Northamptonshire
Health and Care Partnership

Mental Health, Learning Disabilities & Autism Programme

Case for Change – for the Mental Health Collaborative

Version 5.5

Mental Health, Learning Disabilities & Autism Programme Background Information

Northamptonshire Health and Care Partnership

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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.

Mental Health Collaborative
Navigation Page

Northamptonshire Health and Care Partnership

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

Executive Summary

Mental Health Collaborative
Executive Summary

Northamptonshire Health and Care Partnership

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.

Mental Health Collaborative
Executive Summary

Northamptonshire Health and Care Partnership

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.

Mental Health Collaborative
Executive Summary

Northamptonshire Health and Care Partnership

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.

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Mental Health, Learning Disabilities & Autism Programme
Who is the involved in the MHLDA Programme?

Northamptonshire Health and Care Partnership

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

Tranche One providers

- NHS Northamptonshire Clinical Commissioning Group
- People with Lived Experience
- NHS Northamptonshire Healthcare NHS Foundation Trust
- Mental Health Northants Collaboration
- Public Health Northamptonshire

- NHS Northampton General Hospital NHS Trust
- NHS Kettering General Hospital NHS Foundation Trust
- Northamptonshire Police
- NHS East Midlands Ambulance Service NHS Trust

- Voluntary Impact Northamptonshire
- North Northamptonshire Council
- Northamptonshire Children's Trust
- West Northamptonshire Council
- healthwatch North Northamptonshire and West Northamptonshire
- REACH

- jobcentreplus
- General Practice Alliance
- Northamptonshire Carers
- Substance to Solution Northamptonshire
- AC Accommodation Concern
- hopecentre tackling homelessness, rebuilding lives
- NHS Veterans' Mental Health Transition, Intervention and Liaison Service

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Where it began:

Introduction & context to the development of the Mental Health Collaborative

Mental Health Collaborative

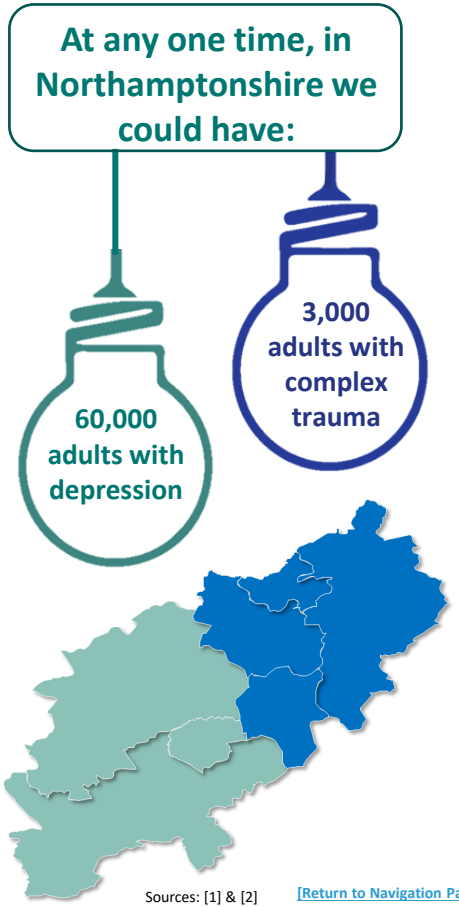
Mental Health – Everybody's Concern

Northamptonshire Health and Care Partnership

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.



Sources: [1] & [2]

Mental Health Collaborative

Mental Health – Everybody's Concern

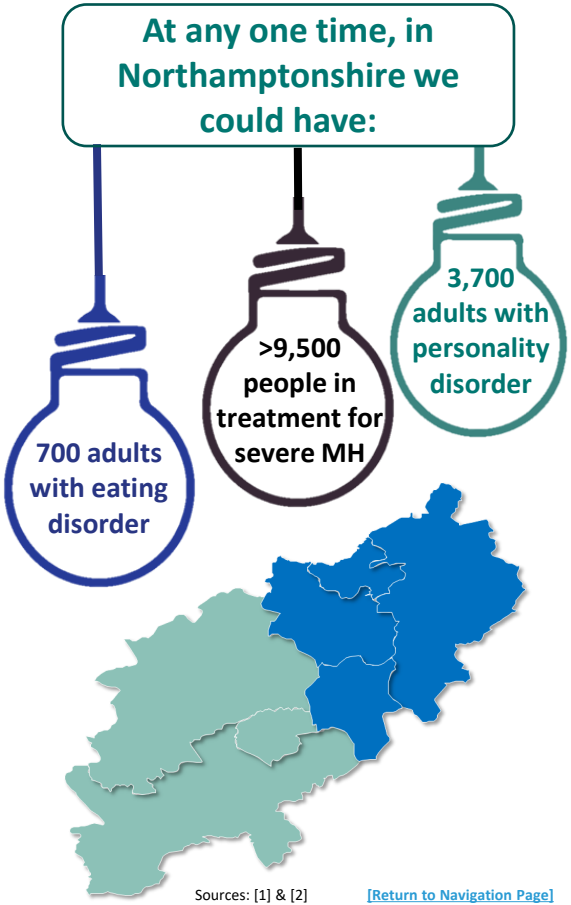
Northamptonshire Health and Care Partnership

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.



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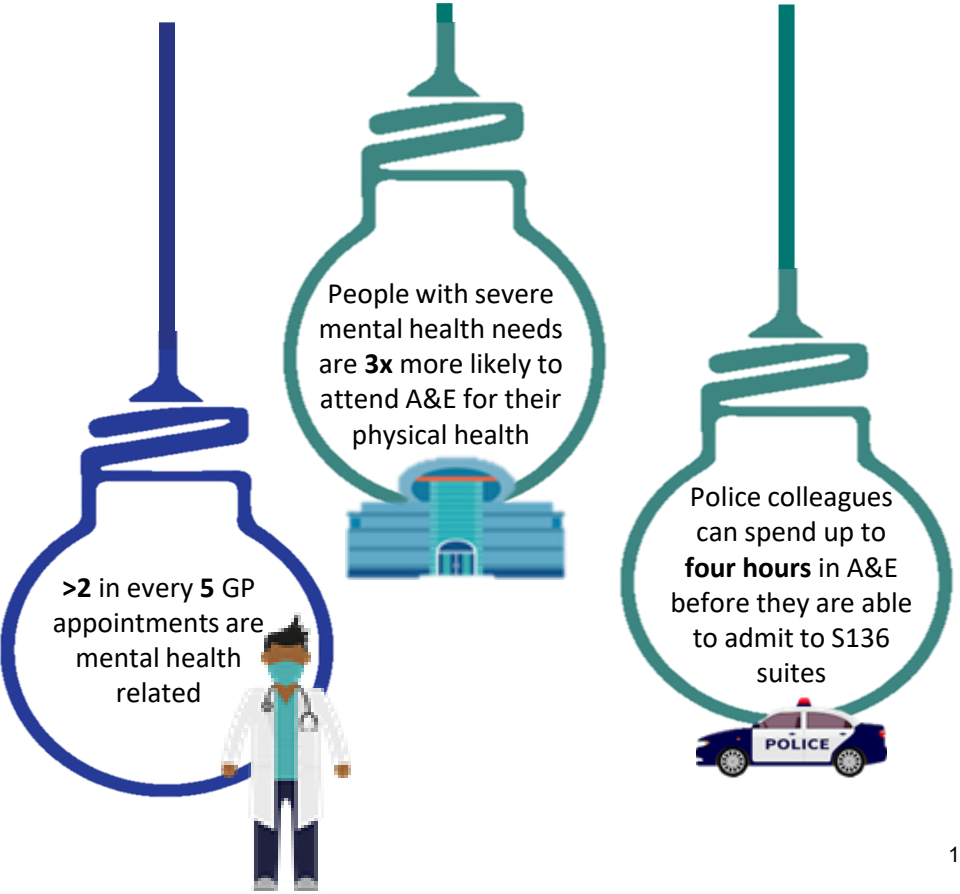
Mental Health Collaborative
Mental Health – Everybody's Concern

Northamptonshire Health and Care Partnership



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.

