









The Yorkshire Centre for
Psychological Medicine

Annual Report 2010/11

Contents

Page

 Introduction	3
 Purpose	3
 Treatment Approaches	4
 Environment	6
 Performance	7
• Activity	7
• Patient experience	10
• Clinical outcomes	13
• Incidents	17
 Appendix	18
Author list	18

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 UK.

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 second YCPM Annual Report. 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.

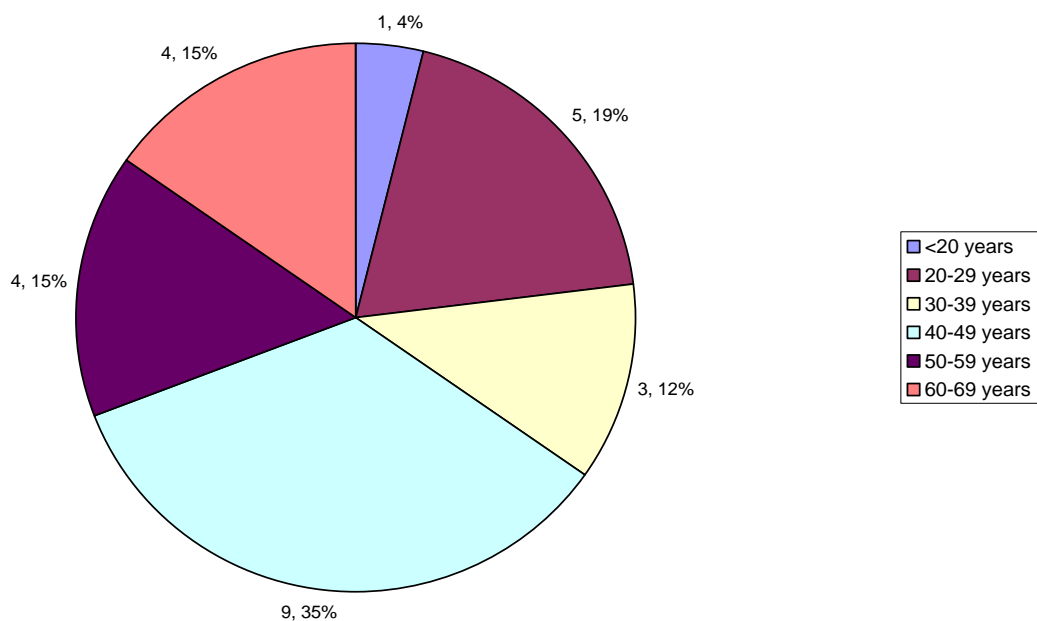
Performance 2010 – 2011

Activity

Inpatient Treatment

Data for all patients discharged from the YCPM between 1st April 2010 and 31st March 2011 were included in this report. There were a total of 26 discharges in this period.

