Hackney

NHS
East London
NHS Foundation Trust

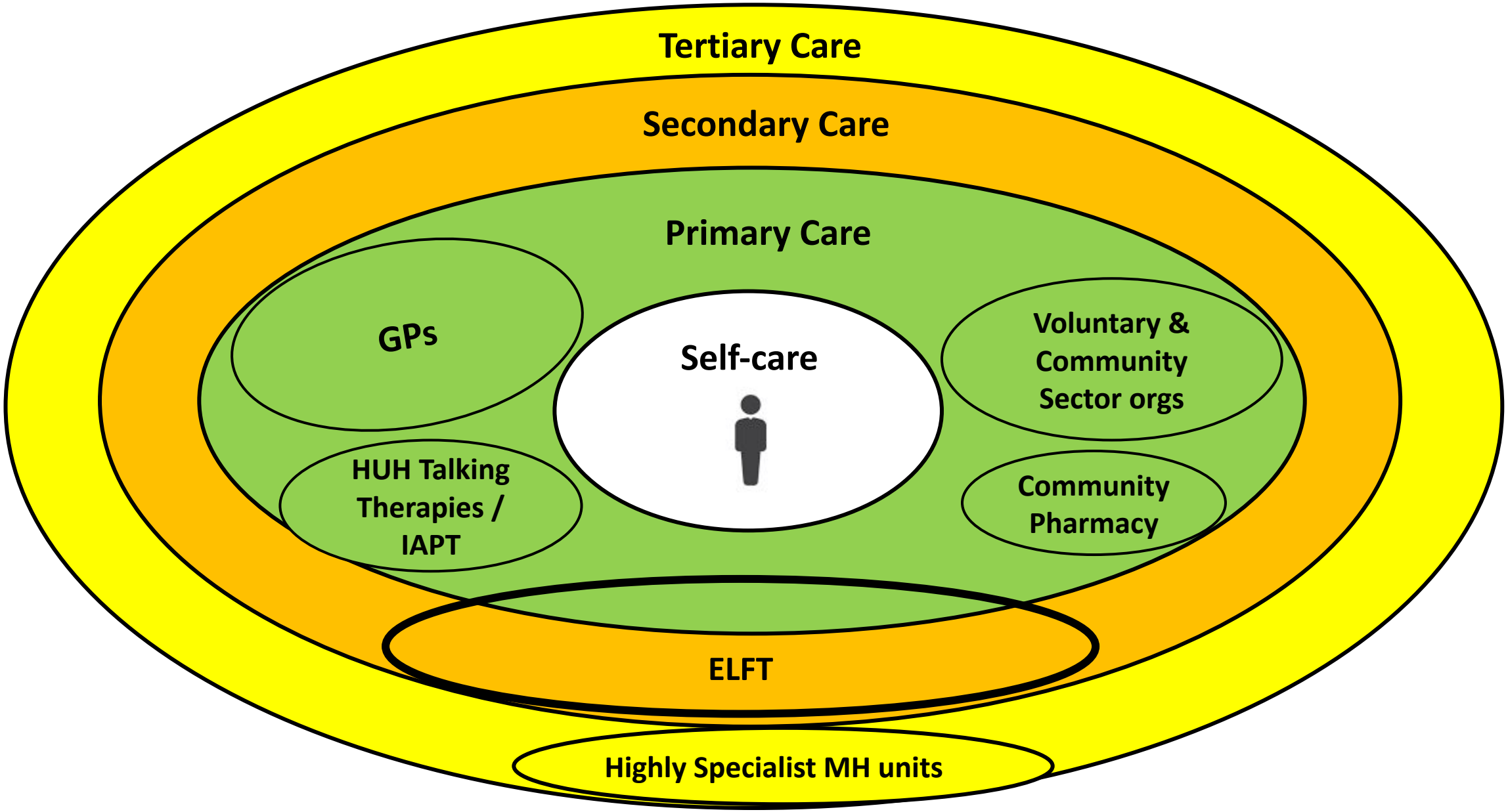
Health In Hackney Meeting, 15 January 2026

Updated ELFT & LBH Adult Community Mental Health Offer (Phase 1)

Jed Francique, ELFT Borough Director
Dr Olivier Andlauer, ELFT Clinical Director
Andrew Horobin, ELFT Deputy Borough Director

