

Editorial

Rediscovering our true purpose: Principles in the competitive PICU market

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Healthcare provision in the UK has changed out of all recognition since our forbears, the monks who ran the first asylums, were nicknamed 'basket-men' because they were compelled to go out into the street carrying baskets in which to collect food to feed the inmates (Nolan, 1993). The degree of sophistication in the way resources are allocated to mental health services is now highly developed.

In fact, the last few years have seen more change for mental health services than any other period in the 60 year history of the UK National Health Service (NHS). Some staff within the NHS may have woken up a year or two ago and realised that all was not as it was. It wasn't just that the dreary brown signage that characterised the NHS for a generation had morphed into brightly coloured replacements with snappy names, there were new people around and they looked different. Old colleagues, who matched the signage, were gone and they had been replaced with whizzy young things who boasted stints at Vodafone, Honda and Virgin Media on their CVs. There were different ways of doing things, business plans, communication strategies, websites, even twitter feeds.



Depending on who you work for, how much you get out and about and how much you notice what is going on around you, you may have picked up on some of these changes. It didn't necessarily feel bad, just different. There was a lot of energy around, and more was being spent. Even if we didn't want to admit it, more money was being ploughed into mental healthcare than ever before.

One of the key factors influencing these changes was the final realisation of the purchaser/provider split. That is to say that one group of organisations: purchasers/commissioners (Primary Care Trusts – PCTs) buys healthcare on behalf of the public from providers.

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Providers include NHS Trusts, but also private businesses and charities, formal processes are now in place which ensure that non-NHS providers are able to compete for business with NHS providers.

This is currently probably more evident in mental health low secure services than in psychiatric intensive care units (PICU). Low secure care, being commissioned in the UK by regional specialist commissioners rather than the usual local PCTs, has emerged into the world of the 'competitive procurement process' whereby services are purchased from a range of providers, the determining factors being quality and price rather than corporate heritage.

In order to commission the right service, commissioners will use a service specification to specify what service they want to buy and providers submit a tender saying how much they will charge to supply it. The specification will describe in detail what the service will be expected to do including contract targets which have to be met.

The service specification forms the key part of the tendering process that the commissioner will set in place. Through a number of stages of increasing complexity, the commissioner will examine the provider's ability to deliver against the specification.

The current implications of the global economic downturn are being revealed by the day. There isn't a week that goes by without comment in the health and mainstream media about threats to NHS services as a result of the recession. At the time of writing, the *Heath Service Journal* has just leaked a Department of Health commissioned report which forecasts the need to save £20bn over five years; this equates to 137,000 jobs (Gainsbury, 2009).

It would be a rare healthcare worker indeed, who did not acknowledge that there are opportunities for efficiency savings within the industry. The urgency to make savings though is likely to necessitate some major initiatives and these may take one of a number of forms.

Firstly, by putting services out to the market, commissioners will hope that competition will stimulate things sufficiently to reduce expenditure.

Secondly, the theory of economies of scale may be used to argue for a reduction in the number of providers offering mental health services; as a result one might anticipate that mergers and acquisitions between services might be more common over the next year or so. This will make non-foundation NHS trusts vulnerable to acquisition by foundation trusts. Foundation trusts are NHS trusts which have successfully negotiated stringent processes in order to achieve greater autonomy and financial freedom. It is an aspiration for all provider trusts to achieve this status, although there are many who are still undertaking the arduous work necessary to meet the requirements.

Thirdly, there is one more critical factor, the effects of which should not be underestimated: the calling of a general election and the potential for a change in administration may have marked effects on healthcare. Were a party with an even higher esteem for market principles to be installed then one might assume that the process of testing the market across all types of healthcare will accelerate.

The shape of the UK health industry has changed. Changes in ideology are always marked by a variety of phenomena. Change will impel some traditionalists to dig in their heels and resist at all costs. Others will embrace it regardless of its value and attempt to advance their own position. Still others will accept the reality and determine to continue to play their own part to the best of their ability.

That said, we do need a few 'heel diggers', they hold the adventurers to account and may even be the required bits of grit that make the odd pearl.

There are two main qualities which will be needed to survive in this new UK mental health business culture:

1. Leadership
2. An adaptable skill base

Firstly, on the issue of leadership: we know that sustainable change only comes about through leadership rather than solely management. As leaders within PICU and low secure environments, we can greatly impact on the attitudes of our colleagues to good effect.

The other necessity is to acknowledge that we now need additional and different skills within our workforce. This appears to be increasingly true at all points in the new organisation of mental health care. Team managers now require additional, and in many ways very different, skills to those they needed five years ago. They need to be able to monitor all types of data in order to ensure that contract targets are met. Targets might include the activity of their staff, compliance with quality standards such as adherence to the Care Programme Approach (CPA) or outcome measures. There is also need for people who can understand and describe systems which will meet service specifications and people who can accurately forecast how much it will cost to run a service to meet the specification. Some of these skills exist or can be developed from within the present healthcare industry, some may need to be imported from the commercial sector.

