FINAL

Innovation Unit

Living Well summary report

November 2022

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Key findings

1. **Living Well aims to work across the mental health system** with the explicit aim of harnessing and amplifying collective effort in new multi-disciplinary ways, rather than focusing on improvements to different discrete *parts* (services, pathways etc) of the system. **Distinctive features** of the Living Well model include: working with people who may not fit traditional criteria for accessing services; an 'easy in easy out' approach, with the ability to self-refer and to return to the service if necessary; flexible, person-centred support from a core multi-disciplinary team; a wider network of services and groups offering practical and emotional support; a strengths-based, recovery focused approach to supporting people; support for people to achieve their own goals, and onward referral to appropriate support.

2. Living Well has **filled a gap in support for people who fall between primary care and secondary mental health services**, breaking the cycle of people 'bouncing' around the system, presenting at multiple different services but not getting help until their mental health needs had escalated.

3. There is good evidence that the **recovery-focused Living Well approach supports people to make progress towards improved mental health and quality of life**. People have also been supported to achieve **wider life goals**.

4. In each site, activity data collected by Living Well services highlighted the **breadth of the support offer** from the multidisciplinary team, and also the wider variety of support to which Living Well services connect people. As a result, Living Well has been successful in **supporting people to make practical improvements** in their lives, such as returning to or gaining employment, claiming benefits, improving their housing situation or making social connections.

5. People who accessed Living Well were able to exercise **personal choice and control** in terms of the care and support they received, with the exact nature of support being tailored to individual needs and preferences and going at the pace that people wanted.

6. By applying a methodology for calculating an increase or decrease in quality adjusted life years (QALYs) for people who completed the Recovering Quality of Life (ReQoL) measure, we found that, on average, **people experienced an increase of 0.13 QALYs**. The estimated cost of achieving this increase is between £800 and £1,160 per person per year – below the recommended costs NICE apply to determine the cost-effectiveness of interventions. This is a useful benchmark when considering the future development of Living Well in other areas.

7. Staff employed in the core Living Well delivery team experience **high levels of satisfaction**. There is evidence across all three sites of a positive and collaborative working environment.

8. **Key enablers of positive staff outcomes** are the success of Living Well teams 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.

9. There have been **challenges in bringing together a collaborative, multi-agency team using new ways of working**. All sites have observed cultural differences between professional groups and pathways that have taken time to understand and resolve. Similarly, it has taken time to ensure that the Living Well multi-disciplinary teams and wider networks have a clear understanding of what support the core MDTs can provide.

10. The evaluation identified the following **key enablers of positive outcomes** for people accessing Living Well:

- **Investment of time for service design forged a strong commitment to Living Well.** This made it possible to develop a shared vision and to build the relationships which provide a strong foundation for the service.
- **Shared values and ethos.** Staff reported strong commitment to the Living Well approach, looking beyond traditional medical models of support, towards an approach that considers a person's life as a whole and prioritises their own goals.
- **Multi-disciplinary working.** The multi-disciplinary model was widely agreed to be a successful, effective approach. It not only contributes to outcomes for people, staff and the system, but makes it easier to maintain a clear view of the values of Living Well.
- **Reaching the right target group.** The model is well suited to preventative support for people who fall between primary and secondary care, including adults with high levels of mental health needs. Because Living Well aims to provide timely access to support, it is more able to offer earlier intervention for this group than services that have long waiting lists.
- **Timely access to support.** A key feature of Living Well is that it provides support quickly, without the lengthy waiting times that people experience in some other services. Average waiting times between introduction and initial conversation were between 14 and 25 days.
- **Leadership.** The evidence suggests strategic leadership has been a key factor in the development of Living Well from the design phase through to the implementation phase.
- **Involving people with lived experience at all stages**. The involvement of people with lived experience of accessing mental health services in the

design and the delivery of Living Well has been a key factor in achieving positive outcomes for people.

- **Peer support**. Involving peer mentors has been a key aspect of Living Well and has been particularly helpful at the start of a person's support journey, when connecting with the person, empathising and building trust are important.

Executive Summary

About Living Well and the evaluation

The Living Well programme is a response to a challenging context and rapidly changing landscape of mental health in the UK. Demand for mental health support has been rapidly rising and this has been exacerbated by recent challenges in context from Covid19, to the increased pressures on people's finances due to the rising cost of living crisis. To date, developments have focused on improvements to different discrete *parts* (services, pathways etc) of the system, rather than looking to work across the system with the explicit aim of harnessing and amplifying collective effort in new multi-disciplinary ways.

The evaluation report draws together evidence from a three-year evaluation process of the impact of the programme on the three Living Well sites (Edinburgh, Salford and Tameside and Glossop). Much of this period coincides with a set of challenging circumstances for services and individuals arising from Covid-19, which meant that Living Well could not be implemented entirely as planned. The report focuses on drawing together evidence of the impact of changes to service level arrangements in order to evaluate impact and generate learning for ongoing processes of development and improvement. Over the course of the evaluation each site has received a detailed baseline, interim and final evaluation report providing more information about the findings summarised here.

Who has Living Well supported?

In the period from May 2019 to March 2022 the three Living Well sites supported 3,438 people.

- 40% of people had an existing mental health diagnosis (n=1,408).
- Additionally, analysis of Recovering Quality of Life (ReQoL) outcomes data shows that 92% of people were within the 'clinical range' for mental health support at the time of their first available ReQoL score, with an average score of 13.4 out of 40 (n=726). This is considerably lower than the threshold at which someone is considered to be in need of mental health support, which is a score of 24 or below.
- In terms of reasons for seeking support from Living Well, people gave three primary reasons for wanting help: to deal with anxiety (33%), to deal with depression (27%), and because they were 'in crisis' or wanting support to deal with trauma and/or difficult experiences (31%) (n=2,650).

Living Well has filled a gap in support for people who fall between primary care and secondary mental health services. Stakeholders in all three sites described scenarios where people's additional needs (for example, in relation to housing, work or drug and alcohol use) meant they could not be effectively supported by a

GP or IAPT service, but may not have met the necessary threshold for a Community Mental Health Team (CMHT) or secondary care service.

Voices of professionals delivering Living Well

"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." Tameside & Glossop stakeholder

As a consequence of a lack of available support and/or support not being effectively coordinated, stakeholders reported that people would often *"bounce"* around the system, presenting at multiple different services but not accessing the right support at the right time. For some people, their mental health needs would increase over time until they required a more specialist response.

The rationale for introducing a Living Well system in these three areas was to create a response that could support people at the right time, not only with their mental health, but also with social and practical issues – for example work, housing, debt, lack of social contact - that might be impacting on their mental health.

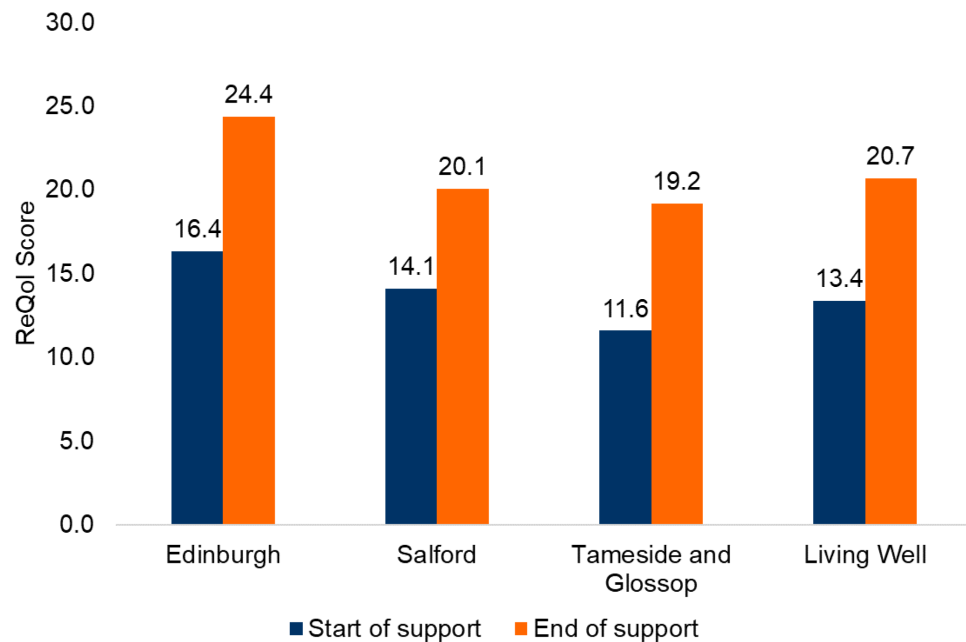
Outcomes for people supported by Living Well

There is good evidence that the recovery-focused Living Well approach supports people to achieve positive outcomes and to make progress towards achieving their own goals. People experienced improved mental health and a sense of increased ability to manage their own wellbeing. They also experienced practical improvements in their lives, such as returning to or gaining employment, claiming benefits, improving their housing situation, or in some cases, being able to stop taking antidepressants and feeling more able to leave the house.

Professionals working in the Living Well sites were confident that, for many people, improvement in mental health and recovery-related quality of life is achieved and sustained, based on the limited numbers of people who return to the service at a later date (although there is not yet data to verify the long-term impact of Living Well).

The evaluation found that people are recovering, staying well and are more able to live the life they want to lead. In all three pilot areas, there was a statistically significant improvement in the ReQoL scores of people who completed the questionnaire at two points in time (see figure 1).

Figure 1: Change in mean ReQoL scores across Living Well pilot sites



Data about people's personal goals also demonstrates that people have made positive progress in achieving the goals they have chosen for themselves. Individuals who accessed support from a Living Well System set individual goals as a part of the introduction process. These goals are not limited to their mental health, but could include a wider range of aims to improve their lives depending on what is important to them.

Across the three sites, there were also statistically significant improvements in people's satisfaction with relationships with friends and family.

By assigning a ReQoL utility value to each person's earliest and most recent ReQoL score, we found that the average increase in quality adjusted life years (QALYs) was 0.13 QALYs per person, at a cost of between £800 and £1,160 per person per year – below the NICE recommended cost for funding interventions. This is based on a methodology used to work out the added value to an individual or to a service commissioner of an improvement in mental health-related quality of life and is a useful benchmark when considering the future development of Living Well in other areas.

How does Living Well support people?

In each site, activity data collected by Living Well services highlighted the breadth of the support offer from the multidisciplinary team, and also the wider variety of support to which Living Well services connect people. This allows Living Well services to offer personalised support, bringing together different services around

the individual. As one Salford citizen described it, the support *"was more personal, more tailored to me".*

There is evidence to suggest people were able to exercise their personal choice and control in terms of the care and support they received as part of Living Well. There is also evidence that people supported by Living Well were better able to exercise choice and control in relation to their wider lives, including how they managed their mental health and wellbeing.

