The COLLABORATIVE

Adult Mental Health Transformation in Lambeth via Alliancing

May 2019
A Whole System Alliance

**Alliance structure**
- All providers encouraged to participate
- 7/8 core alliance members (including primary care, social care, VCS, secondary care & commissioner)
- Other providers will be network providers
- Enabling partners to support transformation
- Community, people who use services & family & carer voice
- Total adult mental health investment of £68m
- 7 years plus option to extend to 10 years
- 14% savings required across years 1 – 7
- Pain and gain share 2.5 to 5%

**Procurement process**
- EU light touch regime since April 2016 requires market notification
- Prior Information Notice (PIN) as Expression of Interest (EOI) – March 2017 (5 EOI received, only one serious and credible from incumbent grouping)
- First NHSE/I checkpoint meeting (1 of 3) held on 4th July ’17, approval to proceed granted.
- VEAT notice served 14 July, closed 25 July 2017
- Shadow Alliance board formed August 2017
- Development/negotiation commenced 6 September 2017
- April 2018 proposed contract commencement
An Alliance is...

- A vehicle to share risks, responsibilities and opportunities
- A way of working based on **alignment** around the outcomes and **commitment** to the principles and behaviours
- Not a legal entity; participants retain own identity and internal controls
Traditional contract

- Separate contracts with each party
- Separate drivers for each party
- Performance individually judged
- Commissioner is the co-ordinator
- Provision made for dispute
- Contracts based on tight specification
- Change not easily accommodated

Alliance

- One Agreement, one performance framework
- Aligned objectives and shared risks
- Success judged on overall performance
- Shared co-ordination, collective accountability
- Expectation of trust
- Agreement describes outcomes
- Change and innovation in delivery are expected
<table>
<thead>
<tr>
<th>Number</th>
<th>Outcome</th>
<th>Person Statement</th>
<th>Big Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Improve people's rating of their own mental health</td>
<td>I feel that my mental health is better</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Increase the number of people able to access support in their own homes</td>
<td>I receive support in my own home as much as possible</td>
<td>Recovery and Staying Well</td>
</tr>
<tr>
<td>3</td>
<td>Reduce the number of people becoming dependent on services</td>
<td>The support that I receive helps me to build up my confidence and independence so that I don't become dependent on services</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Reduce the number of people reaching crisis point</td>
<td>I receive early support that helps me to avoid reaching crisis point</td>
<td></td>
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<tr>
<td>5</td>
<td>Ensure that people in crisis receive appropriate support</td>
<td>I am treated with dignity and respect when I experience mental health crisis</td>
<td></td>
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<tr>
<td>6</td>
<td>Reduce the premature mortality rate for people with mental health issues</td>
<td>I live equally as long as rest of the population</td>
<td></td>
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<tr>
<td>7</td>
<td>Reduce the physical health issues experienced by people with mental health issues</td>
<td>I am supported to improve my physical health</td>
<td></td>
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<tr>
<td>8</td>
<td>Reduce the stigma around mental health and increase awareness of available support</td>
<td>I feel comfortable to speak about my mental health and I know where to go if I need support</td>
<td></td>
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<tr>
<td>9</td>
<td>Reduce the overrepresentation of black ethnic groups in acute mental health services</td>
<td>Different ethnic groups in our communities are represented proportionately in services across the system</td>
<td></td>
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<tr>
<td>10</td>
<td>Increase the range of care and support offers in Lambeth</td>
<td>I can choose support that I feel is suitable for me from a range of different offers</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Ensure that support is delivered in an asset-based way</td>
<td>I receive support which builds upon my strengths, abilities and aspirations</td>
<td>Own Choices</td>
</tr>
<tr>
<td>12</td>
<td>Ensure that support and services are co-produced with people using services</td>
<td>I feel that I have an active and equal role in the design and delivery of services as well as equal, reciprocal relationships with those supporting me</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Increase the number of people living in places of their own choosing</td>
<td>I am able to live in a place of my own choosing</td>
<td>Participation</td>
</tr>
<tr>
<td>14</td>
<td>Increase the number of people in or started on the pathway to work</td>
<td>I have a meaningful day-to-day role in society that suits me</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Increase the number of people with strong social networks</td>
<td>I feel connected to and supported by other people in my community and networks</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Increase the number of carers feeling supported and involved in decision making</td>
<td>I feel sufficiently supported in my role as a carer and respected as key partner in decision making</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Increase staff ability to innovate and influence change</td>
<td>I feel empowered to influence change wherever I work in the system</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Increase staff ability to do their jobs effectively</td>
<td>I have the necessary tools, resources and training to carry out my role effectively</td>
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</tbody>
</table>
Our current resources in Lambeth

