

Public Document Pack



Meeting: EAP Health & Wellbeing and Vulnerable People

Date: Friday 28th January, 2022

Time: 9.30 am

Venue: Remote via Zoom


The meeting will be available for the public to view live at the Democratic Services North Northants YouTube channel:

https://www.youtube.com/channel/UCcH_JAaHaMtgHDeMQEVXi2g

To members of the EAP Health & Wellbeing and Vulnerable People:

Councillors Harrison (Chair), Harrington, Lawal, McGhee, Roberts, Shacklock and Smith-Haynes

Agenda			
Item	Subject	Presenting Officer	Page no.
01	Chair's Announcements		
02	Apologies for absence		
03	Members' Declarations of Interest		
04	Minutes of the Meeting Held on 17 December 2021		5 - 8
Items for discussion			
05	NHCP – Mental Health, Learning Disabilities and Autism Programme	Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust	9 - 84
06	NHCP – Elective Collaborative Case for Change Summary Presentation	Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire	85 - 130

		Healthcare NHS Foundation Trust	
07	Better Care Fund	Executive Director Adults, Communities & Wellbeing	Discussion Item
Items to note			
08	Forward Plan of Executive Items	David Watts Executive Director Adults, Communities & Wellbeing	131 - 138
09	Work Programme	Democratic Services	139 - 140
010	Updates and Alerts <ul style="list-style-type: none"> • Local resilience forum update • ICS • Public Health Arrangements • Poverty Truth Commission • Multi-use community building 	David Watts Executive Director Adults, Communities & Wellbeing	Verbal Updates
011	Close of meeting		
<p>Adele Wylie, Monitoring Officer North Northamptonshire Council</p>  <p>Proper Officer 24 January 2022</p>			

This agenda has been published by Democratic Services.
 Committee Administrator: Francesca McHugo
 ☎07776634147 ✉francesca.mchugo@northnorthants.gov.uk

Public Participation

Public Participation Executive Advisory Panels are not subject to the full Local Government Act 1972 (as amended). Public meeting requirements do not apply for these meetings. If you wish to attend the meeting, please contact the named Democratic Services Officer or email democraticservices@northnorthants.gov.uk

Members' Declarations of Interest

Members are reminded of their duty to ensure they abide by the approved Member Code of Conduct whilst undertaking their role as a Councillor. Where a matter arises at a meeting which **relates to** a Disclosable Pecuniary Interest, you must declare the interest,

not participate in any discussion or vote on the matter and must not remain in the room unless granted a dispensation.

Where a matter arises at a meeting which **relates to** other Registerable Interests, you must declare the interest. You may speak on the matter only if members of the public are also allowed to speak at the meeting but must not take part in any vote on the matter unless you have been granted a dispensation.

Where a matter arises at a meeting which **relates to** your own financial interest (and is not a Disclosable Pecuniary Interest) or **relates to** a financial interest of a relative, friend or close associate, you must disclose the interest and not vote on the matter unless granted a dispensation. You may speak on the matter only if members of the public are also allowed to speak at the meeting.

Members are reminded that they should continue to adhere to the Council's approved rules and protocols during the conduct of meetings. These are contained in the Council's approved Constitution.

If Members have any queries as to whether a Declaration of Interest should be made please contact the Monitoring Officer at – monitoringofficer@northnorthants.gov.uk

Press & Media Enquiries

Any press or media enquiries should be directed through the Council's Communications Team to NNU-Comms-Team@northnorthants.gov.uk

Public Enquiries

Public enquiries regarding the Authority's meetings can be made to democraticservices@northnorthants.gov.uk

This page is intentionally left blank

Minutes of a meeting of the EAP Health & Wellbeing and Vulnerable People
At 9.30 am on Friday 17th December, 2021 held remotely via Zoom

Present:-

Members

Councillor Helen Harrison (Chair)
Councillor King Lawal
Councillor John McGhee
Councillor Russell Roberts
Councillor Geoff Shacklock

Officers

David Watts – Executive Director Adult’s Communities & Wellbeing
Carol Berrevoets – Service Manager, Adult Learning Service
Francesca McHugo – Democratic Services

53 Chair's Announcements

Councillor Harrison welcomed members and officers to the meeting. The Chair advised members that an alteration to the agenda would be made to consider Item 07 Adult Education Offer prior to Item 06 Draft Budget Proposals.

54 Apologies for absence

Apologies were received from Councillor K Harrington

55 Members' Declarations of Interest

MEMBERS' DECLARATIONS OF INTEREST

The Chair invited those who wished to do so to declare any interests in respect of items on the agenda.

No declarations of interest were received:

56 Minutes of the Meeting Held on 29 October 2021

It was AGREED:

- i. That the minutes of the Health, Wellbeing & Vulnerable People Executive Advisory Panels held on 29 October 2021 be approved as a true and accurate record of the meeting.
- ii. That the minutes of the Health, Wellbeing & Vulnerable People Executive Advisory Panels held on 3 December 2021 be approved as a true and accurate record of the meeting.

57 Adult Education Offer

The Service Manager presented members with an overview of the Adult Learning Service and the opportunities on offer. The presentation highlighted the two main income streams from the Department for Education and charges from fee-based courses.

The Service Manager emphasised the benefits of the Adult Learning Service's placement within Public Health and how supported courses linked to the Public Health Outcomes benefitted the community.

During discussion, the Panel raised the following principal points:

- i. Flexibility in location should be used to promote attendance within the heart of communities.
- ii. Provision of split data would be beneficial in the assessment of the impact and reach within our levelling-up communities.
- iii. Key Performance Indicators should be reviewed in relation to the separate needs of the two council areas within Northamptonshire.
- iv. Courses should be placed in our more rural communities to aid in the reduction of social isolation.
- v. Signposting should be used to provide wider opportunities in the leisure and arts sectors in addition to educational and careers guidance.

It was AGREED:

That the Panel would consider areas to select for future in depth discussion.

58 Draft Budget Proposals

The Executive Director for Adults, Communities and Wellbeing outlined the main headline assumptions within the draft budget proposals and highlighted the following;

- A pay increase to meet the Real Living Wage had been implemented, the impact on increased pension contributions would be evident in the budget.
- Words of caution were expressed when considering the funding for social care reform due to anticipated additional spending expectations.
- Proposals included a 1.99% increase in Council Tax and a 1% increase in the Adult Social Care precept for 2022/23.
- There would be opportunity for public engagement through the budget consultation process.
- Social Care grants and Better Care Funds will add clarification to the budget.

- The General Capital Fund Program allocated funds for housing and homelessness prevention.
- Officers continue to seek efficiencies to address the budget requirement for 2023/24.

Members noted contract changes & additional inflation, demographic & service demands, service change and development and COVID demands as additional pressures identified through the budget challenge process.

The Panel considered the draft budget proposals and raised the following principal points:

- The cost of borrowing presented a concern
- Rising costs would be expected as steps towards a carbon neutral council are introduced
- Steps should be taken to limit the use of assumptions within the budget
- Leisure services should have a clear scope for investment
- Allocations should be considered to support services in need of catch-up following the pandemic

It was AGREED:

That further opportunities to scrutinise the draft budget proposals within the Council be supported.

59 Forward Plan of Executive Items

The Panel received the Executive Forward Plan covering the period 1 December 2021 to 31 March 2022.

It was AGREED that the Executive Forward Plan of items be noted.

60 Work Programme

Members reviewed the forward list of items for future consideration by the panel.

It was AGREED that the following amendments be made to the work programme of the Health, Wellbeing & Vulnerable People EAP:

- Community Assets Transfer Policy to be amended to January 2022
- Better Care Fund report to be included for January 2022
- Social Prescribing to be included for January 2022
- Integrated Care Systems as an addition for February/March 2022

61 Updates and Alerts

The Executive Director Adults, Communities and Wellbeing provided updates on the Omicron variant of Covid-19

Concerns over the transmissibility within hospitals and the impact on staffing within care settings were noted.

The Chair raised concerns over the vote in the House of Commons to make vaccination compulsory in care settings. Members noted the potential for staffing shortages to be realised across our care settings from 1 April 2022.

It was AGREED that:

The Panel noted updates on the Omicron variant of Covid-19.

62 Close of meeting

Chair

Date

The meeting closed at 11:31 am

Northamptonshire

Health and Care Partnership



Page 9

Mental Health, Learning Disabilities & Autism Programme

Case for Change – for the Mental Health Collaborative

Version 5.5

Agenda Item 5

Mental Health, Learning Disabilities & Autism Programme Background Information

Key named contacts for the MHLDA Programme:

Name	Role	Contact Details
Angela Hillery	Executive Sponsor	angela.hillery@nhft.nhs.uk
Dr Nathan Spencer	Clinical Lead (Primary Care)	nathanspencer@nhs.net
Dr Itai Matumbike	Clinical Lead (Community and Inpatient Care)	itai.matumbike@nhft.nhs.uk
Paul Sheldon	Finance Lead	paul.sheldon@nhft.nhs.uk
Anne Rackham	Senior Responsible Officer	anne.rackham@nhft.nhs.uk
Morgan Price	Programme Manager	morgan.price1@nhs.net

Introduction

This document tells the journey, the rationale and the detail behind the proposal **to develop a formal Mental Health Collaborative as a subset of the Mental Health, Learning Disabilities and Autism Programme**, as directed by NHCP Partnership Board on 21 January 2021. This sets out the way the programme will level the voice of the third sector, those with lived experience and statutory organisations, as these are implicit core values of the Collaborative. The programme constitutes one of the four key priorities in the Northamptonshire Health & Care Partnership, and the story board has been developed to follow the NHCP Gateways for Collaboratives set by the NHCP work programme on collaboratives. The NHS Planning Guidance emphasises our move to collaboratives. The transformation we have completed to date, take us only so far on our journey. To go further Northamptonshire needs to make changes in the way we work together through the way we commission and contract services. In this document we have identified that way forward through a lead provider contract, enablers additional levers and opportunities to complete the next and future transformation tranches, that meet our system ambitions.

Please use these hyperlinks to navigate the document, setting out the information and rationale on the Mental Health Collaborative.

[Executive Summary](#)

- Executive Summary ([Slide 5-7](#))
- Who is involved in the MHLDA Programme ([Slide 8](#))

[Chapter – Where it Began](#)

- MH – Everybody’s concern ([Slide 10-15](#))
- National drivers and policy context ([Slide 16-17](#))
- Adopting a collaborative approach ([Slide 18-19](#))
- Our achievements (2017-2021) ([Slide 20](#))

[Gateway One](#)

- Vision ([Slide 22](#))
- Goals & Aspirations ([Slide 23-24](#))
- Case for Change – Summary Argument ([Slide 25](#))
- Collaborative High Level Plan ([Slide 26-27](#))

[Gateway Two](#)

- Redefining Collaboration ([Slide 29](#))
- Programme Structure ([Slide 31-32](#))
- Working together to achieve our aims ([Slide 33](#))
- Working with other NHCP Priority Areas ([Slide 34-35](#))
- Working at ‘Place’ & ‘Sub-Place’ ([Slide 36-37](#))
- Addressing Inequalities ([Slide 38](#))

[Gateway Three](#)

- Developing our ‘I’ Statements ([40-42](#))

[Gateway Four](#)

- Programme Governance Structure ([Slide 44](#))
- Programme Resource – Leadership & Delivery ([Slide 45](#))
- Accountable Decision-Making Process ([Slide 46](#))
- Investing for Outcomes ([Slide 47](#))
- Scope of Collaborative Contract ([Slide 48](#)).
- NHCP Collaborative – KLOEs ([Slide 49-50](#))
- Guide to Outcome Framework ([Slide 51](#))

[Gateway Five](#)

- Contracts that enable transformation ([Slide 53-54](#))
- Phased approach to outcome-based contracting ([Slide 55-56](#))
- The Adult/ Older Adult Outcome Based Contract ([Slide 57-58](#))

[Appendices:](#)

- Appendix One – References ([Slide 60-61](#))
- Appendix Two – Mental Health Outcomes Framework ([Slide 62-68](#))
- Appendix Three – Full list of coded ‘I’ Statements ([Slide 69-72](#))
- Further information (available upon request) ([Slide 73](#))
- Version Control Record ([Slide 74](#))

Executive Summary

Page 12



Mental health, learning disabilities and autism partners in Northamptonshire recognise the need to work in a collaborative because the intrinsic needs of the service users do not fit into any one organisation or setting. Service users are supported along pathways that straddle organisations. No organisation, working in isolation or only via a loose partnership, can transform our pathways. Since 2016 we have had a well-defined set of shared challenges that cannot be solved by individual organisations or through competitive contractual processes. We developed a new approach to working collaboratively across whole pathways and populations. We have transformed as much as we can within the current contractual framework. Northamptonshire requires a new arrangement that gives an equal voice to the partners involved and puts the priorities of service users and their families at the centre of strategic planning.

The collaborative has agreed a set of shared ambitions:

- ❖ Improve outcomes
- ❖ Best allocation of limited resources
- ❖ Focus on longer term transformation
- ❖ Collaboration not competition
- ❖ Giving a strategic voice to service users

We need to be radical to achieve these shared ambitions. Pursuing incremental change or arguing for the status quo is indefensible considering the dramatically poorer experience and outcomes of the service users we are focused on.

Delivering transformational change requires the gaps between multiple organisations to be removed and this requires one infrastructure of equal partners to make the best use of available resources.



The rationale for change is clear. If we do not change, we will see:

- ❖ Further increases in mental health, learning disabilities and autism activity across the health and care sector, from police to primary care to acute hospitals.
- ❖ Life Expectancy will continue to move further away from the national average. We already we see a 20-year reduction in life expectancy for this population.
- ❖ Northamptonshire will not deliver all of its Mental Health and Learning Disabilities Long Term Plan ambitions or deliver the full Autism strategy.
- ❖ Our suicide rate will likely increase.
- ❖ Our use of out of area admissions will increase providing a poor experience for patients and their families, wasting our scarce financial resources and resulting in poorer outcomes for our service users.

The call to action led us to consider our contractual options for how we all respond as a system. After analysis of all the options it was agreed at a Board to Board between the CCG and NHFT in November 2019, that we progress with **a lead provider model complimented with the combined power of a system collaborative, to ensure the contract successfully meets the outcomes for our population.** To do this, we need stronger mechanisms to enforce timely change. For example, the ICB will have to report to NHS England regarding challenge with wait-list targets. To meet this requirement consistently, we need a single contractual framework that enables us to meet the growing demands of IAPT & CYP access and wait list management.

The programme has agreed that a collaborative enables clinical leadership, the voice of the service user and equality among system partners. These partners hold the accountability for the collaborative and the programme team has been developed to enable all partners to have equal access to information for the decision-making process to enable transformation across all organisations.



The MHLDA Programme holds the intention for the future of MHLDA in our county.

The *first step* to move from a programme to a collaborative is a focus on **a Mental Health Collaborative**, involving:

1. Outcome-Based Collaborative Contract for Adult & Older People's Mental Health
2. This is based on a Collaborative Contracting Arrangement (using a Collaborative Agreement as a 'document to be relied upon')
3. A Lead Provider Model, offering a single provider lead for administering collaborative planning and delivery
4. A coproduced Outcomes Framework, using logic models to track Population Health Outcomes, System Ambitions and Service User-generated 'I' Statements
5. A delegated budget, aligning the resources to the ambitions (in the first stages this would include only NHFT Block contract for Adult/ Older People's Mental Health; Adult VCSE Mental Health; Mental Health NCA & Section 12 costs).

The contract would take the form of an NHS Standard Contract, which in the first tranche would include existing contracts for NHFT mental health, adult VCSE mental health and some Non-Contracted Activity (NCA) spend for mental health. This allows the commitment and the structure to enable the programme to tackle the more complex issues through the Collaborative.

This document tells the journey, the rationale and the detail behind the proposal **to develop a formal Mental Health Collaborative as a subset of the Mental Health, Learning Disabilities and Autism Programme**. One of the four key priorities in the Northamptonshire Health & Care Partnership.



Mental Health, Learning Disabilities & Autism Programme

Who is the involved in the MHLDA Programme?

The MHLDA Programme is currently made up of the following system partners:

Tranche One providers



People with Lived Experience



Page 16



Where it began:

Introduction & context to the development of the Mental Health Collaborative



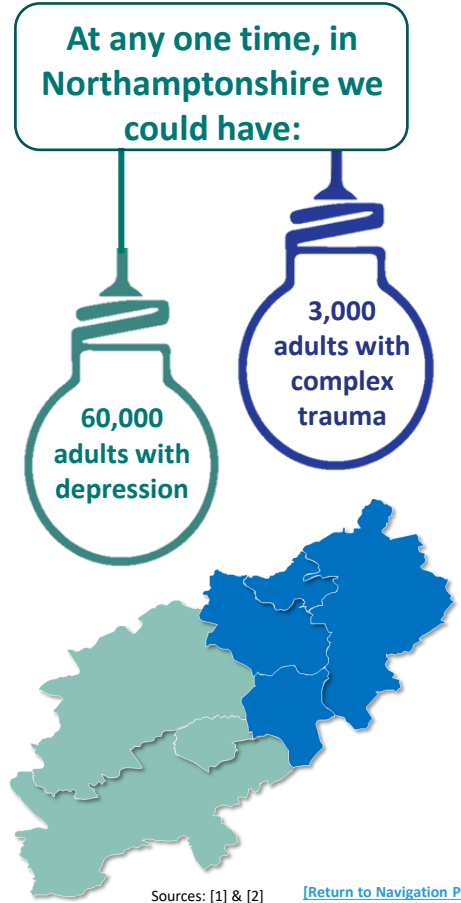
Mental Health Collaborative

Mental Health – Everybody's Concern

The relationship between mental health and wider health and care outcomes is well documented - poor mental health is now one of the largest sources of burden of disease in England – second only to musculoskeletal disorders [3]. Traditionally, strategies have framed mental distress as an individual psychological problem, rather than focusing attention on the root causes of suffering. But for many, material deprivation, social isolation, poor housing, substance misuse, and other wider determinants of health are the factors driving individuals into our mental health services. If left unsupported, psychological health deteriorates and the pressure spreads into our physical health, secondary care and crisis services [4].

The vast majority of people with mental health conditions in England go without structured clinical support entirely. Around two-thirds (including many with complex psycho-social situations) seek support from outside the NHS [6]. This is because people with severe mental health issues face social exclusion from society due to withdrawal from education, employment, daily tasks and activities [7], facing problems forming new relationships and job-related functioning, as well as issues of stigma and discrimination [8]. Having problems with substance misuse further compounds these issues and make our residents more likely to be homeless, incarcerated and have fewer social supports and financial resource [9].

People with severe mental health issues and learning disabilities face stark health inequalities as result. They are significantly more likely to develop preventable, long-term physical health conditions. They are double the risk of obesity and diabetes. They are 3x the risk of hypertension and metabolic syndrome as well as being 3x more likely to smoke.



Mental Health Collaborative

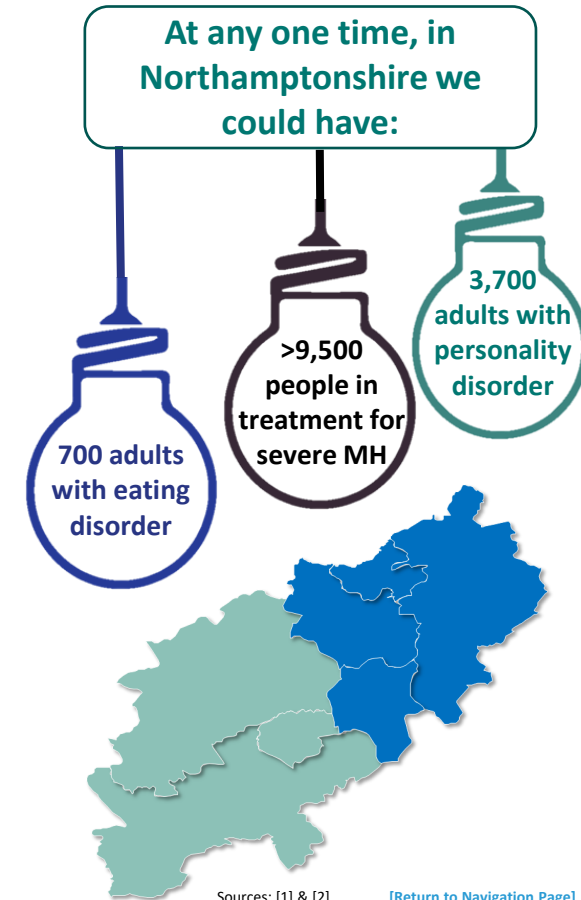
Mental Health – Everybody's Concern

They are 3.5x more likely to lose all their teeth, and 5x the risk of dyslipidaemia [5]. Ultimately, people with severe mental illness and/or learning disabilities are likely to die 15-20 years earlier than people who do not have these conditions [17].

These residents also suffer significant social inequalities. They are most prevalent in areas of low income and deprivation [10]. People with long-term mental illness are twice as likely to lose their employment [11], and almost half (43.2%) of those who claim Employment and Support Allowance (ESA) have made a suicide attempt at some point in their lives [12]. Furthermore, those experiencing fuel poverty, as a proxy measure for financial instability and general poverty, are also at a higher risk of suicide [13]. In England, 8% of children grow up experiencing ≥ 4 adverse childhood experiences – significantly increasing their risk of developing chronic mental health conditions in adulthood.

For those with a learning disability and autism, the risk of developing mental health issues is doubled [14]. Additionally, people with learning disabilities face poorer physical health outcomes due to missed opportunities to screen and intervene coupled with often multiple medication prescriptions [15]. They are more likely to be marginalised from meaningful employment, as well as experience adverse childhood events, poverty, and be victim of crime including abuse [16].

Mental health services alone cannot create meaningful health and care outcomes for our population. Northamptonshire requires a coordinated collaborative from across the system, characterised by partnership, pooled resources and integrated strategies.



Page 20

>2 in every 5 GP appointments are mental health related



People with severe mental health needs are **3x** more likely to attend A&E for their physical health



Police colleagues can spend up to **four hours** in A&E before they are able to admit to S136 suites



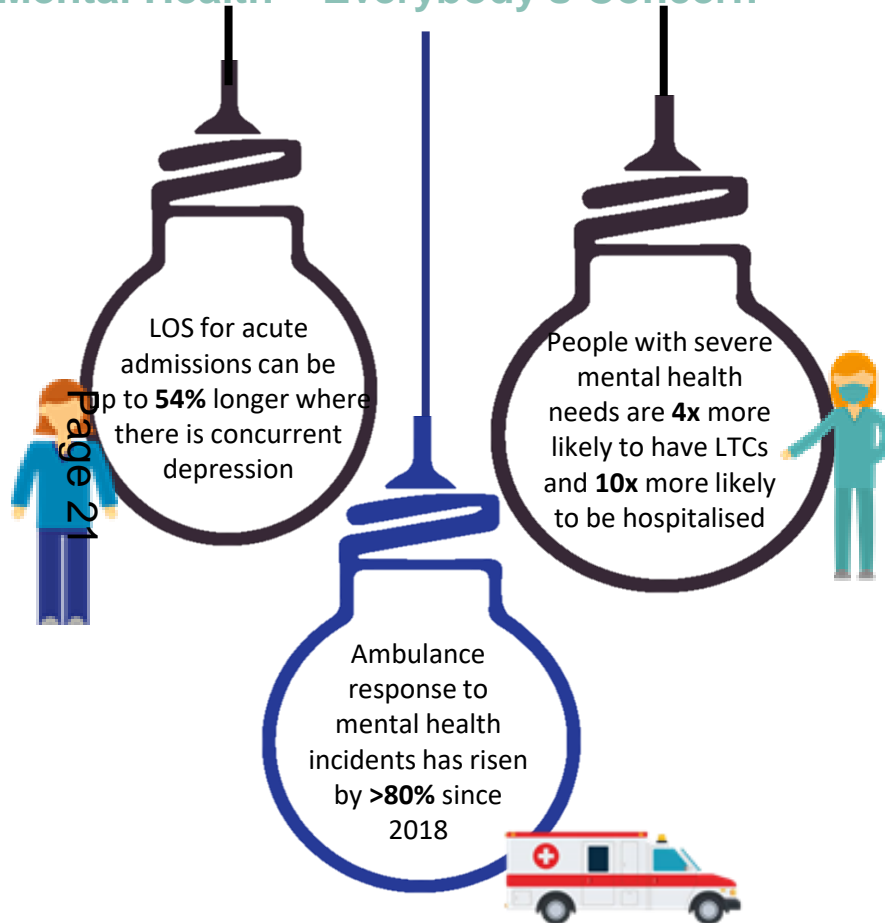
When our residents suffer poor mental health, every part of our system is impacted

People with severe mental illness and/or learning disabilities are 4x more likely to require support from long-term physical health teams. The complications caused by these co-occurring issues are significantly difficult for teams to manage. Perhaps unsurprisingly therefore, people with severe mental health issues are 10x the risk of requiring acute physical healthcare at some point, compared to those without mental health needs [18]. As a result, healthcare costs can be c.50% higher where patients have co-occurring depression or anxiety disorders [11].

Mental health also affects our residents ability to recuperate, meaning their length of stay in acute hospitals can be c.54% longer than those without co-occurring mental health needs [19]. Because poor mental health can affect likelihood of maintaining employment, sustaining housing and living independently, social care caseloads increase within an already stretched workforce. However, social care interventions (such as employment support) are often ineffectual until the underlying health concerns are resolved.

Mental Health Collaborative

Mental Health – Everybody's Concern



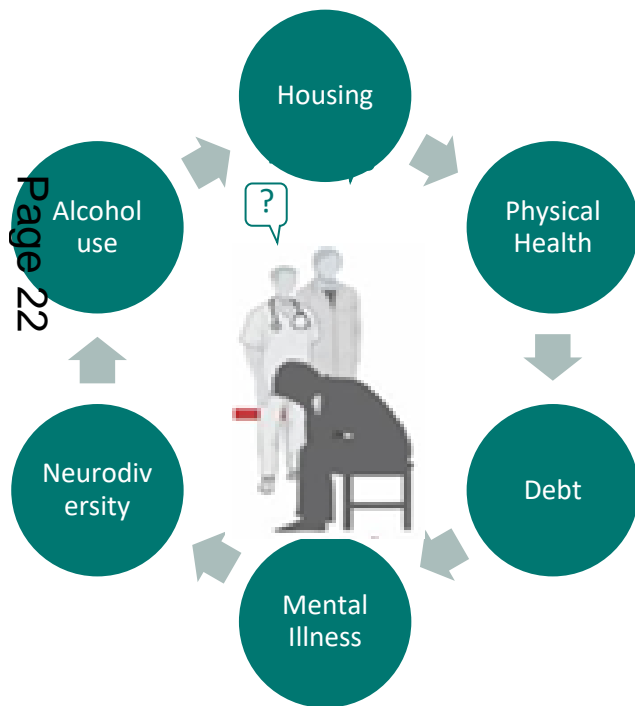
When our residents suffer poor mental health, every part of our system is impacted

When interventions are disjointed, insufficient or unsuccessful, health deteriorates and impacts emergency departments – people with severe mental illness are three times more likely to attend A&E for physical health complaints, and five time more likely to receive an emergency admission for acute care following A&E presentation [18].