There is evidence across all three sites of a positive and collaborative working environment. Stakeholders credit this to effective structures of support and supervision and retaining a strong focus on Living Well's principles. In general, staff were satisfied with many aspects of their work. In particular, peer workers and third sector staff were pleased to be part of a professional network with the NHS and statutory sector staff.

Key enablers to positive staff outcomes are the success of Living Well teams 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.

There have been challenges in bringing together a collaborative, multi-agency team using new ways of working. All sites have observed cultural differences between professional groups and pathways that have taken time to understand and resolve. Similarly, it has taken time to ensure that the Living Well multi-disciplinary teams and wider networks have a clear understanding of what support the core MDTs can provide. Voluntary sector partners also highlighted that it is equally important that all partners in the Living Well MDT and commissioners understand the operating pressures for the voluntary and community sector (VCS), to ensure that enough support and resources are available to allow partners to play a full role.

Impact of Living Well on the wider system

At the heart of Living Well are three system-level aims:

- Timely access to help and support when and where it is needed
- More people getting help
- More people getting the right help / getting help in the right place

There are a number of factors that have made it more difficult to see a quantifiable impact on system-level metrics such as waiting lists and admissions to secondary care. All three sites have faced two main challenges:

- **The scale of roll-out prevents a system-wide impact:** At this stage, Living Well's scale, gradually building from operating in single neighbourhoods, means that its impact on the local health and care system is more limited. Only once Living Well is operating at scale is it more likely to be able to

influence the wider system in terms of demand management, culture or practice.

- **A challenging environment to introduce a new service:** There has been significant disruption and uncertainty created first by COVID-19 and also forthcoming changes to the structure of health and care services. This creates an environment where it is both difficult to make an impact at system level and to measure what that impact might be, without a clear counterfactual to compare against.

Stakeholders were nevertheless confident that the available evidence does suggest Living Well could have a more transformative impact once it is further embedded and rolled-out across the three areas.

One important area where we can be confident that Living 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. This includes people who would not likely have received support otherwise, and people who might have received a sub-optimal service because they did not fit comfortably into the parameters of existing services.

What has enabled positive outcomes?

The evaluation highlighted a range of factors that have underpinned both positive outcomes for people who accessed Living Well and high levels of staff satisfaction within the core Living Well multi-disciplinary teams.

Investment of time for service design forged a strong commitment to Living Well. Time made available for different partners to come together – unusual in an environment of fast-paced response to challenging levels of need - made it possible to develop a shared vision and to build the relationships which provide a strong foundation for the service.

Shared values and ethos. Staff reported strong commitment to the Living Well approach, looking beyond traditional medical models of support, towards an approach that considers a person’s life as a whole and prioritises their own goals. It is clear in all that sites that a shared belief in the values and principles of Living Well has driven the delivery of the service.

Multi-disciplinary working. The multi-disciplinary model was widely agreed to be a successful, effective approach. It not only contributes to outcomes for people, staff and the system, but makes it easier to maintain a clear view of the values of Living Well. The inclusion of voluntary and community sector services also helped frame the support in a social rather than clinical way, which contributes to its person-centred feel. This may contribute to destigmatising the support and making people who may not want to see themselves as a ‘mental health service user’ feel more comfortable accessing services.

Reaching target group. The model is well suited to preventative support for certain people. Because Living Well aims to provide timely access to support, it is

more able to offer preventative, early intervention support than services that have long waiting lists. In Edinburgh, for example, some evidence suggested Thrive Welcome Teams were particularly well-suited as an intervention for people with their first presentation of mental health issues.

Timely access to support. A key feature of Living Well is that it provides support quickly, without the lengthy waiting times that people experience in some other services. Average waiting times between introduction and initial conversation were between 14 and 25 days. People who used the service commented that the short waiting time had been one of the most helpful aspects of the support they received, and some contrasted this with their previous experience of services.

Leadership. The evidence suggests strategic leadership has been a key factor in the development of Living Well from the design phase through to the implementation phase.

Involving people with lived experience at all stages. 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 factor in achieving positive outcomes for people. People with lived experience were involved in co-producing what the new service would look like and creating the tools that the Living Well teams use to support people.

Peer support. All sites include peer support as a core part of the Living Well offer. Involving peer mentors has been particularly helpful at the start of a person's support journey, when connecting with the person, empathising and building trust are important.

However, progress has not been linear. Some stakeholders felt that the involvement of people with lived experience in Living Well had decreased since the initial design phase. They understood this to be in part due to Covid-19 – moving activities online 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 co-production. This is an important area for all sites to focus on in the future.

Challenges and how the sites addressed them

All sites experienced some challenges in implementing their Living Well approach. Some of these challenges were specific to the area while others seemed to be common to the three sites. These include:

- Trying to launch a new service, build teams and develop a network of community service provision against the backdrop of Covid-19 restrictions. Moving to remote working was challenging for many staff and people who used Living Well, and the number of people seeking help reduced temporarily while services were not accessible for face-to-face appointments.

- Creating the new structures, processes and data sharing arrangements that make multi-disciplinary team working run smoothly, whilst also dealing with the

cultural differences between staff groups and people from different organisations.

- Recruiting and retaining staff in the face of national and local shortages of people.
- Managing referrals whose primary need may not be mental health related.
- As the service develops, thinking about how to retain and embed the ethos and values of Living Well without an intensive design phase, and transitioning to a true open access approach while also managing demand effectively.

What has happened since the evaluation?

For Tameside & Glossop, Salford and Edinburgh, Living Well continues to flourish with all three sites committed to continued growth and development. The impact of the global pandemic and subsequent lockdowns means that across the three sites attention to returning to community working and reinvigorating links with community places and offers is a common priority. Additionally:

Tameside is working to more deeply integrate their team with primary care and voluntary and community sector (VCS) offers to create a seamless open door to support. Smaller neighbourhood teams have been configured to hyper localise support. Practice development initiatives continue to respond to findings in the report and to integrate new team members from IAPTs and coterminous VCS offers. Attention is being paid to amplify the voice of lived experience and strengthen collaborative leadership and governance arrangements.

Salford have grown their core team to a Hub and spoke offer that localises support into Primary Care Networks, they have recently welcomed new members to the team including psychiatry and psychology and increased the peer workforce. Recent developments have focussed on community links and building the relationship of wider network offers to the living well team, there is a strong culture of story gathering and listening that continues to underpin developmental activities and shape culture.

Edinburgh Thrive have integrated their primary care mental health workforce into their Welcome Teams thus increasing their capacity and are embarking on a codesign journey to identify how new primary care investment is best spent to support further growth. The Thrive Collective continues to provide a rich array of community support activities and work is ongoing to enhance collaboration between these offers and the four welcome teams enabled by their digital platform iThrive.

1 Introduction

1.1 Overview

Living Well UK is a national programme led by the Innovation Unit that has been working across the UK to transform mental health systems through innovative ways that help people achieve good mental health in community and primary care settings, whilst reshaping wider mental health services and support. The aim of the programme has been to support the transformation of four pioneering sites across the UK, whilst generating evidence and learning to influence transformation across the NHS in the UK.

This evaluation and report aim to understand the impact and learning of the key service model elements developed within sites as part of their Living Well UK development programme.

Understanding and evidencing the impact of changes to mental health services is crucial to both ensuring immediate improvement in outcomes for people, and in equipping system leaders in mental health systems to better assess and review the potential impact of longer-term processes of service improvement and wider system transformation.

This report draws together evidence from a three-year evaluation process of the impact of the programme on sites. It focuses on drawing together evidence of the impact of changes to service level arrangements in order to evaluate impact and generate learning for ongoing processes of development and improvement.

The Living Well UK programme also set out to support wider system level arrangements, relationships and activities. Learning from and evaluating the system level development activities requires a more qualitative approach that draws together learning through observations, interviews and workshops from across the programme. This learning will be described in a separate Living Well System Change Learning Report.

1.2 About the Living Well programme

Launched in 2018, the programme has been awarded £3.4 million by The National Lottery Community Fund, the largest funder of community activity in the UK.

The programme has been designed to draw learning and inspiration from the Living Well approach developed in Lambeth, South East London. Innovation Unit worked in partnership with Lambeth to develop the approach over a five-year period. The approach combines a guiding set of new service model features, underpinned by a core set of new system arrangements, relationships and activities.

A two-year evaluation of the core service model - the 'hub' - was shown to deliver care and support 75% faster and at lower cost with an average of £103 cost per

person, whilst also reducing rates of referral into secondary services by over 25% and demonstrating significant improvement in user experience and staff satisfaction[1].

Living Well UK has been working to support local partnerships in Edinburgh, Luton, Salford, and Tameside & Glossop that will each develop their own version of a Living Well system that draws on the learning from Lambeth's original model.

Alongside the Living Well UK programme, Innovation Unit has been supporting a growing number of places across the UK to adapt and adopt Living Well to their mental health systems. This has included Innovation Unit's support to:

- Derbyshire undertaking a programme to transform adult community mental health support across the County
- Greater Manchester (GM) undertaking a programme to develop a new service model and arrangement for mental health services across all 10 GM localities
- York developing a new community mental health hub and longer-term transformation plan

Although evaluation for these wider developments does not feature in this report, learning has been drawn from across these sites to inform the Living Well System Change Learning Report to be published separately.

It is important to note that due to a unique context of local reorganisation in Luton, a decision was made with Luton's mental health commissioners in the second year of the programme that their relationship to the programme would change and that formal evaluation of their service model would come to an end. Luton have remained engaged in the programme as a learning partner with other sites and have continued to provide significant insights and learning into the challenges and opportunities for service level and system level change. For this reason, Luton does not feature within this programme evaluation report, but instead is also key to the Learning Report.

1.3 Living Well and mental health services in the UK

The Living Well programme is a response to a challenging context and rapidly changing landscape of mental health in the UK. Demand for mental health support has been rapidly rising and this has been exacerbated by recent challenges in context from Covid19, to the increased pressures on people's finances due to the rising cost of living crisis. Mental health services received a record 4.3 million referrals during 2021[2] and it's estimated that up to 10 million people are likely to need new or additional mental health support as a direct

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[1] Living Well Network Hub, Year Two Evaluation report, September 2017

[2] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/03/15/record-4.3-million-referrals-to-specialist-mental-health-services-in-2021

result[3]. Alongside this, significant changes to mental health policy have been experienced, including key changes being driven by the Community Mental Health Framework[4].