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Mental Health Collaborative

Mental Health – Everybody's Concern

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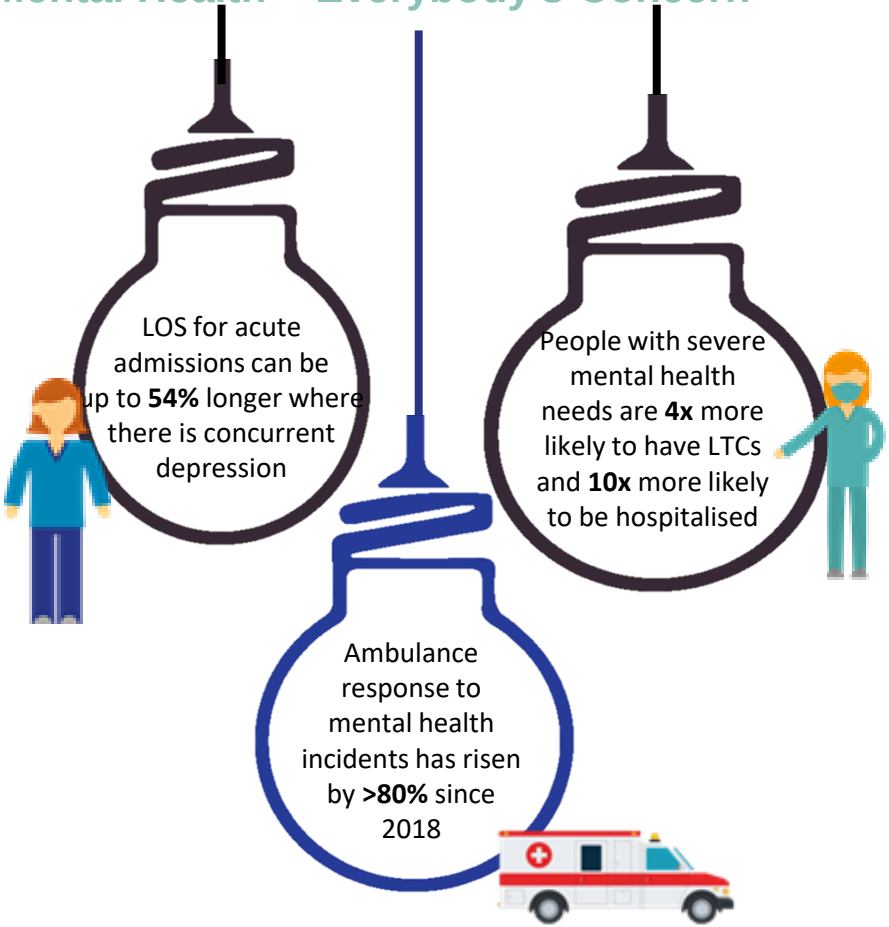

When our residents suffer poor mental health, every part of our system is impacted

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].

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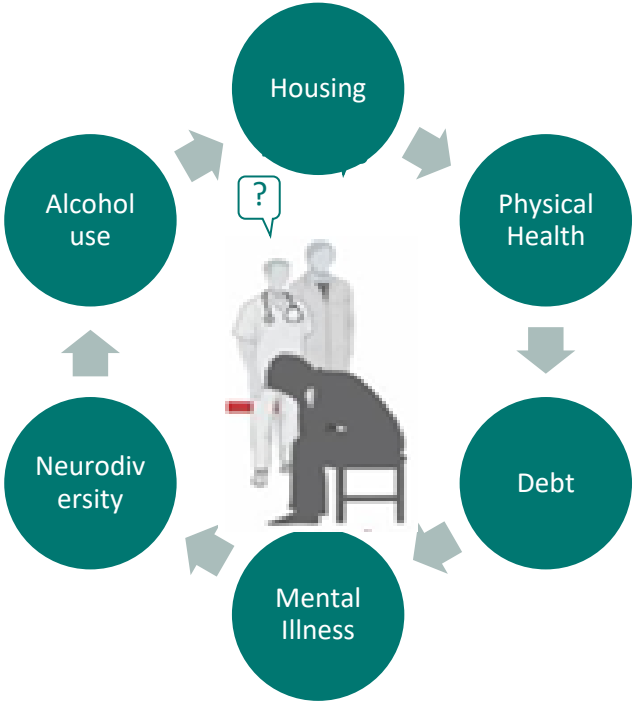
Isolated & compartmentalised health & care pathways cause:



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.

Northamptonshire Health and Care Partnership

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.

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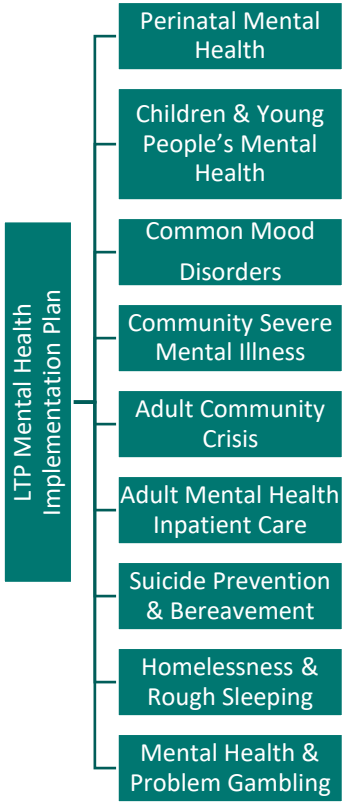
Mental Health Collaborative
National Drivers and Policy Context

Northamptonshire Health and Care Partnership

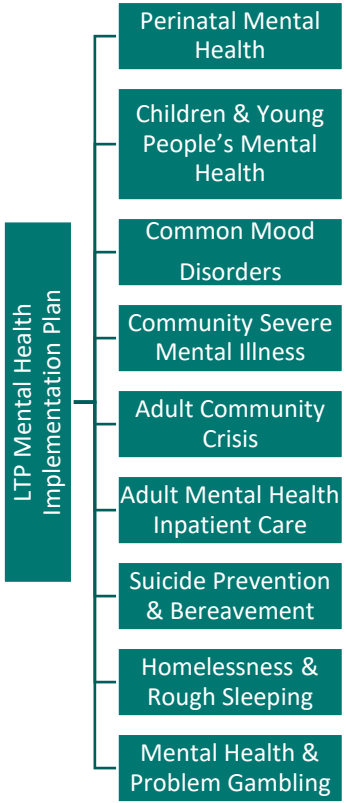


The NHS Long-Term Plan for Mental Health

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.

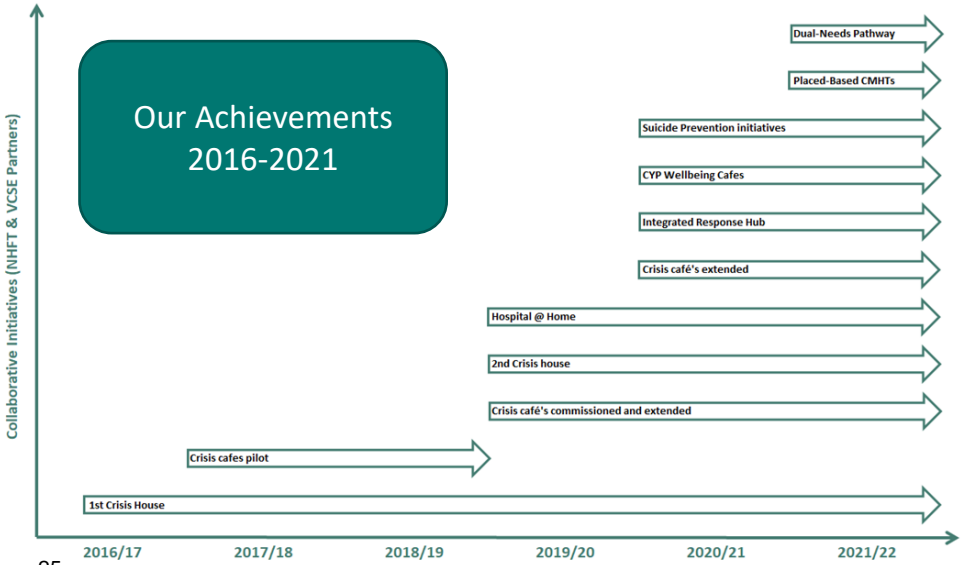
Mental Health Collaborative
Adopting a collaborative approach (2016-2021)

Northamptonshire Health and Care Partnership

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.



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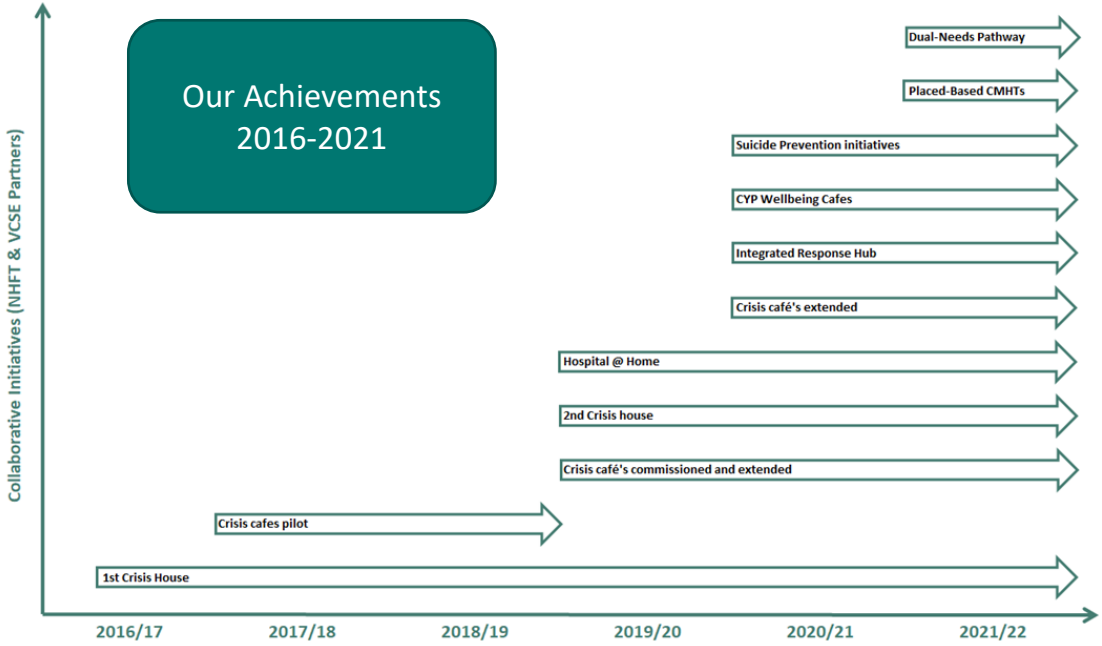
Mental Health Collaborative
Adopting a collaborative approach (2016-2021)

Northamptonshire Health and Care Partnership

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).