Further afield, our police colleagues and ambulance colleagues are seeing a rise in mental health response requests, but do not always have access to clinical records to effectively understand or support the service user. Educators are finding it increasingly difficult to manage mental health presentations, alongside a busy curriculum. This is impacting school attainment and healthy development for young people, which is now known to impact health outcomes in adulthood including increased use of health/care services [11].

Often, the responsibility for managing these complexities falls to Primary care. Approximately 40% of GP appointments involve mental health, whilst 2 in 3 GPs say the proportion of patients needing mental health support has increased in the past 12 month [20].

Isolated & compartmentalised health & care pathways cause:



When mental, physical, neurodevelopmental and social factors combine in complex and co-occurring ways, professionals can be unsure how best to support, often spending significant time and resource navigating appropriate pathways of care, in the correct sequence. In some cases, only a fragment of the issues are known to the presenting team, which can result in misguided care & treatment plans, and further confusion when these are ineffectual.

Alternatively, it becomes easy to simply treat the condition that the presenting team is expert in, and signpost to support for wider concerns separately. This constitutes a short-term solution, but also fragments the care for the individual and reduces likelihood of achieving population health outcomes. Opportunities to prevent future reliance on health and social care systems are missed. As a result, repeat treatment episodes become necessary, sometimes culminating in frequent/ intensive service users and unnecessary costs to the system. Over time, this has a deleterious affect on the wellbeing and morale of our workforce, as well as their trust in wider pathways of care.

No one organisation/ sector has the ideas, solutions or resources to address population needs. We must work together, learn from one another, and co-design integrated pathways of support in partnership

In order to deliver the desired population health outcomes, staff and their system colleagues need time and space to understand and plan a programme of recovery-focused support, in coproduction with the service user and their carers. Access to shared clinical records, existing support and safety plans, and multi-disciplinary professionals meetings would allow the following:

- People get the right **type** of intervention(s) for all their their needs.
- People receive the right **amount** of care to bring about long-term recovery and stability, without excess resource or waste.
- People receive care in the right **sequence**, ensuring priority needs (i.e. homelessness) are addressed prior to secondary needs (i.e. therapy).
- People **do not have to tell their story multiple times** – instead, existing support plans can be reviewed and built-upon wherever the person presents in the system.
- Staff feel **trained, prepared and supported** to make every contact count with our people – they have full command of a person's circumstances, and are aware which pathway of support exist, and how to access them.



LTP Mental Health Implementation Plan

- Perinatal Mental Health
- Children & Young People's Mental Health
- Common Mood Disorders
- Community Severe Mental Illness
- Adult Community Crisis
- Adult Mental Health Inpatient Care
- Suicide Prevention & Bereavement
- Homelessness & Rough Sleeping
- Mental Health & Problem Gambling

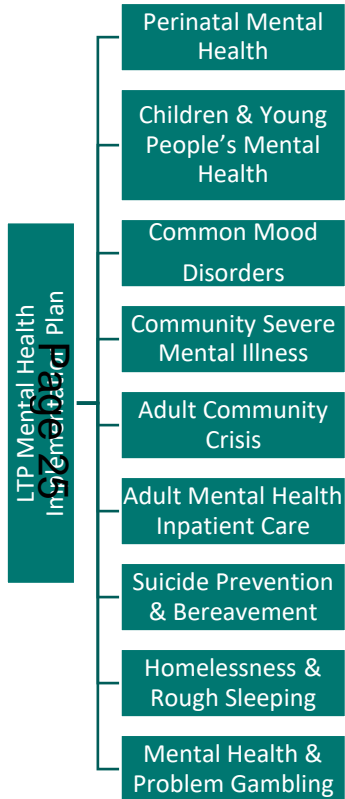
The NHS Long-Term Plan for Mental Health

In 2016/17, NHS England published the Five-Year Forward View Strategy for Mental Health. By 2019, this was replaced by the NHS Long Term Plan, which now sets the agenda of transformation for the ten years 2019/20 to 2029/30. The Mental Health Implementation Framework provides implementation deliverables for the first half of this process, up to April 2025. A similar implementation plan has been published for Learning Disabilities and Autism. NHS England declared that the additional £2.3 billion of ring-fenced funding for mental health will ensure this becomes the fastest growing transformation programme in the NHS for the next five years.

The Mental Health Long-Term Plan includes **38 ambitions across 11 programmes** of work (covering the breadth of mental health pathways, from common mood disorders to crisis and inpatient care). NHS England have provided indicative values for workforce growth and financial investment, aligned to each programme. For the Northamptonshire system, this involves a growth in mental health workforce by **c.281 WTE** over the 5-year period, as well as indicative additional investment of **c.£25.3m**.

The NHS Long-Term Plan is clear that delivery of MH ambitions will not be feasible via traditional mental health services alone, and that all areas will need to develop *“integrated, population-level health systems [with] localised and personalised responses to health inequalities”* in order to achieve the defined outcomes.





The NHS Long-Term Plan for Mental Health

Among the various LTP ambitions are integrated pathways of mental health crisis support and integrated approaches to community mental health, *wrapped around primary care, acute physical health services & community services* and delivered using place-based approaches.

Priority ambitions include the development of physical health monitoring for people with mental health, LD and/or autism. Additionally, new NHS-Led Provider Collaboratives will take on devolved responsibility for managing traditional specialised commissioning functions with a focus on end-to-end pathways of care – secure services, eating disorders, Tier 4 CAMHS and perinatal inpatient services. NHFT is leading the East Midlands Tier 4 CAMHS Collaborative

Local implementation planning has taken place, aligned to the Long-Term Plan deliverables to 2025 – See [Appendix Two](#). Further implementation planning for Phase Two (2025 – 2030) will be undertaken following clarification on the national strategy. The following slides provide a summary of the progress to date in delivering against the LTP Strategy – whereby system collaboration and coproduction of pathway redesign has been the adopted method for delivering transformation.

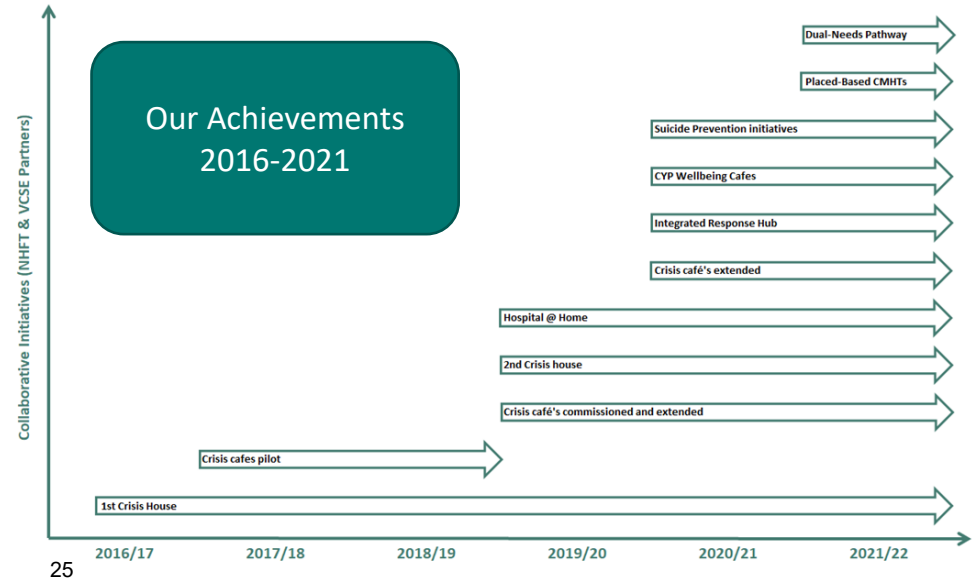
Mental Health Collaborative

Adopting a collaborative approach (2016-2021)

The journey to date, and its early successes:

In 2016/17, Northamptonshire re-launched the **Mental Health Transformation Board**. The objectives were to create an environment of partnership working across our system, in order to deliver against the ambitions of the *Five-Year Forward View for Mental Health* (now the NHS Long-Term Plan). Eight initiatives (shown opposite) provide examples of multi-sector schemes supported by Lead Provider models. Each initiative brings together multiple system providers under single contracts, to deliver health outcomes for residents and relieve pressure in the wider the system.

Crisis cafés provide sub place-based alternatives to A&E, whilst Crisis Houses have thus far prevented 806 mental health admissions and 50 acute hospital admissions. Since its inception in April 2020, the integrated Response Hub (24/4 Mental Health support line) has navigated over 133,000 MH enquiries, and is aligned to NHS 111. Our CMHT transformation programme will see our secondary community MH service disaggregated into 9 sub place-based teams, wrapped around primary care and aligned to the new social care structure. The mental health crisis pathway has since won HSJ awards for its integrated approach, and our proposal for Place-Based CMHTs was published by NHSE/I as an example of best practice.



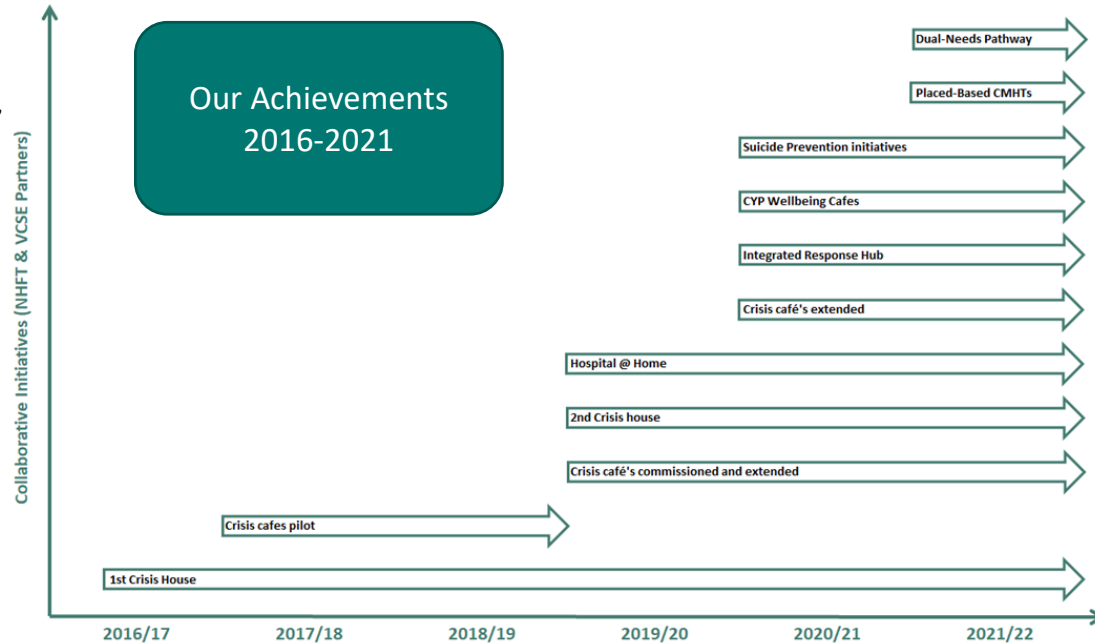
Mental Health Collaborative

Adopting a collaborative approach (2016-2021)

The journey to date, and its early successes:

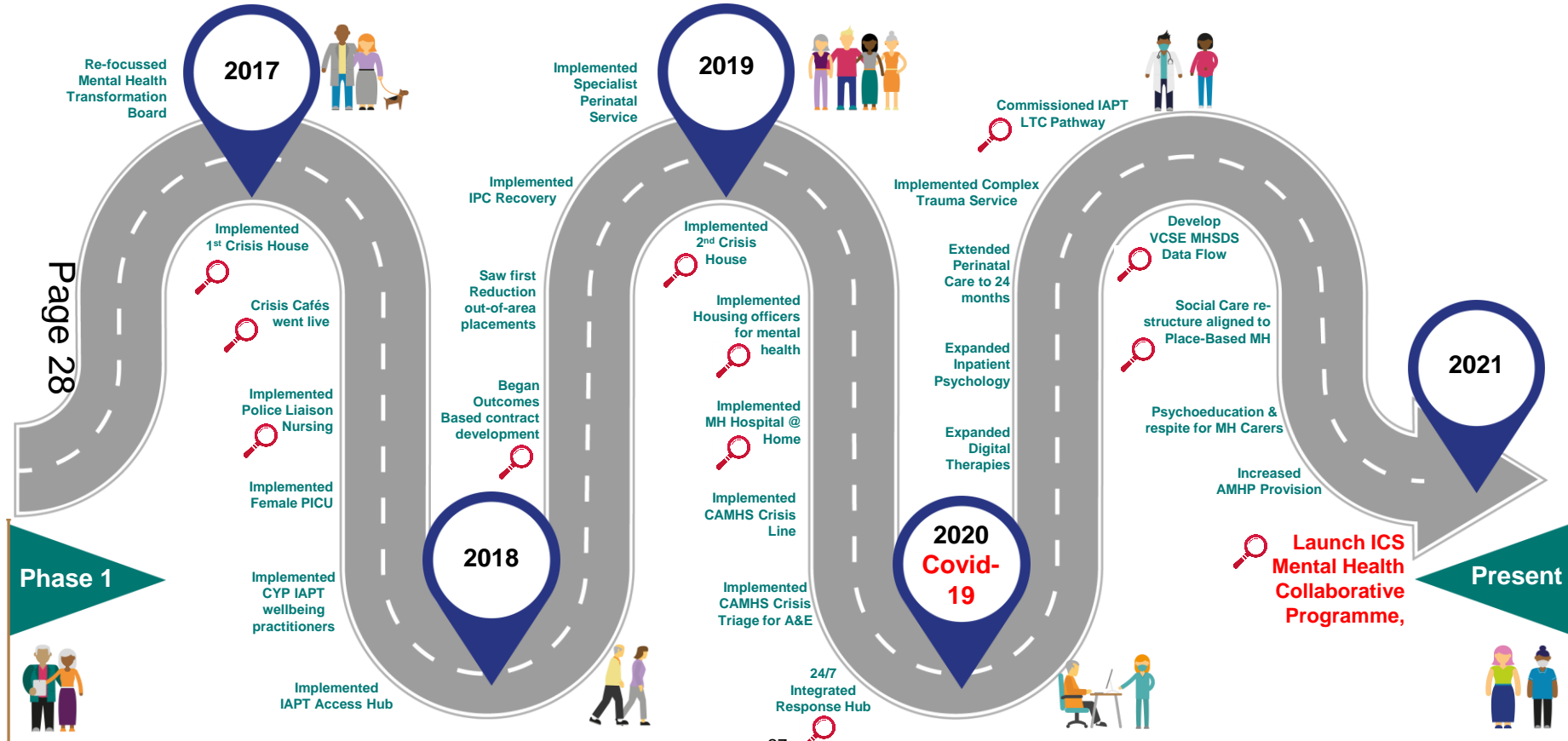
Most importantly, the schemes have provided the opportunity to test integrated commissioning and delivery, whereby system partners could demonstrate the ability to work together under singular (outcome-focused) contracts, and with a Lead Provider approach. These early pilots have given confidence to the broader principle of a single Outcome-Based Contract for all Adult/ Older Adult Mental Health services – discussed in [Slide 22; Vision](#)).

The following slide provides a more detailed roadmap of mental health initiatives since the commencement of the MH Transformation Board, and highlights examples of collaborative schemes (involving two or more system partners) with this symbol - 🔍



Mental Health Collaborative – Northamptonshire

Our achievements (2017-2021)



Page 28

Phase 1

Gateway One:

Vision, goals
and aspirations
of the MH
Collaborative
Programme

Page 29



The agreed vision is to coproduce seamless, responsive pathways of integrated mental health and care services across Northamptonshire, which feel:

Meaningful

1.

For too long we have measured our success on the basis of our system's outputs. These are often indicators that have little meaning or relevance to the outcomes our residents wish to achieve.

Our vision starts with a shift of focus – measuring our success predominantly on the delivery of outcomes for our population.

From whole pathway redesign to individual Care Plans, coproduction will be the defining principle. The approach will be strengths-based, goal-oriented, and recovery-focused. Our residents will feel ownership over their own health and care process.

We believe this will produce longer-term health outcomes, fewer relapses, and relieve key system pressures (such as on Urgent care and Primary care)

Person-Centred

2.

To do this, we must recognise that we have been operating with a 'team-centred' approach – whereby risk thresholds, opening times and strict specifications create criteria for exclusion, and gaps in our system.

Our vision continues with the development of 'person-centred' care – whereby we flex our pathways according to people's needs. To be truly person-centred, physical health and social care needs must be factored in to holistic care plans, and we must broaden our approach to MDT-working at 'Place' and 'Sub-Place' to meet service user expectations.

We believe this will support residents to seek help sooner, reduce DNAs/ withdrawal from treatment, as well as tackle some key inequalities in access and experience of care.

Agile

3.

Ensuring all care is more meaningful and person-centred will require a programme of transformation, and it will be important to consolidate system resources to achieve this within set timescales.

Our vision involves a gradual devolution of mental health resources to a dedicated collaborative of system partners. The ultimate aim of the collaborative would be to manage a left-shift in system spend by targeting investment on the most effective initiatives at any time, as well as efficient withdrawal/ reinvestment according to changes in population need or healthcare policy (e.g. NHS Long-Term Plan).

We believe delegation will allow for faster transformation, and ensure the best use of system resource in the achievement of defined population health outcomes.

Integrated

4.

The mental health programme can demonstrate examples of partnership working for better outcomes (See slide ...). However, integration at pace and at scale will require partnerships to become more formalised.

Our vision includes the development of a single contract for the management of all mental health resource, and for the delivery of all mental health outcomes. The collaborative of system partners would co-design operational strategy and assure achievement of desired outcomes.

A Lead Provider would manage financial administration and sub-contracting arrangements with all partner organisations required to deliver against the agreed Outcomes-Framework, and provide accountability to the Integrated Care Board.

Intelligent

5.

As a system, we hold a significant amount of data and apply a great deal of resource to strategic commissioning across health, public health and social care. However, all too often the teams, plans and data are compartmentalised by organisations and isolated from one another.

Our vision concludes with the gradual unification of skills, data sets and intelligence, to support integrated commissioning within the framework of the collaborative. In this approach, 'commissioner' and 'provider' labels fall away, and strategic commissioning becomes the concern of all partners – informed by amalgamated data sets, directly linked to desired outcomes.

We believe this will drive system efficiencies, address duplication/gaps, and ensure quality of care that is clinically informed.

Mental Health Collaborative

Our Goals and Aspirations

The Collaborative is committed to transforming services for our patients, clarifying pathways for our stakeholders and tackling health inequalities for our residents. To this end, the Collaborative has set itself **5 System Goals** and **14 Collaborative Aspirations**, which it believes will be achievable through partnership:

5 System Goals



Improve outcomes for patients, service users, carers and residents of Northamptonshire with Mental Health, Learning Disabilities and/or Autism.



Delivery of both **known and emerging requirements** – including NHS Long-Term Plan, Public Health Outcome Frameworks, Care Act and local Service User ‘I’ Statements.



Make the **best use of limited resources**, by addressing duplication and gaps within pathways and reinvesting in preventative initiatives (left-shift of system spend).



Enable longer-term transformation, via cross-system partnerships and integrated commissioning approaches.



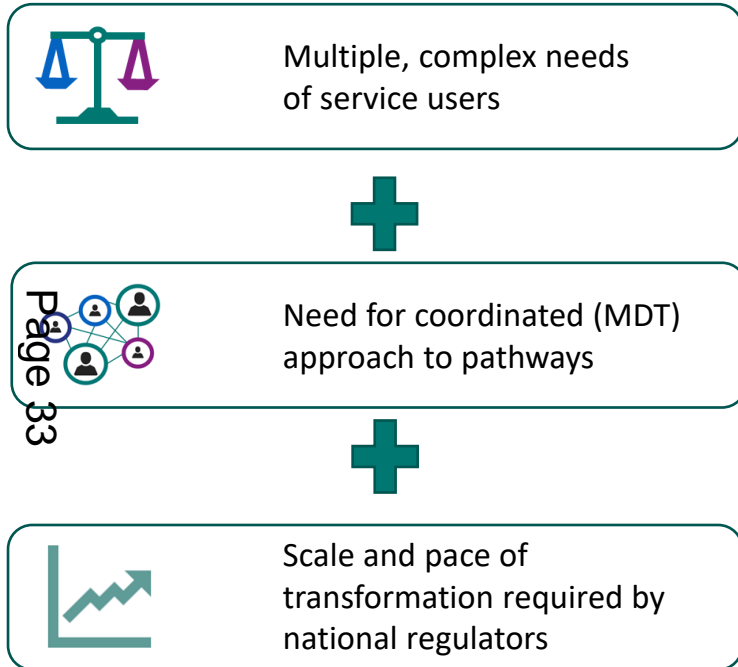
Reframe system relationships in **support of Integrated Care System (ICS)** aspirations, to drive sustainability, transparency and accountability.



The Collaborative is committed to transforming services for our patients, clarifying pathways for our stakeholders and tackling health inequalities for our residents. To this end, the Collaborative has set itself **5 System Goals** and **14 Collaborative Aspirations**, which it believes will be achievable through partnership:

14 Collaborative Aspirations (Population Health Outcomes)

1. Fewer people will end their life by suicide.
2. Fewer people will feel the need to resort to self-harming behaviour.
3. Information & opportunities to monitor and maintain good emotional hygiene, increasing resilience and preventing poor mental health, will be available to all who want it.
4. People will have increased life satisfaction, worth and happiness following experiencing the first signs of mental health problems.
5. People with severe mental illness will have increased hope, control and opportunity to access personalised, integrated (mental, physical & social) care 'at place'.
6. More people with severe mental illness will be supported to obtain and maintain meaningful employment.
7. People with severe mental illness will not die prematurely on the basis of preventable physical health issues.
8. Perinatal women and their partners are supported to maintain the best possible mental health during/after pregnancy, and develop strong emotional bonds with their children.
9. All people experiencing mental health crisis will have the control and opportunity to receive care rapidly, and in the most conducive environment for their needs.
10. All people experiencing mental health crisis will receive personalised, needs-led care, focused on addressing the root-cause of the crisis and decreased likelihood of repeat crisis episodes.
11. All people with severe mental illness will receive compassionate care, as close to home as possible, and in the least restrictive environment.
12. All people who require inpatient care will be supported to recover quickly, and be discharged safely.
13. Children will be supported to maintain stable emotional health and wellbeing when transitioning to adulthood, if they need it.
14. Carers of people with mental health needs will be supported to continue caring for their people, without sacrificing their own health and wellbeing.



Page 33

A collaborative of system partners that can:

- Pool data and expertise to align all system priorities,
- Identify duplication and gaps, and
- Co-produce integrated pathways of MH health and care.

A single contractual framework operating under a Lead Provider Model that can:

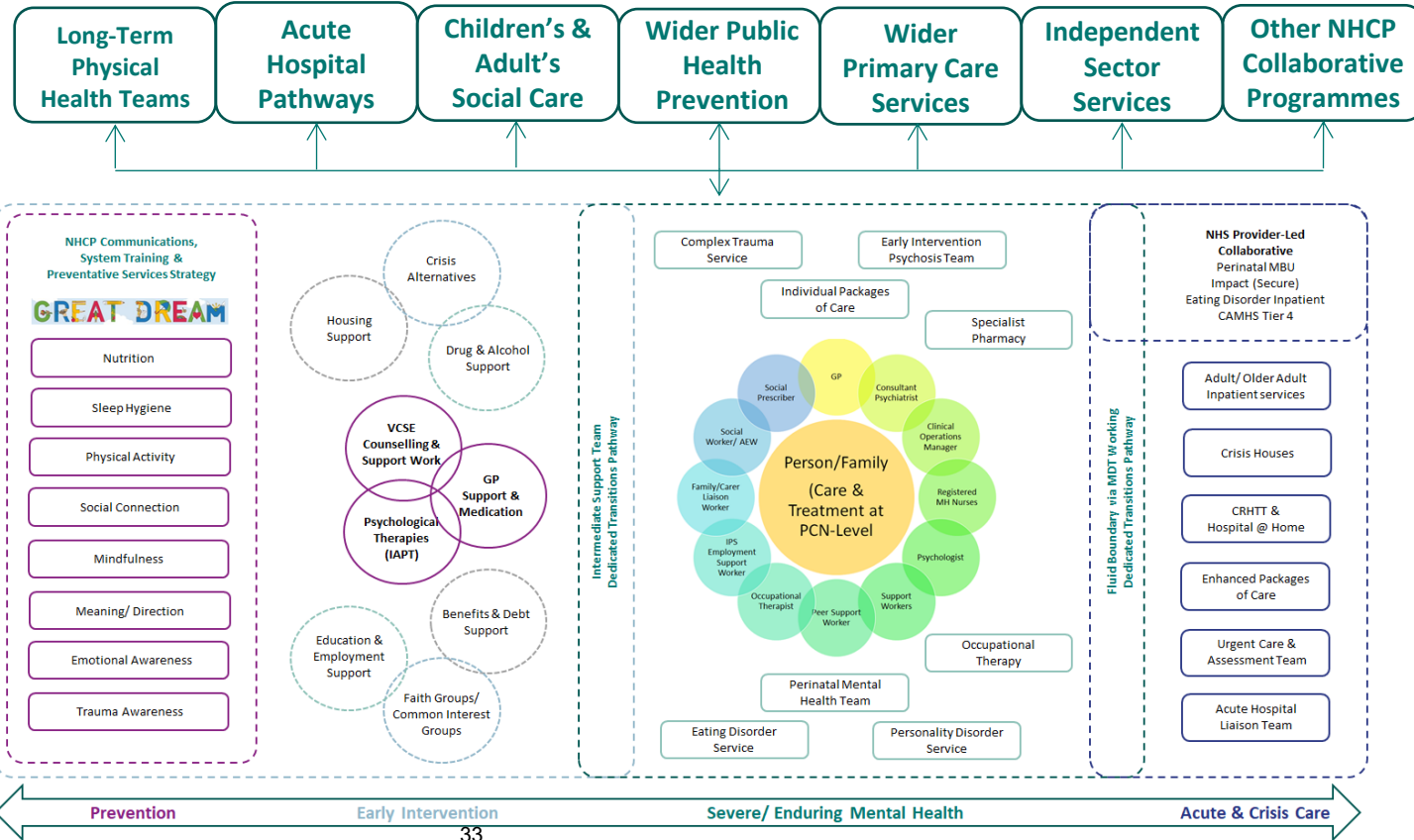
- Centralise responsibility for coordinating a pathway integration between sectors,
- Manage a delegated budget to ensure sustainability as well as move funding rapidly to manage new/emerging need, and
- Apply an Outcome-Based approach that delivers against system priorities.

