By:	Graham Gibbens, Cabinet Member, Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Social Care and Public Health Cabinet Committee – 12 July 2012
Subject:	**KCC/KMPT PARTNERSHIP FOR DELIVERY OF SOCIAL CARE TO ADULTS OF WORKING AGE WITH MENTAL HEALTH NEEDS**
Classification:	Unrestricted

Summary:	This report updates the Cabinet Committee on the new Section 75 Partnership Agreement with KMPT in 2012-13 and sets out the future commissioning intentions for Mental Health services which will affect the Partnership Agreement with KMPT in future years

1. Introduction

(1) Kent County Council has had a Partnership Agreement with NHS organisations to provide mental health services for adults of working age since 2002. In 2006 when KMPT was formed from the merger of the two previous trusts a new section 75 agreement was drawn up which has been in place since.

(2) KCC has circa 280 staff seconded to KMPT. Total KCC investment in mental health is £22.1M, of which £9.25m is the cost of seconded staff and their accommodation. KCC's investment in the Partnership enables the delivery of social care support to adults of working age with mental health needs

2. Review of existing arrangements

(1) KMPT & KCC agreed in 2010 that a number of the aspects of the partnership needed improving therefore KCC, with the agreement of KMPT, commissioned a review of the partnership from an independent organisation. This work commenced in November 2010 and reported in February 2011.

(2) The report highlighted the areas that the partners needed to address. They were reflected into an Improvement Plan that has been monitored for nine months by the Programme Board with exception reports presented to the Partnership Board. KMPT & KCC have shown commitment to the Improvement Plan and have demonstrated improvement highlighted by the review.

3. Budget

(1) The table below details the Mental Health revenue budget for 2011/12 and the outturn for 2009/10 & 2010/11. This clearly demonstrates that the Mental Health budget has been brought under control.

Year	Outturn	Budget	Variance
2009/10	£22,148.7k	£21,749.8k	+ £398.9k
2010/11	£22,481.6k	£21,898.5k	+ £583.1k
2011/12	£21,070.5k	£22,025.3k	- £954.8k

(2) The key reasons for the budget being under control are;

- The monthly complex needs Panel process is an effective way of ensuring that clients are placed in the most appropriate and cost effective placement funded by the appropriate organisation (KCC/NHS).
- A comprehensive RAG analysis identified those ("green" ranked) clients whose needs could be supported by transfers to different services (e.g. from residential care to supported accommodation) or with revised packages of care.
- The KCC Director of Learning Disability and Mental Health has reviewed the mental health budget Recovery Plan at the monthly Divisional meetings. The momentum and more efficient practices from 2010/11 carried through to 2011/12 have had a downward impact on costs.
- Changes to staff teams and the Community Support Service in preparation for the reduction in the Supporting People grant.

4. What is planned over the next year

(1) There are a number of work areas that are underway or planned to start in 2012-13 that will continue to strengthen the infrastructure to deliver social care outcomes, these include:

(a) An ongoing process of auditing safeguarding cases has shown improved outcomes and practice, however KMPT is clear that they have more to do in the continued improvement and scrutiny of their safeguarding practice. The next planned audit is scheduled for June 2012.

(b) KCC & KMPT have agreed to develop an integrated training programme. Currently training departments are looking at commissioned training to develop a joint training strategy that meets the health and social care needs of staff. Work is also underway to start developing a joint competency / capability framework with a social care perspective, due for completion in summer 2012.

(c) KMPT have identified an external consultant to lead on the review of the Approved Mental Health Practitioners (AMHP) service. A project brief has been developed in May 2012 with the outcome to update and produce new practice guidance for AMHPs. The approval process for these will be via the AMHP Good Practice Group.

(d) KMPT are in the process of prioritising the development of a robust system to record and report Fair Access Care Services (FACS). This will include developing a specification for FACS performance monitoring reports to drive up performance.

