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CLINKS CASE STUDY

LANCASHIRE WOMEN'S CENTRES

Case study of good partnership practice between the health and care sector and the voluntary sector

April 2014

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Ensuring the best health outcomes for vulnerable women

Lancashire Women's Centres (LWC) is a Clinks member operating 10 One Stop Shop centres for women in the community throughout Lancashire, with plans to open three more across Cumbria in the coming months. They have a turnover of around £700,000, with 36 staff (full time equivalents) and about 120 volunteers.

Since its beginnings as Women Centre (Blackburn) in 1985, health has always been a core offer for Lancashire Women's Centres, and mental health and criminal justice are now their two main workstreams.

This case study, based on an interview with the CEO Sarah Swindley in March 2014, explores:

- LWC's experiences providing NHS-commissioned mental health services
- Improving health outcomes for their services users
- Benefits to the NHS and to LWC
- Good practice in commissioning the voluntary sector

Introduction

Can you tell us a little about the mental health services you currently provide?

Our main service is the Improving Access to Psychological Services (IAPT) programme, a mental health service using the NHS stepped-care model. In stepped care the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment. So in our case, that might mean supporting women through better self-management, providing online cognitive behavioural therapy, or referral for counselling or CBT depending on their needs. Women are referred from a range of providers including GPs, A&E, police, probation and local authorities, and can also self-refer. It's available to anyone, but women coming through the criminal justice cohort feature highly in the third step (those with higher needs). We're able to host training placements for NHS trainees through the IAPT work stream, which provides additional staffing.

We also operate an assessment and triage service at point of arrest in a local custody suite. We were finding women could be arrested five times or more, but if they didn't meet the thresholds for substance misuse or complex support needs – which are set very high – they would not be referred for any support. So we're identifying a high proportion of women with mental health needs through that service, who we can then refer for support at our local centres.

Another project we have running currently in East Lancashire, where there is a high black, Asian and minority ethnic (BAME) population, involves recruiting BAME women as volunteer health mentors to help in communicating physical health messages. So for example, adapting anti-smoking messages to the needs of local BAME women. GPs can use 'social prescribing' – a means of enabling primary care services to refer patients to a range of local, non-clinical services, often provided by the voluntary and community sector – to refer women to a health mentor for support.

LWC also run a number of well-being groups at our centres, where women can meet together for practical and emotional support around different issues; so we're looking at rebadging those as a social prescribing service to allow GPs to signpost directly to them. After all, so many mental health issues have a social aspect to them.

Improving outcomes

How do your outcomes compare with other NHS services?

Our recovery rates through the IAPT contract are very positive – overall 60% of the women we see recover from their mental health conditions, with 90% reporting an improvement. That's compared to around 30-50% across the NHS.

That's an impressive difference.

Yes, but it's not that our clinicians are better!

Women's needs are across all pathways, not just mental health (or offending). LWC's One Stop Shop model means that they come to us as a woman, and we can see them as a whole person and help them reach their potential. Depression and debt are a massive theme at the moment, and so our housing and debt advice service can help women deal with their underlying financial issues to prioritise bills, plan a budget, and ring creditors to agree sensible repayments – which the women are often too distressed to do themselves. With everything under one roof, they don't have to re-engage with different services to access the support they need.

One recent example of this was a 30-year-old woman, arrested for a first offence of on-street drinking and assessed by our triage team in the custody suite. She scored severely on the Mental Health Minimum Data Set tool, and had been on the waiting list for a counselling referral from her GP for 12 months. She disclosed significant debt problems, associated depression, and a recent bereavement which had added to her debt due to the funeral costs. She'd previously been admitted to hospital having tried to kill herself, but this had been picked up as only a clinical health issue, without recognising her debt problems. We referred her to our debt advice service, and were able to see her at one of our local centres within a few days. She's continuing to engage with us, is attending courses and we're now supporting her with applying for jobs and training, so this has made a real difference for her.

What else is different about your service?

Our use of volunteers and trainees makes us relatively time-rich - so whereas a GP may only have 5 minutes to explain something, we can talk things through in more detail, or call the GP with questions about medication, which women might be too embarrassed to ask themselves. So although LWC don't prescribe, we can help women to be compliant with their medication and so get better outcomes for management of conditions. Our volunteers give a huge amount of time to the service, whether that's having a cup of tea and a chat with someone when they come in, or calling people between appointments to see how things are going or remind them about appointments or meetings they need to get to.

Our waiting lists are also much shorter than for the NHS – some waiting lists for counselling services locally can be up to 2 years, whereas we can see people within a week.

Women also have the chance to see good role models and opportunities for themselves; we actively try to recruit ex-service user volunteers into paid work, as in a sense they've already had an extended probationary period! So we have a number of paid staff who have previously been in the criminal justice system. They receive work experience and develop skills in a supportive environment, and also provide role models and inspiration for other women.

