Leeds Partnerships NHS
NHS Foundation Trust

The Yorkshire Centre for Psychological Medicine

Annual Report

2009/10

Contents

Introduction

The Yorkshire Centre for Psychological Medicine (YCPM) delivers biopsychosocial care for people with complex medically unexplained symptoms and physical / psychological co-morbidities. The YCPM is an eight bed specialist in-patient unit which was originally established on Ward 40 of Leeds General Infirmary in 1980. It is a unique service which has a history over many years of delivering services within Leeds and West Yorkshire. Four of the beds (50%) are funded for Leeds patients, and the remaining bed resource allows the unit to offer access to patients from across the north of England and beyond.

The YCPM is part of the wider Liaison Psychiatry service in Leeds. This is the sub-speciality concerned with clinical service, teaching and research in the general hospital setting. It aims to provide healthcare professionals in general hospitals, primary care and secondary care with defined access to a specialist multidisciplinary team, for the care of patients presenting with psychological as well as physical problems.

The YCPM aims to help people with complex difficulties make significant improvements with regard to their health and quality of life. Clinical outcomes, even in a range of very chronic and complex cases, are often very good and patient feedback very positive. This is possible due to the nature of the YCPM Unit and its function within the general hospital setting, but also due to the depth of experience and breadth of expertise within the team.

Research activity within the service is facilitated by close links with the Institute of Health Sciences at the University of Leeds.

The YCPM is part of Leeds Partnerships NHS Foundation Trust. Everything we do accords with NHS values and our stated Trust purpose of improving health and improving lives.

This is the first YCPM Annual Report, but the intention is to continue to produce these in order to summarise the function, activity and performance of the unit as it continues to develop.

Purpose

The YCPM team specialises in helping people with the following types of problems:

1) Chronic and / or complex and / or severe medically unexplained symptoms and somatisation (psychologically-based physical symptoms and syndromes).

2) Severe physical and psychological / psychiatric comorbidity:

a) in people who are already general hospital in-patients but who have psychological needs at a level that cannot be effectively met on a general medical or surgical unit.

b) in people in other services or the community who could benefit from focussed multidisciplinary treatment provided in an in-patient setting.

3) Patients with severe CFS / ME.

(We provide the in-patient component of the Leeds and West Yorkshire CFS / ME Service).

The YCPM is staffed by a multidisciplinary team, with the following elements:

Liaison psychiatry

Nursing

Occupational therapy

Physiotherapy

Social Work

Dietetics

Pharmacy

Administration

The unit benefits from staff with dual (general / physical in addition to mental health) training, and others trained in cognitive behavioural and psychodynamic psychotherapeutic approaches.

The Unit also has direct access to the following personnel:

Cognitive behavioural therapists

Psychosexual therapists

Outpatient chronic fatigue/ME team

Hospital mental health team

The YCPM provides a biopsychosocial approach to assessing and treating the full range of patients' problems. The expertise of the team has been developed over many years and the YCPM exists within the broader liaison psychiatry service provided by Leeds Partnerships NHS Foundation Trust.

Treatment Approaches

Patients referred to the YCPM will be contacted to discuss the aims of the admission and to answer any questions regarding treatment approaches, length of stay, housekeeping arrangements, etc. A key individual will keep contact with the patient about the proposed admission date. The first meeting may be an assessment in hospital or at home, or a visit to the unit. This, usefully, facilitates meeting key individuals from the team and an appreciation of the location of the unit in the general hospital.

On admission, and in the first week, the various members of the MDT will meet the patient and carry out specific assessments. These are then shared with the patient and at the weekly MDT meeting. The care planning process is designed to encompass physical, psychological and social health needs. Care plans are designed by the team in collaboration with the patient.

Physical (for example)

Physical monitoring - liaison with and input from medical / surgical teams within the general hospital.

Any required physical treatments to improve health.

Programmes to improve physical functioning – Occupational Therapist and Physiotherapist interventions.

Graded activity programmes - particularly in relation to fatigue.

Pharmacological treatments.

Psychological (for example)

'Living with pain', 'Living with anxiety' and 'Living with illness' are all packages of care available to each patient delivered on an individual basis. Patients may also then be referred on to the particular groups focussing on this work.

Programmes to deal with particular fears and anxieties (graded exposure)

Individual sessions with key members of the multidisciplinary team - focus on particular areas of the psychological care plan - working with ambivalence / motivation / symptom management and symptom reattribution, etc.

Cognitive behavioural and psychodynamic psychotherapy approaches.

Family members and carers are offered support and can be included in discussions around clinical care, with agreement and consent from the patient concerned.

Social (for example)

Specific social needs are assessed in relation to the patient's home and community situation. The unit is essentially a social space and patients are encouraged to talk to and engage with each other in the experience of being in hospital. To this end, there are various groups and activities which enable the social environment to work therapeutically.

Groups

The unit provides a group treatment programme with psychotherapeutic, educational, and activity based groups

Risk management

Formal risk assessments are carried out regularly with all patients. Risk management plans are reviewed at all MDT meetings and inform planned interventions, including observation procedures and individual and group therapies.

Environment

The unit is in the centre of Leeds with excellent rail, road and public transport links and parking facilities. This facilitates admission and visiting but also means the unit is ideally placed to help patients re-engage in normal activities in the wider community as and when appropriate.

The eight bedrooms all have:

An electric profiling bed

Vanity suite

Wardrobe

Bedside table

Curtains and blind

Armchair

Privacy / observation window

Extra wide 2 way opening doors

Assistance call facilities

In addition the Unit provides

One assisted bathroom

One independent bathroom

One level access shower room

(each with assistance call facility)

Laundry Room

Patient telephone

The YCPM is based on Ward 40 at Leeds General Infirmary. Although this is a general hospital setting, the environment on the YCPM is specifically designed to provide a therapeutic environment for patients with mixed physical and psychological / psychiatric difficulties.

The unit provides a comfortable environment with communal areas where patients have the opportunity to socialise with peers but also have their own individual bedrooms. Patients have the use of two lounges which provide televisions, DVDs, music and other group and therapeutic activities. The conservatory and balcony areas enable patients to spend time with their fellow patients and with their visitors in a relaxing environment.

Performance 2009 – 2010

In reading this Annual Report it is important to understand that the Liaison Psychiatry service in Leeds adopted the "functional model" on 1st October 2009, mid-way through the period to which this Annual Report relates. Prior to that date patients were admitted under the care of one of five Consultants in Liaison Psychiatry, but from that date onwards a single Consultant has been responsible for all patients on the unit. This has facilitated the creation of the Yorkshire Centre for Psychological Medicine (YCPM), with a single multidisciplinary team working together to develop the service.

At the point of discharge, the care of each patient is transferred back to the appropriate out-patient mental health team.

The YCPM delivers its therapies and treatment packages within the standards and levels of quality assurance set by Leeds Partnerships NHS Foundation Trust. We continually monitor patients' experiences of the treatment through the Patient Discharge Questionnaire and utilise this information in the improvement of the service and development of new service elements.

We also routinely use a range of performance measures including CORE-OM, administered on admission and discharge, the Clinical Global Improvement Scale, and other condition-specific and therapeutic modality-specific measures as appropriate.

With the adoption of the functional model and creation of the YCPM we have made a concerted effort to tighten our procedures for collection of data on these measures. As a result, the information collected is complete since October 2009 but less so for the period before that. All available information has been used to generate this report.

At the YCPM, we receive the most complex cases seen in the general hospital system in Leeds, Yorkshire and across the UK. Over the past year, with the introduction of the functional model, there has been a 32% increase in the number of patients admitted from across the UK. To date, no funding request for admission to this unit has been refused by any PCT; patients have been admitted from Southampton, Derby, Oxford, Chester, Doncaster, Durham, Harrogate, York, Wakefield, etc. In addition, in view of the complexity of the cases seen and their need for this specialist service, no request to any PCT for an extension of funding has been declined-these tend to be for additional periods of between 6 and 12 weeks.

Activity

Inpatient Treatment

Data for all patients discharged from the YCPM between 1st April 2009 and 31st March 2010 were considered for this report. This has been presented in two sections:

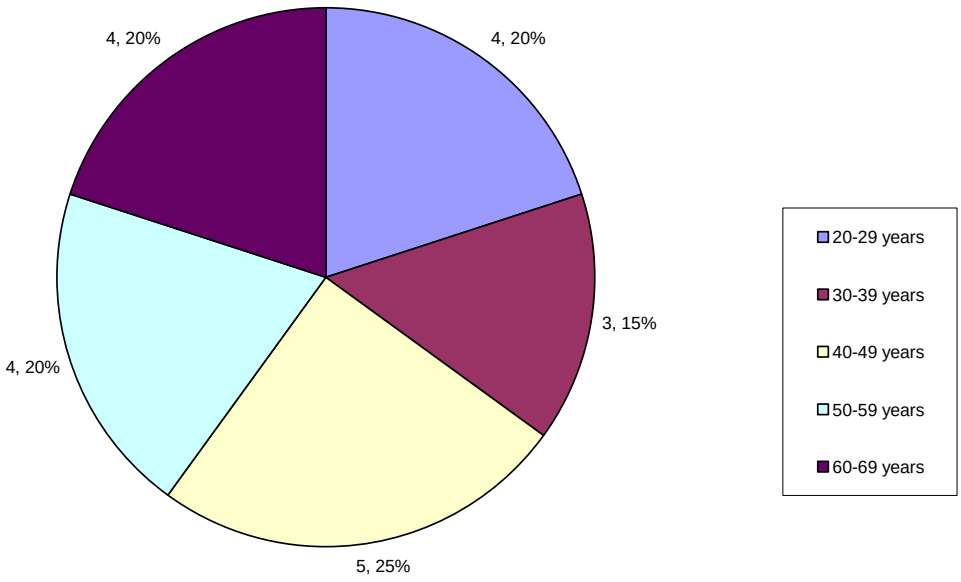
1) for the period from April 2009 to October 2009
2) for the period from November 2009 to March 2010

The reason for presenting the results across these particular periods (ie with Period 1 including October 2009) is to allow us to distinguish between patients who received the bulk of their treatment either before or after adoption of the new model.).

