Innovation Unit

Tameside and Glossop Living Life Well: final evaluation report

July 2022

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Acknowledgements

The evaluation team at Cordis Bright would like to thank everyone who made this report possible, especially the people supported by the Neighbourhood Mental Health Team who shared their experiences with us.

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Executive summary

This is the final evaluation report for Living Life Well in Tameside and Glossop. It is one of three sites participating in Living Well UK, a three-year programme to improve adult mental health which has received £3.4 million in National Lottery Funding, although the Living Life Well model was developed prior to the programme. The Living Well UK programme is delivered by Innovation Unit in partnership with Living Well Lambeth, an independent evaluator (Cordis Bright) and the adoption sites. The evaluation ran between January 2019 and May 2022.

Strong foundations for the Living Life Well system are in place

The Living Life Well model provides support on mental health and related issues for people who would otherwise not have access to a suitable service, being deemed too "complex" for mental health services via primary care yet not meeting eligibility thresholds for secondary care. The new service supporting this group, the Neighbourhood Mental Health Team (NMHT), has supported 1,553 people over the course of this report's data period (May 2019 to March 2022).

The NMHT offers recovery-focussed and flexible support on the psychological and wider issues that matter most to people. People have a say in the type of support they receive and the issues they would like to address, but also how and when they receive that support; they can choose to meet in a clinical setting for a support session, but also in community venues and outdoor spaces – although the Covid-19 pandemic has restricted flexibility in this regard. The team aims to provide support for up to 12 weeks but people are supported for longer if necessary, and the *"easy in, easy out"* ethos means that people can refer themselves back in for support at a later date if they need.

The multi-disciplinary NMHT offers support across a range of psychological and social issues. The team includes psychological therapists, mental health nurses, employment coaches, mental health and wellbeing coaches and peer mentors/peer coaches. The team also works with wider community organisations and services to support people in areas outside of the team's specialisms, such as housing; to link people into other services or groups for onwards support after the team's intervention; and to help people build connections with their local community. However, these wider connections are not yet established as well as the rest of the model – in large part due to Covid-19.

The Living Life Well model also introduces the Open Door, a single point of access for all mental health services in Tameside and Glossop which also connects people into support across the wider Living Life Well network and provides professional and peer advice and support to other staff and services. (This feature is addressed in less detail by this evaluation.)

Living Life Well has been successful at involving people with lived experience from co-producing the model during the design process through to recruiting peer

mentors and peer coaches into the team, as well as involving the people accessing the support in decisions about their support. Although the involvement of people with lived experience appears to have waned more recently, stakeholders have described how the voice of lived experience is now seen as important in the development and provision of support in Tameside and Glossop – it's valued when it is included and missed when it's not.

Valued features of the Living Life Well model

People supported by the NMHT told us the features they found the most helpful were:

- **Recovery oriented support that focuses on the issues and goals that matter most to people.** The Initial Conversation helps ensure that each person's support plan is shaped by the kind of support the person wants to receive and that they set realistic strengths-based personal goals. People also have a say in how and where they access support, such as in a café or in the park, and how frequently. This contributes to people feeling listened to by the team and having a sense of control over the support.

- **Support on wider social issues.** People can access support on wider social issues that may be related to their mental health and wellbeing. This support is provided by the NMHT (for example in relation to employment issues) or by external organisations with support from the NMHT (for example in relation to housing issues). People involved in designing, delivering and commissioning Living Life Well described the NMHT as offering a service unlike any other in the region because it enables people to access support for issues that do not necessarily fall within the remit of clinical mental health services, but which do have an impact on their mental health.

- **Learning tools and techniques.** People described how the NMHT taught them tools and techniques for managing their emotions and mental wellbeing, which played an important part in helping them to better manage their mental health. This was in turn an important factor in supporting improvement in other outcome areas

- **Building relationships with caring and supportive staff.** Having someone non-judgemental, empathic and caring to talk to, who would listen to their concerns, was the most important part of the support for many of the people we spoke to. The relationship with their worker was vital to both their experience of the service and their recovery and improved quality of life.

Challenging conditions have created operational barriers

Living Life Well has faced some important challenges to implementation meaning that some elements of the model are not yet fully established.

Chief amongst these is that activity was restricted due to Covid-19 for a large proportion of the evaluation period. The NMHT was therefore less able to provide face-to-face support, whether in clinical settings or in the community. It also limited the range of community groups and organisations available to provide support outside of the NMHT and slowed the process of the team developing links with such groups.

High demand for mental health support in Tameside and Glossop – again in part due to Covid-19 – means there are now waiting lists for many of the NMHT intervention pathways as well as for other services outside of the NMHT. As a result, people are now waiting longer than originally anticipated for support from some of the NMHT pathways and fewer options are available for linking people into wider support or other services, either as part of their support plan with NMHT or as part of their step-down plan.

Potential partners have also been unclear about referral pathways, who the NMHT aims to support and what the team can offer, and the use of a non-NHS data system has created barriers to sharing information about people with other NHS services outside of NMHT hours.

Emerging evidence of positive outcomes for people supported by the NMHT

Despite these challenges to full implementation, the evaluation has identified some evidence that Living Life Well is helping to make a meaningful difference to people's lives.

We should be cautious about drawing conclusions based on the data available to the evaluation. Firstly, we interviewed a small sample of people supported by the NMHT (seven people) and staff and stakeholders (10 people). Second, valid outcomes and experience data was only available for a small proportion of the 1,553 people supported (between 12% and 25% depending on data type), and these samples are skewed towards people who had a planned ending to support. The sample is therefore not representative of the wider group of people supported by the team. Third, to fully understand the effectiveness of the support and control for other factors contributing to identified changes would require a randomised controlled trial or a quasi-experimental approach involving a counterfactual group, which has not been possible in this evaluation.

However, interviews with people supported by the service corroborate with the views of the staff we interviewed and with the outcomes data. As such, we can have some confidence that positive outcomes are being achieved for some people, and that Living Life Well is contributing to these changes. Qualitative and quantitative data on a larger and more representative sample would be required to have confidence that these findings apply to the group of people supported by the NMHT as a whole.

In collaboration with Innovation Unit, the Living Life Well team identified seven outcomes the model would aim to achieve for people accessing the support. There is some positive evidence in relation to five of these.

Outcome 1: *'People are recovering and experiencing improved quality of life' (positive evidence)*[1]

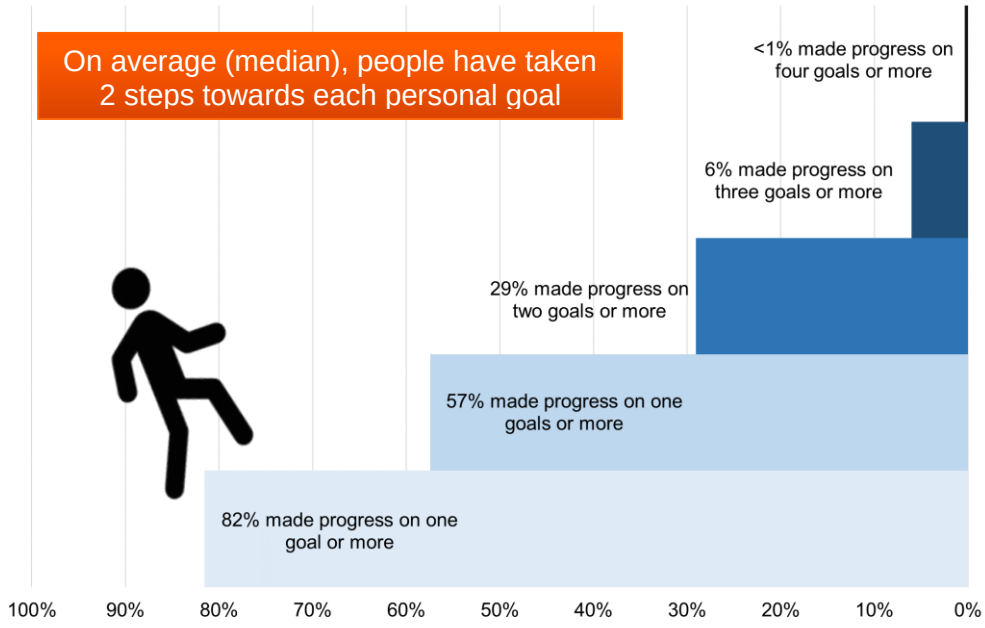
There is evidence from qualitative and quantitative data that people are recovering and experiencing improved quality of life. The people we spoke to who had been supported by the NMHT were mostly highly positive about the team's support and felt it had been impactful in helping them achieve meaningful change in their lives.

> *""It was life changing. I had low expectations, but I walked out a much more clear-headed person than I've ever been."*
>
> Person supported by NMHT

Among the people on whom we have data, there was a statistically significant increase in mean ReQoL score from 11.6 at the earliest available data point to 19.2 at the most recently available, indicating an improvement in recovery and quality of life for this group. On an individual level, 58% of people saw a reliable and meaningful improvement in their recovery and quality of life based on this measure (n=385).

People are also taking steps towards their personal goals: 82% of the people on whom we have data made progress on at least one goal and 57% made progress on at least two goals (Figure 1, n=282).

Figure 1 Progress on personal goals for people with paired data (n=282)



[1] Positive evidence = evidence that an outcome is being achieved; Some evidence = evidence that an outcome is being partially achieved, or weaker evidence that an outcome is being achieved; mixed evidence = evidence is not conclusive.

Outcome 2: *'People feel connected and have positive relationships' (some evidence)*

There is some evidence that people are feeling more connected and have positive relationships. Among the people on whom we have data there was a statistically significant increase in people reporting that they have a close friend (from 66% up to 81%, n=280), they visited a friend in the last week (from 55% to 66%, n=276) and they participate in leisure or community activities (from 26% to 48%, n=280). The outcomes data also shows an increase in satisfaction with relationships with family and friendships (n=267), and improvements in ability to trust others and reductions in loneliness (n=385) for the people on whom we have data – although this is based on non-validated measures.

There is less evidence from qualitative interviews on whether and how Living Life Well has supported people to feel more connected and have positive relationships. This could suggest it was an outcome area of less importance to the people we spoke to or that it is a less central focus of the NMHT's support offer. However, some people have clearly experienced improvements.

> *"When we ended last week she's got a range of occupational performance tasks, she's looking at independent living, getting her son back, she's got social networks."*
>
> NMHT staff member

Outcome 3: *'People are able to learn, work and volunteer' (some evidence)*

There is some evidence that more people are learning, working and volunteering. Among the people on whom we have data, there was a small but statistically significant increase in the proportion of people who are in any kind of work, volunteering or education, from 34% at the earliest available data point up to 39% (n=287). This is primarily due to people starting volunteering and enrolling in education rather than moving into work.

Improved satisfaction in relation to their learning/working/volunteering situation was also the most common experience across the group of people on whom we have data (n=229): 48% of people reported an improvement in satisfaction; 26% reported no change; and 26% reported a decline – although again, note that this is based on a single-item, non-validated measure of satisfaction.

This is corroborated by a small amount of evidence from the qualitative interviews**,** with NMHT staff as well as one person supported by the NMHT reporting that the NMHT had helped them to gain employment. More generally, the people we spoke to were positive about the practical support offered by the NMHT in relation to issues such as employment and housing.

> *"The main thing was sorting out a job, and I did manage to find a job… I'm grateful for the help, particularly that [employment coach] stayed with me for a number of months. It wasn't a case of eight sessions sort of thing, she kept with me for quite a long period."*
>
> Person supported by the NMHT

***Outcome 4:** 'People know their own goals in life' (limited evidence)*

Among the 1,553 people to have accessed the NMHT, 662 people (43%) have at least one personal goal that they have agreed with their NMHT worker, and which will form the focus of the plan they agree together. However, asides from this the evaluation found little evidence on whether people know their own goals in life. More research is required to fully understand any impact on this outcome area.

***Outcome 5:** 'People have choice and control over management of their own mental health' (some evidence)*

Qualitative insight from interviews provides some evidence that Living Life Well is enabling people to have choice and control over the support they receive from the NMHT. People supported by the team whom we spoke to felt the support was tailored based on the issues that mattered to them most.

> *"They tailored it to things I was specifically worried about at the time."*
>
> Person supported by the NMHT

NMHT staff members also described how the Initial Conversation helps ensure that each person's support plan is shaped by the kind of support the person wants to receive and that they set realistic strengths-based goals. However, as mentioned above, less than half of the people who have accessed the team (43%, 662 people) have agreed a personal goal with their NMHT worker.

People also described how, through tools and techniques learnt through the NMHT, they were able to take control of their own mental health and wellbeing outside of the support sessions.

> *"Therapy has helped me understand a lot about myself, how to process things properly and not run away, how to deal with things in the past, coping mechanisms – becoming a better version of myself."*
>
> People supported by the NMHT

***Outcome 6:** 'People have a greater sense that their life has purpose and meaning' (limited evidence)*

There is promising but limited evidence that people have a greater sense that their life has purpose and meaning. Of the 385 people on whom we have paired ReQoL data, 58% (223 people) saw an improvement in relation to the statement "I thought my life was not worth living" and 55% (210 people) reported an improvement in relation to the statement "I felt hopeful about the future". While these are not validated measures of the extent to which someone feels their life has purpose and meaning, they provide cautiously positive indications when considered alongside the qualitative data.

The interviews with people supported by the NMHT and with staff also indicate the support has helped reduce the likelihood of some people taking their own lives.

"I'm not 100% sure I'd still be here [without the NMHT] if I'm being honest. I had had suicidal thoughts prior to seeing the NMHT, which was why the GP put me in touch in the first place."

Person supported by NMHT

"The feedback we get is that people often use phrases like 'it has been life-saving.'"

NMHT staff member

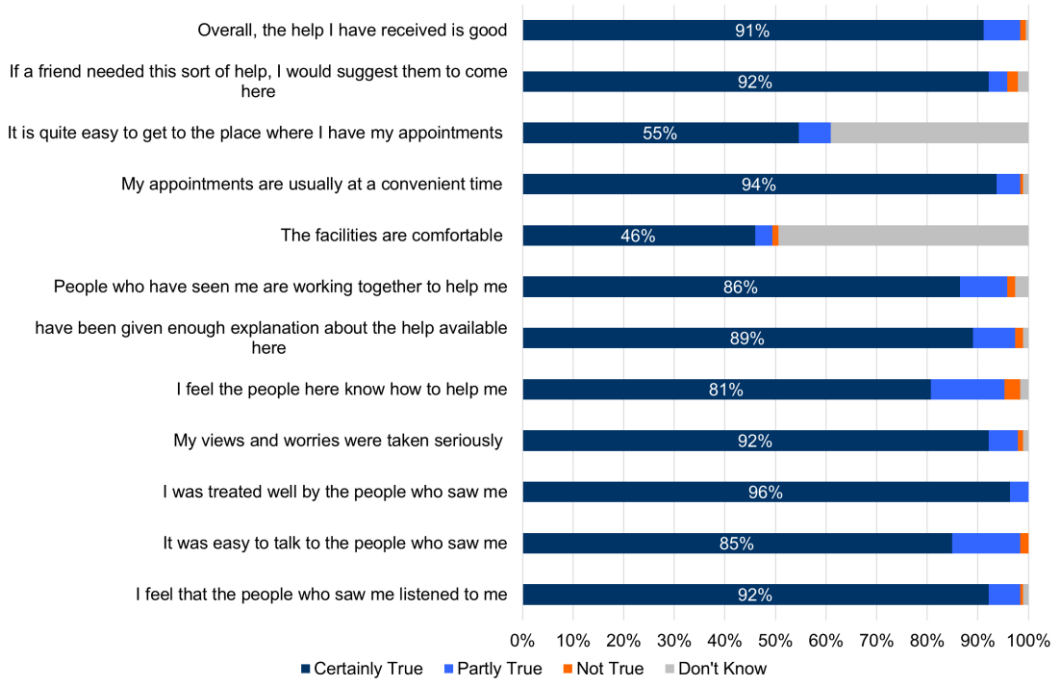
Outcome 7: *'People receive good quality, person-centred help and support' (positive evidence)*

There is positive evidence from the Experience of Support Questionnaire (ESQ) completed by people at the end of support, the staff survey and from qualitative consultation that the help and support provided is both good quality and person-centred.

The support from the NMHT is well-liked by the people on whom we have ESQ data, who found the support helpful and to demonstrate elements of person-centred care (n=174 to 192). For example, 92% of people would recommend the support to a friend and 91% felt that overall, the help they received was good. In relation to person-centred care, 92% of people felt their views and worries were taken seriously, 86% reported that people were working together to support them and 92% felt the people who saw them listened to them and treated them well (Figure 2). Overall, the NMHT staff also perceive the quality of care to be good: of the 20 NMHT staff members who responded to the survey, 16 reported they would be happy with the standard of care provided by the NMHT if a friend or relative needed care.

People supported by the NMHT and NMHT staff both identified the personalised nature of the support as a particularly important feature of the NMHT, and a key factor in enabling people to make improvements in the other key outcome areas.

Figure 2 Satisfaction with the Neighbourhood Mental Health Teams (data labels indicate percentage of respondents selecting "Certainly true" for each statement) (n=174 to 192)



Emerging evidence of positive outcomes for staff despite some key challenges

The evaluation found evidence that, overall, the NMHT staff are satisfied in their work. Most staff enjoy working for the service and believe that the approach, vision, and values of the service are conducive to a positive working environment. Overall, there is also good collaboration and trust between NMHT staff and partner agencies, but the evidence suggests that there is not yet a unified working culture across the whole of the NMHT and that there is not full collaboration between some professional groups within the team.

Key enablers to positive staff outcomes are the success of the NMHT in delivering improvements for the people they support, the recovery-oriented approach to support which staff find fulfilling, and the development opportunities afforded through sharing skills and expertise across agencies.

However, the challenges of implementing a collaborative, multi-agency team using new ways of working are negatively impacting on outcomes for some staff. Cultural differences between some pathways and capacity constraints appear to be limiting staff satisfaction and creating barriers to collaboration in some cases.

Evidence against the key outcome domains is summarised below.

Outcome 1: 'Staff are satisfied in their work' (positive evidence)

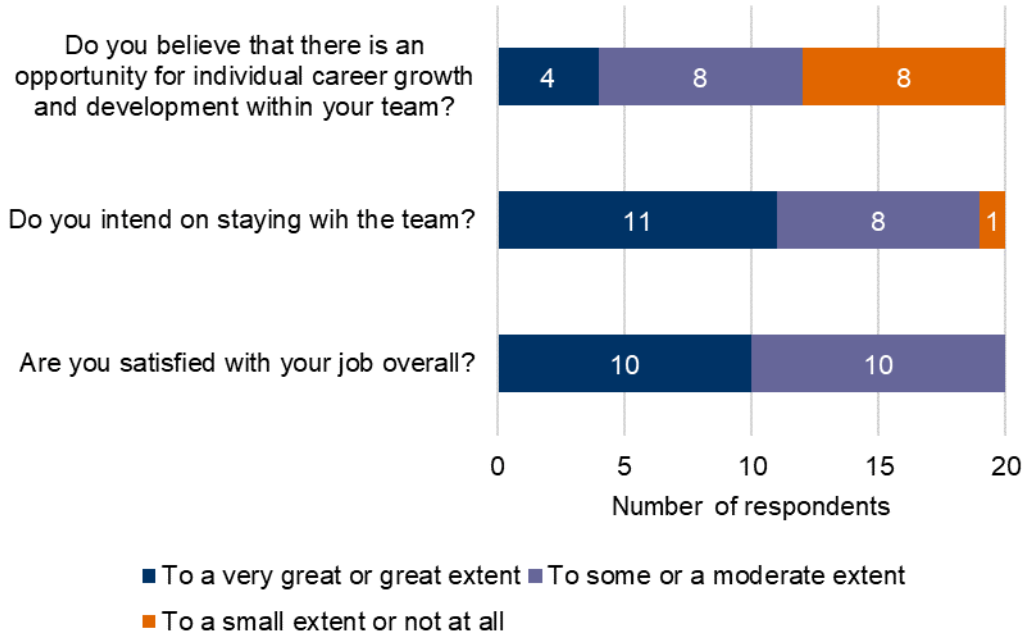
There is positive evidence that overall, staff are satisfied in their work. All staff responding to the staff survey (n=20) reported that they were satisfied with their

job to at least some extent, and nearly all staff (19 out of 20) said they intended to stay in the team to at least some extent (Figure 3). Of the 20 respondents, 15 (75%) said they would recommend the NMHT as a place to work – this compares favourably with both the NHS nationally (60% of responding staff would recommend) and Pennine Care NHS Trust (59%) based on the 2021 NHS Staff Survey.[2]

As mentioned above, 16 of the respondents (80%) would be happy with the standard of care provided by the NMHT if a friend or relative needed care. Again, this compares favourably with both the NHS nationally (68% of responding staff would be happy with the standard of care) and Pennine Care NHS Trust (61%) based on the 2021 NHS Staff Survey.

However, views on opportunities for career growth and development were less positive, with only four of the 20 respondents believing there is opportunity for growth and development to a great or very great extent, and eight believing there were only opportunities to a small extent or not at all (Figure 3).

Figure 3: Staff views on staff satisfaction and career planning (n=20)



Outcome 2: *'Working culture is collaborative and trusting' (mixed evidence)*

Overall, the culture within the NMHT is collaborative and trusting. However, more work may be required to embed this collaboration between some pathways.