Age Range of Patients discharged between April 2010 - March 2011



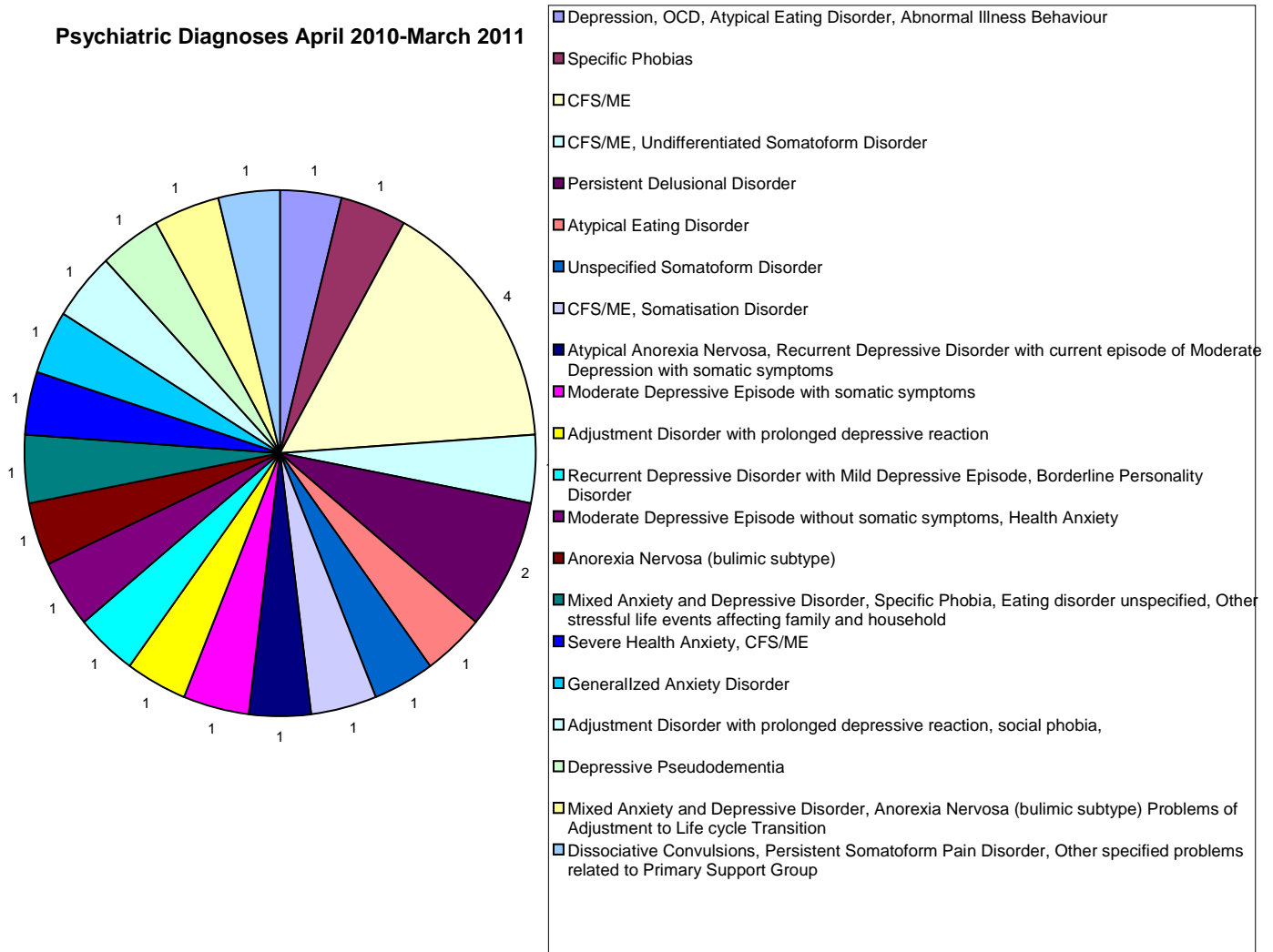
Male : Female = 3 :10

As mentioned earlier in this report, the YCPM team specialises in helping people with three main types of presentation:

- Chronic and/or complex and/or severe medically unexplained symptoms and somatisation (psychologically-based physical symptoms and syndromes).
- Severe physical and psychological/psychiatric comorbidity.
- Patients with severe CFS/ME.

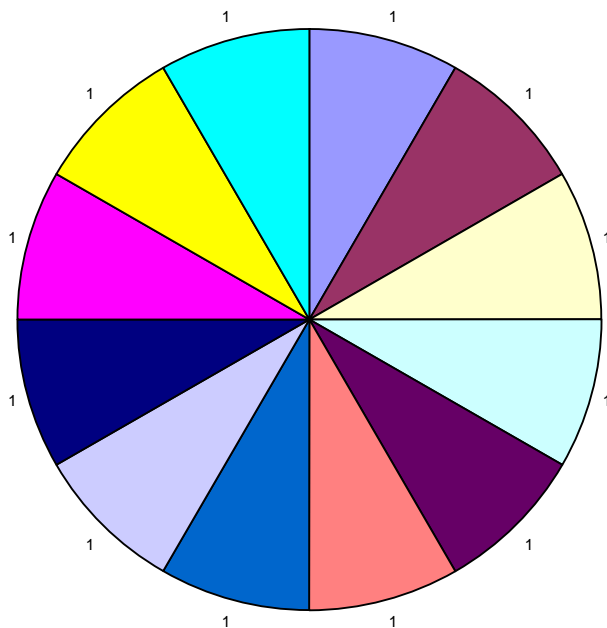
It is also important to note that patients admitted to the unit may present with a broad range of conditions satisfying the criteria for various psychological or psychiatric diagnoses. For the period of this report, this range of diagnoses was as shown below.

Psychiatric Diagnoses April 2010-March 2011



Similarly, patients admitted to the unit tend to present with a broad range of other / comorbid physical health diagnoses. For the period of this report, these diagnoses are as shown below.