Period 1: April - October 2009

There were a total of 35 discharges in this period, with 17 (48.5%) patients being discharged prior to the change over to the "functional model" and 3 (8.5%) being discharged during the transition i.e. in October 2009.

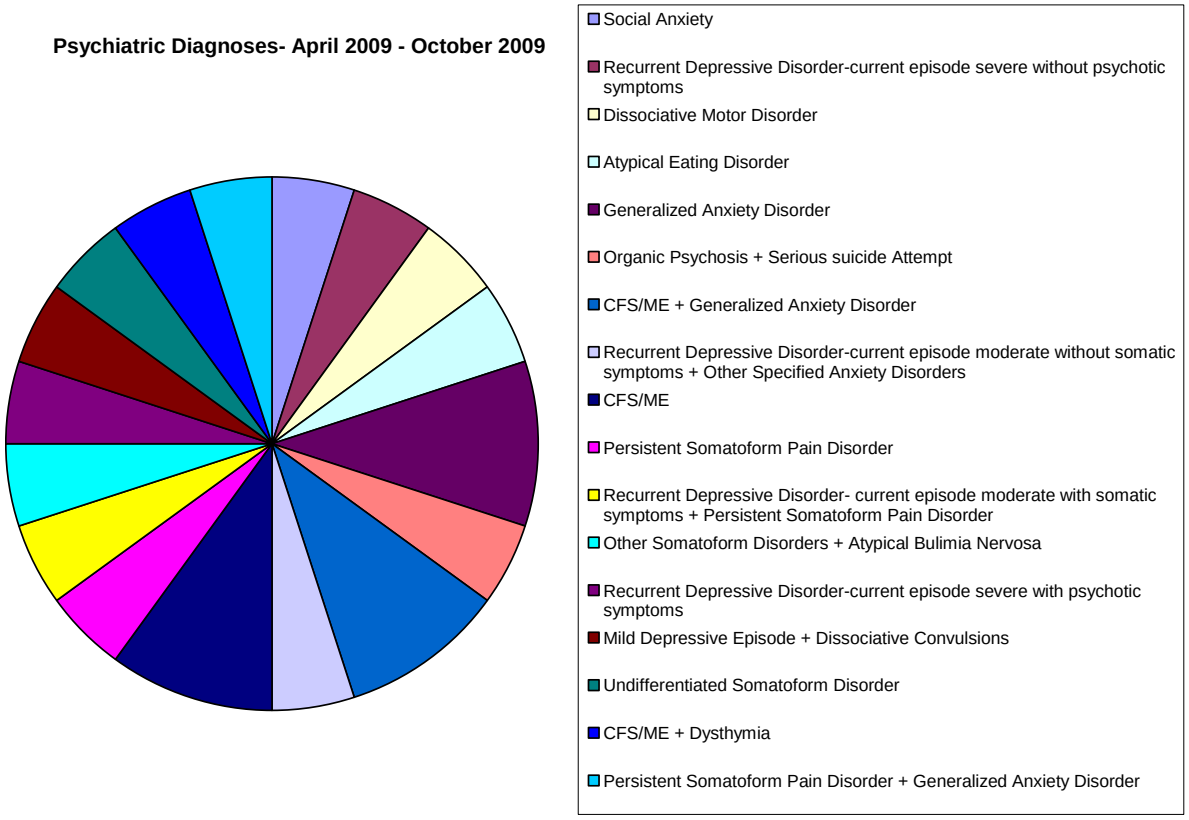
Age Range of Patients Discharged between April 2009 - October 2009



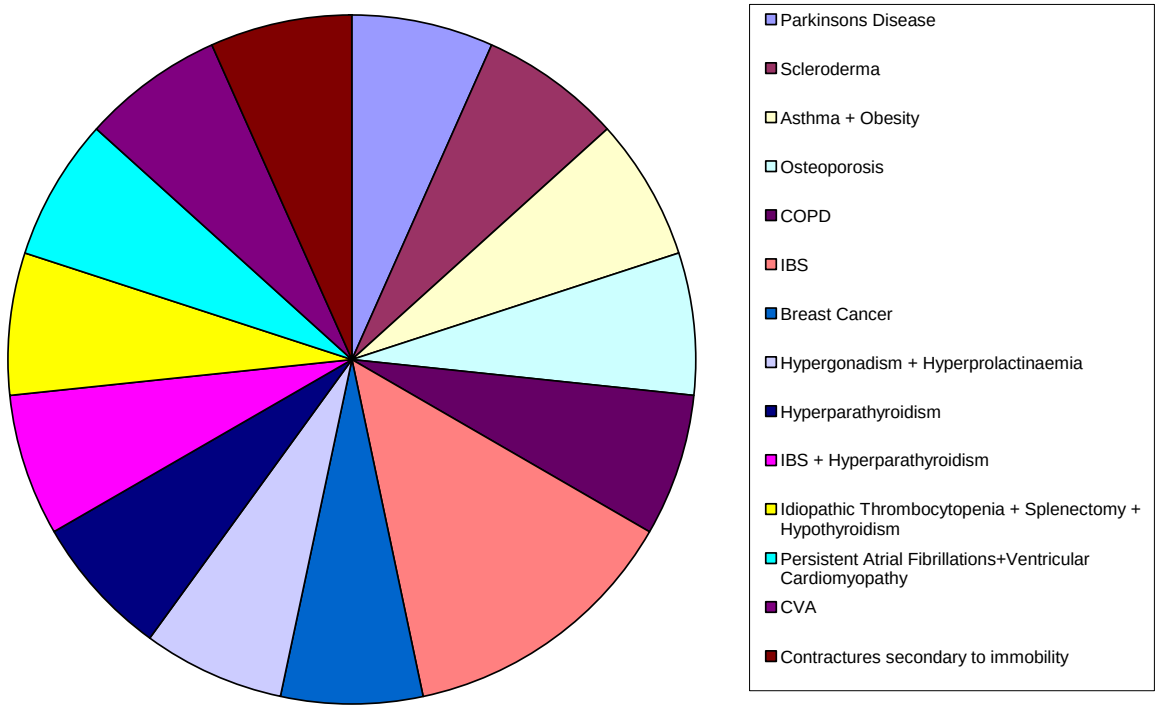
Total Number of Discharges between April 2009 – October 2009 = 20

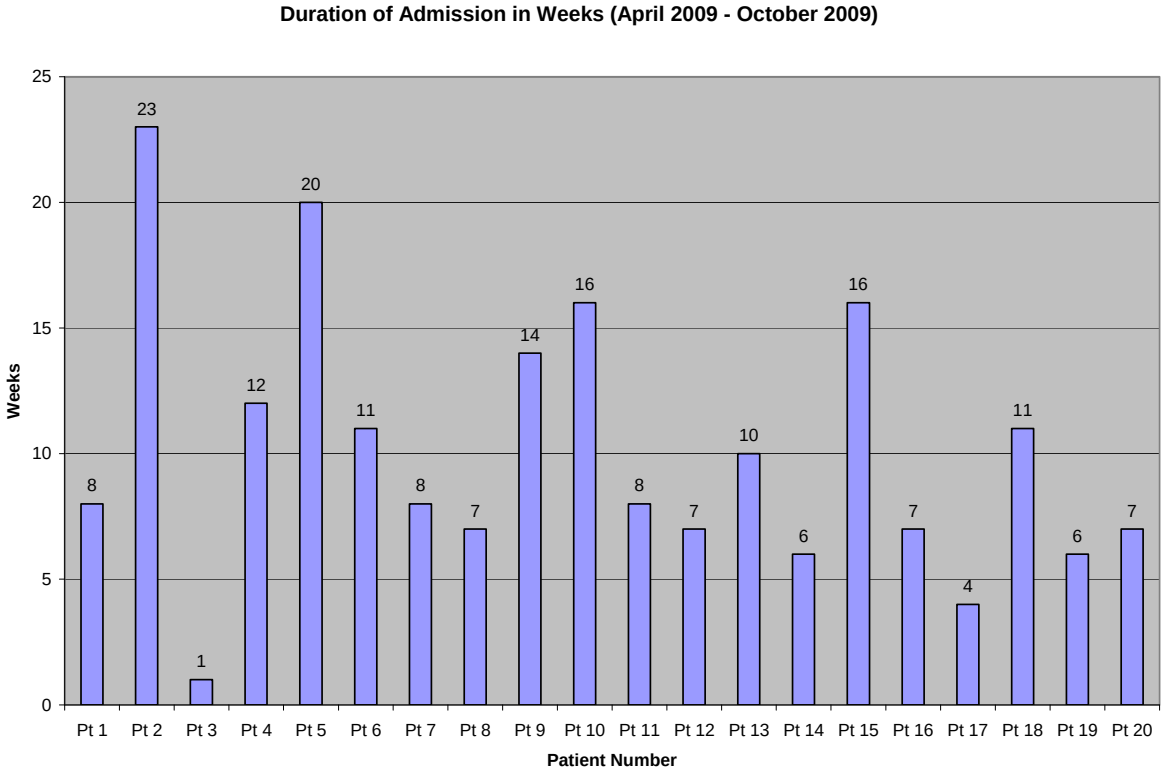
Male: Female = 3:7

Psychiatric Diagnoses- April 2009 - October 2009



Physical Comorbidities - April 2009 - October 2009





The figure above shows the length of stay in weeks for patients discharged from April 2009 to October 2009.