[2] NHS (2021) NHS Staff Survey Interactive Results. Available at: Interactive results and dashboards | NHS Staff Survey (nhsstaffsurveys.com) [Accessed 11/04/22]

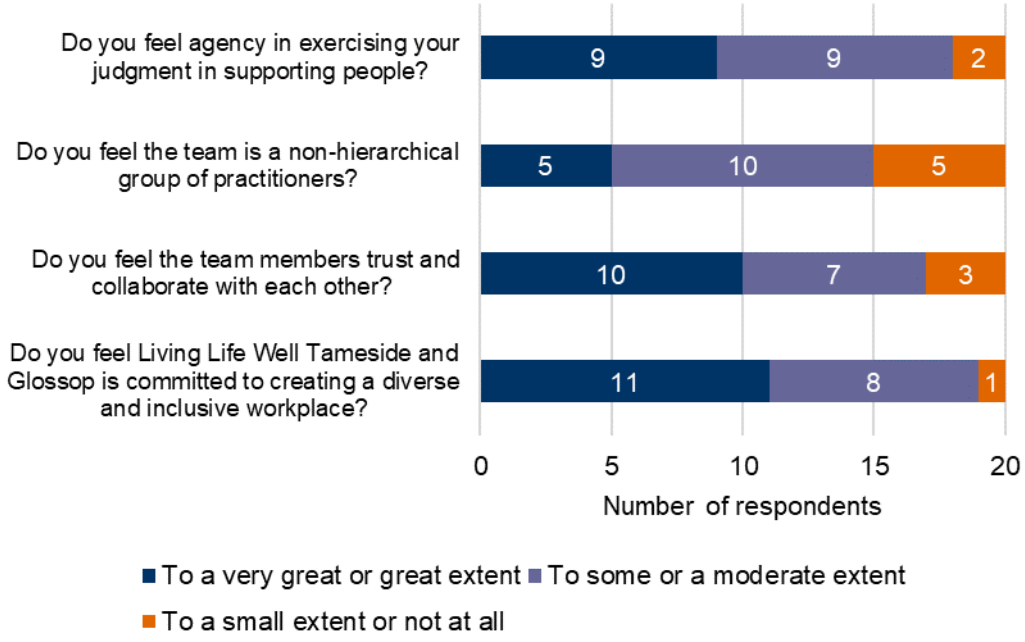
Staff responses to the survey indicate there is relatively strong collaboration between individual team members and the different professional groups (Figure 4). Half of respondents (10 out of 20) reported that they felt team members trust and collaborate with each other to a very great or great extent, with seven reporting that they felt this to some or a moderate extent. Respondents also mostly felt they had agency to exercise their judgement in supporting people, with nine of the 20 respondents reporting that they felt agency to a great or very great extent, and a further nine to some or a moderate extent.

Qualitative insight gathered through interviews and free text survey responses from the NMHT also provide some evidence of collaboration and trust, with organisations sharing expertise and information and supporting each other.

> *"There isn't any one person you couldn't go to on the team that wouldn't be able to offer advice, professional or otherwise. No matter role or hierarchy, we're all treated equally and supported, and I think that reflects back on to the clients."*
>
> *"There are pathway drop-ins so professionals from one pathway can offer support/supervision to other team members."*
>
> NMHT staff members

However, cross-disciplinary collaboration appears to be less strong than it used to be, and not as strong as hoped between some professional groups. For some, the separation of pathways has created tension in the service. This is frustrating for some team members who feel they are not able to fully deliver the joined-up, recovery oriented and strengths-based model intended, and who feel they are at times left *"carrying risk alone".*

Figure 4: Staff views on working culture (n=20)



More people are getting help but there is little evidence of outcomes for the wider system

Evidence of impact on the local health and social care system is more limited so far. This is in part due to the volatile and complex system in which Living Life Well is operating. Covid-19 has also had a significant impact on increasing demand and reducing capacity. High levels of demand across the system, limited capacity of the NMHT and other services to meet this demand, and the wider structural changes taking place across Tameside and Glossop all mean that it is difficult for Living Life Well to make an impact on other services. For the same reasons it is also challenging to attribute any identified changes to Living Life Well.

However, one important area where we can be confident that Living Life Well is making a positive impact is that there is a group of people who previously were not able to access support – who did not meet eligibility thresholds for secondary care but were also regarded as too "complex" for primary care – who do now receive help.

We have reported the limited evidence on outcomes for the system against two broad outcome areas below, rather than against the eight system outcome areas agreed for the evaluation.

As part of the report review process, partners identified some important additional outcomes where they understand good progress to have been made, such as the benefits to VCSE organisations of the additional professional and peer advice and support they have been able to access via the Open Door. However, the evaluation did not set out to assess these outcome areas and as such did not collect sufficient data to explore them in this report.

Outcome area 1: *Impact on other services (no evidence)*

The system data analysed by the evaluation shows no evidence of impact on referrals to or waiting lists for community mental health teams, mental health liaison or Healthy Minds (IAPT), or primary care prescription costs.

However, the qualitative interviews provide some evidence that Living Life Well is enabling some people supported by the NMHT to rely less on A&E or their GP because they are better able to self-manage their conditions and because they know they can contact the NMHT for support if they need. Others may continue to access support elsewhere – and indeed may even be encouraged or supported by the NMHT to access new support to help address their needs.

> *"There's an example of someone who was using all sorts of services and going to A&E twice a week who is now in work – it's massive."*

> *"There is a relief in the system - for some people they are getting an offer they didn't have before and won't need to go to GP anymore. But for others they will still go to GP, because that's what they know*

and like to do. But GPs at least now know that we exist and come to us to help them think about how to support those individuals."

Living Life Well stakeholders

Outcome area 2: *More people getting the right help, in the right place (some evidence)*

As mentioned above, the NMHT meets a gap in provision in Tameside and Glossop by supporting people who do not meet the criteria for secondary care mental health and whose needs are greater, or more complex, than IAPT can support. During the evaluation period, the NMHT has therefore supported 1,553 people who would otherwise be without any appropriate support from statutory mental health services.

"Previously the rest of the referrals to CMHT [other than those accepted] were just getting a "no", but now we can take people on. If we weren't here they would just be sitting on the caseload of the Access Team[3] but without the Access Team being able to do anything with them."

NMHT staff member

"There is an active caseload of 500 plus people that are being supported. So I absolutely will always stand by the fact that we are providing something for people that were getting nothing."

Living Life Well stakeholder

Through the Open Door triaging system, Living Life Well is likely also helping to ensure people are being directed to the correct part of the system for support suitable to their needs. The qualitative interviews indicate that the Open Door's impact here may be limited, but more data would be required to build a clear picture here.

"The concept or main principle should be no wrong door - wherever you turn up, it might not be right service but the idea is that they would help you to access right support […] and that hasn't happened."

Living Life Well stakeholders

Developing and embedding the Living Life Well system

Despite the challenges to implementation, Living Life Well is addressing a long-standing gap in support that the available evidence suggests is helping to achieve some positive outcomes, primarily for the people supported by the NMHT. It has created a flexible and recovery-focussed service that is supporting

[3] The team who, prior to Living Life Well, triaged all mental health referrals coming into secondary care and directed people to Healthy Minds (IAPT service) where necessary.

people on the issues that matter most to them through the NMHT staff team as well as by connecting people into wider resources in the local community – although implementation of the latter is less progressed.

Looking forwards, the challenge for Living Life Well will be to address the implementation barriers identified in this report and further embed the NMHT, Open Door and wider Living Life Well approach into the Tameside and Glossop system and community. This will help ensure the model is fully implemented and maximise its contribution towards wider systems change across Tameside and Glossop.

Recommendations

Figure 5 presents recommendations which we believe may help further develop Living Life Well based on the evidence available to the evaluation. Some of these recommendations have been suggested by Living Life Well stakeholders and we understand that some of the suggested actions are already underway. We hope it is useful to have them gathered together in one place.

Figure 5: Recommendations for development of Living Life Well and the NMHT

Recommendation	Section
Continue to include people with lived experience in the development, review and governance of the service. Their involvement to date has been a key feature of Living Life Well's success, but involvement has been less strong recently. This could involve a forum for people who are using or have used the NMHT, including lived experience representatives (in addition to peer workers) at meetings about governance, recruitment, reviewing or developing the service, and / or through commissioning a user/peer- led organisation to input to this process.	4.2.1
Continue to value and develop the elements of the support that people say they like and find useful, i.e. staff being caring and non-judgemental, support that is tailored to them and focuses on their personal goals, having a say over what their support looks like, and accessing support on the wider issues that might be affecting their mental wellbeing.	3.3.2
Consider how to make the NMHT more accessible to men, older people and people from Asian backgrounds, who are currently under-represented amongst the people supported by the Team. Continue to monitor and review access demographics.	2.4 Appendix
Focus on building a shared, collaborative culture and values within the whole NMHT. Leaders should: • **Communicate a clear vision** for Living Life Well based on the co-production already carried out and work collaboratively with	3.4.1 3.4.2

Recommendation	Section
the Team to address any differences in working cultures or divisions. • **Ensure there is clarity around the roles of different professions / groups within the team.** Leaders may also wish to consider whether having separate pathways within the Team is posing a barrier to developing an inclusive, collaborative culture across all professional groups within the Team.	
Review the Living Life Well outcomes. Several outcomes had limited evidence or less clear relevance to the work of Living Life Well. The report review process has also identified some key outcomes – such as the benefits associated directly with the work of the Open Door – that were not included in the framework for this evaluation, and therefore have not been considered in this report. Reviewing the intended outcomes to make sure that they are focused on Living Life Well's key objectives can help strengthen shared understanding of Living Life Well and ensure the focus is on what matters most. It will also help ensure that any future evaluation activities focus on Living Life Well's most important intended outcomes.	1.4 1.5.2 5.2
Improve information sharing about people using the service with the wider NHS system. There are two key areas of development: • **Ensure key information about people supported by the NMHT can be shared with/accessed by other health partners,** such as the mental health liaison team, including out-of-hours to reduce the possibility of serious untoward incidents. This could involve developing a system for sharing information out-of-hours, recording information on the NHS system instead, or putting summary information such as care plans, risk assessments and key letters on both the NHS and NMHT systems. • **Communicate with referrers such as GPs to confirm when a referral has been received** and provide updates on progress where appropriate and as a minimum, when people end support with the team.	4.3.2
Improve communication about the service. This would involve clarifying and publicising amongst potential partners including referrers: a) who the NMHT supports, b) the NMHT service offer, c) referral pathways into the NMHT, d) how the NMHT aims to work in partnership with other services to support people, and e) publicise what the NMHT has achieved and the positive difference it has made to the lives of the people it has seen. Raising	4.3.2

Recommendation	Section
awareness on these points should help improve partnership working with other organisations such as GPs and primary care networks and integrate the NMHT into the local system. Discussions with potential partners about any concerns or misunderstandings are also likely to be helpful.	
Focus on integrating the NMHT into local communities and working with the wider network and community. This should involve: • **Agreeing access to more community venues** for the Team to deliver support sessions and drop-ins. We understand the Living Life Well team are already planning action in this regard. • **Build relationships with more partner organisations to provide joined-up support on the issues that matter most to people**. In particular, we recommend a focus on relationships with housing services and housing providers, since there is no housing specialism within the team yet it is an area of concern for many people, and with organisations in Glossop, where we understand relationships are currently less developed.	3.3.2 4.3.1
Work with wider partners to create a more collaborative, flexible and recovery oriented system of support. More extensive change, beyond the NMHT and its partner organisations, is required to create a truly effective Living Well system across the whole Tameside and Glossop. Through sharing its successes and working with partners, Living Life Well can contribute to changing the wider system too.	5.2

1 Introduction

1.1 Overview

Living Well UK is a three-year programme to improve adult mental health. The programme received £3.4 million in National Lottery Funding, which was used to support four (now three) adoption sites across the UK to develop and adopt their own Living Well System that meets the needs of their local context. The programme is delivered by Innovation Unit in partnership with Living Well Lambeth, an independent evaluator (Cordis Bright) and the adoption sites.

Innovation Unit commissioned Cordis Bright as its evaluation partner for the Living Well UK programme. The evaluation ran between January 2019 and June 2022 and involved a local evaluation for each of the Living Well system adoption sites as well as a brief over-arching evaluation of Living Well systems across the sites.

Living Life Well is the Living Well system developed in Tameside and Glossop, centred around the Neighbourhood Mental Health Team (NMHT). The Living Life Well model was developed prior to the Living Well UK programme, the NHS Long Term Plan or the Community Mental Health Framework and was therefore funded through a mixture of existing resources and new resources.

This is the final evaluation report for Living Life Well. The report presents the evidence on the processes and outcomes of Living Life Well since its inception and summarises recommendations and learning from the evaluation.

1.2 About the Living Well UK programme and Living Well systems

The baseline report produced by Cordis Bright in September 2019 and most recently updated in March 2020 outlines the key features and rationale of the Living Well UK programme and Living Well systems.

1.3 Evaluation questions

1.3.1 Living Life Well UK programme-wide evaluation questions

As evaluation partner to Living Well UK, the evaluation team has been asked to answer the following evaluation questions:

1. What difference does the Living Well system make?

2. To what extent have the Living Well UK adoption sites adopted with fidelity the features of a Living Well system?[4]

3. To what extent have the adoption sites adopted with fidelity the principles and values of collaborative leadership and commissioning?[4]

1.3.2 Evaluation questions for Tameside and Glossop

In addition, the following evaluation questions have been identified by Tameside and Glossop colleagues:

- Does the new system achieve the Big Three outcomes for local residents, i.e.:
    - People are able to recover and live well;
    - People are connected and able to participate equally in society; and
    - People have control over their lives?
- Does the new model lead to any shift in pressures in the local health and social care system, for example freeing up resources or bringing about a reduction in treatment costs per person?
- Is the new model set up as planned, and if so how has it been established?
- Have ways of working changed within the local health and social care system?
- How do people experience the new Living Life Well system?

1.4 Outcomes and process evaluation frameworks

This report considers outcomes for people supported by the NMHT, for staff working within the NMHT and for the wider system. Figure 6 sets out the anticipated outcomes explored in this evaluation, and associated indicators and evidence gathering methods. The report also explores the process of implementing Living Life Well, as set out in Figure 7.

These were agreed with Innovation Unit and the Living Life Well collaborative at the beginning of the evaluation period, except for system outcomes g) and h) which were added in early 2022. See the baseline report for more information on this process.

Through the process of reviewing this final report, partners highlighted other outcomes of Living Life Well that they feel to be important and where they understand significant progress to have been made – such as the positive benefits to wider partners accessing professional and peer advice and support via the Open Door. However, the evaluation did not collect data in relation to

[4] These evaluation questions are not addressed in this report. The overarching programme evaluation report explores the distinctive key features of Living Well across the three Living Well UK sites.

these outcome areas. This report is therefore not able to consider progress in relation to these outcomes.

Figure 6 Outcomes evaluation framework for Living Life Well

Outcomes		Indicator/evidence gathering method[5]
Outcomes for local people		
a)	People are recovering and experiencing improved quality of life	• ReQoL-10 • Personal Goals
b)	People feel connected and have positive relationships	• ReQoL-10 • Questions About Your Life
c)	People are able to learn, work, and volunteer	• Questions About Your Life
d)	People know their own goals in life	• Personal Goals
e)	People receive good quality, person-centred help and support	• Experience of Service Questionnaire (ESQ)
f)	People have choice and control over management of their own mental health	• Personal Goals • ESQ
g)	People have a greater sense that their life has purpose and meaning	• ReQoL-10 • Personal Goals
Outcomes for staff working in the local system[6]		
a)	Staff are satisfied in their work	• Staff e-survey responses • Qualitative consultation with stakeholders
b)	Working culture is collaborative and trusting	• Staff e-survey responses • Qualitative consultation with stakeholders
Outcomes for the local system		

[5] We have listed "qualitative consultation with stakeholders and people using the NMHT" as an evidence gathering method against the outcome areas for which it is a primary evidence source. However, in practice the qualitative consultation contribute to understanding against all outcome areas.

[6] This outcome domain originally referred to volunteers also. This report focuses on staff only.

Outcomes		Indicator/evidence gathering method[5]
a)	Fewer referrals to community mental health teams (CMHT)	• CMHT referrals • Qualitative consultation with stakeholders and people using the NMHT
b)	Fewer referrals to mental health liaison	• Mental health liaison referrals • Qualitative consultation with stakeholders and people using the NMHT
c)	Reduced demand in primary care	• Qualitative consultation with stakeholders and people using the NMHT[7]
d)	Reduction in numbers of people who are referred but then do not receive any service	• Acceptances into NMHT[8] • Qualitative consultation with stakeholders and people using the NMHT
e)	Reduction in waiting times for psychological therapies	• IAPT waiting times • Waiting times for psychological therapy via NMHT[9] • Qualitative consultation with stakeholders and people using the NMHT
f)	Reduction in prescribing costs in primary care for common mental health disorders	• Primary care prescription costs • Qualitative consultation with stakeholders and people using the NMHT
g)	More people getting the right help/getting help in the right place[10]	• ESQ • CMHT referrals accepted and rejected

[7] Cordis Bright originally planned to conduct a small data study using primary care data, but agreed in March 2022 that it was not proportionate or feasible to pursue this data due to pressures in primary care.

[8] Cordis Bright originally planned to look at the number of people referred to CMHT who were rejected and picked up by NMHT, but agreed not to pursue this as it requires a manual extraction process for which local teams did not have the capacity.

[9] Cordis Bright originally planned to analyse historic data on waiting times from referral to receipt of service for the step 3.5 therapy when it was integrated into the IAPT service, i.e. prior to Living Life Well. However, Cordis Bright agreed not to pursue this as it requires a manual extraction process for which local teams did not have the capacity.

[10] These outcomes were added to the framework in early 2022.

Outcomes		Indicator/evidence gathering method[5]
		• Qualitative consultation with stakeholders and people using the NMHT
h)	Greater integration of support for individuals to provide holistic support across different disciplines and organisations, with greater collaboration between professionals[10]	• Number of concurrent pathways/ interventions accessed by people using NMHT[11] • Staff survey • Qualitative consultation with stakeholders and people using the NMHT

Figure 7 Framework for evaluating Living Life Well system processes

Process questions		Indicator/evidence gathering method
a)	How and why have the person-level outcomes specified above been achieved for people? What are the reasons for any outcomes not being achieved?	• Qualitative consultation with stakeholders and people using the NMHT
b)	How and why have the system-level outcomes specified above been achieved? What are the reasons for any outcomes not being achieved?	• Qualitative consultation with stakeholders and people using the NMHT
c)	To what extent has Living Life Well adopted with fidelity the features of a Living Well system?[12]	• Extent to which description of Living Life Well system and processes of adaptation and implementation maps on to description of key Living Well system key features • Qualitative consultation with stakeholders and people using the NMHT
d)	To what extent has Living Life Well adopted with fidelity the principles and values of collaborative leadership and commissioning?[12]	• Extent to which description of Living Life Well system and process of adaptation and implementation map on to principles and values of

[11] Cordis Bright planned to look at the number of connections made with external organisations. However, this is not currently recorded systematically and in a reportable format.

[12] These process questions are not addressed in this report. They will instead be considered at programme-level in the programme evaluation report.

Process questions		Indicator/evidence gathering method
		collaborative leadership and commissioning. • Qualitative consultation with stakeholders and people using the NMHT
e)	What are the key challenges faced by the Living Life Well system in Tameside and Glossop? How have they been overcome?	• Qualitative consultation with stakeholders
f)	What have been the key successes for the Living Life Well system in Tameside and Glossop? Why were they successful?	• Qualitative consultation with stakeholders
g)	What would be the key learnings to share with other localities that are looking to develop a Living Well system?	• Qualitative consultation with stakeholders

1.5 Methods

1.5.1 Overview of methods

The information presented in this report is based on:

- **Ten semi-structured telephone or video interviews with staff** involved in designing, commissioning, and/or delivering Living Life Well in Tameside and Glossop, conducted in March 2022. Interview participants were identified through discussion with the Innovation Unit and the Living Life Well strategic management team. The topic guides were also designed and agreed in collaboration with Innovation Unit and the Living Life Well strategic management team.

- **Seven semi-structured telephone interviews with people who used the NMHT**, conducted in March 2022. Participants were identified through a random sample of 20 people who had exited support between two to four months prior to the exercise. People who did not engage with the Initial Conversation (the first stage of support) and those whom it would be clinically inappropriate to contact were removed from the sample. The NMHT then contacted the remaining people to invite them to take part in an evaluation interview. Of these, 10 consented share their contact details with the evaluation team, and seven agreed to take part in an interview. The topic guides were designed and agreed in collaboration with Innovation Unit and the Living Life Well strategic management team.

- **Person-level demographic, activity, and outcomes data** relating to 1,553 people who accessed the NMHT between May 2019 and March 2022. See the data appendix for a full analysis of this data and more information on the outcomes measures and our approach to selecting a valid sample for change over time analysis. See the box overleaf for more information on the key measures of outcomes and experience for people supported by the NMHT.

- **System-level data** relating to demand and service activity across Tameside and Glossop between April 2016 and December 2021.

