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1. Introduction

This piece of work was commissioned by the Avon and Wiltshire Mental Health Partnership Trust. The overall aim of the review was to consider the past and present use of adult mental health provision across Wiltshire and Swindon for people whose needs are more complex than can be managed within existing acute inpatient environments. More specifically, the main objectives were to:

- Provide clear and operationally effective definitions of PICU and different types of related bed provision;
- Provide a description of current PICU and related facilities within Wiltshire and Swindon, and an analysis of activity levels;
- Look at the current budgets for the two PICUs within the Wiltshire and Swindon area (Ashdown and Rosewood), and the financial input provided by each of the 4 PCTs and how this relates to their use of these facilities;
- Identify good practice in the provision of PICU and related beds on a local, regional and national basis.

This report sets out the main findings and conclusions of the study. It is divided into the following sections:

- **Section 2**: Overview of PICU and related provision in Wiltshire and Swindon
- **Section 3**: Expenditure on PICU beds and related provision
- **Section 4**: Key issues identified by clinicians and managers
- **Section 5**: Conclusions and recommendations.

The following appendices also support the main body of the report:

- **Appendix I**: Definitions of PICU and related bed provision
- **Appendix II**: Good practice example – Pathways PICU, Essex
2. Overview of current provision

2.1 Introduction

This section of the report provides an overview of the current range of PICU and related provision in Wiltshire and Swindon. Services are provided from three hospital sites – Green Lane Hospital in Devizes, Sandalwood Court in Swindon and Old Manor in Salisbury (soon to be renamed Fountain Way). Services cover acute inpatient beds, psychiatric intensive care, and short term low secure provision. Definitions of the different types of services are provided in Appendix I.

This section includes:

- A summary of the number of beds available in different parts of the system;
- A brief description of the physical facilities within each unit/ward, how it functions, and activity levels in terms of admissions and discharges and lengths of stay for patients.

2.2 Summary of current bed-based service provision

<table>
<thead>
<tr>
<th></th>
<th>Green Lane Hospital</th>
<th>Sandalwood Court</th>
<th>Old Manor Hospital (to be renamed Fountain Way)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute inpatient beds</strong></td>
<td>48 beds (Avebury, Imber and Silbury - see note 1)</td>
<td>36 beds (Redwood and Applewood)</td>
<td>24 beds (Beechleydene)</td>
</tr>
<tr>
<td><strong>Psychiatric intensive care beds</strong></td>
<td>4 (Rosewood) – see note 2</td>
<td></td>
<td>4 (Ashdown) – see note 3</td>
</tr>
<tr>
<td><strong>Short term low secure beds</strong></td>
<td></td>
<td>6 (Rosewood)</td>
<td>2 (Ashdown)</td>
</tr>
<tr>
<td><strong>Seclusion room/extra care area/intensive treatment room</strong></td>
<td>2 seclusion rooms – 1 attached to each adult acute ward (Avebury and Imber)</td>
<td>1 extra care area (Rosewood) 2 observation rooms – (1 on both Redwood and Applewood)</td>
<td>1 de-escalation suite (Ashdown) 1 intensive treatment suite (Beechleydene)</td>
</tr>
</tbody>
</table>

In addition to these beds, there are also 10 step-down rehabilitation beds at Windswept in Swindon and 6 hospital-based rehabilitation beds at Grovely on the Old Manor Hospital site.
Notes

1 Acute wards at Green Lane are being reorganised from late March to separate out older people from younger adults. Beds for younger adults will then be available in Avebury and Imber wards. However, there will be 6 ‘pre-discharge’ beds for younger adults on Silbury (the ward for older people with mental health problems).

2 The original business case for Rosewood did not provide a breakdown of the number of beds anticipated for intensive care use and for low secure use. This figure is based on information obtained during interviews with people working within the locality when Rosewood first opened. Any intended division between the two types of care, has, in practice, proved unworkable.

3 Ashdown also has only a notional division between intensive care and low secure beds.

2.3 PICUs and related services

2.3.1 Rosewood PICU

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
</table>

Rosewood opened in April 2001 on the Sandalwood Court site in Swindon. It was developed as a joint intensive care/short term low secure unit with a proposed maximum length of stay of 6 months. The business case was developed to access national funding for women’s secure services but Wiltshire and Swindon had a need for intensive care beds – hence the ‘hybrid’ model proposed for the PICU. The assumption in the business case was that Rosewood would also serve the Salisbury area, but South Wiltshire decided to provide its own short term low secure accommodation at Bourne Ward on the Old Manor hospital site. Rosewood therefore serves a population of around 490,000 covering West Wiltshire, Kennet and North Wiltshire and Swindon.

Rosewood was originally commissioned and staffed to run as a 12-bedded unit (the costing in the business case was based on 12 beds with 85% occupancy). There are 11 bedrooms and an extra care area (which has a seclusion room). The extra care area is generally only used for patients already in the PICU when there is a need for a low stimulus environment and intensive nursing. One bedroom is smaller than the other rooms and during the time Rosewood has been open, this has not been fully utilised. The reasons put forward for not routinely using the 11th bedroom is that it is too small to practise control and restraint techniques and that staff numbers are sometimes too low to look after 11 patients. At times, Rosewood has therefore effectively been run as a 10-bedded unit.

Of the 11 bedrooms, all but 3 are fully ensuite with a toilet, sink, shower and bath. The remaining 3 rooms that do not have a bath or shower are always occupied by males who share a bathroom. There is no separate communal area for women.

The initial planned division of beds was 6 for patients from the Swindon area and 4 for patients from the West Wiltshire, North Wiltshire and Kennet areas.
(although this division is not fully clarified in the business case). In practice, the extent of bed usage by the two localities (Swindon and Wiltshire) inevitably fluctuates over time.

More recently, 2 low secure beds for women have been commissioned by the West of England Low Secure Services Commissioning Group for use across a wider geographical area. However, it is likely that other localities have had difficulty accessing these beds.