Whole group:

Duration of admission ranged from 1 to 23 weeks, with an average of 10.1 weeks.

80:20 split:

For the 20% of patients with the longest length of stay, duration ranged from 16 to 23 weeks, with an average of 18.75 weeks.

For the remaining 80% of patients the duration ranged from 1 to 12 weeks, with an average of 7.93 weeks.

Patient experience

The Patient Discharge Questionnaire was created by the YCPM inpatient team over the course of the last year based on the guidance set out by the Trust. It was devised to collect both qualitative and quantitative date from inpatients regarding their care on the unit. The team at YCPM felt it was important to collect the views of patients' regarding their care, environment, and therapies provided. The information collected is then collated and reviewed regularly in order to provide the best possible service to our patients. The questionnaire is given to the patient in their last week of admission and collected on discharge. It has recently been amended and updated including, a reduction in the number of questions, following feedback and discussion with patients and members of the YCPM Team. A carer's questionnaire is planned for the future.

Patient Discharge Questionnaire April 2009 – October 2009

9 (35.2%) of the 20 patients discharged between April 2009 to October 2009 returned completed discharge questionnaires. No reasons (whether the patient refused, was not asked, or was not able to complete the feedback) were available for the remaining 11 patients.

Ward environment & Support from staff

44.4% of the patients that completed the feedback forms had used the opportunity to visit the ward and meet staff prior to being admitted.

55.5% reported having an understanding of how inpatient admission could help them prior to admission.

88.8% of the patients had a favourable view of the ward on admission.

77.7% also found staff very supportive and available when needed.

Group Therapy

77.7% of the patients admitted attended 3 or more groups run on the ward. These included the Ward Forum, Gardening, Art & Craft, Cooking and Relaxation groups.

88.8% of them reported having a very positive experience of these groups with 66.6% rating these as good / excellent.

Involvement in their care.

100% of the patients reported being fully involved in their care plan most of the time with 55.5% of these reporting that they were always involved in developing their care plan.

77.7% of patients felt that the key issues related to their mental and physical health were addressed.

At discharge, 88.8% felt they had been fully involved in the planning of their discharge.

Satisfaction with the service

22.2% of patients felt that their discharge plans met most of their needs; with 44.4% reporting that all their needs had been met.

100% of patients reported feeling satisfied with their overall care on the ward with 66.6% rating this as good / excellent.

Clinical Outcomes

Clinical Global Impression (Improvement) Scale

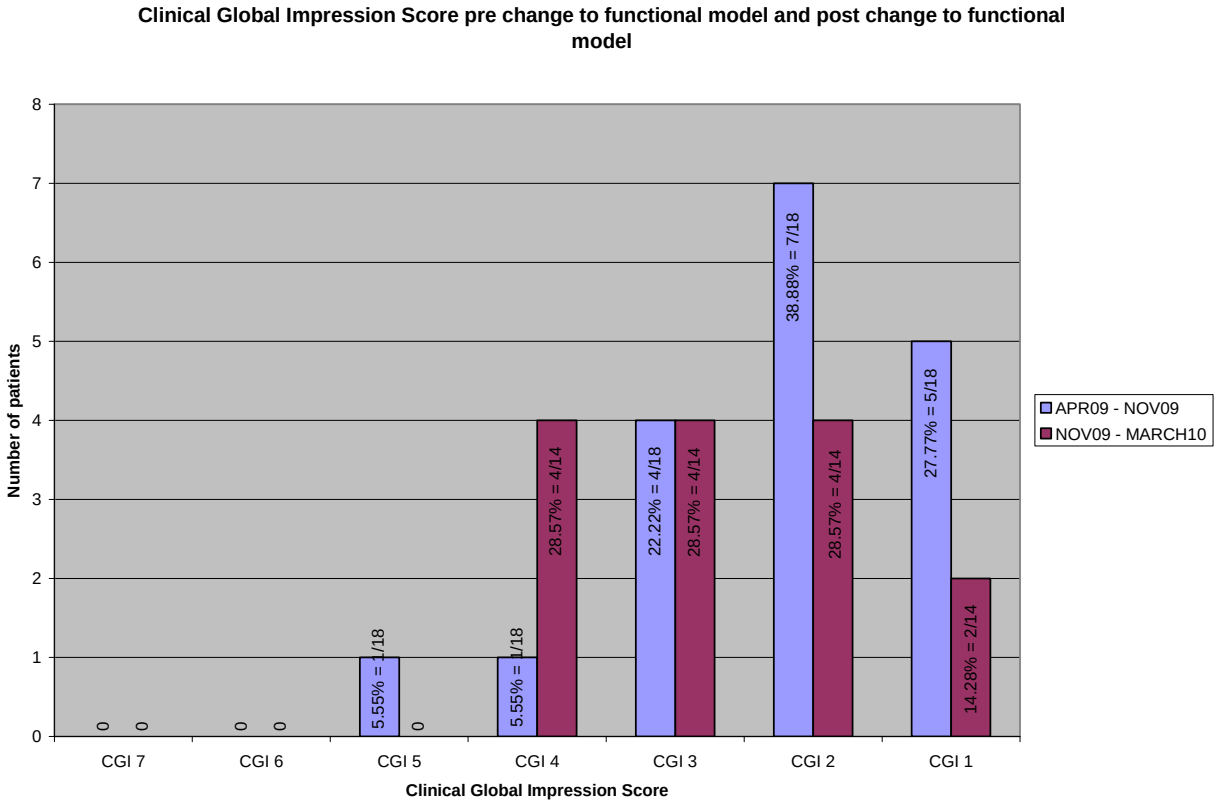
The Clinical Global Impression Scale was developed in 1976 and there are many versions available to use now. The CGI has proved to be a robust measure of efficacy in many clinical settings, and is easy and quick to administer, provided that the clinician knows the patient well.

We have chosen to use the established seven point scale which rates clinical improvement from major deterioration (7), moderate deterioration (6), minor deterioration (5), no change (4), minor improvement (3), moderate improvement (2) and major improvement (1). It is a brief observer rating scale that measures global improvement or change.

Clinical Global Improvement Scores were available for 32 patients, three patients not being admitted for a long enough period to allow us to complete a CGI, as the multidisciplinary team made a concerted effort to ascertain the scores for those with missing data on this scale.

Clinical Global Improvement Scores	**Total number of patients admitted during April 09 - Oct 09**	**Total number of patients admitted during Nov 09 - March 10**
	18	14

Ref: Guy.w. (1976). ECDEU Assessment Manual for Psychopharmacology. Rockville, U.S. Department of Health, Education and Welfare.



Since October 2009, following the creation of the YCPM, we have made a great deal of effort to encourage the routine use of outcome measures, and these will be fully reported in 2011.

CORE-OM

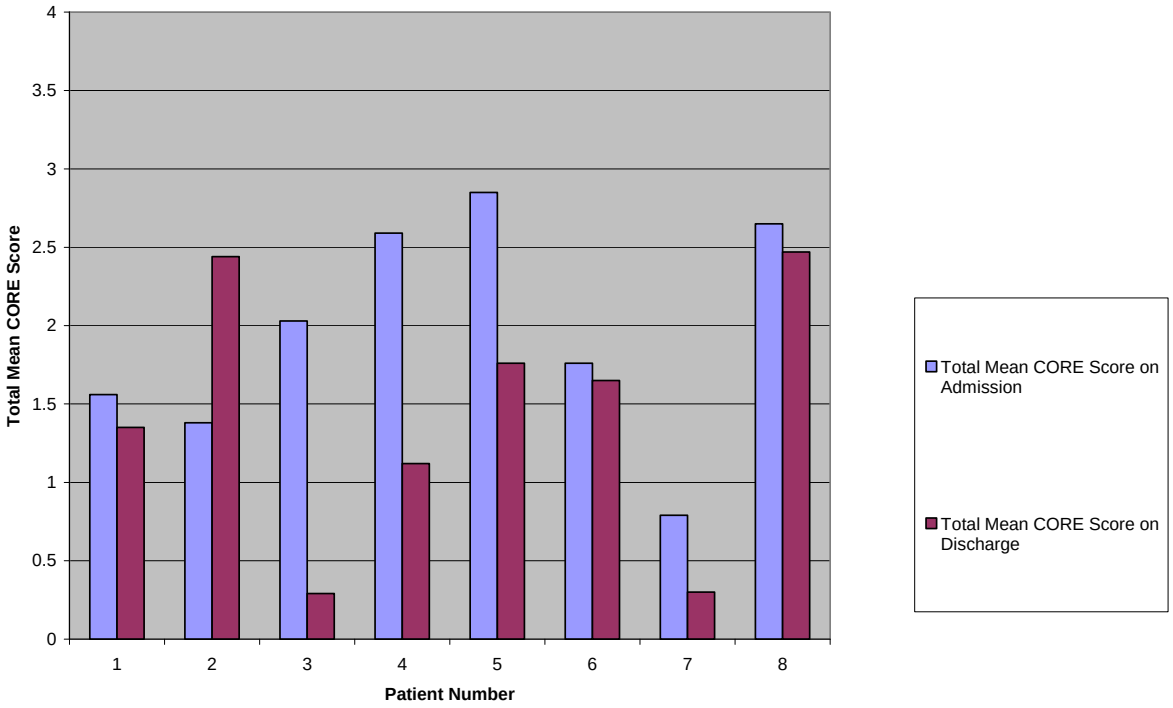
The CORE-OM is a self -report questionnaire that measures patients' level of psychological distress. It consists of 34 questions that cover 4 dimensions: subjective well-being; problems / symptoms; life functioning; and risk / harm. Patients are asked to respond based on how they have been feeling over the last week, using a 5 point scale ranging from 'not at all' to 'most or all of the time'. The responses are then averaged to obtain a mean score to determine patients' level of current global psychological distress and can be rated on a continuum from 'healthy' to 'severe'. The questionnaire is administered on admission and then at discharge to provide a comparison of the pre and post treatment scores as a measure of outcome.