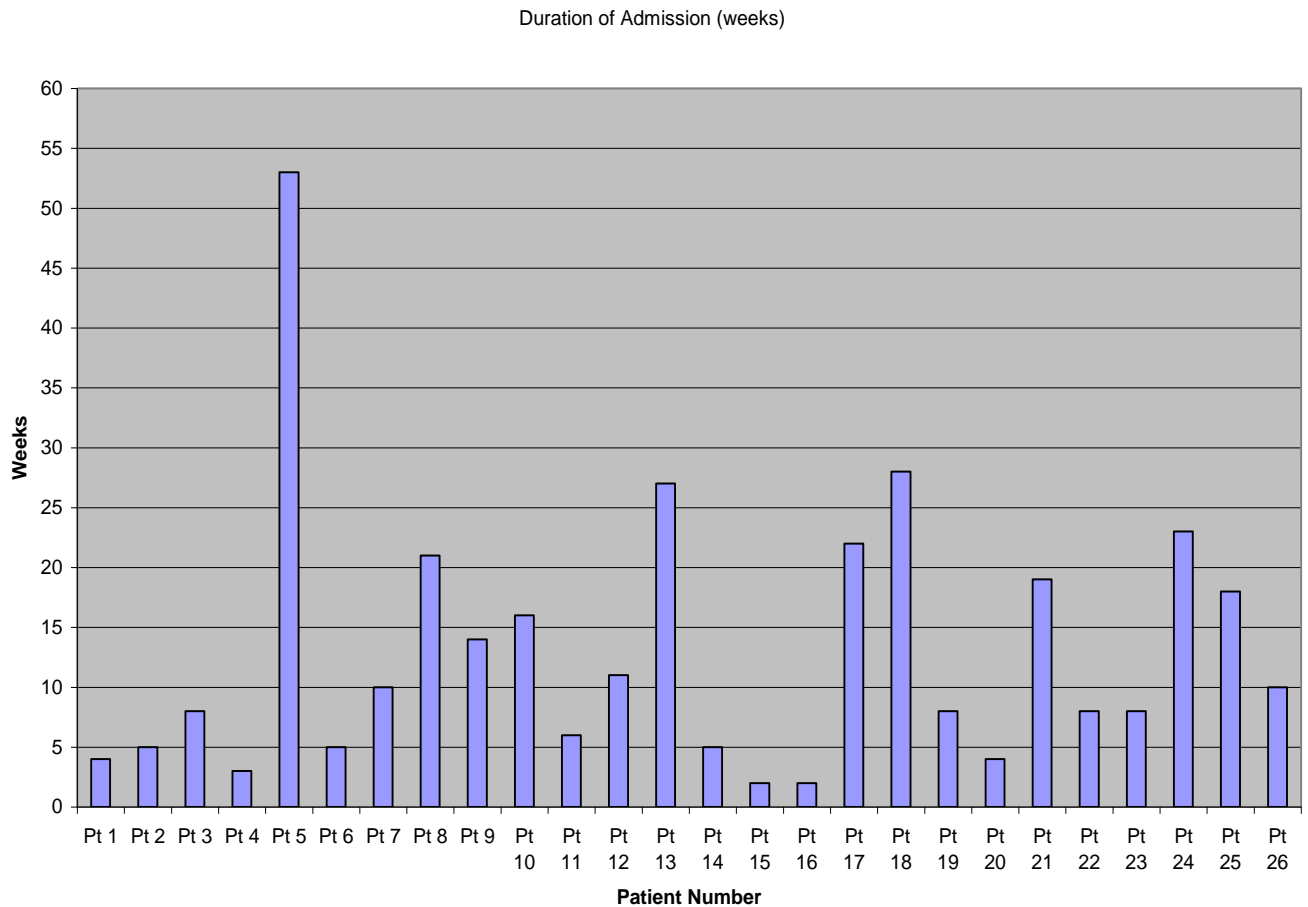
Physical Comorbidities April 2010 - March 2011



- Intestinal Neuronal Aplasia, Ileostomy, Spastic Paraplegia
- Meniere's Disease, Gastro-esophageal Reflux Disease
- Insulin Dependent Diabetes Mellitus with multiple complications (neuropathy, nephropathy, retinopathy and bilateral Cataract)
- Left MCA Infarct with Right sided hemiparesis, Severe Expressive Aphasia, mild-moderate Receptive Aphasia and Speech Apraxia
- Hereditary Cystinuria, Recurrent Renal Calculi, Chronic Abdominal Pain
- Hypokalemia, Acute Renal Failure
- Postural Orthostatic Tachycardia Syndrome, 1st and 2nd Degree Heart Block
- IBS, Obstructive defecation/Anismus
- Stage 3 Kidney Disease, Renal Vascular Disease, Left Adrenalectomy, Pheochromocytoma, Splenectomy, Hysterectomy, Atropic Non functioning Left Kidney, Uncontrolled Hypertension, COPD
- Spinal paraplegia, Chronic Pancreatitis, Hepatitis C, Non-Insulin Dependent Diabetes Mellitus
- Muco-cutaneous Sarcoidosis, Eczema, Asthma, Bronchiectasis, Upper lobe fibrosis, Adenocarcinoma of nose and Upper lip with surgical excision and Prosthetic implant
- Other Specified Diseases of the Pancreas

The result of all of this is that many patients being cared for by the YCPM service are suffering with very complex presentations, involving combinations of multiple physical and psychological symptoms and conditions.

Length of stay, April 2010 – March 2011



The figure above shows the length of stay in weeks for patients discharged from April 2010 to March 2011.

Whole group:

The duration of admission ranged from 2 to 53 weeks, with a whole group average of 13 weeks.

80:20 split:

For the 20% of patients with the longest length of stay, duration ranged from 22 to 53 weeks, with an average of 30.6 weeks.

For the remaining 80% of patients the duration ranged from 2 to 21 weeks, with an average of 8.8 weeks.