- Secondary Care
- IPSA
- IAPT + Primary Care
- VCS
- Social Care
- Supporting People
- Supported Living/Domiciliary Care

Total Investment

£68m
Service Transformation Work

Integrated ‘front door’
Integration and alignment of all first access points to mental health services in Lambeth

Targeted/intensive support
Remodelling of service offer for people in the community, including review of range of community teams and function of care coordination

Rapid crisis response
Development of coordinated service offer for crisis which is available at all hours and offers a speedy response

3 Elements of Community Offer

Community Placements (IPSA+)
Remodelling of all community placements across Lambeth based on learning from IPSA and expanding its scope

Acute Care
Work to reduce delayed transfers of care and length of stay in secondary care, which are driving increased OBDs
Our **brief** in this initial design exercise was to define the key principles underpinning elements of the community offer. In particular, we focused on 3 priority areas:

**Priority 1 - Building an integrated and stronger ‘front door’ to mental health services (building on the Living Well Network Hub)**

**What are we talking about?**
- First points of access to services in routine circumstances.
- Services that provide assessment as well as short term, 'general' support offers.

**What’s not working?**
- There are multiple entry points to mental health services in Lambeth. This is confusing for service users and inefficient for providers.

**Priority 2: Improving targeted/specialist care coordination for people who need more intense/medium term support**

**What are we talking about?**
- Services which are accessed after an assessment has taken place and determined support needs.
- Longer term, more intensive support for more complex clinical or social issues.
- Care coordination.

**What’s not working?**
- Data suggests that currently, over 80% of the people admitted to inpatient care are known to mental health services, which indicates that the care and support provided to a number of people in the community is not having the desired impact.
- There is duplication in service provision.
- Referral routes into CMHT services are complicated and confusing.

**Priority 3: Improving rapid response support, especially out of hours and alternatives to bed admission**

**What are we talking about?**
- Services which are accessed in a crisis/emergency situation.
- Providing support in an emergency as well as short term stabilisation.

**What’s not working?**
- Too many episodes of crisis are treated as emergencies, meaning that too many people find themselves in hospital-based care.
- Crisis response is not 24/7 Waiting times to be seen by secondary services after a crisis Black Wellbeing commission has flagged need for better crisis response as a priority
Front Door

Citizens of Lambeth will be able to access a new, wider Front Door if they are concerned about their mental wellbeing. Citizens will be able to walk-in, phone or contact the Front Door via a website twenty-four hours a day. They could also be introduced by relevant people or professionals in their lives e.g. their GP. People’s contact with the front door will start with a conversation. Should people require a more specialist or intensive offer; conversations will serve as a passport to access relevant mental wellbeing support through the front door and into the broader system.

The Front Door is not one place or one team. It is about having the right offer in the right place when people experience mental health difficulties in Lambeth. It is a presence in the community, so that people can easily and confidently get help where they are, in places where they feel safe and welcome and through channels that are convenient and accessible to them. It is a way of working with people that starts from caring and respectful enquiry about what is going on in their lives, which helps to understand their mental health difficulties in context and directs them towards the most appropriate support. It is enabled by shared protocols, governance and infrastructure, and mutual trust between colleagues across organisations and services. This ensures that people can seamlessly and quickly receive the help they need to feel better and more resilient through proportional interventions that uphold their dignity and human rights.