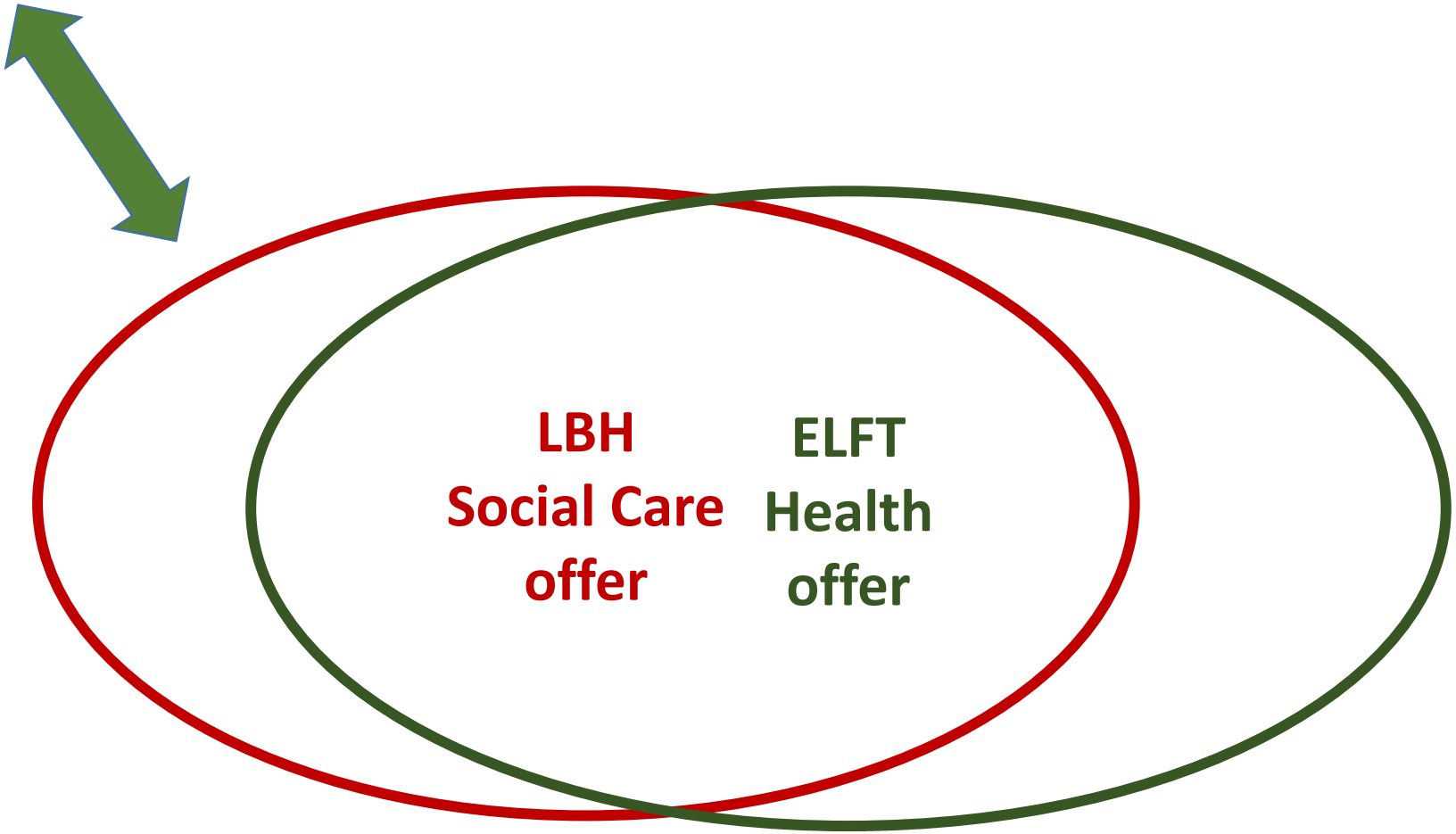
Georgina Diba, LBH Director of Adult Social Care
Aysegul Dirik, LBH Programme Manager

Context - Adult Mental Health (Treatment) System



Integrated Community Mental Health Service (via Section 75 agreement)

(Integrated) Community MH Services	MH Crisis & Emergency Care	MH Inpatient Unit	Specialist Services



Adult Social Care in Mental Health Services

- **Section 75 agreement** between the London Borough of Hackney and ELFT.
- **Commitment to integration** to ensure residents have access to support that is seamless and services are joined-up around their needs.
- As part of this agreement, LBH staff based in ELFT carry out LBH's **statutory social care duties**, including Care Act assessments and reviews and undertaking safeguarding adults procedures.
- **December 2025**: 425 people have an ongoing funded package of social care support, including home care, supported living and residential care.
- **Service user and carer feedback** indicates a desire for better joint-working across agencies, and better communication and continuity of care when in touch with the service.

Adult Social Care in Mental Health Services

Transformation programme objectives

- **Section 75 agreement** between the London Borough of Hackney and ELFT.
- **Commitment to integration** to ensure residents have access to support that is seamless and services are joined-up around their needs.
- As part of this agreement, LBH staff based in ELFT carry out LBH's **statutory social care duties**, including Care Act assessments and reviews and undertaking safeguarding adults procedures.
- **December 2025**: 425 people have an ongoing funded package of social care support, including home care, supported living and residential care.
- **Service user and carer feedback** indicates a desire for better joint-working across agencies, and better communication and continuity of care when in touch with the service.