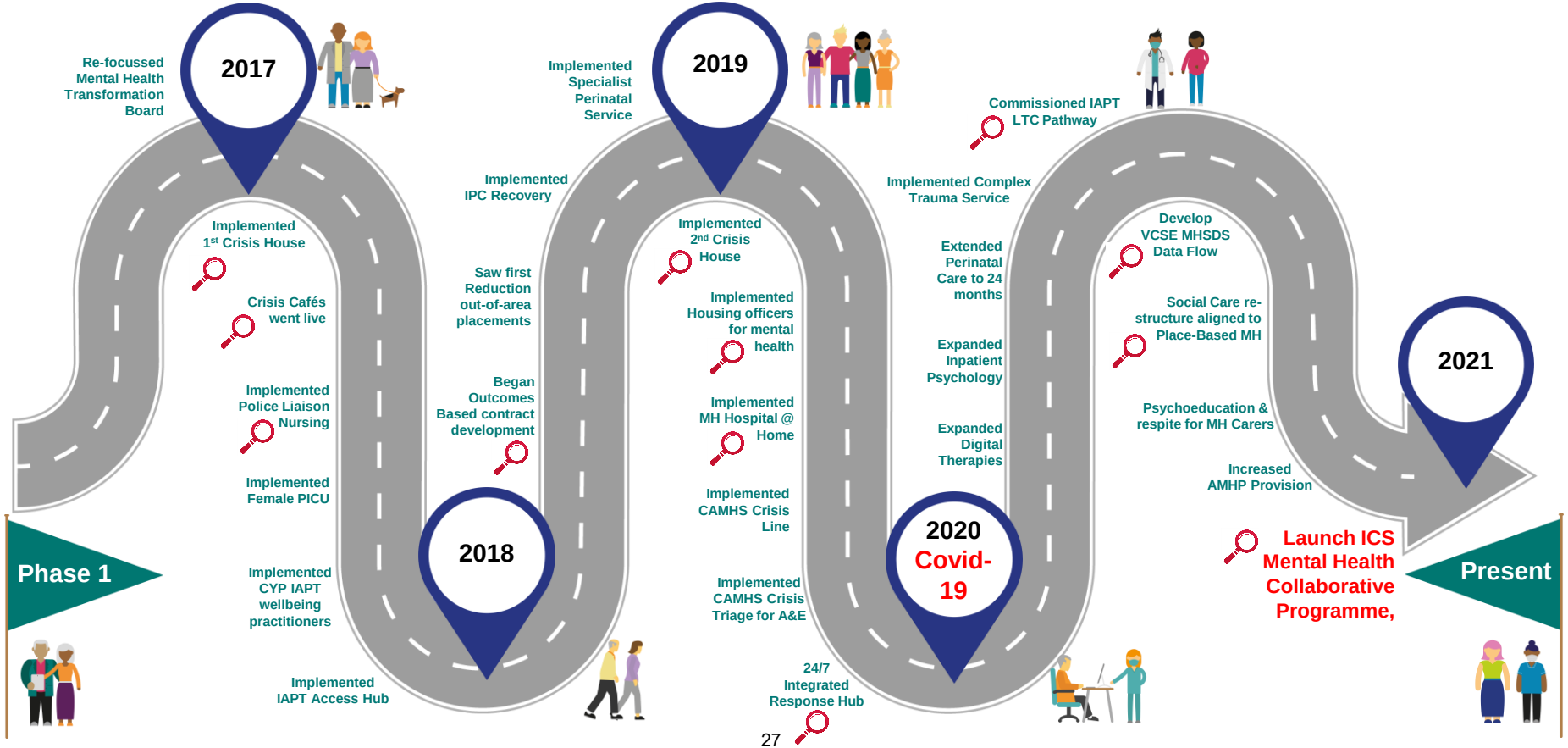
The following slide provides a more detailed roadmap of mental health initiatives since the commencement of the MH Transformation Board, and highlights examples of collaborative schemes (involving two or more system partners) with this symbol -



Mental Health Collaborative – Northamptonshire

Our achievements (2017-2021)

Northamptonshire Health and Care Partnership



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Gateway One:

Vision, goals and aspirations of the MH Collaborative Programme

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Mental Health, Collaborative

Our Vision

Northamptonshire Health and Care Partnership

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

Meaningful	Person-Centred	Agile	Integrated	Intelligent
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)	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.	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.	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.	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.

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Mental Health Collaborative
Our Goals and Aspirations

Northamptonshire Health and Care Partnership

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.

Mental Health Collaborative
Defining our Goals and Aspirations

Northamptonshire Health and Care Partnership

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.

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Mental Health Collaborative
Case for Change Summary

Northamptonshire Health and Care Partnership

Multiple, complex needs of service users

+

Need for coordinated (MDT) approach to pathways

+

Scale and pace of transformation required by national regulators

=

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.

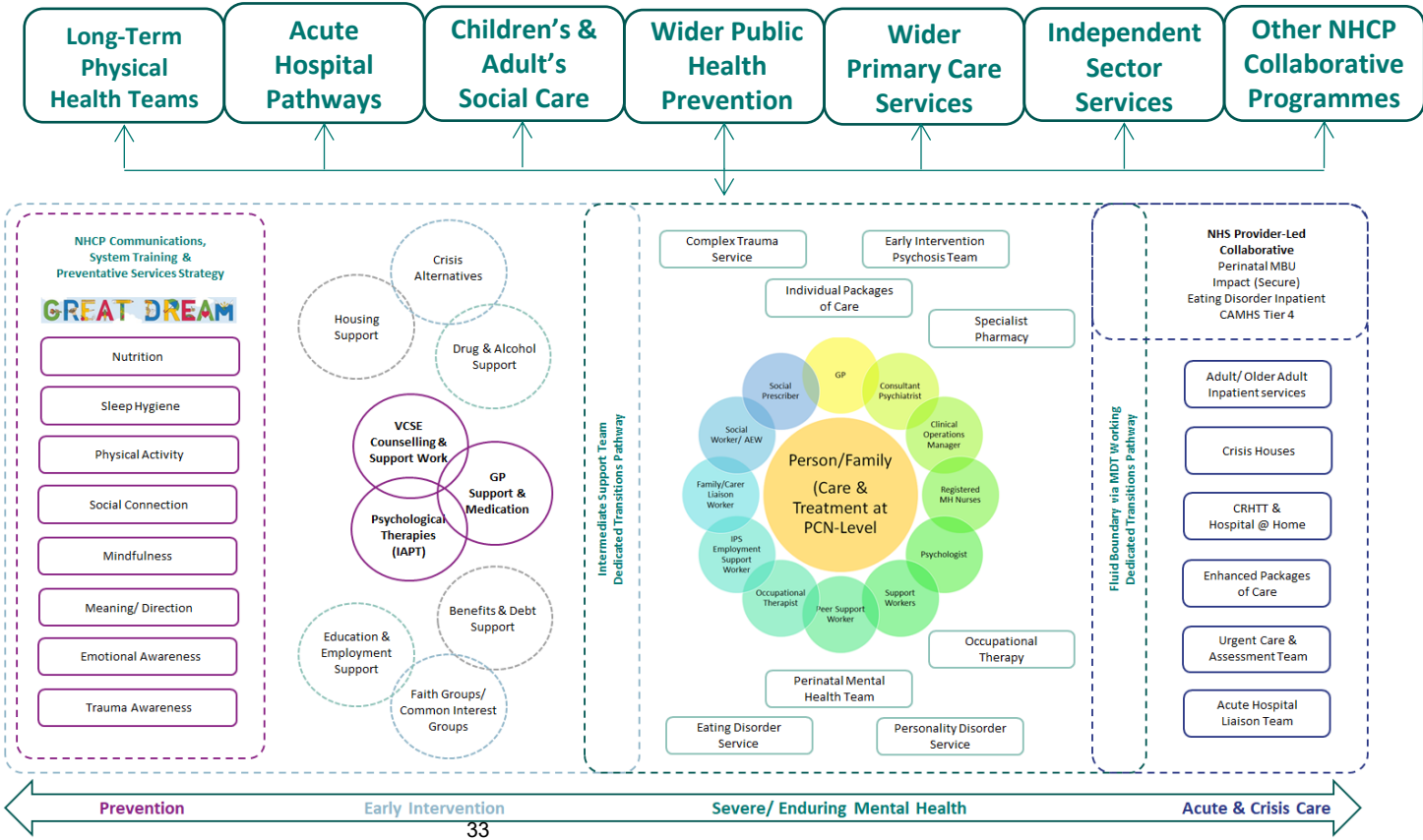
Mental Health Collaborative
High-Level Plan

Northamptonshire Health and Care Partnership

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 advice 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.