The wider front door offer includes an offer of support in emergencies that is prompt, easily accessible and connected with the wider acute care offer.

Key Functions

Screening/First conversation
For people accessing the front door, the first interaction is a 15 minute conversation. The aim of this conversation is to get a holistic understanding of what is going on in a person’s life and to direct them towards the right support.

Advice, information and signposting
To a range of local services, including those that can fix practical issues relating to housing, benefits, employment, as well as groups and activities in the community. This includes one to one support to access these services, but only for people who are unable to do so unaided.

Mental health assessment
People who, based on the first conversation, are deemed to be in need of more intensive clinical support will be offered a mental health assessment. This could be a ‘short’ or a ‘long’ assessment - i.e. the team of front door clinicians may see and work with some patients over a period of time to get an understanding of their presentation and ascertain the most appropriate clinical pathway of support. Its outcome will be that when a patient has been referred to a pathway by the front door, clinicians in the relevant pathway will agree to undertake an assessment of the patient to determine the appropriate treatment. The team delivering assessments in the front door could include clinicians drawn from the services that receive referrals i.e. LEO, HTT, PRT, PMIC and Panel to promote better communication, visibility and trust between different parts of the system and ultimately smoother referral experiences for patients.

Medication advice and management
Medication management for patients whose medication cannot be managed by GPs. This should include physical checks where relevant (see below).

Physical health checks
For patients whose medications are being managed in the Front Door.

Peer support
Support and advice from people with lived experience of mental health issues.

Supporting GPs and coordinating with primary care
Advice to GPs on diagnosis and medication and wider support and communication around mental health service offer. Advice could be available via phone or teleconference, which would enable a three way conversation with the patient involved, where appropriate.

Mental health education, prevention and self-care
Preventative offer focused on enabling people to better understand their own or their loved one’s mental health conditions, understand options, make informed choices and look after themselves and each other to maintain wellbeing and independence.

IAPT
There is an opportunity to align the Front Door and IAPT more seamlessly, or base IAPT in the Front Door.

Psychology offer
A psychology offer that caters for issues that are more complex than anxiety/depression and less intensive than IPTT (i.e. more reflective than CBT, possibly mentalisation based therapy?)

Drug and alcohol support
An offer that works with people who need mental health support and use drug and alcohol. This will help make sure that people who are low level consumers of drug and alcohol are supported to access mental health services and not automatically disqualified.

Care act (social care) assessments
People who have been identified in the first conversation as being in need of a social care assessment will be able to receive one in the Front Door.

Crisis HelpLine (24/7)
24 hour phone line providing support and advice to people in distress. For patients, carers and anyone who needs advice, help and assistance while in crisis or facing difficulties dealing with mental illheath. Offers a range of supportive interventions, advice on mental health and medication, accessing services, crisis reviews and liaison with care teams. This will align multiple existing offers i.e. 24/7 Crisis support line and Solidarity in a crisis.

Safe Place
Physical locations/rooms in the community where people in crisis can be held and feel safe and supported. This provides an alternative to A&E for people who are not deemed to be at risk of harming themselves or others.

Community outreach
Activities for connect with the people who do not come into the Front Door. Informed by deep knowledge of local neighbourhoods and minority groups and delivered in collaboration with community organisations.
A new urgent care pathway for Lambeth will significantly enhance the ability of the mental health system to respond quickly in situations that require response within one to four hours. The current system struggles to respond quickly to urgent care needs; this is left to A&E and the Police.

Key services in scope include: Home Treatment Team, Crisis Line, Safe Place, Sanctuary, AMHP Team, the Police mental health pilot and a proposed new Crisis House.

It is expected that the Front Door will play a bigger role in responding to urgent care in the new system. It is also expected that Front Door and Living Well Centres will have an enhanced ability to prevent and manage crisis situations.