You mentioned previously the difference being gender-specific makes…

Yes – women do have different mental health needs! For instance, we're currently setting up a support group about the menopause at the moment. Lots of women struggle with issues around the menopause, but people don't talk about it, so they don't know where to go to talk it through. But because we're women-specific, we're alert to it.

There are other benefits from being a gender-specific service. Providing access to child-care makes a big difference to whether women can attend appointments. And a high proportion of our service users have experienced abuse. Obviously it's not always the case, but predominately that is perpetrated by men, so being in a female-only environment gives women confidence to talk about it. Fibromyalgia, for example, can be symptomatic of abuse. It wouldn't necessarily be disclosed elsewhere, but might in our support groups.

So you have contracts with a number of different health commissioners?

Yes, we do. The largest one is the Improving Access to Psychological Services (IAPT contract. In some areas that is commissioned directly by the Clinical Commissioning Groups (CCGs), in other places it is managed through the Lancashire Care Foundation Trust; while the training placements are funded by NHS North West.

Then we get smaller amounts directly from health commissioners for specific services such as substance misuse and transgender, and occasional co-located services such as a needle exchange, which is run by NHS staff from our premises.

How have LWC benefitted from these contracts?

Having 20 different funders can be difficult to manage but I think it gives you more security. And having NHS contracts does give assurance to other statutory partners about commissioning you.

We now have a rolling contract for the IAPT work, so they have to give us 6 months' notice to terminate it, which makes for much better stability for us and the women we work with. Previously we sometimes had difficulty retaining our NHS trainees as they would see they could get greater security elsewhere, but now it's more the other way round.

The training placements themselves provide us with highly qualified staff who add a lot to the service generally. Recruitment is a real challenge for us, as staff need to not only be suitably

qualified but also flexible and willing to buy into the service. Sometimes people start and we find they're not suitable, because they might have studied the theory of psychology but have never actually sat in a room with a client before. Having the resource of the trainees is therefore really valuable, whether they stay with us or go back to the NHS at the end of their placement.

What benefits do the CCGs get from commissioning you?

At the core, we're able to help them meet their prevalence targets for IAPT. IAPT and dementia are two health areas where local health commissioners can draw down extra funding from the Department of Health for meeting their targets.

What we do well is help people with mild to moderate mental health problems recover. Many of the women coming through our criminal justice cohort present with poor health outcomes, high levels of emergency access, etc., so addressing their needs reduces pressure on other services.

Being small gives us a lot more flexibility than the Care Trust. For example, if we have a practitioner who isn't working effectively for any reason, we can identify that much more easily and so address it, whereas in the Care Trust that wouldn't be possible. We're also able to be more responsive, and more creative in our solutions.

In Blackburn we're developing a community mental health service, where the Care Trust is funding the rent on the building and we'll co-locate our services. It helps meet their targets as they don't have to hold people on their caseloads for as long. We can continue to work with the women for as long as they need after they've been moved off the Care Trust's books.

Challenges and advice

What are some of the challenges for the voluntary sector in working with the NHS?

Data, data, data! Setting up the Information Governance (IG) toolkit for managing data flow and uploading it to the NHS central portal was a huge headache. The portal is not prepared with the voluntary sector in mind, and the costs are much higher than the sector sees as reasonable. The IAPT database can cost £17,000 a year, for example, so we chose to build our own instead. There are also strict procedures for handling patient data, so you have to show that all your staff and volunteers have been properly trained. There are benefits: it's definitely helped us to improve our systems, so we have much more robust data capture and information governance now; and once you have everything set up it gives you access to service users' health records. We can now access health records for the women we see more easily than the police can, for example. But it takes a lot of hard work to get to that point.

You also have to be prepared to evidence what you can do, and have the data ready to show them. CCGs are mostly interested in binary outcomes – recovery or not – so you have to go some way with that, because that's their language and the performance targets they work to. They might want to commission you, but if your work doesn't meet their priority targets, they won't be able to. CCGs and Health and Wellbeing Boards all have publicly available strategies, so do your research to find

out what their priorities are locally. Generally commissioners do want to commission good services – but you have to show them you have a good service!

Often commissioners don't understand what volunteering is. Good volunteers get jobs, and the not-so-good ones need lots of time and resources to manage – that's where they need the voluntary sector's expertise. It's not as simple as just getting everybody to volunteer in a hospital!

Any other advice for those in the sector?

Get your IG toolkit in place! Be creative, and ask for advice – what outcomes do you have to report on, what bits do you actually need to do and which ones you don't need to.

What would you like to say to any health commissioners reading this? Why should they work with the voluntary sector?

The voluntary sector can deliver on clinical outcomes. Clinical Commissioning Groups only commission clinical interventions, not social outcomes or prevention, so they need to understand that the voluntary sector can deliver clinical services.

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