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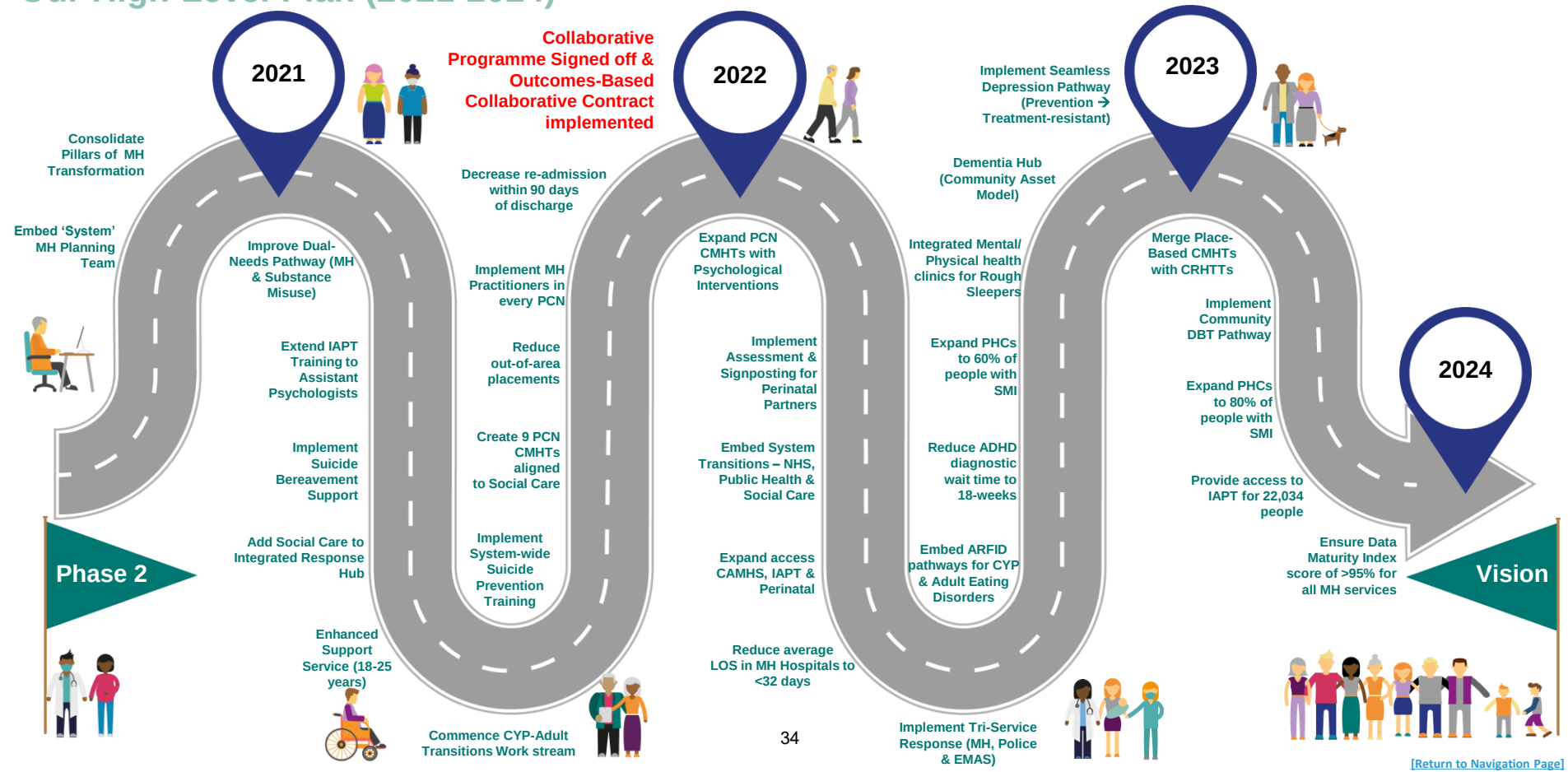
Mental Health Collaborative
Our High-Level Plan (2021-2024)

Northamptonshire Health and Care Partnership



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Gateway Two

Structure & operating model for the Mental Health Collaborative

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Mental Health Collaborative
Redefining 'Collaboration' to deliver long term change

Northamptonshire Health and Care Partnership

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

Northamptonshire Health and Care Partnership

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

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Mental Health Collaborative
Programme Structure

Northamptonshire Health and Care Partnership

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

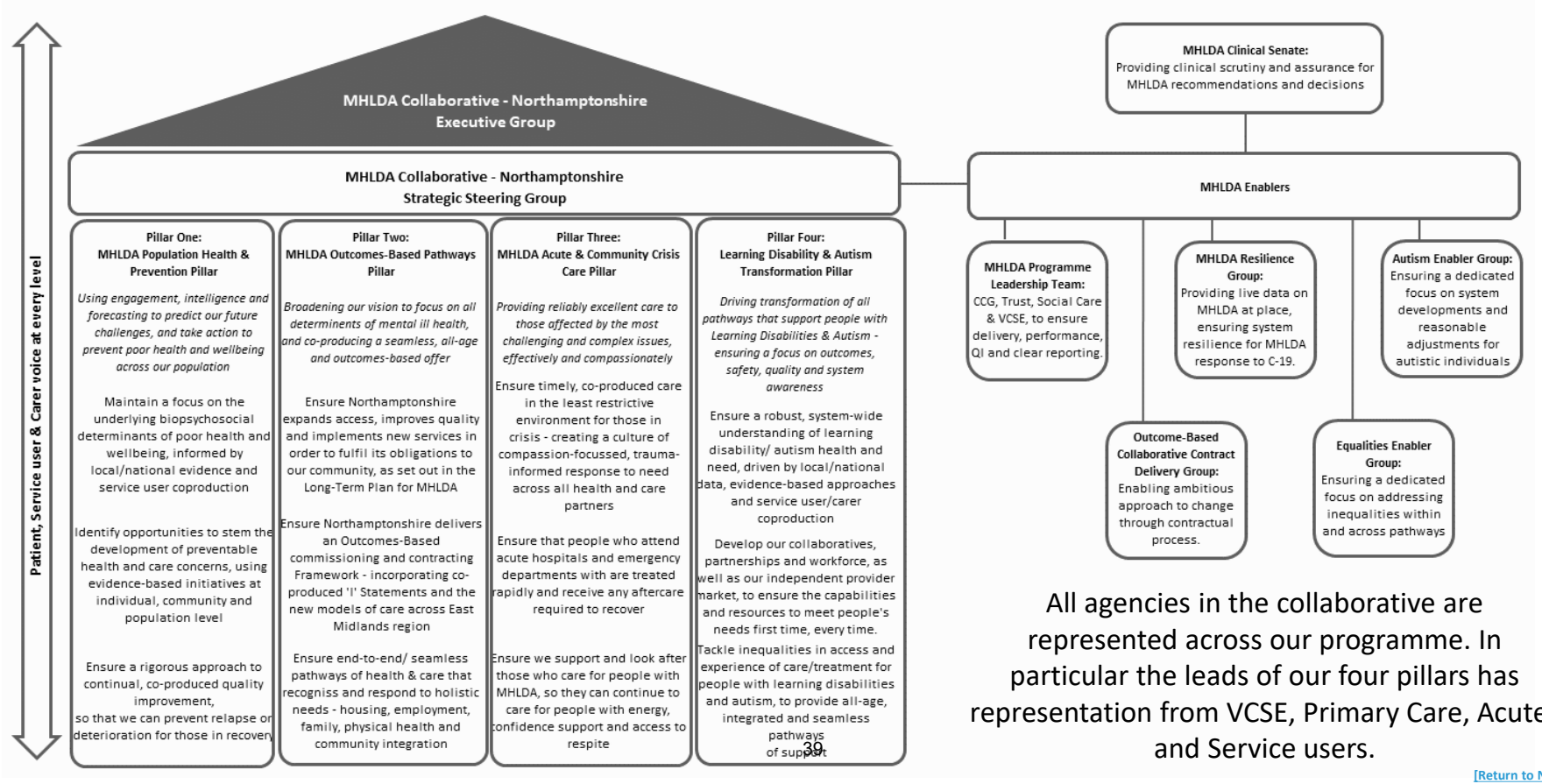
This is a joint Northamptonshire partnership working group with overall responsibility within the ICS ('The Northamptonshire Health and Care Partnership'), for delivering oversight and transformation of mental health, learning disability and autism services in Northamptonshire, reporting to the MHLDA 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

Northamptonshire Health and Care Partnership



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.