All patients admitted *over the last financial year* were requested to complete a CORE-OM questionnaire on admission and discharge. Patients with an extremely short duration of admission (no more than a week), were not asked to complete a CORE-OM questionnaire on discharge. Our service began using the CORE-OM last year and, as results indicate, the data collection on this measure has improved with the introduction of the 'new model'.

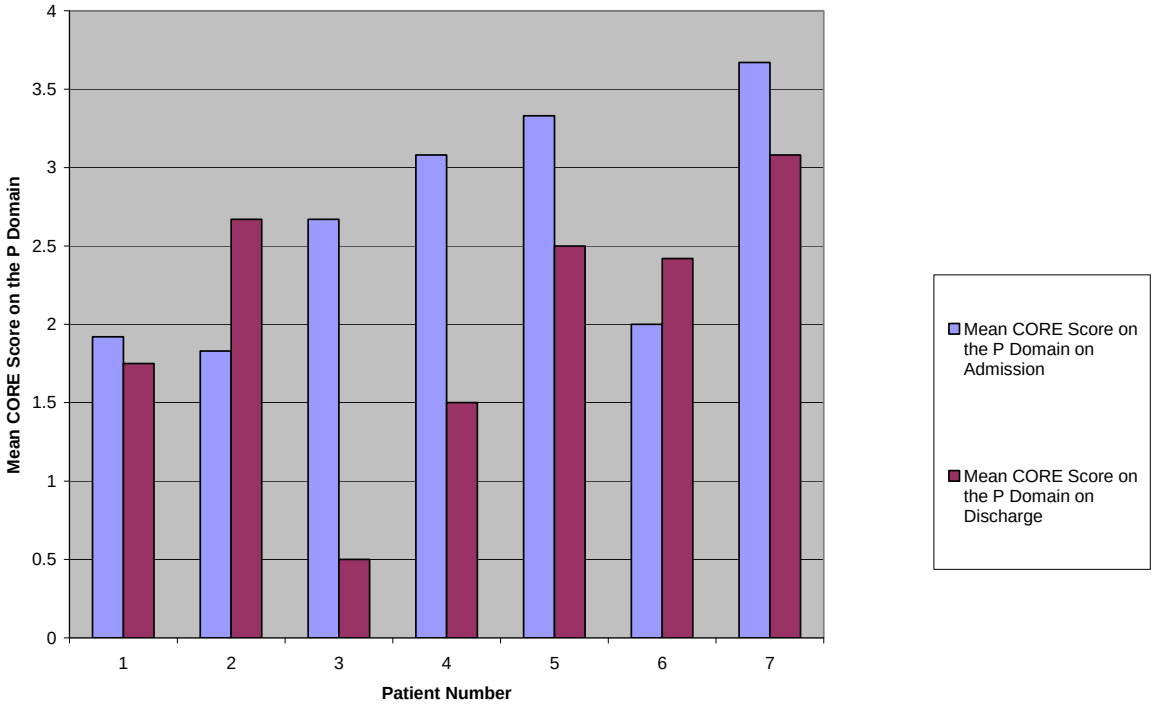
For the period of April 2009 - October 2009 a total of 16 (80%) completed CORE-OM forms were obtained on admission and 8 (40%) on discharge. No reasons (whether the patient

refused, was not asked, or was not able to complete the forms) were documented for the missing data. Data gathered on the CORE-OM forms is represented below.

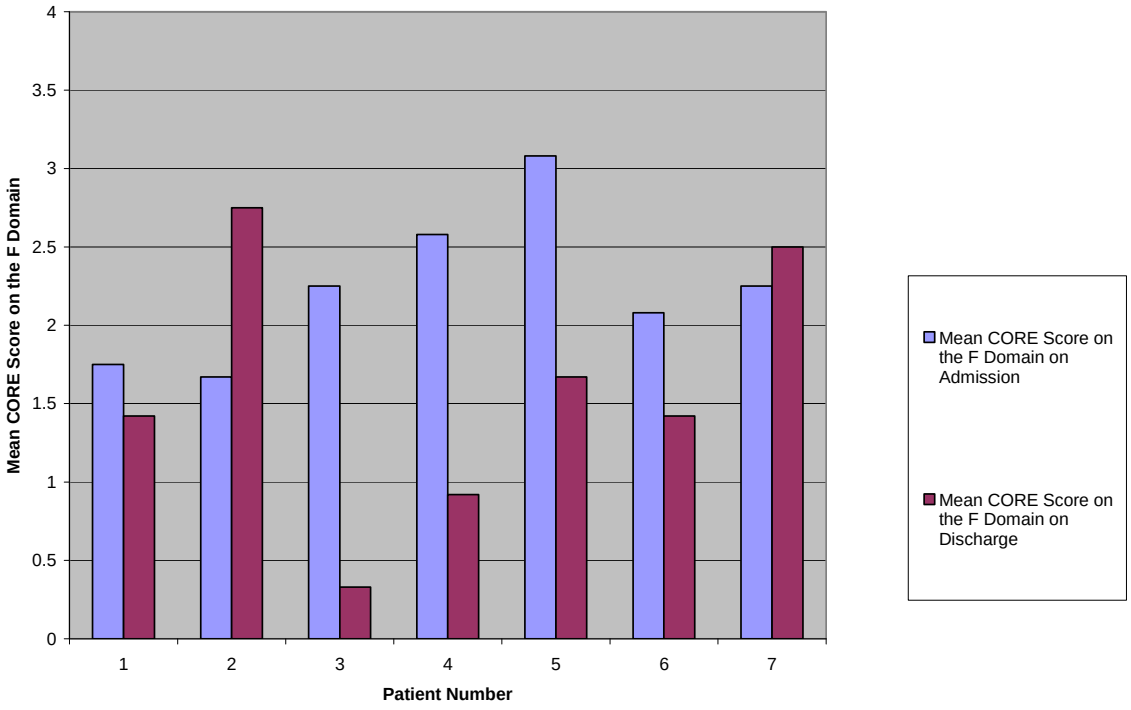
Changes in the Total Mean CORE Scores (April 2009 - October 2009)



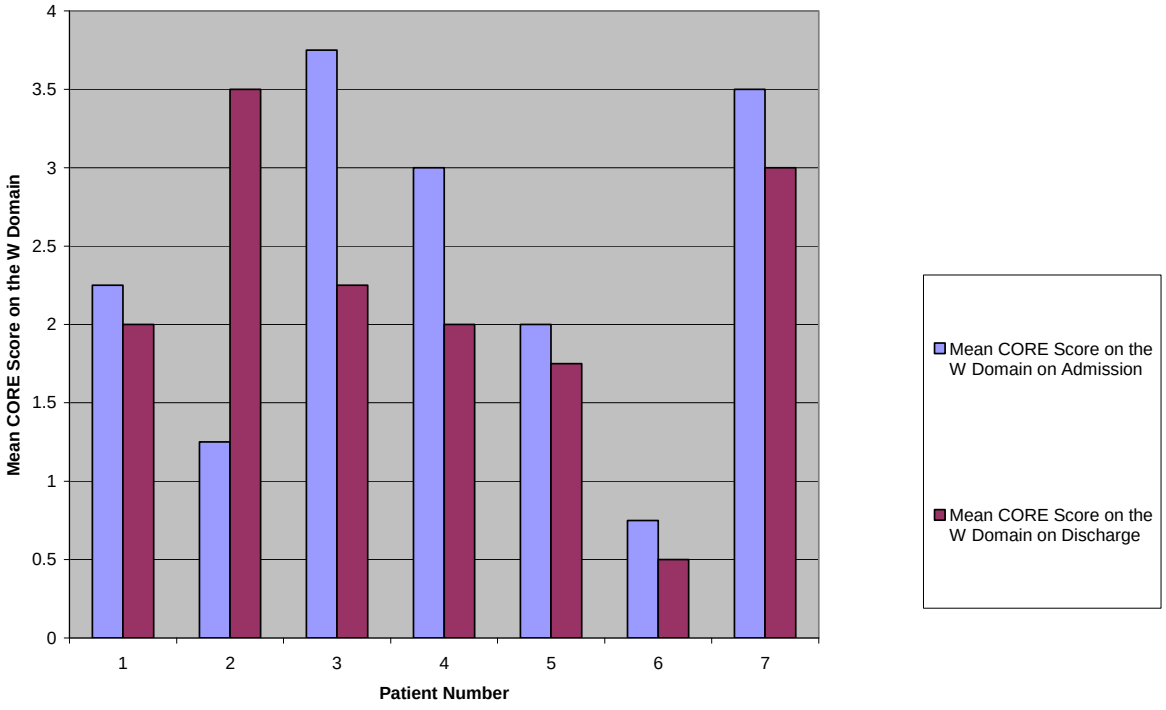
Changes in the Mean CORE Scores on the P Domain (April 2009 - October 2009)