**How Unit functions**

The operational policy for Rosewood stated that it should be a nurse-led Unit, although in practice this has not been the case (although there is a multi-disciplinary assessment process in place). Rosewood was set up as a place of innovative, positive activity. Initially the Unit was able to work in this way with staff skilled in managing patients with a need for psychiatric intensive care joining from the acute wards, and there was also strong occupational therapy input. However, both clinicians and managers consider that it no longer operates in this way. There are many views on why this has occurred, although staff shortages and delayed discharges have clearly not helped.

Although Rosewood was developed as joint intensive care/short term low secure unit, priority has always been given to people who are mentally ill in prison over people who are already in a safe acute hospital environment. An ‘unofficial’ waiting list operates for transfer from the prison service which makes it less likely that patients from acute wards will be admitted. The Unit probably developed in this way due to the interests of the Consultant Forensic Psychiatrist who ran the Unit until January this year. Rosewood has therefore become more of forensic low secure environment than a PICU.

Relationships between staff at Rosewood and acute ward staff both on the Sandalwood Court site and the Green Lane site have often been difficult. The setting up of a specialist unit to deal with the most challenging patients always had the potential to create problematic relationships between acute ward and more specialist staff. There are plans to bring together the management of Rosewood with Redwood and Applewood wards to try and overcome some of these problems on the Sandalwood Court site.

**Activity**

**Referrals to Rosewood**

Between April 2001 and July 2002, 95 people were referred for admission to Rosewood, and 60% were admitted. It is not known how many people were turned away because the Unit was full and how many because they were not appropriately referred. More up to date figures on referrals have not been collected during this review, partly because they would not accurately reflect need for PICU provision – Green Lane acute wards have almost stopped referring due to the extremely low chance of getting a patient admitted.

**Admissions to Rosewood**

Since Rosewood opened in April 2001, data from the Patient Administration System indicates that there have been 130 admissions. Of these, 101 were male (78%) and 29 (22%) were female. Two of the females were admitted
more than once and accounted for 11 of the overall number of female admissions.

Looking at the division of admissions between intensive care and low secure, information on admissions up until May 2003 indicates that 73% of admissions were intensive care and 26% were low secure. However, nearly a third of the intensive care admissions were later re-classified as low secure (due to a risk of abscondion).

**Where patients were admitted from**

<table>
<thead>
<tr>
<th>Source of admission</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redwood/Applewood acute wards</td>
<td>45</td>
</tr>
<tr>
<td>Windswept Rehabilitation Unit</td>
<td>20</td>
</tr>
<tr>
<td>MI/MH Hospital outside Trust</td>
<td>19</td>
</tr>
<tr>
<td>Usual residence</td>
<td>18</td>
</tr>
<tr>
<td>Prison</td>
<td>15</td>
</tr>
<tr>
<td>Police station</td>
<td>8</td>
</tr>
<tr>
<td>Green Lane acute wards</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
</tr>
</tbody>
</table>

This table demonstrates the mixed role that Rosewood has developed with only around half of admissions coming from acute or rehabilitation wards. Admissions from other sources are likely to be related to mentally disordered offenders and the forensic system.

**Length of stay**

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a week</td>
<td>36</td>
</tr>
<tr>
<td>1 – 2 weeks</td>
<td>15</td>
</tr>
<tr>
<td>2 weeks – 1 month</td>
<td>14</td>
</tr>
<tr>
<td>1 – 3 months</td>
<td>33</td>
</tr>
<tr>
<td>3 – 6 months</td>
<td>17</td>
</tr>
<tr>
<td>6 – 12 months</td>
<td>7</td>
</tr>
<tr>
<td>More than a year</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
</tr>
</tbody>
</table>

Half of all patients admitted to Rosewood stayed for less than a month (65). However, the 8 patients who stayed more than a year stayed for an average of 508 days (between 16 and 17 months). Of those who stayed for more than a year, 4 were Swindon residents, 2 were Kennet and North Wiltshire residents and the other 2 were marked as PCT area unknown.

**Patient admissions and occupied bed days by PCT area**

<table>
<thead>
<tr>
<th>Patients’ PCT area</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swindon</td>
<td>93</td>
</tr>
<tr>
<td>Kennet and North Wiltshire</td>
<td>9</td>
</tr>
<tr>
<td>West Wiltshire</td>
<td>3</td>
</tr>
</tbody>
</table>
### Table 1: Patient Admissions and Occupied Bed Days in Rosewood

<table>
<thead>
<tr>
<th>PCT</th>
<th>% of total Occupied Bed Days in Rosewood in 2002-2003</th>
<th>% of total Occupied Bed Days in Rosewood in 2003-2004 (up to Feb)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swindon</td>
<td>69%</td>
<td>64%</td>
</tr>
<tr>
<td>Kennet &amp; N Wiltshire</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>West Wiltshire</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>South Wiltshire</td>
<td>4%</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

The tables above on patient admissions and occupied bed days show that, as predicted in the original business case, Swindon has made substantially more use of Rosewood than the other PCTs. Data for 2001-2002 has too many patients where it is ‘unknown’ which PCT area they come from to include in the table above.
2.3.2 Ashdown PICU (formerly Bourne Ward)

Description

Ashdown PICU is a newly-built unit that provides 6 beds for use by South Wiltshire patients (serving a population of around 110,000). It also has a de-escalation suite with a seclusion room. It is attached to a 24-bedded acute ward (Beechleydene) that has its own extra care area for 1:1 nursing in a safe environment (however, this has not yet been used since Beechleydene opened in early November 2003). Ashdown has single bedrooms and communal space with separate facilities for women, i.e., there is a bedroom which can be used for female patients opposite a female-only lounge. Ashdown has been designed with high ceilings, wide corridors and high levels of natural light in line with research evidence on the best environment for people with acute mental health needs.

The 6 beds currently include patients who have a need for a low secure environment (with a forensic background). There are 3 long term patients at the moment, although one is moving on shortly. From April 2004, Ashdown has earmarked one bed to be used for extra contractual referrals for the purposes of income generation.

How Unit functions

Like Rosewood, the Unit has developed as a ‘hybrid’ service for both psychiatric intensive care and short term low secure provision.