Mental Health Collaborative High-Level Plan

Clear, Accessible, End-to-End Pathways:

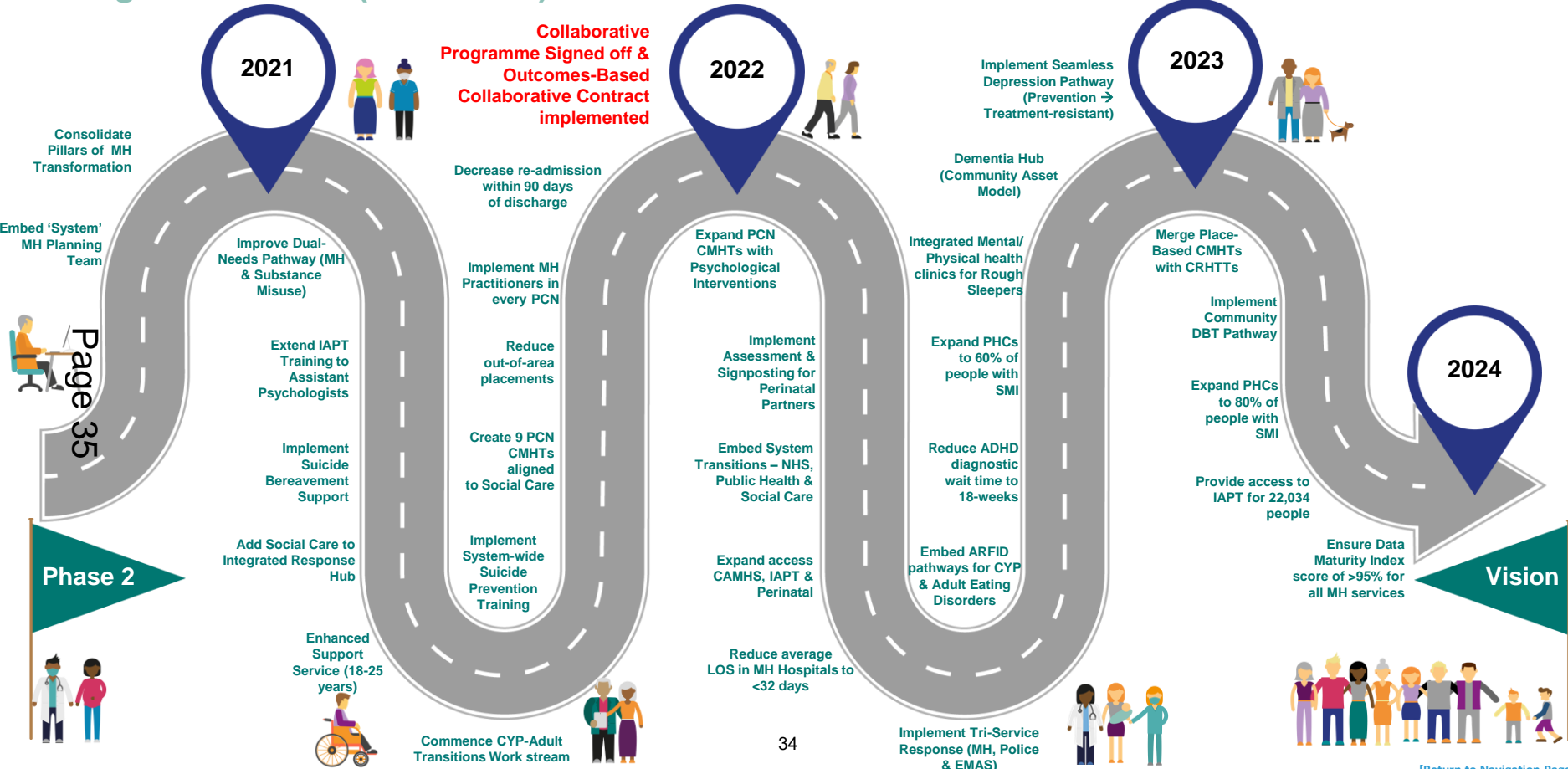
The MH Collaborative is committed to delivering pathways of support for people, that are:

- ❖ **Clear** – Residents, system partners and wider stakeholders can easily find information and guidance for what is available (24 hours a day / 7 days a week).
- ❖ **Accessible** – Services are available at ‘place’ and sub-place’ level where required to produce best population outcomes.
- ❖ **End-to-End** – Removal of traditional frameworks that create exclusion to be replaced with personalised/ needs led models of care.



Mental Health Collaborative

Our High-Level Plan (2021-2024)



Page 35

Gateway Two

Page 36

Structure & operating model for the Mental Health Collaborative



What is the 'MH Collaborative', and why do we need this now?

Collaboration is not a new concept, however the term 'Collaborative' has taken on new and various meanings since the Health & Care Bill (2021) was first launched. Locally, a number of NHCP priority programmes are considering collaborative models of working, and each may define their 'Collaborative' in different ways.

For Mental Health services, the development of a collaborative has been an organic process over a number of years. It began with commissioners and providers simply coming together to engage in planning and delivery of new services with a partnership approach. Over time, this became more structured, moving to a formal collaborative. For us, this meant the following:

- **A new process** for combining all system priorities and ambitions (health, public health and social care) in one Outcomes Framework. This allows for a single-system strategy for MH, including the ability to identify long-standing duplication and gaps in/ between health & care pathways. It provides opportunities for more tactical, integrated commissioning for shared objectives.
- **A new structure** to organise system partners into the right spaces for tactical discussions about whole-pathway transformation. This allows a large agenda to be broken down into manageable work streams (pillars), with sub-collaboratives of partners who have specific areas of focus (e.g. Prevention, or Crisis).
- **A new leadership** approach including a dedicated Executive Sponsor and Executive Board. This provides strategic assurance and accountability to the work of the collaborative, as it reports into the Integrated Care Board. It provides legitimacy to the plans and proposals of the collaborative, as aligned and agreed by the system.



Mental Health Collaborative Programme Structure

The Collaborative has agreed a programme structure that will enable clinical leadership, the voice of the service user and the involvement of an equal set of partners. These partners hold the accountability of the programme and the programme team has been developed to enable all partners to have equal access to information for the decision-making process to enable transformation across all organisations.

The clinical aspects of this for MH are demonstrated within the four pillars of the wider MHLDA programme, the first 3 pillars are part of the MH Collaborative:

Population Health and Prevention

Using engagement, intelligence and forecasting to predict our future to predict future challenges and take action to prevent ill-health wherever possible. Maintain a focus on the underlying biopsychological determinants of poor health and wellbeing and take action to prevent it. Identify prevention opportunities using evidence-based initiatives and ensure a rigorous approach to continual, quality based improvements.

Outcomes-based Pathways

Broadening our vision to focus on all determinants of mental health and produce a seamless, all-age, outcomes based mental health offer. Deliver end to end, seamless pathways of health and care provision that respond to holistic needs (housing, employment, family needs, physical health). Focus on all determinants of mental ill health and co-produce a seamless, all-age, outcomes-based offer.

Acute and Crisis Community Care

Provide reliably excellent care to those affected by the most challenging and complex issues, effectively and compassionately. Produce the most timely response for those in crisis, operating on a compassion focussed, trauma informed basis. Ensure that those in acute hospital settings are treated quickly and support all those that have MH conditions.

Learning Disability and Autism

Driving transformation of all pathways that support people with Learning Disabilities & Autism – ensuring a focus on outcomes, safety, quality and system. Ensure a system-wide understanding of LDA and tackle inequalities in access and experience of care and treatment.

Part of the MHLDA programme but not this phase of the MH collaborative

Strategic Steering Group Leadership Team

This is a sub-group of the Steering Group and comprises members drawn from that body. It will be responsible for formulating the strategic direction, managing the agenda for meetings of the Steering Group, managing the programme streams and managing the PMO function.

Strategic Steering Group

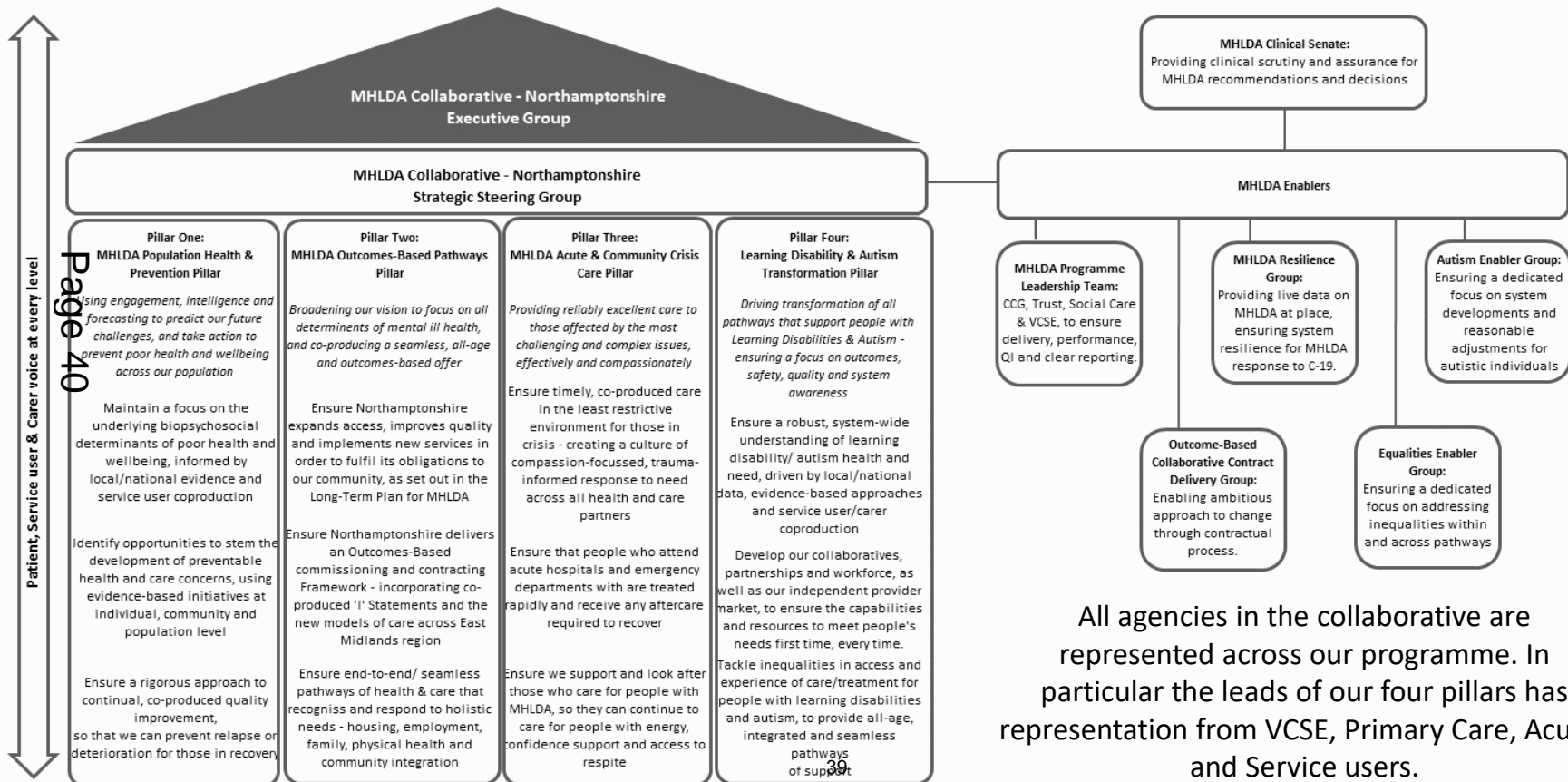
This is a joint Northamptonshire partnership working group with overall responsibility within the ICS ('The Northamptonshire Health and Care Partnership'), for delivering oversight and transformation of mental health, learning disability and autism services in Northamptonshire, reporting to the MHLDA Executive Group. The Steering Group will jointly agree and oversee commissioning activity, propose contracting and service developments and ensure the vision and strategic direction for the future of mental health, learning disability and autism services in Northamptonshire is delivered, within the auspices of an Outcomes Based Commissioning Framework (OBCF) and in delivering the requirements of the NHSE Long Term Plan. It reports to the MHLDA Executive.

MHLDA Executive

This is a joint Northamptonshire partnership strategic leadership group to enable a collaborative approach to the planning and delivery of mental health, learning disability and autism services in Northamptonshire and achieve a fully integrated model of care based on the needs of the population. The Executive will ensure the vision and strategic direction for the future of MHLDA services in Northamptonshire is delivered, with an initial focus on addressing the challenges of the Long-term Plan. The Executive will work collaboratively and in accordance with the governance of the NHCP and will report to the latter by exception.



Mental Health, Learning Disabilities & Autism Programme Programme Structure



All agencies in the collaborative are represented across our programme. In particular the leads of our four pillars has representation from VCSE, Primary Care, Acutes and Service users.

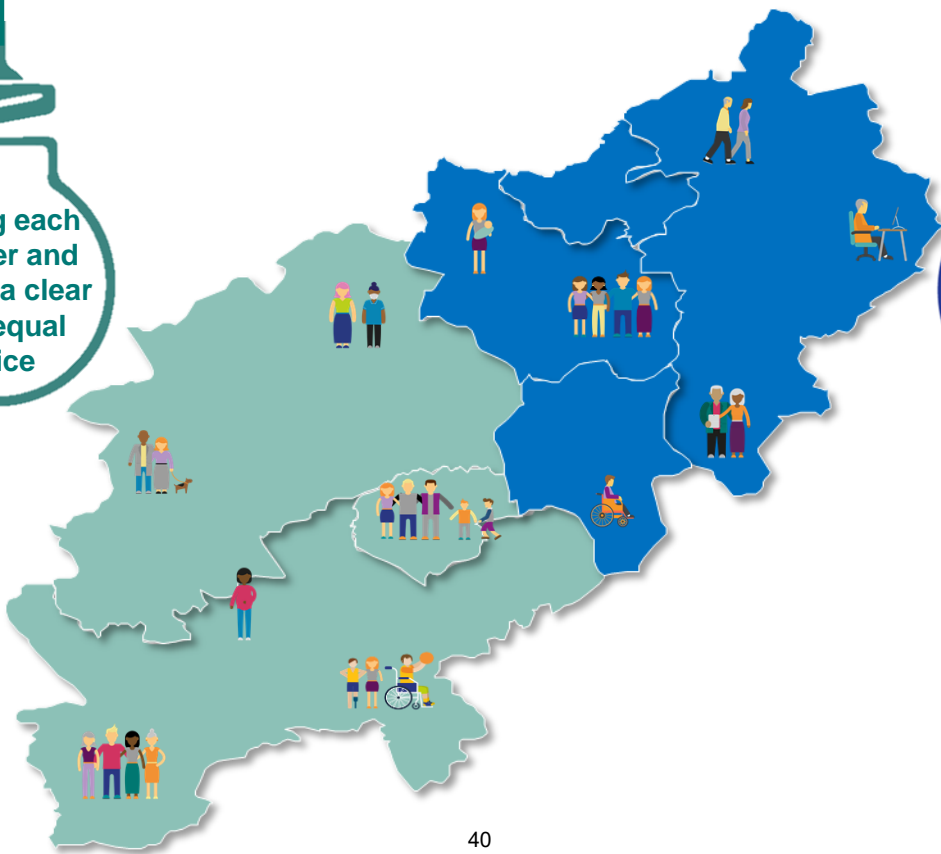
Mental Health Collaborative

Working together to achieve our aims

Generating new ideas, approaches and solutions using the spectrum of system resources

Giving each partner and sector a clear and equal voice

Combining data sets, and sharing intelligence for strategic system planning



Checking facts and challenging assumptions as critical friends

Co-designing new, integrated pathways

Combining resources to eliminate duplication and gaps

Mental Health Collaborative

Working with other NHCP priority areas

Joint working between NHCP programmes (Delineation of Responsibility)

Due to the way some pathways are being transformed, it has been decided that aspects of mental health, will sit within other programmes, in other programmes there are opportunities to provide support to their delivery goals.

For instance, it was felt that Children's Mental Health services should be aligned predominantly with wider children's services (physical health, social care and education). For this reason, the MH collaborative will maintain oversight of children's mental health ambitions, however these will be planned and delivered **via the CYP** Transformation Programme.

System deliverables related to Dementia will also be overseen by the MH Collaborative, but be designed and delivered **via the iCAN** programme, to ensure they align with wider frailty services.

Improved community support for managing mental health and well-being will enable services to support the **elective programme**, helping people prepare for planned care, living with changes and recovering well.

In instances such as these, Programme Leads are working together to map the work streams in other programmes and ensuring reporting structures to provide updates into the relevant pillars of the collaborative.

Mental Health Collaborative

Working with other NHCP priority areas

1.



Page 43

Programme recognises a cross-cutting theme with another programme

2.

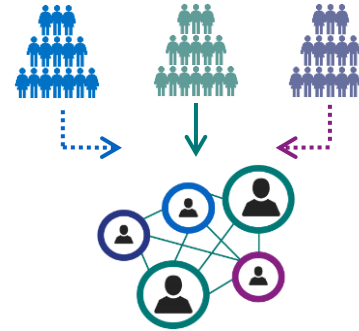


SRO-to-SRO discussion confirms a Programme Owner.

Agreement over:

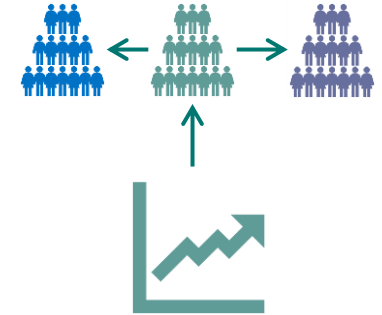
- Affected pathways
- Oversight arrangements
- Working Group members

3.



Owner Programme/Pillar convenes Working Group (with cross-programme members if required).

4.



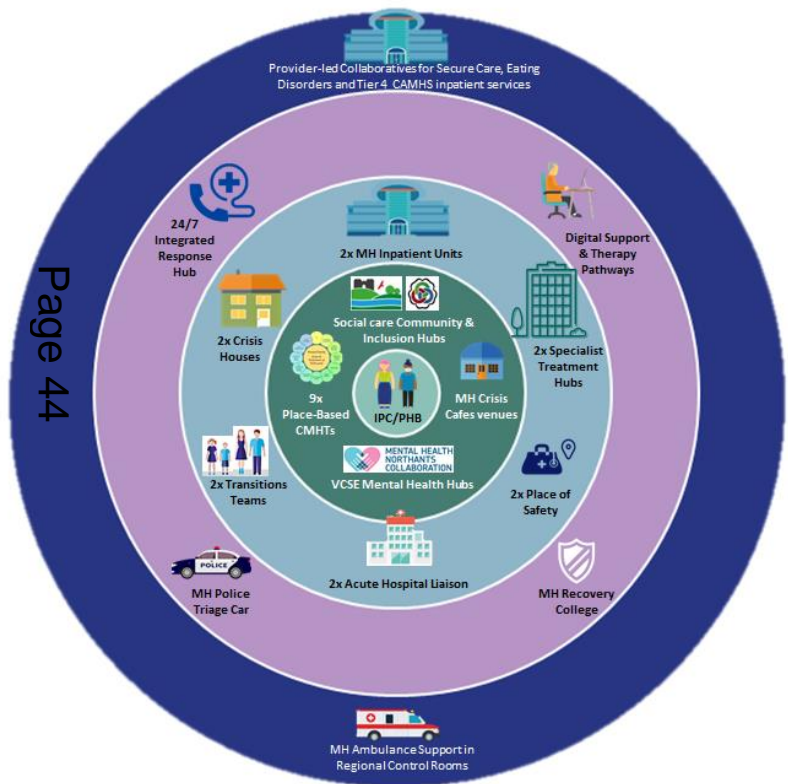
Working Group reports to Pillar/ Programme. Pillar/Programme provides updates/assurance to related programme via agreed arrangements.

Applying a Place-Based Strategy to an Outcomes Framework

Place-Based Care is about understanding our populations needs, and why our residents may have been unable or unwilling to engage in health and care services in the past. It is about understanding where our residents feel their 'community' is, and how those communities (and their specific needs) might differ across the county, as well as how that community could be developed to contribute to better health outcomes. It provides a basis to better understand the most complex inequalities our residents face, and allows a framework for developing strategies to address them.

Mental Health Collaborative has disaggregated existing infrastructure by place and community/ neighbourhoods (see opposite, and **Slide 37**). We have also commenced a range of projects to transform existing services into 'place-based' approaches. For example, *Secondary Care Community Mental Health has now been separated into nine neighbourhood teams, aligned to Primary Care.*

By working as a collaborative and in conjunction with North & West Northamptonshire Health & Wellbeing Boards, we are developing a deeper understanding of each community, ensuring prevention and wellbeing is key to the programme. This will involve mapping their community structures – common interest groups, faith groups and community-led initiatives – and aligning health and care services in convenient and culturally sensitive ways.



Page 44



Mental Health Collaborative

Delivering at 'place' now

Available at 'Place'



Mental Health
Inpatient Hospitals



Specialist Mental
Health Treatment
Centres



Mental Health Crisis
Houses

Page 45



Available at Community/ Neighbourhood Level

Neighbourhood
Community MH Teams



Mental Health
Crisis Cafes



North Northamptonshire
Council – Community Hubs



West Northamptonshire
Council – Community Hubs

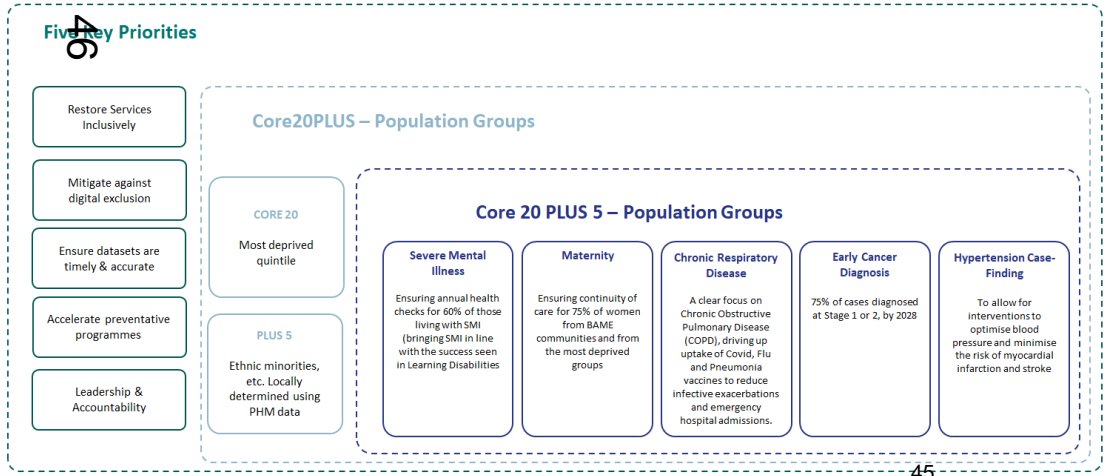


Mental Health
VCSE Sector Hubs

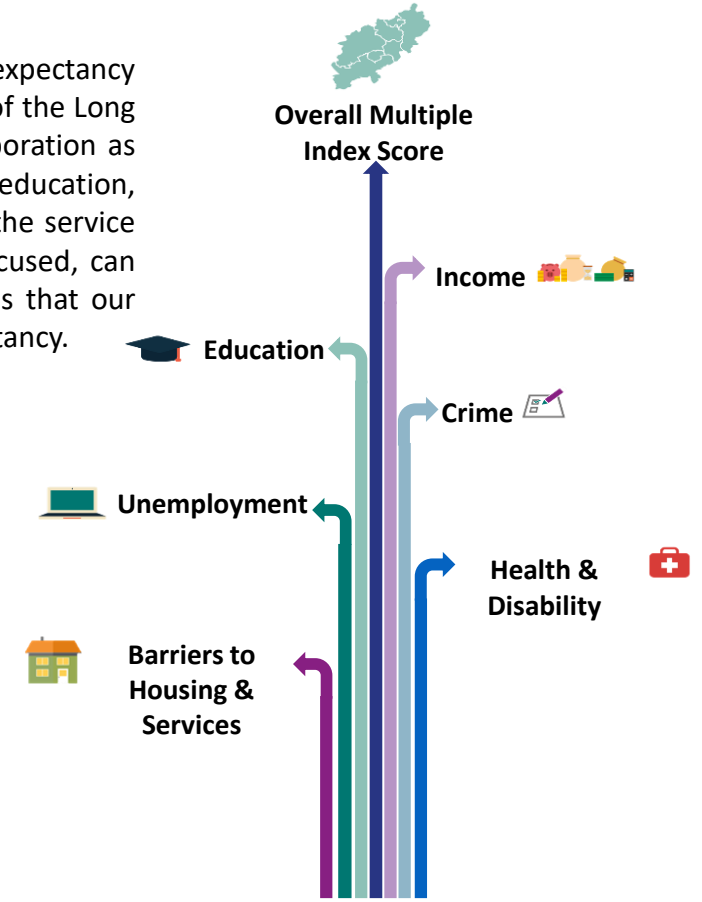


Health Inequalities for people with MH are a key driver for our case for change. Life expectancy for this population is over 20 years lower than the rest of the population. The basis of the Long Term Plans are around reducing these health inequalities and are centred on collaboration as there are so many factors that impact on mental health - including income, education, unemployment, housing issues and more. No one agency can resolve the needs of the service user alone and only by collaborating, with clear processes that are service user focused, can improve the inequalities. Severe mental illness is one of the Core 20 Plus 5 groups that our system will have to effect changes for to improve not only quality of life but life expectancy.

Page 46



45



Gateway Three

System Engagement

Page 47

How co-
production
shaped our
collaborative



We started on a collective journey in **2016** as commissioners, providers and those with lived experience to agree on our main areas of concern / challenge and how we would all be involved in making changes to improve outcomes for those with mental health needs.

This ethos of co production now runs through the veins of our programme with people with lived experience having an equal value in their contribution to the programme and holding leadership roles in each of our pillars alongside clinical leads.

This original co production group developed workshops across the county with the general public to understand from them what would support their recovery and provide them hope, control and opportunity for their future. This work was distilled together through co production into I statements that have been used to shape many of the services that we have developed together since this time, but also provides a basis for our Outcomes Based Contract and sit alongside system and population outcomes.