Our learning from working across mental health services, along with wider learning and evidence has shown that places across the UK share a range of challenges to deliver effective and efficient mental health support for people. These include:

For people receiving support:

- Increasing waiting times for support
- People's experiences of mental distress being met with no offer of help, meaning they resort to A&E services and GPs[5]
- People telling their stories multiple times, and often feeling they have to present their needs in a certain way to gain access to support [6]
- Confusing support offers, that often feel inconsistent and difficult to navigate[7]
- Support focuses on a deficits that fail to harness people's capacity, assets and relationships
- Support offers that focus on the individual, and most often fail to connect with family, friends and community in any meaningful way
- Little or no ability to influence how services should be offered or improved

For practitioners supporting people:

- High caseloads of people to support
- Organising support around a diagnostic categories and predefined pathways, that struggle to respond to multiple or complex needs
- Prescriptive models of support that are not tailored to the needs and context of people's lives
- Poor job satisfaction due to high levels of stress associated with firefighting and gatekeeping access
- Poor or no meaningful collaboration between different services, or indeed people within the same service
- Delivery of support is dominated by risk avoidance with poor practices of effective risk management
- Little or no ability to influence how services should be offered or improved

For services organising support:

- Poor collaboration and transitions between services, specifically between community and specialist support

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[3] https://www.cqc.org.uk/publications/major-reports/soc202021_01d_mh-care-demand
[4] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/
[5] https://www.cqc.org.uk/sites/default/files/20161115_cmh16_statistical_release.pdf
[6] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf
[7] https://www.cqc.org.uk/sites/default/files/20161115_cmh16_statistical_release.pdf

- Difficulty in managing increasing demand that impact on waiting times for assessment and support, that can lead to more acute levels of need
- Confusing and inconsistent thresholds that reduce the opportunity for preventative support
- Poor processes of effective discharge that mean people remain in ineffective support offers too long or have their support ended at the wrong time

For commissioners and strategic decision makers in leading systems:

- Having to respond to a challenging context, including significant reorganisations, changes in national policy, pandemics and pressures to reduce costs in the face of increasing demand
- Strained relationships between different services which corrode opportunities for more collaborative and collective responses to challenges
- Inability to respond to people with complex social and mental health needs, leading to people falling through the gaps of service provision and becoming acutely unwell
- Levers for change favour competition for funding between different services, specifically within the voluntary and community sector, leading to a lack of effective collaboration and joined up working
- Struggling to create effective conditions for required improvement or to support longer-term transformation

To date, developments have focused on improvements to different discrete *parts* (services, pathways etc) of the system, rather than looking to work across the system with the explicit aim of harnessing and amplifying collective effort in new multi-disciplinary ways.

Living Well aims to respond to this challenging context by enabling the local co-design of new service models, whilst also creating and fostering the required system level conditions, relationships and activities to sustain and support ongoing process of longer-term change. This aligns to demands and direction of national policy, in particular the Community Mental Health Framework and the NHS Long-Term Plan.

1.4 Distinctive features of Living Well

The three pilot areas co-produced their own Living Well service models and these work slightly differently in each place. However, the three models do share some distinctive features, which are summarised in Figure 2 below.

Figure 2: Distinctive features of the Living Well model in the three areas

	Tameside and Glossop	Edinburgh	Salford
Target group	People who are deemed too complex for IAPT and GP services, and sub-threshold for secondary mental health services.	People who have mild to moderate mental health problems and have been on the waiting list for psychological intervention for a long time.	People who are deemed too complex for IAPT and GP services, and sub-threshold for secondary mental health services. People who attend urgent care services including A&E, but whose mental health needs may be better met within a community service.
How the service is accessed	• Self-referral • GP/Primary care referral • Secondary care referral	• GP/Primary care referral • Primary care mental health team referral • Psychiatry referral	Referrals are made to the Community Mental Health Team from the GP or Mental Health liaison services based in A&E Departments and triaged to Living Well.
Core support offered	Time-bound (12 weeks, but sometimes longer), person-centred, flexible support for psychological and social issues.	Time-bound (six to ten sessions), person-centred, flexible support for psychological and social issues.	No time limits, person-centred, flexible support for psychological and social issues.
Referral to a wider Living Well network of organisations and groups offering practical, social and emotional support?	Yes	Yes	Yes
Multi-disciplinary core team composition	• Mental health and wellbeing coaching (VCSE)	• Peer workers • Support workers	• Operational manager • Nursing practitioner

	Tameside and Glossop	Edinburgh	Salford
	• Employment coaching (Statutory - Council) • Peer coaching/mentoring (VCSE) • Psychological therapies (Statutory – NHS) • Mental health nursing (Statutory – NHS)	• Nurses • Social Workers • Occupational therapists	• Psychiatrist • Social worker • Social occupational therapist • Recovery worker • Peer mentors
Peer support available?	Yes	Yes	Yes
Recovery focused approach?	Yes	Yes	Yes
Strengths based approach?	Yes	Yes	Yes
Support for social needs and achieving own goals?	Yes	Yes	Yes
Exit process	Completing 12-weeks of support. However, some people will stay on the team caseload for longer than 12 weeks if there is no alternative support for them.	After six to ten sessions, the team uses huddles and reflective sessions to discuss endings.	A flexible approach, with endings decided on an individual basis.
Onward referral	Onward referral to organisations in the Living Life Well Community.	Onward referral to organisations in the Thrive Collective.	Onward introductions to other services in the Living Well Community.

	Tameside and Glossop	Edinburgh	Salford
Post-service support	Re-referral possible “easy in, easy out”.	Open door policy, whereby people supported by the team can return to support at any time.	Re-referral possible if required.

1.5 Setting up and developing the Living Well model

Lambeth's original approach to developing their Living Well model demonstrated the importance of creating a set of new system level relationships and conditions in tandem with developing new models of service and support. This approach formed the basis of the design of the programme of support for sites within the Living Well UK programme. Working closely with commissioners, providers and practitioners across Lambeth, Innovation Unit developed a set of evidenced features for Living Well and how core fidelity to these would be maintained.

Our four sites agreed to hold fidelity to these features and were supported to develop tailored programmes of development that would meet the needs and amplify the assets of each of their unique local contexts.

These development eight features and their corresponding activities that enabled core fidelity were:

1. **Collaboration at all levels**
   Enabled through the establishment of a Living Well Collaborative that convened and facilitated a diverse set of stakeholders in the development and ongoing review of a local vision for mental health services.
2. **Voice of Lived Experience**
   Enabled through supporting the high levels of participation of those with lived experience in both the development of the vision through storytelling and co-design and the co-delivery of mental health services through peer support.
3. **Person-Centred Outcomes**
   Enabled by the articulation of a set of 'big outcomes' for people's mental health support and the impact of this support in their lives. These shape the priorities for practice development and the basis of commissioning for all services.
4. **Easy access**
   Enabled by developing arrangements and criteria for access in ways that increase levels of access for people to mental health expertise, support and resources.
5. **Strengths based**
   Enabled by the development of practice, processes and tools that work to identify an individual's strengths and assets to inform support they receive. Assessed by aligned outcomes and metrics of impact.
6. **People not patients**
   Enabled by the development of practice, processes and tools that work to identify an individual's needs and aspirations beyond that of solely a clinical diagnosis to inform support they receive. Assessed by aligned outcomes and metrics of impact.
7. **Networks and community support**
   Enabled by convening and supporting the development of new networks and relationships across local areas and facilitating processes that strengthen collaboration with and within the VCS, statutory, universal and primary care offers.

8. **Fostering a learning culture**
   Enabled by activity and investment in reflective and developmental practices at both service delivery and system development levels that sought learning and feedback from people using services and focused on continuous refinement.

Each site's development programme was designed to incorporate these eight features and to hold fidelity to them. Each site was supported to review fidelity as an ongoing basis of their development and to continually assess and refine their development activities and processes (learning from this development and the importance of fidelity is synthesised in the Living Well Learning Report 2022).

To ensure fidelity to these features, each site adopted a similar approach that organised initial development activity across a set of convened groups and supported these through a structured process of facilitated development, with support from a designated team from Innovation Unit.

Development was generally phased and paced in the following ways:

- **Phase 1: Programme Design and Set-Up - *1-2 Months***
  Design of an outline programme plan and ensure effective level of authorisation and programme management was in place to support the programme.
- **Phase 2: Developing a case for change and vision - *2-3 Months***
  Developing a platform and conditions for collaboration by convening stakeholders and amplifying the voice of lived experience, in order to build a collective locally specific case for change and a vision for mental health services underpinned by a refreshed common purpose and set of big, shared outcomes.
- **Phase 3: Refining a service model - *1-2 Months***
  Designing and developing a service model to deliver the local vision, whilst holding fidelity to Lambeth's evidenced learning.
- **Phase 4: Prototyping - *2-3 Months***
  Establishing a learning focused prototype service/team that supports a localised target group through new ways of working, whilst simultaneously running disciplined processes to review and refine the model and approach.
- **Phase 5: Extended prototyping and expansion - *6-12 Months***
  Creating the conditions and processes that enable the refined service model to be scaled and established across the locality. This includes finalising processes of commissioning and agreeing new/developed provider arrangements.
- **Phase 6: Sustaining, progressing and refining - *12-24 Months***
  Ongoing processes of collaborative diagnosis and development to refine the service model and to foster the system level conditions to support the new ways of working to be sustained and spread into wider elements of the mental health system (and wider health & care). This includes development of the capacity practitioners and leaders, alongside processes to align system structures, such as governance and assurance.

Timelines and activities for the initial development were variable for each site based on the context of each site, but ranged from 3-month intensive development (such as Tameside & Glossop's 101-day approach), to longer-term 9-month processes.

Variability of the development approach across sites increased as the programme progressed, with unique changes in the relationships and context of each local site - both generated from the programme and by wider local or national circumstances - shaping the programme design and delivery.

The following groups and core activities were consistent across all sites. However, based on the specific needs and assets of each local context, there was variation in each site in the specific participants, activities, timelines, levels of intensity, degree of detail and/or sophistication and corresponding outputs in each site.

Groups and core activities:

1. **Collaborative**
   A facilitated space that brought together diverse group of stakeholders including commissioners, providers (including clinical and VCS), practitioners, carers, people with lived experience and community members. Collaboratives were often run every 1-3 months and aimed to be a collaborative space to diagnose progress, set vision and hold the wider system to account.
2. **Design Team**
   A representative group from across commissioners, providers, practitioners and people with lived experience tasked with developing the vision of the collaborative into actionable service level designs and practices.
3. **Extended Design Team**
   An extension of the design team that focused on specific service-related challenges and developments. Importantly, this also included an extended group of people with lived experience.
4. **Programme/System Leadership group**
   A small group, often led by local commissioning teams that were tasked with managing the programme of development and ensuring effective connections and reporting into wider mental health leadership forums and programmes.