(e) KCC & KMPT have identified a number of issues with data quality and developing mechanisms to report key performance indicators. Work is in progress to determine the data inputting required onto Rio and SWIFT (health and social care recording systems) to reduce the need for dual data inputting, and ensure we have clear reports to measure performance indicators.

(f) A dedicated lead from both KCC & KMPT has been identified to resolve some of the IT infrastructure issues. Work has already commenced to prepare a hardware survey to improve access to systems, with the aim to improve data quality and reporting. This work is will be completed in the next 3 to 6 months

(g) Joint work is underway to develop a Section 117 Register by July 2012.

(h) A number of KCC seconded staff reviews are planned for summer 2012, including KR11 and admin and clerical staff. The reviews will look at the future structure of KCC staff seconded into KMPT to ensure the structure can meet the demands of the future commissioning intentions.

(i) KMPT are undertaking a number of public engagement events for Foundation Trust Status. The presentation, 3, demonstrates their commitment to delivery quality through partnerships.

5. Section 75 – New KMPT/KCC Partnership Agreement

(1) With the expiry of the existing partnership agreement, the opportunity was present to construct a better Agreement for the establishment of an Integrated Provision arrangement in respect of specified mental health services under Section 75 of the National Health Service Act 2006, that would fit with the changes that are required to deliver a modern mental health service in the spirit of “Live it Well” and government policy.

(2) The new Partnership Agreement will achieve the following:

- Be clearer about what the required social care outcomes are
- Be more specific about the roles and responsibilities on each side, especially those areas where KCC have statutory duties and need to have an active input
- Allow greater flexibility for the delivery of social care in the future
- Be fit for purpose in relation to the requirements of section 75

- Be clear what is required from the Partnership in relation to social care practice standards, secondment arrangements, staffing establishments, performance reporting requirements and terms of reference for the governance structures

(3) However the Council does not have the power to delegate to the Trust the following Functions under the Mental Health Act and remains accountable for them all including those which it does delegate :

- Approved Mental Health Practice (AMHP)
- the Guardianship Register (including approval process)
- Safeguarding
- Social Care

(4) The new Partnership Agreement was discussed in draft form at the Mental Health Partnership Board in March 2012 and was formally signed off by them in May 2012 where it will then go via KMPT / KCC governance for sign off. The process of legal ratification of the S75 agreement is now being undertaken by KCC and KMPT.

(5) The agreement will run for a period of one year in the first instance, with a review after 6 months, following which it can be renewed for further years. This will allow both parties to consider the future direction of the partnership and the future commissioning intentions in the current changeable climate, as detailed in section 6.

6. Future commissioning intentions

(1) The KCC Adult Transformation Plan objective is to move Families and Social Care (Adults) to a position whereby, in 3 years time, it can operate on a budget that is at least £66 million less than it is currently, whilst simultaneously improving the social care outcomes for the people of Kent. Savings of the magnitude required will only be achieved through transformation and radically changing the current investment profile. This requires a high level review of how social care is currently delivered. Service redesign will be achieved by understanding the relationship and interdependencies between our key activities, appraising the options and implementing the changes.

(2) Live it Well" is a partnership between social care Mental Health commissioning and NHS commissioning. Live it Well says that we are changing the emphasis, and redirecting some of the resources, away from secondary, statutory services, closer to, and responsive to, the needs of service users and carers, which is and absolute requirement to make the substantial savings required in the health and social care economy. There are three key drivers that commissioners can use to help deliver the transformation change required within the mental health culture in Kent. These are:

i) Personalisation
ii) Partnerships
iii) Primary Care

(2i) Personalisation

- Over the next 5 years, we will be developing an increased personalisation of services - putting people in charge of their care plans and giving them autonomy over the resources that they need. This is a fundamental change in our relationship with service users and a huge challenge for existing mental health services and their staff.
- In order to move to this more facilitative, less directive way of working with people, more account will need to be taken of the whole person. An independent brokerage service will be developed to ensure an equitable approach to personalisation and a clear and transparent pathway for assessment and fund allocation.