- **An e-survey of the NMHT staff** conducted in March 2022. This was circulated by the service manager to all members of staff working in the NMHT and was completed by 20 people: five clinical or counselling psychologists, four members of admin and general management staff, three support workers, and two psychological therapists, with the remaining six respondents being coaches, mental health practitioners and medical staff. The survey was designed by Innovation Unit and Cordis Bright.

Measuring outcomes and experience

The evaluation uses the following tools for measuring the outcomes and experience of people supported by the NMHT:

Personal goals attainment scoring: As part of their support from the NMHT, people agree one or more goal with their NMHT worker. At the start of support and at appropriate review points they assess how far they have progressed towards reaching each goal on a scale of 1 ("not at all") to 5 ("achieved").

ReQoL-10: This is a 10-item validated measure of quality of life for people with different mental health conditions. A score of 25 or below out of a total of 40 indicates someone is within the clinical range for accessing mental health services. An increase of five points or more is considered a "reliable improvement", i.e. people are seeing a meaningful improvement in their quality of life. A decrease of five points or more is considered a "reliable deterioration", i.e. people are seeing a meaningful decline in their quality of life.[13]

Questions About Your Life: The Questions About Your Life (QAYL) tool is based on a larger validated scale, the Manchester Short Assessment of Quality of Life (MANSA).[14] We agreed in evaluation planning co-production meetings to reduce the burden of the tool by only including selected items from the MANSA. The QAYL is therefore not a validated scale and the single

[13] University of Sheffield (no date). *Recovering Quality of Life.* Available online: https://www.reqol.org.uk/p/overview.html [Accessed 25/04/22]

[14] Priebe S, Huxley P, Knight S, Evans S. (1999). *Application and results of the Manchester Short Assessment of Quality of Life (MANSA),* Int J Soc Psychiatry, 1999 Spring; 45(1):7-12.

item satisfaction indicators cannot be considered as reliable as the insight from the Personal Goals and ReQoL data.

The Experience of Service Questionnaire (ESQ) measures service satisfaction in mental health services. It was originally developed by the Commission for Health Improvement (now Health Care Commission).[15]

1.5.2 Limitations

Below we set out the key limitations and challenges for this evaluation.

In relation to the person-level data gathered from the people supported by the NMHT:

- Our approach to analysis looks at change in outcomes over time for people between their earliest and most recently available data point[16], rather than at a distinct start and end point. As a result, the analysis sample includes people who have completed support as well as those who are partway through support (including people who have completed support and returned to the Neighbourhood Mental Health Team at a later date). This difference in 'dosage' means we must apply caution to our interpretations.

- The analysis does not provide an understanding of people's trajectories prior to support, as it looks at the data at two points of time only. For some people, a positive outcome may be to experience no further decline in their recovery. However, without an understanding of trajectory, it is not possible to explore such nuance. We also cannot make any comments about how impact has been sustained.

- The outcomes and experience analysis presented in this report relate only to the people on whom we have data available and cannot be generalised to the wider population of people supported. We only have valid outcomes and experience data for a small proportion of the total number of people supported (ranging between 12% and 25%) and people who had a planned ending are over-represented in the analysis sample. The full implications of this are explored in the technical appendix.

- The change over time analysis does not control for other potential causal variables. The scale of the contribution of Living Life Well to any improvements in outcomes can therefore not be quantified (although qualitative data provides some insight into the likely contribution). Effect sizes for can also therefore appear larger than effect sizes identified through randomised controlled trials or quasi-experimental designs for a range of

[15] Brown, A., Ford, T., Deighton, J. & Wolpert, W. (2014). *Satisfaction in Child and Adolescent Mental Health Services.* Administration and Policy in Mental Health and Mental Health Services Research. 41 (4), pp. 436-446.

[16] A date of recording was not available for some of the outcomes data. Where this occurs, we have used the date of assessment as a proxy date (likely a very accurate proxy), or if this was not available we have used the data entry creation date (likely to be less accurate).

reasons, including the role of other things affecting people's lives in improving outcomes, and regression to the mean.

In relation to the qualitative interviews:

- A small sample of seven people who had been supported by the NMHT and 10 people involved in designing, delivering and commissioning Living Life Well took part in evaluation interviews. This report may therefore only provide a partial picture of Living Life Well.

- All seven of the participants who had been supported by the NMHT started their support between April and June 2021. This precedes the steep increase in referrals to the NMHT and associated increase in waiting times that began in mid-2022. As such, our interview participants likely had a different experience to those accessing support a little later.

- The interviews did not include the people with lived experience who were involved in the co-design of the service offer. It would be highly valuable to speak to this group to understand how they experienced the process of co-producing the programme.

Finally, the evaluation focuses mostly on the outcomes achieved for the people supported by the NMHT (achieved through the NMHT's support and the connections into the wide Living Life Well community). While the Open Door is also a key component of the Living Life Well model, this evaluation does not directly consider the outcomes achieved by the Open Door, for example through the provision of advice and navigation to the wider Living Life Well network.

1.6 Structure of this report

This report is structured as follows:

- Chapter 2 presents the Living Life Well model and implementation so far, including activity data on people who have accessed, received support, and ended support.

- Chapter 3 presents the outcomes achieved so far for people accessing the NMHT, NMHT staff and the local system, and the enablers and obstacles to these.

- Chapter 4 discusses successes and enablers to implementation, and challenges with implementing the model.

- Chapter 5 contains a summary of conclusions and recommendations from the evaluation.

This report is accompanied by a data appendix, which includes analysis of all quantitative data collected to inform the evaluation.

2 About Living Life Well and the Neighbourhood Mental Health Teams

2.1 Overview

The vision for Living Life Well is for statutory and voluntary sector organisations in Tameside and Glossop to work together to provide joined-up, multi-disciplinary support for people in relation to their mental health issues and associated social issues. Living Life Well aims to enable people to recover and live well; to be connected and able to participate equally in society; and to have control over their lives.

This section describes the Living Life Well model as it currently exists in Tameside and Glossop. It also presents analysis of activity data to show the stages of the journey through the Neighbourhood Mental Health Team (NMHT), and characteristics of the cohort of people who have worked with the Team so far.

2.2 About the Living Life Well model

2.2.1 The Living Life Well model

Living Life Well was designed to fill a gap in the Tameside and Glossop mental health landscape. Through the NMHT, it provides support to people with mental health and wellbeing issues who do not meet the criteria for secondary care mental health services, but whose mental health needs are deemed too high or complex to be suitably met by IAPT (Healthy Minds).

> *"There was a big gap for people who were too unwell for IAPT, but not unwell enough for secondary care. Those people were ending up in homeless accommodation, or as frequent presenters in A&E, or street homeless, and it would have an impact on their wider families causing breakdowns."*
>
> Living Life Well stakeholder

> *"We'll pick up people who sit outside Healthy Minds eligibility – people who have multiple needs and might need wraparound service."*
>
> NMHT staff member

The model aims to provide people with time-bound, person-centred and flexible support on the psychological and wider social issues that matter most to them through a new *"easy in, easy out"* mental health service, the Neighbourhood Mental Health Team (NMHT). The NMHT offers support across a range of psychological and social issues, links people into other services for other needs or for onwards support, and helps people build connections with the wider community.

> *"It's not like a counselling service – they have other things and groups they can put you in touch with to help you get extra support."*
>
> Person supported by the NMHT

The Living Life Well model consists of four key elements:

- **The Neighbourhood Mental Health Team (NMHT)**. This is a multi-disciplinary, multi-agency mental health team led by Big Life. The team works with people in a range of ways across a range of needs – see the box below for more detail on the NMHT. People can refer themselves to the team for support, or be referred by statutory or Voluntary, Community and Social Enterprise (VCSE) organisations.

- **The Open Door** sits within the NMHT as a single point of access for all mental health services in Tameside and Glossop. At present the Open Door works across Healthy Minds, CMHT and the NMHT.

- **My Spaces and Places** is a network of safe, supportive and welcoming mental health informed locations across Tameside and Glossop. These spaces can help increase community awareness and the reduce the stigma in mental health and wellbeing and provide opportunities for people to access support from the NMHT in non-clinical environments.

- **The Living Life Well Community** is a community in which mental health awareness, understanding and openness supports the mental wellbeing of all its members. Led by Tameside Oldham and Glossop (TOG) Mind, the work to establish the Living Life Well Community includes training people across Tameside and Glossop to recognise the signs of poor mental health, and learn ways to talk about, gain, and maintain positive mental wellbeing.

What is The Neighbourhood Mental Health Team?

The NMHT is a multi-disciplinary team that draws on the skills and specialisms of multiple organisations to offer a range of interventions to people seeking support for their mental health. Support from the NMHT is intended to be time-bound (up to 12 weeks) and personalised. Support plans are developed in partnership with each person accessing support, and people can access multiple support pathways at once. The support available includes:

The mental health and wellbeing coaching pathway. Mental wellbeing coaches are provided by Tameside, Oldham, and Glossop (TOG) Mind and the Big Life Group.

The employment support pathway. Employment coaches are provided by Tameside Council.

The peer coaching and peer mentoring pathway. Peer coaches are provided by TOG Mind and the Big Life Group.

The psychological therapies pathway. Therapists are provided by Pennine Care and can offer "step 3.5" therapy, which was previously delivered through the IAPT service.

The mental health nursing team. Mental health nurses provided by Pennine Care support the wider team by managing risk and psychological assessments where needed. A consultant psychiatrist is also available to provide diagnoses and prescriptions for medication.

To meet the needs of the people they support, the NMHT works closely with a variety of wider services including: Healthy Minds (IAPT), Minds Matter (step 1, non-clinical mental health service managed by the Big Life Group), GPs, the Community Mental Health Team (CMHT), A&E Mental Health Liaison Team, mental health wards, Psychiatry, Child and Adolescent Mental Health Service (CAMHS), Housing and Homelessness, Debt Management, and the provision across Tameside and Glossop's VCSE organisations.

2.2.2 Implementation so far

The NMHT began prototyping in May 2019. Whilst good progress has been made, the model is not operating fully as intended. The key areas where implementation has been limited or diverged from the model are as follows:

- **The NMHT**: Due to escalating levels of demand and need outstripping capacity in the local system, there are now waiting lists for many of the NMHT intervention pathways as well as for much of the external provision used for onwards referrals.

  > *"When it started, it felt that all the people sat between primary care and secondary care would get the support they needed, but there are still challenges and long waiting times."*
  >
  > Living Life Well stakeholder

  The NMHT is also providing longer than the initially intended 12 weeks of support in some cases where it would feel unsafe to "discharge" someone if their intervention required more time and/or if there was no alternative support within the local system. Full integration and collaboration between the different professional groups within the NMHT also appear to be a work in progress.

- **My Spaces and Places:** The NMHT could not deliver support in community venues for a large proportion of the evaluation period due to Covid-19. Instead, support was delivered remotely much of the time. Many community organisations were also not running activities, limiting the ability of the NMHT to link people into local community assets.

- **The Living Life Well Community**: Stakeholders highlighted that this part of the model has not been progressed over the course of the pandemic.

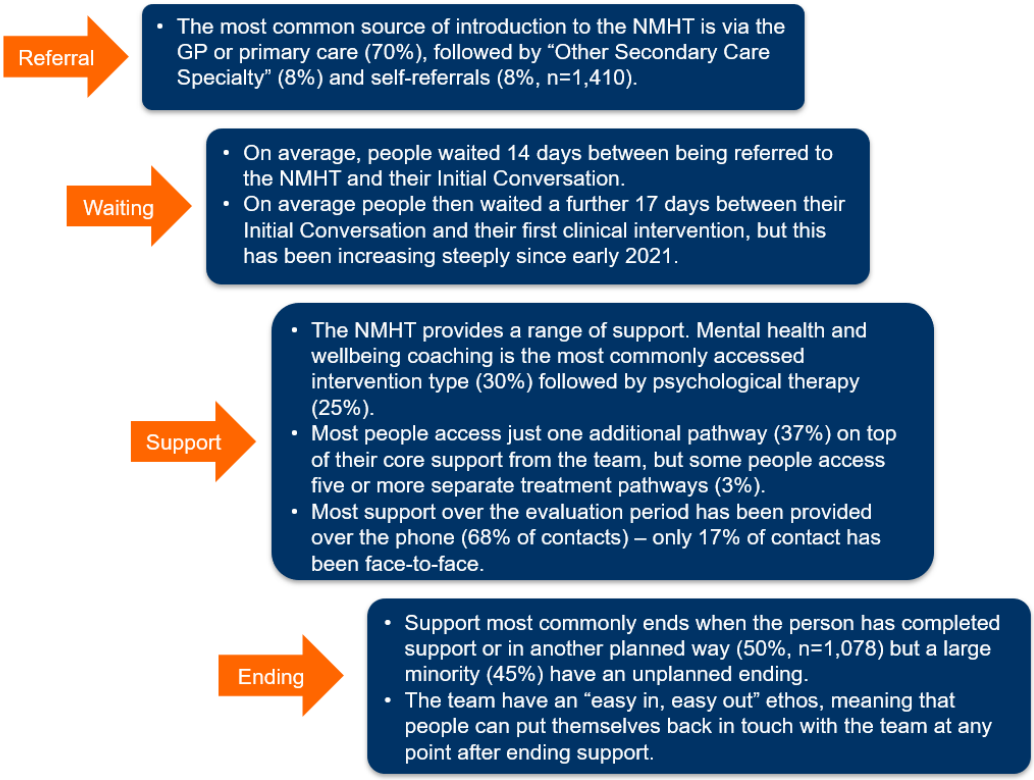
These areas of more limited implementation are discussed in greater detail throughout the report. A full discussion of the factors that have hindered the implementation of the Living Life Well model can be found in section 4.3.

2.3 Journey through the Neighbourhood Mental Health Teams

2.3.1 Overview

Figure 8 presents an overview of the journey through the NMHT.

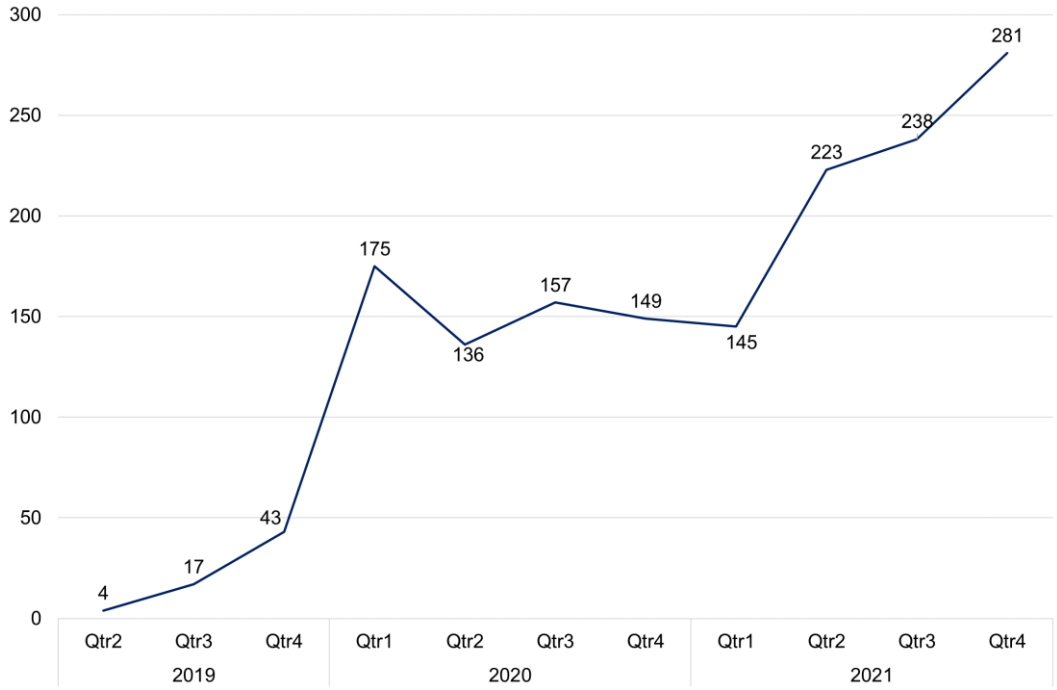
Figure 8 Overview of journey through the NMHT



2.3.2 Accessing the Neighbourhood Mental Health Teams

Between the start of prototyping in May 2019 and 3rd March 2022 (when data was downloaded for analysis), 1,553 people accessed the NMHT. Some people have accessed multiple episodes of support, so over the same period there were 1,830 referrals to the NMHT. Of these referrals, all but one was accepted. Figure 9 shows that referrals have steadily increased over the period, with the highest quarter being in the last quarter of 2021, which was the last full quarter of the reporting period.

Figure 9 Number of quarterly referrals to the Neighbourhood Mental Health Teams, May 2019 to December 2021[17]



People can be introduced to the NMHT via referral from a wide range of statutory and voluntary sector services or by self-referral – referrals from primary care are by far the most common (70%, n=1,410).

People access the NMHT for a variety of reasons related to personal feelings and social issues. The most common reason related to feelings and coping during the evaluation period was to feel less anxious or stressed (31%, n=1152), followed by feeling less depressed / happier (27%). In relation to social issues, the most common reason was to reduce isolation and loneliness (26%, n=993), followed by coping with a loss or other life event (14%).

The Open Door

People are referred in the first instance to the Open Door, which will then triage referrals and ensure that people are directed towards the most appropriate service (Healthy Minds, NMHT or CMHT).

The Open Door represents a key improvement on the previous system. People who are not accepted by Healthy Minds or by CMHT can now access support from the NMHT. It also simplifies the referral process for statutory and voluntary sector partners, who are no longer required to decide for themselves which mental health service is best placed to support someone. Finally, it provides

[17] This chart contains data running to quarter four 2021, as this was the last full quarter of data collection. There were an additional 262 referrals in quarter one of 2022 when the data was downloaded on the 3rd March.

advice and information from professionals and peers to other organisations within the Living Life Well network.

2.3.3 Receiving support

The Initial Conversation

Once a referral is accepted, an NMHT staff member contacts the person for an Initial Conversation. Figure 10 shows the average quarterly waiting times between referral to the NMHT and the Initial Conversation – the median waiting time was 14 days.

The NMHT prioritise having the Initial Conversation as soon after referral as possible and emphasize that there should be no waiting list for this first stage.

> *"If people are waiting to have a conversation about what they need, that's not good enough, so we are prioritizing getting these initial conversations done over everything else."*
>
> NMHT staff member

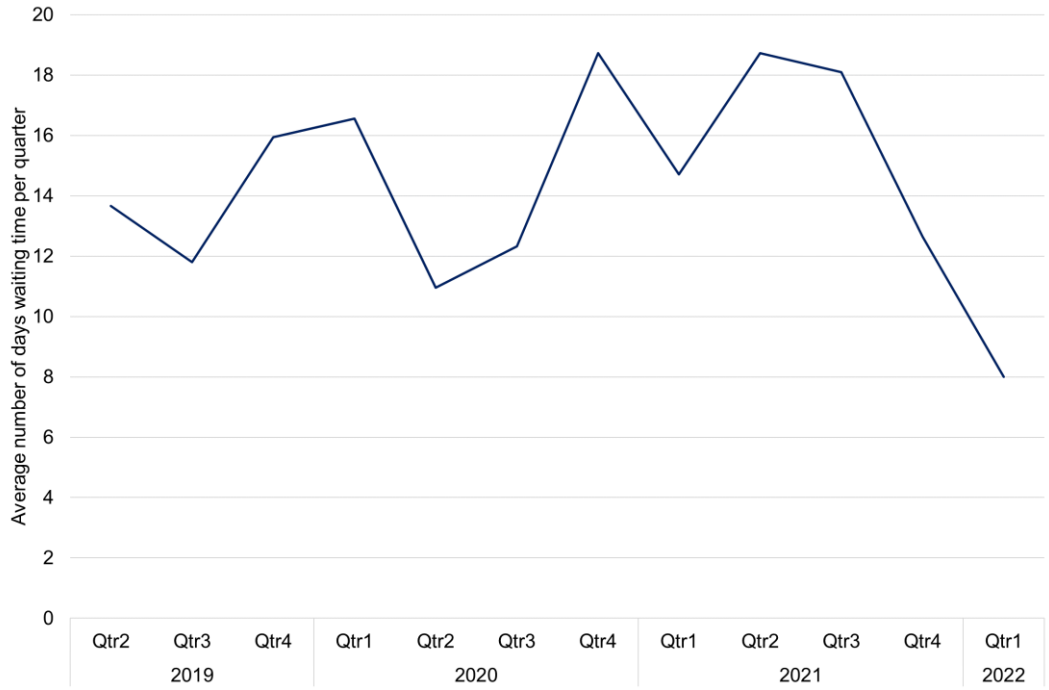
The structure for the Initial Conversation was co-produced with people with lived experience during the service design stage. It takes a strengths-based approach, working in partnership with someone to identify what they would like support with and what they want their support plan to look like.

Based on the evaluation interviews the Initial Conversation approach is highly valued by both staff and the people accessing support.