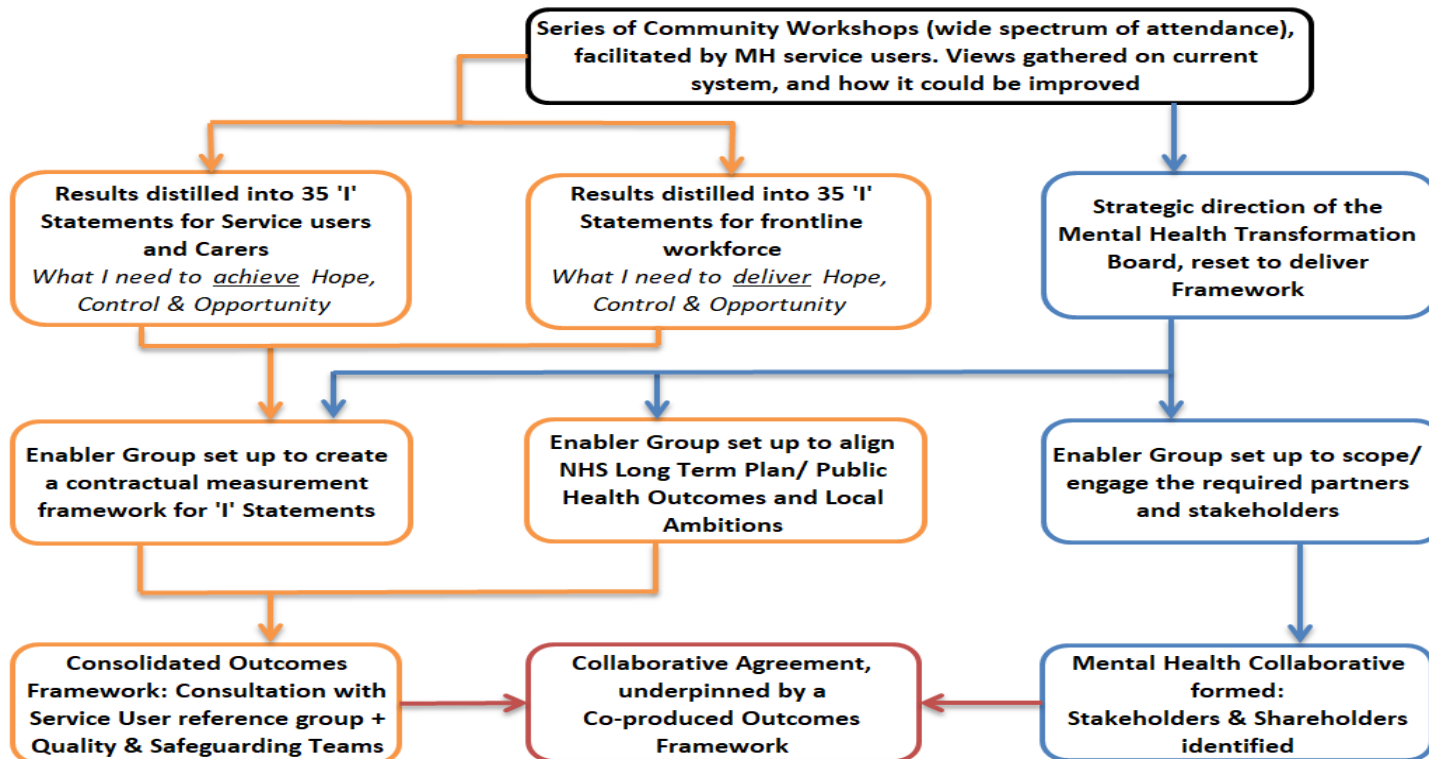
In developing the outcomes and through the learning from our original left shift of resources on a longer term contract into the third sector we commenced discussions on how to contractually make the changes to how we work in mental health.

In 2019 NHFT met with the CCG and identified that the best model moving forward was a lead provider supported by a collaborative. This 2019 meeting was supported by VCS Sector, Service Users and Carers



Mental Health Collaborative

The process that developed our 'I' Statements



Page 49

Mental Health Collaborative

Examples of our 'I' Statements

I have some control over how I access services, when and how the services interact with me and the different treatments available; support is there for me when I feel out of control or unsafe.



What do our residents want their health and care to look and feel like?



I feel the services around me talk to each other and have a joined up approach, reducing the number of times I need to tell my story, they share information in agreement with me to help my journey.

Understanding what our residents want their care to look and feel like has become an integral part of every decision we make, every plan that is considered and the strategic direction ensuring the voice of Lived Experience has equal value around the Collaborative table. Continuously exploring, updating and understanding current experience of all the services we provide and want to provide is evident in our co production work, we surround ourselves by this culture.

This delivers lived experience as an equal voice in strategic development.



I have opportunities to access services that understand me in terms of my history and culture.



I am given opportunities to develop community networks of support beyond my care team encouraging me to access opportunities enjoy every day activities and to gain new experiences.

I have the right support and it is there for me when I need it; those listening to me know how to access services and have information on what is available including crisis options.



I am supported to gain confidence to make my own decisions and maintain control over important aspects of my life, such as finances, budgeting and where I choose to live.



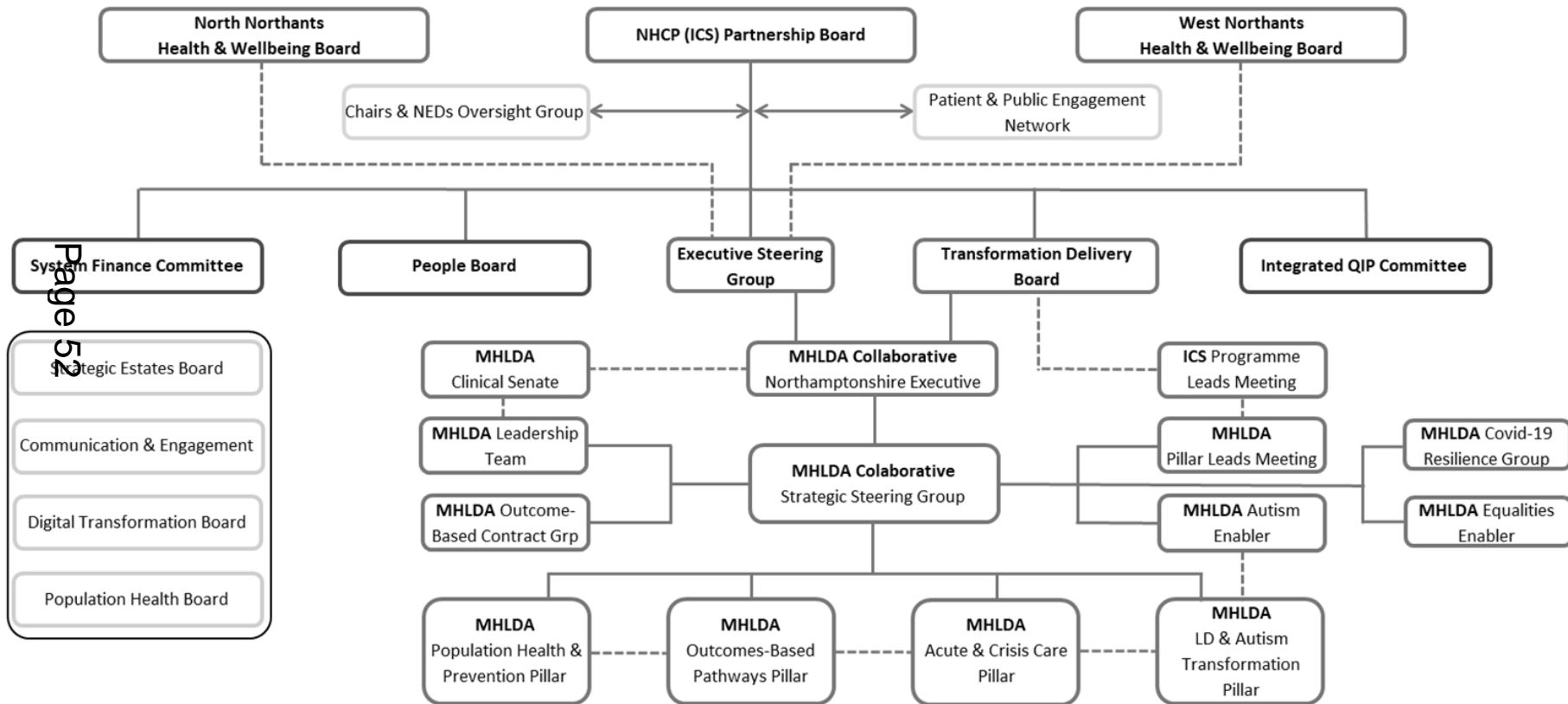
Gateway Four

Accountability,
Finance &
Outcomes
Framework

Page 51



Mental Health, Learning Disabilities & Autism Programme Governance Structure



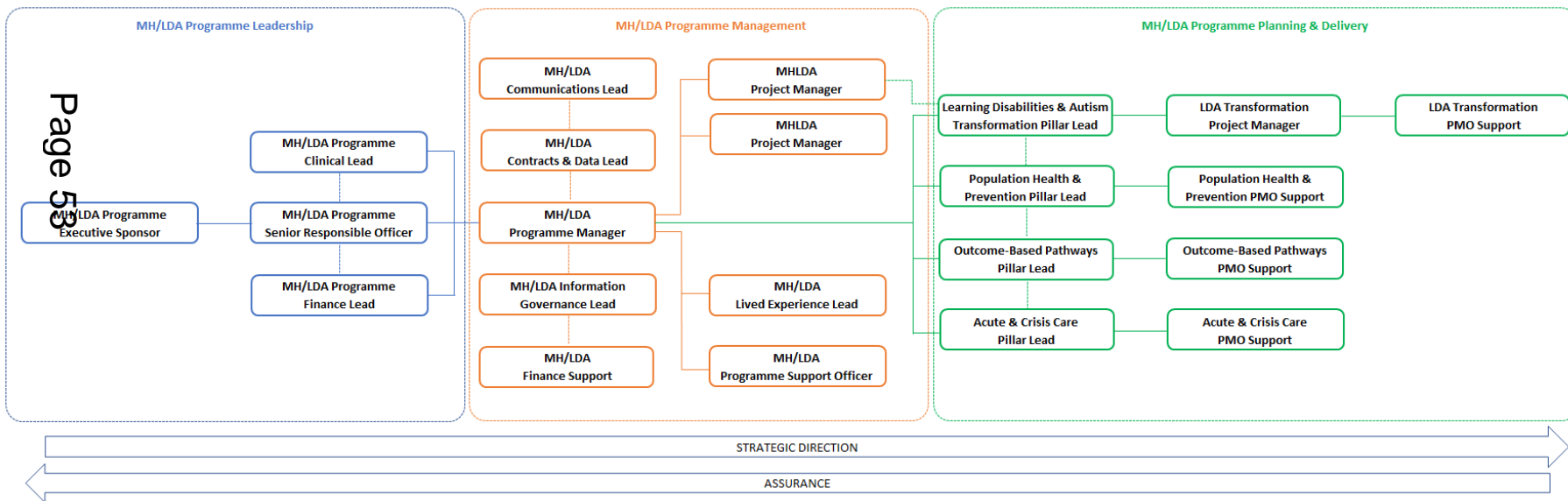
- Strategic Estates Board
- Communication & Engagement
- Digital Transformation Board
- Population Health Board

Mental Health, Learning Disabilities & Autism Programme Programme Resource – Leadership, Management & Delivery Planning

Prior to the formation of the programme, technical functions across the system were fragmented, with various partners undertaking their commissioning, contracting, communications, training, coproduction and finance/ workforce planning separately to one another. The MHLDA programme offers the opportunity to gradually centralise these efforts into one coherent strategy for the county.

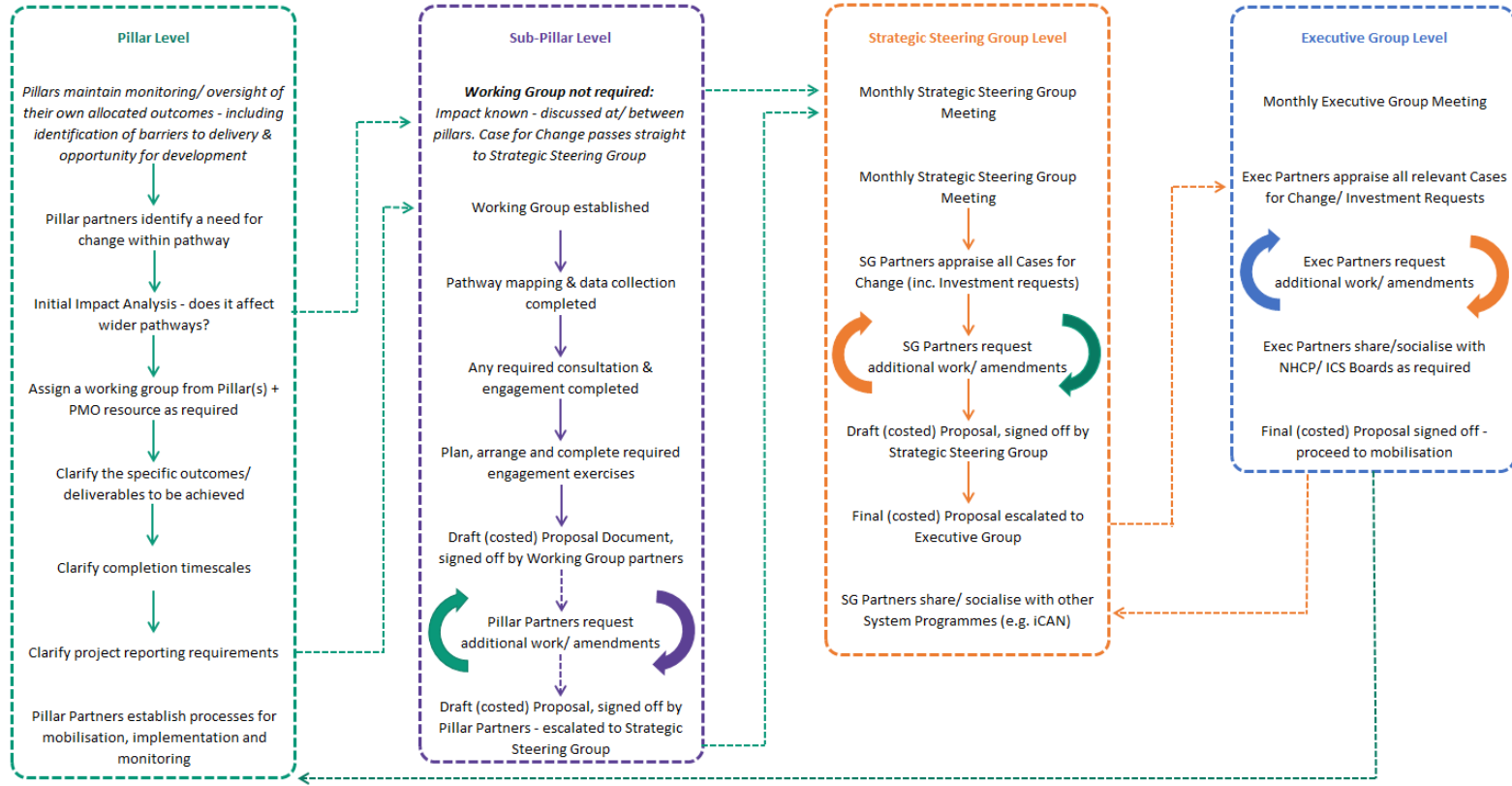
The first phase of this development is shown below. Leadership functions for the system will include an Executive Sponsor, Finance Lead, Clinical Lead and Senior Responsible Officer. Supporting them will be a management team – including allocated resource for overall management support, communications, contracting, IG, Finance and Business Intelligence. This includes the secondment of commissioning functions into this centralised team. In other cases, colleagues will remain with their own organisations, but be allocated as single points of contact for their area of the programme.

Planning and delivery functions will take place in the pillar structure, each of which has a Pillar Lead and Clinical Lead from across the system.



Mental Health, Learning Disabilities & Autism Programme Accountability – How will Collaborative Planning & Decisions take place?

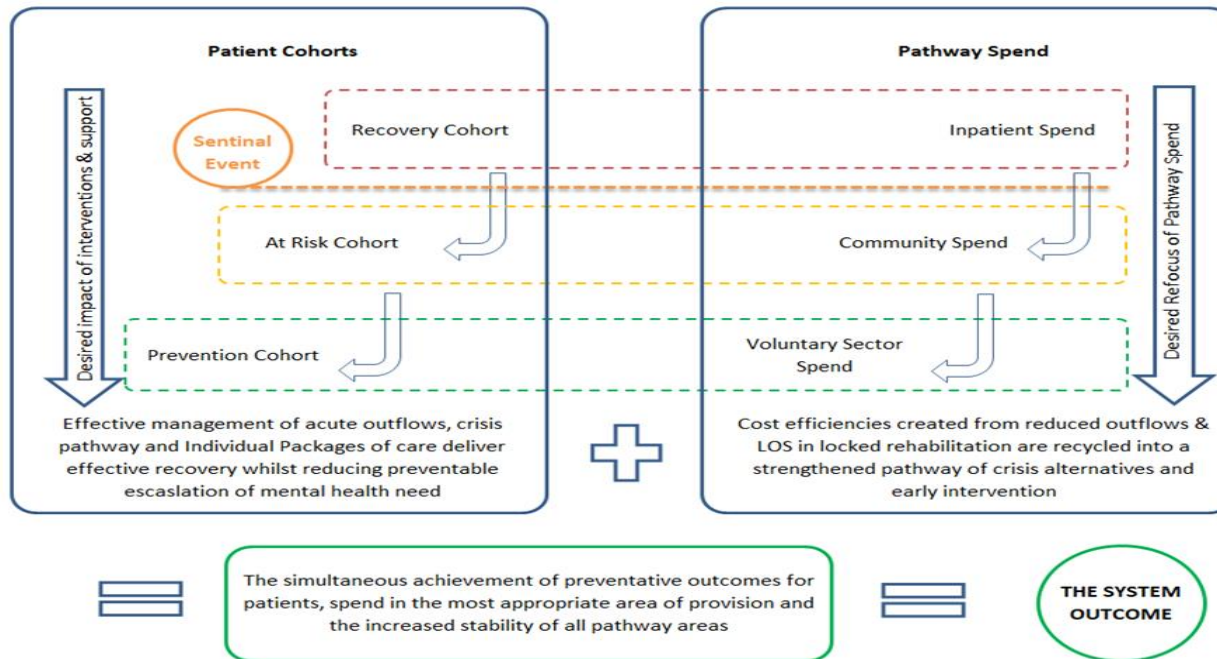
Page 54



Mental Health Collaborative

Contractual Enablers – Investing for Outcomes

Ensuring Sustainability in our Long-Term Strategy



Page 55

Enabling the left shift of resources prioritises progress from acute crisis towards the prevention agenda to: Improve outcomes for service users, reduce expensive spend on acute areas & enable more investment into the community and Third sector – increasing not only funding but their voice in strategic development. This enables further devolved decision making at sub-place'

Mental Health Collaborative

Collaborative Contract - Scope of Tranche One

Core Adult Mental Health Funding 21/22 (Reported through MHIS)

Existing NHFT Block Contract for Adult mental Health	79,976,074
Tranche 1 additions from 1 April 2022 (Existing VCS contracts, Section 12 and NCA)	1,560,355
	81,536,429

Other Source of Funds 21/22 (Not part of MHIS Reporting)

Service Development Review (SDF) - Adults Only	2,698,000
Spending Review (SR) - Adults Only	2,913,000

Total Tranche One plus allocated SDF/SR

87,147,429

Future Tranches to be discussed

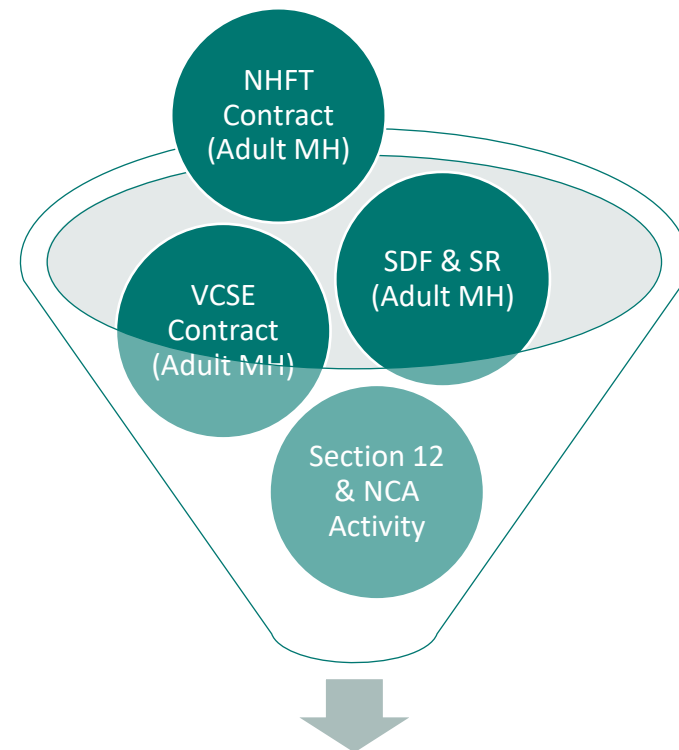
Continuing Care - Mental Health Package Costs	2,316,448
Adult Mental HRG Tariffs (NGH & KGH)	4,504,241
Package Costs of MH S117	2,511,525
Individual Packages of Care - M7 Forecast (Nursing/Residential, community/Supported Accommodation)	9,916,270

Total 106,395,913

MHIS spend not currently considered for future tranches

Adults other - reported within IPC	441,023
Childrens - reporting at M7	12,027,629
SMI - part of CCG funding not above	302,609
Prescribing Mental Health Expenditure	6,263,450
	19,034,711

Total MH spend 2021/22 125,430,624



**Total Tranche One Contract Value:
£87,147,429**

Contract values for 2022-23 onwards would be subject to usual inflation and growth, as well as being committed to the system's efficiency programme.

NHCP Key Lines of Enquiry for Emerging Collaboratives	RAG	Mental Health, Learning Disabilities & Autism Collaborative Evidence (including Slide Reference)
The collaborative will be inclusive involving all system partners to plan, transform and deliver services – including the Integrated Care Board; NHS providers; local authorities; independent sector; and the VCSE sector		All required system partners (and more) are included (Slide 8). Collaborative functions include planning, delivery & transformation (Slide 30)
The collaborative needs to transform services and improve population health in specific areas, reducing unwarranted variation and inequity in health outcomes, access to services and experience		Population Health outcomes accounted for as part of transformation plan (Appendix Two). Equalities enabler included in Programme structure (Slide 38). Addressing duplication and gaps included in both vision and design (Slide 22).
The collaborative needs to take a whole pathway approach to their transformation and consider the life course approach to ensure services are fit from conception to death		Pathway includes End-to-End objectives (Prevention to Crisis/ Inpatient care) (Slide 26). Life course considered in conjunction with other Programmes (Slide 34).
The collaborative will need to include specialised and direct commissioning		Specialised Commissioning incorporated into Pathway considerations. NHFT working with Specialised Commissioning as a lead provider.

NHCP Key Lines of Enquiry for Emerging Collaboratives	RAG	Mental Health Collaborative Evidence (including Slide Reference)
The collaborative will need to include places and local government to ensure services are designed to meet the needs of the different communities across Northamptonshire		Strategy is developed in place (Slide 36-37).
The collaborative needs to improve resilience across providers particularly in relation to the workforce – we expect collaboratives to jointly plan their workforce		Joint workforce planning noted as rationale for Programme Structure (Slide 29)
The collaborative needs to consider where specialisation and consolidation would provide better outcomes and value		See Slide 22 – Point 3 (Agile)
The collaborative will need to work across all partners and where appropriate with national and regional networks to transform services		Collaborative Programme Management Team and Pillar Leadership structure has functions within it to manage relationships with regional and national teams and Clinical Network
All partners will have an equal voice		Equal voice is key to Collaborative ethos (Slide 33) Collaborative Agreement as part of Outcome-Based Collaborative Contract provides assurance to the concept of equal voice (Slide 53)

Mental Health Collaborative

Outcomes Framework – Example of the detail in every pillar

A summary of the Logic Model used to inform the Outcome-Based Collaborative Contract (Tranche One – Adult & Older People’s Mental Health) can be found in Appendix Two. Below provides an example of one programme work stream, including how and where the information for Logic Model stages were/ will be derived from, and aligns to the wider NHCP Outcome Framework (prioritisation programme) led by Public Health.

Population health outcomes derived from Public Health data, service user co-production and NHCP system priorities

System ambitions derived from NHS Long-Term Plan, national Planning Guidance and NHCP system priorities

Deliverables and Implementation Plan derived from NHS Long-Term Plan trajectories, and in accordance with local system readiness

Guiding principles and measurement methods derived from ‘I’ Statements

Perinatal Mental Health										
Logic Model			Implementation Plan					Guiding principles for measuring success		
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code
Perinatal women and their partners are supported to maintain best possible mental health during/ after pregnancy, and develop strong emotional bonds with their children. Children are supported to receive the best possible start in life.	Provide access to specialist perinatal services available to 10% of the live birth rate by 2024	Increase capacity in specialist perinatal services year on year, in line with NICE recommended workforce structure	NHFT NHS PCs NGH/KGH Maternity	≥404	≥637	≥772	≥894	≥894	IS004 IS006 IS007 IS020 IS022 IS033	HONOS QPR PHQ-9 GAD-7
		Extend the period of available care to 24 month where clinically indicated.	NHFT			Go live				
		Implement a range of psychological therapies to provide choice and control for service users (including infant, couple, co-parenting and family interventions)	NHFT VCSE		Go live					
	Provide support to partners of perinatal women	Implement assessment framework for partners of perinatal women, aligned to the maternity process for earliest possible identification.	NHFT NGH/KGH Maternity				Go Live		IS016 IS025 IS007	
		Implement signposting process for partners of perinatal women, aligned to wider mental health service provision (IRH, IAPT, VCSE & CMHT)	NHFT IAPT MHNC				Go Live			
	Provide Maternity Mental Health Services to support with mental health issues directly arising from/ related to the maternity experience (e.g. miscarriage or birth trauma)	Implement place/sub-place-based structured Maternity Outreach Clinics, aligned to wider maternity services	NHFT Primary Care NNC WNC		Go Live				IS001 IS022 IS007 IS011	

Gateway Five

Contractual Agreements

Outcome-Based Collaborative Contract



Creating the right environment for the positive change

Contracts do not, in themselves, produce good outcomes for our residents. However, the right contractual framework can be an **enabler** for systems to work differently. Conversely, a poor contracting approach can be a barrier to achieving desired outcomes. In short, we should **choose the contract to fit the vision** – not the other way around.

Since 2016/17, the CCG and wider partners reflected on the way current contracts were working. We started with Adult & Older People's Mental Health services, and concluded that

- Current contracts focus too much on service outputs, and not enough on population & system outcomes.
- Having lots of separate contracts with multiple providers makes it difficult to see duplication and gaps in commissioning.
- Providers can become siloed by their specifications, and competitive with each other for finite resources.
- Smaller organisations (particularly VCSE partners) can become lost and marginalised.

Since then, the various contracting options have been appraised, which are:

Direct Award
Status Quo, in which ICB

Alliance Contracting
Generally considered non-compliant with NHS Standard Contracts

Collaborative Contract Arrangements
A Lead Provider assumes delegated responsibility, but must operate in the context of a Collaborative Agreement

Lead Provider Arrangements
Delegative approach, in which a Lead Provider sub-contracts with other system partners on behalf of ICB



Mental Health Collaborative

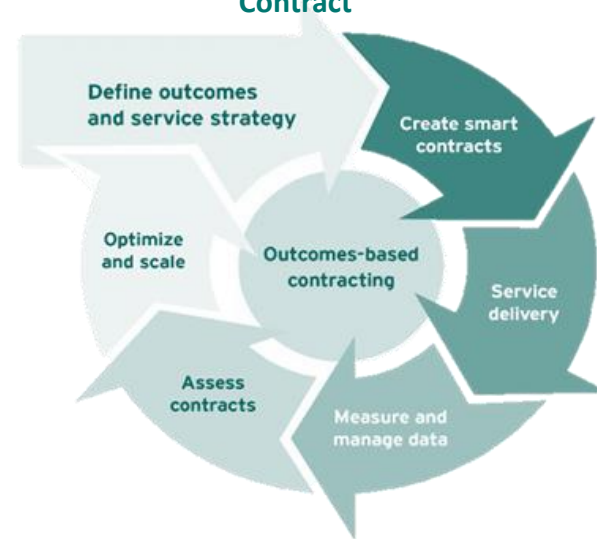
Contracts that Enable Transformation

The MH Collaborative identifies (following discussion and after Board to Governing Body meetings with NHFT and the CCG, supported by Service Users and VCSE organisations:

1. **Collaborative Contracting Arrangements** offer the most effective way of enabling desired population health outcomes and transformation goals, and give scope for wider health and care outcomes (e.g. Public Health and Social Care) to be considered as part of a whole-pathway approach to improving outcomes for our people. This could include bold approaches for bringing health and social care workforce, contracts and packages of care under one integrated model.
2. **Lead Provider** models allow clear lines of accountability to the Integrated Care Board, and the Collaborative Agreement offers additional assurance that strategic planning is being system-led and system-owned.
3. The addition of a **Collaborative Agreement** provides support to the Lead Provider, ensuring that all partners have an equal voice and decisions/ activities are assured to be system-led.