We know more about what our services cost than ever before and we are increasingly developing ways of ensuring quality. AIMS-PICU (the Accreditation of Acute Inpatient Mental Health Services for PICUs, a scheme operated by the Royal College of Psychiatrists) is one obvious example. Some may feel cynical about efficiency, however, most people in the UK pay for the NHS as taxpayers and should feel no desire for it to cost any more than it has to. Over the next few years it will be unavoidable that we need to continue to develop our understanding of cost and become more sophisticated in how quality is measured.

To some extent the responsibility for costing rests with the financial experts, but the respons-

ibility for quality and its measurement rests with those who deliver services, the staff who work face to face with service users in our PICUs and LSUs. As commissioners begin to demand demonstrable quality assurances, the intention is that there will be a closer relationship than ever before between what people do on the wards and whether contracts are renewed or even fully paid.

CQUIN (Commissioning for Quality and Innovation payment framework; Department of Health, 2008) is a part of a contract which withholds a certain percentage of the funding until certain criteria are met. These performance measures are locally agreed between commissioners and providers and may reflect local priorities. If, for example, a provider agreed to make AIMS accreditation a CQUIN, then the achievement of that CQUIN will rely significantly on the efforts of the staff who operate the ward.

Therefore, from the clinician's point of view, the success of the increasingly important 'business' aspect of the PICU or LSU will in future largely depend on what is measurably achieved and how it is demonstrated. The health business model theorists advance the persuasive logic that – just as the success of a motor manufacturer will rely on the quality of the workmanship of its assembly staff – the success of a healthcare provider will rely on the work of its clinical staff.

Traditionally, many staff have been accountable to our professional bodies and our service users, but more than ever we may also feel increasingly accountable to each other for the success or failure of our organisation as a business.

As provider organisations develop their understanding of operating in a competitive business culture, a key issue will be that of values. Reflecting on the free market economy one wonders how healthcare might fit in.

In considering what values and principles might apply to the PICU and LSU 'business', it seems reasonable to start by considering what values apply on the 'shop floor'.

In low secure care in particular, there has been a great deal of alignment of services around the concept of recovery. According to NIMHE (2005) recovery oriented services will:

- Focus on people rather than services
- Monitor outcomes rather than performance
- Emphasise strengths rather than deficits
- Educate to combat stigma
- Foster collaboration between those who need support and those who support
- Promote autonomy.

Having considered these principles it seems that it might be possible to apply them not only at ward level but throughout an organisation. Furthermore, if we apply these principles morally to our business development we might find we have services which truly meet the needs of service users!

Healthcare professionals are called upon to be seen to be ethical and accountable people. This may not sit obviously within a competitive market-place but it is still essential. Many may find themselves in a business environment which believes it has a lot to teach them, but it is the view of this author that the clinicians and staff have a lot to teach it as well. Progress through human history has often only been achieved through bloody mindedness, the determination to shape the world around you rather than simply be shaped by it. The healthcare providers entering the business economy would be well advised to stick to strong clinical and patient best interest principles and let the market place be shaped by them. The British Army uses a mantra: *Right attitudes lead to right actions*. Exactly the same thing should be said to all staff who work in PICUs and LSUs. If they have the right values at the core of how units operate, then the 'right thing' is more likely to be done.

There are of course, many tensions between patient best interests and clinical principles and business methods. Mental health care can often be characterised by the playing of the 'long game'. In particular in LSU practice we plant acorns in the hope that in years to come there will be oak trees. Our work with people experiencing psychosis could extend over many years

and many business cycles. When contracts between commissioners and providers only last for a few years we need to remind ourselves that the needs of our service users will often be much more long term.

At the 2009 NAPICU conference Malcolm Rae observed that to be successful in the delivery of contemporary health care in the UK, one needs to be politically astute, adding that the most important skill is to be able to "exploit the inevitable" (Rae, 2009). One could advance the very credible argument that that's exactly where we are now. There is an inevitability about the business and free market type changes currently occurring in UK mental healthcare. As people concerned with PICU and LSU care, we can either let it happen or shape it to the best advantage of service users.

The architects of some of the changes will argue that they have immediate merit. For example, in being able to prove that what is being offered are indeed, quality services, but also in delivering services in an efficient way and in being required to develop and improve.

The market place, we are told, has much to teach us – but PICU and LSU practitioners and service users also have something to teach the market place. Something about principle and values, something about working now for something which may happen in the future. Now is the time to adapt to the new world and to adapt it to the needs of service users. It will be frontline staff who have the most to offer with respect to many of the challenges we face.

We are not in business for the sake of ourselves or our share holders, but for the people who need our care: who come through our doors at three o'clock in the morning wearing a paper suit, the people for whom being locked up is all they have known for most of their adult life, the people who, in their distress, need our services to keep them safe.

We are on the brink of a new paradigm in mental healthcare provision. Our clinical values have much to offer that paradigm; we can

allow ourselves to be shaped or we can do the shaping.

History will judge whether if, over the next few years, we survive in the business world and are able to uphold that first tenet of Recovery:

‘to focus on people rather than services’.

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