> *"We try to focus on the positives not the negatives, using the ethos of coaching, thinking about goals, and using that as a springboard versus trying to assess or diagnose. We ask what is it that you want, where do you want to get to? We take a collaborative approach to assessment versus us asking loads of questions and making a decision."*
>
> NMHT staff member

> *"When I had my Initial Conversation, she ran a few different types of therapy by me and asked what I'd feel most comfortable with - so it definitely wasn't just being told what I needed. […] After she explained compassion-focused therapy I felt like it was exactly what I needed. I felt heard and like what they've offered is customised to my needs."*
>
> Person supported by the NMHT

Figure 10 Average quarterly waiting times between referral and initial conversation (between May 2019 and March 2022, n=1246)[18]



Waiting to start support

After the Initial Conversation, the person's case is discussed at a multi-disciplinary team meeting, where the team conducts a risk assessment and agrees the support plan.

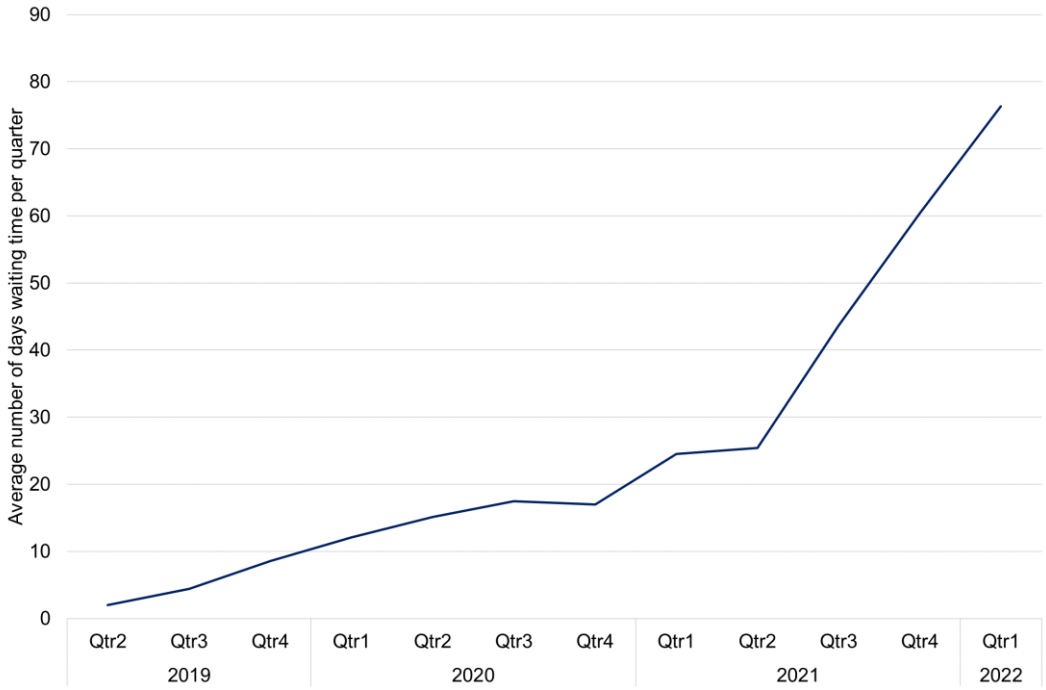
For many people there is now a longer waiting time between their Initial Conversation and the first clinical intervention. The NMHT's different intervention pathways now have waiting lists due to high demand and limited capacity. The median waiting time was 17 days over the evaluation period, but Figure 11 shows that waiting times between Initial Conversation and the start of the first intervention have been increasing steeply since mid-2021.

However, by having the Initial Conversation promptly, the team can make sure urgent issues are identified, people know they have someone they can contact if they need, and where possible people are linked into alternative support whilst they are waiting to start their NMHT intervention pathway. This is a clear change from previous approaches.

[18] Of the 1,830 referrals to the Neighbourhood Mental Health Team between May 2019 to March 2022, 1,246 received a follow up conversation. During the same period, there were 1,415 first conversation attempts.

> *"I think the fact that we can offer something while people are waiting – it's not ideal but it doesn't feel it's stopping people from achieving outcomes once they do get into their support."*
>
> NMHT staff member

Figure 11 Average quarterly waiting times between initial conversation and first clinical intervention (between June 2019 and March 2022, n=984)[19]



Personalised support from a range of specialisms

The team aims to offer support that is strengths-based, tailored to what people want and that empowers people to have a say in how, where and when they receive support. This is discussed more in sections 3.3.1 and 3.3.2.

They work with people to address the social and emotional issues that may be impacting on their mental health and wellbeing. For example, as well as offering psychological therapies such as cognitive behavioural therapy (CBT), the NMHT offers employment coaches that work with people during difficult situations in the workplace or to support people with mental health concerns to access work safely.

[19] Of the 1,246 follow up conversations, only 984 resulted in a clinical intervention.

"We manage a whole myriad of needs – be it complex or otherwise. Sometimes it feels like you are a social worker, managing everything and not just mental health needs."

NMHT staff member

"I got advice with housing and they helped refer me into other services in Glossop."

Person supported by NMHT

People can access support from a range of different intervention pathways in addition to the core support from their nominated worker. Of the 2,221 additional interventions accessed, mental health and wellbeing coaching (30%), psychological therapy (25%) and peer support coaching (19%) were the most frequently accessed (Figure 12).

Most contact between the NMHT and people accessing support was by telephone (68% of 18,850 contacts). Only 17% of contact was face-to-face. This is unsurprising given the fact that the NMHT have been primarily operating during the COVID-19 pandemic, and the proportion of contact delivered face-to-face has increased by three percentage points since our last report in August 2021.

Figure 12 Additional intervention type

Support type	Number of interventions	Percent
Mental health and wellbeing coaching	667	30%
Psychological therapy	542	25%
Peer support coaching	413	19%
Senior mental health nurse/practitioner	265	12%
Employment support coaching	215	10%
Peer mentor volunteer	60	3%
Psychiatry	49	2%
Total	**2,211**	**100%**

2.3.4 Next steps[20] after the NMHT support

The NMHT has an "easy in, easy out" ethos, meaning that people can drop out of the support (for example if their emotional wellbeing has improved) and then re-refer refer themselves back in (if support is needed at a later date) without having to re-tell their story or repeat an assessment.

> *"At the end of support, we review where things were, where they are now, what's the future plan, what other support they are linked into, and are they happy with that? All our endings are on the basis that people know they can come back."*
>
> NMHT staff member

While 828 people (53%, n=1,551) had exited support once during the evaluation period, 116 people (7%) had exited support more than once.

Support from the Neighbourhood Mental Health Team most commonly ends when the person has completed support or in another planned way (50% of support endings, n=1,078[21]). 38% of people had an unplanned exit during the evaluation period.

2.3.5 Linking to support from the wider Living Life Well system

The Living Life Well model aims to link people into the wider support available in the community. This plays an important role in supporting people on issues outside of the NMHT's expertise, helping people to connect with their local community, and ensuring people have longer-term sustainable support in place for when they step back from the NMHT.

However, this component of the model has been limited by pandemic-related closures of community groups and subsequent high demand on community services once they started opening back up again.

> *"In terms of linking people into the community, things have opened up now, but it has been slow, and we've been cautious about promising too much to people about what the system can offer - it has been so fragile. As things have opened up, places are developing waiting lists. So the system is a bit gummed up still."*
>
> NMHT staff member

This in turn has contributed to the waiting lists that are developing for the NMHT's pathways, as staff may be reluctant to stop supporting someone while there is no

[20] Endings from the NMHT are discussed in terms of 'next steps'. This is because feedback from people with lived experience during the design phase suggested that the language of 'discharging patients' had negative connotations for many who had accessed mental health support previously.

[21] This figure is higher than the number of people who have exited the service because people who have exited the support multiple times will have multiple support endings included in the table.

onward support plan in place for them in the community. See section 4.3 for the limitations on this part of the approach during Covid-19 pandemic.

2.4 Characteristics of people accessing the Neighbourhood Mental Health Teams

Based on the people for whom we have relevant data, analysis shows that so far:

- The service mainly supported adults aged 18 to 64 (94%), with very few people (1%) aged 65 or older (n=1,300).
- Approximately two thirds (64%) identified as female (n=1,309).
- The majority (92%) identified their ethnicity as White English/Scottish/Welsh/Northern Irish/British, with 3% of people from other White backgrounds and the remaining 5% from Asian, Black, mixed and other ethnic groups. (n=978).
- In terms of sexual orientation, 81% identified as heterosexual, 7% as bisexual, 5% as gay or lesbian, with 4% identifying as "other" or were unsure (n=920).
- Over a third (38%) identified as disabled (n=943), 66% had a long-term health condition (n=737) and 38% are receiving benefits for long-term sickness and disability (n=943).
- Of the 369 people on whom we have data about a primary medical condition, 7% (25 people) were autistic.[22, 23]
- Additionally, analysis of the available ReQoL data shows that 94% of people were within the clinical range for needing mental health support[24] at the time of their first available ReQoL score, with an average score of 11.9 (n=978).

A more detailed breakdown of this information is available in the data appendix.

[22] Of the remaining 1,184 people who not have a primary medical condition listed, we do not know how many people have no medical condition and for how many people this data is simply missing.

[23] The stakeholders we spoke to also identified an unexpectedly high level of referrals of autistic people, and explained how there was no specific Autism Spectrum Disorder (ASD) service in Tameside and Glossop. In response to this unexpected need, the NMHT has therefore developed an 'Autism Champion and Therapist' who will provide direct support to autistic people as well as support the team to work effectively with this group.

[24] Indicated by a ReQoL score of 24 or below.

Representativeness of the wider Tameside and Glossop population

Demographic data indicates that the NMHT cohort is not currently representative of the wider population in Tameside and Glossop based on age, gender and ethnicity:

- **Older people are under-represented:** 60% of Tameside and Glossop's population are aged 18 to 64 and 18% are over 65 years old based on the 2020 mid-year population estimates, with the remaining 22% under the age of 18. In contrast, only 1% of NMHT users are aged 65 or older.

- **Men are under-represented:** There is an even split between males and females in Tameside and Glossop based on the 2020 mid-year population estimates,[25] but two-thirds of NMHT users identified as female.

- **People from Asian ethnic backgrounds are under-represented:** 7% of the Tameside and Glossop population are from an Asian background based on the 2011 census, and 90% are from a White background. This contrasts with only 2% of the NMHT users being from an Asian background and 95% identifying as White. People from Black and other ethnic groups are a very small proportion of the local Tameside and Glossop population, as well as the NMHT users.

It was not possible to compare the NMHT and general Tameside and Glossop population for the other protected characteristics.

Living Life Well team may wish to consider whether the under-represented groups are experiencing barriers to accessing support, and what steps could be taken to improve access. The Living Life Well team should continue to gather and monitor the protected characteristics of the people accessing the Team.

[25] Mid-year estimates do not include other gender or sex categories.

3 Findings

3.1 Overview

This section discusses the outcomes achieved by Living Life Well for people supported by the NMHT, staff, and for the wider system so far. This section focuses on the outcomes for which we have the best evidence. (See section 5.1 for an overview of the evidence on each of the outcomes in the evaluation framework.)

3.2 Summary of outcomes

3.2.1 People accessing the NMHT

The evaluation found evidence of positive changes for people who have been supported by the NMHT and Living Life Well system. People are recovering and experiencing improved quality of life. There is also evidence – although less strong – that people are improving their relationships and connections and moving into education, voluntary roles or paid work. People feel they have a say in what form the support they receive from the NMHT takes and the goals they are working towards. The small sample of people consulted were also gaining more control over the management of their own emotions and mental health, outside of the Team's support.

Importantly, the support provided by the NMHT is clearly well liked by many of the people who access the team, with people particularly valuing their relationship with the caring and empathic staff; the recovery-focused approach that supports them on the issues that matter most to them, including wider social issues; and the tools and techniques to manage their mental wellbeing they have learnt from the team.

3.2.2 Staff in the local system

The evaluation found evidence that, overall, the NMHT staff are satisfied in their work. Most staff enjoy working for the service and believe that the approach, vision, and values of the service are conducive to a positive working environment. Overall, there is also relatively good collaboration and trust between NMHT staff and partner agencies, although the evaluation found that more work is required to ensure a shared working culture across the whole of the NMHT and full collaboration across the different pathways.

Key enablers to positive staff outcomes are the success of the Team in delivering improvements for the people they support, the recovery-oriented approach to support, and the development opportunities afforded through sharing skills and expertise across agencies.

However, the challenges of implementing a collaborative, multi-agency team using new ways of working are negatively impacting on outcomes for some staff. In some cases, the cultural differences between pathways and capacity

constraints appear to be limiting staff satisfaction and creating barriers to collaboration.

3.2.3 The local system

The evaluation found no evidence of impact on other services, although the support of the NMHT may enable some people to rely less on other services such as A&E and their GP (or indeed to access other services more).

Living Life Well faces some key challenges with regards to making any impact on other services: there is a high and increasing level of demand for care and support across the system, yet the capacity of the NMHT (and other services) is limited and exceeded by the high level of demand. Other concurrent changes to the local system also contribute to changes in healthcare use. Any potential impact of Living Life Well cannot be isolated from the impact of these factors.

However, Living Life Well *is* helping to ensure more people are getting help – the 1,553 people supported by the NMHT within the evaluation period would not have been eligible or suitable for support from primary or secondary care. Despite some operational challenges, the Open Door is also helping to ensure people get the right help in the right place. More broadly, any improvements in getting people into the right help brought about by Living Life Well may have been countered by reduced capacity and accessibility elsewhere in the system.

As part of the report review process, partners identified some important additional outcomes where they understand good progress to have been made, such as the benefits to VCSE organisations of the additional professional and peer advice and support they have been able to access via the Open Door. However, the evaluation did not set out to assess these outcome areas and as such did not collect sufficient data to explore them in this report.

3.3 Outcomes for and experience of people accessing the NMHT

3.3.1 Evidence in key outcome areas

Outcome 1: *'People are recovering and experiencing improved quality of life' (positive evidence)*[26]

The evaluation has found qualitative and quantitative evidence that overall people are recovering and experiencing an improved quality of life.

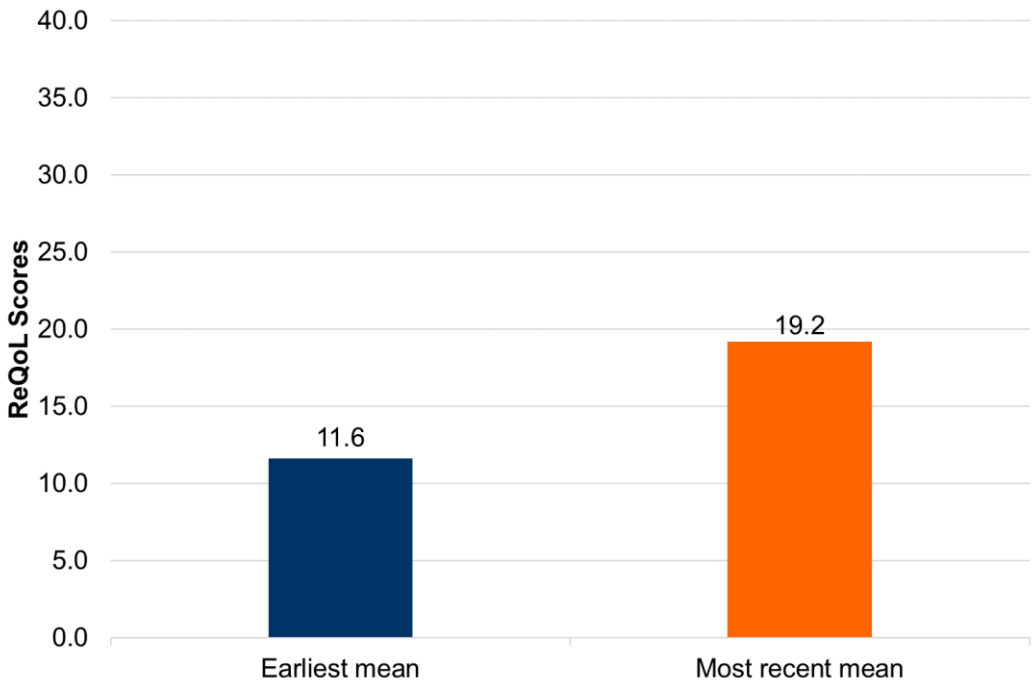
[26] Positive evidence = evidence that an outcome is being achieved; Some evidence = evidence that an outcome is being partially achieved, or weaker evidence that an outcome is being achieved; mixed evidence = evidence is not conclusive.

The ReQoL data provides evidence in three ways that people are recovering and experiencing improved quality of life. Firstly, the mean ReQoL score increased from 11.6 at the earliest available data point to 19.2 at the most recently available data point for the 385 people[27] on whom we have paired ReQoL data (Figure 13). This is a statistically significant increase and suggests overall the group are recovering and experiencing improved quality of life ($p<0.05$, medium effect size=0.48).[28]

Secondly, of the same sample of 385 people, 95% were within the clinical range for needing mental health support (indicated by a ReQoL score below 25) at the earliest available time point; this had reduced to 70% at the most recently available time point.

Analysis of individual level changes in scores also shows that over half of people (58%, 225 people) on whom we have data saw a reliable improvement in their recovery and quality of life, i.e. an increase in ReQoL score of five points or more. This means that they experienced a meaningful improvement in their recovery and quality of life. However, 24% (131 people) saw no reliable change and 8% (29 people) saw a reliable deterioration in their ReQoL score, i.e. a decrease of five points or more, indicating a reduction in quality of life (Figure 14, n=385).

Figure 13 Mean ReQoL index score at the earliest and most recently available time points (n=385)



[27] This sample of 385 people is 25% of the total 1,553 people supported during the evaluation period.

[28] Based on paired t-test and Cohen's D.

Figure 14 Change in ReQoL index score (earliest available to most recently available, n=385)

Change over time	Number of people	Proportion
Reliable improvement	225	58%
No change	131	34%
Reliable deterioration	29	8%
Valid total	**385**	**100%**

Personal goals data also shows positive progress for this outcome area. Among the 1,553 who have accessed support, 662 people (43%) have agreed at least one personal goal as part of their support plan. Among the 282 people on whom paired personal goals data was available, a high proportion have made progress towards their goals:[29]

- 82% (230 people) made progress on at least one goal between their earliest available and most recently available data (Figure 15).
- 57% (162 people), made progress on two or more goals and 29% (82 people) made progress on three or more goals (Figure 15).
- 48% (135 people) mostly or fully achieved at least one goal, and 30% (85 people) fully achieved a goal.
- Only 9% (26 people) moved backward on a goal.

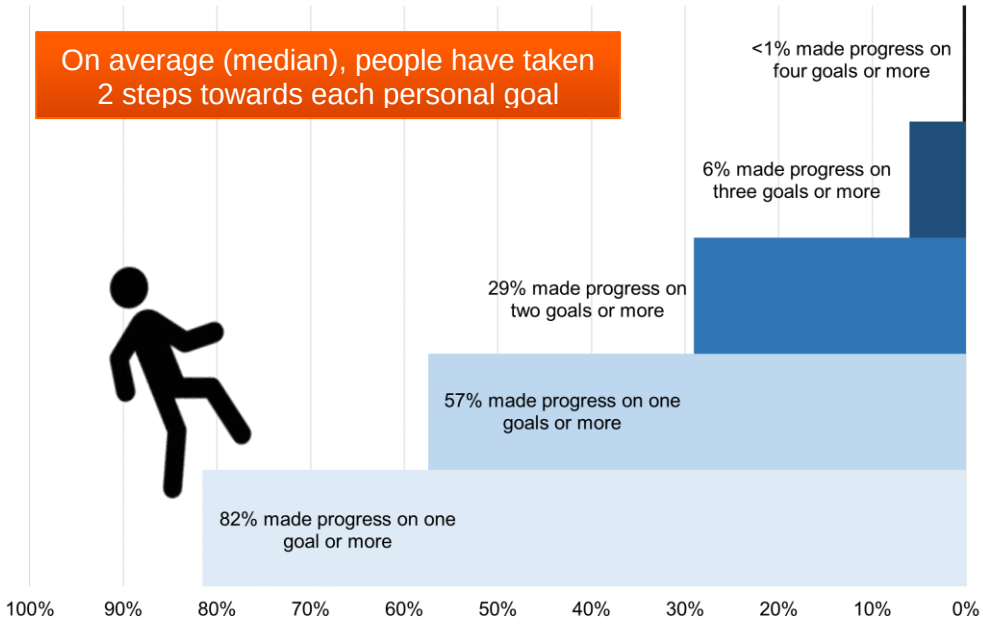
The group also made statistically significant improvements[30] on their average personal goals progress scores ($p<0.05$, large effect size=0.58).[31] People improved from a median of 1 (having "not at all" made progress toward their goal) to 3 ("half way" to achieving their goal), with an average improvement of two steps per goal (n=282).

[29] (i)This includes a total of 652 paired goals - most people had paired progress scores on more than one goal. (ii) This sample of 282 people is 18% of the total 1,553 people supported during the evaluation period

[30] Based on Wilcoxon signed rank.

[31] Effect sizes for pre/post analysis can appear larger than effect sizes identified through randomised controlled trials for a range of reasons, including the role of other things affecting people's lives in improving outcomes and regression to the mean.

Figure 15 Progress on personal goals for people with paired data (n=282)



The qualitative interviews with people who have accessed the NMHT also provide evidence of people recovering and experiencing improved quality of life, and the important role of the NMHT in this. The people we spoke to were mostly highly positive about the NMHT's support and felt it had been impactful in helping them achieve meaningful change in their lives. Although we should be cautious in drawing overarching claims based on the small sample of people we interviewed, this is encouraging evidence of positive outcomes.