The Collaborative is working with the CCG to deliver our Collaborative Contract from 1 April 2022, with further delegation and greater responsibilities to be made clear as ICS legislation is progressed through parliamentary approval. We recognise that delivering a collaborative contract places new responsibilities within the members of the collaborative and the programme. The CCG and Collaborative are working together to be clear on these responsibilities.

Proposed contracting cycle for an Outcome-Based Collaborative Contract



Mental Health Collaborative

Phasing our approach to Outcome-Based Contracting

A Phased Approach to Outcome-Based Contracting as a System:

To ensure the transition is done cautiously and in a way is manageable for the NHCP & the Lead Provider, the Outcome-Based Collaborative Contract will be rolled out in Tranches.

The scope of Tranche One (2022-23) will include:

- NHFT Block Contract - Adult & Older People's Mental Health services
- VCSE Funded Adult & Older People's Mental Health Services
- Mental Health Non-Contracted Activity
- Section 12 Assessment costs
- Service Development Funding (SDF) – Adult Mental Health
- Spending Review (SR) Funding – Adult Mental Health

Elements in scope for later Tranches (to be included in accordance with system readiness and via Transition Arrangements within Contract Schedule):

- Continuing Healthcare – Mental Health Package costs (CCG/ ICB)
- Adult Mental Health HRG Tariff spend (NGH & KGH)
- Other Non-IPC Section 117 Package costs (e.g. Eating Disorders)
- Joint-funded Packages of Care (Social Care)
- Learning Disabilities & Autism (various)

The Collaborative will continue to apply a programme approach to the oversight of system outcomes and integrated pathway redesign as far as possible, until such time as the remaining tranches of the Outcome-Based Contract have been transitioned-in. The ultimate goal is to expand the scope of the Outcome-Based Collaborative Contract to cover all of the MHLDA Programme – as shown overleaf

Mental Health Collaborative

Phasing our approach to Outcome-Based Contracting

Page 64

Tranche One:
Commence
2022-23

Tranches Two onwards:
Commence
as/when
additional
partners are
ready to
align with
Outcomes
Contract
structure

Collaborative Tranches

Tranche One:

Adult & Older People's MH (NHFT & VCSE, S12 & NCA, SDF & SR)

Tranche Two:

Tranche 1 + Additional Function
(e.g. MH Continuing Healthcare & Other Non-IPC Section 177)

Tranche Three:

Tranche 1 & 2 + Additional Function
(e.g. Joint-Funded Packages of Care – Social Care)

Tranche Four:

Tranche 1 -3 + Additional Function
(e.g. MH Acute Care – NGH/KGH)

Tranche Five:

Tranche 1 -4 + Additional Function
(e.g. LD & Autism Pathways)

Sequence of additional tranches is for example only, and may be done in a different order, timescales to be agreed

Adult & Older People's Mental Health Outcome-Based Collaborative Contract (A Summary):

Having chosen to formalise Collaborative arrangements through a Collaborative Agreement, the inclusion of this Agreement is the main element of collaboration within the contract content. Outside of the contract itself, Section 75 Agreements are used to capture the arrangements between CCG and Local Authority commissioners that support the pathway. To ensure the contract is based around outcomes, the following specific content is included:

Outcome-Based Payment Mechanism

This mechanism functions in a similar manner to the established CQUIN mechanism, ie. 2.5% of total contract value is made dependent upon the evidenced improvement of outcomes, in this case Clinician Reported Outcome Measures (CROMs) and Patient Reported Outcome or Experience Measures (PROMs and PREMs).

CROMs have been reported for several years by the majority of NHFT and Voluntary Sector services and have been deliberately structured to contain both a Coverage (percentage of new patients who receive an initial clinical score) and Achievement (percentage of discharging patients who evidence an improved clinical score). As the outcome measures are structured similarly, they can be combined to form aggregate Coverage and Achievement scores for all contributing services.

PROMs & PREMs for this pathway are based upon the extensive I-Statement coproduction work undertaken with service users and carers between 2017 and 2019. The majority of the desired outcomes expressed through these I-Statements can be measured and aggregated via service user feedback gathered through existing tools (such as I Want Great Care). The remainder can be monitored and supported via specific purpose focus groups.

The Outcome Based Payment Mechanism for this contract covers both CROMs & PROMs (with 1.25% of contract value attributed to each).



Adult & Older People's Mental Health Outcome-Based Collaborative Contract (A Summary):

Sector Growth Expectations (the System Outcome Measure)


To support continued focus upon the Prevention agenda and increased stability for Voluntary Sector providers, all contractual spend at contract commencement is classified as Voluntary Sector, Community/Outpatient and Inpatient. Initial percentages of each of these classifications are clearly stated alongside an expectation of year-on-year percentage spend increases with the Voluntary Sector. Achievement of this System Outcome is included as one of the 4 key criteria for consideration for the Continuation, Cessation, Expansion or Extension of the contract.

Supporting Improvements to Population Outcome Measures

Improving the outcome measures reported for our population is key to both contract continuation and the design of locally reported outcome measures.

Alongside the achievement of Voluntary Sector growth, organisational stability and patient safety, improvements to Population Outcome Measures is one of the 4 key criteria for consideration for the Continuation, Cessation, Expansion or Extension of the contract. Essentially, if Population Outcome Measures are not showing signs of improvement or worse, are showing signs of deterioration, consideration should be given to ceasing the contract with appropriate consideration given to the reporting lag associated with national reporting. This reporting lag was a key driver in the development of locally reported CROMs and PROMs, alongside the desire of providers and commissioners to capture the clinician and patient voice in reporting specific to individual local services. Wherever possible, the link between existing locally and nationally reported measures is established and, where the direct contribution of a service to a Population Outcome Measure can be captured, this development is undertaken.



A person is shown from the waist down, wearing a dark denim jacket and a pleated tan skirt. They are holding a white laptop in their left hand and a white coffee cup in their right hand. The background is a blurred cafe interior with a wooden table and a brick wall.

Page 67

Appendices

Appendix One: References



1. NEL Commissioning Support Unit, Northamptonshire (2021)
2. Public Health Fingertips, Northamptonshire (2020) - [Severe Mental Illness - Data – PHE](#)
3. Public Health England. Health profile for England: 2019. Available from: [gov.uk](#)
4. Thomas F, Hansford L, Ford J, Hughes S, Wyatt K, McCabe R, Byng R (2019). *Poverty, pathology and pills: DeStress Project final report*. DeStress Project website. Available at: <http://destressproject.org.uk>
5. NHSE (2019), Physical health check and follow-up intervention for people with severe mental illness (technical guidance - 000379). Available from engald.adultmh@nhs.net
6. Alonso J, Liu Z, Evans-Lacko S, Sadikova E, Sampson N, Chatterji S, et al. Treatment gap for anxiety disorders is global: Results of the World Mental Health Surveys in 21 countries. *Depress Anxiety* [Internet]. 2018 Mar [cited 2018 Jun 26];35(3):195–208. Available from: [ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)
7. Langan, M., McLean, G., Park, J., Martin, D., Connolly, M., Mercer, S. & Smith, D. (2014). Impact of socioeconomic deprivation on rate and cause of death in severe mental illness. *BMC Psychiatry*, 14(261). Available at: <https://doi.org/10.1186/s12888-014-0261-4>
8. Thornicroft, G. & Sunkel, C. (2020). Announcing the Lancet Commission on stigma and discrimination in mental health. *The Lancet*, 396(10262), 1543-1544. Available at: [https://doi.org/10.1016/S0140-6736\(20\)32203-0](https://doi.org/10.1016/S0140-6736(20)32203-0)
9. Khokhar, J., Dwiel, L., Henricks, A., Doucette, W. & Green, A. (2018). The link between schizophrenia and substance use disorder: A unifying hypothesis. *Schizophrenia Research*, 194, 78-85.
10. National Institute of Mental Health (2019). Mental Health Information: Serious Mental Illness. Available at: [https://www.nimh.nih.gov/health/statistics/mental-illnesses.shtml#:~:text=Serious%20mental%20illness%20\(SMI\)%20is,or%20more%20major%20life%20activities.](https://www.nimh.nih.gov/health/statistics/mental-illnesses.shtml#:~:text=Serious%20mental%20illness%20(SMI)%20is,or%20more%20major%20life%20activities.)
11. Stephenson D, Farmer P. Thriving at work: The Independent Review of Mental Health and Employers [Internet]. 2017 [cited 2017 Nov 22]. Available from: [gov.uk](#)
12. Public Health England (2018). Severe mental illness (SMI) and physical health inequalities: briefing. Available at: <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>
13. Samaritans (2017). Dying from inequality: socioeconomic disadvantage and suicidal behaviour. Available at: https://media.samaritans.org/documents/Samaritans_Dying_from_inequality_report_-_comary.pdf
14. National Institute for Health and Care Excellence (NICE) (2016). Mental health problems in people with learning disabilities: prevention, assessment and management. [Available as a PDF online here](#).
15. National Institute for Health and Care Excellence (NICE) (2016). Mental health problems in people with learning disabilities: prevention, assessment and management. [Available as a PDF online here](#).
16. Bond, L., Carroll, R., Mulryan, N., O'Dwyer, M., O'Connell, J., Monaghan, R., Sheerin, F., McCallion, P. and McCarron, M., (2019). The association of life events and mental ill health in older adults with intellectual disability: results of the wave 3 Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing. *Journal of Intellectual Disability Research*, 63(5), pp.454-465. [Available online here](#)
17. Branford, D., Gerrard, D., Saleem, N., Shaw, C., & Webster, A. (2019). Stopping over-medication of people with intellectual disability, Autism or both (STOMP) in England part 1—history and background of STOMP. *Advances in Mental Health and Intellectual Disabilities*, 13(1), 31-40.
18. NHSE (2019), Physical health check and follow-up intervention for people with severe mental illness (technical guidance - 000379). Available from engald.adultmh@nhs.net
19. NEL Commissioning Support Unit, Northamptonshire (2019)
20. MIND, *GP Mental Health Training Survey: Summary of Findings*, 2018



Appendix Two: Mental Health Outcomes Framework (Aligned to NHCP Outcomes Framework)



Mental Health Collaborative

Outcomes Framework – Mental Health Prevention

Mental Health Prevention										
Logic Model			Implementation Plan					Guiding principles for measuring success		
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code
Fewer people will end their life by suicide	Develop system understanding for causes of suicide and strategies for suicide prevention	Implement Real-Time Surveillance to inform strategic planning and responsibility	Coroners Team Public Health Police		Go Live				IS001 IS004 IS005 IS007 IS014 IS017 IS018 IS020 IS021	N/A
		Refresh System Suicide Prevention Strategy, disaggregated by 'Place'	Public Health All SPSPG Partners				Go Live			
	Reduction in number of suicides	Increase digital support options for people who are not in contact with clinical services	Togetherall Public Health NHFT		Go Live				PHQ-9 GAD-7 WEMWeBS	
		Implement targeted Communications campaigns, aligned to regional/national campaigns (promoting local support pathways).	NHCP Comms Public Health NHSE/I				Go Live			
	Deliver suicide awareness and mitigation training to Primary Care staff, Local Authority teams and Community Groups - including consistent approach to safety planning	4 Mental Health Primary Care WNC/ NNC NHFT CIGs				Go Live				
	Increased support for people bereaved by suicide	Implement a Suicide Bereavement Support and Therapy pathway	REACH MHNC WMMM				Go Live		Outcomes Star	
Fewer people will feel the need to resort to self-harming behaviour	Reduction in hospital admissions for 15-24 year olds who self-harm (As per NHCP Outcomes Framework; Ref: 1.b.ii & 1.b.iii)	Extend Rapid Response Counselling services, including referral routes by School Nursing/ Safeguarding leads	NHFT REACH NGH/ KGH Education			Go Live		IS001 IS004 IS005 IS013 IS014 IS016 IS018 IS021	C-GAS Outcomes Star WEMWeBS	
		Extend CYP Well-being cafes up to seven sessions per week, and availability North and West	NHFT REACH NGH/ KGH			Go Live				
	Increased support for parents & carers to develop knowledge and skills to help CYP & Young Adults to manage emotional challenges	Pilot Emotional Coaching model for parents & carers including referral routes by School Nursing/ Safeguarding leads	NHFT REACH Education CIGs				Go Live		C-GAS Outcomes Star WEMWeBS	
		Deliver Self-Harm awareness and mitigation training to Primary Care, Educators and Carers - including consistent approach to safety planning.	4 Mental Health Primary Care WNC/ NNC Education CIGs				Go Live			
People will have access to information and opportunities to monitor and maintain emotional hygiene, increasing resilience and preventing poor mental health where possible	Promote clear & accessible advice and guidance, across a range of platforms, aligned to '10 Keys to Happiness' approach	Update NNC & WNC websites with consolidated/ comprehensive information and support opportunities related to MH determinants (physical activity, combating isolation, sleep hygiene, nutrition, etc).	Public Health NNC/ WNC NHFT VCSE NHCP Comms				Go Live	IS001 IS002 IS003 IS006 IS007 IS008 IS009 IS010 IS013 IS017 IS018 IS021 IS022	N/A	
		Implement social prescribing model with specific focus on mental health and overall wellbeing.	Public Health SPRING VCSE Primary Care				Go Live			
	Provide access to 'Get Started' Support programmes that assist people to develop personal health plans.	Increase facilitated access to exercise/ nutrition planning/ smoking cessation/ debt management/ employment/ housing advice/ etc.	Public Health VCSE NHCP Comms				Go Live		Outcomes Star	



Mental Health Collaborative

Outcomes Framework – Early Intervention for Common Mood Disorder

Early Intervention for Common Mood Disorders												
Logic Model			Implementation Plan					Guiding principles for measuring success				
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code		
Increased rates of satisfaction, worth and happiness among Northamptonshire residents experiencing first signs of mental ill health	Expand access to Psychological Therapies for mild-moderate, common mood disorders to ≥22,035 residents by 2024. (As per NHCP Outcomes Framework, Ref: 2.d.i)	Increase workforce/ capacity within IAPT services - across Step 2 & Step 3 therapies	NHFT Primary Care Substance2Solution	≥13,954 service users	≥16,399 service users	≥18,561 service users	≥20,045 service users	≥22,034 service users	IS002 IS006 IS007 IS009 IS011 IS012 IS018 IS021	N/A		
		Ensure access is equitable and proportionate to overall population cohort sizes (e.g. older adults, BAME)		Go Live								
		Ensure/ maintain ≥50% Recovery rate using clinically reliable measurement tools		Live - maintain/ further improve							PHQ-9 GAD-7	
	Ensure a range of culturally-sensitive, person-centred, needs-led support for people with mild-moderate common mood disorders	Provide person-centred counselling, peer mentoring, support work and group work, delivered at sub-place (via 8x hubs across the system)	Provide structured psychoeducation and respite for mental health carers	Primary Care VCSE Substance2Solutions WNC & NNC	Live - maintain/ further improve					IS011 IS016 IS021 IS035	WEMWeB	
			Embed psychological therapists into Long-Term Physical Health teams (starting with areas of highest need - Diabetes, Respiratory, Cardiac and Oncology)	NHFT Primary Care NGH/ KGH	Go Live						IS022 IS023 IS029	PHQ-9 GAD-7
			Decrease waiting time for early support for mild-moderate common mood disorders (As per NHCP Outcomes Framework, Ref: 2.d.i)	NHFT VCSE	Live - maintain/ further improve						IS004 IS006 IS009 IS031	N/A
	Ensure 95% of referrals commence treatment within 18 weeks		Live - maintain/ further improve						N/A			
	Ensure 90% of referrals wait less than 90 days between 1st & 2nd treatment appointment.		Live - maintain/ further improve						N/A			

Page 72

Mental Health Collaborative

Outcomes Framework – Severe Mental Illness

Severe Mental Health - Community Pathway										
Logic Model			Implementation Plan					Guiding principles for measuring success		
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code
People with severe mental illnesses have increased choice, control and opportunity to access personalised care 'at place', whereby mental, physical and social care needs are delivered via Integrated Care Plans	Treatment for severe mental illness is accessible within 28 days, and convenient - delivered at 'place' / 'sub-place'.	Transition Community Mental Health from 2x CMHTs, into 9x Place-Based Teams (aligned to sub-place structures both North and West)	NHFT Primary Care			≥1,564 service users	≥3,200 service users	≥4,620 service users	IS002 IS003 IS006 IS007	N/A
		Mobilise 28-day Referral to Treatment Wait time standard across Place-Based CMHTs	NHFT			Go Live				
	Treatment for severe mental illness is holistic, person-centred and needs-led - able to support with a range of health, social care goals	Expand & embed VCSE Support Work into each Place-Based CMHT for pathway alignment		NHFT MHNC			Go Live		IS005 IS011 IS012 IS020 IS023 IS029 IS033	HONOS QPR DIALOG WEMWeB Outcomes-STAR
			Embed Drug & Alcohol Support Staff (Substance to Solutions) into each Place-Based CMHT structures for pathway alignment.	NHFT VCSE Substance2Solution			Go Live			
			Align North & West Social Care workforce structures to Place-Based CMHTs for MDT approach to care delivery.	NHFT NNC & WNC			Go Live			
			Recruit and embed Housing Support Officers into each Place-Based CMHT and connect into Local Authority Housing Teams.	NHFT Accommodation Concern NNC & WNC			Go live			
Decrease gap in employment rate for those in contact with secondary mental health services	Expand access to structured employment services to support people with mental health to obtain and/or maintain employment	Increase workforce capacity in Individual Placement & Support service to meet access trajectory	NHFT MHNC	≥282 service users	≥339 service users	≥396 service users	≥547 service users	≥687 service users	IS025 IS026 IS028 IS029	Outcomes-STAR
		Embed Individual Placement & Support into each Place-Based CMHT structures for pathway alignment.	NHFT MHNC			Go Live				
Reduce premature mortality among people with severe mental illness (aged ≤75 years of age)	Expand access to annual physical health checks in both primary and secondary care - including action against all indicated follow-up interventions, to >80% of SMI QOF register (As per NHCP Outcomes Framework, Ref: 2.a.i)	Implement Incentive Scheme for delivery of Primary Care Annual Health Checks for those post-12 months diagnosis (stable)	NHFT Primary Care				4,238 service users	5,049 service users	IS022	Bradford Tool
		Implement Training & Development Programme across Primary Care teams, to support effective engagement and delivery of AHCs to SMI registers	NHFT WORTH (VCSE)			Go Live				
		Implement Place-Based Clinics for delivery of secondary care Annual health Checks for those pre-12 months diagnosis (stabilising)	NHFT			470 service users	560 service users			

Mental Health Collaborative

Outcomes Framework – Perinatal Mental Health

Perinatal Mental Health											
Logic Model			Implementation Plan					Guiding principles for measuring success			
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code	
Perinatal women and their partners are supported to maintain best possible mental health during/ after pregnancy, and develop strong emotional bonds with their children. Children are supported to receive the best possible start in life.	Provide access to specialist perinatal services available to 10% of the live birth rate by 2024	Increase capacity in specialist perinatal services year on year, in line with NICE recommended workforce structure	NHFT NHS PCS NGH/KGH Maternity	≥404	≥637	≥772	≥894	≥894	IS004 IS006 IS007 IS020 IS022 IS033	HONOS QPR PHQ-9 GAD-7	
		Extend the period of available care to 24 month where clinically indicated.	NHFT			Go live					
		Implement a range of psychological therapies to provide choice and control for service users (including infant, couple, co-parenting and family interventions)	NHFT VCSE		Go live						
	Provide support to partners of perinatal women	Implement assessment framework for partners of perinatal women, aligned to the maternity process for earliest possible identification.	NHFT NGH/KGH Maternity				Go Live		IS016 IS025 IS007		
		Implement signposting process for partners of perinatal women, aligned to wider mental health service provision (IRH, IAPT, VCSE & CMHT)	NHFT IAPT MHNC				Go Live				
	Provide Maternity Mental Health Services to support with mental health issues directly arising from/ related to the maternity experience (e.g. miscarriage or birth trauma)	Implement place/sub-place-based structured Maternity Outreach Clinics, aligned to wider maternity services	NHFT Primary Care NNC WNC		Go Live				IS001 IS022 IS007 IS011		

Mental Health Collaborative

Outcomes Framework – Community Crisis Pathway

Community Crisis Pathway										
Logic Model			Implementation Plan					Guiding principles for measuring success		
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code
People experiencing mental health crisis have control and opportunity to receive care rapidly and in the most conducive environment for their needs	Reduction in preventable A&E/ Emergency attendances for singular or associated mental health presentations	Implement and promote Crisis Cafes, available at sub-place level 7-days per week	NHFT VCSE	82 hours per week	88 hours per week	158 hours per week			IS004 IS005 IS006 IS008 IS009 IS011 IS012 IS015 IS016 IS033	N/A
		Implement and promote a 24/7 Crisis Telephone line, aligned to NHS111 and able to hear/treat/refer mental health queries (including MH crisis response)	NHFT VCSE WNC & NNC (AMHP) NHS 111 EMAS	Go Live					N/A	
		Contribute to increased capacity in EMAS Regional Central Control Room (increased hear & treat)	NHFT EMAS			Go Live			N/A	
		Implement dedicated Mental Health Ambulance Response (with capacity for at-scene physical health assessment).	NHFT EMAS			Go Live			N/A	
	Reduction in use of Section 136 and improved outcomes for people with mental health in contact with justice system	Integrated Mental Health Ambulance support with Police Street Triage	NHFT EMAS Police			Go Live			IS005 IS011 IS015 IS016 IS020	N/A
		Embed Mental Health support in Police Custody (providing assessment, navigation and diversion)	NHFT Police VCSE			Live - maintain/ further improve			N/A	
People experiencing mental health crisis receive person-centred, needs-led care, focussed on addressing the root cause of crisis, and decreasing likelihood of repeated crisis episodes.	Timely and effective delivery of outcomes for people in mental health crisis, regardless of where they present in the system	Referrals to MH Crisis Teams are responded to within 1 hour	NHFT NGH/KGH NNC/ WNC (AMHP) EMAS			Live - maintain/ further improve			IS005 IS008 IS011 IS012 IS015 IS016 IS033	N/A
		Referrals to MH Crisis Teams, classified as emergency, receive a Biopsychosocial assessment and UEMH Care Plan within 4 hours	Primary Care VCSE NHS Provider-Led Collaboratives			Go Live			BPS Assess UEMH Care Plan	
		Referrals to MH Crisis Teams, classified as emergency, receive appropriate follow-up care within 4 hours				Go Live			N/A	
		Referrals to MH Crisis Teams, classified as urgent, receive a Biopsychosocial assessment and UEMH Care Plan within 24 hours				Live - maintain/ further improve			BPS Assess UEMH Care Plan	
		Referrals to MH Crisis Teams, classified as urgent receive appropriate follow-up care within 24 hours				Live - maintain/ further improve			N/A	

Page 75

Mental Health Collaborative

Outcomes Framework – Acute Inpatient Mental Health (Adults)

Mental Health Adult/ Older Adult Acute Inpatient Care										
Logic Model			Implementation Plan					Guiding principles for measuring success		
Population Outcome	System Ambition	Deliverables	Partners Required	2019-20	2020-21	2021-22	2022-23	2023-24	IS Code	CROM Code
People with severe mental health conditions receive compassionate care, as close to home as possible, and in the least restrictive environment Page 76	Reduction in avoidable acute mental health admissions	Operate 2x Crisis Houses (North & West)	NHFT VCSE	Live - maintain/ further improve					IS001 IS004 IS005 IS007 IS010 IS017 IS020 IS027	HONOS QPR DIALOG
		Expand capacity in CRHTT and Hospital @ Home Packages, year on year to 2024	NHFT VCSE	Go Live						
		Identify & divert escalation of MH acuity via earlier access to Place-Based CMHT support (IRH)	NHFT VCSE Primary Care				Go Live			
	Reduction/ elimination of Out-of-Area Placements for inpatient care	Pilot a Clinical Observation Area to provide safe waiting space and access to immediate care.	NHFT			Pilot Phase				
		Implement 7-day Bed management to manage efficient flow and repatriation	NHFT NGH/KGH WNC/NNC (AMHP)	Go Live						
		Increase local capacity for Psychiatric Intensive Care (PICU)	NHFT				Go Live			
People who require inpatient care are supported to recover rapidly and be discharged safely.	Reduction in 60+ LOS for Adult Acute inpatients to ≤32 per 100,000 population	Increase capacity and availability for a range of therapeutic interventions (psychology, OT) across acute MH inpatient settings	NHFT				Go Live		IS005 IS010 IS012 IS015 IS017 IS023	N/A
	Reduction in 90+ Day LOS for Older Adult Acute inpatients to ≤43 per 100,000 population	Implement/ Maintain Red2Green Bed Management system across both MH Inpatient hospital sites.	NHFT	Live - maintain/ further improve						
	Ensure ≥80% of discharged patients are follow-up by Community MH team within 72 hours.	Repurpose Supported Accommodation AQP Framework to increase availability of outcome-based community placements	NHFT WNC/ NNC Independent				Go Live			
	Reduce the number of discharged patients who are re-admitted within 90 days.	Mobilise flexible/ Personal Health budgets for person-centred discharge care needs	NHFT WNC/ NNC				Go Live			

Appendix Three: Coproduced 'I' Statements



Mental Health Collaborative

Outcomes Framework – Coded ‘I’ Statements

IS Codes	'I' Statement	Experience: In Control Listened to Understood Informed	Expectations Visible Convenient Recovery-focused Holistic	Interactions Integrated Knowledgeable Supportive
IS001	I have a care Team that hold hope for my future recovery, understand what recovery means to me through compassion and by sharing realistic and positive goals	Control	Recovery focussed	Supportive
IS002	I know how to enter services and I was taken seriously from my first contact, treated with dignity and respect at all times.	Understood	Visible	Supportive
IS003	My GP understands and supports my mental health and can help me access the right service	Understood	Convenient	Knowledgeable
IS004	I have the right support and it is there for me when I need it; those listening to me know how to access services and have information on what is available including crisis options.	Informed	Convenient	Knowledgeable
IS005	Staff worked with me and my carer (if I wanted them involved) to co-produce a care plan that met my needs and helped me to move quickly to recovery	Control	Recovery-focussed	Supportive
IS006	I have some control over how I access services, when and how the services interact with me and the different treatments available; support is there for me when I feel out of control or unsafe.	Control	Holistic	Supportive
IS007	I am given the opportunity to access care as close to home as possible and for social care and health services to work together with me.	Control	Convenient	Integrated
IS008	I feel able to and am encouraged to participate in the co-production of my care, taking into consideration a plan to help me in the event of a relapse.	Control	Recovery focussed	Supportive
IS009	I have the awareness, information and opportunity to refer myself to services if I chose to.	Informed	Visible	NA
IS010	I have the opportunity for my voice to be heard by service providers. These positive contributions, support to influence the delivery of the care I receive	Listened to	Holistic	Supportive
IS011	I have opportunities to access services that understand me in terms of my history and culture.	Understood	Holistic	Supportive
IS012	I am supported to access other agencies in the wider community to advice and assess my housing needs. My care team support me to make my home feel safe and comfortable and provide appropriate community support at the right time and when I really need it.	Informed	Holistic	Integrated

