Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Cherries High Dependency Unit Closure		
Report Summary		
Purpose of this Report: As part of the redesign of the acute care pathway all elements of inpatient services have been scrutinised and considered within the context of the overall in-patient service and its safe delivery. As part of this process it is proposed that AWP will close the Cherries High Dependency Unit providing any intensive care needs within the identified Psychiatric Intensive Care Unit (PICU) capacity for BANES, ensuring that this type of care is always provided within a nationally determined and governanced framework of care delivery.		

1. Purpose of the Report

The purpose of the report is to inform stakeholders of the background to the proposed changes, how the proposal was arrived at and to identify the significant changes, benefits and risks.

This paper is in addition to that presented at the Wellbeing Policy Development and Scrutiny panel and follows a first engagement meeting with a stakeholder group to discuss the HDU beds. This paper, and the presentation at the first engagement meeting, will be part of the information used to inform an impact assessment process to be held on xxxxxx.

2. Background

In summary (see appendix 1) a national development of Psychiatric Intensive Care Unit (PICU) provision was undertaken in the mid 1970s in response to the need to manage individuals with challenging behaviours in a more secure environment.

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This development of PICUs has resulted in robust assurance frameworks for their use and has standardised the development of the clinical specialty nationally. The UK is at the forefront of the developing PICU services.

In contrast, there is no national background or standards for the development of High Dependency Units in acute care. The implementation of the High Dependency Unit provision within AWP was predicated on a particular clinician's desire for these services to be developed .This saw the last High Dependency Unit being set up in 2005/6 as part of the Callington Road development.

In most cases the term High Dependency Unit is attached to specialist hospitals who may provide a high dependency unit within their own service, acting as an area for the management of individuals who are experiencing a relapse in active psychiatric symptoms (i.e. usually within forensic services). Services which utilised a High Dependency Unit in the past, such as London and Westminster, no longer use this model of care delivery and, to the best of AWP's knowledge, there are currently no other Mental Health Trusts delivering this service either currently or within the last 5 years.

Therefore, in line with our (and commissioner's) aspirations to deliver modern mental health care based on nationally recognised models, AWP considered that the use of the High Dependency Units was not an evidenced way to deliver a governanced and frame-worked model of intensive care delivery.

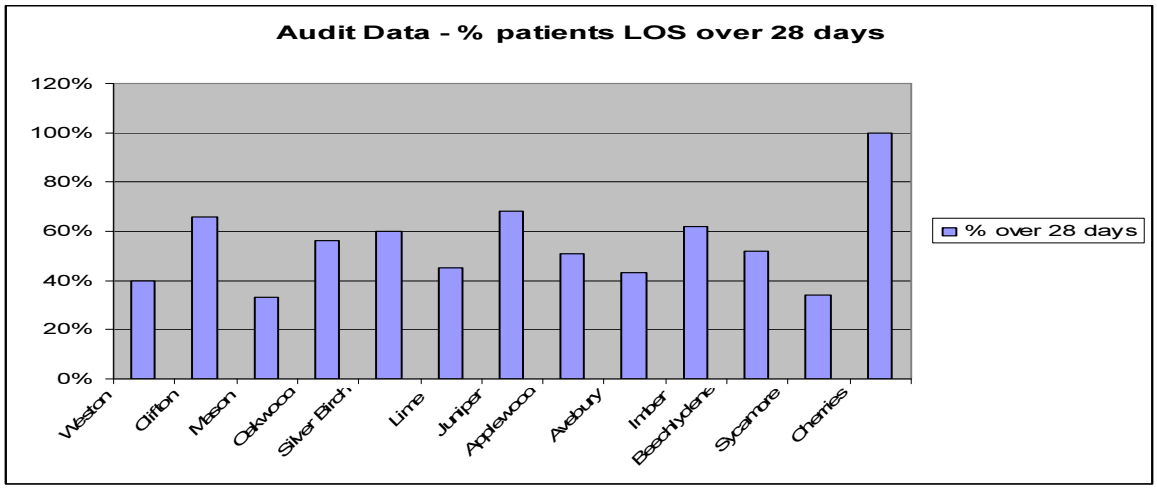
3. Local History and challenges

Within AWP, since the 1990s, High Dependency Units were usually attached to adult acute wards. Their development initially centred on Bristol but expanded across some

other AWP areas. In B&NES this resulted in the Cherries being developed, staffed on a rotational basis with Sycamore.

Whilst the evidence base to support such developments is not apparent it appeared to be a method of increasing the ability of staff to manage service users who presented as requiring increased levels of observation and clinical management for a short period of time. The HDU initiative was intended, therefore, to provide a higher level of intervention than general adult acute inpatient wards could provide, but *not* to provide PICU care which was considered to be of longer duration and for individuals whose risk profile was more severe.