Patient experience

The Patient Discharge Questionnaire was created by the YCPM team based on the guidance set out by Leeds Partnerships NHS Foundation Trust. It was designed to collect both qualitative

and quantitative data 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 collated and reviewed regularly in order to continuously improve and 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.

The new version of the patient discharge questionnaire, which included only 7 questions instead of the 17 that were asked in the previous version was introduced in February 2011.

Patient Discharge Questionnaire April 2010 – March 2011

19 (73.07%) of the 26 patients discharged returned completed discharge questionnaires. 5 patients refused to complete the questionnaire and 1 patient had two episodes of admission but was unable to complete the questionnaire for clinical reasons (impairment / disability). Of the 19, 16 patients had been offered the older version of the questionnaire while 3 completed the modified, 7 question version. For the purposes of this report, only the key areas covered in both the questionnaires are being reported.

Ward environment & support from staff

62.5% of the patients who completed the feedback forms stated that they had been shown around the ward and had meal times explained to them upon admission (although due to the practice of pre-admission visits to the unit some may have had that routine explanation at an earlier point).

93.75% reported that their Key nurses and Associate workers were identified for them, while 62.5% were introduced to other staff members and patients at the time of admission.

Involvement in their care.

62.5% of the patients reported that they were provided with copies of their care plans.

Less than 30% of patients felt that key issues related to their care / needs were not addressed during the admission.

Satisfaction with the service

84.2% of patients reported feeling satisfied with their overall care on the ward with 68.4% rating this as good/excellent.

Patient Feedback

(verbatim comments)

Ward environment & support from staff

What stands out for me is how very nice all the staff have been and how much they genuinely want to help.

All staff/ team were the best you could wish for. Excellent!

I don't know how the doctors and all staff put up with me....they could not have done any more....brilliant!

The right support and encouragement was given when needed

Very safe environment...staff are nice, pleasant and smiling...

Experience of the service

You have given me a fresh start and I am able to start to live and walk. Without your perseverance I would not feel as good.

....Clinical support when needed, made new friends....

Excellent consultation.... Staff and team who know what they are talking about and can put you at ease.

I learned a lot about my illness and myself.

I didn't always agree but it worked...

I didn't necessarily feel I could dictate the activities or pace but was informed.

Patients' suggestions for service improvement

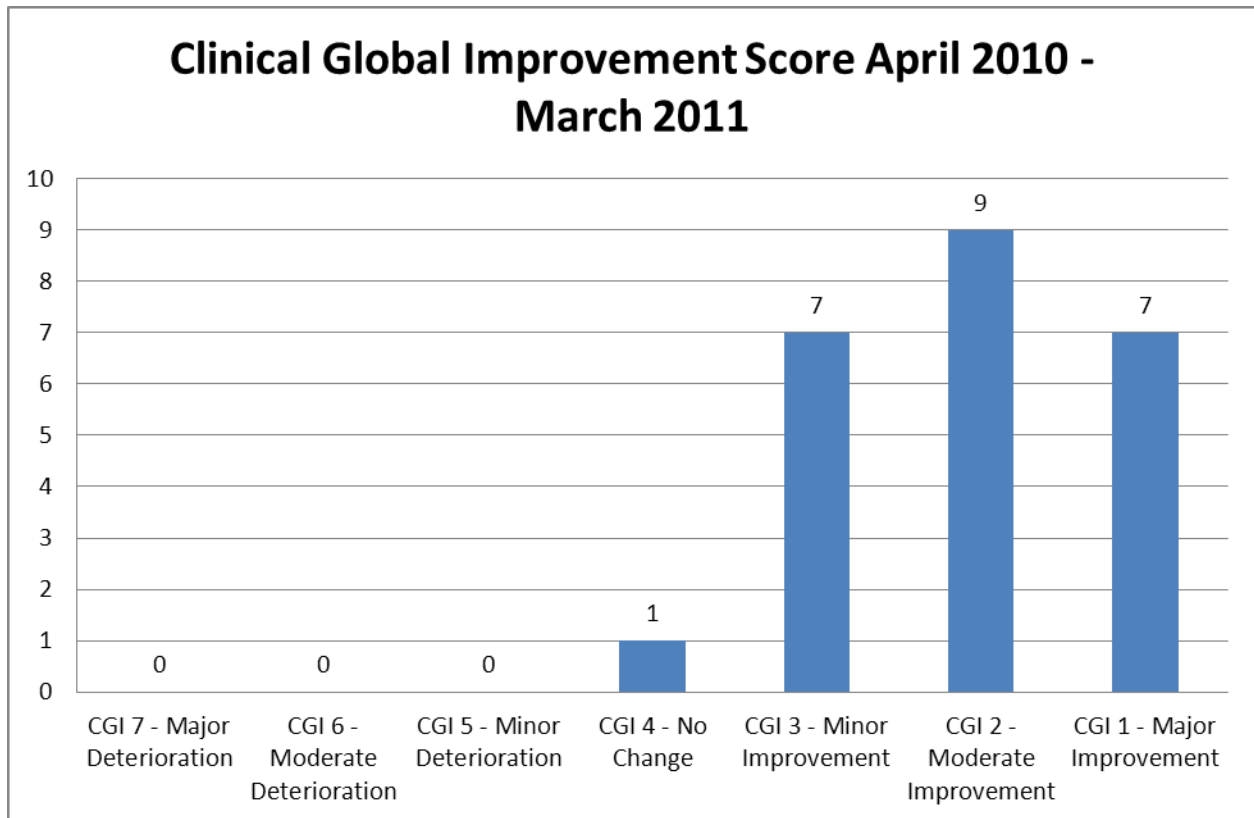
More staff availability on occasions so 1:1 aren't interrupted.