Alongside these local level programme groups and forums, Living Well UK convened and ran a number of national level events and groups to support cross-site learning and development. These included:

- **National Learning Events** - bi-annual events that brought together a diverse range of stakeholders from each site to share learning, capture insights, provide critical friendship to one-another and engage with relevant theory.
- **National leadership forums** - bi-annual sessions that brought together key site programme leaders to share learning about leadership

challenges, work together on shared issues and connect with relevant theories and practices of leadership from around the world.
- **Community of practice** - a fortnightly facilitated reflective development space where practitioners shared learning, codified shared practices and supported each other with problem solving.

1.6 About the evaluation

The evaluation ran between January 2019 and June 2022 and involved a local evaluation for each of the Living Well system adoption sites, the findings from which are summarised in this report. The evaluation team produced detailed baseline, interim and final evaluation reports for the each of the three sites, which aimed to answer the following questions:

- How and why have **person-level outcomes** been achieved for people? What are the reasons for any outcomes not being achieved?
- How and why have **system-level outcomes** been achieved? What are the reasons for any outcomes not being achieved?
- What are the **key challenges** faced by the sites implementing Living Well systems? How have they been overcome?
- What have been the **key successes** for the Living Well sites? Why were they successful?
- What **learning** is there for other localities that are looking to develop a Living Well system?

Evaluation methods included:

- **Semi-structured telephone or video interviews with staff** involved in designing, commissioning, and/or delivering Living Well.
- **Semi-structured telephone interviews with people who used Living Well.**
- **Person-level demographic, activity, and outcomes data** relating to people who accessed Living Well in the three sites between May 2019 and March 2022. Evaluation reports for each site include a **data appendix** containing 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 Living Well.
- Analysis of **system-level data** relating to demand and service activity.
- **An e-survey of Living Well staff** conducted in March 2022. 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 Living Well:

Personal goals attainment scoring: As part of their support from Living Well, people agree one or more goal with their 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: The Recovering Quality of Life (ReQoL) measure was developed as an alternative to existing quality of life measures which were thought to be less appropriate for people experiencing mental health challenges. ReQoL-10, the shorter version of Re-QoL, has been used to assess changes in recovering quality of life for people supported by the Living Well programme. This is a 10-item validated measure of quality of life for people experiencing a range of mental health issues, from mild to severe. 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.[8]

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

A user feedback questionnaire measures people’s satisfaction with the service they received. Different questionnaires are used in each area to be consistent with measures of service satisfaction already in use in the area.

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[8] University of Sheffield (no date). Recovering Quality of Life. Available online: https://www.reqol.org.uk/p/overview.html [Accessed 06/06/22]
[9] 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.

2 Summary findings from the evaluation

2.1 Profile of people who access Living Well

Overview

In the period from May 2019 to March 2022 the three Living Well sites supported 3,438 people. The sites were not able to collect data from every person who used the service, but were able to collect basic demographic data from the majority. In this summary of key characteristics of people who accessed Living Well, we show total number of people for whom data is available (n) in each case. Percentages are based on the sample not on the total population of service users.

Demographic characteristics

- Living Well mainly supported adults aged 18 to 64 (99%), with very few people (1%) aged 65 or older (n=3,108).
- Almost two thirds (62%) identified as female (n=3,074).
- The majority (82%) identified their ethnicity as White English/Scottish/Welsh/Northern Irish/British, with 6% of people from other White backgrounds and the remaining 12% from Asian, Black, mixed and other ethnic groups (n=2,605).
- In terms of sexual orientation, 80% identified as heterosexual, 16% as lesbian, gay or bisexual, with 4% identifying as “other” (n=2,206).
- Just over a quarter (28%) identified as disabled, 66% had a long-term health condition and 38% are receiving benefits for long-term sickness and disability (n=2,409).

Mental health needs

- 40% of people had an existing mental health diagnosis (n=1,408).
- Additionally, analysis of ReQoL data shows that 92% of people were within the clinical range for needing mental health support[10] at the time of their first available ReQoL score, with an average score of 13.4 (n=726).
- In terms of reasons for seeking support from Living Well, people gave three primary reasons for wanting help: to deal with anxiety (33%), to deal with depression (27%), and because they were ‘in crisis’ or wanting support to deal with trauma and/or difficult experiences (31%) (n=2,650).

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

Living Well has filled a gap in support for people who fall between primary care and secondary mental health services. Stakeholders in all three sites described scenarios where people's additional needs (for example, in relation to housing, work or drug and alcohol use) meant they could not be effectively supported by a GP or IAPT service, but may not have met the necessary threshold for a Community Mental Health Team (CMHT) or secondary care service.

Voices of professionals delivering Living Well

"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." Tameside & Glossop stakeholder

As a consequence of a lack of available support and/or support not being effectively coordinated, stakeholders reported that people would often *"bounce"* around the system, presenting at multiple different services but not accessing the right support at the right time. For some people, their mental health needs would increase over time until they required a more specialist response.

The rationale for introducing a Living Well system in these three areas was to create a response that could support people at the right time, not only with their mental health, but also with social and practical issues – for example work, housing, debt, lack of social contact - that might be impacting on their mental health.

2.2 Outcomes for people who access Living Well

Overview

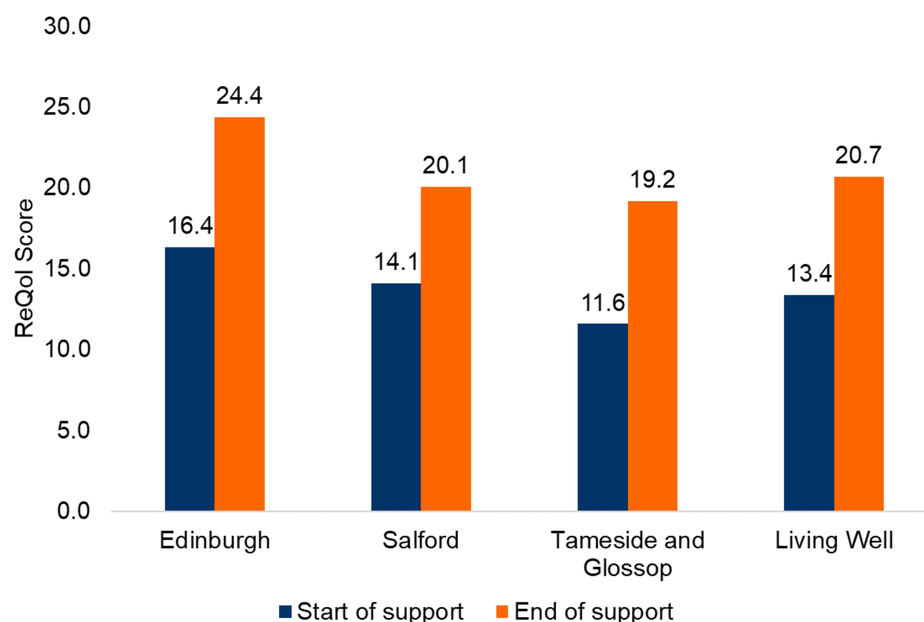
There is good evidence that the recovery-focused Living Well approach supports people to achieve positive outcomes and to make progress towards achieving their own goals. People experienced improved mental health and a sense of increased ability to manage their own wellbeing. They also experienced practical improvements in their lives, such as returning to or gaining employment, claiming benefits, improving their housing situation, or in some cases, being able to stop taking antidepressants and feeling more able to leave the house. This section summarises the changes achieved for people across the three sites.

People are recovering, staying well, and can live the life they want to lead[11]

The evaluation found that people are recovering, staying well and are more able to live the life they want to lead. In all three pilot areas, there was a statistically significant improvement in the ReQoL scores of people who completed the questionnaire at two points in time, with a medium to large effect size (i.e. the change in scores is significant in practical terms).

- **Edinburgh:** The mean ReQoL score increased from 16.4 at the start of support to 24.4 at the end of support (n=186). This is statistically significant ($p<0.05$, large effect size=0.99). Over half of people with paired data (53%) saw a reliable improvement in the ReQoL score between the start and end of support (i.e. an increase of five points or more).
- **Salford:** The mean ReQoL score increased from 14.1 at the earliest point of support to 20.1 at the most recent measurement (n=155). This is a statistically significant increase ($p<0.05$, medium effect size=0.63). Over half of people made reliable improvements (55%).
- **Tameside & Glossop:** The mean ReQoL score increased from 11.6 at the earliest point to 19.2 at the most recent point (n=385). This is a statistically significant increase ($p<0.05$, medium effect size=0.48). Over half of people saw a reliable improvement in their ReQoL score (58%).

ReQoL scores for Living Well Pilot sites

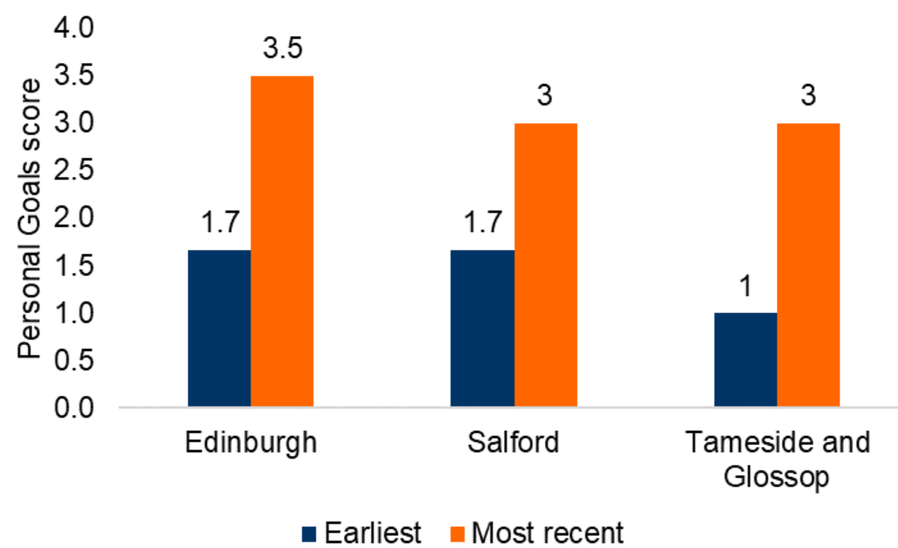


[11] Local outcomes: **Edinburgh**: *People are recovering, staying well, and can live the life they want to lead*; **Salford:** *People are recovering and staying well enough to live the life they want to lead*; **Tameside & Glossop:** *People are recovering and experiencing improved quality of life*

Data about people's personal goals also demonstrates that people have made positive progress on their own terms. Individuals who accessed support from a Living Well System set individual goals as a part of the introduction process. These goals are not limited to their mental health, but could include a wider range of aims to improve their lives depending on what is important to them.