> *"This service was the only one really that I counted on. I'd say the word vital comes to mind - it was vital to me."*
>
> *""It was life changing. I had low expectations, but I walked out a much more clear-headed person than I've ever been."*
>
> People supported by the NMHT

People also told us they were no longer having suicidal thoughts, that they felt stronger because of the NMHT's support, and that they believed their mental wellbeing would have deteriorated considerably without the input of the NMHT.

> *"I'm not 100% sure I'd still be here if I'm being honest. I had suicidal thoughts prior to getting support."*
>
> Person supported by the NMHT

Overall, the NMHT staff and wider Living Life Well stakeholders we spoke to also believed the support was helping people recover and improve their quality of life.

"Based on who I work with, people are thriving when they leave. And if they are not, they come back to us."

NMHT staff member

Outcome 2: *'People feel connected and have positive relationships' (some evidence)*

There is quantitative evidence that some people are experiencing improvements in their relationships with family and friendships. More people are also participating in leisure or community activities. However, the qualitative insight into the role of the NMHT in supporting these improvements is more limited.

The Questions About Your Life data indicates positive progress in relation to people feeling connected and having positive relationships. Based on the people for whom we have paired Questions About Your Life data, there was a statistically significant[32] increase in the number of people reporting positive relationships and engagement with community or leisure activities:

- Among the people on whom we have data, the proportion of people who have someone they would call a "close friend" increased from 186 people (66% of valid sample) at the earliest available data point to 228 people (81%) at the most recently available data point ($p<0.05$, small effect size=0.27, n=280).

- The number of people who reported having visited a friend in the last week increased from 151 people (55% of valid sample) to 183 people (66%) ($p<0.05$, small effect size=0.18, n=276).

- The number of people who reported they participate in leisure or community activities increased from 72 people (26% of valid sample) to 134 people (48%) ($p<0.05$, medium effect size=0.35, n=280).

People were also asked to rate their satisfaction concerning their relationship with their family and the number and quality of their friendships. Whilst treating analysis of these satisfaction measures with more caution as they are not validated measures, the results contribute to the understanding that people are seeing improvements in their relationships. Overall, the group of people on who we have data reported an increase in satisfaction (although a large minority also reported a decline in satisfaction):

- The median satisfaction score for relationships with family increased from 4 (mixed satisfaction) to 5 (mostly satisfied), a statistically significant[33] increase in scores ($p<0.05$, medium effect size=0.34, n=267). Individual level changes also show that an increase in satisfaction was the most common experience

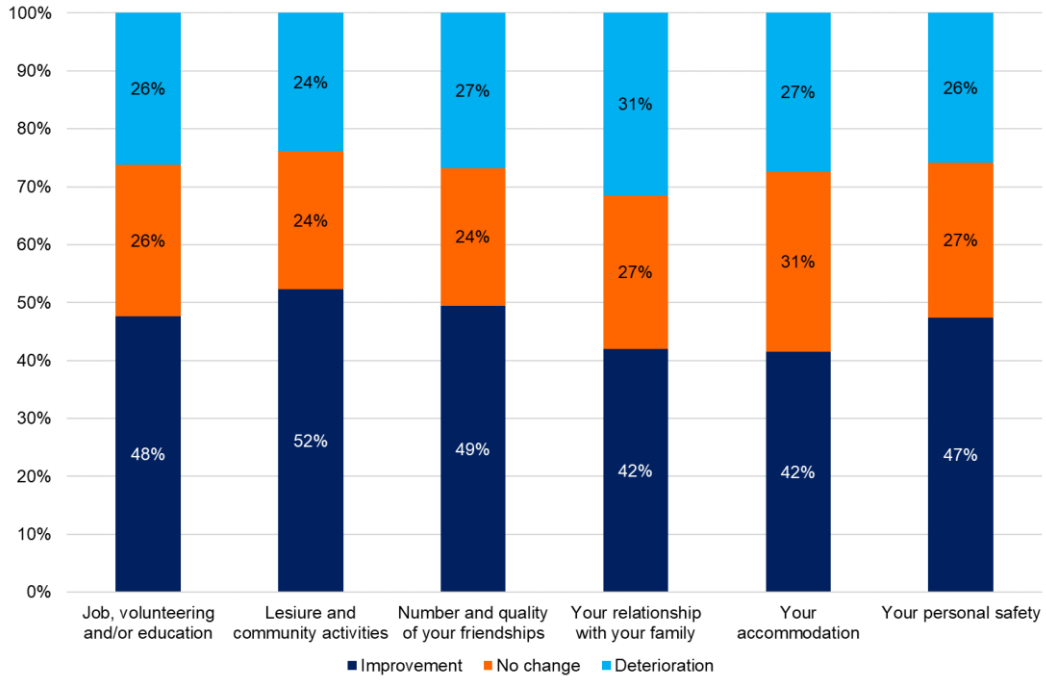
[32] Based on Chi Square test.

[33] Based on Wilcoxon signed rank.

with regards to relationships with family: 42% of people saw an improvement in their satisfaction score, 27% saw no change and 31% saw a deterioration (Figure 16).

- The median satisfaction score for number and quality of friendships remained at a median of 4 (mixed satisfaction) at both time points. However, there was in fact a statistically significant improvement in satisfaction in number and quality of friendships for the group as a whole ($p<0.05$, small effect size=0.15, n=269).[34] This is supported by the analysis of individual level changes: 49% of people reported an improvement in satisfaction with the number and quality of friendships; 24% saw no change and 27% saw a deterioration (Figure 16).

Figure 16 Change in Questions About Your Life satisfaction scores between earliest and most recently available data point (n=227 to 277)



While ReQoL is a well validated and reliable measure of recovery using all ten questions as a scale, the single items are not designed nor validated to be analysed individually. However, **responses to two individual ReQoL items provide further supporting evidence that people are seeing improvements in relationships and feeling more connected:**

- The most common experience for the people on whom we have data was an improvement in their ability to trust others (n=385): 44% (168 people) reported

[34] The Wilcoxon Signed Rank test ranks the sum, not median; therefore it is possible for the ranks to differ and show statistically significant improvement while the medians remain the same.

an improvement in their ability to trust others, 30% (116 people) saw no change; and 26% (101 people) saw a deterioration.

- Positive progress was even greater in response whether people "felt lonely" (n=385): 51% (196 people, n=385) reported an improvement, 31% (120 people) reported no change, and 18% (69 people) saw a deterioration.

There is less evidence from qualitative interviews on whether and how people were supported to feel more connected and have positive relationships. This could suggest it was an outcome area of less importance to the people we spoke to or that it is a less central focus of the NMHT's support offer. However, some people have clearly experienced improvements:

> *"When we ended last week she's got a range of occupational performance tasks, she's looking at independent living, getting her son back, she's got social networks."*
>
> NMHT staff member

Outcome 3: 'People are able to learn, work and volunteer' (some evidence)

There is some evidence that people are more able to learn, work and volunteer. There was a small increase in the proportion of people who are in any kind of work, volunteering or education for the people on whom we have data. Overall, the same group experienced an improvement in satisfaction with their jobs, studies and other occupations. The qualitative insight from people supported by the NMHT also shows that the team's practical support on issues like employment and housing is highly valued by people accessing the service.

Questions About Your Life data provide positive evidence that more people are in education, work or volunteering. Among the sample of people on whom we have paired data (n=287), the number of people who were in any kind of work, volunteering or education rose from 99 people (34% of valid sample) at the earliest data point up to 113 people (39%) at the most recent data point. This was a statistically significant[35] increase ($p<0.05$, medium effect size=0.35). This is primarily due to increases in volunteering (from 4% to 7%, n=281) and in education (from 7% to 11%, n=273). Increases in paid work were much more modest (from 24% to 25%, n=287). There were also small increases (ranging from 1% to 3%) in the proportion of people who are not yet volunteering, in paid work or education but who are applying (see Figure 17).

Based on the single item satisfaction question[36] the median satisfaction score stayed at 4 (mixed satisfaction) at both time points. However, overall, the group

[35] Based on Chi Square test.

[36] See section 1.5.2 for more information on the limitations to this measurement tool.

experienced a statistically significant increase in satisfaction[37] with their jobs, studies or other occupation ($p<0.05$, small effect size=0.29, n=229). Analysis of individual level improvements also shows that an improvement in satisfaction in this domain was the most common experience across the group of people on whom we have data: 48% of people reported an improvement in satisfaction; 26% reported no change; and 26% reported a decline (Figure 16).

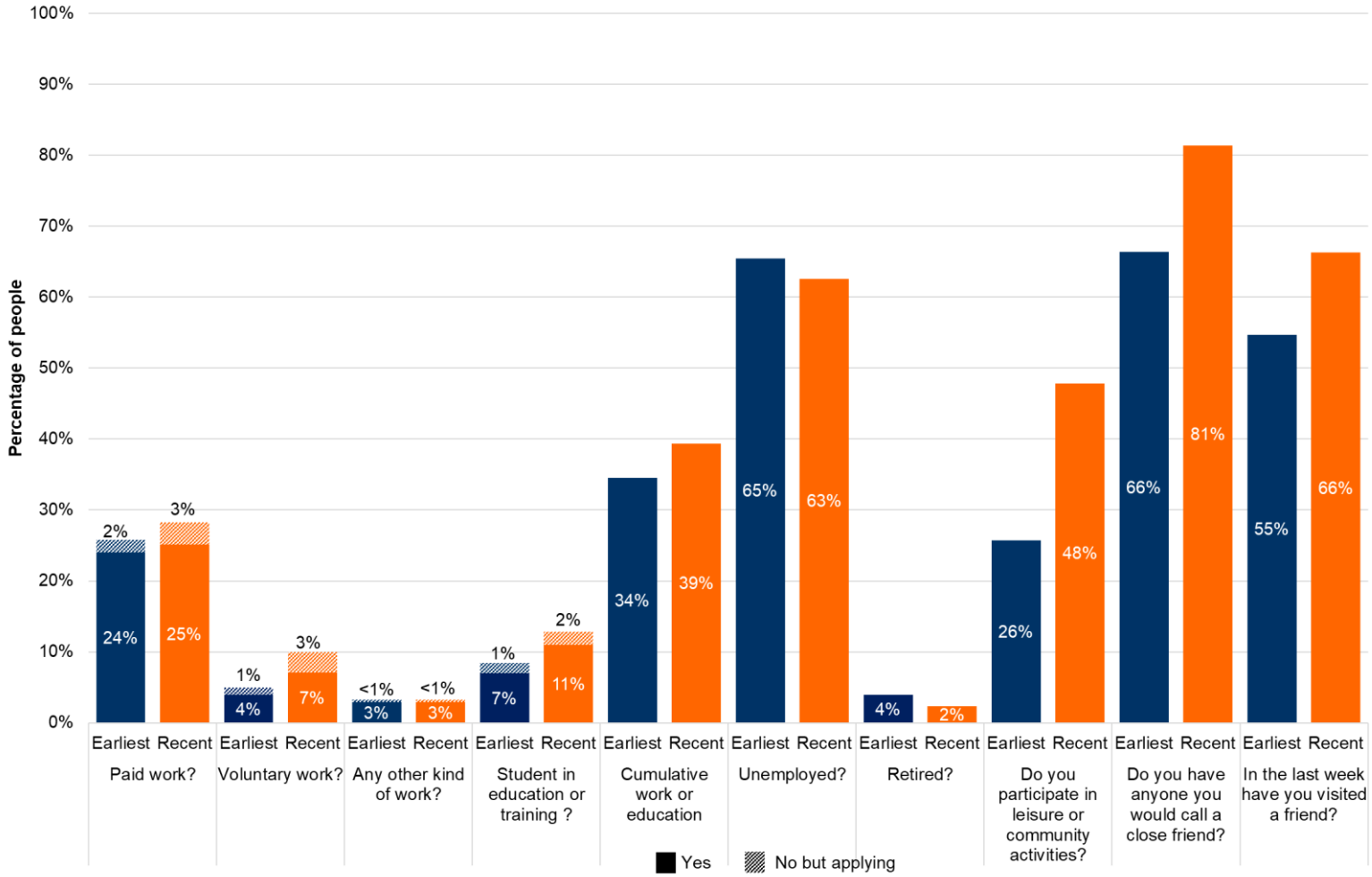
There is a small amount of evidence in relation to people's ability to work from the qualitative interviews, with NMHT staff as well as one person supported by the NMHT reporting that the NMHT had helped them to gain employment. More generally, the people we spoke to were positive about the practical support offered by the NMHT in relation to issues such as employment and housing.

> *"The main thing was sorting out a job, and I did manage to find a job… I'm grateful for the help, particularly that [employment coach] stayed with me for a number of months. It wasn't a case of eight sessions sort of thing, she kept with me for quite a long period."*
>
> Person supported by the NMHT

> *"I have an example of someone who was using all sorts of services and going to A&E twice a week who is now in work."*
>
> NMHT staff member

[37] The Wilcoxon Signed Rank test ranks the sum, not median; therefore it is possible for the ranks to differ and show statistically significant improvement while the medians remain the same.

Figure 17 Percentage of people in work, volunteering, and participating in leisure and friendships at the earliest and most recent time points (n=254 to 287)



Outcome 4: *'People know their own goals in life' (limited evidence)*

There is little evidence that Living Life Well helps people to know their own goals in life.

Among the 1,553 people to have accessed the NMHT, 662 people (43%) have at least one personal goal that they have agreed with their NMHT worker, and which will form the focus of the plan they agree together. However, asides from this the evaluation found little evidence on whether people know their own goals in life. More research is required to fully understand any impact on this outcome area.

Outcome 5: *'People have choice and control over management of their own mental health' (some evidence)*

There is some evidence, primarily from the qualitative data, that the NMHT is successful at enabling people to have choice and control over the support they access from the NMHT, as well as developing the tools and techniques to take control of their own mental health and wellbeing outside of the support sessions

The NMHT support is designed to allow people to have a say in how they access and receive support, and what they want to work towards. **NMHT staff members described how the Initial Conversation helps ensure that each person's support plan is shaped by what kind of support the person wants to receive and that they set realistic strengths-based goals** – 662 people (43%) have at least one personal goal that they have agreed with their NMHT worker and which will form the focus of the plan they agree together. **People supported by the NMHT also described how they were involved in deciding what their support would look like.**

> *"They tailored it to things I was specifically worried about at the time."*
>
> *"There's a certain amount of me being in control of my sessions and then also being steered in the right direction."*
>
> People supported by the NMHT

Insight from the qualitative interviews also suggests people were able to choose how and when they access the support (although the team's ability to provide support face-to-face and out in the community was limited during the Covid-19 pandemic).

> *"The beauty of our services is that the client has control over where they see us."*
>
> NMHT staff member

Beyond having choice and control over their support plan, **people described how support had enabled them to take control over their mental health and wellbeing in their own lives.** This was the most common theme amongst

interview participants when describing the most important changes in their lives since they started working with the NMHT. Although this is drawn only from a small sample of interview participants, the consistency of the message from the people we spoke to means there is promising positive evidence for this outcome area.

> *"I'm able to let things go […] The overthinking and over fixation was the core of my mental health issues. To have that relieved is life changing."*
>
> *"Therapy has helped me understand a lot about myself, how to process things properly and not run away, how to deal with things in the past, coping mechanisms – becoming a better version of myself."*
>
> People supported by the NMHT

However, the staff survey indicates that staff may not feel fully supported to create choice and control for the people they support. Half of the 20 respondents reported feeling encouraged to share ownership of people's support and co-produce solutions with them to a very great or great extent, 8 reported that they felt this to some or a moderate extent and 2 reported that they felt this to a small extent or not at all (n=20). This may reflect that staff are seeking to create choice and control for the people they support, but do not always feel fully supported to do so – see the discussion on the challenges of joint working across the different NMHT pathways in section 3.4.2.

***Outcome 6:** 'People have a greater sense that their life has purpose and meaning' (limited evidence)*

There is more limited but promising evidence that people have a greater sense that their life has purpose and meaning.

Analysis of responses to two of the items on the ReQoL scale provide some evidence that people have a greater sense their life has purpose and meaning – although these findings should be treated with caution as the single ReQoL items are not validated measures of these constructs:

- Of the 385 people on whom we have paired ReQoL data, 58% (223 people) saw an improvement in relation to the statement "I thought my life was not worth living". 27% (103 people) saw no change, and 15% (59 people) saw a deterioration.

- 55% (210 people) reported an improvement in relation to the statement "I felt hopeful about the future", 32% (122 people) saw no change, and 14% (53 people) saw a deterioration.

The qualitative interviews with people supported by the NMHT as well as NMHT staff and wider Living Life Well stakeholders also provide some limited supporting evidence of positive progress in relation to this outcome area. People spoke about feeling less alone due to the support, and how they thought that they

"might no longer be here" if it weren't for the support of the Team. Likewise, one stakeholder described how *"the feedback we get is that people often use phrases like 'it has been life-saving'"*.

***Outcome 7:** 'People receive good quality, person-centred help and support' (positive evidence)*

There is positive evidence from the Experience of Support Questionnaire (ESQ), the staff survey and from qualitative consultation that the help and support provided is both good quality and person-centred.

The ESQ provides relatively strong evidence that, for the 192 people on whom we have data, the support from the NMHT is well-liked and helpful, and demonstrates elements of person-centred care. For example, 92% of people would recommend the support to a friend and 91% felt that overall, the help they received was good. In relation to person-centred care, 92% of people felt their views and worries were taken seriously, 86% reported that people were working together to support them and 92% felt the people who saw them listened to them and treated them well. See Figure 15 for full results.

The only domains where less than 80% of respondents replied positively were about ease of travelling to the venue for support and comfort at the facilities. In both cases this was because a relatively large proportion (39% and 49% respectively) were unsure about how to respond ("don't know"), which is likely due to the support taking place remotely under COVID-19 restrictions.

Defining person-centred care

The Health Foundation's framework[38] for person-centred care identifies four key principles:

1. Affording people dignity, compassion and respect

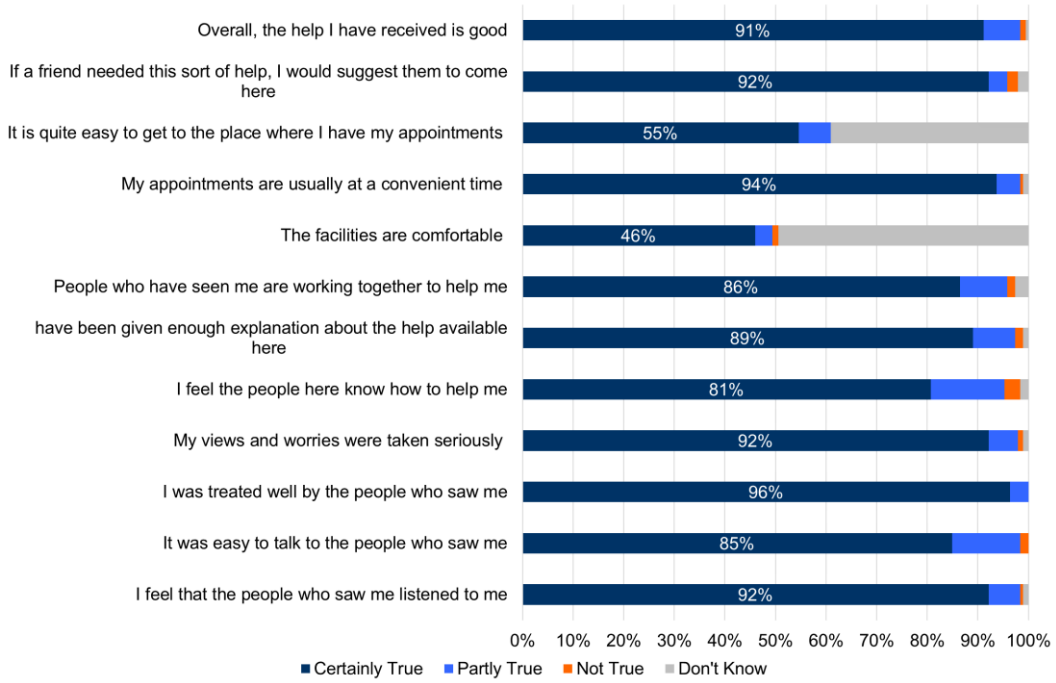
2. Offering coordinated care, support or treatment

3. Offering personalised care, support or treatment

4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

[38] The Health Foundation (2016). Person-centred care made simple. What everyone should know about person-centred care.

Figure 18 Satisfaction with the Neighbourhood Mental Health Teams (data labels indicate percentage of respondents selecting "Certainly true" for each statement) (n=174 to 192)



Responses to the staff survey also indicate that staff perceive the care and support provided by the NMHT as high quality. 16 out of 20 respondents (80%) reported that they either strongly agree or agree with the statement "If a friend or relative needed treatment I would be happy with the standard of care provided by the Living Well team".[39]

Qualitative consultation with people who have accessed the NMHT provides supporting evidence that the care and support from the NMHT is both good quality and person-centred. The people we spoke to described how the NMHT focused on providing support based on their needs and circumstances at the time and said they would recommend the NMHT to friends (and in some cases already had) because of the positive impact they felt the support had made on their lives. In fact, **people supported by the NMHT and Living Life Well stakeholders both identified the personalised nature of the support as a particularly important feature of the NMHT, and a key factor in enabling people to make improvements in the other key outcome areas.** (See section 3.3.2 for more discussion.)