### Key Functions

**24/7 Home Treatment Team**
Assessment and treatment at home as an alternative to Hospital. Short-term treatment for people who are having a mental health crisis. Wherever possible, avoiding the need for hospital admission.
Brings together different professional health and social care professionals, including nurses, social workers and psychiatrists. Works closely with the patient, their carers, GP, local day care centre and housing provider as required.

**Clinic advice line**
A team of MH clinicians available on a rota to provide advice to GPs and other health professionals in crisis. Advice could be available via call or teleconference, which would enable a three way conversation with patients involved. (NB - Envisaged as part of 24/7 Support Line)

**Safe Place**
Located in the Front Door. Physical location/room where people in crisis can go to feel safe and supported.

**AMHP Team**
Actively supports independence and least restrictive alternatives for adults with mental health illnesses. Completes assessments under the Mental Health Act 1983.

**Crisis House**
Accommodation from 48 hours to a maximum of 2 weeks, a small number of beds, a home-like environment, intensive treatment, supported by HTT.

**Police street triage pilot**
Mental health street triage service designed to improve the experience for people with mental health problems who come into contact with the capital’s front line police officers, reducing police involvement where possible.

**Place of Safety suite 136**
Hospital based place of safety.

It is proposed that a virtual Urgent Response Team is created to better coordinate response to urgent care needs. This team will be made up of mental health specialists from existing CMHTs who, in the future system, will be part of Living Well Centre teams. They will work on a rota basis and will: assess need; talk to service users by phone, visit them in their homes. Whereas the Front Door 24/7 Crisis Line is for service users/members of the public, the Urgent Response Team is for professionals.

It is proposed that the system maintains spare bed capacity for emergencies, for example by commissioning a Crisis House. This could help reduce demand on inpatient beds and the need to spot purchase beds.
Living Well Centres

When people require support to recover and stay well for a period longer than 12 weeks, or where their safety needs are such that they require more intensive support, they will have access to a local Living Well Centre, which will offer a mixed model of social, clinical, recovery focused options to improve wellbeing. The offer for some people will be determined by level of complexity and how this impacts on a person’s quality of life and safety. Tailored offers will ensure that the person’s assets and recovery are optimised, agreeing and achieving outcomes that matter most to them. Offers and care plans will be co-produced with service users.

Wherever possible, people will be empowered to use their Living Well Centre, with support from their GP and to manage their wellbeing independently. However, some people may need someone alongside them to help them plan and access their care who they trust and who has the best skills to support them, we have called this the Key Person. The key person is a function which aims to build a trusting, mutual relationship with the citizen using the mental health centre. The Key Person could be a community mental health nurse or a housing support worker. A young black afro Caribbean man may prefer for their key person to also be a young black afro Caribbean man. Someone struggling with a psychotic illness may be supported by an Occupational Therapist who is able to connect with and motivate them to get a job.

The vast majority of people will be receiving support from a key person that can be from any part of the system, such as their PA, housing or other Network keyworker. Interventions at this point will be weighted toward social and preventative models, so that we can optimise recovery and control.

A service user with more complex needs, including where there are concerns for their safety or risk of relapse will be supported by a professional Key Person from either health or social care. Multidisciplinary interventions will be provided for people who have relapsed and/or are in crisis (the goal of MDT teams is to ensure that treatment and care is as least restrictive as possible).

The service offer will ensure that the number of assessments are kept to a minimum and where appropriate build on the assessment carried out at the Front Door. Assessment information will be used to formulate needs and inform the development of a personalised menu of clinical and community options which will in turn form the basis of a co-produced care plan. The care plan will be reviewed at regular intervals with the service user and people most important to them.

Care and support will be delivered in the Living Well Centres and other community settings, at home, or in other agreed locations. We will be sensitive to the diverse cultural needs of the citizens we serve in Lambeth; we will not expect different communities to ‘fit into’ this system, the system must fit to them. We will work with our local communities to ensure the targeted support is accessible and relevant to them and enables them to get the support they need. These specialist clinical offers need to be supported by personalised social support that can help sustain social and community networks and support recovery.