The Unit is nurse-led rather than consultant-led, and nurses make decisions about admission and discharge. Occasionally, patients will come from medium secure, but they usually need longer term low secure provision.

There has recently been problems in finding space for new admissions, although it is usually possible to get a PICU bed for a patient from Beechleydene acute ward. Sometimes a patient from the acute ward is placed in PICU for just a few hours. Whilst being a relatively high user of the OATs budget, South Wiltshire staff consider that they have rarely had to request an out-of-area placement simply to solve PICU capacity problems, i.e., requests are generally only made for very specialist placements. No waiting list is kept for the Unit, although it is sometimes known that a low secure patient is waiting for a place.

There have been some recruitment problems in the past 12 months. A year ago, no agency staff were used, but they have to be called in now. However, the amount spent on agency nurses is still very low compared with other units.

Activity

Referrals to Ashdown

Full records of all referrals to Ashdown (formerly Bourne Ward) are not kept, although it is known that during 2002/03 only 1 male was turned down for a PICU bed because the Unit was full. During 2003/04 (to date) 1 female
and 5 males have been turned down for a PICU bed due to capacity problems.

Admissions to Ashdown

Since early 2002, there have been 110 admissions to the South Wiltshire PICU (this figures includes Hampshire patients who used to have 4 beds in the old 10-bedded Bourne Ward). Of these 110 admissions, 71 people were from Wiltshire – 47 (66%) were male and 24 (34%) were female.

It is not known how many of these admissions were for intensive care and how many due to a need for a low secure environment.

Where patients were admitted from

<table>
<thead>
<tr>
<th>Source of admission</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute wards</td>
<td>40</td>
</tr>
<tr>
<td>Private Unit</td>
<td>10</td>
</tr>
<tr>
<td>Usual residence</td>
<td>8</td>
</tr>
<tr>
<td>Police station</td>
<td>5</td>
</tr>
<tr>
<td>Residential/Home/Rehabilitation Unit</td>
<td>7</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>

Two-thirds of Ashdown’s patients were admitted from an acute ward or a residential home or rehabilitation unit.

Length of stay

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a week</td>
<td>15</td>
</tr>
<tr>
<td>1 – 2 weeks</td>
<td>21</td>
</tr>
<tr>
<td>2 weeks - 1 month</td>
<td>11</td>
</tr>
<tr>
<td>1 – 3 months</td>
<td>15</td>
</tr>
<tr>
<td>3 – 6 months</td>
<td>6</td>
</tr>
<tr>
<td>6 – 12 months</td>
<td>1</td>
</tr>
<tr>
<td>More than a year</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>

Around two-thirds of patients stay in Ashdown for a month or less and 87% stay for less than three months. Ashdown operates largely as an intensive care environment rather than a low secure environment for patients with less acute needs.
### 2.3.3 Green Lane acute wards (Avebury and Imber)

#### Description

From late March, there will be 2 adult acute wards at Green Lane with a seclusion room attached to each ward. All patients have their own rooms with ensuite toilets and sinks, and there are communal bathrooms. There are also communal recreation areas. Plans are in place to provide a female only lounge by blocking off a bay.

Seclusion is used mainly when a person is aggressive or violent. However, the environment on the ward is not right for managing violent patients in terms of available space, and not all staff are trained in managing aggression. On any shift, there is a need for three staff trained in control and restraint methods across the three wards (currently adult patients are also on Silbury ward).

#### How wards function

Until recently, Green Lane acute wards have had a lower staffing level than other acute wards, but have still managed to contain some very volatile patients without effective access to Rosewood PICU. Some staff have moved from the Rehabilitation Unit at Green Lane in the last year due to its closure, and this has reduced staffing vacancies, although this has not necessarily given the wards any additional skills in managing volatile patients.

Due to low staffing levels, Green Lane acute wards have had a history of underspending on the staffing budget. However, this year there will be an overspend due to higher use of agency staff. There is pressure not to use agency staff, but this is sometimes unavoidable. If additional staff are needed because a place is unavailable in Rosewood, then the acute wards have to pay for this. The Modern Matron at Green Lane has been unable to admit a patient to Rosewood since April 2003. A couple of patients have been admitted to Brockley House PICU in the Avon area of the Trust.

#### Activity

**Admissions**

The acute wards at Green Lane are generally full. On occasion, the seclusion rooms have been used as overflow bedrooms. The Crisis and Home Support Team, which has been operating for 3 months, has not yet made any significant impact on the number of admissions to acute care.

**Use of seclusion**

Between April 2003 and January 2004, the two seclusion rooms on the acute wards have been used on 27 occasions. The length of time patients have been secluded for varies from just over an hour to 12 days. Seclusion has been used for more than 24 hours at a time on nine occasions. It is likely that some of these patients would have been referred to a PICU if Green Lane had effective access to one.
When a patient is in seclusion, this requires the attentions of an RMN throughout each 24 hour period. There is also often the need for agency or bank cover as acute ward staff levels are generally at a minimum level and unable to provide cover for the use of seclusion (or where 1 – 1 nursing is required on the ward sometimes following a period in seclusion). It is estimated that Green Lane has needed 330 shifts of agency or bank cover between April 2003 and January 2004 to cope with aggressive and violent patients. Green Lane has spent £190,000 on agency nurses this financial year to date. This figure has increased from £162,888 in 2002/2003 and £26,291 in 2001/2002. Clearly, agency nurses are called on for a variety of reasons including staff sickness, but bringing in agency staff is also sometimes the only way of ensuring a volatile patient can be managed on the ward.
2.3.4 Redwood/Applewood acute wards

Description

There are 36 beds on Redwood and Applewood wards including two double rooms on each ward. All bedrooms have toilets and washbasins. Baths/showers have to be taken in communal bathrooms.

There is an ‘observation’ room attached to each acute ward that can be used to manage very acutely ill patients for a short period of time (up to 72 hours). These are slightly bigger than the other bedrooms with vinyl floors and ensuite showers. Each of the observation rooms has a window through which patients can be observed from the nurses’ station. These rooms are off the main thoroughfare of the ward and can be used when a patient needs a low stimulus environment and a high level of observation. However, they are not currently suitable for longer term use because they would need a separate living area.

