

Editorial

Clusters, garlands or bouquets?

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It has been almost a decade since the first publication of this journal and a lot has happened within psychiatric intensive care and low secure services since then. I have been privileged to be a member of NAPICU, working alongside talented individuals and, as a member of the editorial team, watching this journal grow from the inside. I have found many of the published papers to be deeply thought provoking, providing evidence within what was a poorly evidenced based speciality and challenging me to think differently about psychiatric intensive care. Much of my thinking and opinion in this area has been fostered by involvement with patients, carers, colleagues and NAPICU executive members, alongside some challenging papers written within this journal. For me, some of the most memorable where Roland Dix's series of editorials addressing the meaning of the term Psychiatric Intensive Care and what occurs within these services, what could be done better and what the future may bring (Dix, 2007a; Dix, 2007b). Also, more recently, Len Bowers's editorial and accompanying paper (Bowers, 2012; Bowers et al. 2012) that was, I think, designed to challenge the belief that PICUs do provide benefit! Throughout the journal's history, many papers seemed to be stating that 'much has been achieved' but 'there is lots more to do'.

So, what has changed since Dix posed the question: 'Psychiatric intensive care – what's in a



name?? He transcribed what many within NAPICU had been opining for some time: that the term means more than describing treatment provided within a specific type of ward; it extends to a set of interventions and care protocols, which can be performed within a variety of settings. This seemed somewhat at odds with the financial provision from the UK government to improve PICU environments, the place within which such specialised care was to be delivered. At first glance it also seems at odds with NAPICU's response to the Department of Health consultation upon the future for Low Secure and Psychiatric Intensive Care commissioning (Department of Health, 2012; NAPICU, 2012). In response to the question 'What is your view on the principle that Psychiatric Intensive Care is a model of treatment that can be provided in general adult services, in Low, Medium and High Secure

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Inpatient Services?’ posed by the Department of Health (2012), we argued that ‘The evidence supports the theory that Psychiatric Intensive Care should be provided within a designated Psychiatric Intensive Care Unit’ (NAPICU, 2012). This function, we stated, could be performed within different levels of security (high, medium or low) but we were careful to point out that the term ‘psychiatric intensive care’ should not be confused with PICU, given that the latter also incorporates specific infrastructure, resources and a range of clinical interventions. Extending our argument, given appropriate infrastructure and resources, and maybe a mindset shift, perhaps psychiatric intensive care is a set of interventions that comes close to what Dix was arguing in his original paper.

Certainly, over recent years we have seen the introduction of admission or assessment wards in some organisations, within which some of the most ‘intensive’ holistic care has to be provided. The introduction of crisis teams as the gatekeepers to admission and the locking of doors to acute wards with increased frequency have indicated that the acuity of symptomatology has risen within acute wards. Personally, having moved back to work from a PICU to an acute ward setting, I have noticed an increased level of concentrated care provided within a shorter time frame. All these indicate that more intensive psychiatric care is being delivered in different settings. The catalyst to this current editorial was the case report by Krabbenbos et al. (2012, this issue) which outlines a case that may be described as ‘intensive’ liaison psychiatry. One of the arguments against providing separate PICUs was that this could potentially lead to de-skilling of staff elsewhere within acute services. However, with increased need for more acute care provision, staff involved in all acute services must surely see the need for, and be developing skills previously associated with, psychiatric intensive care. Does this mean that the speciality itself is waning?

Different organisations have varying needs for intensive care and, as the bar continually rises throughout acute care, patient needs and methods of meeting them change. Many have

previously described differences between [inner city and rural] PICUs but there will always be a requirement for more intensive care to be given to more severely unwell and risky patients within services. Variation in care may be a reflection not only of the local patient population’s type of needs but also of the standard of practice on the unit. There is a requirement for practice standards to be upheld and one challenge is to provide some form of uniformity to ensure care is provided to a high standard throughout. This may be met in different ways: via practice guidance (NAPICU was the driver behind the national minimum standards), accreditation schemes (again NAPICU, in conjunction with the Royal College of Psychiatrists developed AIMS-PICU) or through development of standardised care pathways that can be measured in a meaningful fashion. This leads on to another paper in this issue which illustrates ways of addressing patient care provision in a manner that is helpful clinically and may be beneficial from a commissioning perspective (Kearney et al. 2012).

In the UK, one of the biggest challenges in recent times for managers (and thus clinicians) has been the introduction of a process of payment by results. By setting costings for care that is delivered, the intention was to help with the modernisation process and to improve effectiveness. Agreed prices needed to be set for specific care delivered as opposed to ‘block contracts’ for services. It has been decided that by clustering groups of patients into those presenting with differing symptom and needs profiles, a care delivery package can be charged (and thus presumably provided) for each ‘cluster’. Whilst I have no difficulty with care pathways being outlined, variation in intensity of care provided must surely be acknowledged. Pathways outlined, and costed for, must recognize this. Unfortunately, at present with the process in its infancy, ‘details’ such as this seem to have been overlooked.

The paper written in conjunction with colleagues adds to a previous paper (Kearney & Dye, 2010) and argues for description of a care pathway that is clinically driven and can be costed for in as much detail as required with

completion of specific elements within the pathway. In the previous paper we had argued that these pathways should be developed locally given different needs in each wider organization or service. However, given that the care provided must be to the same high standard, and the recent development of payment by results as a supposed measurement to achieve this, we feel that measurements and pathways can and should be described in further detail to demonstrate an alternative commissioning arrangement.

By arguing against care for specific patient clusters as described currently by the Royal College of Psychiatrists (and outlined in Kearney et al. 2012), we have suggested a pathway for different types of patients who need intensive care and give an example detailing care for one specific patient sub-type. An extension of this could be description of a psychiatric intensive care pathway rather than care provided within a PICU. This then makes the process of payment by results more meaningful by describing intensity of care provision that is required for groups of patients (as opposed to ill defined, perhaps meaningless care packages that attempt to define the care provision for a wide variety of needs within a large patient cluster group). Maybe, as the payment by results bandwagon rolls on and becomes more refined, it will be able to give more robust measures. In the meantime, should psychiatric intensive care take the plunge (as it did with the national minimum standards in 2002) and redefine the tool for describing needs for requirement of care as opposed to symptomatology?

The case report in this issue (Krabbenbos et al. 2012) certainly supports the age old idea of providing the care needed in a timely and comprehensive fashion rather than defining it based on clusters. The aims of NAPICU include

improving service user experience and outcome by improving mechanisms for the delivery of psychiatric intensive care and auditing effectiveness. I feel that the challenge of providing robust, meaningful, appropriately financed measures upon which we judge our service (and hopefully show the evidence for its effectiveness) is something we must not shy away from.

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