Mental Health Collaborative

Outcomes Framework – Mental Health Prevention

IS Codes	'I' Statement	Experience: In Control Listened to Understood Informed	Expectations Visible Convenient Recovery-focused Holistic	Interactions Integrated Knowledgeable Supportive
IS013	I am listened to and feel understood by other people in my care, my care team have developed open and honest relationships with me and given me choice to make decisions with those involved in my life	Control	Recovery focussed	Supportive
IS014	My strengths and resourcefulness are acknowledged and my diagnosis / risk do not become a barrier to my future recovery.	Understood	Recovery focussed	Supportive
IS015	When I am experiencing challenges and have difficulty engaging my care team do not give up on me	Understood	Recovery focussed	Supportive
IS016	I have hope when services communicate clearly, listen effectively and validate carers opinions and concerns.	Listened to	NA	Supportive
IS017	I want to build positive relationships which will to empower me to gain control. This support will help me to acknowledge when I need to share that control with others and identify where I am on my journey to recovery.	Control	Recovery focussed	Supportive
IS018	I am supported to gain confidence to make my own decisions and maintain control over important aspects of my life, such as finances, budgeting and where I choose to live.	Control	Recovery focussed	Supportive
IS019	I am informed by those around me to make decisions about my life and I feel supported to take positive risks, push my limits to help me achieve important goals.	Informed	Recovery focussed	Supportive
IS020	I feel the services around me talk to each other and have a joined up approach, reducing the number of times I need to tell my story, they share information in agreement with me to help my journey.	Understood	Holistic	Integrated
IS021	I can take back more control over my own life when I am given skilled information, practical support and time from services. This gives me confidence in the care team which then enables me to think about my own needs as a carer. I have I have more control when I have an equal balance between my own needs and my caring role.	Informed	Recovery focussed	Knowledgeable
IS022	I receive a holistic approach to my care which helps to identify that my physical health is equally important as my mental health	Understood	Holistic	Integrated
IS023	I am given opportunities to develop community networks of support beyond my care team encouraging me to access opportunities enjoy every day activities and to gain new experiences.	Control	Holistic	Integrated
IS024	I feel I have something worthwhile to get out of bed for I am supported to follow my dreams, aspirations and given opportunities to access education and training regarding my mental health and behaviours.	Control	Recovery focussed	Supportive

Page 79



Mental Health Collaborative

Outcomes Framework – Mental Health Prevention

IS Codes	'I' Statement	Experience: In Control Listened to Understood Informed	Expectations Visible Convenient Recovery-focused Holistic	Interactions Integrated Knowledgeable Supportive
IS025	I have opportunities to be involved/employed by the trust supporting to shape services from a carer perspective. Developing stronger positive relationships for future outcomes.	Listened to	Recovery focussed	Supportive
IS026	I have the opportunity to be employed in a role that has a positive impact on my mental health, motivates me and which I am able to sustain	Control	Holistic	Supportive
IS027	I have the opportunity to be financially secure during bouts of illness when I can't work	Control	Holistic	Supportive
IS028	I have the opportunity to find a job that enables me to become financially self-sufficient and not reliant on welfare benefits	Control	Holistic	Supportive
IS029	I feel supported to develop control over my day-to-day life and future – hobbies, finances, employment and physical health. I am supported to maintain links and connections with people who are important to me.	Control	Holistic	Integrated
IS030	I am supported to be as independent as possible at each step of my journey doing the best I can at any given time.	Control	Recovery focussed	Supportive
IS031	I have the awareness, information and opportunity to refer myself to services if I chose to.	Informed	Visible	NA
IS032	I am respected for who I am today. My past experiences have shaped my future. I am supported to develop resilience in preparation for a fresh start.	Understood	Recovery focussed	Supportive
IS033	I am supported to access other agencies in the wider community to advice and assess my housing needs. My care team support me to make my home feel safe and comfortable and provide appropriate community support at the right time and when I really need it.	Informed	Holistic	Integrated
IS034	There are opportunities for me to use my lived experience to contribute to the recovery of others and give back and make a difference to services and the community	Listened to	Recovery focussed	Supportive
IS035	I felt the services had the skills and expertise to help me in a positive way and my carers had access to support	Understood	Holistic	Knowledgeable

Further documents (available on request):

- Signed Collaborative Agreement (NHFT, CCG & VCSE)
- Terms of Reference
 - MHLDA Executive Board
 - MHLDA Strategic Steering Group
 - MHLDA Clinical Senate
- MHLDA Programme Workbook

Page 81



Version 5.3:

Version 5.3 incorporates feedback from NHCP Collaborative work programme, Executive Sponsors, CEOs from across NHCP and MHLDA Executive and others.

Slide 6 – Highlighted contract and collaborative agreement, and included examples.

Slide 18 – Highlighted Collaborative Contract – Tranche One providers.

Slide 20 – Considered position in slide deck. Decision to maintain it in its current position.

Slide 24 – Amended to read ‘Mental Health Collaborative’, rather than ‘MHLDA Programme’

Slide 27 – Amended to show sign off for Collaborative Programme in 2022

Slide 36 & 37 – Change of language from Sub-Place to Community/ Neighbourhood.

Slides 44-49 – Purple Bar denotes MHLDA Programme. Green Bar denotes Mental Health Collaborative/ Contract.

Slide 48 – New slide added to show scope of Tranche One (Outcome-Based Contract).

Slide 54 – Added visionary statement on integration of health and social care workforce & contracts



Version 5.4:

- Slide 48 – Addition of table showing breakdown of Mental Health expenditure (in scope and out of scope for Tranche One)
- Slide 48 – Includes confirmation of Collaborative commitment to system efficiency programme.
- Slide 51 – Includes confirmation of alignment between Collaborative Outcomes Framework and NHCP Outcomes Priorities.
- Slide 54 - Additional information clarifying the process for delegation of additional responsibilities to Collaborative partners.

Version 5.5:

- Appendix Two – shows where Mental Health Collaborative Outcomes Framework aligns to the NHCP Outcomes Framework



This page is intentionally left blank

Northamptonshire

Health and Care Partnership



Page 85

Elective Collaborative Case for Change Summary Presentation

(V 9.4)

Agenda Item 6

Executive Summary

Contents

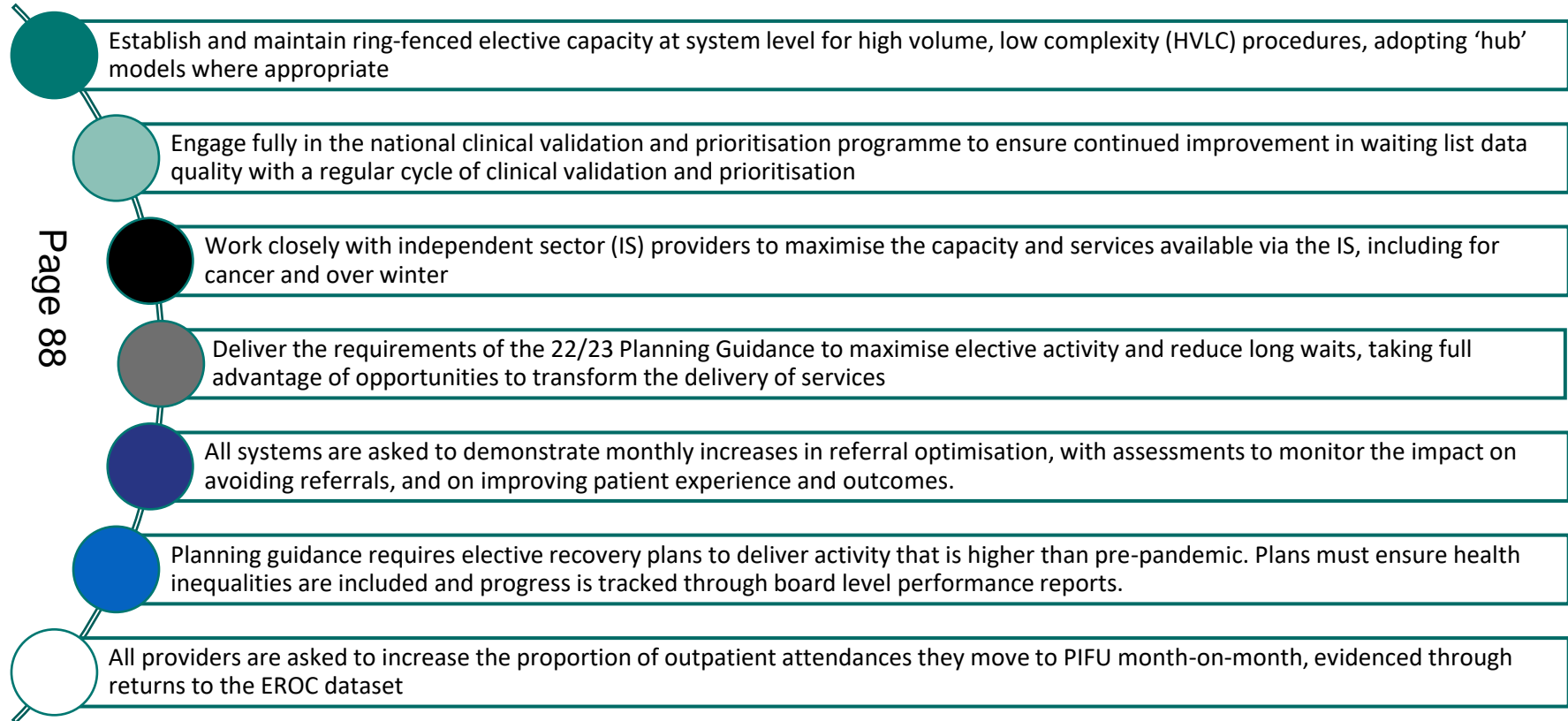
1. What is the 'ask' of Elective Care Provision in the NHS? What is it that we need to respond to and prepare for in the short and medium term?
2. What are the problems we need to try to fix locally?
3. Why is a collaborative the most effective way to respond to these issues?
4. What could the ambition for Elective Care in Northamptonshire really be?
5. How might we initially approach achieving this ambition?

Page 87

Questions to Consider

1. Is the case for change to develop an Elective Collaborative strong enough?
2. Have we been ambitious enough?
3. Do we all agree that the proposed approach is the right one?

The 'Ask' - National Priorities Elective Care



The 'Ask' - 2022/23 Planning Guidance

Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards taking full advantage of opportunities to transform the delivery of services

- Ambition for systems to deliver 10% more elective activity in 22/23 than before the pandemic (2019/20); moving up to 30% by 2024/25
- Eliminate 104 week waiters, reduce waits over 78 weeks and develop plans for overall reduction 52 weeks
- Reduce follow-up outpatient appointments by 25% compared to 2019/20 by March 2023; moving or discharging 5% of outpatients to PIFU pathways by March 2023
- Delivering 16 specialist advice (including A&G) per 100 outpatient first attendances by March 2023
- Diagnostic activity minimum 120% of pre-pandemic levels across 2022/23. Deliver further capacity through Community Diagnostic Hubs
- Improve performance against all cancer standards
- Return number of cancer patients waiting >62 days to February 2020 levels
- Implementation of further cancer patient stratified follow-up (PSFU) pathways

'The Problems' - Stakeholder view of the issues need to fix?

Capacity

Not maximising whole system elective capacity equitably

Page 90

Activity delivery not optimally planned for system VfM

Prior approval adds administration, additional time and uncertainty during the process

Diagnostic waits

Growing Population and Increasing Demand

Community diagnostic service issues

Covid Impact

Need to maintain elective care capacity

Not Person Centric - Service Centric

Fragmented Pathway with multiple handovers can confuse patients

We have health inequalities on our waiting lists

Number of patients deteriorating during wait

Difficulty to retain and recruit staff

Non Elective Impact

Cancellations of activity as a result of NEL demand

We often duplicate work

Clinical variations in care delivery

Multiple Waiting Lists

Inefficiencies of working as separate organisations

Information not transparent for patients or GP's

Working in silos, different contracts, limited aligned incentives

Limited Early Diagnostics

Longer waiting times than we would want, particularly to diagnosis

Preventative care to reduce elective demand

NHCP Elective Collaborative

Reductions in unwarranted variation in outcomes and access to planned care services

Our current priority issues

Increasing elective waiting lists

- Each organisation holds different pieces of the elective care jigsaw and multiple waiting lists
- There is no single version of the truth
- Patients deteriorating during wait
- System digital innovation on single PTL

Understanding our capacity

- We plan capacity at organisational level
- We don't have the ability to share knowledge at specialty level to ensure space/equipment and staff resource are maximised

Not person centric

- Fragmented pathways with multiple handovers
- Compising for patients and heavy communication burden on all partners

Workforce constraints

- Each organisation competes for staff with separate skill mix models for the same service
- Recruitment and retention managed separately

Value for Money is compromised

- Pricing and activity is based on organisational activity and not pathways or outcomes
- Variation in costs across the System
- PBR and National contractual directives issues

How working as a collaborative would address these

- ✓ A single PTL resulting in equitable access to care
- ✓ Standardising protocols, policies and pathways
- ✓ System wide transformation to improve efficiencies, create capacity and introduce innovations
- ✓ Delivering consistency in diagnosis, treatment and care; new service and pathway development meaning equal access to high quality services

- ✓ Demand and capacity is planned at system level
- ✓ Knowledge is formally shared to ensure capacity and resources are maximised
- ✓ Opportunities are maximised to create dedicated elective facilities enabling us to protect our elective capacity, provide timely care, minimising infection rates and reduce length of stay in hospital

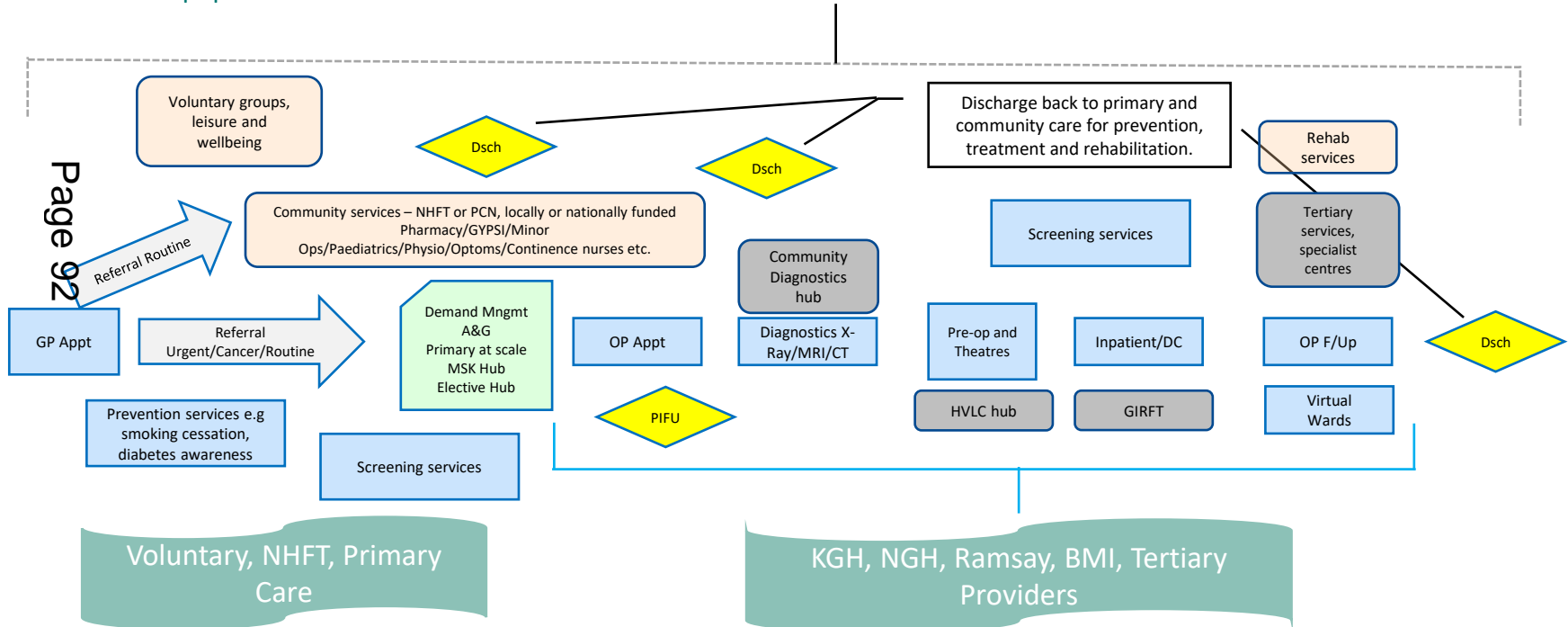
- ✓ Commissioning end to end pathways enabling us to focus on prevention and out of hospital care
- ✓ More assessments, diagnosis and treatment being offered in a one-stop pathway, in the community or virtually to minimise disruption to patient's lives
- ✓ Working to engage with patients to design and transform services to deliver improved outcome

- ✓ Integrated teams will increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing
- ✓ By working across the system, we will have the scale to explore and pilot new roles and workforce models

- ✓ A lead provider model, offering a single provider lead for administering collaborative planning and delivery
- ✓ Outcomes based commissioning focused on delivering end to end pathways
- ✓ Best allocation of available resources to deliver transformational change, reducing duplication and reinvestment in community services and prevention (left shift)

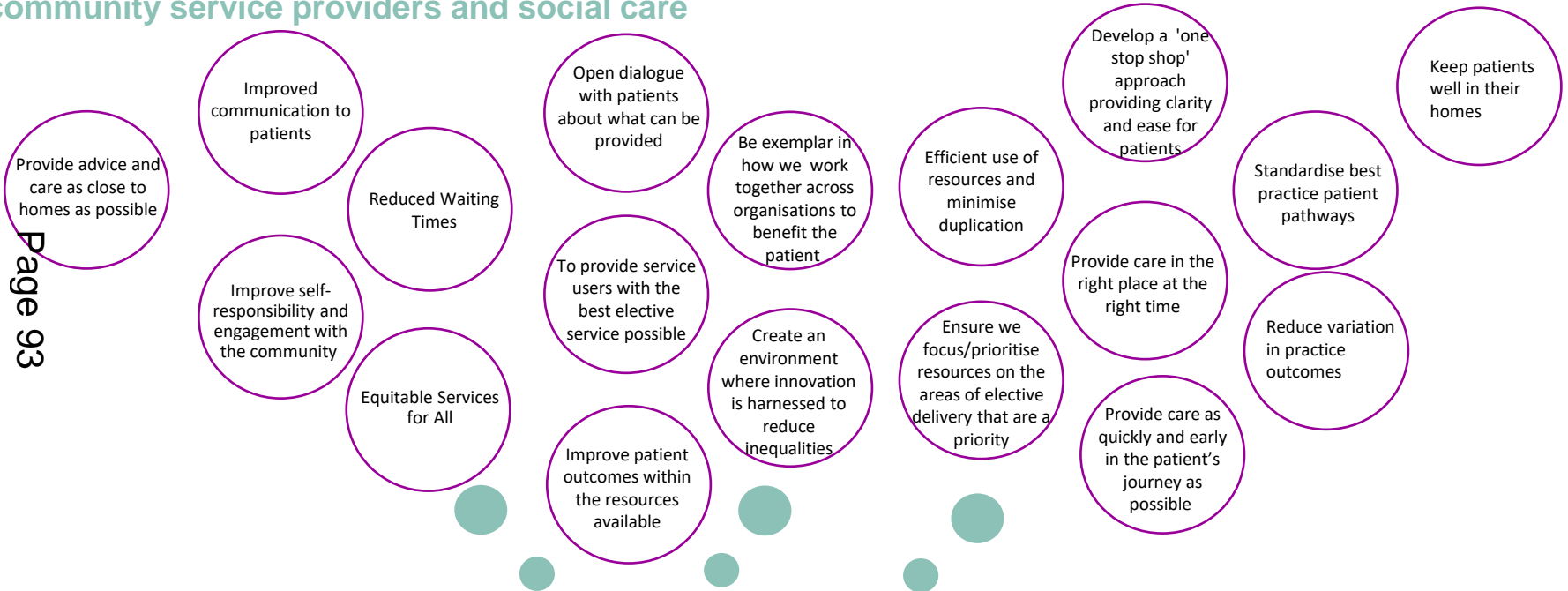
'Our Ambition' - The eventual scope

The elective pathway is not as simple as it seems, there are many hand offs and fragmented elements of the pathway, which can lead to duplication and delays for patients. There is limited focus on prevention and psychological support for those with long term conditions. Pathways can be different by provider even within specialties. There is not a collective elective service offer for the Northants population.



'Our Ambition' - What our stakeholders have told us they want

We engaged our stakeholders to understand their priorities. The following are the elective collaborative aspirations derived from this engagement with service users, GP's, acute and community service providers and social care



'Our Ambition' - A whole system approach to elective delivery

- Slick seamless access
 - **Single referral hub** that makes it seamless for primary care, supported by a **system PTL** that triages and directs referrals to where the capacity exists in a prospective way (rather than retrospectively moving patients to providers when their length of wait is long)
 - Prior approvals and consultant to consultant referrals managed within the hub to **reduce bureaucracy on system clinicians** and speed up access.
 - **Health inequalities** directing access to care
- Acute Provision – protected elective capacity, reducing patient cancellations
 - High volume low complexity care **close to patient homes** – dedicated capacity in the North and West of the county
 - **Specialist cancer surgery** on a single site – co-locating specialist staff and equipment to drive up clinical outcomes
 - **Non-specialist elective** work on a single site, with nationally exemplar theatre utilisation and single pathways for patients
 - The four providers working together to **maximise capacity**
- In the community
 - Integrated informative **public health messaging** to keep patients well
 - **Advice and guidance** direct to patients to ensure conditions are escalated to the right clinician to prevent delay associated deterioration and A&E attendances
 - Prevention and Living Well forefront
 - **Community Diagnostic Hubs** – with primary, community and secondary care access into one stop clinics
 - A range of prevention and schemes **keep communities well**
 - Voluntary sector groups supporting the chronically unwell
 - **Psychological support** for those with chronic conditions

'Our Ambition' - Some examples of what will success feel like?

If I am a Patient

- I will know at point of referral how long I can expect to wait for treatment, and I can get regular updates on that from my GP, the referral hub or a digital solution on my phone or tablet.
- Whilst I will be offered choice of provider, I will be able to make an informed choice on the total expected length of my pathway at each provider, rather than just on first outpatient consultation.
- I will get the same treatment, outcomes, after care and support at any provider I choose.
- I will get the same equitable access to the range of services available in the county, and if I have health inequalities then I will get prioritised in a way that ensures I am not disadvantaged by my situation.
- There will be a range of community-based services to help support me to keep well and manage my own health

If I am a GP

- I know how long my patient will wait for treatment before I even make a referral. This means I can give advice, and direct to community or voluntary services that will help them to self-care whilst they wait, and not clinically deteriorate.
- I do not have to waste my clinical time undertaking bureaucratic prior approvals, or re-referring for consultant to consultant referrals, I know the collaborative referral hub will be managing that for me.
- When patients phone me up to enquire about their wait, I will be able to tell them at the touch of a button how much longer they can expect to wait and what clinical urgency they are.
- My time can be saved and re-focussed to clinically managing patients.

For the System

- We will release clinical time across the system by reducing bureaucracy and duplication through implementing a central referral hub for all elective patients, supported by a suite of digital solutions that work across the collaborative.
- We will shorten waiting times for patients by reducing 'handing patients' from provider to provider or sector to sector, and maximising the available capacity across providers. This will reduce attendances at A&E due to deterioration during long waits.
- We will create value for money by delivering the same best practice pathways at the same cost, sharing resources and estate amongst providers.
- We will transform pathways through the ability to invest collaborative funds in out of hospital schemes.

If I am a staff member

- I will be working in an innovative county wide collaborative, offering a full range of elective services from HVLC procedures to specialist procedures usually undertaken at tertiary providers. This provides an exciting place to work for me with lots of opportunities to get more experiences that would be available in a single provider.
- I will have excellent training and development that will support me to work across the collaborative to develop my career.
- People doing the same job as me will be paid the same rates no matter where they work.

'Proposed approach' - Phase 1 Collaborative Options

An options appraisal process was undertaken to identify and evaluate options. The three options reviewed included risks and benefits of each option and assessed against the HCP asks for Collaboratives (slide 7). A summary of each option (details of the options and the scoring matrix are included in appendix 1). The preferred option is Option 3.

Option 1: Collaborative to commission and deliver an acute level system activity

Page 96

- This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers
- May also include community diagnostic and referral hub(s)
- Opportunity to maximise whole system elective capacity equitably
- Enables us to better manage our growing population and increasing demand for services
- Reducing variation and streamlining services

Option 2: Collaborative to commission end to end pathways

- Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology
- Visibly putting the patient first from the outset, with care wrapped around the patient
- Supports investment and transformation in demand management and out of hospital schemes to control demand
- Avoid duplication across the system to reduce cost and minimise poor patient experience

Option 3: Hybrid of options 1 & 2

- To include some elements of elective capacity and system PTL and some end to end patient pathways.
- Reflects and incorporates all system partners to some degree, so all can be a part of the collaborative in a meaningful way
- More in line with our final vision, just an initial step on the journey

What will be included in the collaborative?

Preferred Option Scope for Phase 1, from July 22

Collaborative to commission and deliver all acute level system activity. This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers. May also include community diagnostic and referral hub(s). Opportunity to pilot an agreed number of pathways e.g. MSK/Spinal and Cardiology to prepare for commissioning end to end pathways in a later phase.

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
<ul style="list-style-type: none"> • Opportunity to maximise whole system elective capacity equitably 	<ul style="list-style-type: none"> • Doesn't involve/include/acknowledge the non-acute elements of an elective pathway
<ul style="list-style-type: none"> • Enables better management of a growing population and increasing demand for services 	<ul style="list-style-type: none"> • Risks alienating other system partners, doesn't reflect a true collaborative at system level and continues to support the wide belief the acutes 'think it is all about them' – compromises the 'lead provider' direction?
<ul style="list-style-type: none"> • Reducing variation and streamlining services 	<ul style="list-style-type: none"> • Maintains the limited ability to transform out of hospital care, so still reaction-based response rather than proactive
<ul style="list-style-type: none"> • Joint planning and use of acute capacity 	<ul style="list-style-type: none"> • Does not allow for demand management and long-term condition management schemes
<ul style="list-style-type: none"> • Information sharing across providers 	
<ul style="list-style-type: none"> • Joint workforce planning & scheduling to meet capacity demands 	
<ul style="list-style-type: none"> • Proof of concept of the different approaches, to enable learning and further refinement before wholesale responsibility shift 	<ul style="list-style-type: none"> • More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners
<ul style="list-style-type: none"> • Reflects and incorporates all system partners to some degree, so all can be a part of the Collaborative in a meaningful way 	
<ul style="list-style-type: none"> • More in line with our final vision, just an initial step on the journey 	95

Full Pack

National priorities for elective care

The ask from NHCP Board for collaboratives

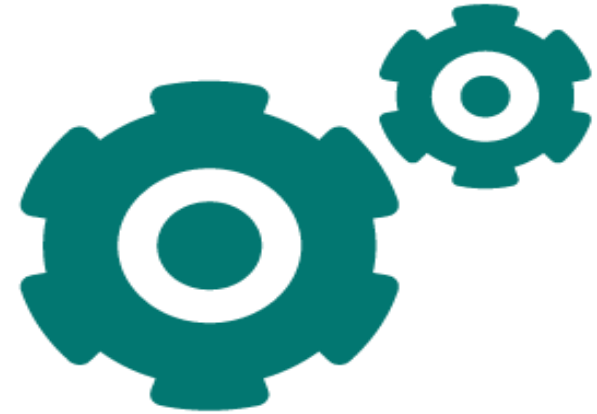
What issues are we trying to fix?