(2ii) Partnerships - a range of providers

- To deliver holistic services in normal, non stigmatising settings (because that is where people live and will choose to have access to services) a range of providers is required. Both the Health and Social Care commissioners are committed to a single strategy that places equal emphasis on health and social care aspects of mental health.
- No one organisation "owns" mental health: Each organisation must be seen as equally important if holistic, non stigmatising services are to happen. This will only work if providers embrace and adopt a culture of partnership working with each other. To achieve the services that people deserve; that will be non-stigmatising and delivered where people choose; we will need a culture of partnership adopted by all stakeholders, including the statutory, voluntary and independent sector.

(2iii) Shifting resources to primary care

- More than 90% of people with mental health problems are treated exclusively within primary care, usually by their GP, without any reference to specialist mental health services (Goldberg and Huxley 1992). It is also estimated that between 25 and 40 per cent of all patients with schizophrenia are managed entirely by GPs, with no input from specialist mental health services (Cohen 1998).

The epidemiological data suggests that services need to be commissioned across the wider mental health economy; and in the places where people live their lives. This means a shift in commissioning resources to primary care settings. The benefit is earlier intervention - people will be able to get access to helpful resources earlier, before their mental health issue becomes bigger. This means developing more services in primary care and at the interface with primary care. In the first year to deliver clusters 1, 2 and 3 and potential future years for clusters 7, 11 and 12 (see diagram on page 6).

The Move to Commissioning through Payment by Results (PbR)

(3) *Equity and Excellence: Liberating the NHS commits* us to introducing the mental health care clusters as the contract currency for 2012-13 with local prices

(Health Of the Nation Outcome Scores HONOS PbR). This means that prices will be agreed between commissioners and providers, and are not set at a national level

(4) KMPT state in their annual business plan that 1800* existing cases will transfer to primary care through clusters 1, 2 and 3 and that GP referrals will fall by 23%. *The figure of 1800 was correct in January 2012, since that time cases have been and continue to be reviewed, and a number of cases have been closed. The actual figure for transfer as of April 2012 would be around 800. This continues to reduce as cases continue to be reviewed.

(5) The following diagram set out a vision for the redesign of delivering mental health services in each of the HONOS PbR. The biggest single change that will be required is a shift of a proportion of the social care resources to primary care in the first year to deliver clusters 1, 2, 3, and potential future years for clusters 7, 11 and 12.