How wards function

The staff on Redwood and Applewood wards do manage some quite volatile patients. If someone is known to the staff, then they will try particular medication or other techniques to calm a patient within 72 hours. All staff are trained in control and restraint methods. However, whilst it is possible to manage one aggressive person on each acute ward, it is not possible to manage several at the same time. When there are volatile or aggressive patients on the wards, the Modern Matron and Ward Manager have to be ‘creative’ and move staff around to change the ratios of qualified and unqualified staff in each area of the ward.

Activity

Admissions

Until the Crisis and Home Support Team was set up at the end of November, the two adult acute wards were often operating at 100% occupancy. However, since the CHST started work there has consistently been 6 or 7 empty beds across Redwood and Applewood.

Use of PICU beds

Between April 2001 and January 2004, Redwood and Applewood made 64 referrals to Rosewood of which 33 were admitted and 31 were turned down. Most of the referrals were turned down because they were considered to be inappropriate although 4 were turned down because there were no beds available.

Over the last few months since April 2003 as it become more difficult to access a PICU bed in Rosewood, there have been 10 placements made of people from Redwood and Applewood acute wards in private PICUs outside the locality. The basic cost for these placements is about £3,500 per week, plus potential additional nursing costs and the quality of care is very variable.
In addition, during this financial year, there have been two forensic patients where it has proved necessary to bring in agency nursing staff due to Rosewood being full. It is possible for agency nursing to cost up to £50,000 for one patient if ‘specialling’ is required for up to a month. As at Green Lane Hospital, expenditure on agency nurses for Redwood and Applewood wards has increased substantially over the last couple of years – from around £48,500 in 2001/02 to £221,500 in 2002/03 and £154,000 this financial year to date.
3. Expenditure on PICU beds and related provision

This section of the report provides:
- A summary of the costs of running the two PICUs within Wiltshire and Swindon;
- The division of funding for Rosewood PICU by PCT;
- An overview of expenditure from the out of area treatment budgets that are used to purchase specialist care that cannot be provided within the locality.

3.1 Costs of running Rosewood and Ashdown PICUs

<table>
<thead>
<tr>
<th>Rosewood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosewood PICU was set up from April 2001 with funding of £892,000. Of this, £787,000 was provided by Wiltshire Health Authority and AWP found £105,000 internally.</td>
</tr>
<tr>
<td>In 2002/03, Rosewood’s first year of being fully operational, the Unit overspent its budget by around £200,000, largely due to the use of agency nurses (£393,000). However, the projected outturn for this financial year is an underspend of around £100,000. It is not clear why there is substantially lower use of agency nurses this financial year, although it is possible that this reflects greater use of beds for low secure rather than intensive care patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ashdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashdown’s budget for this financial year is £404,805. As in the two previous financial years, this budget is projected to be slightly overspent. The use of bank and agency nurses at Ashdown has always been relatively low (around £50,000 this financial year to date, up from £14,500 last financial year).</td>
</tr>
</tbody>
</table>

3.2 Funding of Rosewood PICU by the PCTs

When Health Authorities ceased to exist, the mental health funding for AWP was split on a weighted capitation basis between the Primary Care Trusts, unless a service was earmarked to a particular PCT. It is assumed that the PICU funding for Rosewood was not earmarked and therefore funding is split according to the Department of Health’s weighted capitation formula (Swindon 32.3%, South Wiltshire 23.2%, West Wiltshire 16.2% and Kennet and North Wiltshire 28.3%).
3.3 Expenditure on out of area placements

**Swindon**

Swindon’s budget for out of area placements during 2003/04 is £760,329. There is a projected overspend of around £0.5M on this budget. Although the budget is for a range of specialist placements, much of the projected overspend is related to an increase in private PICU placements due to Rosewood being full. Between April 2003 and the end of February 2004, 10 patients were placed in private PICUs outside the locality for periods ranging from a month to 6 months. It is estimated that these 10 placements have cost around £300,000.

There are currently 6 patients in low/medium secure or PICU placements paid for from Swindon OATS budget at a cost of between £1,200 and over £4,000 per week each. All are male and 5 have been admitted to their current placement from either Rosewood or from prison. Three of the patients would be suitable for long term low secure provision in Wiltshire now if it were available, and the remaining 3 could require this type of facility in the future (following a period in medium secure provision).

**Wiltshire**

The Wiltshire pooled budget for out of area placements is £1.056M for this financial year. However, the projected spend for 2003/04 is £2.38M.

Wiltshire is currently paying for 15 PICU, long term low secure and medium secure placements. The 4 PICU placements are all for patients from the Kennet and North Wiltshire and West Wiltshire PCT areas (although South Wiltshire has also used PICU placements at times during this financial year). The cost of the PICU placements used over the last few months varies from £3,000 to £5,000 per week. This compares with an estimated cost of around £1,300 per week at Ashdown and around £1,700 per week at Rosewood (based on use of 10 beds).

There are 8 people currently in or requiring long term low secure placements, including 2 women. Two of these patients are from Kennet and North Wiltshire, 2 are from West Wiltshire, 3 are from South Wiltshire and 1 is from Swindon. The average cost of each long term low secure placement is around £3,000 per week or £156,000 per year.
4. Key issues identified during the review

During the course of this review, over 30 people have been interviewed including key clinicians, Modern Matrons, managers within AWP and commissioners from the PCTs. This section of the report summarises the key issues raised during the review under the following headings:

- Development and use of the two PICUs;
- Role of acute wards;
- Care planning and care pathways.

4.1 Development and use of the two PICUs

- Both PICUs in Wiltshire and Swindon have developed to provide a ‘hybrid’ service providing psychiatric intensive care and short term low secure services. There are some differences of opinion on whether this ‘hybrid’ model can work. However, even amongst those who support this approach, it is considered that it can only work when there is available alternative provision for people who need a longer term low secure placement. If this is not available, beds quickly become blocked with longer term patients, and PICUs are no longer able to provide the intensive care part of their service. With a hybrid model, it is all too easy for the PICU to become a catch-all for everybody with complex needs.

