EDITORIAL

Leaving Europe and leaving home for an out of area PICU bed: who’s really paying the price?

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Funding for healthcare is dictated by socio-political factors. Here in the UK we are gearing up for Brexit after the recent referendum when a slender majority voted to leave the European Union (EU). In the recent referendum, the Leave campaign promised that, by leaving the EU, substantial sums of money would be freed up for the NHS but it now seems those claims were unfounded.

At the Journal for Psychiatric Intensive Care however, we are proud of our international perspective and intend to maintain strong links with our European and other international colleagues and contributors. We believe that the UK needs to remain outward looking and continue to collaborate with other nations.

That aside, Brexit will affect healthcare in the UK in other ways, not least because Government is likely to be pre-occupied with negotiations and the social, economic and legal ramifications of leaving the EU, giving less time for addressing the ongoing difficulties in the NHS.

These difficulties within the NHS are considerable. The demographics of an ageing population allied with increasing life expectancy have combined with advances in medicine and greater patient expectations. This has led to considerable concerns about how healthcare will be funded in a sustainable way from here onwards. Currently the NHS is viewed as one of the most efficient healthcare systems in the world but despite being one of the top three economies in Europe, we spend less GDP on healthcare than the European average.

The Government’s response to these changing demands was their Five Year Forward View, published in 2014 (NHS England, 2014). This projected a gap of about £30 billion a year between resources and patient needs in the NHS in England by 2020/21 unless there were significant changes.

The Five Year Forward View set out ambitious plans for reforming health and social care to achieve the significant savings required. It also marked a key change in strategy, moving away from competition between elements of the system (particularly providers) and encouraging collaboration, integration and planning.

The development of Sustainability and Transformation Plans (STPs) is the vehicle by which this change will be organised, but STPs have been met with some scepticism being viewed by some as a further round of funding cuts. Nonetheless the STPs focus on prevention, intervening early, providing treatment in primary care and the community, integrating health and social care and a re-organisation of acute and specialist care, is likely to be viewed as reasonable by many clinicians.

Whilst there are positive aspects to STPs there are also significant concerns. Finance is a key issue. The transformation plans are proposed at a time of austerity; many NHS
trusts are already in financial difficulties and no additional funding has been identified to manage the change. Similarly, social care budgets, funded by local authorities (LAs), are also in great difficulty as LAs have had their funding reduced by 37% over the last six years (National Audit Office, 2014).

In the UK, mental health services, as part of the wider NHS, are profoundly affected by the issues outlined above. National funding decisions are, of course, played out at local levels and one issue that has received criticism in the national news recently is that of patients being sent out of area, sometimes hundreds of miles away, due to a lack of local resources. In this issue of *JPI* we have two articles by Haw and colleagues on this theme.

Haw et al. (2016a) addresses the reasons behind referrals. In this study, most of the male referrals had schizophrenia whereas the female referrals usually had personality disorder and, concerningly, the authors identify a lack of PICU beds in-area accounting for over 90% of referrals. In the second article, the authors review the characteristics and length of stay of those patients (Haw et al. 2016b). Interestingly this shows that the median distance travelled by patients was 81 miles, and that 30% of patients had extended admissions, usually due to a lack of appropriate facilities for transfer back to their home area.

Also in this issue, we have an article by Lopez and Sethi on factors associated with re-admissions to a PICU for female patients which shows some association with co-morbidity and substance misuse, although the numbers are small (Lopez & Sethi, 2017). Sticking with gender, we also have an article from Learmonth et al. (2017) on patient-pathway outcomes from a female PICU. Interestingly this looked not just at discharge destinations from PICU but also where patients were located six weeks later. This showed that, reassuringly, over half were back in the community whilst a third remained in hospital; however, 4% were back in a PICU and 4% had gone absent without leave.

In addition, Beazley et al. (2017) present a thought provoking article on how the HCR-20, a structured professional judgement instrument commonly used for risk assessment, can be used in clinical practice, proposing a number of good practice points.

Finally, we have an article from Taube-Schiff et al. (2016) on dealing with patient’s boredom through implementing a behavioural activation programme on a PICU. This presents some innovative ideas on developing activities for patients and is well worth reading.

References