Greater staff saturation...

More time sometimes to talk and feel you are understood....a few more groups of interest to others...

Clinical outcomes

Of the 26 patients discharged in this period, Clinical Global Improvement ratings were carried out for 24, with 2 patients being admitted for assessment only. The data collected is as shown below.



This shows that 16 of the 24 patients (66.6%), in a highly selected group with severe and complex presentations, scored at either Moderate or Major improvement on the CGI Scale.

CORE-OM

The CORE-OM is a self-report questionnaire which, in essence, measures patients' level of psychological distress. It consists of 34 questions that cover 4 dimensions:

- subjective well-being
- problems/symptoms
- life functioning
- 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 the patient's level of current global psychological distress, which can be rated on a continuum from 'healthy' to 'severe'. At the YCPM 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.

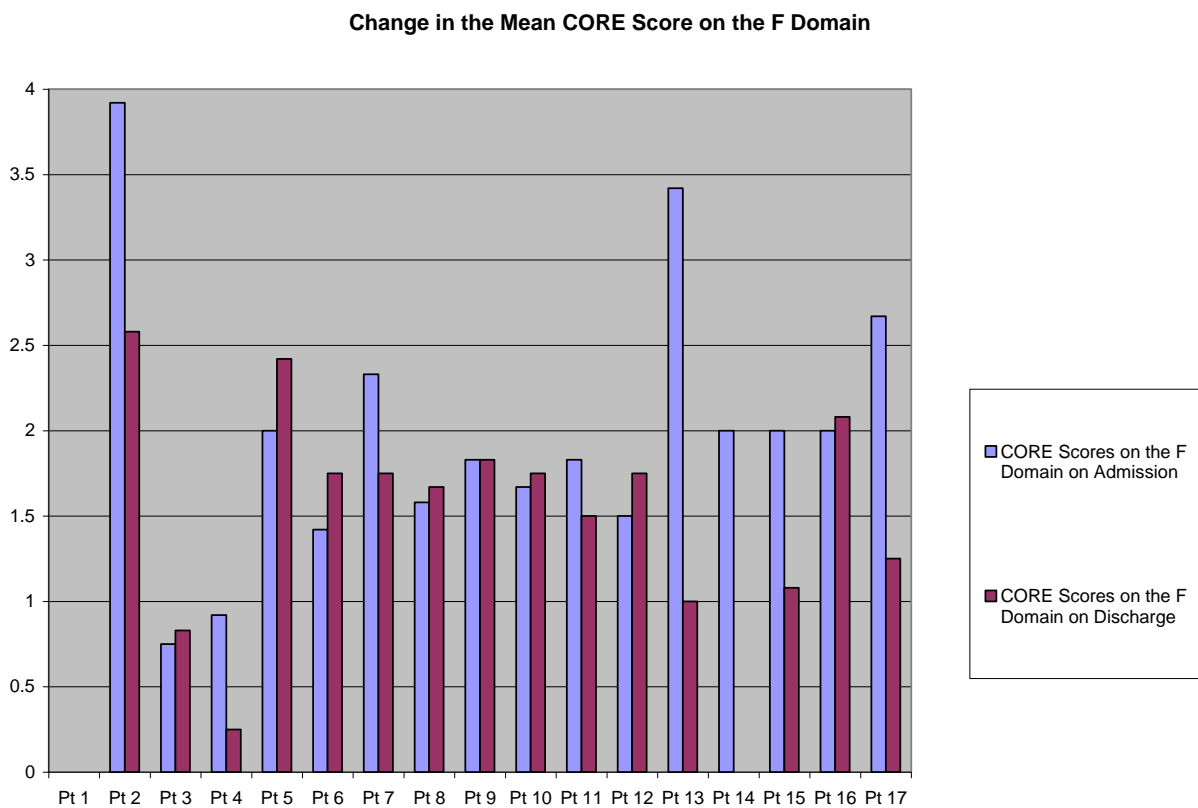
All patients admitted *over the last financial year* were requested to complete a CORE-OM questionnaire on admission and discharge. Patients who were admitted only for a period of assessment or with a very short duration of admission (no more than 2 weeks), were not asked to complete a CORE-OM questionnaires on discharge. Our service began using the CORE-OM last year.