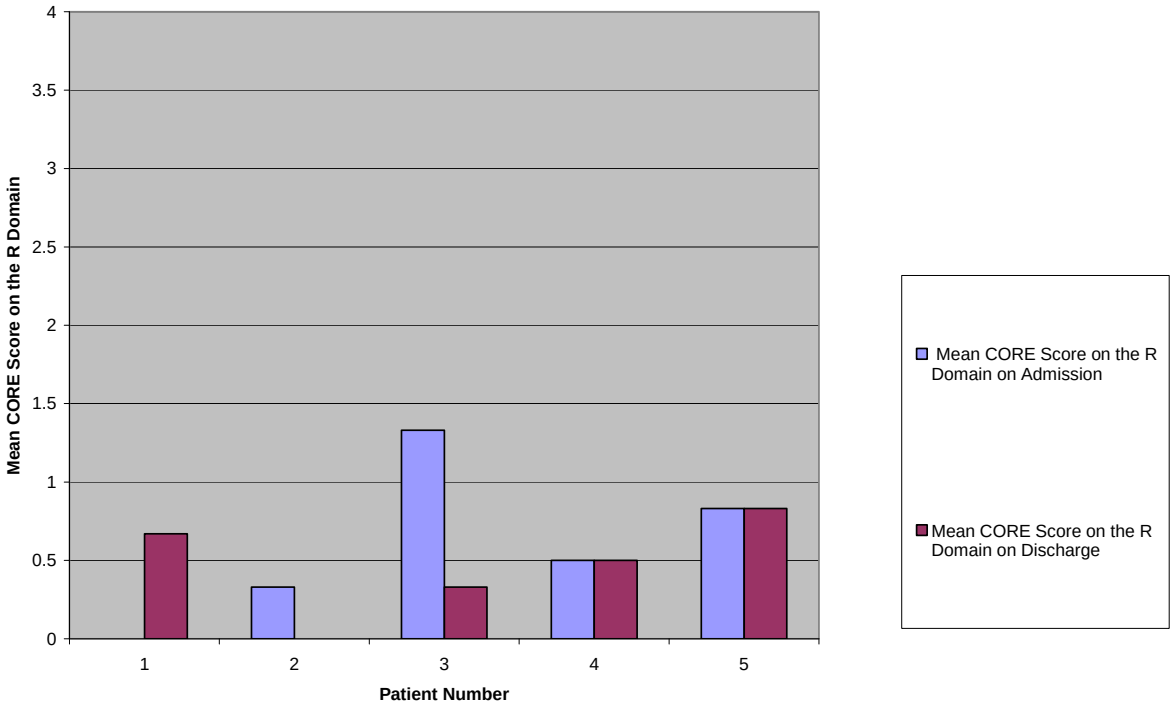
Changes in the Mean CORE Scores on the F Domain (April 2009 - October 2009)



Changes in the Mean CORE Scores on the W Domain (April 2009 - October 2009)

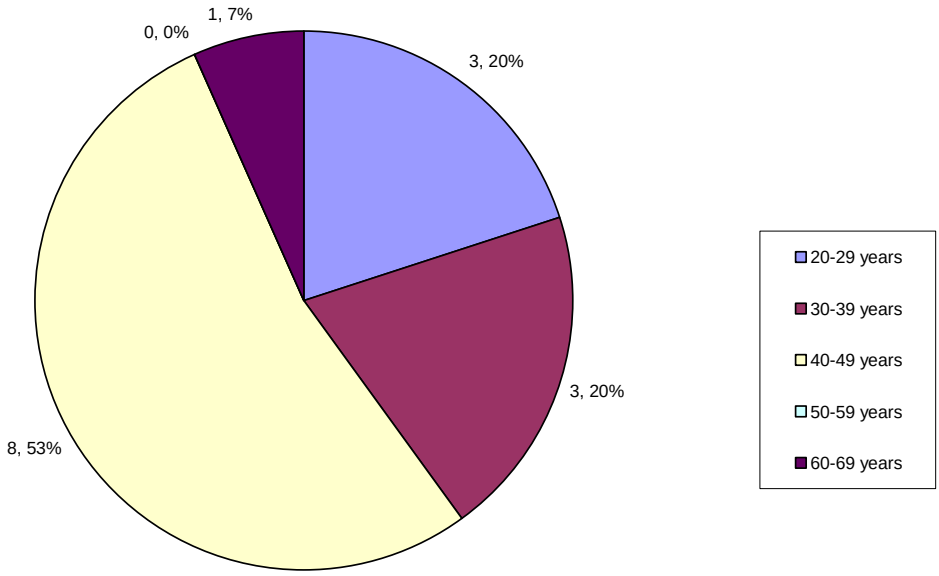


Changes in the Mean CORE Scores on the R Domain (April 2009 - October 2009)



Period 2: November 2009 - March 2010

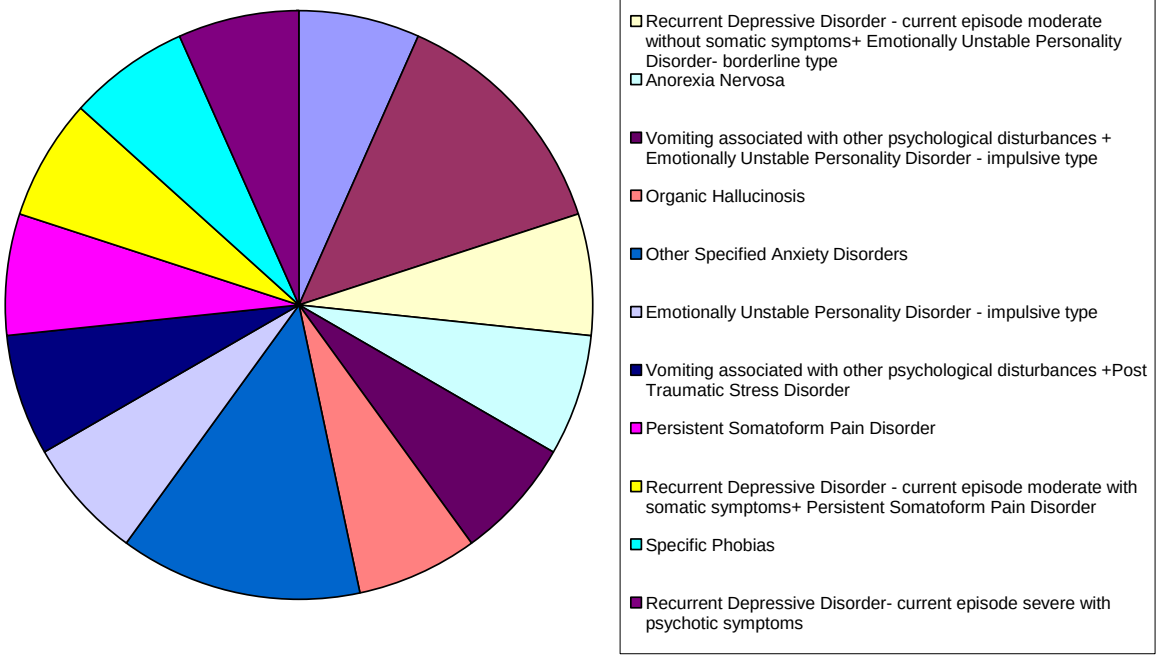
Age Range of Patients Discharged between November 2009 - March 2010



