced abuse when she was a child and she was struggling to cope with the effects of this. Sally had experienced domestic abuse from her ex-partner, which she was also struggling to cope with.

When we started to work with her she had some significant financial concerns, but she wasn't ready to tackle those as she wanted someone to listen to her, help her talk through her feelings. She also had to prepare for an ESA Benefits Tribunal, which she was finding daunting and overwhelming to deal with.

Sally was allocated a Localities Support Worker, who spent a lot of time listening to Sally, providing a reassuring and friendly 'ear' to enable Sally to have enough space to explore her thoughts and feelings with us.

As they continued on their support journey, Sally built up trust in her Support Worker, and started to use our service to help her achieve her own aims and ambitions. Sally began to have very proactive conversations with her support worker, and began to guide her own support, letting her Worker know clearly what help she wanted from the Hub.

We successfully helped Sally to submit and win an appeal against a decision to stop her ESA Benefit. Sally's Benefits had stopped as she had borrowed £20,000 from a friend, which she needed to pay back, but the DWP were arguing that this was a gift that made Sally ineligible to receive ESA. Sally had received some initial advice from Every Pound Counts (EPC), who said she needed to ask her friend to confirm to the Tribunal Hearing that the money she received was a loan that she had to pay back and not a gift that she could keep.

Sally was worried about getting her friend involved in her Benefits case, and was worried that she could get her friend into trouble. Sally's Support Worker worked to build up trust with Sally and encouraged Sally to include her friend in the Tribunal, helping to explain to Sally why it was important for her friend to attend and explain that the money they gave Sally was a loan. This was successful and Sally's friend attended the Tribunal with Sally and an EPC worker.

Sally was also avoiding seeing an EPC Worker before her Tribunal Hearing as she was finding it stressful and anxiety provoking to think about the case. Sally's Support Worker managed to encourage and support Sally to meet with an EPC Worker beforehand, and accompanied Sally at the meeting so that we could help Sally follow up on the actions she needed to take (as advised by EPC) to prepare for her Tribunal Hearing. We also helped advocate for Sally at the meeting.

Our work helped Sally to attend her Tribunal Hearing with her friend, where she was awarded backdated ESA as the Tribunal were satisfied that her friend had given her a Loan, and not a gift (based on her friend giving evidence to the Tribunal Hearing Panel).

After the Tribunal Hearing Sally still didn't receive her ESA Benefit. It appeared that the Job Centre hadn't received notification of the Tribunal's decision to award Sally her ESA Benefit, and so she wasn't paid the ESA she was entitled to. This caused Sally some stress and upset. Sally's Support Worker supported Sally to go to the Job Centre to show them her Tribunal Notification letter, so that Sally could receive the money she was awarded.

Sally was awarded backdated ESA. This funded Sally to redecorate and furnish her home, which helped Sally to improve her mood and have a fresh start.

Sally's support worker linked Sally in with Mosaic Clubhouse and helped Sally to participate in other leisure activities. It was challenging to help Sally reach the point where she identified that she had hope and had the ability to achieve her ambitions with the right help.

We successfully helped Sally to start attending Mosaic Clubhouse. Sally's support worker supported Sally to go to Mosaic Clubhouse with her, so Sally could explore the service and find out what activities, groups and courses she can get involved with these. Sally sustained her attendance at Mosaic and goes there regularly throughout the week. Sally has done voluntary work in the Café / Kitchen at Mosaic, and is keen to work with Mosaic to see if they can help her set up a jewelry and Vintage Clothing Business

A:5 Tariq's Story

'Tariq was introduced to the Hub by his GP. Tariq had a history of psychosis and his GP was concerned as he had stopped taking his antipsychotic medication and was presenting with signs of a relapse of his mental health problems. Tariq's father had also contacted the GP as he was very worried about his son.

I telephoned Tariq to discuss his introduction to the Hub and have a conversation with him regarding his hopes and fears. It transpired that Tariq had stopped taking his medication as he hated the side effects. He felt that the medication made him drowsy and sluggish, and not fully present in his life or what was going on around him. We talked about this and I asked him ultimately what he wanted to achieve for himself and his life. Tariq was very interested in exploring and learning more about different ways to manage his mental health including mindfulness, meditation and creative media. He ultimately wanted to achieve good mental health, to stay well and to develop different approaches and strategies to help him to manage and maintain positive relationships with family and friends.

An important part of these early conversations with Tariq was exploring the possible emotional, physical, social and psychological impact of a relapse of his mental health problems. We discussed whether there had been any particular stressors that may be affecting his mental health and we found that there was, and this subsequent conversation's Tariq to consider different ways he could manage these stressors, and also to make the decision that he would go back on his medication as an acceptable short term solution, as he was finding his symptoms really distressing. However, as a longer term goal he wanted support and guidance to access different ways to manage his mental health and ultimately make positive changes to his life that this could afford him.

When we met a few days later, Tariq's symptoms of his psychosis had reduced and he was much more relaxed. We talked about how his symptoms could be really distressing for him, and how he was really fearful of becoming unwell again. Together we explored ways to stay well and consider how the negative and distressing experiences of mental health problems can also help us to learn and grow as individuals.

Tariq was interested in finding out more about the cultural and societal aspects of mental health. We met regularly for a few weeks to discuss this. I was able to share my own experiences of mental health problems and talk about how these brought about life changing decisions for me and other people I knew through my work and my life outside work. We also talked about famous and well known people who had experienced mental health problems including writers, artists, actors and musicians and how ultimately they had used their experiences to inform their creativity and self- expression. Tariq was so motivated and eager to learn. We worked really well together and during our meetings he would write notes when we met and then go and explore and learn more.