A single system approach – Vision and art of the possible?

Benefits of working as a collaborative

Options and scope

National Context



National Priorities Elective Care

Page 100

Establish and maintain ring-fenced elective capacity at system level for high volume, low complexity (HVLC) procedures, adopting 'hub' models where appropriate

Engage fully in the national clinical validation and prioritisation programme to ensure continued improvement in waiting list data quality with a regular cycle of clinical validation and prioritisation

Work closely with independent sector (IS) providers to maximise the capacity and services available via the IS, including for cancer and over winter

Deliver the requirements of the 22/23 Planning Guidance to maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

All systems are asked to demonstrate monthly increases in referral optimisation, with assessments to monitor the impact on avoiding referrals, and on improving patient experience and outcomes.

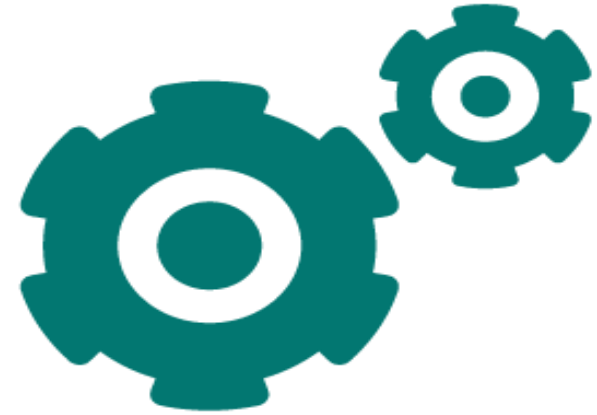
Planning guidance requires elective recovery plans to deliver activity that is higher than pre-pandemic. Plans must ensure health inequalities are included and progress is tracked through board level performance reports.

All providers are asked to increase the proportion of outpatient attendances they move to PIFU month-on-month, evidenced through returns to the EROC dataset

Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards taking full advantage of opportunities to transform the delivery of services

- Ambition for systems to deliver 10% more elective activity in 22/23 than before the pandemic (2019/20); moving up to 30% by 2024/25
- Eliminate 104 week waiters, reduce waits over 78 weeks and develop plans for overall reduction 52 weeks
- Reduce follow-up outpatient appointments by 25% compared to 2019/20 by March 2023; moving or discharging 5% of outpatients to PIFU pathways by March 2023
- Delivering 16 specialist advice (including A&G) per 100 outpatient first attendances by March 2023
- Diagnostic activity minimum 120% of pre-pandemic levels across 2022/23. Deliver further capacity through Community Diagnostic Hubs
- Improve performance against all cancer standards
- Return number of cancer patients waiting >62 days to February 2020 levels
- Implementation of further cancer patient stratified follow-up (PSFU) pathways

Page 102
Local Context

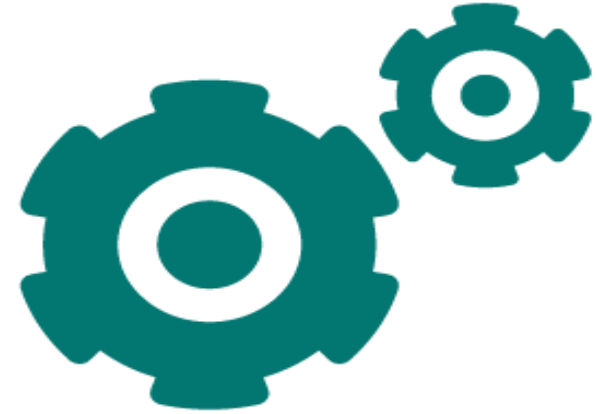


Our Design Principles - Northamptonshire (NHCP) emerging Integrated Care Board ask of collaboratives

- 1 The collaborative will be **inclusive involving all system partners** to plan, transform and deliver services – including the Integrated Care Board; NHS providers; local authorities; independent sector; and the VCSE sector
- 2 The collaborative needs to transform services and **improve population health in specific areas**, reducing unwarranted variation and inequity in health outcomes, access to services and experience
- 3 The collaborative needs to **take a whole pathway approach** to their transformation and consider the life course approach to ensure services are fit from conception to death
- 4 The collaborative will need to **include specialised and direct commissioning**
- 5 The collaborative will need to include places and local government to ensure services are **designed to meet the needs of the different communities** across Northamptonshire
- 6 The collaborative needs to improve resilience across providers particularly in relation to the workforce – we expect collaboratives to **jointly plan their workforce**
- 7 The collaborative needs to consider where specialisation and consolidation would **provide better outcomes and value**
- 8 The collaborative will need to **work across all partners** and where appropriate with national and regional networks **to transform services**
- 9 All partners will have an **equal voice**

Page 104

What are the **issues** we are trying to fix? Views from partners and patients



What issues are we trying to fix?

Capacity

Not maximising whole system elective capacity equitably

Diagnostic waits

Need to maintain elective care capacity

Covid Impact

Not Person Centric - Service Centric

Fragmented Pathway with multiple handovers can confuse patients

Non Elective Impact

Cancellations of activity as a result of NEL demand

Multiple Waiting Lists

Inefficiencies of working as separate organisations

Limited Early Diagnostics

Longer waiting times than we would want, particularly to diagnosis

Page 105

Growing Population and Increasing Demand

Activity delivery not optimally planned for system VfM

Community diagnostic service issues

Prior approval adds administration, additional time and uncertainty during the process

We have health inequalities on our waiting lists

Difficulty to retain and recruit staff

We often duplicate work

Information not transparent for patients or GP's

Preventative care to reduce elective demand

Number of patients deteriorating during wait

Clinical variations in care delivery

Working in silos, different contracts, limited aligned incentives

NHCP Elective Collaborative

Reductions in unwarranted variation in outcomes and access to planned care services

Some examples

Northamptonshire population is projected to increase by 14% 2018 - 2038. In 20-64 yr olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase

There are multiple separate waiting lists patients can be on at different stages of their pathway.

- Organisational level; KGH, NGH, NHFT, BMI, Ramsey.
- Within organisations: Planned treatment, Diagnostic waiting, Treatment waiting, Outpatient waiting etc.

There are specific shortages in nursing, ODP's, therapies and Anaesthetists.

Northamptonshire nursing vacancy rates are around 9%, with a yearly turnover of 6.8%.

Pages 105

As at September 2021 there were over 800 Northamptonshire patients waiting over a year for treatment

NHCP Elective Collaborative

Day case levels, Northamptonshire in lower Quartile, with high conversion from day case to inpatients

Monthly cancellation rates on average 7% prior to the pandemic

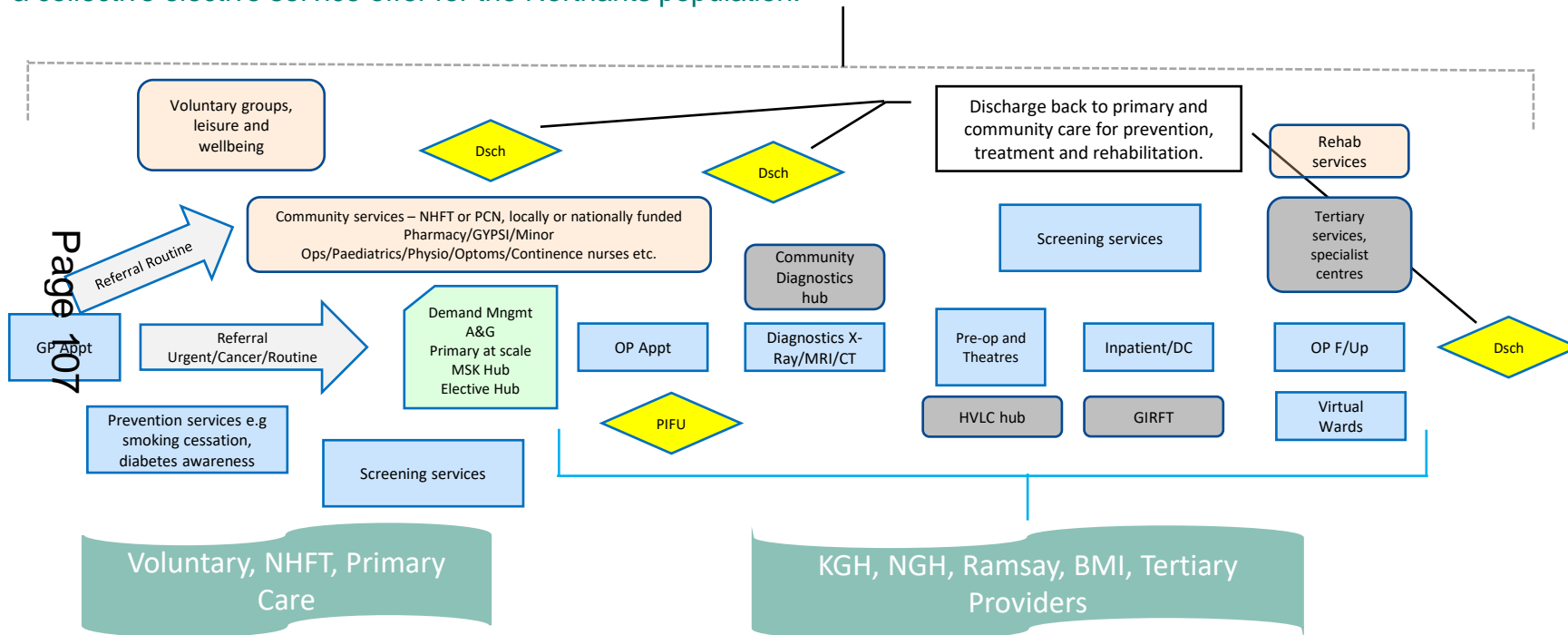
Reductions in unwarranted variation in outcomes and access to planned case services

Long waiters have increased . There were 51 waiting over 2 years and 1,029 over 1 year at October 21.



The scope of elective care is very broad

The elective pathway is not as simple as it seems, there are many hand offs and fragmented elements of the pathway, which can lead to duplication and delays for patients. There is limited focus on prevention and psychological support for those with long term conditions. Pathways can be different by provider even within specialties. There is not a collective elective service offer for the Northants population.



Why a collaborative?

The Collaborative will commission and deliver the required **improved patient outcomes and experience** by working together within robust governance. This will allow the **delivery of care to be re-imagined and transformed** through aligned resources (capacity, money and workforce) and operations to address problems by:

- Working with patient representatives to ensure **patient-centred** consistent whole pathways are delivered with effective engagement with patients throughout their journey
- Providing **seamless pathways** for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible
- Bringing teams' expertise, experience and innovation together to transform services and improve outcomes through **clinically-led, outcomes-based** commissioning
- Developing a patient-centred culture to ensure **quality outcomes** based on shared patient and clinical needs
- Improving quality, using resources most effectively, and delivering best practice to all patients – working at scale across the county to deliver **value for money and reduce duplication** across clinical and corporate services thereby releasing savings for re-investment in further pathway development
- Providing staff with a supportive, rewarding environment to learn, develop and grow their careers in stable, **highly skilled teams** with seamless movement between organisations that will deliver a sustainable workforce

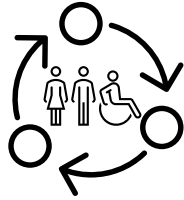
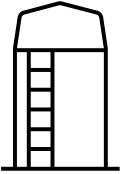
Our current priority issues	How working as a collaborative would address these
<p>Increasing elective waiting lists</p> <ul style="list-style-type: none"> • Each organisation holds different pieces of the elective care jigsaw and multiple waiting lists • There is no single version of the truth • Patients deteriorating during wait 	<ul style="list-style-type: none"> ✓ A single PTL resulting in equitable access to care ✓ Standardising protocols, policies and pathways ✓ System wide transformation to improve efficiencies, create capacity and introduce innovations ✓ Delivering consistency in diagnosis, treatment and care; new service and pathway development meaning equal access to high quality services
<p>Understanding our capacity</p> <ul style="list-style-type: none"> • We plan capacity at organisational level • We don't have the ability to share knowledge at specialty level to ensure space/equipment and staff resource are maximised 	<ul style="list-style-type: none"> ✓ Demand and capacity is planned at system level ✓ Knowledge is formally shared to ensure capacity and resources are maximised ✓ Opportunities are maximised to create dedicated elective facilities enabling us to protect our elective capacity, provide timely care, minimising infection rates and reduce length of stay in hospital
<p>Not person centric</p> <ul style="list-style-type: none"> • Fragmented pathways with multiple handovers • Confusing for patients and heavy communication burden on all partners 	<ul style="list-style-type: none"> ✓ Commissioning end to end pathways enabling us to focus on prevention and out of hospital care ✓ More assessments, diagnosis and treatment being offered in a one-stop pathway, in the community or virtually to minimise disruption to patient's lives ✓ Working to engage with patients to design and transform services to deliver improved outcome
<p>Workforce constraints</p> <ul style="list-style-type: none"> • Each organisation competes for staff with separate skill mix models for the same service • Recruitment and retention managed separately 	<ul style="list-style-type: none"> ✓ Integrated teams will increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing ✓ By working across the system, we will have the scale to explore and pilot new roles and workforce models
<p>Value for Money is compromised</p> <ul style="list-style-type: none"> • Pricing and activity is based on organisational activity and not pathways or outcomes • Variation in costs across the System 	<ul style="list-style-type: none"> ✓ A lead provider model, offering a single provider lead for administering collaborative planning and delivery ✓ Outcomes based commissioning focused on delivering end to end pathways ✓ Best allocation of available resources to deliver transformational change, reducing duplication and reinvestment in community services and prevention (left shift)

Life Before the Collaborative

Working in silos

Competing for limited workforce

Long waits / cancelled operations

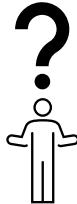


Page 110

Avoiding difficult conversations

Fragmented pathways can confuse patients

Organisation centric



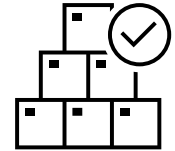
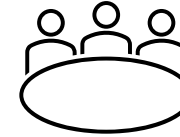
Multiple organisations commissioned individually

Life After the Collaborative

Shared / Pooled workforce

Strong relationships: Collaboration and Co-operation

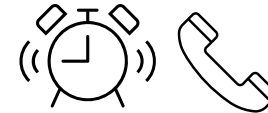
Streamlined pathways and services



Improved patient outcomes

No long waits / patients engaged

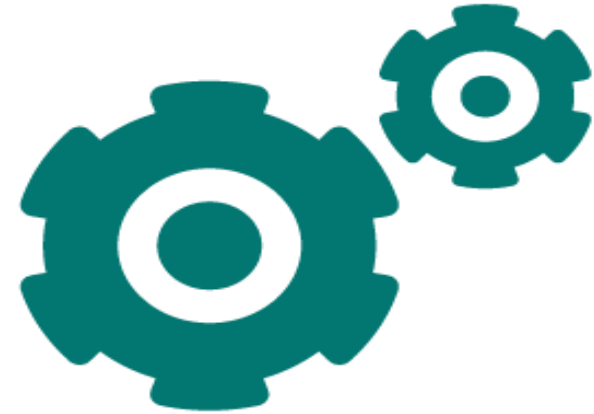
Strategic System Planning



Collaborative clinically led outcomes commissioning

The “vision” for
elective care and the
art of the possible in a
collaborative

page 114



Vision for the Elective Collaborative

To improve health outcomes, inequalities and quality of life through a single system patient-centred approach across the whole elective pathway transforming delivery of services to ensure equitable access to timely treatment for patients across the county and to enable patients to be supported to keep well.

What our stakeholders have told us

We engaged our stakeholders to understand their priorities. The following are the elective collaborative aspirations derived from this engagement with service users, GP's, acute and community service providers and social care



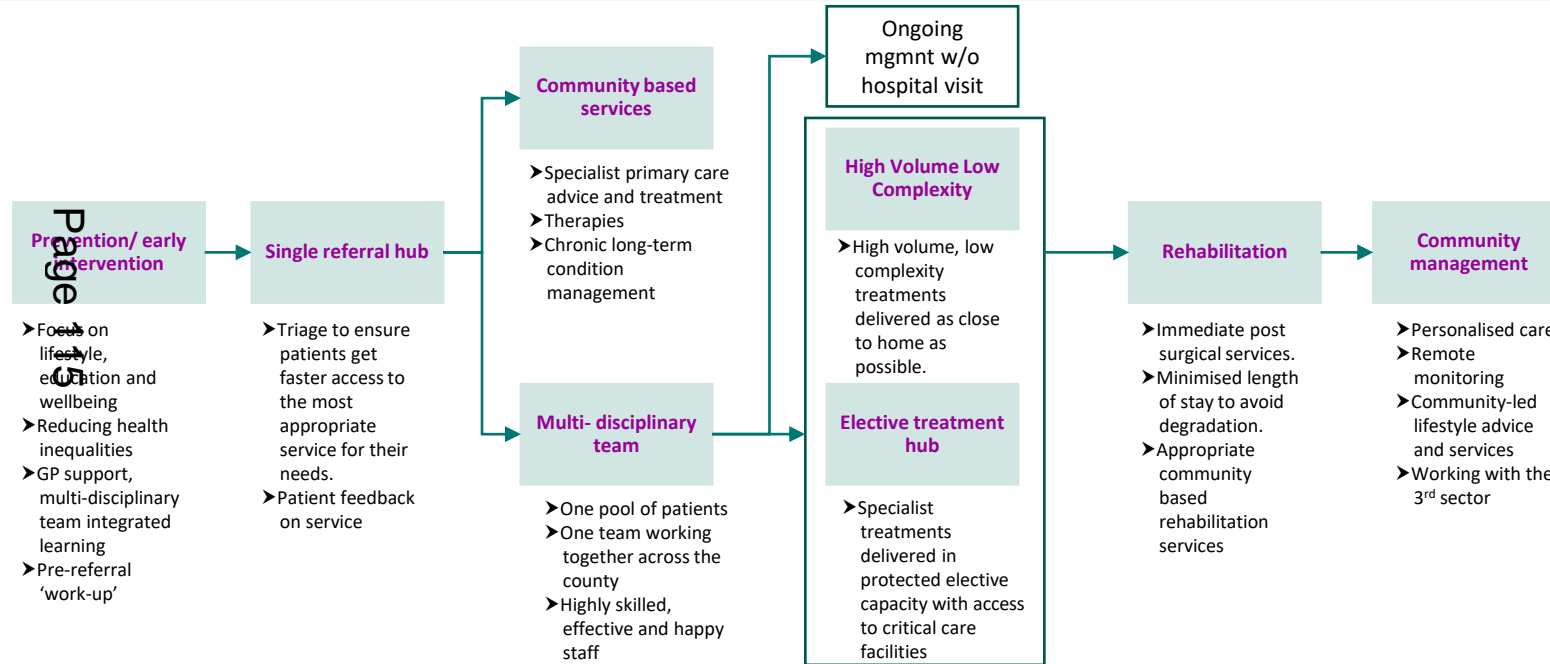
A future whole system approach to elective delivery

- Slick seamless access
 - Single referral hub that makes it seamless for primary care, supported by a system PTL that triages and directs referrals to where the capacity exists in a prospective way (rather than retrospectively moving patients to providers when their length of wait is long)
 - Prior approvals and consultant to consultant referrals managed within the hub to reduce bureaucracy on system clinicians and speed up access.
 - Health inequalities directing access to care
- Acute Provision – protected elective capacity, reducing patient cancellations
 - High volume low complexity care close to patient homes – dedicated capacity in the North and West of the county
 - Specialist cancer surgery on a single site – co-locating specialist staff and equipment to drive up clinical outcomes
 - Non-specialist elective work on a single site, with nationally exemplar theatre utilisation and single pathways for patients
 - The four providers working together to maximise capacity
- In the community
 - Integrated informative public health messaging to keep patients well
 - Advice and guidance direct to patients to ensure conditions are escalated to the right clinician to prevent delay associated deterioration
 - Prevention and Living Well forefront
 - Community Diagnostic Hubs – with primary, community and secondary care access into one stop clinics
 - A range of prevention and schemes keep communities well
 - Voluntary sector groups supporting the chronically unwell
 - Psychological support for those with chronic conditions

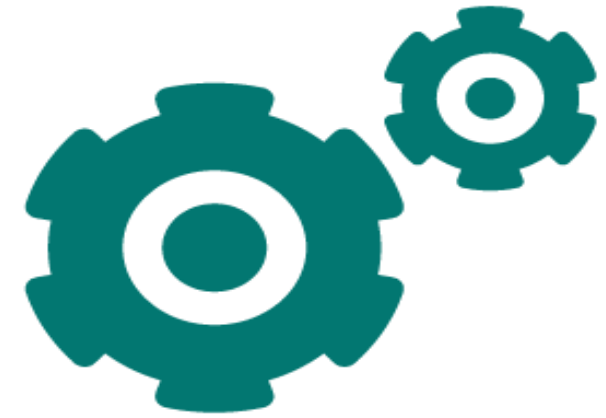
A single system approach – art of the possible

A single system approach would improve care along the whole elective pathway over the next 3 – 5 years

One system-wide waiting list (PTL), delivering equitable access to timely treatment for patients across the county, transparency to all clinicians including GPs to enable patients to be supported to keep well while they wait



Preferred Option and Scope of the collaborative



How will we develop as a collaborative?

- A new contractual framework will be developed, which is designed to facilitate collaborative working, set clear lines of accountability to the Integrated Care Board, and allow financial/ operational resources to be deployed to achieve the required outcomes, performance and quality ambitions in a sustainable way. This will include;
- A **Lead provider approach** - creating a single point of delegation and accountability for the Integrated Care Board. Unlike other approaches, this ensures that system efforts, plans and data are centralised
- **Delegated budget** - a delegated budget allows for resources to be rapidly moved or re-aligned according to emerging needs, creating a more agile and responsive health and care system
- **Collaborative agreement** - a document that clarifies the arrangements for partnership working, flexibility, transparency, and shared commitment to deliver ambitions aligned to local and statutory expectations for the system. This will include a risk and gain share agreement.
- **Agreed outcomes framework** - resetting the measure of success to align with the overarching outcomes the system and its residents seek to achieve

Phasing – There is a need to agree what can meaningfully be started on delivering the whole vision, and what a phased approach might be in terms of steps. This should be:

1. Focussed on the priority problems to be resolved
2. Testing solutions in a safe environment, to enable a more robust roll-out of the scope through 2022/23.
3. Timely and at pace, with a clear risk management framework.

Collaborative Options Considered

An options appraisal process was undertaken to identify and evaluate options. The three options reviewed included risks and benefits of each option and assessed against the HCP asks for Collaboratives (slide 7). A summary of each option (details of the options and the scoring matrix are included in appendix 1). The preferred option is Option 3.

Option 1: Collaborative to commission and deliver acute level system activity

Page 118

- This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers
- May also include community diagnostic and referral hub(s)
- Opportunity to maximise whole system elective capacity equitably
- Enables us to better manage our growing population and increasing demand for services
- Reducing variation and streamlining services

Option 2: Collaborative to commission end to end pathways

- Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology
- Visibly putting the patient first from the outset, with care wrapped around the patient
- Supports investment and transformation in demand management and out of hospital schemes to control demand
- Avoid duplication across the system to reduce cost and minimise poor patient experience

Option 3: Hybrid of options 1 & 2

- To include some elements of elective capacity and system PTL and some end to end patient pathways.
- Reflects and incorporates all system partners to some degree, so all can be a part of the collaborative in a meaningful way
- More in line with our final vision, just an initial step on the journey

What will be included in the collaborative?

Option 3 is the preferred option and is described in more detail on the next slide.

Implementation of this option will be phased across 22/23. Step 1 will be to collaborative to commission and deliver all acute level system activity from July 2022 (in shadow form from April 22) with a devolved budget, collaborative agreements and accountability framework in place. The proposed phased timeline is shown below.

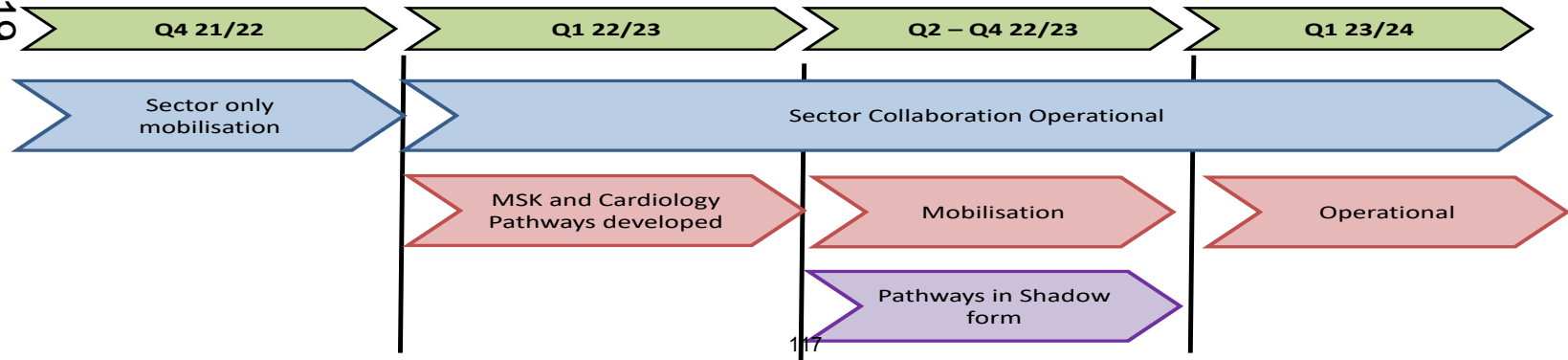
Step 2 will be to test the proof of concept of transforming and commissioning two end to end pathways; Cardiology and MSK from April 2023. Pathway budgets are complicated and need to be understood and agreed before a budget can be devolved. The intention will be to run the pathway in shadow form from Q4 2022/23.

The Collaborative will develop commissioning intentions with patient representatives to ensure service transformation meets the strategic objectives.

The Collaborative scope includes surgical and medical services for adults, children and young people.

Page 119

Phased Timeline



What will be included in the collaborative?