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Mental Health Collaborative

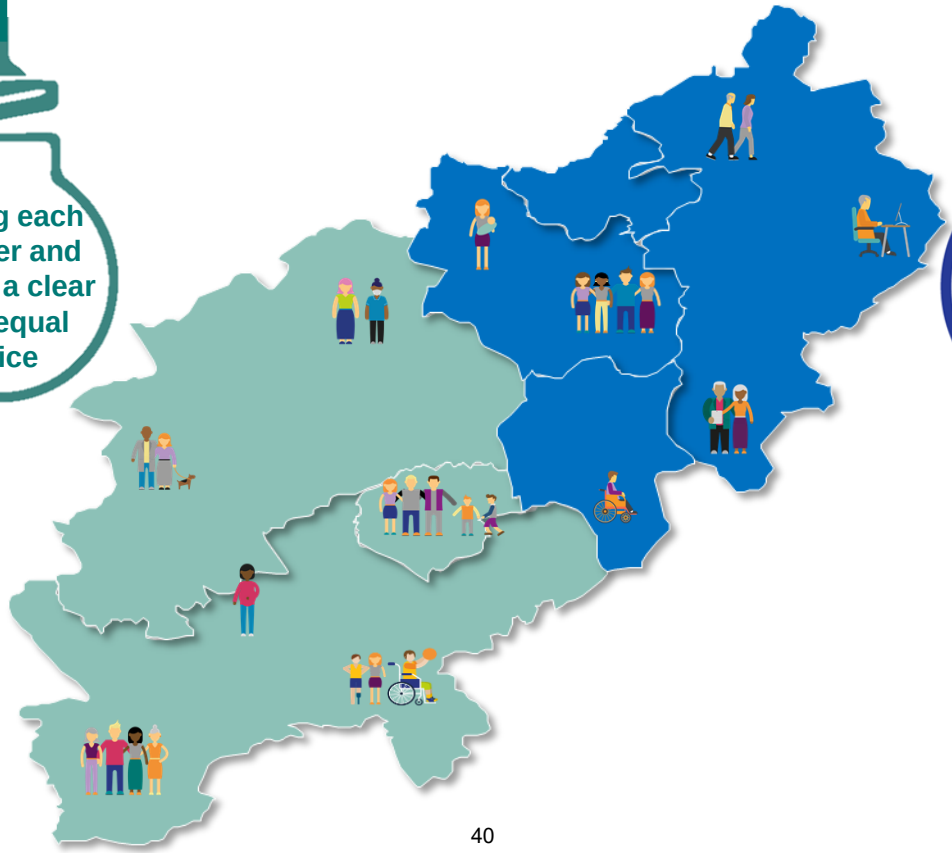
Working together to achieve our aims

Northamptonshire Health and Care Partnership

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

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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

Northamptonshire Health and Care Partnership

1.

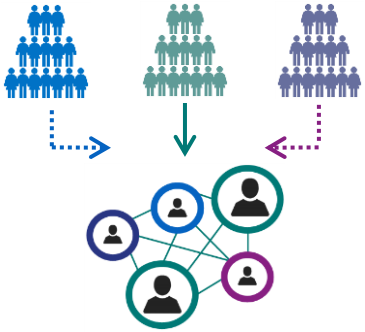
Programme recognises a cross-cutting theme with another programme

2.

SRO-to-SRO discussion confirms a Programme Owner.
Agreement over:

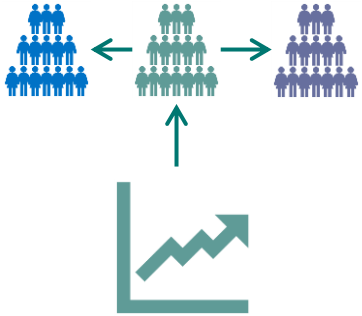
- Affected pathways
- Oversight arrangements
- Working Group members

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.

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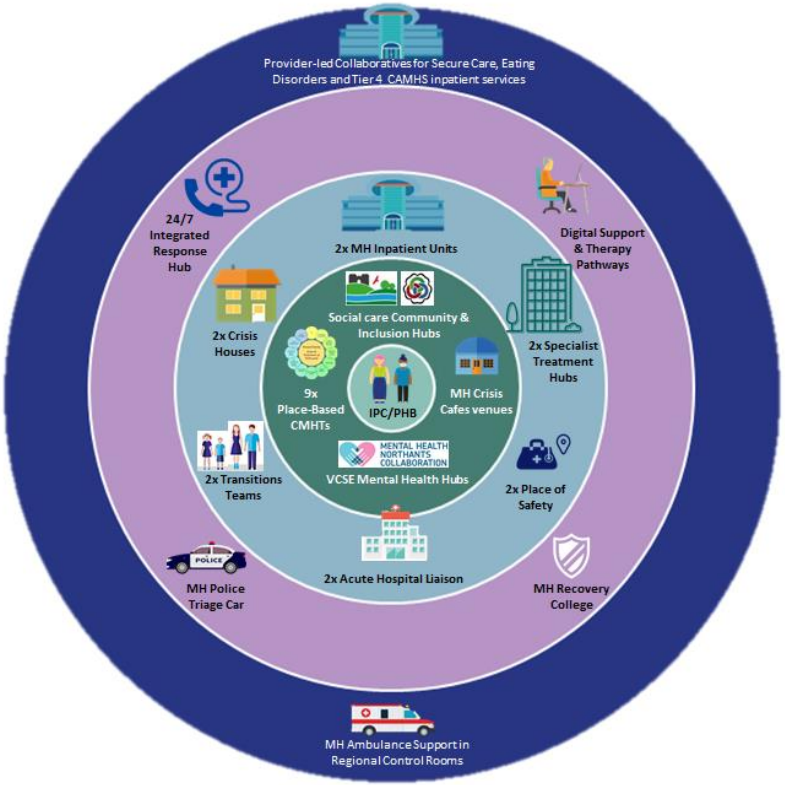
Mental Health Collaborative

Building on our work at Place, and Communities/ Neighbourhoods

Northamptonshire Health and Care Partnership



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.

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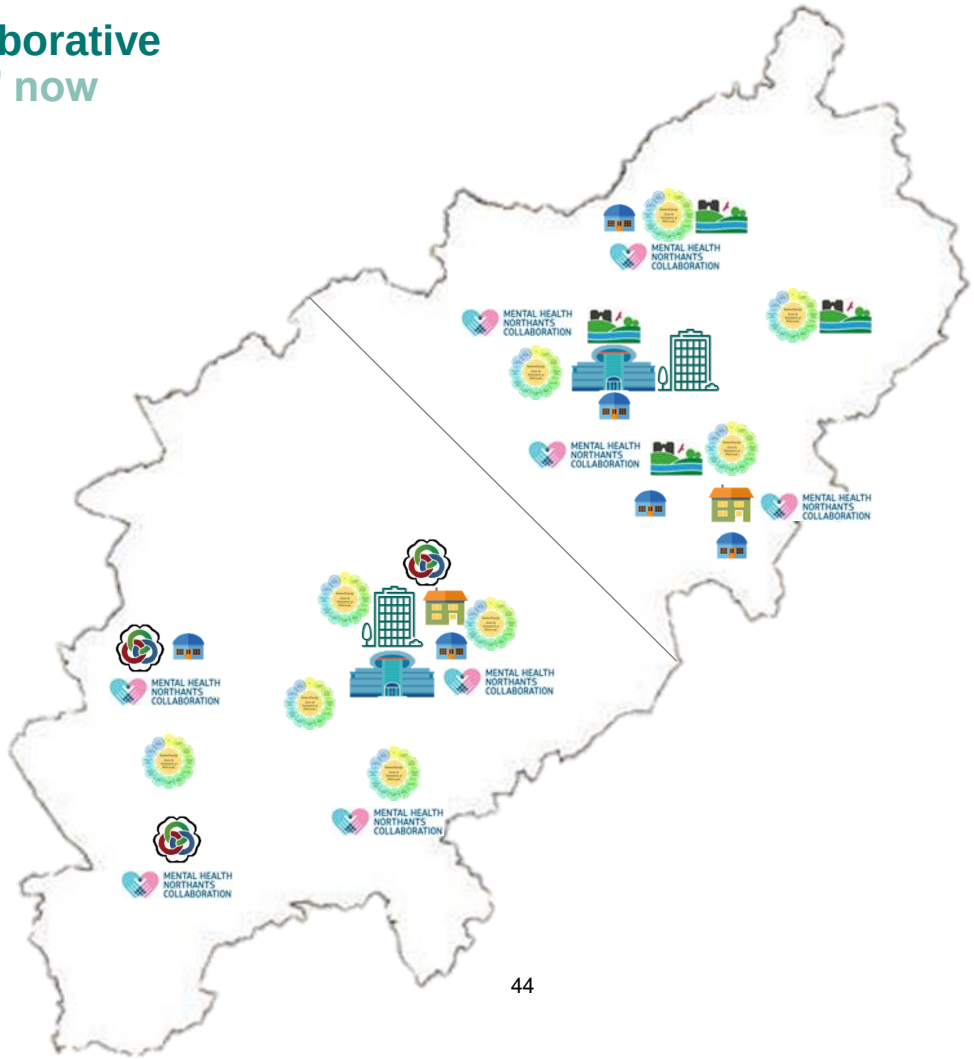
Mental Health Collaborative
Delivering at 'place' now

Northamptonshire Health and Care Partnership

Available at 'Place'

- Mental Health Inpatient Hospitals
- Specialist Mental Health Treatment Centres
- Mental Health Crisis Houses