- When people with long term rehabilitation needs are placed with people who are acutely unwell, the only common need is for containment. The skills required to support patients needing short term intensive care and those needing a greater focus on rehabilitation are very different. PICU staffing levels are high to enable Units to cope with intensive care patients (who may need 2 to 1 nursing). However, patients who simply have a need for a secure environment require less nursing input, but more OT and other therapeutic input.

- Rosewood PICU, until recently under the control of a Consultant Forensic Psychiatrist, has had a focus on mentally disordered offenders and there have been some difficulties in bringing together in one Unit both general and forensic psychiatry patients. There are some managers who consider this is inappropriate.

- Both PICUs admit both female and male patients. Whilst Ashdown has a separate communal lounge for females opposite a designated female bedroom, Rosewood has no separate communal areas. Whilst Rosewood staff make considerable efforts to ensure the safety of female patients, the physical environment is far from ideal for looking after a mixed gender group of patients.
• Ashdown PICU only serves South Wiltshire residents, whilst Rosewood PICU in Swindon is a shared resource for West Wiltshire, Kennet and North Wiltshire, and Swindon residents. These specialist resources appear to be viewed as ‘belonging’ to the PCT in which they are based. In the case of Rosewood, this means that the Unit is often viewed as being largely for Swindon residents rather than for Wiltshire residents. This is exacerbated by the fact that Rosewood shares the same hospital site as Redwood and Applewood acute wards whereas the Green Lane acute hospital wards are some distance away.

• Amongst both commissioners and provider managers and staff, there is a strong perception that residents from Wiltshire use more than their share of the beds at Rosewood. However, the activity data included earlier in this report demonstrates that this is not the case. There have been occasions when the Consultant Forensic Psychiatrist previously in charge of Rosewood has admitted Wiltshire residents to Rosewood straight from prison without immediately informing the relevant general psychiatry consultant. It has then often proved difficult to find appropriate placements for these patients to move on to.

• Some of the concern over whether Swindon and Wiltshire residents receive an appropriate share of the beds at Rosewood relates to rising expenditure on Out of Area Treatment budgets. If a place is unavailable at Rosewood, this may mean Swindon or Wiltshire paying for a placement in the private sector at great cost. As outlined in the previous section, the Out of Area Treatment budgets for both Swindon and Wiltshire are projected to be substantially overspent this financial year.

• Both PICUs have had problems with patients becoming ‘stuck’ on the Unit, partly due to the difficulty in finding placements and getting funding agreement. A number of people who are labelled ‘delayed discharges’ from the two PICUs require a long term low secure placement which is generally only available in the private sector at a high cost.

• The recent audit of PICU and related services undertaken by the Extra Care Facilities Audit Group in July 2003 highlighted the relatively low number of staff at Rosewood who are trained in de-escalation, breakaway and control and restraint techniques (30%). This does not appear to be a problem for Ashdown.

4.2 Role of acute wards

• There is general agreement that staff on acute wards have become less confident at managing difficult patients since the two PICUs were set up. Some of this is a training issue and the need for acquiring skills in techniques to manage aggression, in addition to physical management through control and restraint. There also needs to be confident medication management on acute wards and it has been suggested that there are some inconsistencies in
prescribing. Greater cross-fertilisation between staff on acute wards and the PICUs could help ensure that skills in managing aggressive patients are not lost on the acute ward.

- Whilst Modern Matrons consider that acute ward staff lack the resources and training to manage aggressive patients, ways often have to be found to maintain a person on the acute ward because PICU beds are not available. This is particularly the case at Green Lane which has not had access to an intensive care bed at Rosewood for some months. Units in other parts of AWP can sometimes help out, eg, Brockley PICU in Bristol.

- Many managers consider that psychiatric intensive care should be provided on the same site as acute care to allow easy movement of patients between the two types of care. There is no doubt that Green Lane acute wards have ‘lost out’ in accessing intensive care beds at Rosewood partly due to the distance between Devizes and Swindon. The operational policy at Rosewood states that patients in acute wards on the Sandalwood Court site will be assessed within two hours of a referral, whilst patients from the rest of Wiltshire could wait up to 2 days. This difference in responding to referrals is due to the time required for Rosewood staff to travel to assess patients.

- When a bed is unavailable at Rosewood, acute wards sometimes need to bring in agency nurses to help manage a patient requiring 2:1 or even 3:1 care. The use of agency nurses is not only very expensive, but also creates difficulties with other staff on the ward who are paid a much lower hourly rate. Although there is a move towards greater use of bank staff, they cannot always meet the requirement for immediate assistance and may not yet be trained in control and restraint methods.

- There are a number of people on acute wards who are waiting for another placement and are therefore counted as delayed discharges. It is very difficult to manage volatile patients alongside people who no longer need acute care.

- The number of admissions to acute wards should be reducing now that the Crisis and Home Support Teams are up and running based in Swindon and Devizes. In reality, the CHSTs are operating different models. The Swindon team have reduced admissions quite dramatically. The Green Lane Crisis Team has not yet made an impact on admissions to acute beds. This may be because it is under-resourced and yet trying to carry out a number of different roles – gatekeep acute beds, assessment, home support and screen patients for early discharge. Whilst the Crisis and Home Support Teams have the potential to reduce the number of acute beds needed in Wiltshire and Swindon, it is likely that those patients who are admitted will require more intensive support from acute ward staff.
4.3 Care planning and care pathways

- Once a patient is admitted to a PICU, it is often very difficult to work out who is responsible for ensuring that patients stay for the shortest time possible. This is particularly true for the low secure patients who are less likely to return to an acute ward even if they were admitted from there.

- Where a person is admitted from the community to an acute ward and then into a PICU, in theory the Care Co-ordinator from the Community Mental Health Team should ‘follow’ the patient and be involved in planning for discharge as early as possible. However, this does not appear to happen.

- Rosewood PICU sometimes admits people from Ravenswood or prison and then there may not be an identified Care Co-ordinator or a Responsible Medical Officer. If an RMO and Care Co-ordinator are not identified quickly, then this can delay discharge. Some delays are also due to the complex process required for gaining Home Office permission for a change in placement when patients have a Home Office restriction under Section 37(41).