3.3.2 Enablers and obstacles to achieving outcomes for people accessing the NMHT

This section discusses the components of the NMHT and Living Life Well that make the most difference in improving outcomes for people, i.e.:

[39] This is the Neighbourhood Mental Health team.

- Building relationships with caring staff who listen.
- Support that is recovery-focused
- Support for social issues and the wider determinants of mental health.
- Tools and techniques to help manage emotions and mental wellbeing.
- Having regular sessions with the team.

It also considers key obstacles to achieving outcomes.

Building relationships with caring staff who listen

Most of the people supported by the NMHT that we spoke to identified the most important part of the support as having someone non-judgemental and caring to talk to, who would listen to their concerns.

> *"Having someone there to talk to you about things. You genuinely felt you had support and someone genuinely trying to help you."*
>
> *"Talking it out with them to get stuff off your mind rather than thinking negatively."*
>
> People supported by NMHT

The relationship that people developed with their NMHT worker was vital to both their experience of the service and their recovery and improved quality of life. The empathic approach of the staff was key to building positive relationships.

> *"They were extremely knowledgeable and compassionate – they understand you're a human not a number."*
>
> Person supported by NMHT
>
> *"I think the main component is relationships - it's very much about the relationship they have with us, and being able to have that relationship […] what's been successful for her is having that relationship - the first human relationship that has been nurturing, has had a modelling element, has been profitable for her."*
>
> NMHT staff member

Given the importance of a positive therapeutic relationship, staff turnover and changes in staff within the NMHT can have a negative impact on outcomes for the people they support. For example, one person we spoke to described having experienced multiple wellbeing coaches in quick succession – they felt they were only able to start making progress once they had a more permanent coach in place.

Recovery-focused support

The recovery-focused elements of the support were identified by stakeholders and people supported by the NMHT as key enablers. They described an approach that is hopeful, strengths-based and that focuses on people's own goals and the issues that matter most to them.

> *"I [previously] came from a service where we were rigidly focused on symptom reduction, but here we think about what people come through the door with - being able to be goal focused and strength-based instead of deficit focused. We think about where we want to get to and how to get here - taking a hopeful approach. And hope is really important for suicide prevention - our coaching approach gives people hope and ability to see potential for things to be different."*
>
> *"We try to think about positives not the negatives, using the ethos of coaching, thinking about goals and using that as a springboard versus trying to assess or diagnose. We ask what it is you want, where do you want to get to."*
>
> NMHT staff members
>
> *"She tailored it to things I was specifically worried about at the time."*
>
> People supported by NMHT

Offering the support where people feel more comfortable, such as in a café or the park, contributed to people feeling a sense of control over the support. (See section 3.3.1 for more discussion.) As a result, people felt listened to and heard by the team.

Support for social issues and wider networks and determinants of mental health

Support for wider social issues was a key factor in the improvement of their mental wellbeing for some of the people we spoke to. This includes the support provided within the multidisciplinary NMHT that people could access alongside support from other pathways, and support from external organisations in the wider Living Life Well Network. The people we spoke to experienced this as a different approach from the mental health support they had previously accessed, which focused on events in the past, or the type of support they were expecting. In contrast, they felt the NMHT approach enabled them to address issues that were currently affecting their mental health and wellbeing.

> *"Being put in touch with other groups that allowed me to get the support and things I needed. That was a boost at a low time."*
>
> *'Helped me discuss about dealing with my employer whilst off sick… helped me look at options for getting a different job, helped me with interviews'*
>
> People supported by NMHT

Offering tailored support for an individual's social issues, such as employment, was identified as a key mechanism for achieving positive outcomes for people. Stakeholders described the NMHT as offering a service unlike any other in the region because it enabled people to access support for issues that did not necessarily fall within the remit of clinical mental health services but did have an impact on their mental health.

However, the qualitative consultation identified three barriers to providing people with support on social issues and connecting them into wider community resources:

- While housing is a key issue for many people, the support the NMHT can provide for housing issues is more limited, as there is no housing specialist or housing organisation represented within the NMHT.

  "All we can do is liaise with housing associations or signpost, as we do not have that specialism within the team."

  "The only thing missing in terms of the wraparound support is some kind of housing support as there are so many referrals for people struggling with housing"

  NMHT staff members

- The NMHT's connections with wider community organisations are stronger in Tameside than in Glossop. As such, it is currently easier to link Tameside residents into external support for issues outside of the NMHT's expertise than it is for Glossop residents.

  "But they [the NMHT] are based in Tameside and I'm in Glossop, which is another housing area, so that was difficult. But she did phone the housing association to have a chat whilst I was there, which was good."

  Person supported by NMHT

- It can be challenging to link people viewed as "higher risk" (for example due to dual diagnosis or emotional regulation difficulties) into other universal services and groups.

Yet despite the NMHT's ability to provide support on a range of social issues, the wider socio-economic challenges that people face in their lives were identified by stakeholders as an important barrier to them recovering and experiencing improved quality of life. These are often beyond the realm of what the NMHT can influence. The pandemic has also contributed to increased levels of poverty and multiple disadvantage amongst the people who are accessing the Team, with poverty levels set to increase further as the cost of living increases across the UK.

"The biggest barriers are the socio-economic ones - we work in a deprived area. There are pockets of more affluent but for most there

is a high incidence of poverty, drug and alcohol use - those factors come into play and can be a barrier."

NMHT staff member

"The problem is that mental health is not just about mental health services – we need to change a lot more than just the services."

"What we've seen is that the demand has increased and we've got a lot more complexity is coming through and Covid is obviously had an impact on people's mental health. The social barriers that people are facing now, like unemployment, loss and bereavement, and just that isolation for a two-year period."

Living Life Well stakeholders

Tools and techniques

People described how the NMHT taught them tools and techniques for managing their mental wellbeing, which played an important part in helping them to better manage their mental health, and which was in turn an important factor in supporting improvement in other outcome areas.

"Learning coping techniques and how to sit with my emotions and how that is a healthy thing."

"My support worker [made this positive difference]. She taught me a technique which I find is the first thing to come to my head now when I'm presented with an issue. It's to question – can I control this? If the answer is no, I go and speak about it with someone, like my mum. After I've spoken about it, I let it go."

People supported by NMHT

Frequency and length of support

People accessing the support generally found the regularity of the support helpful. The scheduled support sessions helped them to implement their learnings in between sessions.

"The pathway was a call a week to see what you're doing, and it worked for me. I knew a phone call was coming so I was motivated to do what we discussed during the week."

Person supported by NMHT

However, some felt they would have benefited from more sessions or a longer intervention.

"I think it could have been longer. Not the work but the services. Even just for a check in."

Person supported by NMHT

Wider support networks

Where people had a wider support network available outside of the NMHT, this appears to have played an important role in helping people to recover. For example, people described support from "*my wife […] wider family, my church […] friendships".* However, many of the people we spoke to did not have a wider network of people to support them – for these people the NMHT appears to have played an even more important role in enabling them to recover.

> *"I've got some family but they are down in [South West England city] and my parents are in [North of England county] so I was on my own as far as that's concerned. So that's one of the reasons having this support was so significant."*
>
> *"I don't have any friends, I didn't have anyone to speak to to get things off my chest."*
>
> People supported by NMHT

3.4 Outcomes for staff in the local system

3.4.1 Evidence in key outcome areas

***Outcome 1:** 'Staff are satisfied in their work' (positive evidence)*

Overall, the NMHT staff are satisfied in their work. However, views on whether the team provides opportunity for career growth and development are more mixed, and less embedded collaboration between some NMHT pathways appear to be hampering satisfaction for some team members.

Responses from the staff survey indicate that the NMHT staff are satisfied in their work:

- All staff reported that they were satisfied with their job: 10 out of 20 participants reported that they were satisfied with their job overall to a very great or great extent, with the remaining 10 reporting that they were satisfied to some or a moderate extent (Figure 19).
- Nearly all staff said they intended to stay in the team: over half of respondents (11 out of 20) reported that they intend on staying with the team to a very great or great extent, and eight to some or a moderate extent. Only one reported that they intend on staying with the team to a small extent or not at all.
- Most staff felt satisfied with the standard of care provided: 16 out of 20 participants said they would be happy with the standard to care provided by the NMHT if a friend or family needed support (Figure 21).
- A majority said they would recommend the NMHT as a place to work: 15 out of 20 participants (75%) said they strongly agreed or agreed that they would

recommend the NMHT as a place to work; and two reported that they neither agreed nor disagreed with the statement (Figure 20). In contrast, the remaining three respondents reported that they strongly disagreed or disagreed with the statement.

Most staff also told us that they enjoy working for the service and believe that the approach, vision, and values of the service are conducive to a positive working environment. They highlighted positive aspects of the service that contribute to their enjoyment such as the flexible and person-centred nature of the service and the possibility to positively change mental health care.

However, when we consider future opportunities for staff career growth and development, which also contribute to staff satisfaction, the staff survey suggested views were mixed. Only four respondents believed there was opportunity for individual career growth and development within their team to a very great or great extent. Eight staff felt there were opportunities to some or a moderate extent, and the remaining eight they felt this to a small extent or not at all (Figure 20).

For some staff the challenges to working in a multi-disciplinary and collaborative way across all disciplines have limited their satisfaction in the role – see discussion in section 3.4.2.

Figure 19 Staff views on staff satisfaction and career planning (n=20)

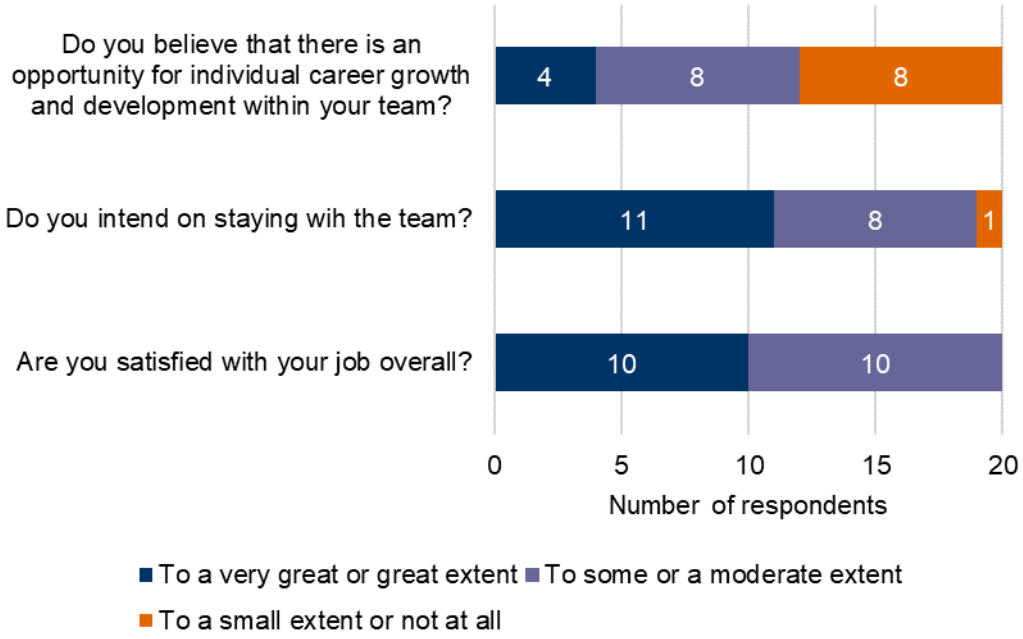


Figure 20 Staff recommendation as a place of work (n=20)

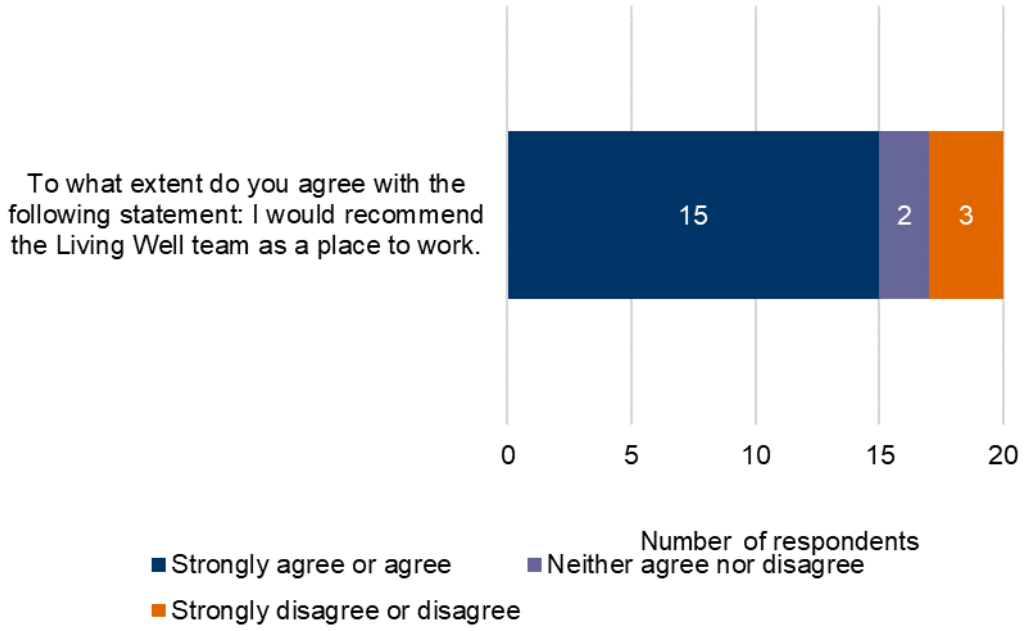
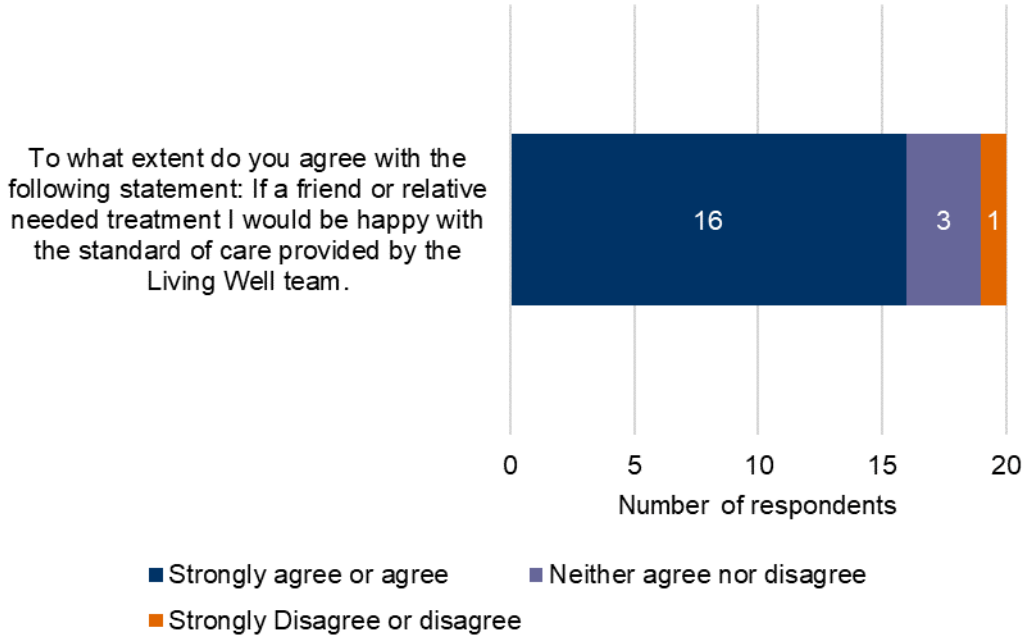


Figure 21 Staff rating of quality of service (n=20)



Outcome 2: *'Working culture is collaborative and trusting' (mixed evidence)*

People have varied views on the extent to which working culture in the NMHT is collaborative and trusting. Overall, there is relatively strong collaboration between individual team members and the different agencies, with Team members working together creatively and flexibly to support people. However, collaboration between some pathways appears to be less embedded.

The evidence indicates that, overall, the culture is collaborative and trusting within the team. However, there are some areas where work to support further collaboration may be required.

Collaboration and trust across most of the team

Overall, stakeholders were proud of how the NMHT had developed a culture of working creatively and compassionately across disciplines to support people in a personalised way. There is a sense that, despite the challenges of bringing multiple organisations and professional groups into one team, there is a growing understanding of the need to work in this way.

> *"[The NMHT model] excites people and it's a sense of hope for things to come. Still, you know, in even more pressured times, we are still able to be innovative and do things differently, are putting the person at the centre of everything […] I think it's definitely shifted people's mindsets around traditional versus more flexible ways of offering support for people. And I think that that has stuck in a lot of spaces."*
>
> Living Life Well stakeholder

> *"Developing good relationships and trying to be creative as a team – this has been a real positive."*
>
> NMHT staff member

Many described the culture within the NMHT team as collaborative, supportive and non-hierarchical, with individual team members and organisations sharing expertise and information and supporting each other.

> *"There isn't any one person you couldn't go to on the team that wouldn't be able to offer advice, professional or otherwise. No matter role or hierarchy, we're all treated equally and supported, and I think that reflects back on to the clients."*
>
> *"People bring cases to the MDT. Other colleagues will contribute suggestions and ideas for how to support people."*
>
> *"There are pathway drop ins so professionals from one pathway can offer support/supervision to other team members."*
>
> NMHT staff members

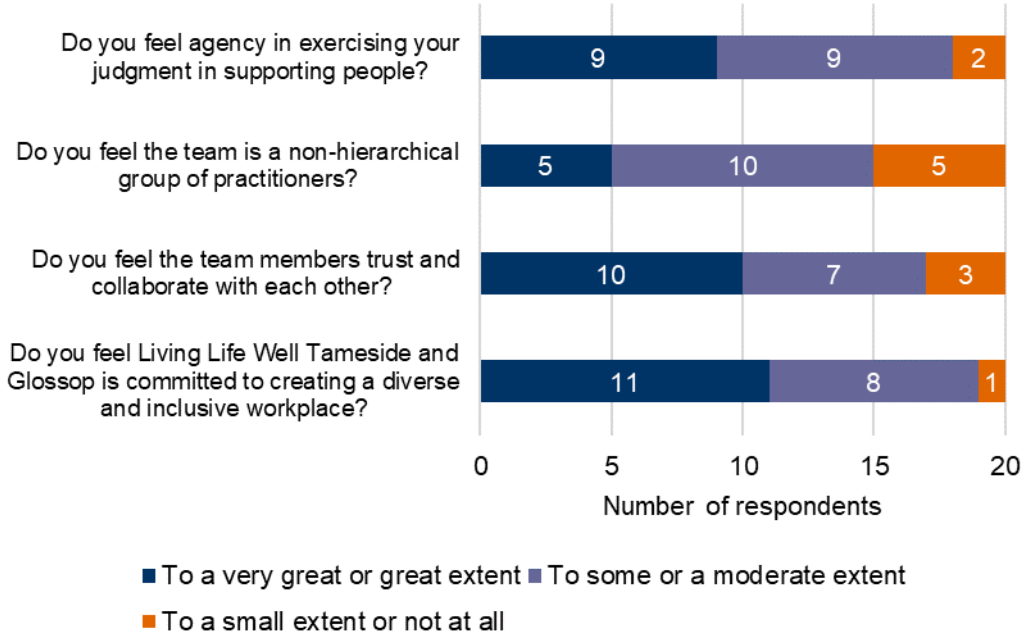
Staff responses to the survey were also relatively positive about the extent of collaboration amongst team members and the extent to which they have agency to exercise their own judgement:

- Half of respondents (10 out of 20) reported that they felt team members trust and collaborate with each other to a very great or great extent, with seven reporting that they felt this to some or a moderate extent. The remaining three reported that they felt this to a small extent or not at all (Figure 22).

- Respondents mostly felt they had agency to exercise their judgement in supporting people. Nine of the 20 respondents reported that they felt agency to a great or very great extent, and a further nine to some or a moderate extent. Two respondents reported that they felt agency only to a small extent or not at all.

Views were more mixed on the extent to which the group is non-hierarchical. Only a quarter of the 20 respondents felt the NMHT is a non-hierarchical group of practitioners to a great or very great extent. Half (10) felt this to some or a moderate extent and the remaining quarter (five) felt it was only non-hierarchical to a small extent or not at all (Figure 22).

Figure 22: Staff views on working culture (n=20)



Collaboration less embedded between some professional groups

However, other stakeholders described how this collaboration was less embedded between some professional groups, and that the cross-disciplinary working was not as strong as it used to be or as strong as they had hoped.