1. **Enhance service delivery**, so that LBH residents who access mental health services from ELFT receive high quality social care support that is well integrated, safe, effective and personalised to their needs.
2. **Strengthen partnership and stakeholder relationships** between LBH and ELFT frontline staff, management and senior leaders.
3. **Ensure clear oversight of relevant processes,** including budget monitoring, HR support and Care Act activity.
4. **Create a clear Mental Health Social Work identity** in the workforce that is distinct from other professions in the multidisciplinary team. This will include clear Care Act responsibilities for social workers to lead on.

Drivers for change

NHS East London NHS Foundation Trust

To realise nationally driven Community MH transformation goals & good practice

To complement updated local social care model & arrangements under the LBH / ELFT Section 75 partnership

To respond to service user, carer and other stakeholder feedback

To support financial sustainability

Original national policy drive

To deliver **NHS Long Term Plan** ambitions for **new models of integrated primary and community care** for **adults (including 18 – 25 year olds)** and **older adults** with **severe and enduring mental illness**, as close to home as possible:

- Create a "**new community-based offer**" that will include:
  - ✓ access to **psychological therapies;**
  - ✓ improved **physical health** care;
  - ✓ **employment support;**
  - ✓ **personalised** and **trauma informed care;**
  - ✓ **medicines management;**
  - ✓ support for **self-harm** and **coexisting substance misuse issues;**
  - ✓ proactive work to **address health inequalities, incl. racial disparities**.

Who we will work with

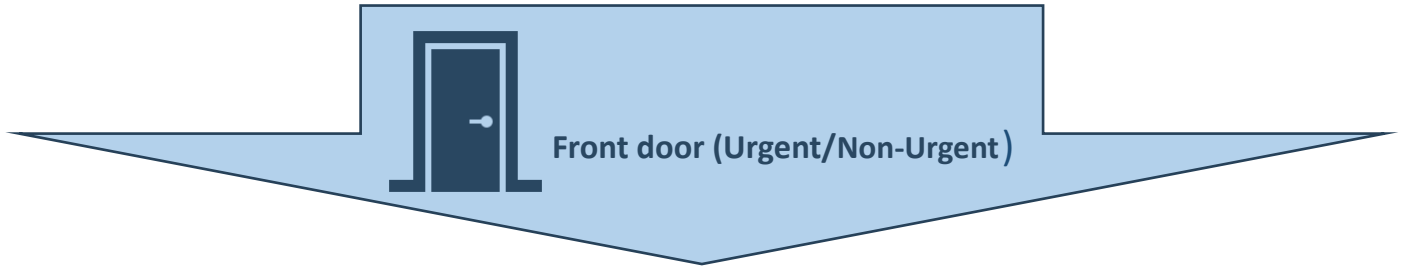
Our services will work with people who have or are suspected to have a mental illness, which causes them a significant level of impaired functioning, vulnerability and risk and means that they cannot safely be cared for in primary care. There are likely to be additional complex needs.

Overall schematic of the new ELFT community MH model (phase 1)

Placed on pathway according to need.

