Committee:	Kent Health Overview and Scrutiny Committee
Date of Meeting:	11 June 2010
Subject:	Accessing Mental Health Services: Adult and Older People's Inpatient Services
Lead Director:	Lauretta Kavanagh, Kent and Medway Director of Commissioning for Mental Health and Substance Misuse

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1. Introduction

The approach taken to responding to the 12 questions asked has been to respond to them under three categories:

- Adult acute beds provided by Kent and Medway Partnership Trust
- Older people's acute beds provided by Kent and Medway Partnership Trust
- Specialist and secure beds provided by both KMPT and contracted across other NHS or independent sector providers (not split by age but older people spend and utilisation is minimal)

Our strategic changes to bed utilisation focus on reducing acute admissions and lengths of stay in acute settings, delivered by a range of service alternatives. These range from:

- Improving primary care interventions
- More effective Crisis Resolution and Home Treatment Services (e.g. fewer admissions, more support to stay at home)
- Earlier response in crisis
- Widening therapy alternatives
- Improving recovery
- Supporting choice and personalisation
- Supporting some specific high-risk groups such as those with dual diagnosis and those in the Criminal Justice System

These are a significant area of focus of the Live It Well strategy that is coming to fruition.

Investigating spend on acute mental health in-patient services requires an understanding of three sets of figures:

a. *PCT contracted spend (on behalf of both the PCTs and the Councils as a lead commissioner).* We are able to provide spend on inpatient services by locality for specialist or secure secures services outside of the KMPT contract. In the KMPT contract neither the adult inpatient nor older people's inpatient contract value is broken down by locality.

b. *Adult and older people mental health mapping data (supplied by Mental health Strategies).* Mental Health financial mapping data includes the PCT and Local Authority spend on mental health services, adults and older people separately, and spend on provider categories (NHS, LA, non-statutory) but with no separate expenditure line for inpatient services. The data does give points of comparison, i.e. against the SHA spend, the ONS cluster spend and the English national average.

c. *NHS programme budgeting by PCT.* The NHS programme budgeting data shows spend by PCT only, by any type of provider on clients categorised as having a primary mental health diagnosis, and of any age. NHS programme budgeting data has five subcategories (including CAMHS services, substance misuse services, dementia, and covers far more than expenditure on beds or on contracted services with mental health providers. No specific subcategory relates to in-patient care.

Wherever relevant or possible, all these figures are provided.

The document attached goes on to describe how mental health commissioning is integrated across health and social care for all three PCTs in Kent and both Councils and gives a short summary of developments in accessing talking therapies in primary care.

2. Conclusions

In our strategy we would certainly anticipate less acute beds across Kent in five years time than we have now, and less expenditure on high-cost placements.

Live it Well sets an expectation that we develop new care pathways. These will emphasise more support for service users in primary care and community settings, with primary care services being better supported to access more and wider resources for service users, so needing less recourse to an acute bed. These supports would include access to more information, access to helplines for those in distress, more crisis response in primary care, wider voluntary sector help and service delivery, wider access to liaison psychiatry, more support for achieving recovery, and more support for carers and relatives.