- A key factor in establishing effective care planning is partnership working and communication between different parts of the mental health system. This has not worked particularly well around the PICU at Rosewood and there have been a number of concerns including the fact that discharge planning does not involve key people early enough and that Care Co-ordinators are often not given much notice of CPA meetings.

- There is no clear care pathway for low secure patients coming out of Rosewood and Ashdown PICUs. Whilst the intensive care patients will usually go back to acute wards, low secure patients often need some longer term rehabilitation (whether this is in an open or a low secure environment). The only resources currently available within the NHS for open rehabilitation are either at Grovely in Salisbury (6 beds) or Windswept in Swindon (10 beds). However, there is some debate about whether Windswept can be accessed by Wiltshire patients. There is no long term low secure accommodation in the area and the most easily accessible provision is run by the private sector outside the locality and is very expensive.

- The lack of a care pathway for low secure patients is partly caused by lack of provision for longer term low secure accommodation. However, if a decision is taken to provide this within the locality, then step-down accommodation is needed to ensure that this facility does not become ‘blocked’. In Avon which has a longer term low secure facility (2 – 5 years), it is estimated that 80% of patients will need some further rehabilitation in an open setting while up to 20% of patients will continue to require some level of security.
5. Conclusions and recommendations

This final section of the report summarises the main conclusions and recommendations to arise from this review. These are brought together under the following headings:

- Overall conclusions;
- Changes to existing provision;
- Processes and systems.

5.1 Overall conclusions

Despite the fact that Wiltshire and Swindon have increased capacity for psychiatric intensive care and low secure provision over the last three years, these services are now often blocked and there is also increasing expenditure on psychiatric intensive care and low secure provision in the private sector outside the locality. In addition, there is extensive use of agency and bank nurses on acute wards, some of which is related to a lack of access to intensive care provision.

There is an over-riding sense of the different parts of the ‘system’ working in isolation rather than in partnership to ensure that patients are appropriately placed and are able to move on as quickly as possible.

A further problem has been the tendency to view individual services as belonging to the PCT area in which they happen to be based, rather than viewing these very specialised services as being available across the whole locality.

The recommendations below for changes to existing intensive care and low secure provision need to be underpinned by better care co-ordination for individual service users and the establishment of clearer care pathways through the ‘system’. There also needs to be agreement on the use of resources for the whole of Wiltshire and Swindon, rather than trying to develop separate services around each hospital base. This means a pooling of resources and risk and an acceptance that each PCT’s use of these very specialised services will fluctuate over time.

It should be stated that the recommendations put forward are ideas for discussion with key managers and clinicians. This is an area in which there are no right or wrong answers. Discussion with managers from the Avon and Gloucester areas and the PICU run in Essex by a leading expert in the field (see Appendix II) has highlighted the fact that there are many models for PICU and low secure services, and that different models can be effective. The size, role and effectiveness of any PICU will partly depend on the related services around it. Once the range of services needed is agreed, it will be necessary to develop shared definitions across Wiltshire and Swindon as there are few nationally agreed definitions of PICU and related beds.
5.2 Changes to existing provision

5.2.1 Acute wards

This review has involved discussions with staff involved in the management of acute wards at the three hospital sites – Green Lane, Sandalwood Court and Old Manor. Many managers are concerned about the potential loss of confidence and skills amongst acute ward staff to manage volatile patients now that separate PICUs exist.

Recommendations:

- Consider setting up locked Units attached to the acute wards (along the lines of the HDUs that operate in Avon). These should be separated from the open ward since they are locked units. The locked units would take many patients who would previously have gone straight into a separate specialist PICU.

- Each locked unit is likely to need 3 – 4 bedrooms (based on ratios operating in Avon).

- Each locked unit should have a minimally furnished observation room where extremely disturbed patients can be looked after separately if need be.

- Some re-organisation of acute wards may be needed alongside the setting up of locked units so that they are on a separate ward from patients who are stable and nearly ready for discharge.

- There could be one staff group for the acute wards and the locked unit, with staff working on a rotation system in the locked unit to ensure that all staff maintain skills in managing volatile patients. Additional training is likely to be needed for this model of staffing.

Rationale behind recommendations:

- The work of the Crisis and Home Support Teams should reduce the number of admissions to acute wards with a subsequent requirement for a smaller number of beds and slightly higher staff to patient ratios. (although increased funding may be required for CHSTs to enable them to reduce admissions by 30% - as has happened in other parts of the country).

- Each of the acute wards already has some facility for observation, intensive treatment or seclusion but these facilities are not physically appropriate for looking after acutely disturbed patients for more than a few hours. Creating separate locked units alongside acute wards would allow staff to try different strategies for calming patients over a period of a few days/weeks.

- Locked units attached to open acute wards give people an opportunity to stabilise without the need to move to a separate PICU facility. In Avon, the HDUs take patients either from the acute ward or directly from the community for up to a month.
The development of locked wards attached to acute wards would leave PICU beds for those patients who simply cannot be managed on an acute ward, i.e., a range of strategies have already been tried (with the support and advice of PICU staff, if necessary) and it is clear that more specialist care is needed over a longer period of time than a couple of weeks.

A smaller number of PICU beds should be needed because patients would no longer be coming in for just a couple of days to be stabilised (sometimes through changes to medication or because they have been abusing drugs or alcohol). Looking at the figures on length of stay at Rosewood and Ashdown, this could reduce admissions to a specialist PICU by up to half (those who stayed less than two weeks).

### 5.2.2 Psychiatric intensive care and low secure services

The two PICUs at Ashdown in Salisbury and Rosewood in Swindon have both developed as ‘hybrid’ services to deal with both intensive care and short term low secure patients. In practice, Ashdown is more orientated towards intensive care to support acute beds and Rosewood gives priority to forensic patients requiring a low secure environment.