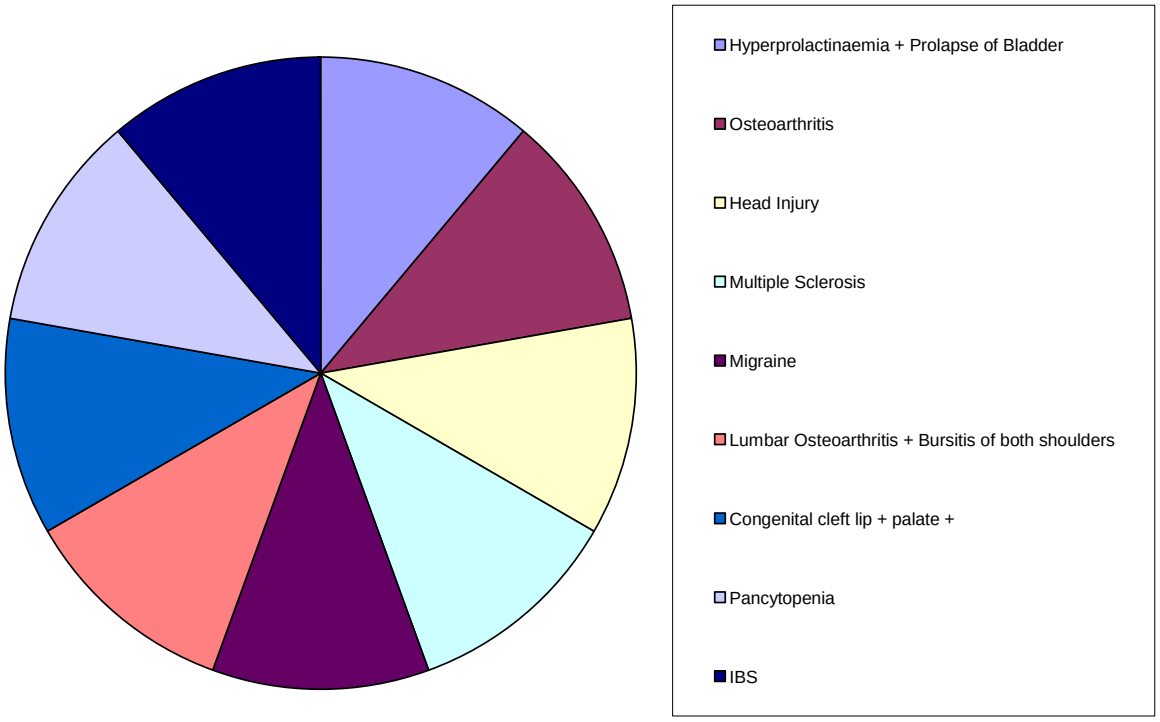
Total Number of Discharges between November 2009 – March 2010 = 15

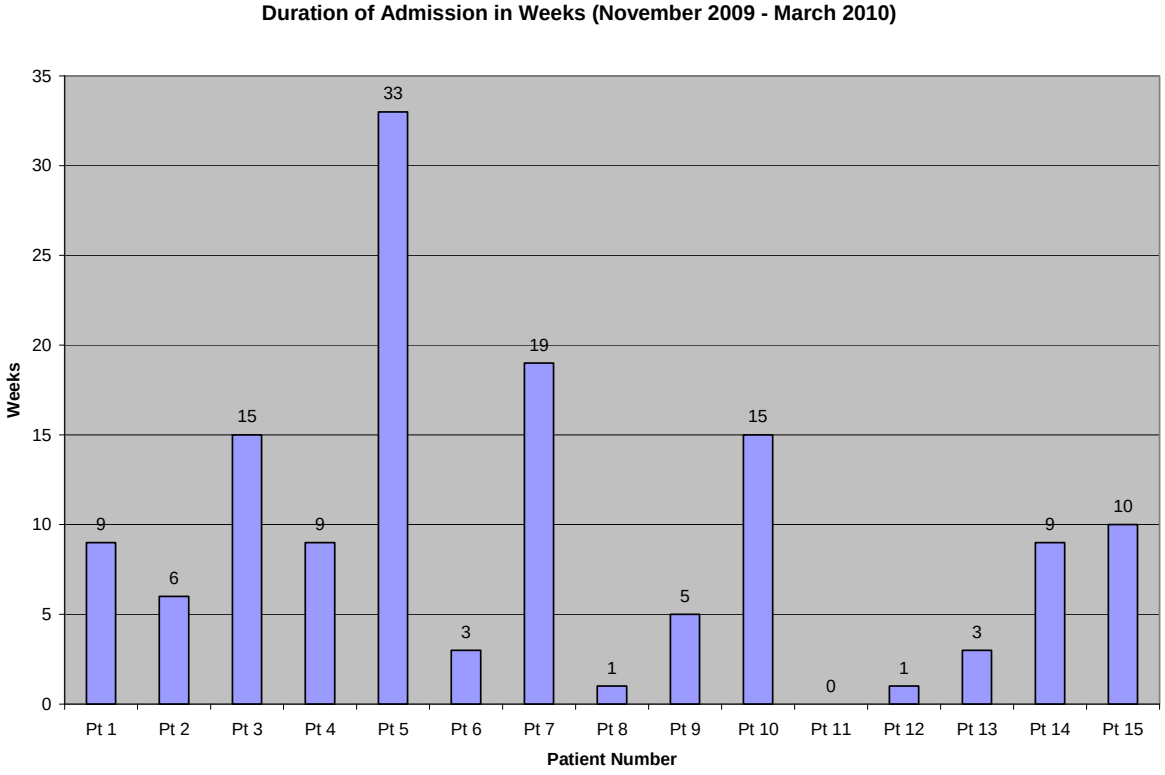
Male: Female = 1:2

Psychiatric Diagnoses- November 2009 - March 2010



Physical Comorbidities - November 2009 - March 2010





The figure above shows the length of stay in weeks for patients discharged from November 2009 to March 2010.

Whole group:

Duration of admission ranged from 1 to 33 weeks, with an average of 9.2 weeks.

(Patient 11 was only on the unit for 2 days and decided to leave, hence her results have been excluded from the analysis; she returned a few months later for a longer period of treatment.)

80:20 split:

For the 20% of patients with the longest length of stay, duration ranged from 15 to 33 weeks, with an average duration of 20.5 weeks.

For the remaining 80% of patients the duration ranged from 1 to 10 weeks, with an average of 5.09 weeks.

Patient Discharge Questionnaire November 2009 – March 2010

10 (66.6%) of the 15 patients discharged between November 2009 to March 2010 returned completed discharge questionnaires. Of the remaining 5, 3(20%) refused to fill in the questionnaire and 2 (13.3%) had an extremely short admission and were not considered eligible to fill in the questionnaire.

Ward environment & Support from staff

40% of the patients that completed the feedback forms had used the opportunity to visit the ward and meet staff prior to being admitted.

60% reported having an understanding of how inpatient admission could help them prior to admission.

80% of the patients had a favourable view of the ward on admission.

80% also found staff very supportive and available when needed.

Group Therapy

50% of the patients admitted attended 3 or more groups run on the ward. These include the Ward Forum, Gardening, Art & Craft, Cooking and Relaxation group.

80% reported having a very positive experience of these groups with over 40% rating these as good / excellent.

Involvement in their care.

70% of the patients reported being fully involved in their care plan most of the time with 40% of these reporting that they were always involved in developing their care plan.

50% of patients felt that the key issues related to their mental and physical health were addressed.

At discharge, 70% felt they had been fully involved in the planning of their discharge.

Satisfaction with the service

60% of patients felt that their discharge plans met most of their needs; with 30% reporting that all their needs had been met.

80% of patients reported feeling satisfied with their overall care on the ward with 60% rating this as good / excellent.

CORE-OM

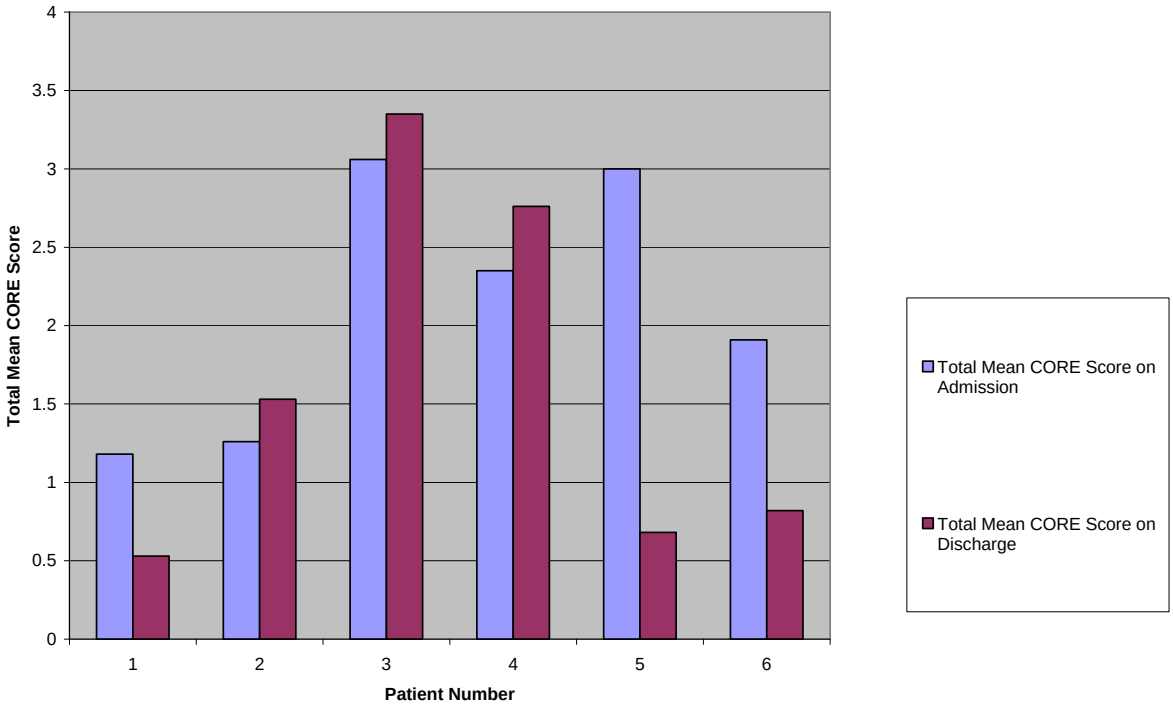
Completed CORE-OM forms were available for 6 patients out of the 15 that were discharged after October 2009.