For the period of April 2010 – March 2011 2009 a total of 23 (88.46%) completed CORE-OM forms were obtained on admission and 16 (61.53%) on discharge.

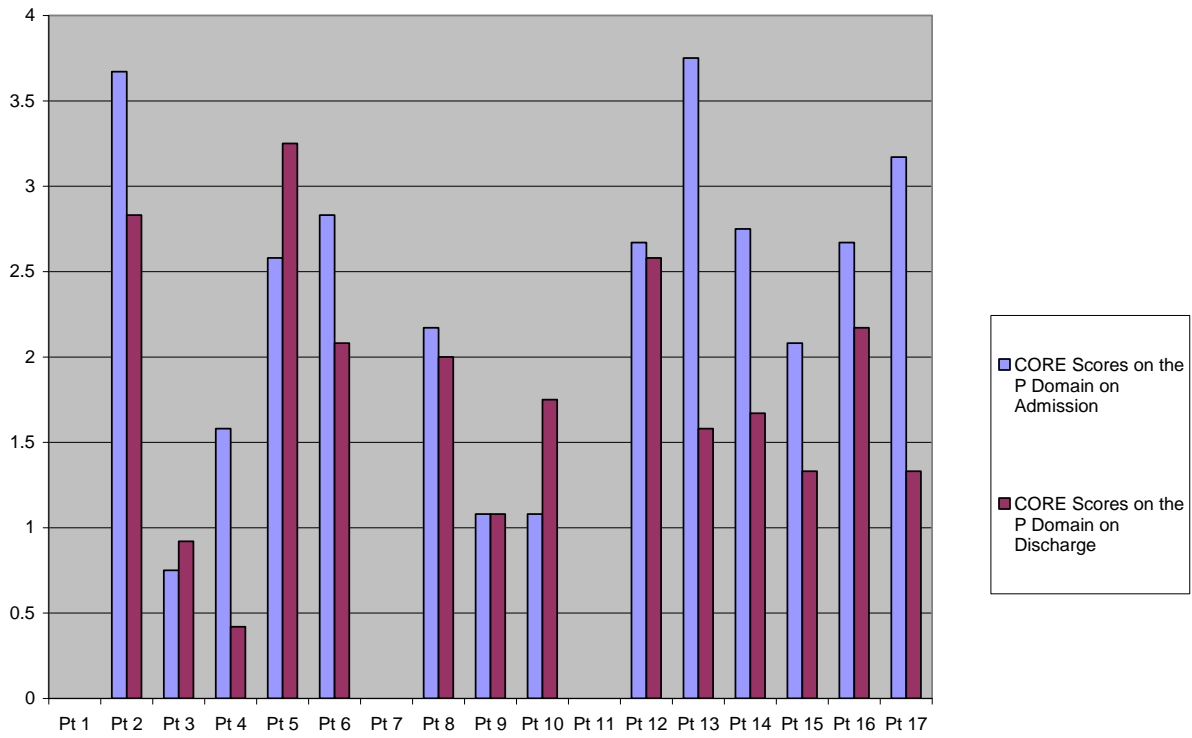
Reasons for the missing discharge CORE-OM forms during this period were as follows:

- 1 of the 26 patients (3.8 %) had an extremely short admission, making collection of repeat CORE scores inappropriate
- 7 (26.9%) patients refused to complete the forms
- 1 patient had two periods of admission (19.2%) but was unable to complete the forms, due to the severity and impact of his physical illness.