In each pilot area, there was evidence that people made positive progress to achieve their personal goals, suggesting that Living Well does enable people to better lead the life they would like to lead, as shown in Figure 3.

Figure 3: Summary of progress on personal goals for people with paired data



People who accessed Living Well gave their own examples of progress they had made towards recovery, and what this meant to them. This included people gaining the skills and understanding to effectively manage their emotional and mental wellbeing. Others highlighted how their mental health had improved, for example, reporting reduced suicidal ideations.

Voices of people who used Living Well

"I'm less stressed with work. Before I'd get stressed out about anything and everything. It was about teaching myself I'm not to blame for things. I've got a more positive outlook." Edinburgh citizen

"We've been talking about strategies around working towards my goals, it's lifted my mood by talking to them, I have got a lot from the CBT." Salford citizen

"I'm not 100% sure I'd still be here if I'm being honest. I had suicidal thoughts prior to getting support." Tameside & Glossop citizen

Professionals working in the Living Well pilots were confident that, for many people, improvement in mental health and recovery-related quality of life is achieved and sustained, based on the limited numbers of people who return to the service at a later date (although there is not yet data to verify the long-term impact of Living Well).

Voices of professionals delivering Living Well

"In terms of people recovering and staying well, the majority of the people who we see don't come back." Salford professional

People feel connected and have positive relationships

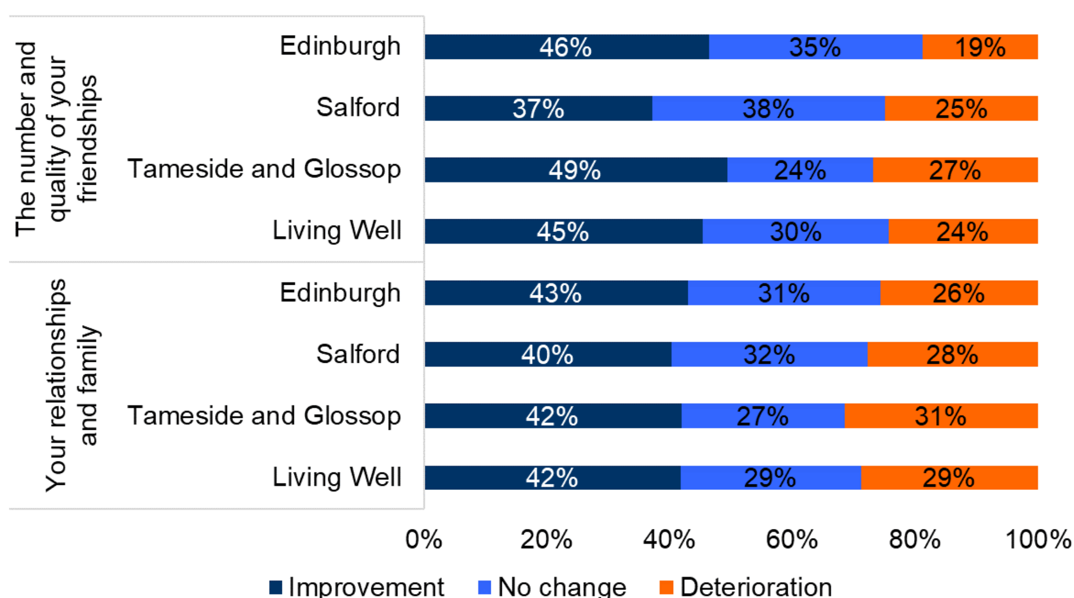
Across the three pilot sites, there were statistically significant improvements in people's satisfaction with relationships with friends and family. It is important to recognise that this change may not be attributable to support from Living Well alone, since, for many people, completing a second outcome questionnaire coincided with the end of COVID-19 lockdown restrictions. As physical distancing requirements were removed, we might reasonably have expected that people would report feeling better connected to other people.

In terms of people's satisfaction with **the number and quality of friendships** they have and the quality of their **relationships with their family,** there were statistically significant improvements in the median satisfaction scores in Edinburgh, Salford and Tameside and Glossop.

Figure 4 Median satisfaction with friendships and relationships

Outcome and median scores		Edinburgh	Salford	Tameside & Glossop
Number and quality of friendships	Time 1	4 (mixed satisfaction)	5	4
	Time 2	5 (mostly satisfied)	5	4
	Statistically significant change	✓	✓	✓
Relationship with family	Time 1	4	4.5	4
	Time 2	4	5	5
	Statistically significant change	✓	✓	✓

Overall, there was a mixed picture in terms of the proportions of people whose satisfaction with relationships improved or worsened.



In Edinburgh, there was some qualitative evidence from people supported by Living Well, however in other areas, staff were cautious about the role Living Well may have played – especially during the COVID-19 pandemic.

Voices of people who used Living Well

"At first it was hard to express my emotions. I wouldn't speak to my mum, boyfriend, or family. Through Thrive I learned coping mechanisms and now I talk to those people more." Edinburgh citizen

People receive good quality, personalised help, care and support

People in Edinburgh, Salford and Tameside & Glossop all received good quality, personalised care and support. Feedback suggests that the support Living Well delivers is personalised, well-coordinated, enabling and people are treated with compassion and respect.[12]

Voices of professionals delivering Living Well

"A person-centred approach is something that we have talked about in Mental Health services for years, but this is the first time I've seen it in reality. Individuals are given the choice and control to realise how they are feeling." Salford professional

In each site, activity data collected by Living Well services highlighted the breadth of the support offer by the multidisciplinary team, and also the wider variety of support that Living Well services connect people to. This allows Living Well services to offer personalised support, bringing together different services around the individual. As one Salford citizen described it, the support *"was more personal, more tailored to me".*

Interviewees provided examples of effectively coordinated support, for instance the ways that introductions were managed. A person supported by Living Well described their experience, highlighting that they did not feel passed onto a new person.

[12] Health Foundation definition of the four principles of person-centred care.

Voices of people who used Living Well

"[My support worker] has put me in touch with other people but it wasn't a case of passing me on. They explained, 'we thought it could be good for you' and it wasn't just a hand off, not just like next customer." Salford citizen

User experience surveys gathered in Edinburgh and Tameside & Glossop reinforce this finding. For example, in Tameside & Glossop:

- 92% of people felt their views and worries were taken seriously
- 86% reported that people were working together to support them
- 92% felt the people who saw them listened to them and treated them well

In Edinburgh, at least 95% of people who completed a client experience questionnaire responded that:

- They would use the Thrive Welcome Team again
- They would recommend the programme to a friend
- The support made sense to them
- They felt able to express how they felt
- They had an appointment at a time that suited them
- Their Welcome Worker was supportive and helpful
- The Thrive Welcome Team listened to them.

People have choice and control

There is evidence to suggest people were able to exercise their personal choice and control in terms of the care and support they received as part of Living Well. There is also evidence that people supported by Living Well were better able to exercise choice and control in relation to their wider lives, including how they managed their mental health and wellbeing.

There was broad agreement between staff and citizens that Living Well support prioritises people exercising choice and control. The use of goal setting as part of the initial conversations was seen as important, as well as staff's willingness and ability to offer people a range of different support options. This allowed people to set the direction and also to pursue the support most of interest to them. Progress to achieve people's personal goals (see above), would suggest that this approach has been effectively delivered.

Voices of people who used Living Well

"I felt [Thrive worker] had an agenda of points he wanted to touch but it didn't feel pressured – it played out like a conversation, and I felt free to bring up what I needed to." Edinburgh citizen

"They tailored it to things I was specifically worried about at the time." Tameside & Glossop citizen

"We've been talking about strategies around working towards my goals, it's lifted my mood by talking to them, I have got a lot from the CBT." Salford citizen

People who used Living Well also reported that they were more able to exercise choice and control in their lives as a result of improved mental health and wellbeing, and the range of new skills and strategies they had learnt to manage. For some people, support to access a mental health diagnosis was important to help them gain greater understanding of themselves. For others assistance with practical issues, as well as emotional support, helped them to tackle these problems and regain control.

Voices of people who used Living Well

"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." Tameside & Glossop citizen

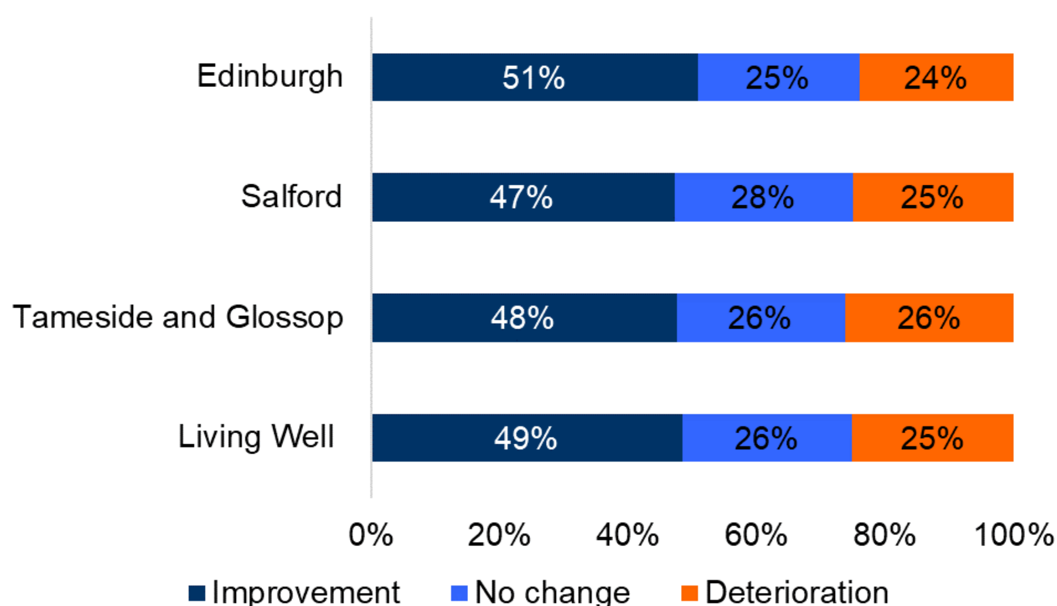
"I've got lots of quotes that help pick me up, I'm not as low or anxious as I was. I understand it more, and knowing I can pick myself up helps." Salford citizen

People have opportunities to learn, work and volunteer

Across all three sites there was emerging evidence that people's median satisfaction with their jobs/studies/other occupation had increased. There was also a mix of people who reported positive change, no change or a negative change.