**Recommendations**

- Ashdown PICU could continue to provide intensive care services, but for the whole of Wiltshire and Swindon. Patients should be admitted for a maximum of 6 months. Managers may even wish to develop Ashdown as a service for female patients now that Avon’s application for funding for a female PICU has been unsuccessful (on the grounds that beds could be sold to other areas if there was not enough demand from Wiltshire and Swindon). If Ashdown remained a mixed gender PICU, then the ratio of 6 PICU beds to around 100 acute beds (across the whole locality) is about the same as for Pathways PICU in Essex, but less than in Bristol which is likely to have a higher concentration of problems due to being an urban area.

- Rosewood PICU could focus on providing an intensive care/short term low secure forensic service for males (up to a year). However, the model of care should be re-focused towards rehabilitation rather than security and containment. The admission criteria need to be changed to ensure that people who clearly need a longer term low secure placement are not admitted (Rosewood currently takes such people in the absence of any alternative NHS facility). Rosewood would still need strong links to general psychiatric services to offer advice and support in the management of violent patients.

- The two 6-bedded wards at the Grovely Unit should be considered for providing long term low secure care (2 – 5 years). This could be run on a similar basis to Wickham House in Bristol or the Montpelier Unit in Gloucester with a strong rehabilitation focus. The space at Grovely is well-suited for this type of care with a reasonable amount of therapy space, a big sitting room, a separate smoking room, and a kitchen leading into the dining room which would be appropriate for service users to self-cater (with support).
The consultant in charge of a local long term low secure service should assess all referrals for this type of provision and provide advice on purchasing places using the OATS budgets if necessary.

In the future, there may be the potential to develop a further longer term low secure unit at Green Lane as 12 beds at Grovely is unlikely to be enough for Wiltshire and Swindon in the medium – longer term.

Wiltshire and Swindon should link with Avon to develop or jointly commission longer term low secure services for the very small number of female patients likely to require this. In the short term, this is likely to be through a preferred provider arrangement with a private unit.

**Rationale behind recommendations:**

- There is clearly an issue about the location of Ashdown PICU for serving Wiltshire and Swindon, but this is balanced by the fact that it is a newly-built unit which meets all the physical standards for a PICU and the staff are well-trained to provide this service.

- It makes sense to separate out services for male and female patients as far as possible within the limited resources available for PICU/low secure services. Female patients are more likely to be suffering from a borderline personality disorder and to exhibit self-harming behaviour. The physical environment at Rosewood is unsuitable for looking after a mixed-gender group of patients with no separate female communal area. It does not meet the standards laid down in the National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units and Low Secure Environments.

- One of the most pressing needs is for long term low secure provision within the Wiltshire and Swindon locality. People often stay far too long in both Rosewood and Ashdown because there is no local provision of this type. There are currently at least 8 – 10 males in out of area placements and 2 – 3 people on acute wards who need longer term rehabilitation in a low secure environment.

- The capital work required to create a secure unit would be minimal if all 12 beds could be used for long term low secure (this would, of course, mean finding alternative open rehabilitation places for the people currently using one-half of Grovely). Discussions with staff about the Grovely rehabilitation service suggest that it is a good active rehabilitation service, but that it may not be necessary to provide this from a hospital site. The closure of the rehabilitation houses at the Green Lane Hospital site demonstrates that it is possible to find alternative community placements for people needing this type of resource.

- The opening of 12 long term low secure beds should, at least in the short term, dramatically reduce expenditure from out of area treatment budgets. If 10 patients came back into the locality from long term low secure placements, this would save about £1.3 Million from the OATs budgets (based on an average cost of £2,500 per week per placement).

- Having an in-house long term low secure resource could potentially provide a better quality of care for patients thereby speeding recovery.
and reducing length of stay. Placements purchased through the OATs budgets are of variable quality, and in some cases they provide little more than ‘warehousing’. It is also very difficult to move people back quickly from other parts of the country due to the lack of established processes for regular reviews and the time required to travel to check progress.

- If further long term low secure provision is opened on the Green Lane Hospital site, it would be possible to sell beds to other localities (such as Avon or Gloucestershire) if they were not all in use for Wiltshire and Swindon residents.

- The advantage of developing a joint preferred provider arrangement with Avon is that closer links with a private unit helps to ensure greater quality of care. If the preferred provider is relatively close geographically, then a Consultant can visit and review more frequently to try and get the patient back into the area as quickly as possible.

## 5.3 Step-down facilities

Whether longer term low secure care is provided in the locality or whether it is purchased from Units in other areas, there is still the need for step-down facilities for many of these patients.

**Recommendations:**

- Windswept should be considered as a resource for the whole locality, rather than just for Swindon residents.

- The need for a further open rehabilitation facility located in Wiltshire should be considered. This could re-house the people currently in open rehabilitation at Grovely and also provide additional places for step-down from long term low secure provision.

**Rationale behind recommendations:**

- Windswept currently provides a pathway out of Rosewood. If only Swindon residents are admitted to windswept, then this may cause Kennet and North Wiltshire and West Wiltshire patients to ‘block’ beds at Rosewood.

- Although an open rehabilitation facility is likely to cost around £600 per week per place, the availability of open rehabilitation is likely to reduce lengths of stay in more expensive long term low secure provision.

## 5.4 Processes and systems

Whatever the future configuration of resources across Wiltshire and Swindon for PICU and low secure services, there are a number of processes and systems that will need to be put in place to ensure that they work effectively. These include:

- **Clearer admissions policies.** The purpose of each Unit needs to be fully defined and clear admission guidelines developed. Several leading experts in this field who run PICUs believe this is a vital component of
an effective PICU - clear admission criteria ensure that it does not become a resource for all challenging patients.

- **Partnership working between PICUs and acute wards.** Consultants and managers within effective PICUs work very closely with managers and clinicians from acute wards. This needs to follow through from the referral process, to admission and planning for discharge. Once a patient is admitted, PICU staff should be in frequent contact with acute ward staff, for example, through inviting them to ward rounds or sending weekly written reports.