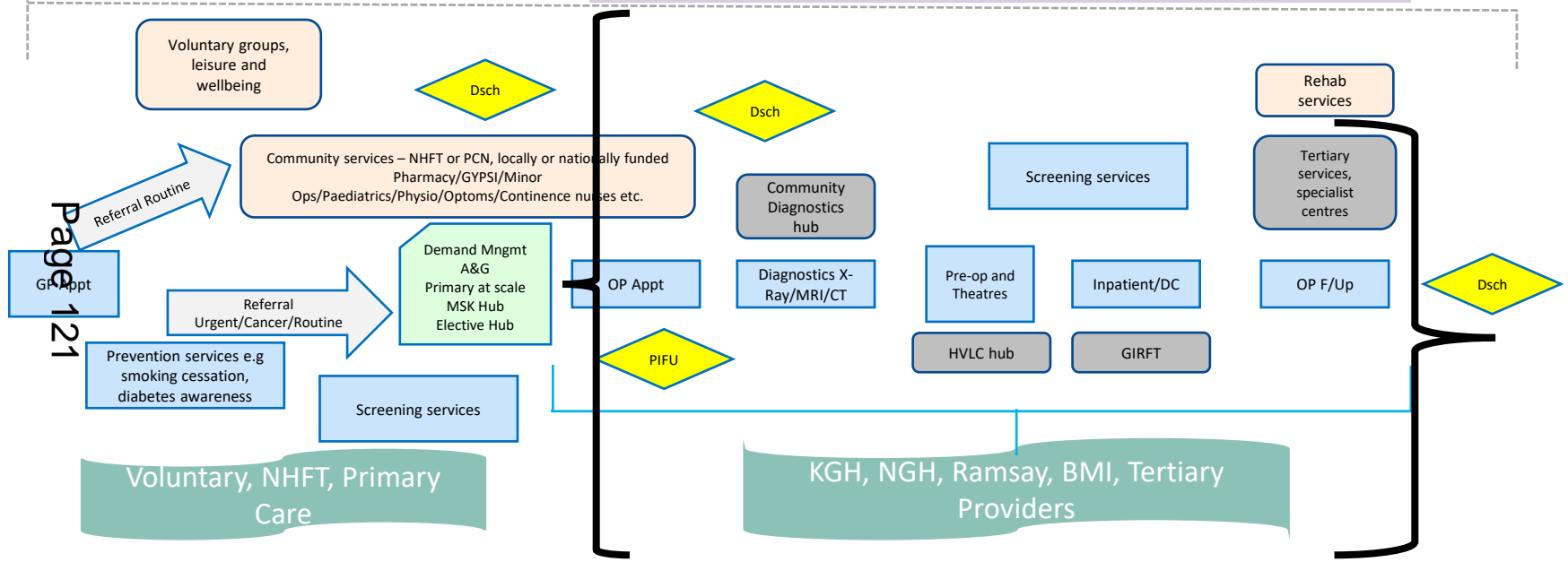
Preferred Option Scope for Phase 1, from July 22

Collaborative to commission and deliver all acute level system activity. This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers. May also include community diagnostic and referral hub(s). Opportunity to pilot an agreed number of pathways e.g. MSK/Spinal and Cardiology to prepare for commissioning end to end pathways in a later phase.

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
<ul style="list-style-type: none"> • Opportunity to maximise whole system elective capacity equitably 	<ul style="list-style-type: none"> • Doesn't involve/include/acknowledge the non-acute elements of an elective pathway
<ul style="list-style-type: none"> • Enables better management of a growing population and increasing demand for services 	<ul style="list-style-type: none"> • Risks alienating other system partners, doesn't reflect a true collaborative at system level and continues to support the wide belief the acutes 'think it is all about them' – compromises the 'lead provider' direction?
<ul style="list-style-type: none"> • Reducing variation and streamlining services 	<ul style="list-style-type: none"> • Maintains the limited ability to transform out of hospital care, so still reaction-based response rather than proactive
<ul style="list-style-type: none"> • Joint planning and use of acute capacity 	<ul style="list-style-type: none"> • Does not allow for demand management and long-term condition management schemes
<ul style="list-style-type: none"> • Information sharing across providers 	
<ul style="list-style-type: none"> • Joint workforce planning & scheduling to meet capacity demands 	
<ul style="list-style-type: none"> • Proof of concept of the different approaches, to enable learning and further refinement before wholesale responsibility shift 	<ul style="list-style-type: none"> • More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners
<ul style="list-style-type: none"> • Reflects and incorporates all system partners to some degree, so all can be a part of the Collaborative in a meaningful way 	
<ul style="list-style-type: none"> • More in line with our final vision, just an initial step on the journey 	118

What will be included in the first phase of the Elective Collaborative from April 22

We will collaborate to commission and deliver all acute level system activity. This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers. May also include community diagnostic and referral hub(s). From April 22



We will pilot an agreed number of pathways, e.g. MSK and Cardiology, to prepare for commissioning end to end pathways by April 23

Mobilisation questions and next steps:

- Case for change approval through the system governance as per the Collaborative approvals process
- Confirm the detail of the operating model and what will be done by ICB and what will be done by the collaborative (functions of each)
- Finalise the outcomes framework to agree the required System outcomes, measures and KPIs and use a logic model to track population health outcomes
- Develop the collaborative and contracting arrangements, ensuring all partners and patients are represented.
- Confirm the legal form for the collaborative.
- Accountability Framework to be developed to include finance, performance and risk/gain share
- Establish governance of Collaborative and the interdependencies with the other collaboratives (CYP, MHLDA, iCAN).
- Develop case for progression through Collaborative Gateways 3-5

Appendices

Page 123

Scope Option 1

Collaborative to commission all acute level system outpatient, inpatient and day-case capacity, and deliver through a single PTL
To include independent sector, community diagnostic and referral hub(s)

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
<ul style="list-style-type: none"> Opportunity to maximise whole system elective capacity equitably 	<ul style="list-style-type: none"> Doesn't involve/include/acknowledge the non-acute elements of an elective pathway
<ul style="list-style-type: none"> Enables us to better manage our growing population and increasing demand for services 	<ul style="list-style-type: none"> Risks alienating other system partners, doesn't reflect a true collaborative at system level and continues to support the wide belief the acutes 'think it is all about them' – compromises the 'lead provider' direction?
<ul style="list-style-type: none"> Reducing variation and streamlining services 	<ul style="list-style-type: none"> Maintains the limited ability to transform out of hospital care, so still reaction based response rather than proactive
<ul style="list-style-type: none"> Joint planning and use of acute capacity 	<ul style="list-style-type: none"> Does not allow for demand management and long term condition management schemes
<ul style="list-style-type: none"> Information sharing across providers 	
<ul style="list-style-type: none"> Joint workforce planning & scheduling to meet capacity demands 	

Scope- Option 2

Collaborative to commission end to end pathways

Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
<ul style="list-style-type: none"> Visibly putting the patient first from the outset, with care wrapped around the patient 	<ul style="list-style-type: none"> Complex pathways to understand, with multiple providers and more resistance to change
<ul style="list-style-type: none"> Supports investment and transformation in demand management and our of hospital schemes to control demand 	<ul style="list-style-type: none"> Multiple contracts and commissioning relationships
<ul style="list-style-type: none"> Opportunity to improve the patient experience through streamlined less fragmented pathways with multiple handovers 	<ul style="list-style-type: none"> Doesn't allow for maximising acute capacity utilisation for inpatient and day case work aligned to elective recovery
<ul style="list-style-type: none"> Opportunity to reduce variation in pathways and access to voluntary and community services across the system 	<ul style="list-style-type: none"> Longer time period to implement
<ul style="list-style-type: none"> Avoid duplication across the system to reduce cost and minimise poor patient experience 	
<ul style="list-style-type: none"> Provide a clear patient pathway that all stakeholders understand and agree 	
<ul style="list-style-type: none"> Get the right patient to the right place at the right time 	

Scope Option 3

Hybrid of options 1 & 2 to include some elements of elective capacity and system PTL and some end to end patient pathways

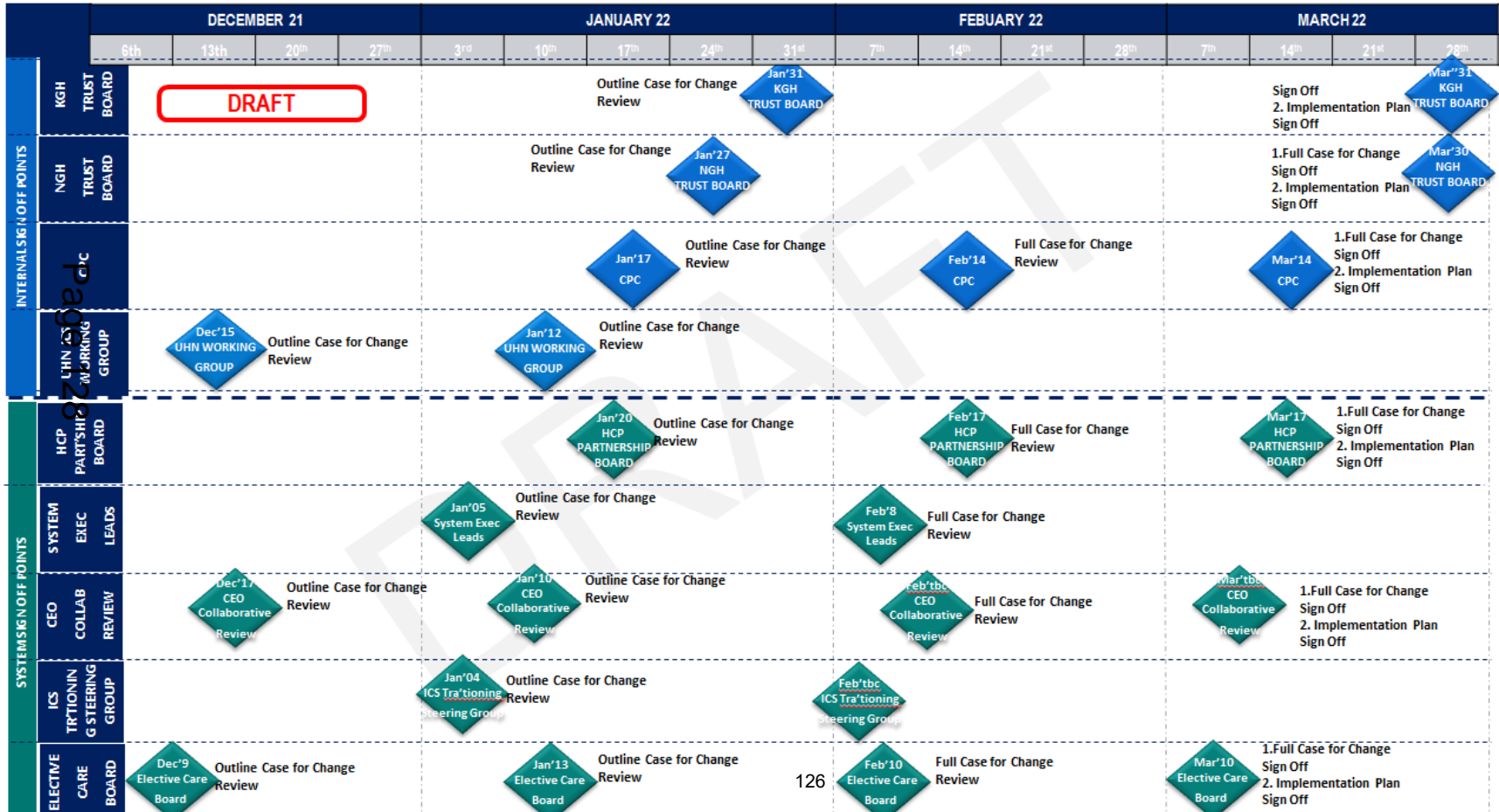
BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
<ul style="list-style-type: none"> Offers all the practical benefits of Option 1 and 2, but with an ability to implement and deliver the benefits over time 	<ul style="list-style-type: none"> Larger breadth of diverse programmes may dilute impacts
<ul style="list-style-type: none"> A greater degree of 'testing' of the different approaches, to enable learning and further refinement before wholesale responsibility shift 	<ul style="list-style-type: none"> More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners
<ul style="list-style-type: none"> Reflects and incorporates all system partners to some degree, so all can be a part of the collaborative in a meaningful way 	
<ul style="list-style-type: none"> More in line with our final vision, just an initial step on the journey 	

We reviewed the following options to identify and agree the scope for phase 1 of the collaborative

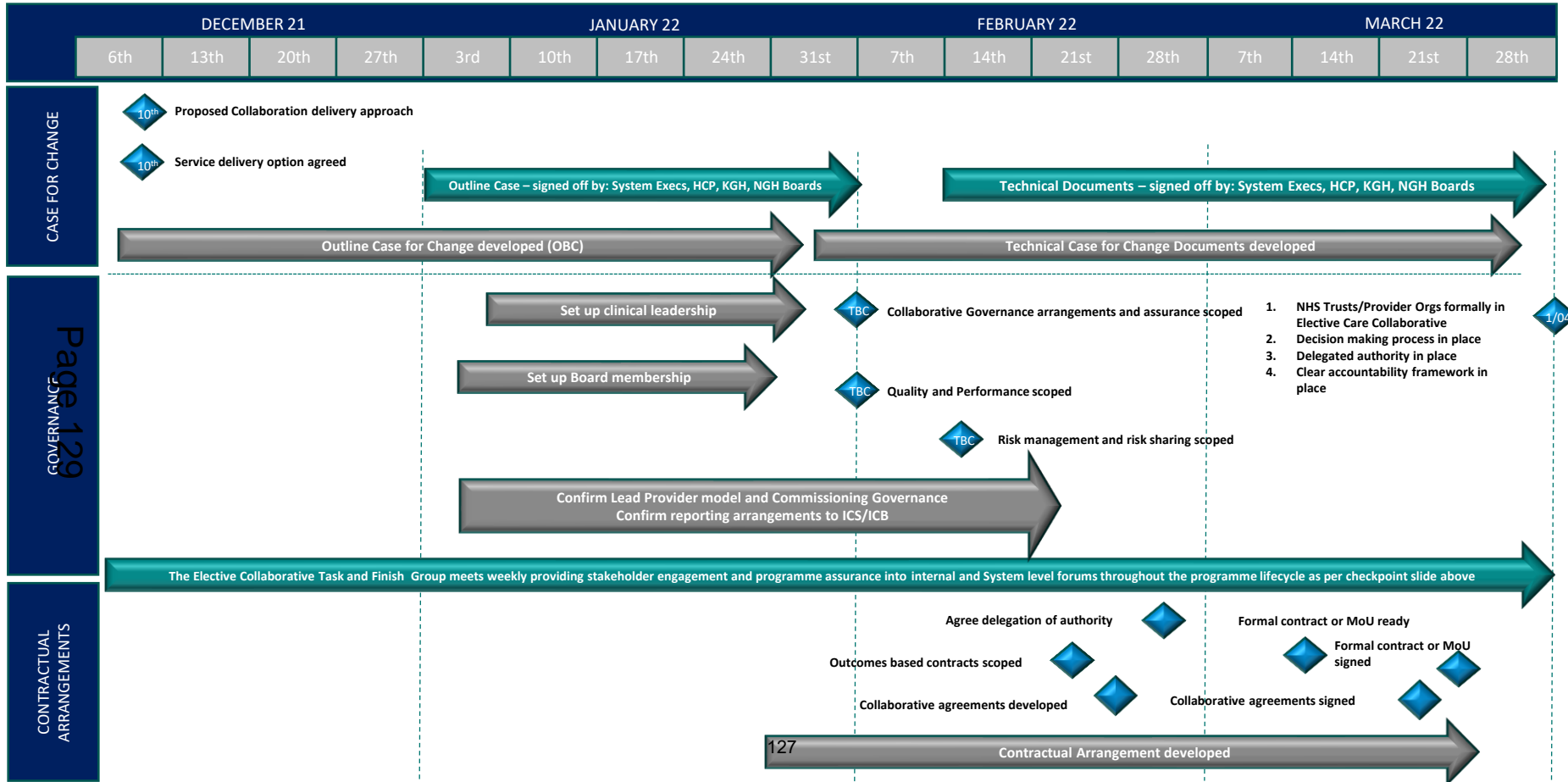
	What issues are we trying to fix		NHCP Board ask of collaboratives (Design Principles)								
PHASING OPTIONS	BENEFITS	RISKS	Inclusive involving all system partners	Reduce unwarranted variation and inequity in outcomes and access	Whole pathway approach to transformation services & delivery	Specialised and direct commissioning	Meet the needs of different communities	Improve resilience across providers	VFM via specialisation and consolidation	Working with national and regional networks	All partners will have an equal voice
Collaborative to commission all acute level system outpatient, inpatient and day-case capacity, and deliver through a single PTL To include independent sector, community diagnostic and referral hub(s)	<ol style="list-style-type: none"> 1. Maximise whole system capacity equitably 2. Better manage increasing demand 3. Reducing variation and streamlining services 4. Joint planning and use of acute capacity 5. Information sharing across providers 6. Joint workforce planning & scheduling to meet capacity demands 	<ol style="list-style-type: none"> 1. Doesn't involve/include/acknowledge the non-acute elements of an elective pathway 2. Risks alienating other system partners, doesn't reflect a true collaborative at system level 3. Maintains the limited ability to transform out of hospital care, so still reaction based response rather than proactive 4. Does not allow for demand management and long term condition management schemes 	✓			✓		✓	✓	✓	✓
Collaborative to commission and to end pathways Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology	<ol style="list-style-type: none"> 1. Supports demand management and our of hospital schemes 2. putting the patient first from the outset, with care wrapped around the patient 3. improve the patient experience through streamlined less fragmented pathways 4. reduce variation in pathways and access to voluntary and community services across the system 5. Provide a clear patient pathway that all stakeholders understand and agree 6. Get the right patient to the right place at the right time 	<ol style="list-style-type: none"> 1. Complex pathways to understand, with multiple providers and more resistance to change 2. Doesn't allow for maximising acute capacity utilisation for inpatient and day case work aligned to elective recovery 3. Multiple contracts and commissioning relationships 4. Longer time period to implement 	✓	✓	✓	✓	✓		✓	✓	✓
Hybrid of options 1 & 2 to include some elements of elective capacity and system PTL and some end to end patient pathways	<ol style="list-style-type: none"> 1. Offers all the practical benefits of Option 1 and 2, but with an ability to implement and deliver the benefits over time 2. A greater degree of 'testing' of the different approaches, to enable learning 3. Reflects and incorporates all system partners to some degree 	<ol style="list-style-type: none"> 1. Larger breadth of diverse programmes may dilute impacts 2. More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners 	✓	✓	✓	✓	✓		✓	✓	✓

Page 127

Overall Elective Collaborative Governance Roadmap



Elective Task and Finish Group Roadmap



This page is intentionally left blank

North Northamptonshire Council

1 JANUARY 2022 TO 30 APRIL 2022

Published by: Democratic Services

Leader of North Northamptonshire Council: Councillor Jason Smithers

INTRODUCTION

This is the North Northamptonshire Council's Forward Plan. It is published pursuant to The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012. Its purpose is to provide the required 28 days notice of the Council's intention to take 'key decisions' and to hold meetings or parts of meetings in private. It gives advance notice of all the "key decisions" and "exempt decisions" which the Executive or another body or officer so authorised are likely to take over a four month period. The Plan is updated on a rolling monthly basis.

The Members of the Executive are:	
Councillor Jason Smithers	Leader of North Northamptonshire Council
Councillor Helen Howell	Deputy Leader of North Northamptonshire Council Sport, Leisure, Culture and Tourism
Councillor Helen Harrison	Adults, Health and Wellbeing
Councillor Scott Edwards	Children, Families, Education and Skills
Councillor Harriet Pentland	Climate and Green Environment
Councillor Lloyd Bunday	Finance and Transformation
Councillor David Brackenbury	Growth and Regeneration
Councillor Graham Lawman	Highways, Travel and Assets
Councillor Andy Mercer	Housing and Community
Councillor David Howes	Rural Communities and Localism

The concept of a "key decision" is intended to capture the most important or significant decisions. "Key decisions" will normally be made at meetings open to the press and public. The press and public will only be excluded from such meetings as and when the Council's Monitoring Officer considers that this is necessary in order to avoid the public disclosure of confidential or exempt information.

The authority has decided that a Key Decision is one which is likely:-

- (a) to result in the authority incurring expenditure of which is, or the making of savings which are, significant; or
- (b) to be significant in terms of its effects on communities living or working in an area comprising two or more electoral wards in the area of the authority."

The Council has decided that significant expenditure or savings are those amounting to above £500,000.

In determining the meaning of "*significant*" for these purposes North Northamptonshire Council will also have regard to any guidance for the time being issued by the Secretary of State in accordance with section 9Q of the Local Government Act 2000.

At times it may be necessary for the North Northamptonshire Council to give consideration to items where the public may be excluded from the meeting. Members of the public are excluded from meetings whenever it is likely that, in the view of the nature of the business to be transacted or the nature of the proceedings that confidential information would be disclosed. This includes exclusion from access to any pertinent documents. Details of the exemption categories can be found in the 'Access to Information Procedure Rules' section in the Council's [Constitution](#). This plan provides advance notice of any items which may be held in private.

Paragraph 5 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 provides for members of the public to make representations to the Council on why an exempt item should be considered in public, rather than in private. Persons wishing to make such representations and/or obtain further details in respect of any issues referred to in the Plan should contact the undermentioned officer.

The Monitoring Officer may also include in the Forward Plan references to such other decisions, which are to be taken by the Council or any of its Committees or Sub-Committee or officers as they consider appropriate. These will be those decisions that are considered to be significant or sufficiently important and/or sensitive so that it is reasonable for a member of the public to expect it to be recorded and published.

All general questions or queries about the contents of this Forward Plan or about the arrangements for taking key decisions should be raised with David Pope, Democratic Services.

Please email: democraticservices@northnorthants.gov.uk

January 2022

Subject of the Decision:	Decision Maker	Is it a key decision?	Will it contain exempt information? /Reasons for exemption, if any	Consultation undertaken	Anticipated Date of Decision:	Report Author	Support documents (if any)
Budget Forecast Update 2021/22	Executive	Yes	No		13 Jan 2022	Executive Director of Finance	
Capital Programme Update 2021/22	Executive	Yes	No		13 Jan 2022	Executive Director of Finance	
Afghan Refugee Resettlement	Executive	Yes	No		13 Jan 2022	Executive Director - Adults, Communities and Wellbeing	
Community Programme to Support Growing, Cooking and Eating of Healthy Foods	Executive	Yes	No		13 Jan 2022	Director of Public Health	
Procurement of Short-Term Home Care Service for North Northamptonshire	Executive	Yes	No		13 Jan 2022	Executive Director - Adults, Communities and Wellbeing	
Domestic Abuse Strategy	Executive	Yes	No		13 Jan 2022	Executive Director - Adults, Communities and Wellbeing	
Re-procurement through Open Tender of the Countywide Carers Support Service	Executive	Yes	No		13 Jan 2022	Executive Director - Adults, Communities and Wellbeing	

February 2022

Subject of the Decision:	Decision Maker	Is it a key decision?	Will it contain exempt information? /Reasons for exemption, if any	Consultation undertaken	Anticipated Date of Decision:	Report Author	Support documents (if any)
Budget Forecast Update 2021/22	Executive	Yes	No		10 Feb 2022	Executive Director of Finance	
Capital Programme Update 2021/22	Executive	Yes	No		10 Feb 2022	Executive Director of Finance	
HRA Final Budget 2022-23 and Medium Term Financial Plan	Executive	Yes	No		10 Feb 2022	Executive Director of Finance	
General Fund Final Budget 2022-23 and Medium Term Financial Plan	Executive	Yes	No		10 Feb 2022	Executive Director of Finance	
Capital Programme 2022-26	Executive	Yes	No		10 Feb 2022	Executive Director of Finance	
Agreement to Implement a Dynamic Purchasing System for the Provision of Care Home Services for Older People in North Northamptonshire	Executive	Yes	No		22 Feb 2022	Executive Director - Adults, Communities and Wellbeing	
Housing Development - Former Grange Methodist Church Site, Kettering	Executive	Yes	No Part exempt		22 Feb 2022	Executive Director - Adults, Communities and Wellbeing	

Voluntary Sector Grant Agreements for 2022/23 and 2023/24	Executive	Yes	No		22 Feb 2022	Executive Director - Adults, Communities and Wellbeing	
Gallery, Museum and Library (GLaM) Site Business Plan	Executive	Yes	No		22 Feb 2022	Executive Director - Adults, Communities and Wellbeing	
Proposed amalgamation of Tennyson Road Infant and Alfred Street Junior Schools	Executive	Yes	No	Yes – all relevant stakeholders	22 Feb 2022	Director for Children's Services	
Determination of Admission Arrangements for Local Authority Maintained Schools for the 2023 Intakes	Executive	Yes	No		22 Feb 2022	Director for Children's Services	
Priors Hall Golf Course	Executive	Yes	No		22 Feb 2022	Executive Director - Adults, Communities and Wellbeing	

March 2022

Subject of the Decision:	Decision Maker	Is it a key decision?	Will it contain exempt information? /Reasons for exemption, if any	Consultation undertaken	Anticipated Date of Decision:	Report Author	Support documents (if any)
Budget Forecast Update 2021/22	Executive	Yes	No		17 Mar 2022	Executive Director of Finance	
Capital Programme Update 2021/22	Executive	Yes	No		17 Mar 2022	Executive Director of Finance	
Asset of Community Value Policy	Executive	Yes	No		17 Mar 2022	Executive Director – Place & Economy	
Community Asset Transfer Policy	Executive	Yes	No		17 Mar 2022	Executive Director – Place & Economy	
Annual Inflationary Uplift – Adult Care and Support	Executive	Yes	No		17 Mar 2022	Executive Director - Adults, Communities and Wellbeing	
Tree Strategy and Policy	Executive	Yes	No		17 Mar 2022	Executive Director – Place & Economy	
Pollinator Strategy	Executive	Yes	No		17 Mar 2022	Executive Director – Place & Economy	
Stanton Cross Development of Governance Arrangements	Executive	Yes	No		17 Mar 2022	Executive Director – Place & Economy	

April 2022

Subject of the Decision:	Decision Maker	Is it a key decision?	Will it contain exempt information? /Reasons for exemption, if any	Consultation undertaken	Anticipated Date of Decision:	Report Author	Support documents (if any)
Council Housing Development - Former Grange Methodist Church Site, Kettering	Executive	Yes	No Part exempt		14 Apr 2022	Executive Director - Adults, Communities and Wellbeing	

**Executive Advisory Panel
Health Wellbeing & Vulnerable People**

January

Item	Objective	Lead Officer	Partner Organisations
<p>Northamptonshire Health & Care Partnership (NHCP)</p> <p>1. Mental Health, Learning Disabilities and Autism Programme</p> <p>2. Elective Collaborative Case for Change Summary Presentation</p>	<p>To receive presentations from the Northamptonshire Health and Care Partnership</p>	<p>David Williams, Director of Strategy & Partnerships</p>	<p>Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust</p>
<p>Better Care Fund</p>	<p>To receive an update on the final submission for the Better Care Fund</p>	<p>David Watts, Executive Director Adults, Communities and Wellbeing</p>	

March

Item	Objective	Lead Officer	Partner Organisations
Social Prescribing	To receive an update on the Northamptonshire social prescribing service	Stuart Mallett, NHS	Department for Public Health NHS
Integrated Care Systems	To receive an update on the Integrated Care System	Toby Sanders,	NHS Northamptonshire CCG
Community Assets Transfer Policy	To consider the Community Assets Transfer Policy and provide feedback to the Executive	Jonathan Waterworth, Assistant Director Assets and Environment	

Future agenda items for consideration

- Supporting independence
- Big Community Funds (Update item)