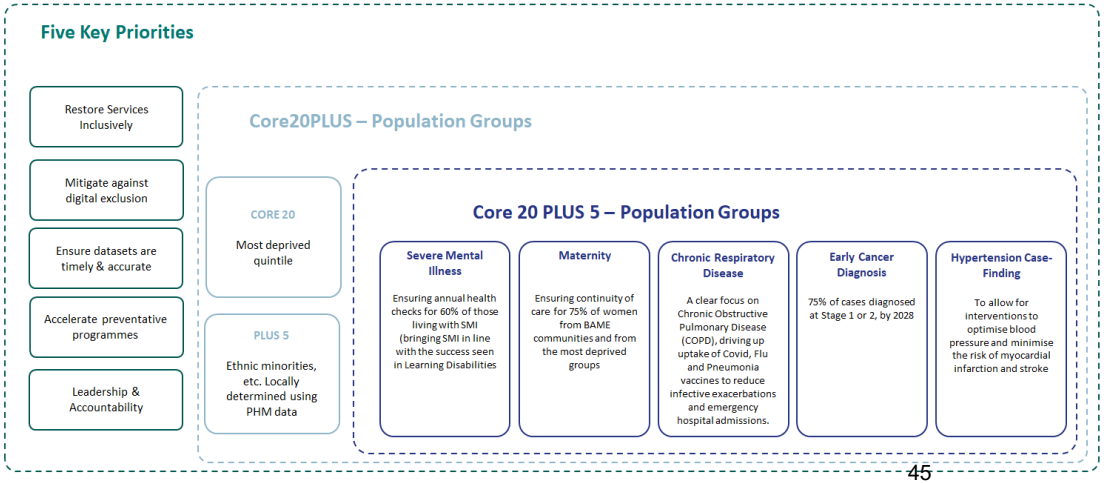
Available at Community/ Neighbourhood Level

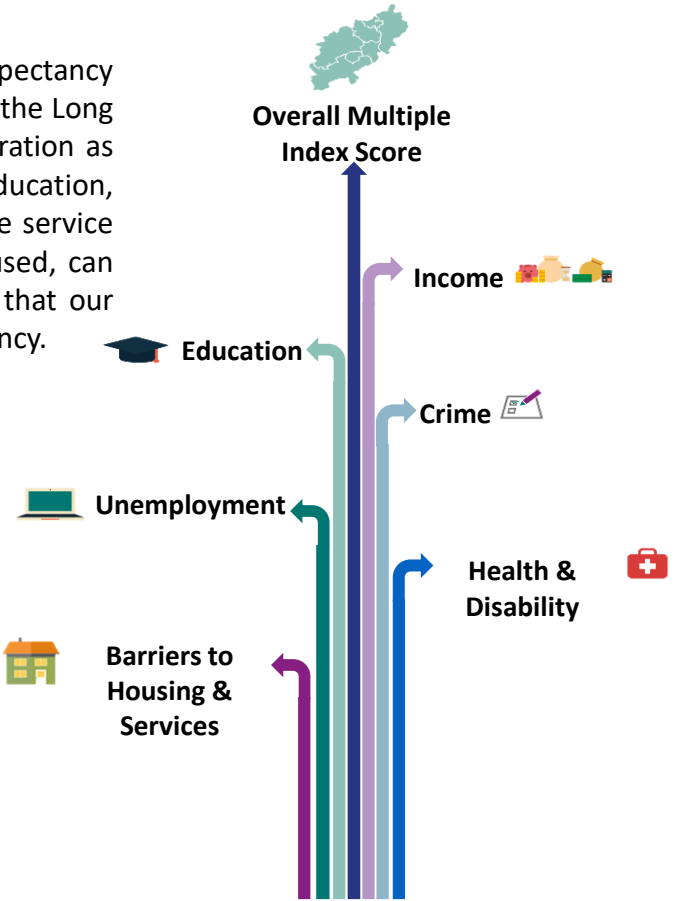
- Neighbourhood Community MH Teams
- Mental Health Crisis Cafes
- North Northamptonshire Council – Community Hubs
- West Northamptonshire Council – Community Hubs
- Mental Health VCSE Sector Hubs

Mental Health Collaborative
Addressing inequalities

Northamptonshire Health and Care Partnership

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.





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Gateway Three

System Engagement

How co-production shaped our collaborative

Mental Health Collaborative
Development of 'I' Statements

Northamptonshire Health and Care Partnership

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.

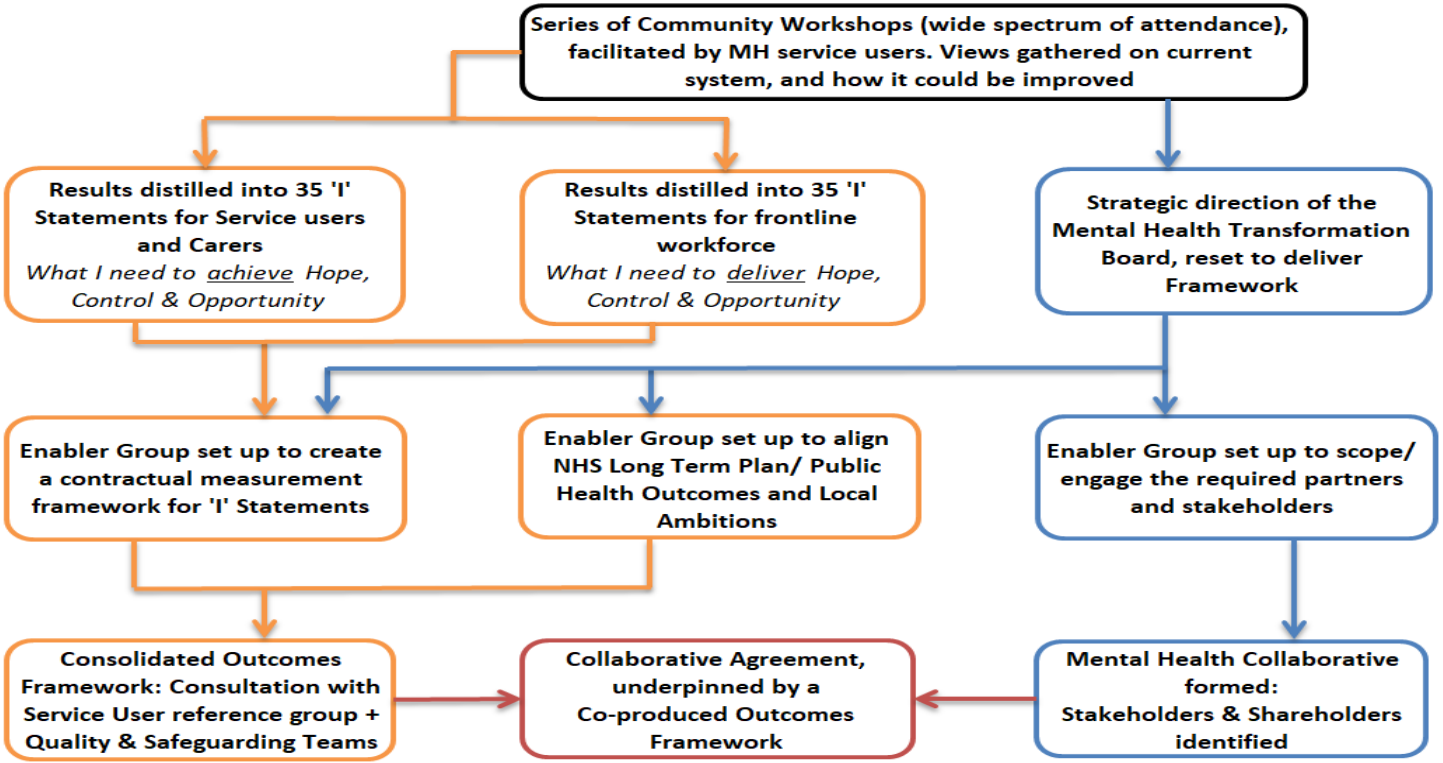
In developing the outcomes and through the learning from our original left shift of resources on a longer term contract into the third sector we commenced discussions on how to contractually make the changes to how we work in mental health.

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

Northamptonshire Health and Care Partnership



Mental Health Collaborative
Examples of our 'I' Statements

Northamptonshire Health and Care Partnership

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.

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.

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

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.

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

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.

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

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 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.

