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Editorial

Supply versus demand: Market forces in Low Secure and Psychiatric Intensive Care Units

Mathew J Page[1], Roland J Dix[2]

[1]*Clinical Nurse Specialist, Manager Montpellier Secure Recovery Service, 2gether NHS Foundation Trust for Gloucestershire;* [2]*Consultant Nurse PICU and Secure Recovery, 2gether NHS Foundation Trust for Gloucestershire*

The face of healthcare in Britain is changing. The UK National Health Service (NHS) has core principles which have existed since its inception in 1948. In 2000 these were added to and developed and although the central premises remain, the manner in which services are delivered has changed. The pace of change in the NHS is now progressing at such a rate that it may be worth pausing for a moment to remind ourselves of those principles.

The Original 1948 Core Principles for the NHS were:

- That it meet the needs of everyone
- That it be free at the point of delivery
- That it be based on clinical need, not ability to pay.

The Principles Added by the 2000 NHS Plan (Department of Health, 2000) included:

- The NHS will provide a comprehensive range of services
- The NHS will shape its services around the needs and preferences of individual patients, their families and their carers
- The NHS will respond to the different needs of different populations
- The NHS will work continuously to improve the quality of services and to minimise errors
- The NHS will support and value its staff
- Public funds for healthcare will be devoted solely to NHS patients
- The NHS will work with others to ensure a seamless service for patients.

For many people both within and without the UK, arguably coloured by the above, there may have been a long standing misconception that the NHS core principles require *all* healthcare to be provided within the format of a nationalised industry. In terms of the format of organisations that deliver services, these principles only require that care and treatment are free at the point of delivery.

In terms of business acumen, those who operate Psychiatric Intensive Care Units (PICUs) and other types of secure mental healthcare, either in the NHS or Private Sector (PS), are likely to have a distinct advantage over peers from other mental health specialities during the coming years. Unlike many other areas of mental healthcare in the UK, there has been a significant provision of PICU/Low Secure Unit (LSU) services from outside of the NHS for many years. Pereira et al. (2006a) found that the PS provided 10% of PICUs and 28% of LSUs although these figures will have risen significantly since this research.

While service directors and others try to negotiate the uncharted waters of prequalification questionnaires, tenders and acquisitions, specialists from PICU and secure mental healthcare will often find themselves further ahead on

Correspondence to: Mathew Page, Montpellier Unit, Wotton Lawn Hospital, Horton Road, Gloucester, GL1 3WL. Tel: 01452 891581; Fax: 01452 891585; E-mail: mathew.page@glos.nhs.uk

the same journey. There is of course no time for complacency amongst any of us. Most PICU/LSU managers and clinicians have a vested interest in ensuring that the services they provide remain operational. This means that, in the new business culture, whether traditionalists enjoy it or not, business principles need to be clearly understood and applied.

Business principles in healthcare may conjure up images of Machiavellian entrepreneurs expanding vast empires of hospitals and, in the case of secure services, housing people who don't need to be there. With this in mind, it is far from immediately obvious what market forces could do to improve PICU/LSU services. Beyond the basic NHS sentiment that profiting from illness and deprivation of liberty are deeply unpalatable, the time has perhaps come to look further than this rudimentary view – to a view which sees a future of innovation and excellence characterised by the best businesses and not the worst.

The NHS is in the process of embracing Lean Thinking (NHS Institute for Innovation and Improvement, 2007) a concept developed in the motor industry, the principles of which are:

1. Specify value
2. Identify value/patient journey
3. Make the process and value flow
4. Let the customer pull
5. Pursue perfection.

Such principles may bring with them a danger that patients are seen simply as units to be processed. This of course, could be in tension with the celebrated and contemporary guiding principles of mental healthcare such as the Recovery Model (Repper & Perkins, 2003). But before we dismiss the potential future impact of lean thinking, it may be worth considering some common current practices; a good case example being patient assessments. Rather than an uninterrupted flow through a healthcare system, patient journeys are often punctuated by repetitive assessments, the outcomes of which may significantly affect not only the individual's healthcare but their whole life. Lean approaches applied to patient pathways might yield benefits for the patient in terms of greater clarity and continuity and benefits to the provider in terms of improved efficiency and decreased cost.

Measuring the benefits of intervention in mental healthcare (outcome measurement) remains contentious and is yet to be fully embraced. The enigmatic nature of mental illness and all of the associated bio-psychosocial issues mean that in mental healthcare, there is often not the benefit of the more binary characteristics of some physical health conditions. Nonetheless, some experts believe that simply monitoring outcomes by the application of a battery of standardised assessments in a longitudinal fashion has benefits to mental health service users in terms of reduced admission rates and consequently costs (Slade et al., 2006). There is cause for caution in that, as Georgiou & Pearson (2002) observed, the effort involved in developing the outcome measurement tools and collecting the data, must be justified by the potential benefits.