In practice, however, the High Dependency Units have been used as de facto PICUs: providing care in a locked facility for extensive periods of time, in some cases up to a year, without the implementation of a robust evidence base of standards of care provision. An audit completed in 2010 demonstrated that all of the clients in the Cherries had been there for longer than 28 days - the longest length of stay in comparison to acute units and other High Dependency Units – as well as being too long for the intended purpose of the unit.



The HDU environments are also not considered to be inherently therapeutic due to their limited size. This is because the High Dependency Unit provision within AWP was not been designed using the standards of the Implementation Guide for PICU (2002) and

as such did/does not adhere to any nationally set guidance or criteria. In addition, individual therapy input can also be compromised due to the needs of the general ward being prioritised.

There has also been increasing evidence that the use of High Dependency Units has led to a reduction in adult acute psychiatric wards' abilities to manage risk in a pro active and engaged way and has led to an over reliance on using locked environments as a method of containment, thereby contradicting the aim of providing care in the least restrictive setting.

These challenges have been supported by research findings from Australia where the High Dependency Model or acute psychiatric close-observation area has been popular. They too have struggled to develop a therapeutic environment and have experienced difficulties with:

"design and environment, lack of activity and structured time, and nursing care"

(Brien and Cole 2004 International Journal of Mental Health Nursing)

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Ward staff and medical staff have worked hard to provide high quality care in these environments, at times relying on very junior staff to manage the unit, and have tried to provide a PICU experience for service users. Whilst staffing provision has been equal to that of PICU, due to the small size of the units, it has not provided value for money in comparison to PICU wards due to economies of scale and without the investment or expertise required AWP were running the risk of expanding the PICU bed population of the Trust in an uncoordinated, ungoverned and cost inefficient way.

3.1 Audits of HDU 2010

Two audits took place on HDU usage in 2010 as part of an inpatient audit of clinical placements. In May 2010 none of the individuals that were in the Cherries environment

required PICU and could have been cared for within an acute care ward with appropriately skilled staff and resources .

In November 2010, of the 5 patients on the High Dependency Unit , 2 service users were assessed as requiring PICU care with the remaining 3 service users being able to be cared for elsewhere either on an acute ward or in the community. The 2 service users requiring PICU were female. (AWP had already understood the need to provide more flexible PICU provision for women and had agreed with Commissioners and local authorities to move the PICU provision for women - Elizabeth Casson House – from Blackberry Hill Hospital to Callington Road, where an increase in provision can be achieved. This brought facilities closer to B&NES.)

3.2 Activity information

Attached are the numbers of B&NES occupied PICU bed days from 2008 until the present day.

Year	2008/09	2009/10	2010/11	2011/12 (year to date October 2011)
AWP bed usage	920	479	695	685
External to AWP bed usage	232	127	34	0
Total	1152	607	729	0

From the above table we can see that B&NES clients have been using the PICU provision throughout the times we have had the HDU in place. A problem we faced with

PICU provision was that we were using it so much in 2008/09 we had to use "out-of-AWP" provision for 232 bed days and internal PICU usage was very high. This has slowly decreased and this year we have used no out of area PICU provision. Whilst our number of PICU bed days is high at the moment (685 up to October) this is because we have had 2 clients in PICU on a long term basis because we cannot secure long term placements for them – i.e. they would not be using a HDU bed.

3.3 Admissions

1st December 2009 – 30th November 2010 (Cherries open)	**34 admissions to PICU**
December 1st 2010 – 22nd November 2011	**39 admissions to PICU**

The table above demonstrates the amount of admissions to a PICU bed during the 12 month period prior to Cherries high dependency unit being temporarily closed and the following twelve months. As can be seen there is a slight increase of 5 admissions for a comparable period. This is something that we might expect to see as an annual variation.

4. Description of the main changes and implications

The main changes are: closure of the Cherries High Dependency Unit with an associated increase in senior staff input on the main ward and, as part of work taking place across the Trust, a review of the input of Occupational Therapy (recognised as already good on Hillview). In addition, we will develop an extra care/de-escalation area and investigate different use of the Hillview estate with commissioners.

4. Implications

4.1. Access

Service users will be admitted into ward and service environments which meet predetermined and national criteria. Access to high care at a time when a service user requires complex and intensive support will occur within specifically designed

environments with appropriately trained staff and access to equitable services - PICU. In line with our practice to date this will not be in the immediate local area but will be as close to the service users home as possible in either Bristol (Callington Road) or Salisbury. Please note that Callington Road is the PICU of choice for B&NES.

This will necessitate service users and carers travelling, as it has done over the years - however, specialist care is provided out of the immediate area in many instances within other health care settings and it is envisaged that service users and carers will be assisted to manage these upheavals in the same way that they have done to date.

We will also work with commissioners to understand how to manage an all age unit as we recognise that on some occasions for some older adults Sycamore is not always appropriate. This is a key area of work for 2011-13.