Reasons for the missing discharge CORE-OM forms from this period were as follows:

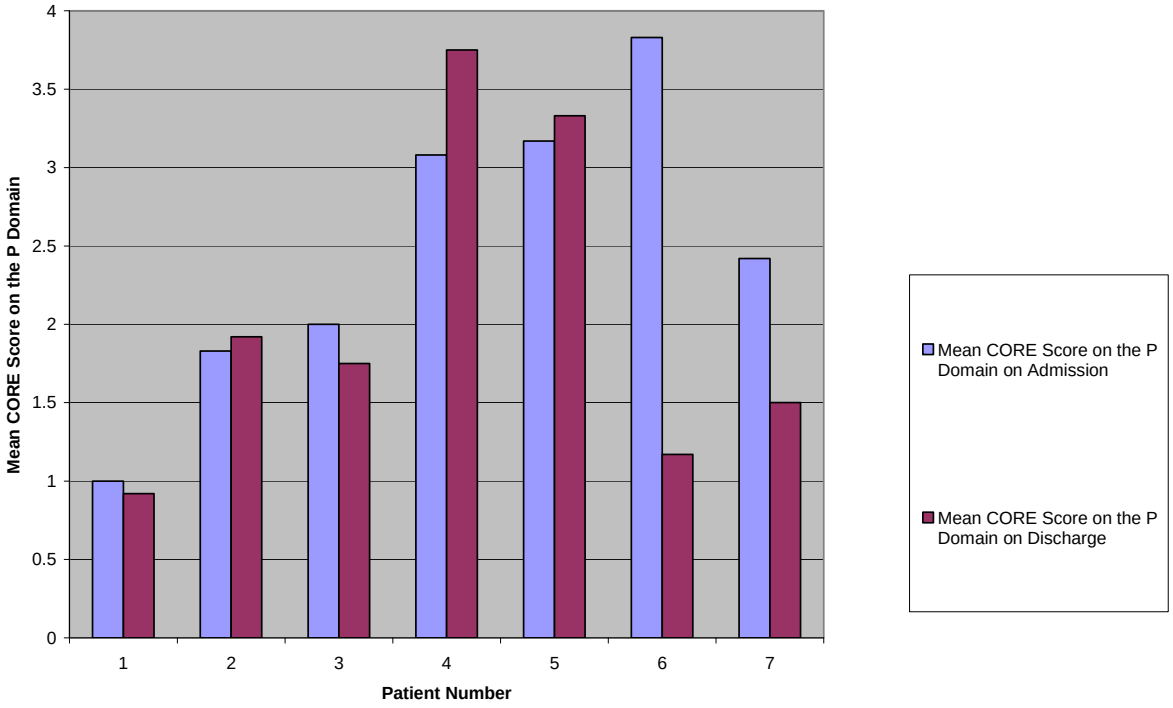
- 3 (8.5%) patients had an extremely short admission, making collection of repeat CORE scores inappropriate
- 2 (5.7%) patients refused to complete the forms
- 2 (5.7%) had incompletely filled forms which could not be used for analysis
- 2 (5.7%) could not complete the forms due to physical illness / transfer prior to discharge

CORE-OM results for the patients discharged since the 'new model' has been in place (post October 2009) are displayed below.

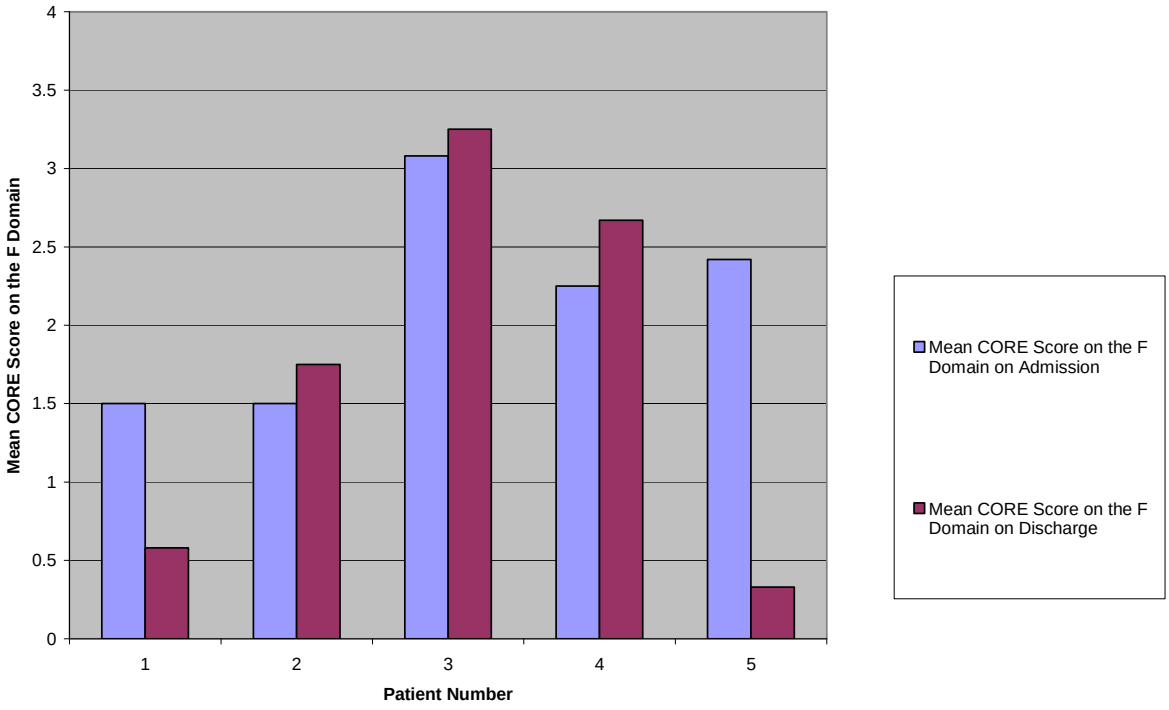
Changes in the Total Mean CORE Scores (November 2009 - March 2010)



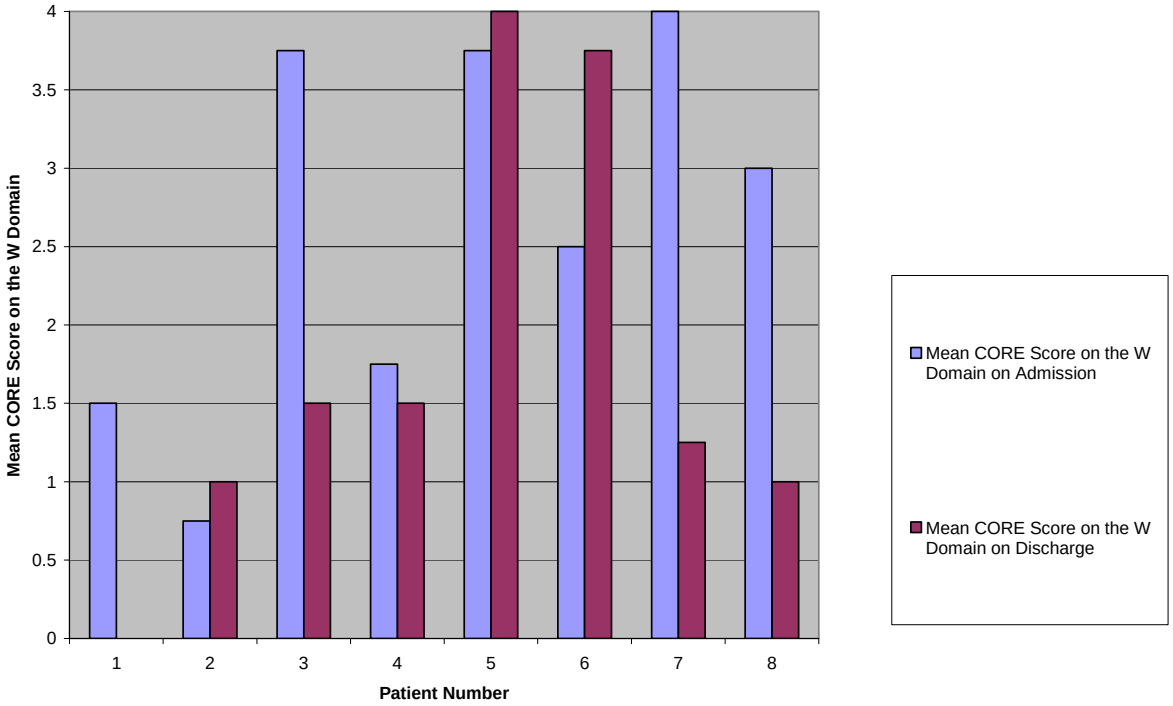
Changes in the Mean CORE Scores on the P Domain (November 2009 - March 2010)