Pathway 1 - Less intense
Pathway 2 - Intense
Pathway 3 - More intense

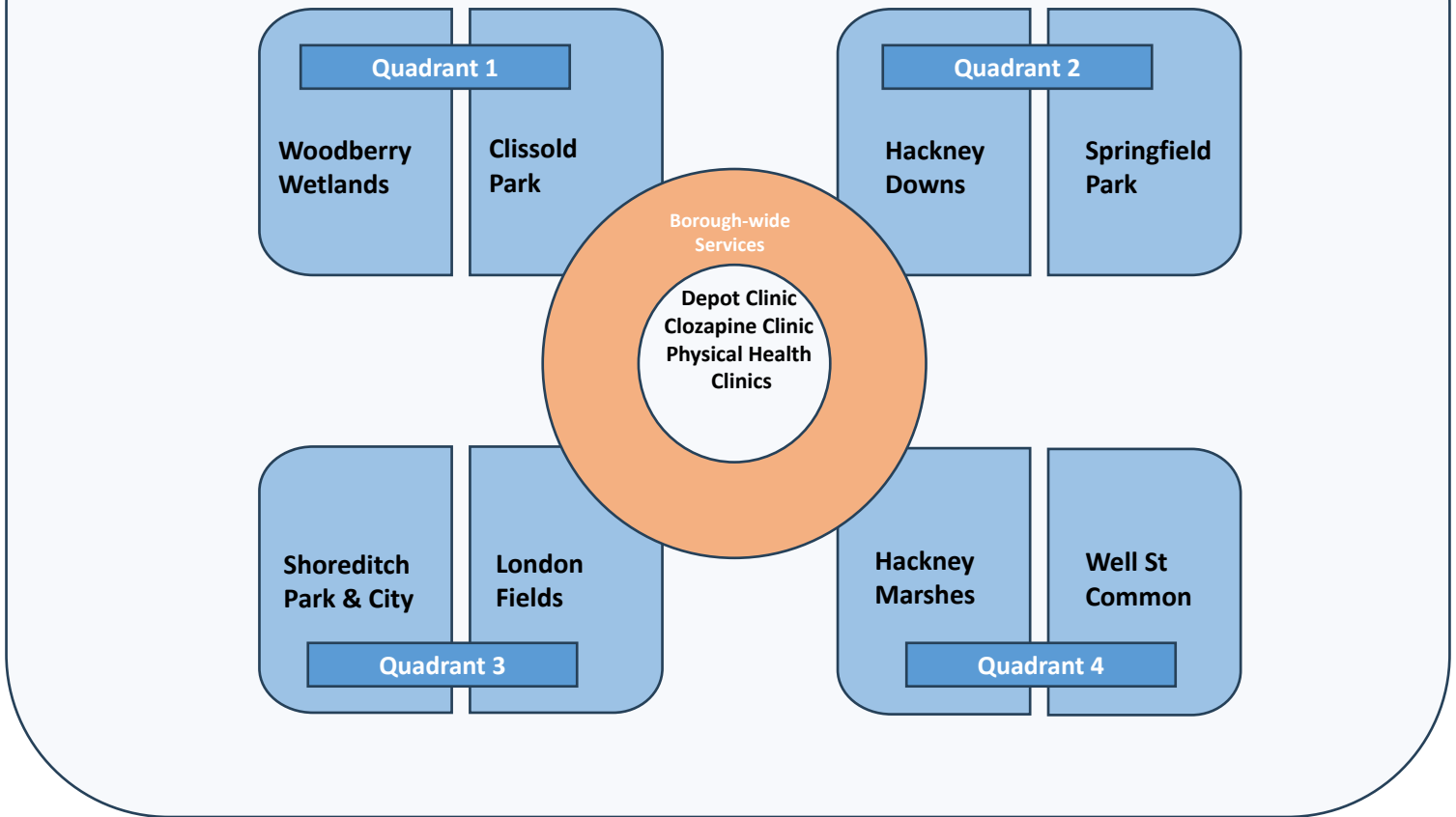
Can move through pathways as need changes



Pathway 1

Pathway 2

Pathway 3



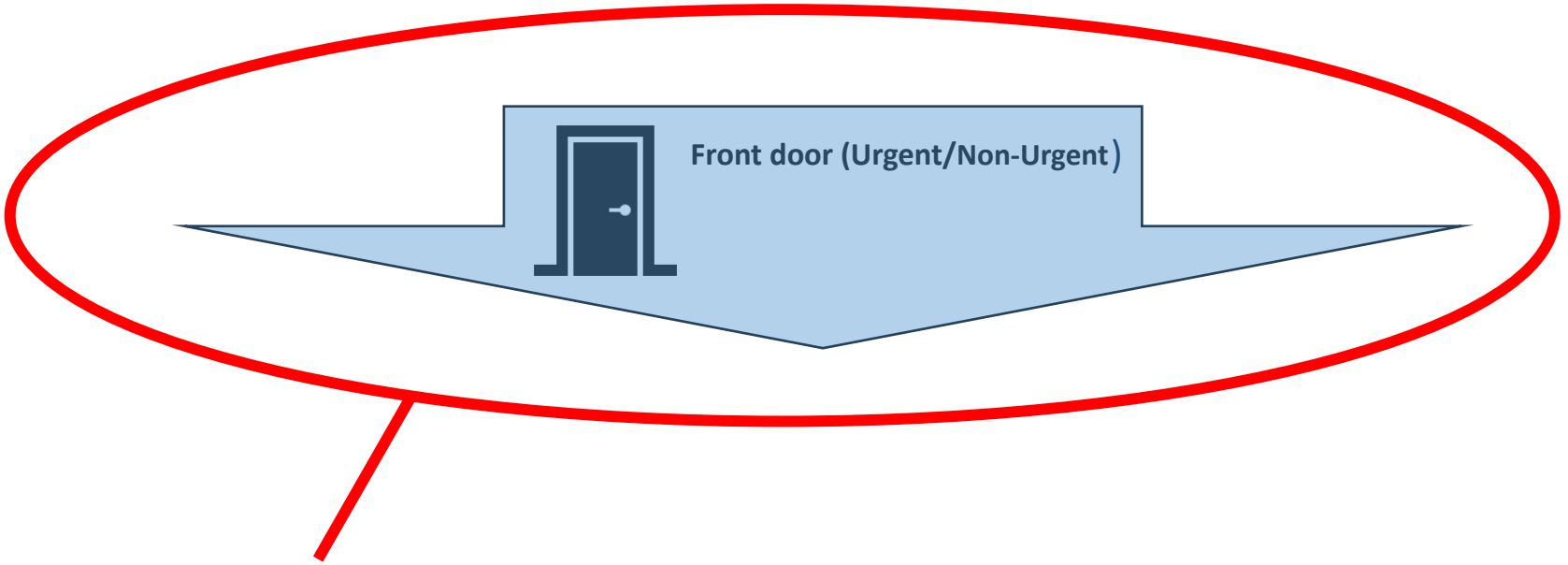
Other teams:

EIS = Standalone Team
Home Treatment Team
Older Adults (MHCOP)
Perinatal

Targeted Social inclusion work

- MH / SU pilot
- "BME" Access Team
- 18-25 work
- IPS

Initial management of referrals (urgent & non-urgent)



A new single point of entry ("front door") for all urgent and non-urgent referrals. Will have a multi-disciplinary workforce to undertake the initial phase of referrals management:

- **Will take crisis 'walk ins' at the Raybould Centre;**
- **Screening referrals,**
- **Triaging referrals,**
- **Plug gaps in referral information / initial liaison with referrers and service users;**
- **allocate for assessment;**

- **effective liaison with other service providers, where referrals do not meet ELFT criteria**

Integrated Mental Health Service (IMHS) - Social Care at ELFT

Initial Response and Safeguarding Pathway	Longer-term Support Pathway	Carers, Reviews & Discharge Pathway	Business Support	Approved Mental Health Professional (AMHP) Service
Responsible for **screening** for and supporting with social care needs at an early stage. Includes short-term support, signposting and other **preventative** work. Responsible for the management of **safeguarding** adults enquiries across the Trust.	Primarily for people accessing ELFT services who require **ongoing social care support**. Working closely with health teams in quadrants to provide **holistic** support to residents.	Responsible for ensuring that where relevant, all residents receive timely statutory **reviews** of their existing support packages, timely **hospital discharge** support and **carer** support. Includes collaboration with health partners to deliver joint duties.	Provides essential support across all IMHS pathways to ensure smooth running of the service, including high quality information management and compliance with statutory requirements.	Responsible for coordinating and carrying out statutory duties under the **Mental Health Act 1983**. The team are located in the City & Hackney Centre for Mental Health and their activities are facilitated via a rota system that includes both health and care staff.

Categorisation of needs of service users

Placed on pathway according to need.

Pathway 1 - Less intense
Pathway 2 - Intense
Pathway 3 - More intense

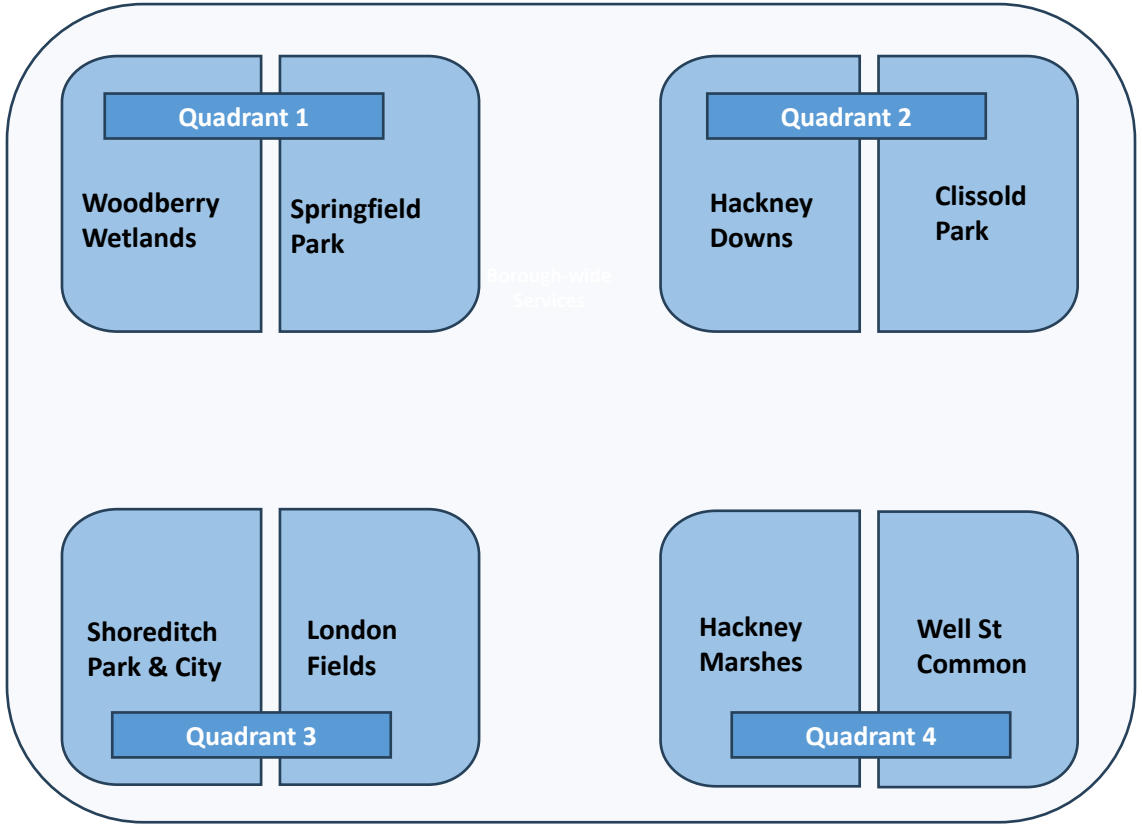
Can move through pathways as need changes