Figure 5 Median satisfaction with job/studies/occupation

Outcome and median scores		Edinburgh	Salford	Tameside & Glossop
Satisfaction with job / studies / occupation	Time 1	4 (mixed satisfaction)	3 (mostly dissatisfied)	4
	Time 2	5 (mostly satisfied)	4	4
	Statistically significant change	✓	✓	✓



In Salford, staff and stakeholders were cautious to attribute any change to Living Well because there was not a clear link between the support provided and this outcome – some stakeholders suggested that improved satisfaction may be linked to the end of COVID-19 restrictions.

In Tameside and Glossop there was a small amount of qualitative evidence about the impact of Living Well on people's opportunities to work, learn or volunteer.

However, in Edinburgh there were the clearest examples that this has been achieved for some people.

Voices of people who used Living Well

"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." Tameside & Glossop citizen

"My whole life has changed from working with [Thrive worker]. Before, I'd sit on my bed and not even remember by own name. I was so brainwashed and stuck that I couldn't think straight. After working with [Thrive worker], I can go back to work. I'm working in a workplace which I never thought I'd be able to do." Edinburgh citizen

People are living in settled accommodation of their choice where they feel safe and secure[13]

For the three pilot sites, obtaining settled accommodation was not a core outcome of support (only Edinburgh included '*settled accommodation'* as one of their intended outcomes for individuals), but nevertheless there is some evidence from professionals and people who accessed Living Well that progress was made in places.

For example, in Tameside & Glossop the Neighbourhood Mental Health Team (NMHT)[14] works with wider community organisations and services to support people in areas outside of the team's specialisms, including housing organisations.

Voices of people who used Living Well

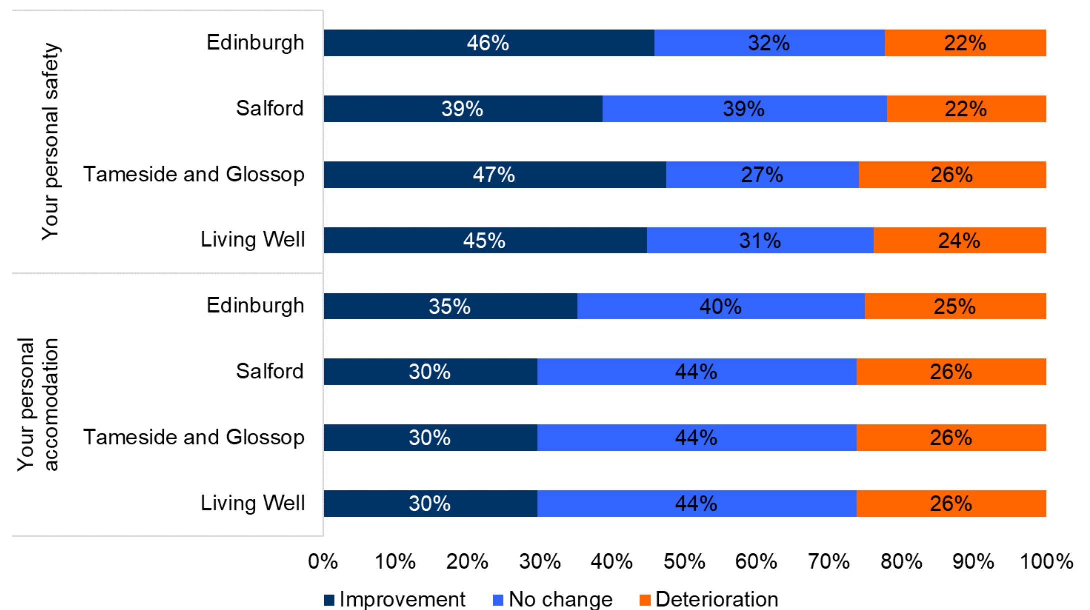
"I got advice with housing and they helped refer me into other services in Glossop." Tameside & Glossop citizen

In each pilot area, analysis of 'Questions About Your Life' data showed that between one third and half of people with data at two points in time reported greater satisfaction with their personal safety and their accommodation,

[13] Local outcomes: **Edinburgh**: People are living in settled accommodation of their choice where they feel safe and secure; **Salford:** *People feel comfortable, safe and secure'*; **Tameside & Glossop:** *People are recovering and experiencing improved quality of life.*

[14] NMHT is the name of the team that delivers Living Well support in Tameside & Glossop.

compared to between a fifth and a quarter of people who reported less satisfaction.



Staff and commissioners involved in Living Well were cautious about attributing changes in relation to personal safety or settled accommodation to Living Well given that it has not been a priority focus so far.

Insofar as Living Well services have impacted positively on outcomes in this area, it has been as a result of helping people make connections to other services.

In some areas, they are expecting to expand their offer around housing in the future. For example, in Salford, as Living Well expands to a city-wide service, it will also include a housing officer as part of the multidisciplinary team.

2.3 Economic benefit

2.3.1 ReQoL scores analysis

Paired ReQoL data (i.e. a completed questionnaire at the start of support and at a later point in time) was available for 726 people across all three sites. Analysis of the ReQoL scores shows that:

- Of the 726 people with paired ReQoL data, 92% were within the clinical range for needing mental health support (indicated by a ReQoL score of 24 or below) at the earliest available time point; this reduced to 63% at the most recently available time point.
- The mean ReQoL score at the earliest available data point was 13.4; at the most recently available data point the mean ReQoL score was 20.7. This is a

statistically significant increase with a large effect size ($p<0.05$, effect size = 0.88).[15] See Figure 6.

- Over half (60%, 445 people) saw a reliable improvement in their ReQoL score (an increase of five points or more), meaning that they experienced a meaningful improvement in their recovering quality of life; 33% (236 people) saw no reliable change, and 8% (55 people) a reliable deterioration. See Figure 7.

Figure 6 Mean ReQoL index score at the earliest and most recently available time points (n=726)

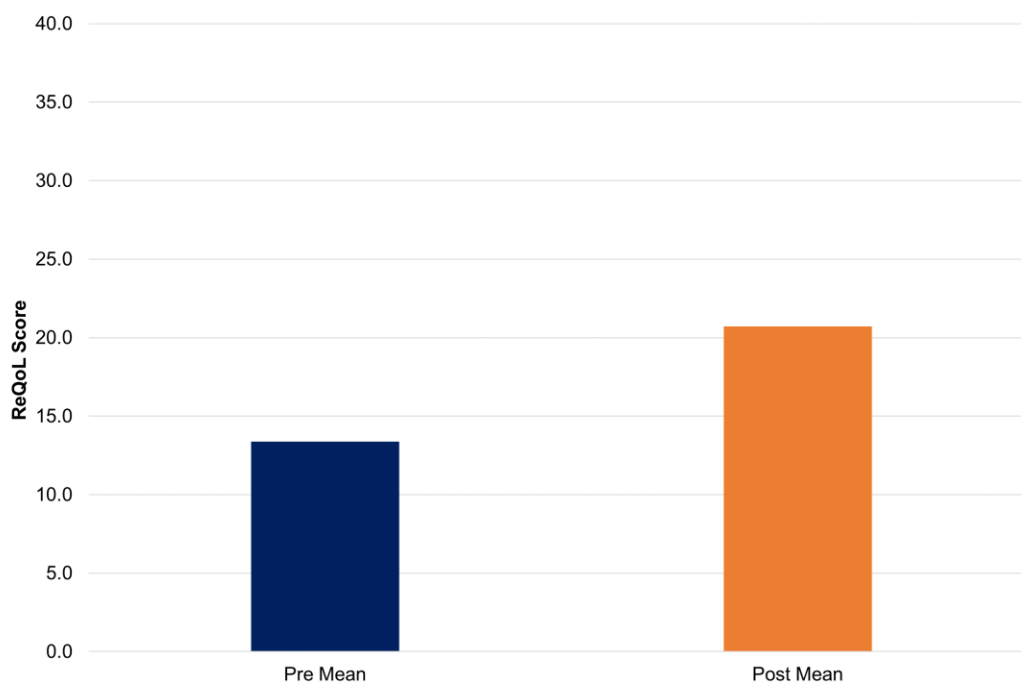


Figure 7 Change in ReQoL index score (earliest available to most recently available, n=726)

Change over time	Number of people	Proportion
Reliable improvement	435	60%
No reliable change	236	33%
Reliable deterioration	55	8%
Valid total	**726**	**100%**

2.3.2 ReQoL Utility Index

The Recovering Quality of Life – Utility Index (ReQoL-UI) is a recovery-focused generic preference-based data analysis tool for extracting valuable health

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

economics data from the existing ReQoL Patient Reported Outcome Measure. The ReQoL-UI was created through a novel application of item response theory methods for generating the classification system and selecting health states for valuation. The ReQoL utility index places a value on an individual's health. The scores range from worst state ("worse than dead") to best state ("full health"); a score of 1 represents full health, 0 represents a person being dead, and less than 1 represents a state worse than death (i.e., life is so bad that it is not worth living).

Conventional time-trade-off was used to elicit utility values that are modelled to enable the generation of quality adjusted life years (QALYs) for use in cost-utility analysis of mental health interventions.[16] A QALY is a measure of the state of health of a person or group in which the benefit of longer life is adjusted to reflect life quality. One QALY is equal to one year of life in perfect health.[17]

2.3.3 Utilities scores for Living Well

Paired ReQoL scores and a physical health score were available for 559 people across Edinburgh, Salford, and Tameside & Glossop. This data was utilised to generate a utility score for each person at both the earliest time point available and most recently available. The data for the 559 people shows that:

- The mean ReQoL utility score at the earliest available time point was 0.60; and at the most recently available time point the mean ReQoL utility score was 0.73. This was a statistically significant increase ($p<0.05$, effect size = medium 0.5).[18]
- 79% (439 people) experienced an improvement in their ReQoL utility score. On average, people experienced an improvement of 0.13 in their ReQoL utility score.