- **A rehabilitation focus in all Units.** Although it is clearly important for all patients and staff to be safe within PICU and low secure environments, over-emphasis on physical containment and security does not make an effective service. Even when patients are only likely to be looked after for a matter of weeks, therapeutic activities should be provided as a way of engaging patients. The literature on PICUs suggests that activities can not only enhance an individual’s development, but also assist in the management of problematic behaviour and the maintenance of a safe environment.

- **A stronger focus on discharge planning.** The principle that should be applied in all services for acutely mentally ill people is that patients should be cared for in the least restrictive environment possible for the shortest length of time possible. This means that all Units need to focus on discharge planning as soon as a patient is nearly stabilised or assessed. This can only be done through close contact with acute ward staff and Care Co-ordinators from the Community Mental Health Teams. A number of reasons have been put forward during this review as to why discharge from low secure provision can take a long time, including the difficulty in establishing a Responsible Medical Officer for people without a GP in Wiltshire. It should be relatively easy to set up a rotation system amongst Consultant Psychiatrists so that a Responsible Medical Officer for people from the forensic system can be quickly identified.
6. Appendices

6.1 Definitions

Acute beds

The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It is for patients whose care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting. Lengths of stay should therefore be under six months, although problems with discharge may mean that this is not achieved in practice.

Reference

- Adult Mental Health Service Mapping Website (supported by the Department of Health)

Psychiatric intensive care units (PICU)

PICUs are highly structured locked units for patients who are compulsorily detained and who are in acutely disturbed phase of a serious mental disorder. They usually have between 6 and 15 beds. Every acute inpatient facility should have access to an identified PICU in their area. Patients who cannot be safely managed and successfully engaged on open acute wards on account of their behavioural disturbance (resulting from mental illness) should be considered for referral to PICUs. This should be done after all possible strategies to effect positive change to such disturbances have been tried on open acute wards.

Due to the high levels of disturbance on PICUs, it is essential that patients remain on these units for the shortest time necessary, usually no more than eight weeks in duration. Following this intensive care, it is expected that patients will return back to a less intensive environment as appropriate to their needs, typically open acute wards. Admission and discharge criteria should be well defined to prevent inappropriate admission, long lengths of stay for patients and delayed discharges. As part of a core service, PICUs should have a specifically allocated and skilled multidisciplinary team.

References

- Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision
- **Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICUs) and Low Secure Environments**

**HDU beds**

In some areas, longer term low secure units (for slow stream rehabilitation) are referred to as high dependency units. Wards may be locked all the time or be lockable, but will have higher staff/patients ratios than an ordinary open ward. Length of stay will usually be **in excess of 6 months and often years**.

**Reference**

- Adult Mental Health Service Mapping website (supported by the Department of Health)

**Low secure beds**

Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. Units should be run in accordance with an agreed philosophy of operation underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely secure environment that has occupational and recreational opportunities and links with community facilities.

Patients will be detained under the mental health act and may be restricted on legal grounds, needing rehabilitation usually for up to 2 years.

**Reference**

- Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric intensive Care Units (PICU) and Low Secure Environments

**Longer term secure care**

This refers to both medium or low secure provision and is for patients who require longer periods of inpatient care, ie, usually more than 2 – 3 years.

**Reference**


**Low secure forensic care**
This refers to care delivered by a forensic team and is distinct from similar services provided by general mental health services. A person who is admitted to these settings usually presents with behaviour at a level of risk greater than general mental health services could safely address. Staff working in this setting must have experience in the provision of forensic mental health services and the provision of secure care. Forensic low secure inpatient services are a critical part of the spectrum of forensic services and without them transfers from high and medium secure units would be adversely affected. These services are fundamentally different from intensive care services provided in general mental health hospitals.

Reference


Forensic provision

The services provided within this spectrum include high secure inpatient care, medium and low secure forensic inpatient care, including longer stay secure inpatient care, provided by a forensic team. The spectrum also includes community and outpatient forensic services, and prison, court and police diversion schemes, and also in-reach services provided to prisons, young offender institutions, local authority managed secure units and bail and probation hostels. All adults in receipt of specialised forensic mental health services will have a mental disorder, and possibly a personality disorder or learning disability. Some will have committed criminal acts and others will pose a significant danger to themselves or to other people.
6.2 Good practice example – Pathways PICU, Essex

Description

Pathways is a 14-bedded PICU serving the London Boroughs of Waltham Forest and Redbridge. It admits acutely unwell patients from acute wards within the two boroughs (serving around 200 beds) and people through the prison and court liaison services. It has been open for about five years.

Activity

- Over 600 referrals in the five years the Unit has been open. However, the Unit has never been completely full and unable to take appropriate referrals.

- The number of patients admitted through the prison/court services is small – these patients have never occupied more than three beds at any one time. Some referrals through this route are turned down because it is clear that people do not need a short term placement due to being acutely unwell.

- Patients are admitted for as short a time as possible – generally a maximum of 4 – 6 weeks. Less than 20% of patients stay longer than this. Only one person has ever stayed longer than a year and this was due to a delay in finding a long term low secure placement.

- Only 1 – 2 patients a month need to be controlled and restrained. There is an observation room which is used very infrequently. There is no use of seclusion and the door is never locked.

What makes it work?

- Good, supportive relationships with acute ward staff – understanding that anxiety levels amongst staff can be very high when dealing with volatile and potentially aggressive patients.

- A strong consultant who can resist pressure from acute ward consultant psychiatrists to admit patients who may not be appropriate for the PICU whilst still maintaining a partnership approach to working.

- Very clear admission criteria, ie, PICU is only for patients who are compulsorily detained and where other strategies for stabilisation have not worked. Except in emergencies, acute ward staff need to complete a written referral that outlines the strategies they have already used to stabilise a patient.

- Continuous involvement of acute ward staff with patients admitted, for example, staff are invited to PICU ward rounds and are sent reports every week following the ward round.

- An emphasis on developing a very structured environment that suits patients who are acutely unwell. For example, bedrooms are closed.
for most of the day while patients are expected to attend groups within communal areas.

- A focus on positive activities such as reflexology, yoga and music and art therapy to engage patients rather than a focus on security and containment.

- A separate forensic service that deals with people where it is known that a longer term placement is likely to be needed.