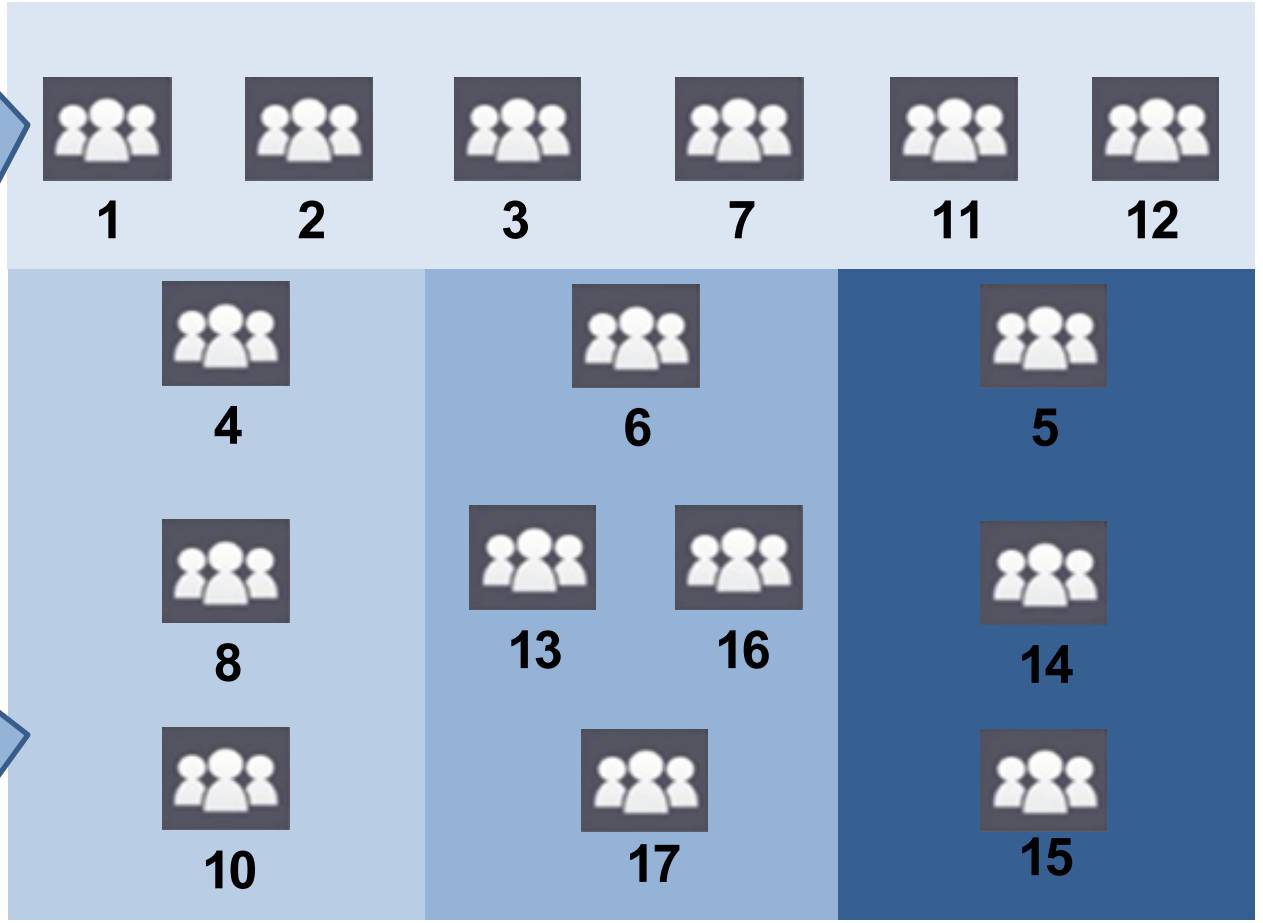
Community Mental Health Service Re-design

TOP HORIZONTAL BLOCK in the diagram represents primary care.

- Each of the numbered icons represents a Mental Health care pathway or 'care cluster'.
- Nationally the clusters are being used to inform PbR implementation.
- Locally we are using this change as an opportunity to improve the quality and efficiency of community Mental Health services.
- We are planning for 6 care pathways to be delivered in a primary care setting (with some shared care arrangements where needed).

THREE VERTICAL BLOCKS in the diagram represent secondary care services.

- **ACCESS** receives new referrals (intake). There will be 3 Access care pathways.
- **RECOVERY** will provide longer term care/support and will have 4 defined care pathways.
- **ACUTE** (CRHT and in-patients) will deliver 3 care pathways.



1 – Common MH conditions (mild)
2 – Common MH conditions (moderate)
3 – Common MH conditions (severe)

7 – Stable mood and anxiety conditions (high disability)
11 – Stable psychotic conditions
12 – Stable psychotic conditions (high disability)

4 – Complex mood and anxiety conditions
8 – Complex personality disorder
10 – Early intervention in psychosis

6 – Enduring mood and anxiety conditions
13 - Enduring psychotic conditions
16 – Dual diagnosis
17 – Assertive outreach

5 – Acute mood and anxiety conditions
14 – Acute psychotic crisis
15 – Acute psychotic depression

(6) From April 2012, work has started to provide the social care resource for clusters 2 and 3 in primary care. Then, after April 2013, delivery of clusters 7, 11 and 12 in primary care will be implemented. Together, this will mean a movement of some staff and resources into new settings.

(7) The commissioning intention is that during 2012, a proportion of social care staff will move to primary care settings where they will start to deliver the social care requirements in that setting. The Improving Access to Psychological Therapies (IAPT) service In Dartford, Gravesham and Swanley is the proposed first locality to adopt the new commissioning model.