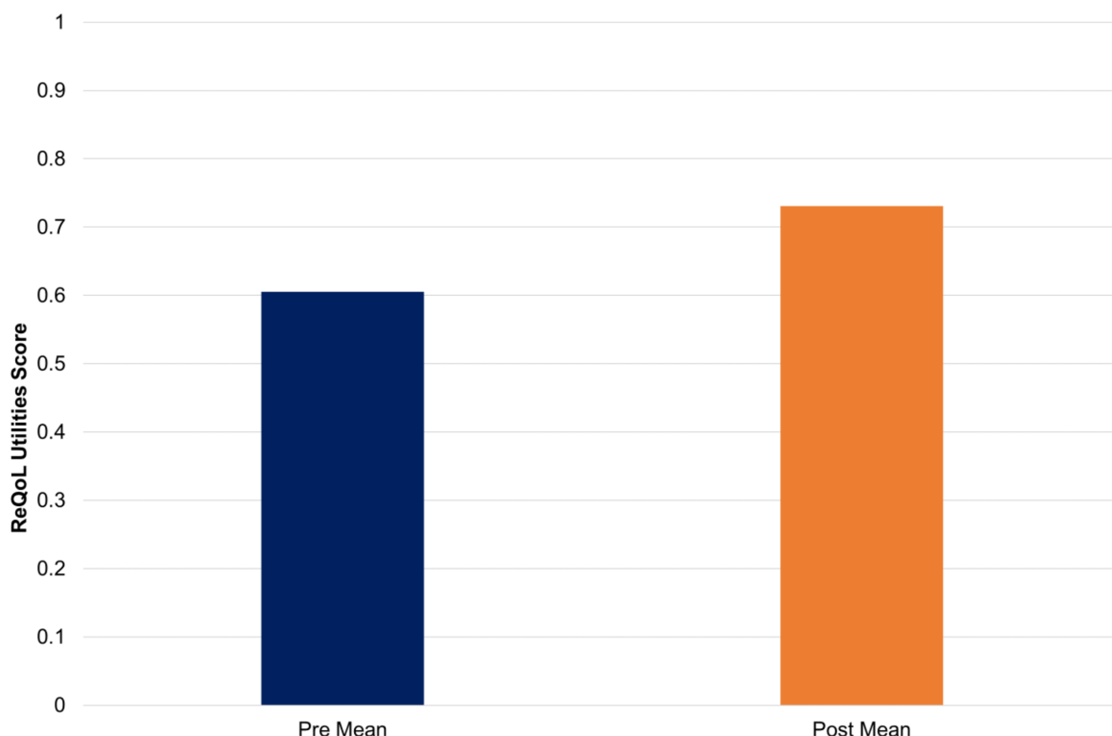
On average, there was a difference of 202.6 days between the earliest available time point and the most recently available time point. People whose most recent time point was recorded as earlier or the same as their earliest available time point have been excluded from the analysis. We assume that the improvement in mental health related quality of life might last for one year, meaning that the average annual QALY gain per person is 0.13.

[16] Keetharuth AD, Rowen D, Bjorner JB and Brazier J (2020). Estimating a Preference-Based Index for mental health from the Recovering Quality of Life (ReQoL) measure: Valuation of ReQoL-UI

[17] https://www.nice.org.uk/glossary?letter=q#:~:text=One%20quality%2Dadjusted%20life%20year,a%200%20to%201%20scale) [Accessed 06/06/22]

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

Figure 8 Change in ReQoL utility score (earliest available to most recently available, n=559)



2.3.4 Cost of QALY gain

It is difficult to estimate the real on-going cost of Living Well, as the sites developed and recruited staff at different stages. Based on approximated annual cost data from sites, the cost per person of the core Living Well model is between £800 and £1,160. Therefore, the likely cost of achieving a gain of 0.13 QALYs is between £800 and £1,160. NICE recommends funding interventions costing between £20,000 and £30,000 per QALY[19] (equivalent to between £2,600 and £3,900 per 0.13 QALYs). Living Well is likely to be considered cost-effective in these terms, since the cost of the intervention is below the NICE recommended cost. These findings may provide a useful benchmark when considering the future development of Living Well in other areas.

2.4 Experiences of Living Well team members

The Living Well teams wanted to create a positive, collaborative working culture as an intrinsic part of the service. This is a key part of the Living Well vision, and contributes not only to wellbeing for staff, but to making the service effective for people using it.

[19] National Institute for Clinical Excellence (2013) 'How NICE measures value for money in relation to public health interventions'. Local government briefing, September 2013

Voices of Living Well team members

"I feel extremely positive about this element [the culture] particularly, we have worked really hard on the relational part, that has been the foundation of the success of what we've got. We have felt frustrations naturally, but with the relationships there, we have trust that cuts across professional and organisational boundaries."

Living Well stakeholder

There is evidence across all three sites of a positive and collaborative working environment. Stakeholders credit this to effective structures of support and supervision and retaining a strong focus on Living Well's principles. In general, staff were satisfied with many aspects of their work. In particular, peer workers and third sector staff were pleased to be part of a professional network with the NHS and statutory sector staff. The staff survey indicated that all staff were satisfied with their job to some extent, with over half satisfied to a very great or great extent. This reinforced the relatively positive picture from the qualitative consultation. The results from the Living Well staff survey compare favourably with findings from the national NHS staff survey, as shown in Figure 9.

Figure 9: Staff survey results: percentage answering 'yes'

Question	Salford	Edinburgh	Tameside & Glossop	NHS National staff survey results 2021
Would you recommend your organisation as a place to work?	82%	72%	75%	59%
If a friend or relative needed treatment, would you be happy with the standard of care provided by the organisation?	94%	Not asked	80%	68%

Key enablers to positive staff outcomes are the success of Living Well teams 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.

There have been challenges in bringing together a collaborative, multi-agency team using new ways of working. All sites have observed cultural differences between professional groups and pathways that have taken time to understand

and resolve. Similarly, it has taken time to ensure that the Living Well multi-disciplinary teams and wider networks have a clear understanding of what support the core MDTs can provide. Voluntary sector partners also highlighted that it is equally important that all partners in the Living Well MDT and commissioners understand about the operating pressures for the voluntary and community sector (VCS), to ensure that enough support and resource is available to allow partners to play a full role in Living Well.

2.5 Impact of Living Well on the wider local system

There are a number of factors that have made it more difficult for Living Well to be impactful on a system level. All three sites have faced two main challenges:

- **The scale of roll-out prevents a system-wide impact:** At this stage, Living Well's scale, gradually building form operating in single neighbourhoods, means that its impact on the local health and care system is more limited. Only once Living Well is operating at scale is it more likely to be able to influence the wider system in terms of demand management, culture or practice.

- **A challenging environment to introduce a new service:** There has been significant disruption and uncertainty created first by COVID-19 and also forthcoming changes to the structure of health and care services. This creates an environment where it is both difficult to make an impact at system level and to measure what that impact might be, without a clear counterfactual to compare against.

Stakeholders were nevertheless confident that the available evidence does suggest Living Well could have a more transformative impact once it is further embedded and rolled-out across the three areas.

At the heart of Living Well are three system-level aims:

- Timely access to help and support when and where it is needed
- More people getting help
- More people getting the right help / getting help in the right place

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.

This includes people who would not likely have received support otherwise, and people who might have received a sub-optimal service because they did not fit comfortably into the parameters of existing services.

> *"I think what happened before, they'd just go round and round the system or suffering in silence."*

Living Well stakeholders

"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[20] but without the Access Team being able to do anything with them."

Living Well staff member

In terms of **more people getting help**, people in Edinburgh, Salford and Tameside and Glossop may get more support from non-mental health services than before, because Living Well is able to connect people with the wider Living Well network and community.

There is also evidence that Living Well offers **timely support,** including support delivered via in-person and online mediums. It is not clear though whether the presence of Living Well is creating the capacity in other mental health services (e.g. CMHT or IAPT) to support people more quickly at a system level.

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 Well is enabling some people supported by the team 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 someone for support if they need. Others may continue to access support elsewhere – and indeed may even be encouraged or supported by the Living Well team 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 Well stakeholders

The aspiration in all three sites is that Living Well should be a place where anyone can come, have their needs assessed and be directed to the appropriate support – a 'no wrong door' approach. However, this is not yet happening to the extent that stakeholders would like. Partly this is because only the Tameside and

[20] The Tameside and Glossop 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.

Glossop service is open access. In the longer-term sites are considering making Living Well the first point of access for all mental health services.

3 Discussion and key learning

3.1 What has enabled positive outcomes?

Across the three sites, the evaluation found some common factors that appear to underpin positive outcomes.

Investment of time for service design forged a strong commitment to Living Well

Allowing enough time to co-design Living Well was an important enabler. Many of those involved said that time made available for different partners to come together made it possible to develop a shared vision and to build the relationships which provide a strong foundation for the service. As one stakeholder described:

> *"We've not been rushed and its given space to think, allowed innovation to develop, to be creative but it's been luxurious to develop."*
>
> Living Well stakeholder

Examples of the benefits of a long design phase included allowing time for the initial ethnographic research to be fully understood, creating the space for the service to be co-designed with a wider group of stakeholders, and building stronger working relationships within the wider Living Well Network.

Stakeholders across the three sites also praised the amount of time allocated for ongoing reflection about how to improve the service, through forums such as the Collaborative. Having time to reflect on performance and whether Living Well was delivering in line with its principles was seen as important for embedding the service ethos. While this process is time consuming for partners to engage with, stakeholders reported it had resulted in a strong commitment to the values of Living Well.

Shared values and ethos

The values and principles of Living Well were very strongly in evidence in the conversations the evaluation team had with stakeholders. Staff reported strong commitment to the Living Well approach, looking beyond traditional medical models of support, towards an approach that considers a person's life as a whole and prioritises their own goals. A shared belief in the values and principles of Living Well has driven the delivery of the service:

> *"The values and principles of the service are embedded: people at the centre, working with people, setting smart goals, being collaborative, thinking about spaces and places, the bread and butter of the service is in place – I regard that as a win"*
>
> Living Well stakeholder

> *"The values and principles in design have been implemented, the staff really hold on to those values, they are so on it. When we talk*

about being trauma informed, we have made a trauma informed pathway, have trauma informed supervision, have been continually asking ourselves to continue the learning and our values."

Living Well stakeholder

Stakeholders stressed that values have been important as the service has grown and developed over time, emphasising that they provide a framework for supporting effective team working and practice.

"With each phase comes new relationships and challenges… my personal learning is that it gets worse before it gets better, as long as you have some compassion you can work through anything… if you arrived in Living Well you would get a sense of team and ownership."

Living Well stakeholder

Multi-disciplinary working

The multi-disciplinary model was widely agreed to be a successful, effective approach. It not only contributes to outcomes for people, staff and the system, but makes it easier to maintain a clear view of the values of Living Well:

"People from different sectors sitting together hasn't happened before. The third sector help to drive values and keep the support away from box-ticking exercises."