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Gateway Four

Accountability, Finance & Outcomes Framework

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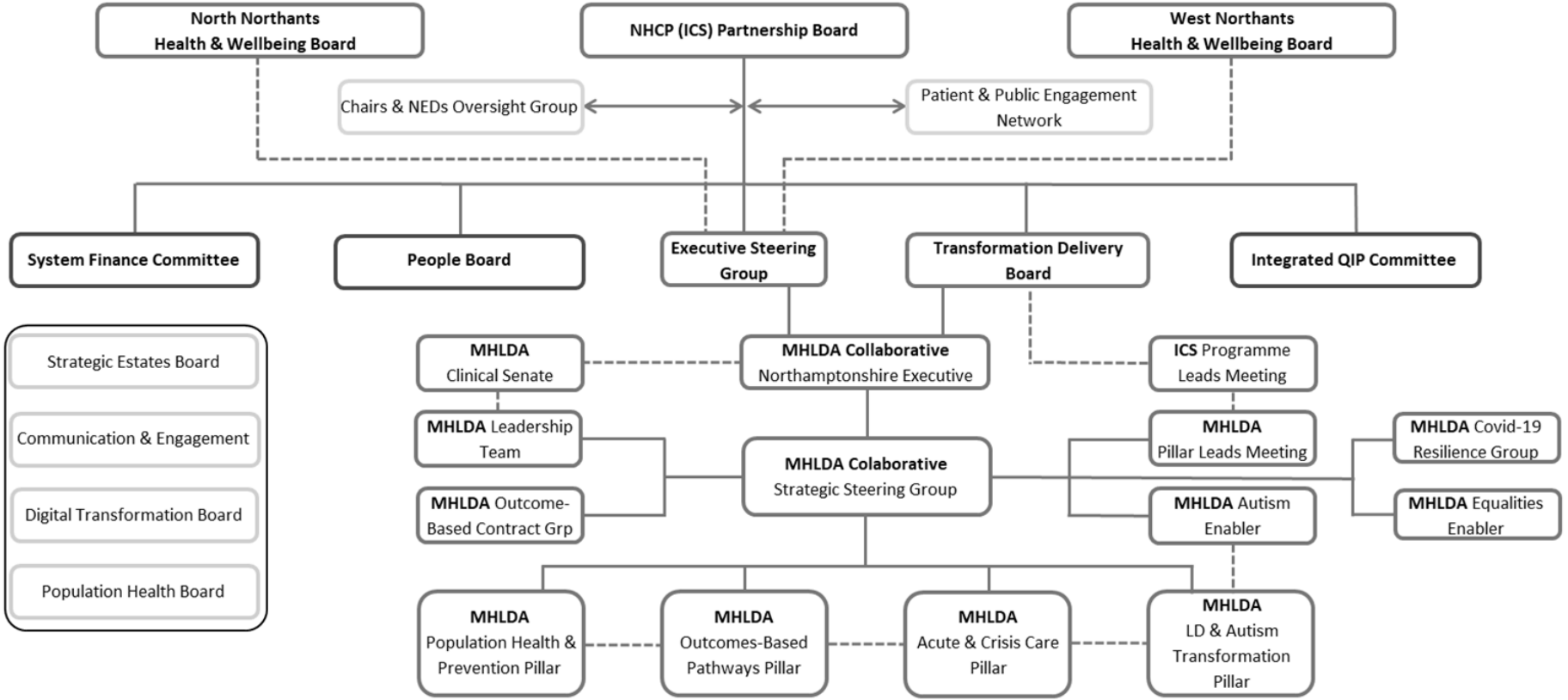
Mental Health, Learning Disabilities & Autism Programme
Programme Governance Structure

Northamptonshire Health and Care Partnership



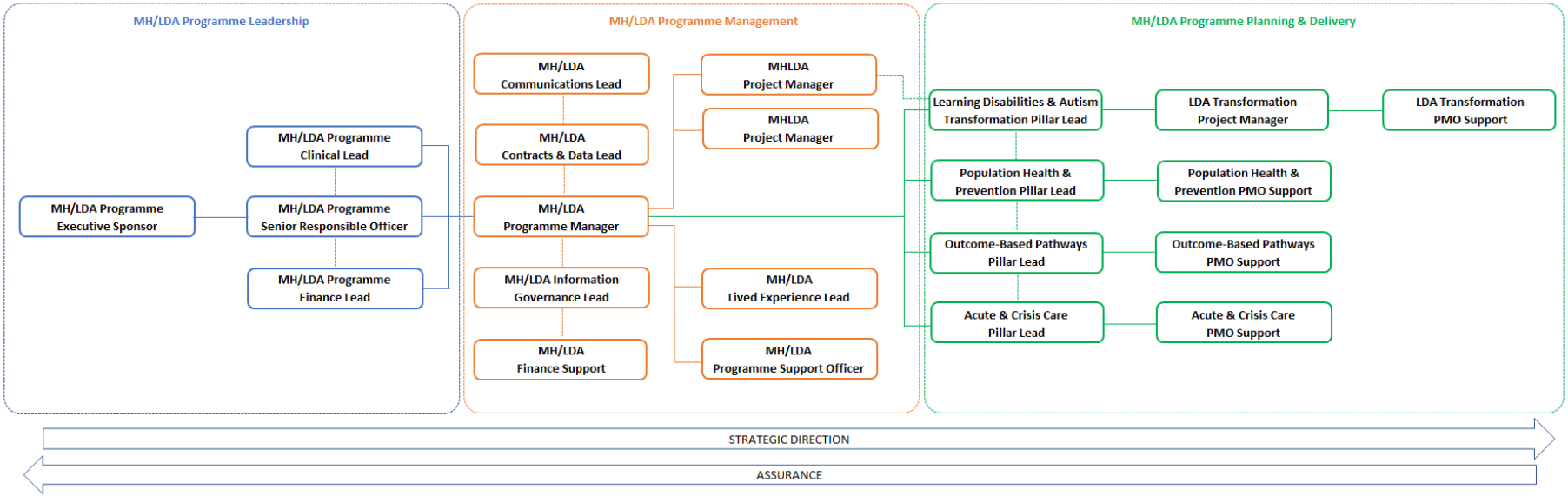
Mental Health, Learning Disabilities & Autism Programme
Programme Resource – Leadership, Management & Delivery Planning

Northamptonshire Health and Care Partnership

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 theses efforts into one coherent strategy for the county.

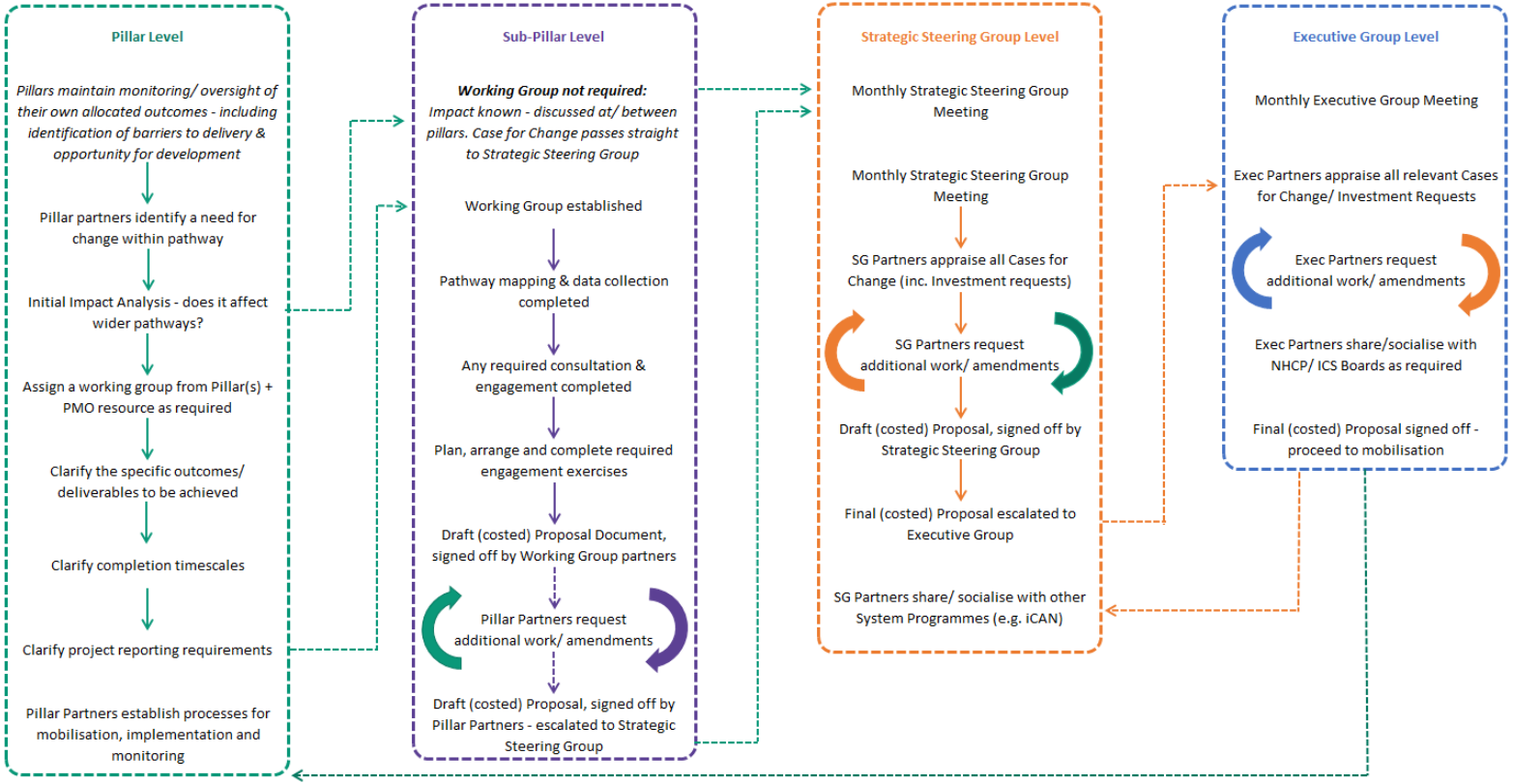
The first phase of this development is shown below. Leadership functions for the system will include an Executive Sponsor, Finance Lead, Clinical Lead and Senior Responsible Officer. Supporting them will be a management team – including allocated resource for overall management support, communications, 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?