Undoubtedly, outcome measures will play a central role in healthcare delivery in the future. They form part of a system of quality assurance which has long been the norm in manufacturing and retail industries. The complexity of neuro-chemistry and the inexact nature of human relationships which together complicate the delivery of mental health services, suggests that outcome measures may be limited in their true accuracy and value. In the new PICU/LSU business world, regardless of their problems, it seems that outcome measures may well be more central than ever before to service funding and, hopefully, able to contribute to service improvements. The subjectivity associated with such issues as mental 'wellness' and 'contentment' will always mean that some of the things we hold most dear may be the factors which attract the least business interest and scrutiny. We should be able to reasonably hypothesise that a well run unit, where patients are given many choices and opportunities to improve their quality of life, will ultimately lead to improved measurable outcomes. Furthermore, in the case of many forensic LSUs, rates of recidivism may also provide a useful outcome measure. The PICU/LSU business reality may be that some of the best and most

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person centred practice may not be acknowledged in the way it deserves, but that is, in part at least, for those of us who run those services to address.

Outcome measures will also be critical in the development of the payment by results agenda (PbR). The NHS is hoping to be, if not the first, then one of the first healthcare systems in the world which uses a PbR system in mental health. The project is still formative at the time of writing and is concentrating on a taxonomical approach to dividing service users up into specifically described groups, patients in PICU and low secure services will certainly form a group or groups with certain common characteristics. What will perhaps be most interesting and, where PbR is concerned, may be most helpful to patients, will be a comparison of the performance and outcomes of different units working with the same group. It has become apparent to some in the PICU and low secure clinical community that comparisons simply on a cost per night basis are no means by which to commission a service. An examination of average lengths of stay will yield the much more instructive data of cost per episode. With different providers reporting wildly disparate figures for average length of stay, it seems vital that commissioners consider firstly those services which appear to safely return the patient to the least restrictive environment in the shortest period of time. Average length of stay may well become an important part of the PbR agenda, as it may well be the most instructive figure to commissioners and providers in working out how much to charge for patients care.

Some hope that a PICU/LSU business culture may produce increased quality and choice for PICU/LSU patients, an interesting recent example occurring in our own low secure service. In common with many of our fellow services, only part of our service is commissioned by our local Primary Care Trust (PCT). For the remainder there is a need to sell LSU beds on the 'open market'. One commissioner looking for a placement for a patient offered him the opportunity to choose between three available LSUs in different counties. Following his visit he chose our LSU. In effect, the detained patient with a history of offending awarded our service £150 000 per year contract. Not on the basis of glossy literature or skilled marketing, but on the fact that the unit operates a fully functional market garden; organised within the framework of a workers cooperative, in which patients are voting members and derive an income. This particular man was sufficiently impressed that he chose this LSU over others as the place where he most wanted to receive treatment. In the new business culture of PICUs and LSUs, directors of finance may well need to catch up with the business potential of innovative seemingly extravagant approaches to LSU care illustrated in the above example. In addition, the experience of staff meeting a potential LSU patient for the first time and effectively having to sell him the service, profoundly drove home how the future of PICU/LSU service delivery may be very different from anything we have yet seen.

In asserting that there may be some benefits from the application of business principles in PICU/LSU care, we should make a brief visit to our own understanding of what business is. We may anxiously assume that the NHS will attempt to model itself on a 'pile 'em high sell 'em low' model beloved of certain retailers. Such models take no account of quality assurance which our rational minds will be forced to acknowledge the NHS is currently developing. There are of course any number of other models which strive for quality and have a vested interest in the welfare of both employees and customers. Models such as cooperatives and mutual organisations may have a value base not so different from the values of the NHS, which 'dyed in the wool' public servants may find much more attractive than some of the more global corporation structures which are often feared.

Some of the greatest challenges facing clinicians particularly in the low secure sector are associated with the throughput of patients. This is made evermore important by the probability that it is likely to become a key performance indicator of the efficiency and therefore competitiveness of a PICU/LSU on which funding may well depend. Often issues of criminal justice process, Ministry of Justice