> *"Teams are very much in their pathways now and don't have cross-co-ordination of conversations, so the coaches are all in their coaching world and therapists in the therapists' world, and there is some conversation between people but I don't think it's as strong as it was in the beginning."*
>
> Living Life Well stakeholder

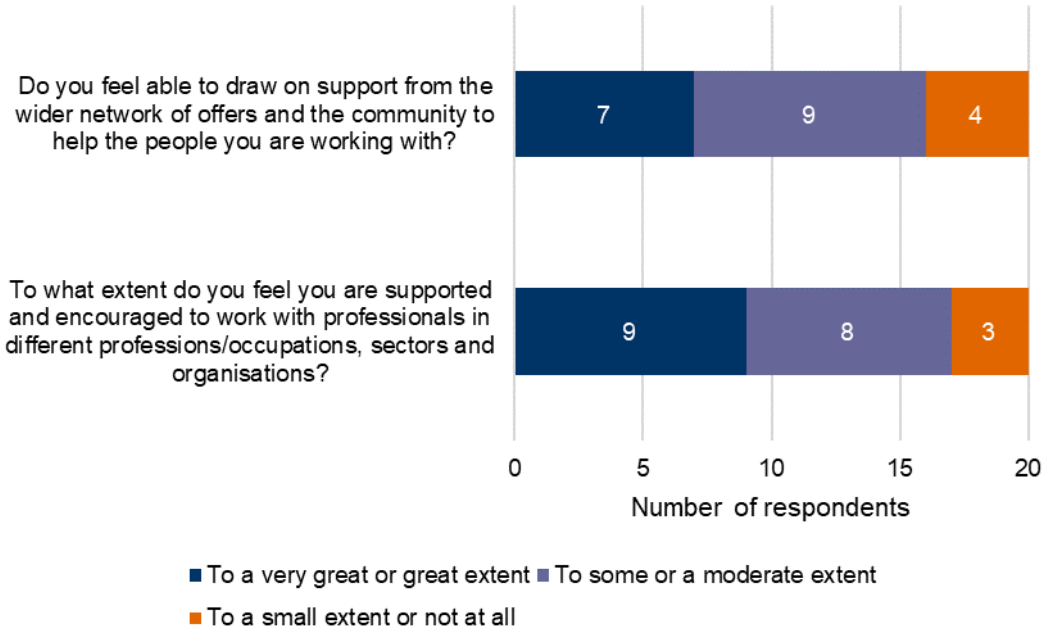
For some, the reduced collaboration has created tension in the service and prevented it from realising its full potential. One or two people suggested that these tensions might stem from some pathways operating under the medical model of mental health (as opposed to social model) and not being aligned with the principles of the Living Life Well model. As a consequence, some staff feel frustrated they are not able to fully deliver the recovery oriented, strengths-based approach set out by the model and believe that they are *"carrying risk alone".*

This is reflected in the staff survey, which shows that staff have mixed views on the extent of multi-agency working:

- Only seven of the 20 respondents felt able to draw on support from the wider network of offers and the community to help the people they are working with to a great or very great extent; whereas nine people felt this to some or a moderate extent and four to a small extent or not at all (Figure 23).

- Nine of the 20 participants reported that they felt they were supported and encouraged to work with different professionals in different professions/occupations, sectors, and organisations to a very great or great extent; and eight felt this to some or a moderate extent. However, three felt this only to a small extent or not at all.

Figure 23: Staff views on multi-agency support (n=20)



3.4.2 Enablers/obstacles to outcomes for staff and volunteers

Positive outcomes for the staff are enabled by:

- The success of Living Life Well for the people using the service.
- The recovery-oriented approach with its focus on putting people at the centre and helping people work towards their own goals in life and connecting with their communities.
- The sharing and development of skills and expertise facilitated by the NMHT's multi-agency, multi-disciplinary approach.

However, staff satisfaction and the extent to which the team has a collaborative and trusting working culture may be limited by the challenges of bringing together different organisations with different working cultures and approaches to mental health. People describe the importance of inclusive and collaborative support and leadership from senior management in addressing this.

This section explores these enablers and obstacles in more detail.

Achieving outcomes for the people they support

Staff have seen the positive impact of the NMHT's approach and how it has helped people whom other services have failed to make important improvements in their lives. This has created a strong sense of staff morale within the team and a belief in their approach.

Recovery oriented approach to support

The NMHT's recovery-oriented approach has been rewarding and *"liberating*" for staff working within the NMHT. Staff value the focus placed on addressing individual people's psychological and social concerns, supporting people towards their own personal goals and helping them to manage and live more fulfilling lives whether or not their symptoms improve. They described this as a very different work experience to other services they may have worked in, which were much more focused on symptom reduction and/or service-defined goals.

> *"It can be quite liberating being part of Living Life Well because it enables me to think I don't need to get this person well and recovered and having a particular outcome score - it can just be about getting people to the point where they are managing things better. How can we help people feel more integrated in the community and in a more holistic way than just specific treatment?"*
>
> NMHT staff member

Sharing and developing skills and expertise

The multi-disciplinary and multi-agency nature of the NMHT creates opportunities for training and sharing expertise that contribute to staff satisfaction and working

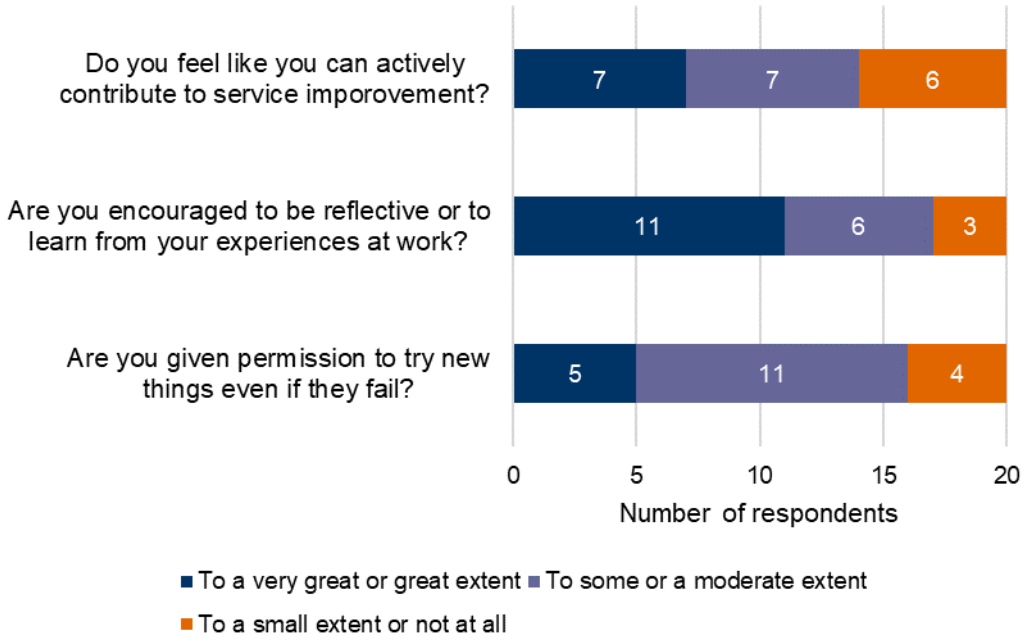
culture, as well as the sense of being able to provide an effective service for people. For example, one stakeholder described upskilling opportunities for peer coaches and peer coaches sharing skills and experience with other team members on innovative ways of engaging with people:

> *"There are great development opportunities through learning from each other. You see peer coaches coming to us with risk formulations, so there is the skilling up of peer coaches for example, but also peer coaches showing other professionals about different ways of doing things and engaging with people and being more flexible."*
>
> NMHT staff member

Responses to the staff survey indicate this is supported by reflective practice and sharing of experiences. Eleven of the 20 respondents felt they were encouraged to a great or very great extent to be reflective or learn from experiences at work, and six felt this to some or a moderate extent. However, three felt they were encouraged to be reflective and learn only to a small extent or not at all (Figure 24).

Yet staff views were much more mixed on the extent to which people felt they were given permission to try new things, even if they fail, with only five of the 20 respondents agreeing to a great or very great extent (Figure 24).

Figure 24 Staff views on development & learning (n=20)



Cultural differences between pathways

Differences in working cultures and approaches to mental health appear to be a barrier to full collaboration between different pathways within the NMHT. Stakeholders identified two ways in which the cultures tend to differ between organisations and individuals:

- Some professional groups within the Team may take a more person-centred approach to support and follow a bio-psycho-social model of mental health, whilst others take a more directive approach and follow a medical model.

> *"[Named pathway] don't seem to have a good understanding of the Living Life Well model or work within the Living Life Well model. I believe that's a lot to do with the leadership being heavily weighted to the medical model as opposed to the bio-psycho-social model of mental health."*
>
> NMHT staff member

- Different staff or professional groups may have different understandings of how best to use resources and share risk and responsibility across the system.

> *"We've got staff who have worked in the system for a while, and they're still stuck in their old ways. […] They used to be the gatekeepers of mental health services, protecting the specialist support for people who need it. […] We're having to still work with them to say no, it's all of our business. […] People have not grasped it is a whole system of support."*
>
> Living Life Well stakeholder

However, others felt that initial challenges had now been resolved.

> *"It was difficult when you first brought people together to collaborate […] some Pennine Care staff who were clinicians maybe struggled a bit with the change […] there were a few missed opportunities to change the culture of an organisation when they first started with the NMHT. As it developed those people left and new people came in – it's now in a good place."*
>
> Living Life Well stakeholder

Changing organisational cultures and ways of working inevitably takes time. While progress appears to have been neither straight forward nor linear for Living Life Well, the insight gathered for the evaluation suggests that some progress towards a shared culture has been made in this regard, but that some differences in approach remain.

Capacity

Stakeholders described how some pathways and team members were incredibly busy and suggested that they might lack capacity to work in innovative and collaborative ways. They described the challenge of ensuring they get the support they need from other pathways and how they struggled to *"find a middle ground where none of us feels overwhelmed by our workload".*

The need for collaborative and supportive leadership

The NMHT staff tend to feel very well supported and encouraged by their pathway managers and within their own pathway teams. However, some described how they were reluctant to approach some of their colleagues because they felt as if senior staff from other pathways were dismissive and they wanted more support and co-operation with them. Some reported that that they had raised their concerns about the challenges of collaborating with colleagues from other pathways but felt their concerns had not been addressed or acknowledged.

3.5 Outcomes for the local system

3.5.1 Evidence in key outcome areas

Outcome area 1: *Impact on other services (no evidence)*

The system data analysed by the evaluation shows no evidence of impact on referrals to or waiting lists for community mental health teams, mental health liaison or Healthy Minds (IAPT), or primary care prescription costs.

There is no quantitative evidence of impact on other services. In summary:

- Since 2016/17 there has been considerable fluctuation in the number of referrals to community mental health teams, mental health liaison. However, there has been no clear change in trajectories since the introduction of the NMHT in May 2019 (Figure 25).
- Waiting times for IAPT have been improving since our data time series begins in 2016-17. However, there is no clear relationship with the start of Living Life Well, and much of the improvement took place prior to the introduction of the NMHT.[40]

[40] We understand that any reduction in waiting times for psychological therapy was expected to relate to the step 3.5 therapy, which was part of the IAPT offer prior to Living Life Well and has since been integrated into the NMHT. However, it has not been possible isolate the waiting times for step 3.5 therapy from the other therapy steps within IAPT.

- There is no discernible relationship between primary care prescription costs for common mental health disorders and Living Life Well. [41]

See section 3 in the data appendix for more information.

While there is no evidence of impact on other services at the system level, the qualitative interviews indicate that the NMHT is enabling some people they support to rely less on A&E or their GP because they are better able to self-manage their conditions and because they know they can contact the NMHT for support if they need.

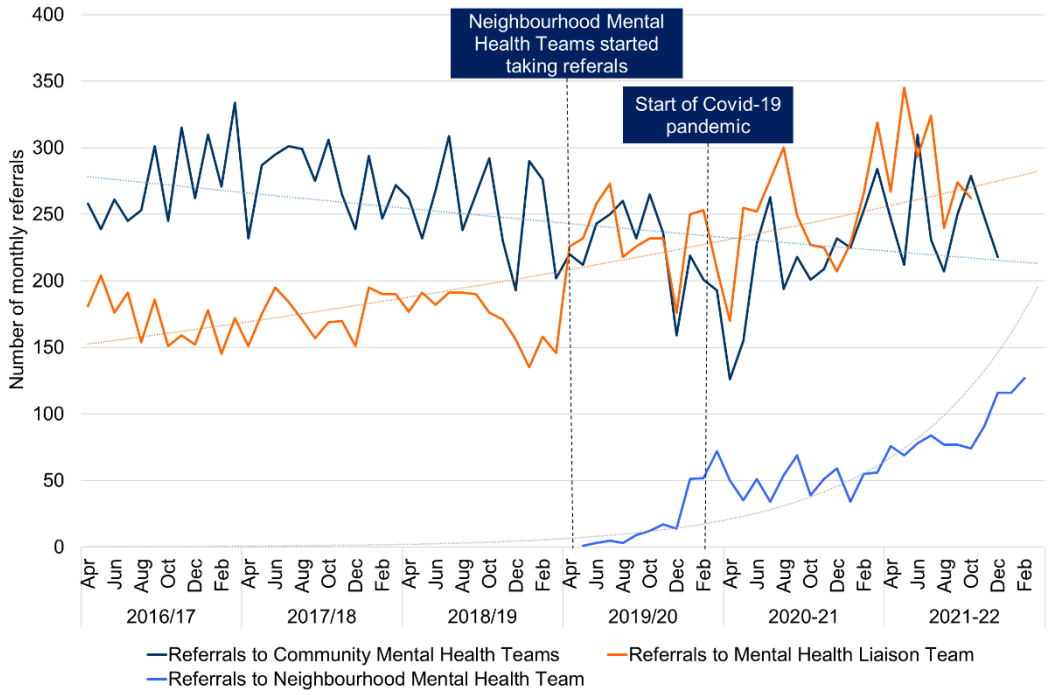
> *"There's an example of someone who was using all sorts of services and going to A&E twice a week who is now in work – it's massive."*
>
> Living Life Well stakeholder

Others may continue to access support elsewhere – and indeed may even be encouraged or supported by the NMHT to access new support to help address their needs.

> *"Even those groups we say we struggle to achieve outcomes for, but we are seeing improvements for them all the same - increase in trust, reduced A&E attendances, better engagement with services and engaging with us in a different way."*
>
> *"There is a relief in the system - for some people they are getting an offer they didn't have before and won't need to go to GP anymore. But for others they will still go to GP, because that's what they know and like to do. But GPs at least now know that we exist and come to us to help them think about how to support those individuals."*
>
> Living Life Well stakeholders

[41] Quantitative data on primary care demand was not available. We had planned to conduct a small data study using primary care data but agreed in March 2022 that it was not proportionate or feasible to pursue this data due to pressures in primary care.

Figure 25 Monthly referrals to Community Mental Health Teams, Mental Health Liaison Team and Neighbourhood Mental Health Teams 2016/17 to 2021/22 (data available up to February 2022)



***Outcome area 2**: People getting the right help, in the right place (some evidence)*

There is evidence that Living Life Well is helping to ensure more people are getting help. The evidence on whether more people may be getting the right help in the right place is more mixed.

The NMHT is helping to ensure more people are getting help and that fewer people are referred for support without receiving any service offer. The NMHT meets a gap in provision in Tameside and Glossop by supporting people who do not meet the criteria for secondary care mental health and whose needs are greater, or more complex, than IAPT can support. Since its inception, the NMHT had supported 1,553 people up to 3rd March 2022 – people who would otherwise be without any appropriate support from statutory mental health services.

> *"Previously the rest of the referrals to CMHT [other than those accepted] were just getting a "no", but now we can take people on. If we weren't here they would just be sitting on the caseload of the Access Team[42] but without the Access Team being able to do anything with them […] they were just getting stuck with all these people who didn't have anywhere to go. Now the Access Team is part*

[42] The team who, prior to Living Life Well, triaged all mental health referrals coming into secondary care and directed people to Healthy Minds (IAPT service) where necessary.

> *of the Open Door – there are more staff [in the new team] and now there's actually an option for all these people who fall between primary and secondary care."*
>
> NMHT staff member

> *"There is an active caseload of 500 plus people that are being supported. So I absolutely will always stand by the fact that we are providing something for people that were getting nothing."*
>
> Living Life Well stakeholder

The NMHT is supporting people who would likely also be without support from wider community organisations or networks. Most of the people we spoke to were not accessing any wider support in the community. Many felt alone and did not have family or friends to help support them. Others felt that their families were not equipped or the most suitable people to offer them support. Without the NMHT they felt that they may not have received any other support for their mental health at all.

> *"If I hadn't had that [the support from the NMHT] I wouldn't have had much support at all."*
>
> *"I've got family but they are in Plymouth and Yorkshire so I was on my own. That's one of the reasons this support was so significant."*
>
> People supported by the NMHT

Living Life Well may also be helping to ensure people are getting the right help and in the right place, but the evidence is more mixed here. Stakeholders described how they understood the Open Door and the NMHT to have enabled more people to be referred to the correct part of the pathway.[43] This is because the Open Door triages all mental health referrals and in theory ensures people are navigated to the most appropriate service.

> *"In the past, each individual mental health organisation whether statutory or voluntary required an individual referral. So, you could make four or five different referrals and see who accepted."*
>
> Living Life Well stakeholder

However, others suggested that the Open Door may not yet be fully working as intended, meaning that people were still being referred to the NMHT who would be better supported elsewhere in the system, and that there is no system-wide "no wrong" door approach.

[43] The data appendix includes trend data on the number of CMHT referrals accepted and rejected. However, we do not have data preceding the start of Living Life Well and are therefore not able to comment on whether this has changed since the introduction of Living Life Well.

"There's been a risk of people just referring to us as we are a new service, we still have our own criteria and there are other services that are more appropriate – there needs to be more work done around the boundaries of our criteria."

NMHT staff member

"The concept or main principle should be no wrong door - wherever you turn up, it might not be right service but the idea is that they would help you to access right support […] and that hasn't happened."

Living Life Well stakeholder

3.5.2 Enablers/obstacles to achieving outcomes for the local system

The key barriers to Living Life Well making system-wide impacts are the limited capacity of the NMHT, the high level of demand on service and wider changes across the local system. Any potential impact of Living Life Well cannot be isolated from the impact of these factors.

High level of demand

There are many other pressures contributing to an increasing demand on services across Tameside and Glossop, such as the impact of Covid-19. These will be countering any positive influence Living Life Well might be having on demand for other services.

"I'm sure the NMHT has had a big impact on people in the borough, but at the minute it's difficult for me to say whether it's made an impact on the referrals to CMHT– we're in the middle of a mental health pandemic."

Living Life Well stakeholder

"Things have changed dramatically in the last two years. People are less accessible than they were previously. It's very hard for our clients to even get access to their GP and a lot of the time people will just give up. So some people you can clearly see they might benefit from further testing or medication - but we can't get appointments for them to get any of this ruled out by GPs."

NMHT staff member

Limited capacity

In the face of this high demand, the limited capacity of the NMHT again limits its ability to make much impact on demand elsewhere in the system.

> *"It is achieving some positive outcomes but capacity is the biggest issue. The number of people versus services - there's more demand than capacity."*
>
> Living Life Well stakeholder

Wider changes across the system

Other changes in the service landscape were also underway over the course of the evaluation period, which will also have impacted on demand patterns.

> *"There has been lots of change! There have been so many changes over the last two years – continuing changes, and CMHT is now at the start of massive transformation."*
>
> Living Life Well stakeholder

4 Implementation of the model

4.1 Overview

This section discusses successes and enablers to Living Life Well's implementation so far: involving people with lived experience, reaching people who would otherwise be without support, and improved relationships and collaboration between organisations in the NMHT.

It then discusses the key challenges with implementation: Covid-19, information sharing and communication, the need for collaborative and inclusive leadership, and waiting lists.

4.2 Successes/enablers to implementation

4.2.1 Involving people with lived experience

The involvement of people with lived experience of accessing mental health services in the design and the delivery of Living Life Well is a key success.

Co-producing Living Life Well

People with lived experience were involved in co-producing what the new service would look like and creating the tools that the NMHT use to support people. This includes the Initial Conversation and My Story tools, which stakeholders believe to be key to the model's success, and which people using the service reported made them feel heard. Leadership from commissioners was a key enabling factor for co-production in the design phase.

> *"They [commissioners] felt strongly that people with lived experience should be involved. People who were going to benefit should be a part of developing the services. They were determined it was going to happen and that came across strongly."*
>
> Living Life Well stakeholder

Overall, stakeholders felt that the general culture across Tameside and Glossop values the voice of people with lived experience, and that there is a willingness to incorporate this in local work.

> *"The general culture in Tameside and Glossop versus Greater Manchester is that the willingness to incorporate lived experience volunteers and service users is absolutely there and the desire is there. In practical terms, it's not been so straightforward because of Covid."*
>
> Living Life Well stakeholder

However, progress has not been linear. Some stakeholders felt that the involvement of people with lived experience in Living Life Well had decreased

since the initial design phase. They understood this to be in part due to Covid-19 – moving activities online had posed a barrier to some being involved, and there were fewer volunteering opportunities available – and in part due to the decreased involvement of the Innovation Unit, who had been championing coproduction.

> *"The voice of lived experience. That's kind of fallen off a little bit in terms of bringing people into our forums to support, be a critical friend, etc. That hasn't been maintained."*

> *"When Innovation Unit were involved, it didn't matter what the leaders wanted because there was someone there that enabled you to have that voice. [Lived experience] need an advocate in meetings, e.g. the Innovation Unit can put a hand up and say - can you explain this acronym. It's an organisation more authorised to do it and makes a massive difference. Without them you just feel that they'll forget to invite you to next meeting."*

Living Life Well stakeholders

Involving people in shaping their own support

People accessing the NMHT are involved in shaping their own support so that they are supported on the issues that matter most to them and in a way that works for them.