(8) It is also proposed that, during 2012, those staff remaining in secondary care settings will concentrate on developing the social care responses in clusters 4, 5, 6, 8,10 and 13. Once these have been established, then, after April 2013, the social care elements of the final clusters 14, 15, 16 and 17 are established.

(9) The Local Authority (KCC) has certain key social care requirements in all clusters, which it needs to be sure are being carried out, in order for it to meet the statutory obligations. From the commissioning perspective, this is also important to ensure that people with mental health problems are not being disadvantaged in relation to the rest of the population.

Clinical Commissioning Groups (CCGs)

(10) Following the Health Bill re-structure, responsibility for the commissioning of secondary care will shift as the National Commissioning Board (NCB) and Clinical Commissioning Groups (CCGs) are established and Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are phased out.

(11) CCGs will be responsible for commissioning the majority of local health services and they will have statutory obligations for obtaining advice from other health and care professionals and involving patients and the public in doing this. They will work closely with their local authorities through Health and Wellbeing Boards to undertake a Joint Strategic Needs Assessment and to then determine their commissioning plans.

(12) The National Commissioning Board, already operating in shadow form as the NCB Authority, will begin to assume its formal responsibilities once it is established (likely to be between July and October 2012). It will have a significant role in supporting and developing CCGs to realise their full potential and that services are developed that will support not only CCGs but also the NHS CB, who will also be responsible for directly commissioning some services like military healthcare, highly specialised services, prison health services, primary care and some public health services. The NCB is hosting commissioning support, during the period 2013 –16, as CCGs become clear about their requirements and are ready to form.

(13) KCC and the Health and Wellbeing Board will have specific roles around the joint commissioning agenda, working in partnership with CCGs. We have a clear role to play both as a key partner in health commissioning but also as a potential partner in, and provider of, commissioning support. In the same way that emerging services from PCT clusters must be clear about their offer and build customer focused and responsive models, so too must we be clear about our contribution and how we can add most value to CCGs.

(14) CCGs are developing within Kent and due to the size of the County and our location to neighbouring boroughs we are expecting different CCG arrangements across the County. As an authority we need to be nimble and swift to respond to the changing climate and the differing requirements of the CCGs to ensure we have services that meet the need of the patient

7. Rationale for continuing the Partnership

1) As detailed in section 3 and 4 of the report, KMPT have demonstrated clear improvements in a number of work areas that were identified in the review and have detailed plans in place to deliver further improvements. There are a number of reasons why it is important to continue with the partnership, as follows;

   a) The key to developing patient centred primary mental health care services is to put the patient's needs at the heart. It is vital that the services we commission and deliver are integrated as peoples needs straddle health and social care. Therefore it is important that KCC and KMPT continue to improve and nurture the integrated service and partnership.

   b) Live It Well, which covers 2010-2015, sets out a vision for promoting mental health and well-being, intervening early and providing personal care when people develop problems, and focusing on helping people to recover in an integrated way. It was developed by the mental health commissioners for Kent and Medway (the three primary care trusts and the two social care directorates), with people who use services, family carers, health and social professionals, voluntary organisations and others. Therefore it is impetrative that KCC continues to support the strategy and its partners.

   c) Following the Health and Social Care Act all NHS Trusts must become, or be part of, an NHS Foundation Trust by April 2014. KMPT have relaunched the Foundation Trust Status application, and currently readiness assessments are taking place. KMPT are excepting to meet with the Strategic Health Authority in August 2012, with an expected referral to the Secretary of State in September 2012. KMPT are committed to delivering partnerships through the FTS process, which is reiterated in their annual business plan, and KCC will want to support them in the FTS process.

d) There are ongoing improvements in the safeguarding practice within KMPT, which was demonstrated in the recent audit. KMPT continues to focus on safeguarding via the comprehensive Improvement Plan. They have strengthened their governance and risk structures and take every opportunity to review practice. The Safeguarding Group continues to hold service lines to account and ensures that safeguarding is on the agenda of all local patient safety and clinical governance meetings.