Living Well Centres will ensure delivery of universally high standards of care coordination across the system, with shared (not separate/different) policies and protocols.

Key Features

- Service users are supported by the right Key Person for them
- Key Person is empowered to make decisions; takes an asset based approach; and stays with service user as they move through different services
- Clinical thresholds do not control/govern access to services
- There is a menu of offers - a ‘modular offer’ and we won’t use the language of referrals
- People who access clinical/specialist offers (eg from SLaM) will also be supported to access universal/social offers, which don’t disappear simply because a person accesses clinical/specialist services
# Living Well Centres

**Population:** Anyone who needs more specialist help to recover, stay well and stay safe.

## User Groups

<table>
<thead>
<tr>
<th>User groups</th>
<th>HIGH NEED AND RISK (risk impacting on quality of life)</th>
<th>MODERATE NEED (risk of relapse)</th>
<th>LOW NEED (in recovery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clusters: as per Moderate Need</td>
<td>Clusters: 5, 6, 7, 8, 12, 13, 14, 15, 16</td>
<td>Clusters: 5, 6, 7, 11</td>
<td></td>
</tr>
</tbody>
</table>

## Coordination approach

- MDT approach, lead keyworker, least restrictive treatment, care and safety
- Lead Professional eg CPN, social worker, OT or other trusted professional, backed up by colleague
- Keyworked by appropriate service, supported by clinician until CPA no longer needed eg CPN, social worker, OT or other trusted professional (backed up by colleague), and in some cases non-professionals, e.g. friends and family.

## Key functions

- Assessment (building on Front Door assessment, where relevant)
- MDT supported interventions
- Relapse prevention
- Diagnosis
- D&A assessment and harm minimisation
- Risk assessment and management
- Physical health support for SMI
- Emotional support
- ADL & Adaptation
- Intensive support
- Carer support
- PHB
- NICE approved Specialist therapy
- Medication management
- Psycho-education
- Access to range of social offers
- Peer support
- Targeted outreach to BME communities
- Information, advice & signposting
- Coping strategy enhancement
- Lifestyle support
- PHB
- Care navigation
- Recovery college
- Self management - focus on prevention, education, self-help and resilience
- Peer support
- Access to range of social offers
We defined key ways in which the new system will be different and better, with user experience and outcomes in mind:

- **Easier access to services** - there will be single points of access in the three Living Well Centres and clear routes to treatment and care, visible to both users and health professionals. Services will be easier for people to access, closer to where they are and open according to need, working towards 24/7 provision.

- **Greater continuity of care** - because each person will only have one care plan, rather than many. Care plans will be managed by one person (the ‘Key Person’), who will broker help and support from across the system and a “menu of options” (a “modular” offer). This means people will be supported across service boundaries.

- **Fewer referrals and handoffs** - because access to different service offers will be opened up and made much easier, and because all services (in different organisations) will be supported to develop a shared culture of collaboration.

- **Better integrated physical, social and psychological support** - because service offers will be designed around the whole person and their emotional, medical and social needs, not around professional identities and specialisms.

- **More support for people to build new and extended networks** - because we know that good mental health is not just the absence of illness, and is supported by good quality relationships with friends, family, neighbours.

- **More stimulating offers that fit with people’s interests and aspirations** – there is an ambition to work harder to help people pursue interests and ambitions that matter to them, including work to connect people to others with similar interests and ambitions.

- **More intensive clinical support earlier** (where needed) - including when an urgent response is needed to prevent relapse and manage crisis. It is proposed that the Front Door will be able to draw on specialist clinical support quickly and flexibly. Overall, the new system will have an enhanced ability to intervene earlier and prevent problems escalating.

- **True rapid response in crisis** - timely support in crises and more alternative safe options to admissions to hospital.