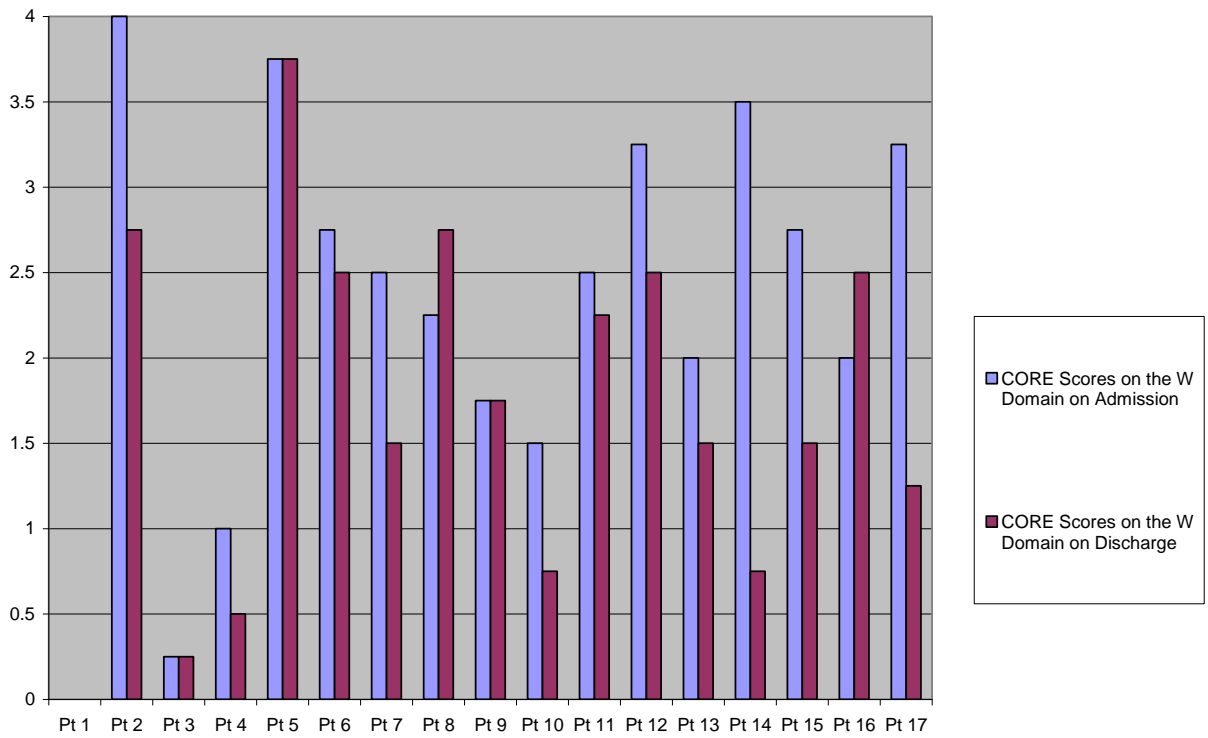
Data gathered on the CORE-OM forms is represented below.



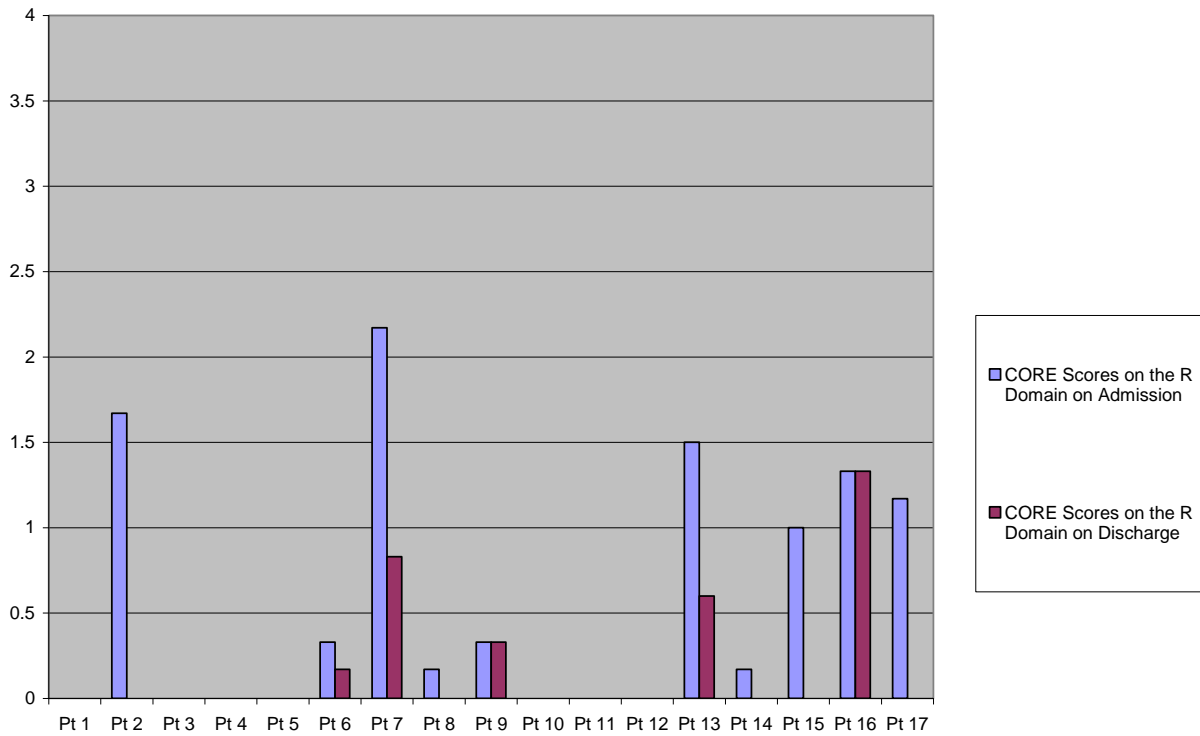
Changes in the Mean CORE Scores on the P Domain