Pathway 1

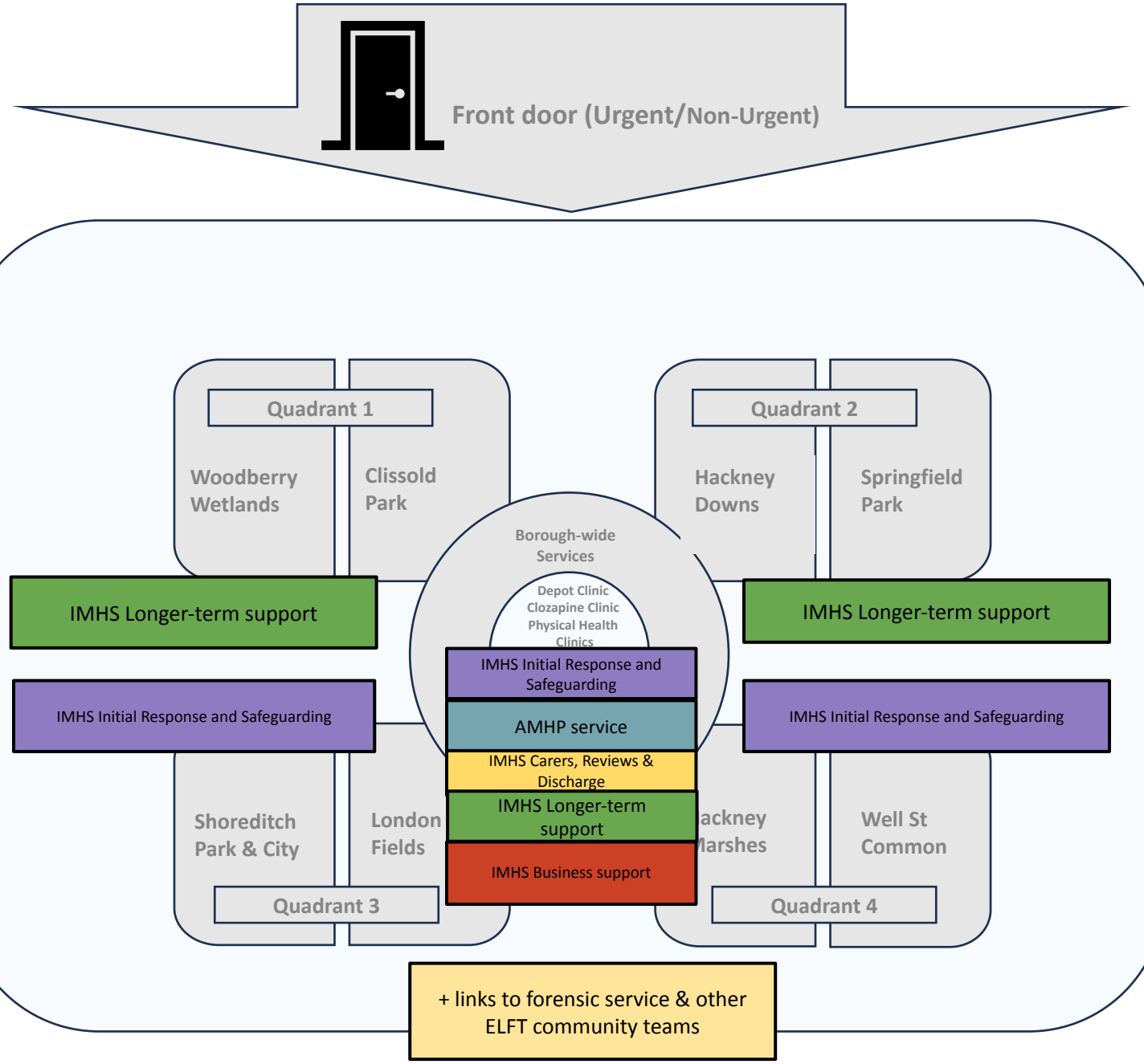
Pathway 2

Pathway 3

The new model will initially categorise service users in terms of their level of need, with level 3 being the most significant level of need. The needs of service users will occasionally fluctuate between levels and the intention with the new model is that the local teams will still support service users as their need changes, avoiding team switches.