restrictions, challenging behaviour and sometimes simply reputation of the unit or patient can have a hugely dilatory effect on the process of discharge. Pereira et al., (2006b) found that in a comprehensive survey of survey of PICU and LSU patients 25% were categorised as delayed discharges. This situation is problematic in that it represents a contravention of the principle of treatment in the least restrictive environment (Department of Health, 2004) in addition to increased cost. The imposition of market forces may prove beneficial for patients who find themselves in such circumstances. For instance, if commissioners were to fund placements on a cost per episode basis, then it would be a huge motivating factor for providers to move people into less restrictive environments. Herein the PS may have had an advantage up to now in the expediency by which new services can be commissioned under a business model in the PS rather than the more traditional NHS approach. A provider who finds difficulty in discharging patients from its LSU, due to a lack of suitable step down accommodation, may develop its own solution such as a new step down unit, thereby increasing patient throughput. A business model encourages innovation and solution focused thinking in a manner that is more dynamic than that which has been conventionally practised in the NHS. The flip side of this hope is that if a service is not viewed as having potential to achieve new or increased funding then it may not be developed in the first place. Erroneous logic and entrenched thinking could simply lead to a continued upsurge in the development of secure services rather than a development of alternative services; on the basis that more money can be made from locking people up than can be made from letting them out.

This raises the prickly question of how clinicians hold in tension their accountability to their professional code and the needs of their employer to be solvent. There is some anecdotal evidence that some providers may too readily admit people to their secure services where other providers feel they do not require that level of care. This ethical complexity is not new, for as long as detention under mental health legislation has existed, clinicians have needed to balance competing demands and factors in the decision making process, such as those of families or local communities. In the future the hard business reality of needing to keep beds filled in order to get paid may become an increasing concern.

What business principles should never be able to do is alter professional practice for pecuniary reasons, therefore professional bodies will need to develop systems of much greater vigilance to ensure that in the rocky terrain of the secure mental healthcare business, it is the needs of the patient which are being met first and not those of the company shareholders. This will require significant thought in the coming years, and may necessitate a paradigm shift in the way professional regulation is organised.

For many years critics may have levelled the view that difficult patients have been located in PICU/ secure placements a long way from their home area, and treated in a manner to suggest 'out of county – out of sight and out of mind'. The all too often destructive nature of enduring mental illnesses means that people in longer term LSU 'out of county' care commonly have no-one to advocate for them. However, the drive to efficiency and cost minimisation will mean that we will very likely see the mobilisation of an army of commissioning case managers surveying the home counties, visiting the former hotels and country houses that are now mental health LSUs. Their mission will be to ensure that people are being well looked after or clearly cannot be returned to less secure accommodation closer to home. Where increasing business principles rather than traditional approaches may be advantageous to those patients, is in the fact that there will be a much greater scrutiny of whether they need that level of service. It is the conjecture here that there are many individuals in long term secure care in both the NHS and the PS who simply do not need that type of service any longer, but there has been no one to ask the right questions and no reason to ask them.

CONCLUSION

The 2007 film 'Sicko' by controversial director Michael Moore, gives cause for alarm at the

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prospect of a healthcare system organised almost solely on the basis of profitability. The US system seems to continue to rely on the ability of people to pay for themselves, or with funds from private insurance companies that agree to pay for treatment episodes. Moore pointed out in the tales of despair and injustice in his film that his focus was only on people who had or thought they had healthcare insurance. The care principles of the NHS, if nothing else, would seem to offer some protection against the profound injustices described by Moore. But before those of us committed to the NHS become content that we have nothing to learn from business, we need to satisfy ourselves that our PICUs/LSUs are not delivered on the basis of a slow, bureaucratic and convenience orientated approach which stifles innovation, quality and efficiency.

The application of market forces and business principles to a system which has been nationalised since 1948 will be anathema to many. The state of perpetual revolution that the NHS has existed in for most of that time has accelerated to a cadence hitherto unprecedented. While the public eye has been staring intently at general medical services, GP practices and maternity units, the secure mental health sector has gradually been privatised; to a point where NHS provider organisations are now competing openly with the PS peers. Other parts of the NHS are well advised to look at how this process has occurred and what might be learnt from it.

Those of us working in the NHS may be fearful of further change, but we also have an interest as tax payers and as (potential) users of the services we provide. Lean and efficient services which treat patients with dignity and respect in an effective and timely manner are in all of our interests and when those services minimise the call on our wallets we will surely applaud that as well.

It seems increasingly clear that in mental healthcare the PICU/LSU services are once again at the cutting edge of a quickly changing culture.

The new dawn which appears to be breaking brings with it new hopes. Hopes of improved efficiency and better value, better services for those we serve. Before we see the break of day we should pause a while and consider our part in it. How will we shape what is to come? The cautionary comments about the perils of market forces in healthcare should be heard and only the underpinning principles of those who lead will shape healthcare in Britain into something to be proud of. The price if we get it wrong now may well not be paid by us, but by those who come after us and there is little doubt that the PICU/LSU population are some of the most vulnerable amongst them.

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