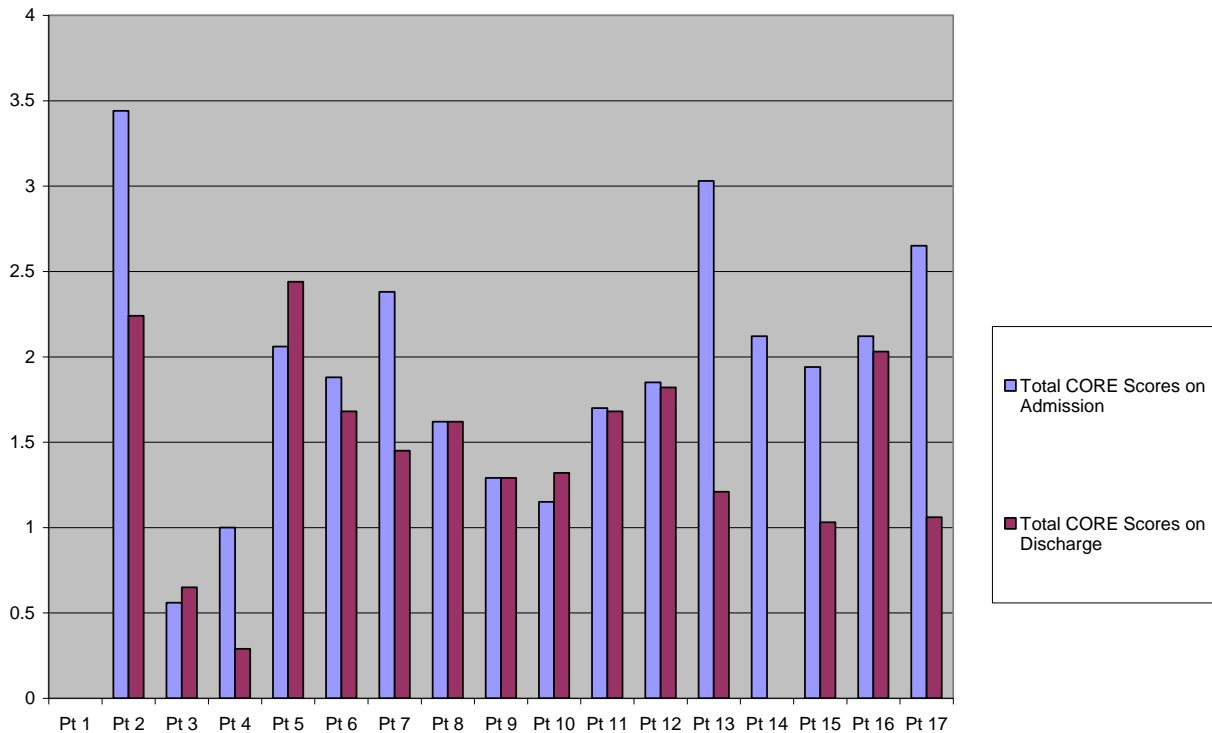
Changes in the Mean CORE Scores on the W Domain



Changes in the Mean CORE Scores on the R Domain



Changes in the Total Mean CORE Scores



NOTE: In addition to using the CORE-OM, we have recently begun to pilot data collection using the EQ-5D-5L. The data obtained will be available and reported upon in the next Annual Report.

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; ie as mapped against the National Patient Safety Agency (NPSA) gradings for levels of harm they are 'no harm' or 'minimal harm' (see Appendix).

In total, 56 incident forms were completed within the period to which this report relates, as detailed below.

April 2010- March 2011

Injuries

Falls x 9, no injuries sustained.

Medications

Drug not signed and administered for 14 days x 1

Prescribing error x 3

T3 form advised oral, patient given via NGT x 1

Medication administration error x 2

Patients withholding medication/self medicating x 3

Error in recording controlled drugs available x 4

Miscellaneous = 33

Door unlocked x 1

Drug keys missing x 1

The remaining 31 incidents were also of low severity (grade 1 or 2, NPSA).

One of these incidents was related to the relatives of a patient being aggressive and hostile towards staff and other patients.

Two were related to the hospital premises and estates / contractors.

One was related to a leak coming from a neighbouring ward, causing minor disruption to services.

Appendix

NPSA Ratings:

1. No injuries, very minor financial loss, and / or service interruption.
2. First aid treatment, minor financial loss, minor service interruption
3. Medical treatment required, moderate financial loss, service interruption.
4. RIDDOR reportable, significant loss of service capability, major financial loss, legal consequences.
5. Death, huge financial loss, permanent / semi permanent loss of service, threat to achievement of Trust's objectives, legal consequences.

Author list

Kairon Eustace	Senior Clinical Nurse
Dr Madhu Kewalramani	Speciality Doctor
Diane Neil	Senior Clinical Nurse
Russell Saxby	Clinical Team Manager
Dr Peter Trigwell	Consultant in Liaison Psychiatry

Yorkshire Centre for Psychological Medicine (YCPM)

Leeds Partnerships NHS Foundation Trust

2011