4.2 Staff

Staff have been redistributed into Sycamore. There is no current risk of redundancies to the staff group. Staff also expressed concerns regarding providing care for individuals with challenging behaviour or who are experiencing high levels of distress within adult acute wards. The redesign process has sought to increase each inpatient wards skill set and capacity. Staff will continue to be trained in the skills of therapeutic engagement and the therapeutic environment on the unit will be enriched. Research has shown that developing these skills leads to a reduction in aggression and provides a better experience for the service users.

4.3. Estate - Cherries, Hillview Lodge.

It is proposed that AWP develops a de-escalation area for service users who experience high levels of distress to enable the safe and therapeutic management of individuals using some of the estate of the Cherries. A scoping exercise has been undertaken and the project is being taken forward.

Further use of the estate is also under review with commissioners and may be used in the future as additional capacity for the local and cross-AWP services.

4.4. Information Systems and Technology

There is no known impact.

4.5. Finance

There are minimal savings in estate costs. There are cost savings related to the use of agency and bank over the unit. A total of 8073 shifts were used by High Dependency Units over the last financial year which equates to 17% of the Trust's total. In terms of cost this is £939,213. The overall cost to the Trust in the last financial year for bank and agency was £4,866,214. As can be seen the spend is significant and we would hope to reduce this.

5. Relationship to National Targets and Trust Objectives

5.1 Care Quality Commission (Standard for Better Health)

Patients receive effective treatment and care that:
a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;

5.2. Trust Objectives

To continue the development of our services, providing modern, recovery-focussed services that:

- Are personalised
- Enhance choice
- Change Lives
- Provide a modernised, timely and effective acute care pathway – from CRHT, through Acute and into PICU

Appendix One

The Butler Report (Home Office, Department of Health and Social Security 1975), and its interim version of 1974, advocated the development of forensic psychiatric services in the NHS and suggested a figure of 2000 secure beds. It was proposed that regional secure units (RSUs) would be crucial in supporting the general psychiatric hospital as well as relieving overcrowding in Special Hospitals and providing a service to courts and prisons.

The RSUs were to be 50 - to 150 bedded units closer to major centres of population than the Special Hospitals. The Department of Health and Social Security very quickly made money available for 1000 beds to be provided in RSUs and in Interim Secure Units (ISUs) whilst the former were being built. These ISUs were usually converted psychiatric wards; most had a double door 'airlock' system to enter the unit and secure external exercise areas, as well as unbreakable glass and alarm systems.

Bluglass (1976) proposed that the admission criteria should include any acutely ill patient whose illness was accompanied by difficult and dangerous behaviour but should exclude wandering demented patients, the severely learning disabled and the difficult acute patients.

Thus, historically, the RSU network has been centrally planned and funded whereas locked beds for acutely ill, non-offender patients , PICU have not.

In the UK, PICUs have developed independently of the RSU network, and have provided a range of services in line with local circumstances and needs. This development is wholly appropriate. Units may variably describe themselves as PICUs, extra care wards, intensive care, high dependency, special care, challenging behaviour, locked wards or low secure units. None of these terms initially had a universally agreed definition.

The Glancy report (DHSS, 1974) called for facilities to be set up for psychiatric patients who were violent or unmanageable in open wards. As a result, a number of existing open units upgraded to locked status and some new units were opened. These were called Psychiatric Intensive Care, special care, extra care or high dependency units

(Beer et al., 2001).

The first publications which described locked PICUs came from the USA. Rachlin (1973) stated that 'an open-door policy cannot provide adequately for the treatment needs of all psychiatric patients'. He described the establishment of a 'locked intensive care unit' serving the Bronx area of New York, 'to treat several types of patients who did not respond on open wards'. Half were referred because they were absconders. Crain and Jordan (1979) also reported on a PICU in the Bronx which admitted mainly violent patients, 'who simply cannot be treated with an acceptable level of safety on a regular ward'.

In England the first designated PICU was opened in St James's Hospital, Portsmouth; Mounsey (1979) described the setting up of a twelve-bedded PICU in Salisbury. This was a lockable converted ward for disturbed patients referred from the rest of the psychiatric hospital.

Psychiatric intensive care units (PICUs) have become an integral part of inpatient services. Developments in research and evidence have led to a national recognition of PICU as a standardised service which delivers specific care services defined as follows,

"Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward."

Care and treatment offered must be patient-centred, multidisciplinary, intensive, comprehensive, collaborative and have an immediacy of response to critical situations. Length of stay must be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks.

(NAPICU national minimum standards for general adult services in PICU and low secure environments, DOH , April 2002)

To monitor the development of implementation of the National Minimum Standards, a National PICU Governance Network was created in 2004 as a joint venture of the National Institute of Mental Health in England (NIMHE), North East London Mental Health Trust (NELMHT) and NAPICU (Pereira *et al*. 2006.)

Today, the psychiatric intensive care 'movement' in the UK is much further ahead than in any other country including the US. In no other country are there National Minimum Standards for PICUs (developed by a multidisciplinary team including service users) or a textbook dedicated to psychiatric intensive care.