e) Since summer 2011 both organisations have made concerted efforts, via their leadership teams, to resolve issues about the partnership that members had identified. KMPT now have a new Chairman, Chief Executive Officer and Director of Finance, that have signed up to an annual business plan. Appendix 4, which states their vision; 'The Trust aims to deliver quality through partnership. Creating a dynamic system of care, so people receive the right help, at the right time, in the right setting with the right outcome'. Andrew Ling, KMPT chairman has also met with a number of cabinet members to discuss the future vision of KMPT.

f) The new Partnership Agreement is a clear statement that both orgainsations are committed to the continuous improvement that is required to adapt to the changing climate within health and social care. The Partnership has clear governance arrangements to monitor its effectiveness and will be review after 6 months to ensure it is fit for purpose.

g) KMPT & KCC have a number of joint and independent reviews, as necessary, that are planned over the next year, which will ensure we have the correct structures in place to deliver health and social care outcomes for the future. It is important that both organisations completed the service reviews before looking to change partnership arrangements, otherwise there is the possibility of having to change more than once, which will have a negative impact on patients and staff.

h) Members will be aware that in February 2012 Medway Council withdrew from its partnership with KMPT. We need to learn from the experience of Medway Council withdrawing from the partnership as they have experienced a number of issues and now have a detailed transition plan in place to rectify some of the outstanding issues as a result of a sudden withdrawal. The pace and scale of what Medway need to do has provided KCC with learning that shows the importance of getting the current issues right before we make any significant changes to the partnership.

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i) Due to the introduction of PbR and CCGs the mental health and commissioning landscape is set to drastically change over the next few years. Multi-agency and partnership commissioning for mental health and wellbeing will be required to deliver seamless services. It is

important that the partnership continues whilst we collaboratively understand the needs of the patient and redesign services to meet their needs.

j) KCC & KMPT have jointly developed robust governance arrangements to monitor the partnership, which include the Mental Health Partnership Board, Programme Board, Finance and Performance monitoring via the KCC LDMH Divisional Management Team and the Joint Performance Review Group. This has supported robust performance monitoring and ensured the budget has been brought under control.

k) To deliver the KCC Adult Transformation it will require radically changing the current investment profile high level reviews of how social care is currently delivered. Service redesign will be achieved by understanding the relationship and interdependencies between our key activities, and partnerships, therefore it is important that we work with key partners to deliver the programme.

8. Conclusion

(1) Members will note from the report significant progress has been made on improving the Partnership and work is planned for 12-13 to continue improvements. Although much has been done there are still some concerns in relation to staff morale. However the Mental Health Partnership Board feels confident and assured that the good outcomes will be delivered by the new Partnership Agreement.

(2) The key progress made to date is:

- The re-established Governance structure; with a Programme Board and Partnership Board embedded since July 2011
- The continual high profile for and commitment to the Improvement Plan across both organisations.
- The new Professional Assurance Team, led by the Head of Social Work making significant progress in a number of work areas
- The improved monitoring not only of the Improvement Plan but also the key performance indicators, with a clear joint approach to RIO and Swift
- The improved status of key work streams; including safeguarding and personalisation
- The appointment of a new Chairman at KMPT and a permanent Chief Executive Officer.
- The robust performance management and clear guidelines set out in the new Partnership Agreement permits KCC to have confidence in the future delivery of mental health services within the new commissioning clusters.

(3) Of course close scrutiny and monitoring will need to continue over the next year to ensure progress is maintained.

9. Recommendations

Cabinet Committee members are asked to

a) **NOTE** the revised Partnership Agreement from April 2012 for one year.

b) **COMMENT** on the intended review of the Partnership Agreement in September 2012, whilst we fully assess the impact of the delivery of Commissioning Clusters 1,2 and 3, 7, 11 and 12, the Clinical Commissioning Group and the KCC Transformation (Adults) Plan.

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