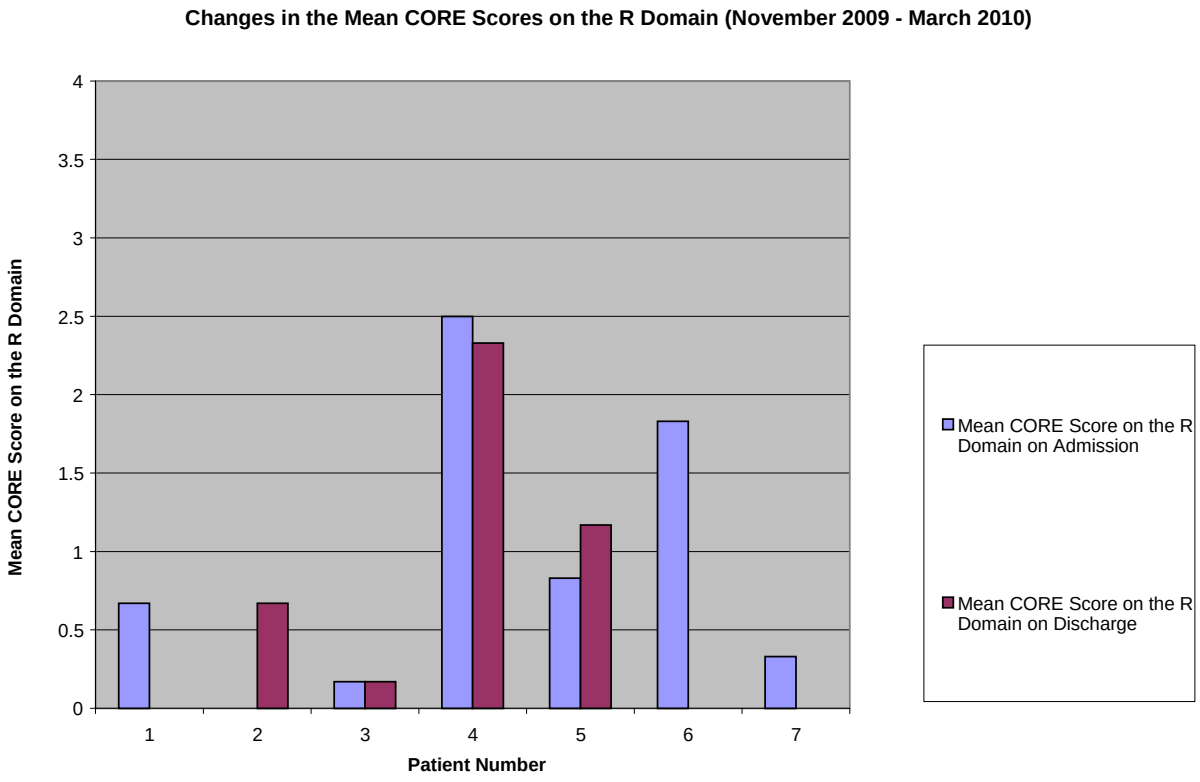


Changes in the Mean CORE Scores on the F Domain (November 2009 - March 2010)



Changes in the Mean CORE Scores on the W Domain (November 2009 - March 2010)





Looking at this preliminary data it is evident that most of our patients have shown a trend towards improvement based on assessments with CORE-OM, but there are concerns that this measure may not be appropriate for most patients admitted to the YCPM. CORE-OM measures the level of psychological distress, whereas the patients we work with often present with a high degree of physical complaints with relatively little psychological distress. As a result, it is likely that a number of our patients may not score significantly on the CORE-OM measures and may fall under the healthy / normal subgroup on admission. At the same time, improvement in their symptoms can often be associated with increasing psychological distress as the underlying psychosocial stressors become more evident. This may account for some of the raised scores we have seen at the time of discharge. Often this requires long term psychological work which, once formulated and established in the inpatient setting, is then continued on an out-patient basis. Keeping this in mind, we aim to explore the utility of CORE-OM for our service, whilst also considering alternative measures that may be used alongside it or as a better alternative.

<u>Patient Feedback</u>: verbatim comments

Ward environment & support from staff

I found the ward warm and welcoming.

…staff made me feel comfortable at a stressful time.

I felt a bit alienated at first but things improved.

…found my key nurses to be most helpful…

I can't say enough about all the staff on ward 40. Excellent…couldn't have done enough for us.

It is a calm environment.

Group Therapy

They helped patients meet and talk.

The ward forums have been helpful and a good way to meet the other patients.

Experience of the service

I have trusted the staff at all times…I have been encouraged during my admission to think for myself and problem solve. This has helped me so much in building my confidence.

I would like to thank all staff for all their help and kindness.

I am determined to stay well and enjoy the rest of my life now that I can enjoy everyday.

Outstanding service and care!

Patients' recommendations on service improvement

…would prefer a board with pictures of ward team and an information pack on admission.

… provide a greater variety of groups.

Increase facilities by providing internet access for patients, an extra washing machine and increase the number of bathrooms available for patients.

Recorded Incidents

In line with the general approach across Leeds Partnerships NHS Foundation Trust, and with what is considered to be a sign of a mature service and team, the YCPM has a relatively low threshold for reporting incidents. As a result, the numbers are not small but, importantly, the incidents seen are almost all of low severity or risk. This severity rating is mapped against the National Patient Safety Agency (NPSA) grading of 'no harm' or 'minimal harm''

April 2009- October 2009

There were 37 incidents recorded in this period and they were all low in severity.

Accidents

Falls x 11, same patients and managed within MDT care plans.

Minor cuts / grazes x 6, e.g. cut to finger.

Flood x 1

Clinical

Medication dispensing errors x 4

Prescribing error x 2

Patient intoxicated x 1

Patients withholding medication / self medicating x 3

Error in recording controlled drugs available x 1

Nurse call not answered x 1

Doctor not answering bleep x 1 (role of A+E nurse clarified)

Security

Patient left transport before return to ward x 1

Theft from office x 1

Self Harm

Patient found lying under bathwater x 1

Verbal Abuse

Verbal aggression toward staff x 1

Patient angry when light switched on to assist at night x 1

Property

Equipment failure x 1

November 2009 - March 2010

There were 31 incidents in this period, with the highest severity being a cardiac arrest and the remainder being low.

Accidents

Falls x 2 (managed by MDT care plans)

Minor bruising / cause unknown x 2

Flood x 1

Clinical

Cardiac arrest x 1- (patient successfully treated + transferred to medical ward)

Dispensing error x 2

Missing drug chart at pharmacy x 1

Liquid controlled drug shortage x 2

Concealed tablets x 3

Self medicating x 1

Security

Missing medication keys x 1

Theft x 1

Patient given medical notes to transport by another department x 1

Self Harm

Self injury x 5

Verbal Abuse

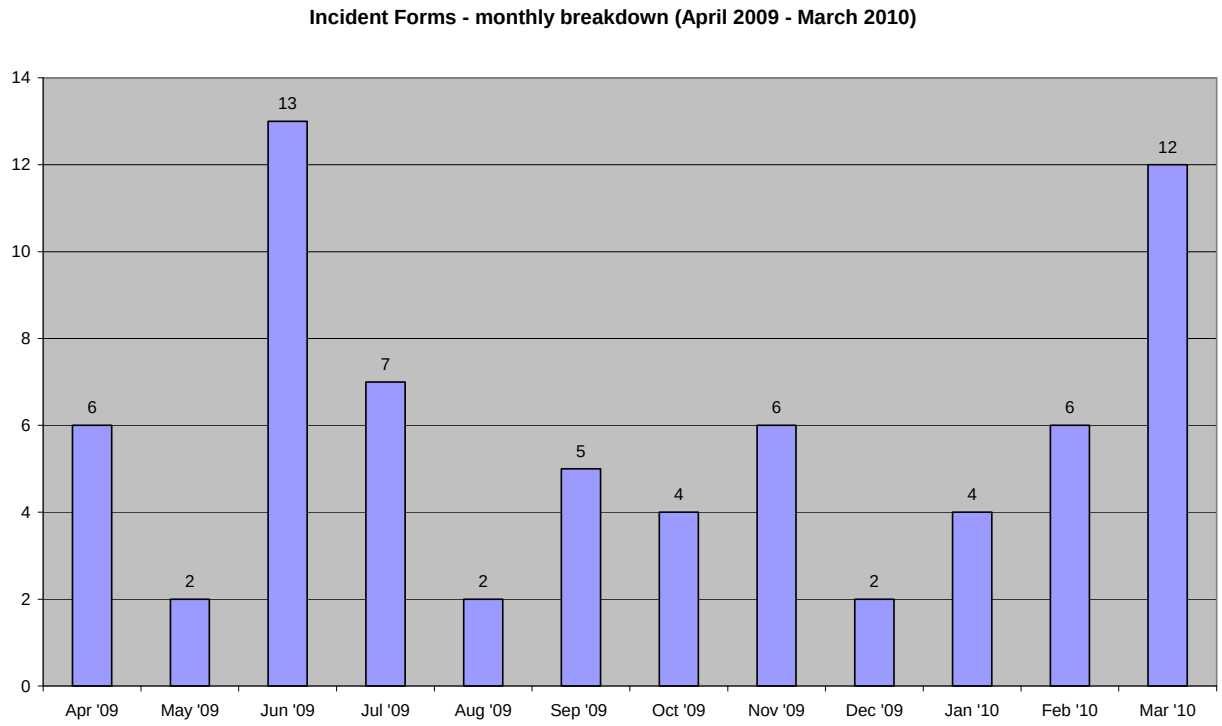
Verbal abuse to staff and patients x 4

Property

Equipment failure x 3

Other

Patient didn't return from planned leave x 1



(This is the first of these reports, but Annual Reports for the YCPM will be produced from now on.)

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