It also emerged that for various reasons it was difficult for Tariq to manage his daily mindfulness practices at home. We identified community resources where he could go and practice and learn more about meditation and mindfulness. Tariq identified courses and free classes and began to attend these. Tariq also wanted to get back into work and education. His mental health had really improved and he felt able to undertake this. Tariq was introduced to a Support Worker in the locality team who helped him to identify and access education, training and employment resources, and who also supported him to apply and successfully obtain a personal health budget which enabled him to enroll and complete a mindfulness course. Tariq was ultimately able to reduce his medication. The strategies and techniques he developed from using mindfulness approaches enabled him to continue to develop his insight, awareness and understanding of the impact of stress on his mental health.' This story is told by a clinical practitioner in the Introductions Team.

A:6 Julia's story

When the Hub had its first conversation with Julia, she wanted help to go to the gym so she could stay healthy and well. We quickly linked Julia in with a local gym and helped her to attend her first session by a support worker going with her.

Julia could see that the Hub were able to work quickly to help her achieve her ambitions. This led to Julia trusting the Hub staff more with other areas that she needed support in. Julia told staff that she thought she was going to be evicted from her flat in a week. She hadn't told any support service about this.

Staff's relationship with Julia then involved identifying the informal support networks that Julie had – in this case, her adult children – and working with them and with Julie so we could collaborate on helping Julie to avoid being evicted. The Hub advised Julia and her family on the steps they needed to take to request a Court Hearing, so they could try and stop the eviction. The Support Worker gave them advice on what type of hearing to ask for. They also gave advice on how quickly they would need to do this.

The Support Worker then represented and advocated for Julia at the Court Hearing itself. They successfully helped Julie to avoid being evicted at the Court Hearing and linked Julia in with legal representation so she could receive expert advice and help at future Court Hearings.

It was positive working in partnership with Julia and her family to collaboratively work on helping Julie avoid eviction. This story is written by a Lead Worker from the Locality Team.

A:7 Funke's Story

Funke is a 36-year-old woman who had been known to services for a number of years but had never really engaged with them. She was working with the Community Options Team prior to the borough wide opening of the Hub. COT were working with Funke to support her to engage with education and training, she also had a history of depression and was hoarding in her home. Funke also had physical health issues which often prevented her from attending appointments which then led to her being discharged for non-engagement. She had been referred to other services in the past however due to not being able to attend appointments she was discharged.

As a result of the COT input, Funke was supported to complete certificates in computing and business. However, during this time Funke suffered a deterioration in her physical health, support workers then attended her home because she was unable to come out and it was discovered that Funke's hoarding was worse than she had described and was a risk to herself and others. Funke was also admitted to hospital due to her physical health shortly after the home visit from the Hub.

Due to these concerns a safe guarding alert was raised and Funke was assessed by a Hub clinician using the FACE (functional assessment of care environment) to ascertain what her social care needs were. The clinician also completed a mental health assessment. The Hub worked with Lambeth Housing to provide Funke with temporary accommodation to allow her to be in a safe environment on her discharge from hospital to ensure she could take her medication and care of herself, while the support worker and clinician provided Funke with practical support to start sorting through her flat to ensure it was safe for her to return home.

Funke engaged with this interaction and she herself identified that she needed more support around her processing the loss around her possessions' she was throwing out and also that part of her hoarding was due to having Obsessive Compulsive Disorder, which she had never admitted before. Funke and the Hub staff agreed that she needed additional specialist support regarding her hoarding through group psychological treatment in MAP. This group was full at the time so Funke was unable to attend. Funke continued to engage with the Hub, however her physical health continued to have a significant impact on her life. She had several admissions in quick succession and with a lot of support from the hospital metabolic nurse and Hub Clinician we succeeded in getting Lambeth physical health services involved to provide personal support.

Funke is now closed to the Hub as we have referred her to MAP for more psychological support regarding her hoarding and OCD, she has additional support at home from the Lambeth Physical Health Services as well. She is also under Neuropsychiatry services at St Thomas hospital due to the nature of her physical illness.

A:8 Hannah's Story

Hannah is a 42-year-old Polish woman, with a 7-year-old son, living on her own. Hannah was introduced by her GP to the Hub experiencing suicidal ideation, depression and anxiety. She was finding it difficult enjoying life and recognised that this was affecting the relationship with her son. During the joint working between Hannah, the clinician and support worker and following brief mental health intervention, it was agreed that Hannah would benefit from support with her social issues and wider wellbeing.

One of the main issues impacting on Hannah was claiming and depending on benefits as she had a strong determination to start her own business. After completing a recovery and support plan with her support worker Hannah identified a course that supported her work in jewellery making which the support worker discussed with the wider Hub team and a PHB was agreed to paid for the course. Her work has been highly regarded by the college and they supported her to have an exhibition of her work at a gallery in the Mall. In addition to gaining the additional skills in making jewellery, Hannah attended a business course through the job centre and applied for the Enterprise Allowance Scheme, which entitled her to an income while she set up her business.

"Working with the staff with the Hub has enabled me to build up my confidence in dealing with day to day issues, and coping when things get difficult. I also feel better equipped to make confident decisions and when I am well I enjoy every moment playing with my son".