> *"Speak to the people who want support and ask what they want. Put the person at the forefront."*

Living Life Well stakeholder

This is discussed in more detail in sections 2.3.3 and 3.3.1.

Delivering support as peers

People with lived experience are also involved in delivering the NMHT's support as peers. Peer support coaching is a core part of the NMHT's offer (see section 2.3.3). Stakeholders described a shift in attitude towards valuing the involvement of people with lived experience in delivering support.

> *"At the start, people thought if we include this lot it's going to take three times as long. But I think there's been a shift – teams like the NMHT are using peer support more, and they absolutely understand and see the benefit of that, and respect for that sector is growing."*

Living Life Well stakeholder

4.2.2 Reaching people who would otherwise be without support

This was highlighted as a key success of Living Life Well. See section 3.5.1 for more detail.

4.2.3 Improved relationships and collaboration between organisations

Despite the challenges relating to the separate pathways within the NMHT, as discussed in section 3.4.2, stakeholders identified the improved relationships and partnership working between different partner organisations in Tameside and Glossop as a key success. This was particularly notable in relation to the inclusion of and greater parity accorded to organisations from the voluntary and community sector, who had been involved in the design stage and were now part of a commissioned offer in Tameside and Glossop. There was a sense that *"getting people round the table"* in the design process had *"levelled up"* the mental health system in Tameside and Glossop.

> *"There is still a way to go as we are all competing for same funds but a massive success is embedding VCSE offer into the service offer. In all the conversations I'm having, there's absolutely a recognition that the VCSE sector has a big part to play. In Tameside they have done some brilliant work in making us feel a part."*
>
> Living Life Well stakeholder

Stakeholders also suggested that the relationship between the NMHT and Healthy Minds was strong.

4.3 Challenges with implementation

4.3.1 Restricted activity due to Covid-19

Covid-19 presented significant barriers to the implementation of Living Life Well. Below we discuss two key areas of limited implementation.

Restrictions to in-person working

Due to social distancing requirements during the Covid-19 pandemic, the NMHT pivoted to providing support over the phone or virtually for much of the evaluation period, unless there was a direct concern that had to be addressed in-person.

Most of the people consulted who had been supported by the NMHT did not feel their experience or outcomes had been negatively affected by receiving most of their support remotely. Some people chose to continue meeting remotely once the social distancing restrictions were lifted. However, for others, face-to-face support was preferable.

However, stakeholders felt that remote working had been a barrier to the development of strong working relationships within the NMHT. This had impacted organisations' ability to work collaboratively and reduced the speed at which they could develop a shared culture.

> *"Covid had a big impact. Collaboration across different parts of the Living Life Well system haven't worked well as initially intended. It's made us more distant."*

> *"The huddle that we talk about a lot in Lambeth - the way every day the team gets together in a huddle to kind of review people – that's not necessarily happening."*
>
> Living Life Well stakeholders

Restricted "in the community" support

Support from the NMHT was originally intended to take place within community settings as well as clinical settings, with the aim of reducing stigma, reaching people who may not have otherwise accessed support, and making it easy for people to see the Team. Prior to the pandemic, the Living Life Well prototyping phase involved securing community venues to conduct support sessions – such as in supermarkets, above charity shops in a town centre and Mind's Topaz Café – but pandemic-related closures and social distancing restrictions limited the extent to which the Team could use these community venues.

The pandemic also posed barriers to the NMHT linking people into the wider Living Life Well community; community groups were not meeting, and venues were closed. This impacted the peer coaching pathway the most acutely.

> *"The pathway hit the hardest with the change was the peer coaching pathway as this was very much to do with getting out and about - doing walk and talks, going to local cafes. Because the nature of peer coaching is about getting people into communities and community groups, that had to stop because groups themselves closed down."*
>
> Living Life Well stakeholder

Unexpected benefits

The pandemic brought unexpected positives in terms of the new ways of working the service had been forced to adopt. Covid-19 restrictions led to innovation in the NMHT's practice, for example offering more flexible support online or over the phone.

> *"Although ultimately our goal is to integrate people into the community, so we do want to get people outside, we can work more flexibly now and some clients have appointments over Teams."*
>
> Living Life Well stakeholder

These innovations were so successful that they will be continued even when no longer required for reasons relating to the pandemic.

4.3.2 Information sharing and communication with the wider Living Life Well system

Stakeholders identified three areas where poor communication has been a barrier to the full implementation of the Living Life Well model.

Unclear referral pathways

Despite the Open Door referral and triage system for all mental health referrals, stakeholders outside of the NMHT appear to be confused about the process of accessing the Team.

> *"The narrative on the ground still is that people aren't sure where to go for support."*
>
> *"It's difficult, confusing. We've got so many different forms of communication, phone numbers. If you go to the web page to access support there's no straight forward way."*
>
> Living Life Well stakeholders

Unclear support offer

Stakeholders outside of the NMHT described being unclear about exactly what the NMHT offers and who it is for.

> *"I don't think it's a bad model but it's not clear enough outside of that service to know what the offer is - if we're referring on what's happening to patients, what's the support? We hear about peer coaches and we're not sure what they do."*
>
> Living Life Well stakeholders

This makes it hard for partners outside of the NMHT to make good judgements about when to refer people to the Open Door for support from the NMHT. It also makes it difficult for them to provide accurate information to the people they are referring into the NMHT.

This is supported by insight from interviews with people supported by the NMHT. Many of the people consulted were not aware of what the NMHT could offer before they started support, and some described feeling *"nervous"* or "*wary"* prior to their Initial Conversation because they did not know what it would entail.

Need for more communication of and access to information on referral outcomes and support plans.

Improvements to the sharing of information with referral partners may help to increase collaboration with wider system partners and better integrate the NMHT into the wider system. Stakeholders who have referred their patients or service users into the Open Door reported that they received no communication about the receipt or outcome of their referral.

> *"When you send a referral in you should get acknowledgement it's been received. This could reduce the number of phone calls to the Neighbourhood Mental Health Team - this could be why they're getting the volume of calls they're getting."*
>
> Living Life Well stakeholder

Stakeholders highlighted that the NMHT uses the Big Life Group's data system (as opposed to NHS systems used by secondary care or primary care), which they are unable to access. This poses challenges to providing appropriate support to people outside of the NMHT. For example, if a person being supported by the NMHT presents at A&E, the liaison team need to call the NMHT to establish what support the person has been accessing. This is only possible during 9am to 5pm, Monday to Friday (NMHT working hours) and one stakeholder also reported that it is not clear whether the NMHT can share information with them.

> *"People are turning up at A&E who have been supported by the NMHT but we have no idea what support they are getting – this causes a problem, this impacts on our decision making […] When we've phoned up in hours from [service] we have also sometimes been told they can't share information, but sometimes they do – it's not clear."*
>
> Living Life Well stakeholder

4.3.3 The importance of collaborative, inclusive and strong leadership

Some Living Life Well stakeholders felt that stronger overarching strategic leadership during the Covid-19 pandemic could have helped to address some of the implementation challenges and better consolidate the elements of the Living Life Well model that currently feel a "work in progress", i.e. delivering a more robust information sharing processes, a more cohesive sense of inclusion from all Living Life Well partners including those external to the NMHT, better clarity on referral routes, and a more unified NMHT culture.

> *"We've lost the strong sense of someone pulling us together and us all feeling we're equal parts."*
>
> Living Life Well stakeholder

There were mixed opinions about the role of commissioners. Some stakeholders suggested that the commissioners had played a key role in the success of the Living Life Well model. However, others felt that there had not been enough transparency from the commissioners, and they wanted more openness and communication.

4.3.4 Waiting lists for the NMHT and for the wider community

There are now waiting lists for the NMHT pathways and for many other partner organisations in the wider Living Life Well network. Stakeholders described three inter-related causes of the waiting lists: staffing shortages and high staff turnover across the NHS, including the NMHT; demand outstripping capacity; and the increasing needs of people accessing support, in part due to the Covid-19 pandemic.

As a result, people are now waiting longer than originally anticipated for some of the NMHT support pathways and fewer options are available for linking people into wider support or other services, either as part of their support plan with

NMHT or as part of their step-down plan. This in turn means some people will stay on the NMHT caseload for longer than 12 weeks if there is no alternative suitable support available for them.

> *"Demand in all of our system is increasing, so there are waiting times and there's a national issue around staffing, so it won't be a surprise that vacancies are in a lot of our services. So that impacts what we can deliver."*
>
> Living Life Well stakeholders

5 Conclusion and recommendations

5.1 Overview

In this section we summarise the strength of evidence for each of the key outcome areas, discuss the evaluation's key findings and provide recommendations on the development of Living Life Well and future data collection.

5.2 Key findings summary and discussion

Over the course of this report's evaluation period, the NMHT has supported 1,553 people who previously would not have had access to a suitable service for their mental health and related issues. **Providing support for this group of previously under-served people is a key success of Living Life Well.**

There are some limitations to the data available to the evaluation. Valid outcomes data was only available for a relatively small proportion of the total number of people supported and for a sample skewed towards people who had a positive ending to support.[44] However, the broadly positive findings from the outcomes data are largely corroborated by evidence from the small number of people we interviewed who had been supported by the NMHT (seven) and who were involved in designing, delivering and commissioning Living Life Well (ten).

There is some evidence that the NMHT is helping people make positive steps towards recovery and experiencing improved quality of life. The people on whom we have data experienced an improvement in recovery and quality of life, with a statistically significant increase in mean ReQoL score from 11.6 at the earliest available data point to 19.2 at the most recently available (n=385). 58% of the same group saw a reliable improvement in their recovery and quality of life based on this measure. People are also taking steps towards their personal goals, with 82% of the people on whom we have data making progress on at least one goal and 57% making progress on at least two goals (n=282).

There is also some evidence of positive progress for people in relation to other key outcome areas identified for Living Life Well – i.e. that people feel connected and have positive relationships; that people are able to learn, work and volunteer; and that they have choice and control over the management of their own mental health. However, the evidence is less strong here. Evidence on whether people know their own goals in life or have a greater sense that their life has purpose

[44] Valid data on a small proportion of the population: 25% of the 1,553 people supported had paired ReQoL data enabling analysis of change over time, 18% of people had paired personal goals and Questions About Your Life data, and 12% had a completed ESQ. Sample skewed towards those with positive endings: paired ReQoL data was available for 45% of people with a planned end to support but only 11% of people with an unplanned ending or other type of ending.

and meaning is more limited; further research would be required to understand whether these outcomes are being achieved.

Importantly, the evidence indicates that the **Living Life Well approach is well liked by both staff and the people accessing the NMHT**, and that they judge the NMHT's support to be good quality and person-centred. 92% of the people supported by the team on whom we have data said they would recommend the support to a friend (n=192) and 80% of staff said they would be happy with the standard of care provided if a friend or relative needed treatment (n=20). Based on responses to the 2021 NHS staff survey, this compares favourably to both the NHS nationally and to Pennine Care NHS Trust where 68% and 61% of respondents respectively said they would be happy with the standard of care.[45]

People described the following features of the support as particularly helpful: building relationships with caring and supporting staff, the recovery-focussed support provided by the Team, the tools and techniques the Team showed them for managing their emotions and mental health, and being able to access support on wider social issues from the Team and the wider Living Life Well community. Speaking to friends and family and building wider support networks have also been important enabling factors for some, but many of the people we spoke to did not have such networks and had felt alone in their worries until they were put in touch with the NMHT.

There is also some evidence of positive staff outcomes, although there are some important challenges here. Overall, staff are satisfied in their work. 15 out of 20 participants (75%) would recommend the NMHT as a place to work. Again, this compares favourably with both the NHS nationally (60% of respondents would recommend) and Pennine Care NHS Trust (59%) based on the 2021 NHS Staff Survey.[46]

However, staff views on the extent of collaboration, trust, and multi-agency working were more mixed. While the NMHT appears to be more collaborative than previous or alternative models of support, this collaboration is less embedded between some pathways – delivery of support via separate discipline-specific pathways may be a contributing barrier to full collaboration and creating a unified culture across the NMHT. The NMHT appear to be delivering effective work despite these challenges, but the challenges are negatively impacting on outcomes for some staff.

Evidence of impact on the local health and social care system is limited so far. This is in part due to the volatile and complex system in which Living Life Well is operating, and the impact of Covid-19 on both demand and capacity. High levels of demand across the system, limited capacity of the NMHT and other services to meet this demand and the wider structural changes taking place

[45] NHS (2021) NHS Staff Survey Interactive Results. Available at: Interactive results and dashboards | NHS Staff Survey (nhsstaffsurveys.com) [Accessed 11/04/22]

[46] NHS (2021) NHS Staff Survey Interactive Results. Available at: Interactive results and dashboards | NHS Staff Survey (nhsstaffsurveys.com) [Accessed 11/04/22]

across Tameside and Glossop all mean that it is difficult for Living Life Well to make an impact on other services. For the same reasons it is also challenging to attribute any identified changes in demand or waiting times to Living Life Well.

However, one important area where we can be confident that Living Life Well is making a positive impact is that there is a group of people who previously were not able to access support – because they did not meet eligibility thresholds for secondary care but were also regarded as too "complex" for primary care – who do now receive help. The Open Door is also likely contributing to other positive outcomes for people and for the system, by ensuring more people across the system are navigated to the right service and providing advice and support to organisations in the wider Living Life Well network. The evaluation has not gathered sufficient evidence on this outcome area to draw any conclusions in relation to this – although during the report reviewing process partners have described this as an important outcome area where meaningful progress has been made.

Overall, despite implementation challenges, Living Life Well is successfully addressing a long-standing gap in support and is helping to achieve some positive outcomes, primarily for the people supported by the NMHT. It has created a flexible and recovery-focussed service that is supporting people on the issues that matter most to them through the NMHT staff team as well as by connecting people into wider resources in the local community – although implementation of the latter is less progressed.

Looking forwards, the challenge for Living Life Well will be to address the implementation barriers identified in this report and further embed the NMHT and wider Living Life Well approach into the Tameside and Glossop system and community. This will help ensure the model is fully implemented and maximise its contribution towards wider systems change across Tameside and Glossop.

Figure 26 provides a summary of the strength of evidence for each evaluation outcome area that was agreed with Innovation Unit and the Living Life Well team.

Figure 26 Strength of evidence for each outcome

Outcomes		Evidence rating
For people accessing the NMHT		
a)	People are recovering and experiencing improved quality of life	Positive evidence
b)	People feel connected and have positive relationships	Some evidence
c)	People feel able to learn, work and volunteer	Some evidence
d)	People know their own goals in life	Limited evidence
e)	People receive good quality, person-centred help and support.	Positive evidence
f)	People have choice and control over management of their own mental health.	Some evidence
g)	People have a greater sense that their life has purpose and meaning	Limited evidence
For staff working in the local system		
a)	Staff and volunteers are satisfied in their work	Positive evidence
b)	Working culture is collaborative and trusting	Mixed evidence
For the local system		
a)	Fewer referrals to community mental health teams (CMHT)	No evidence
b)	Fewer referrals to mental health liaison	No evidence
c)	Reduced demand in primary care	No evidence
d)	Reduction in numbers of people who are referred but then do not receive any service	Positive evidence
e)	Reduction in waiting times for psychological therapies	No evidence
f)	Reduction in prescribing costs in primary care for common mental health disorders	No evidence
g)	More people getting the right help/getting help in the right place	Some evidence
h)	Greater integration of support for individuals to provide holistic support across different disciplines and organisations, with greater collaboration between professionals	Mixed evidence

5.3 Recommendations

5.3.1 Recommendations for development of Living Life Well and the NMHT

Below we provide recommendations based on the evidence available to the evaluation, which we believe may help further develop Living Life Well. Some of these recommendations have been suggested by Living Life Well stakeholders and we understand that some of the suggested actions are already underway. We hope it is useful to have them gathered in one place.

Figure 27: Recommendations for development of Living Life Well and the NMHT

Recommendation	Section
Continue to include people with lived experience in the development, review and governance of the service. Their involvement to date has been a key feature of Living Life Well's success, but involvement has been less strong recently. This could involve a forum for people who are using or have used the NMHT, including lived experience representatives (in addition to peer workers) at meetings about governance, recruitment, reviewing or developing the service, and / or through commissioning a user/peer- led organisation to input to this process.	4.2.1
Continue to value and develop the elements of the support that people say they like and find useful, i.e. staff being caring and non-judgemental, support that is tailored to them and focuses on their personal goals, having a say over what their support looks like, and accessing support on the wider issues that might be affecting their mental wellbeing.	3.3.2
Consider how to make the NMHT more accessible to men, older people and people from Asian backgrounds, who are currently under-represented amongst the people supported by the Team. Continue to monitor and review access demographics.	2.4 Appendix
Focus on building a shared, collaborative culture and values within the whole NMHT. Leaders should: • **Communicate a clear vision** for Living Life Well based on the co-production already carried out and work collaboratively with the Team to address any differences in working cultures or divisions. • **Ensure there is clarity around the roles of different professions / groups within the team.** Leaders may also wish to consider whether having separate pathways within the Team is posing a barrier to developing an inclusive, collaborative culture across all professional groups within the Team.	3.4.1 3.4.2

Recommendation	Section
Review the Living Life Well outcomes. Several outcomes had limited evidence or less clear relevance to the work of Living Life Well. The report review process has also identified some key outcomes – such as the benefits associated directly with the work of the Open Door – that were not included in the framework for this evaluation, and therefore have not been considered in this report. Reviewing the intended outcomes to make sure that they are focused on Living Life Well's key objectives can help strengthen shared understanding of Living Life Well and ensure the focus is on what matters most. It will also help ensure that any future evaluation activities focus on Living Life Well's most important intended outcomes.	1.4 1.5.2 5.2
Improve information sharing about people using the service with the wider NHS system. There are two key areas of development: • **Ensure key information about people supported by the NMHT can be shared with/accessed by other health partners,** such as the mental health liaison team, including out-of-hours to reduce the possibility of serious untoward incidents. This could involve developing a system for sharing information out-of-hours, recording information on the NHS system instead, or putting summary information such as care plans, risk assessments and key letters on both the NHS and NMHT systems. • **Communicate with referrers such as GPs to confirm when a referral has been received** and provide updates on progress where appropriate and as a minimum, when people end support with the team.	4.3.2
Improve communication about the service. This would involve clarifying and publicising amongst potential partners including referrers: a) who the NMHT supports, b) the NMHT service offer, c) referral pathways into the NMHT, d) how the NMHT aims to work in partnership with other services to support people, and e) publicise what the NMHT has achieved and the positive difference it has made to the lives of the people it has seen. Raising awareness on these points should help improve partnership working with other organisations such as GPs and primary care networks and integrate the NMHT into the local system. Discussions with potential partners about any concerns or misunderstandings are also likely to be helpful.	4.3.2
Focus on integrating the NMHT into local communities and working with the wider network and community. This should involve:	3.3.2 4.3.1

Recommendation	Section
• **Agreeing access to more community venues** for the Team to deliver support sessions and drop-ins. We understand the Living Life Well team are already planning action in this regard. • **Build relationships with more partner organisations to provide joined-up support on the issues that matter most to people**. In particular, we recommend a focus on relationships with housing services and housing providers, since there is no housing specialism within the team yet it is an area of concern for many people, and with organisations in Glossop, where we understand relationships are currently less developed.	
Work with wider partners to create a more collaborative, flexible and recovery oriented system of support. More extensive change, beyond the NMHT and its partner organisations, is required to create a truly effective Living Well system across the whole Tameside and Glossop. Through sharing its successes and working with partners, Living Life Well can contribute to changing the wider system too.	5.2

5.3.2 Recommendations for on-going evaluation data collection

The size of the person-level dataset has almost doubled from our previous report in August 2021. 1,553 people were supported by the NMHT during this report's analysis period, compared with 937 people in the August 2021 report. We know that gathering this data is not easy, so thank you to the NMHT staff for their efforts with this. It is important the team continues to collect data to help understand its impact once the external evaluation has concluded. We have suggested the below recommendations to continue improvements in this.

Figure 28 Recommendations for on-going evaluation data collection

Recommendation	Section
Continue focus on using routine outcomes data. The amount of outcomes data available is encouraging, as this is important in helping people see the improvements they are making in their lives and enabling the Team and commissioners to see the good work the Team is doing. However, the proportion of people for whom we have paired data has decreased since the last report, indicating a drop off in data collection in recent months.	1.5.2 Appendix
Improve spread of outcomes data. Paired outcomes data is skewed towards people who had a planned exit from support. It is far more challenging to collect outcomes data from people who have disengaged from support, but continuing efforts towards this	1.5.2 Appendix

Recommendation	Section
and making sure to collect data on reasons for support ending wherever possible will make future evaluation findings more robust. In particular it may be helpful to learn whether unplanned exits are due to dissatisfaction with the service or because people's lives have improved and they no longer need the service. Living Life Well may therefore wish to prioritise gathering the experience data (ESQ) and where possible arrange an ending meeting with people who have unplanned exits "*to help us understand why you are leaving and how we could improve the service"*.	
Gather feedback about the programme co-design process from the people with lived experience who were involved. This could be via qualitative consultation or more co-productive research methods. They were not included in the qualitative interviews conducted as part of this evaluation. This report has therefore not been able to provide any insight on how they experienced the process, what worked well and how it could be improved.	1.5.2

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