Living Well partner

The inclusion of third sector and community services also helped frame the support in a social rather than clinical way, which contributes to its person-centred feel. This may contribute to destigmatising the support:

"*Having it in the NHS medicalises the service […] but it is moving towards a more social model. Having people from the voluntary sector in the team helps to stop medicalised way of talking and thinking."*

Living Well staff member

In Tameside and Glossop, for example, 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

Reaching target group

The model is well suited to preventative support for people whose needs are too great to be met in primary care, but who may not meet the criteria for secondary care. Because Living Well aims to provide timely access to support, it is more able to offer preventative, early intervention support than services that have long waiting lists. In Edinburgh, for example, some evidence suggested Thrive Welcome Teams were particularly well-suited as an intervention for people with their first presentation of mental health issues:

> *"People have said it's their first time ever opening up about mental health. Because we can see people quickly, it prevents escalations to the point that they need further support."*
>
> Thrive Welcome Teams staff member

Timely access to support

A key feature of Living Well is that it provides support quickly, without the lengthy waiting times that people experience in some other services. In Edinburgh people waited 25 days on average between being introduced to the Welcome Teams and their initial conversation. Staff commented that this was a notable improvement in comparison to before Thrive, where people would be likely to be put on long waiting lists for support. In Salford and in Tameside and Glossop people waited an average of 14 days between being introduced to the programme and their initial conversation with a member of the team. People who accessed the service in all three areas commented on the speed and also the ease of access, for example:

> *"[Accessing Living Well was] so easy, I literally didn't have to do anything, everything was set up straight away, was very quick compared to other services I have used in the past, they were very clear with who I would be speaking to and where and when."*
>
> Person supported by Living Well

In Tameside and Glossop people are introduced in the first instance to 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. The Open Door will triage referrals and ensure that people are directed towards the most appropriate service. Living Life Well enables people who aren't accepted by Healthy Minds (IAPT) or the Community Mental Health Team to receive a service that is tailored to their needs. 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.

Leadership

The evidence suggests strategic leadership has been a key factor in the development of Living Well from the design phase through to the implementation phase. This resulted in the following successes:

- Innovation Unit modelled a clear direction for the programme and were able to provide examples of the Living Well model which could be applied to the three sites.
- Unity between strategic leaders of different agencies has enabled buy-in to the Living Well approach.
- Individual teams were still given freedom to try things and innovate the model in accordance with their specific needs.

In Salford, for example, the difference between Living Well Salford and some other services that stakeholders have been involved with (in Salford and elsewhere) is that the commissioners have shown greater flexibility, allowing the service to develop over time. They have achieved a balance between offering guidance, while allowing other voices to input into the development of the service. As one stakeholder explained:

> *"We've not been rushed and it's given space to think, allowed innovation to develop... Trust has also been key, between commissioners and team, to bend and to flex to try new things."*
>
> Living Well Stakeholder

Other stakeholders in all three sites highlighted that the programme's leadership and commissioners placed a greater focus on values than outputs during the early implementation. This was considered helpful to creating the ethos of Living Well.

Involving people with lived experience at all stages

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 factor in achieving positive outcomes for people.

People with lived experience were involved in co-producing what the new service would look like and creating the tools that the Living Well teams use to support people. For example, in Tameside and Glossop 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

Stakeholders reported that the process of collecting people's stories at the beginning of the design process had been key in deciding what the model would look like. For example, based on the ethnographic research conducted by Health Watch, Living Well in Salford has recruited a member of staff with a specialism in supporting people with issues relating to loss.

Peer support is a core part of the Living Well offer. Involving peer mentors has been particularly helpful at the start of a person's support journey, when connecting with the person, empathising and building trust are important. 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 are using peer support more, and they absolutely understand and see the benefit of that, and respect for that sector is growing."*
>
> Living Well stakeholder

However, progress has not been linear. Some stakeholders felt that the involvement of people with lived experience in Living 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. This is an important area for all sites to focus on in the future.

3.2 What challenges did the sites face and how were these overcome?

All sites experienced some challenges in implementing their Living Well approach. Some of these challenges are specific to the area, for example in one site setting up Living Well coincided with a major organisational change process affecting staff. In this section we draw out challenges that seem to be common to the three sites and may provide useful learning for other areas considering adopting a Living Well model.

Covid-19

Not surprisingly, Covid-19 presented significant challenges to all three sites. It impacted on people's experiences of accessing Living Well. It also impacted heavily on the service's implementation in the following ways:

Restricted in-person support. Support was originally intended to take place within community settings, with the aim of reducing stigma and reaching people who may not have otherwise accessed mental health support. Offering in-person

meetings within community settings is integral to the original ethos of Living Well, but had to be paused during much of the period covered by the evaluation.

Restricted activity of the wider Living Well network. In the early stages of the pandemic, social distancing rules meant that many VCS organisations were not able to operate as they usually would; 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."*

Stakeholders emphasised that, in addition to the operating challenges created by Covid-19, the pandemic (and policy responses) also contributed to **increased levels of need in the community** and put the rest of the health and care system under stress. All this contributed to a more challenging environment to launch a new service.

However, the pandemic brought **unexpected positives** in terms of the new ways of working the service had been forced to adopt. For example, in Tameside and Glossop Covid-19 restrictions led to innovation in the team's practice, offering more flexible support online or over the phone. These adaptations were so successful that they will be continued even when no longer required for reasons relating to the pandemic.

Challenges with bringing together multi-disciplinary teams

All sites experienced to some extent the **operational barriers that are common when bringing together multidisciplinary teams**. These included creating the right structures to bring together teams of people employed by different organisations; managing the impact of differential terms and conditions, and making sure that decision-making processes and accountability and leadership structures were clear. While all sites aimed to create flatter structures with devolved decision making and more autonomy for people working in a Living Well system, in practice this was took time to embed. This is perhaps in part because staff came from services where hierarchical structures are the norm and it took time to adapt. It may also be due to some initial lack of clarity around what a 'flattened hierarchy' might mean and how decision making and accountability would work.

Data sharing was also a challenge for some sites. In one area staff described difficulties in establishing data sharing agreements, and VCS partners noted that adjusting to NHS processes and governance was an initial challenge. In Tameside and Glossop the lead provider was a VCS organisation. This meant that NHS organisations were unable to access their system, posing some challenges. For example, if a person being supported by the Living Well core team presented at A&E, the liaison team would need to call the team to establish what support the person has been accessing. This was only possible during 9am

to 5pm, Monday to Friday, and there would be no other way of getting this information.

Staff recruitment and retention

While staff experience of Living Well was generally highly positive, stakeholders nevertheless did highlight that there had been challenges relating to staff recruitment and retention. In terms of recruitment, stakeholders noted that finding mental health professionals with the right levels of experience is both a local and national challenge. At the time of the evaluation stakeholders reported that there was a national shortage of certain professionals including Band 6 Mental Health Practitioners and Band 7+ Psychologists.

Across all three sites, stakeholders suggested that for some staff, particularly in the non-clinical roles, retention challenges may have been a consequence of failing to articulate the types of challenges that people accessing Living Well might be experiencing – including people with more complex challenges than some staff were expecting.

As the service grows both in the initial three sites and nationally, there may be a challenge in making sure that new recruits are properly inducted into the Living Well approach, ensuring that they understand and adopt the service's specific values as well as its practice model.

Managing referrals whose primary need is not mental health-related

All three sites have received some referrals for **individuals whose primary need is not connected to their mental health**. While part of the purpose of Living Well is to take a whole person approach that supports people to address a range of issues in their lives, there is a challenge in not allowing Living Well to drift from its core aims. This is particularly the case when there are gaps in service provision in an area; people may be introduced to Living Well because it has a wide range of professionals and connections to other support who might be able to help, and referring agencies view Living Well as a catch-all or service of last resort. Stakeholders agree that it is important to manage these referrals carefully to prevent Living Well from drifting from its aims.

Expanding Living Well without a design phase

The role out of Living Well to other areas may not benefit from the same extended design phase as was available to these three areas. Stakeholders emphasised that Living Well depends on the quality of relationships between different practitioners and organisations and the shared ethos. Since these were fostered during the extended design phase, a faster roll-out would be more challenging.

Connected to this, the future model is likely to more closely integrated with other structures and services in primary and community care. Whereas the Living Well sites had more or less a blank canvas to develop their own ways of working, this may not be the case as the model is expanded. Stakeholders were keen that that

the ethos, principles and values of Living Well should not be diluted and that all Living Well services should share the same core values.

Effectively managing open access

Stakeholders interviewed were still supportive of the principle of open access to Living Well, however they were cautious about how any future move in that direction would function. Challenges that were identified include:

- **Demand management:** Stakeholders were cautious about whether Living Well would be able to manage the potential demand for an open access service. As one stakeholder explained:

> *"I don't know how open access would work in practice, the idea of open access provokes anxiety in practitioners… the sheer number of cases that would come through is unknown and it's unclear what our offer would be?"*
>
> Living Well stakeholder

- **Mission drift:** Stakeholders reported that if Living Well was open access, it would be important to make sure that its purpose does not become diluted. Stakeholders recognised that open access could create significant pressure to support people with a lower level of mental health need, who may struggle to access an alternative service. Similarly, it could lose its distinctiveness as a mental health service, if open access resulted in people without a mental health need referring themselves to Living Well to access support from the Living Well Network and community.

- **Appropriate facilities:** Stakeholders highlighted that an open access service would require a physical space. This may be possible to in some areas, but not all.

3.3 What is the future of Living Well?

For Tameside & Glossop, Salford and Edinburgh, Living Well continues to flourish with all three sites committed to continued growth and development. The impact of the global pandemic and subsequent lockdowns means that across the three sites attention to returning to community working and reinvigorating links with community places and offers is a common priority. Additionally:

Tameside is working to more deeply integrate their team with primary care and VCS offers to create a seamless open door to support. Smaller neighbourhood teams have been configured to hyper localise support. Practice development initiatives continue to respond to findings in the report and to integrate new team members from IAPTs and coterminous VCS offers. Attention is being paid to amplify the voice of lived experience and strengthen collaborative leadership and governance arrangements.

Salford have grown their core team to a Hub and spoke offer that localises support into Primary Care Networks, they have recently welcomed new members

to the team including psychiatry and psychology and increased the peer workforce. Recent developments have focussed on community links and building the relationship of wider network offers to the living well team, there is a strong culture of story gathering and listening that continues to underpin developmental activities and shape culture.

Edinburgh Thrive have integrated their primary care mental health workforce into their Welcome Teams thus increasing their capacity and are embarking on a codesign journey to identify how new primary care investment is best spent to support further growth. The Thrive Collective continues to provide a rich array of community support activities and work is ongoing to enhance collaboration between these offers and the four welcome teams enabled by their digital platform iThrive.

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