Integrated Mental Health Service



IMHS

Borough-wide social care service.

For residents who are accessing support at ELFT and appear to have needs for care and support under the Care Act 2014.

Staff are based within paired quadrants to:

1. Work closer to where residents access support.

2. Ensure ongoing integration with health teams, including case discussions and other joint-working.

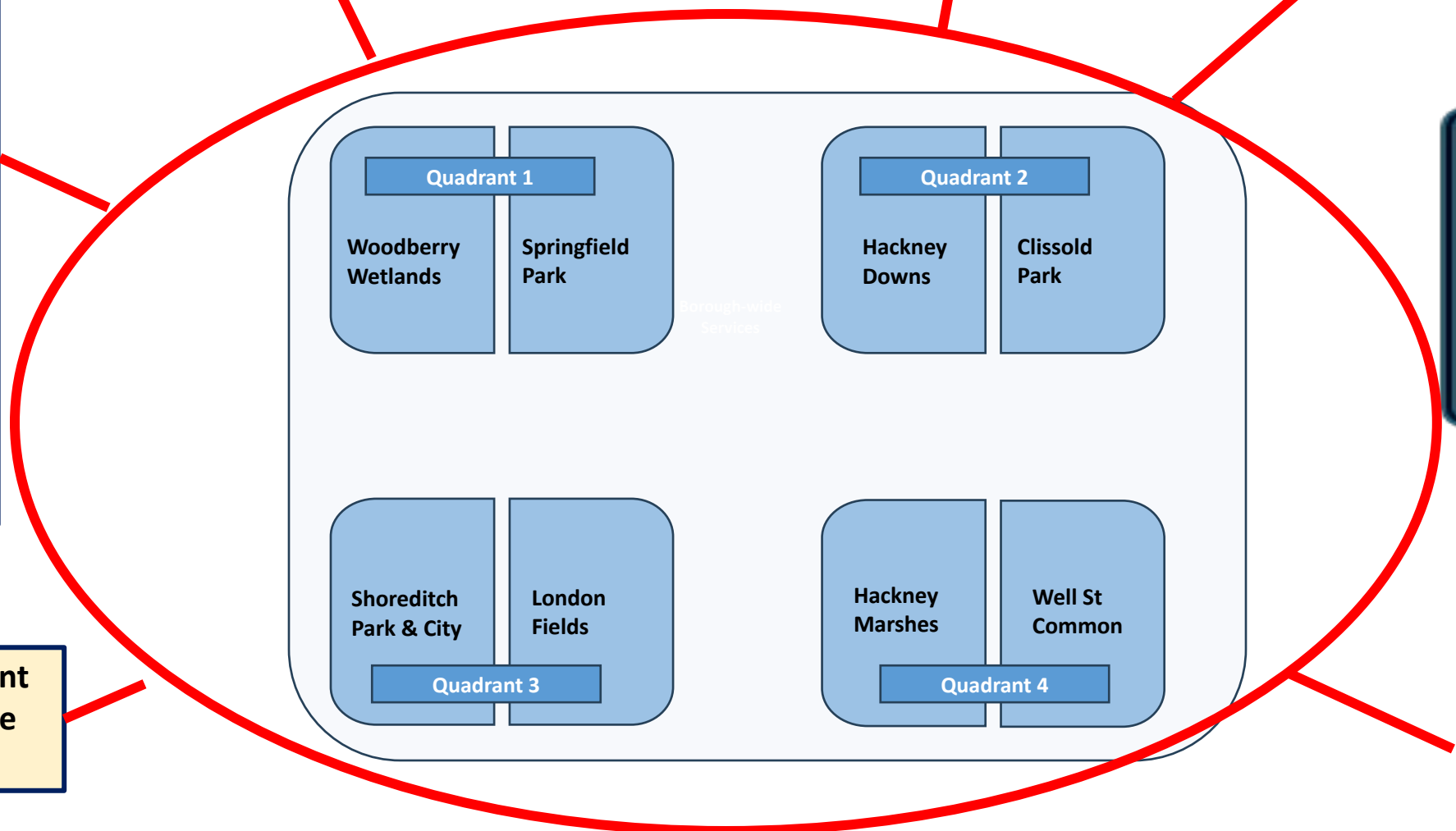
Strengthened, integrated neighbourhood care – features

Organise the majority of the core community MH offer into "quadrants" / paired neighbourhoods, including integration of specialist psychotherapy services and core MH rehab functions;

Non-urgent assessments will generally take place in the 'quadrants'.

Enhanced primary care liaison and input via Consultant Psychiatrists and primary care liaison staff.