Northamptonshire Health and Care Partnership



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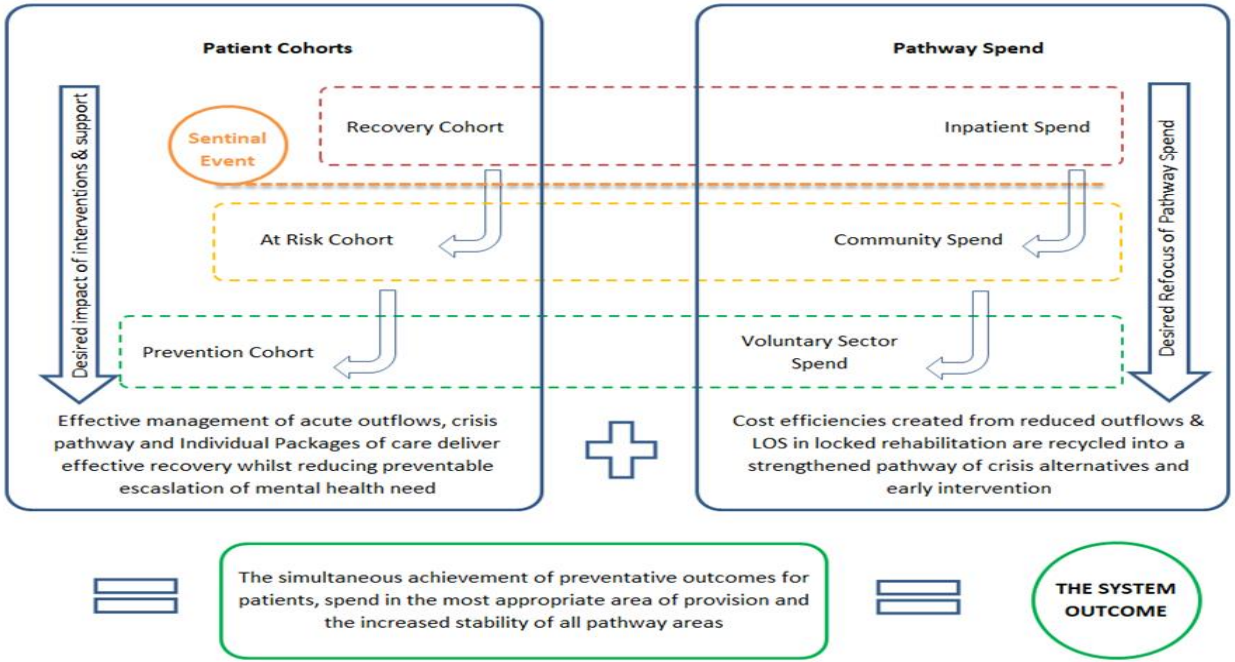
Mental Health Collaborative
Contractual Enablers – Investing for Outcomes

Northamptonshire Health and Care Partnership

Ensuring Sustainability in our Long-Term Strategy



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'

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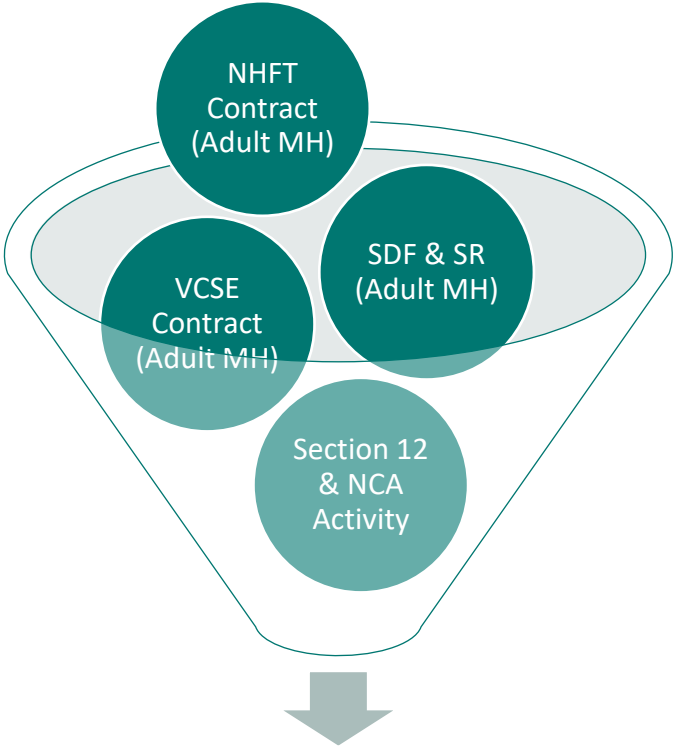
Mental Health Collaborative
Collaborative Contract - Scope of Tranche One

Northamptonshire Health and Care Partnership

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**



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.

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

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Mental Health Collaborative

Northamptonshire Health and Care Partnership

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.

Mental Health Collaborative

Northamptonshire Health and Care Partnership

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

Northamptonshire Health and Care Partnership

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

Mental Health Collaborative
Contracts that Enable Transformation

Northamptonshire Health and Care Partnership

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

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

Alliance Contracting
Generally considered non-compliant with NHS Standard Contracts

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

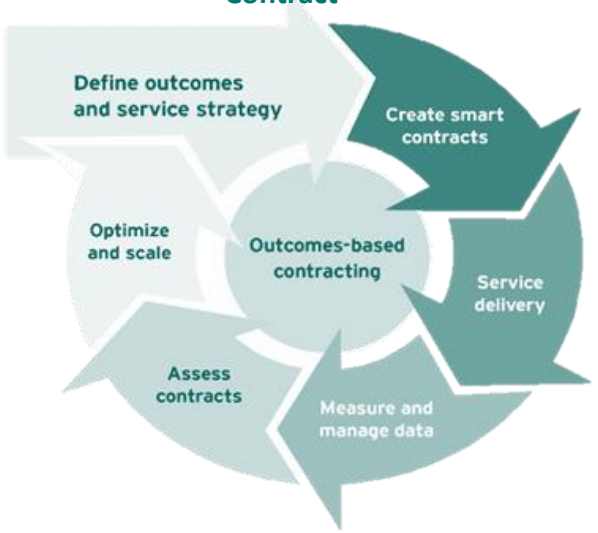
Northamptonshire Health and Care Partnership

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 heath 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



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Mental Health Collaborative
Phasing our approach to Outcome-Based Contracting

Northamptonshire Health and Care Partnership

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

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Mental Health Collaborative
Phasing our approach to Outcome-Based Contracting

Northamptonshire Health and Care Partnership

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

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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.

Appendices

Northamptonshire
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Appendix One:
References

Mental Health Collaborative
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Northamptonshire
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Appendix Two:

Mental Health Outcomes Framework
(Aligned to NHCP Outcomes Framework)

Mental Health Collaborative
Outcomes Framework – Mental Health Prevention

Northamptonshire Health and Care Partnership

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 if suicide and strategies for suicide prevention	Implement Real-Time Surveillance to inform strategic planning and responsivity	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 SPSG 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 targetted 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 WMKM			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

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Mental Health Collaborative
Outcomes Framework – Early Intervention for Common Mood Disorder

Northamptonshire Health and Care Partnership

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)	Primary Care VCSE Substance2Solutions WNC & NNC	Live - maintain/ further improve						**WEMWeB**
		Provide structured psychoeducation and respite for mental health carers	Primary Care VCSE NHFT WNC & NNC				Go Live		**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)**	Ensure 75% of referrals commence treatment within 6 weeks	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**

Mental Health Collaborative
Outcomes Framework – Severe Mental Illness

Northamptonshire Health and Care Partnership

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 Indidvidual 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		

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Mental Health Collaborative
Outcomes Framework – Perinatal Mental Health

Northamptonshire Health and Care Partnership

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

Northamptonshire Health and Care Partnership

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 condusive 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 liklihood 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 Primary Care VCSE NHS Provider-Led Collaboratives	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					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

Mental Health Collaborative
Outcomes Framework – Acute Inpatient Mental Health (Adults)

Northamptonshire Health and Care Partnership

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	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 Reduction in 90+ Day LOS for Older Adult Acute inpatients to ≤43 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
		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. Reduce the number of discharged patients who are re-admitted within 90 days.	Reprocure Supported Accommodation AQP Framework to increase availability of outcome-based community placements	NHFT WNC/ NNC Independent					Go Live	IS008 IS009 IS010 IS014 IS017	HONOS QPR DIALOG WEMWeB
		Mobilise flexible/ Personal Health budgets for person-centred discharge care needs	NHFT WNC/ NNC			Go Live				

Northamptonshire
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Appendix Three:
Coproduced 'I' Statements

Mental Health Collaborative
Outcomes Framework – Coded 'I' Statements

Northamptonshire Health and Care Partnership

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

Northamptonshire Health and Care Partnership

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

Mental Health Collaborative
Outcomes Framework – Mental Health Prevention

Northamptonshire Health and Care Partnership

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

Mental Health Collaborative
Further information

Northamptonshire Health and Care Partnership

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

Mental Health Collaborative
Version Control

Northamptonshire Health and Care Partnership

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 8 – 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

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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