Leadership in each 'quadrant' by 2x Consultant Psychiatrists, Lead Psychological Professional & an Operational Lead

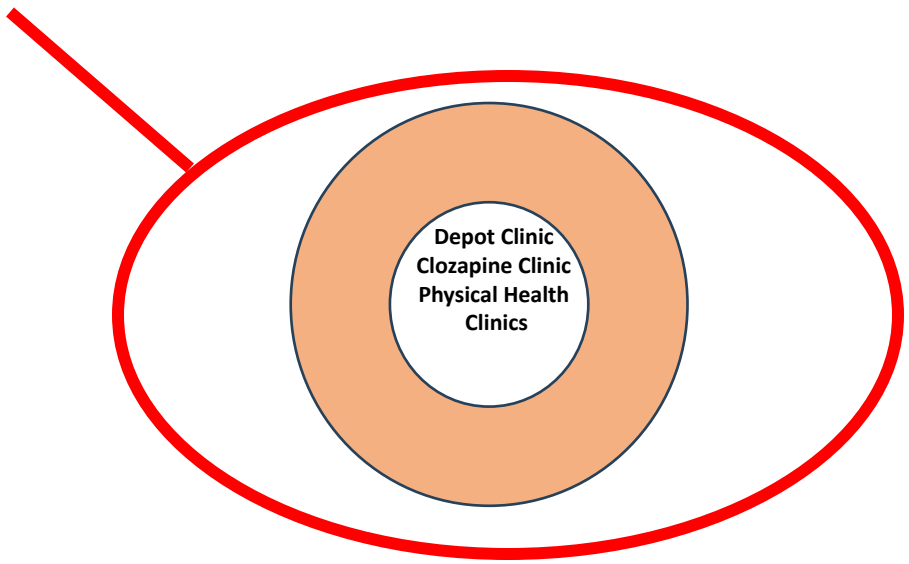


Co-development of updated care pathways

Intend to increase physical presence in local neighbourhoods to deliver care – community venues being explored – plus strengthened partnership working with other local agencies

Overall schematic of the new community MH model (phase 1)

Proposed City & Hackney-wide depot and clozapine clinic, with physical health checks. Support for primary care colleagues to manage appropriate cases in primary care.



Other services

Early Intervention Service (EQUIP) – remains a standalone specialist service

The Home Treatment Team will initially be aligned to 2 halves of City & Hackney.

Older Adults (MHCOP) service – the community team will be considered as part of the next phase of transformation.

Social Inclusion – work is progressing to continue to define our offer for specific groups who are at greater risk of poorer outcomes & experiences, such as young adults (18 – 25), access to psychological therapies for people from racialized communities, people with co-occurring substance use and MH difficulties, people needing employment advice;

Future developments =

- **24/7 Neighbourhood MH Centres in each quadrant, involving partners.**
- **Increased opportunities to align inpatient services (e.g. exploring the "continuity model");**

Other teams:

EIS = Standalone Team
Home Treatment Team
Older Adults (MHCOP)
Perinatal Service

Targeted Social inclusion work

- MH / SU pilot
- "BME" Access Team
- 18-25 work
- IPS

Understanding the level of success of the new model

NHS East London NHS Foundation Trust

Improvements in quality, service-user experiences, safety, effectiveness, efficiency and equity, reflected in:

- Strengthened integrated working between ELFT & LBH and within the ELFT offer;
- Increased levels of delivery of care in neighbourhoods / localities;
- Strengthened interfaces with primary care and other partner agencies;
- Achieve trusted assessments / reduce service users needing to repeat their story;
- Timely responses to referrals; reduced waits for assessment and treatment;
- Strengthened response to inequalities and also to differential levels of need;

Partner Agency Reference Group (quarterly)

Experts by Experience Reference Group (quarterly)

Staff feedback / reference groups (ongoing)

Ask about the #ELFTPromise

We care
We respect
We are inclusive

Implementation

East London NHS Foundation Trust

Phase 1 implementation: start in January 2026, end in July 2026

What we need from system partners:

- Ongoing feedback on and support with implementation,
- engagement in co-development opportunities (e.g. of pathways);
- strengthening service interfaces;
- Support to identify neighbourhood estates solutions and co-location opportunities;
- Co-developing cohesive neighbourhood multi-agency MH service offers;

Next steps

NHS East London NHS Foundation Trust

LBH

- Implementation of the proposed IMHS model, including a staff training and support package and an update to standard operating procedures.
- Refresh of safeguarding procedures to ensure better joined-up working between ELFT and LBH.
- Strengthening mechanisms for service user and carer feedback to improve service delivery.
- Targeted work on service quality, to ensure residents have the best possible outcomes from social care assessments and reviews

ELFT

- Phased implementation between January 2026 and July 2026.
- Reintroduction of Partner Agency Reference Group to support ongoing engagement with system partners during implementation.
- Confirmation of Service User, Carer and Staff Reference Groups.
- Establishment of an evaluation framework
- Organisational development work to support new ways of working

Ask about the #ELFTPromise

We care
We respect
We are inclusive