Annual Report

2012/13

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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 at 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 the Leeds and York Partnership NHS Foundation Trust. Everything we do accords with NHS values and our stated Trust purpose of improving health and improving lives.

This is the fourth 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 Chronic Fatigue Syndrome (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

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 CFS/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 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.

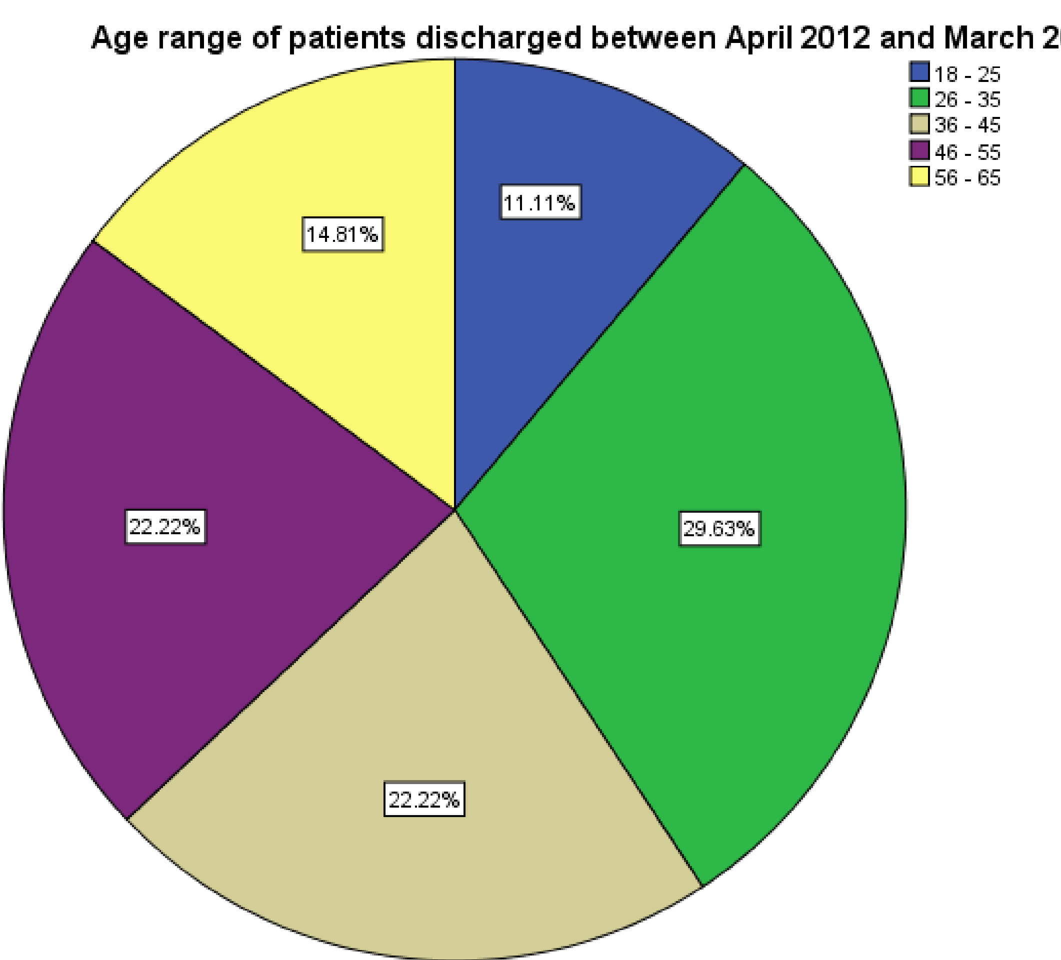
The conservatory and balcony areas enable patients to spend time with their fellow patients and with their visitors in a relaxing environment.

Performance 2012-13

Activity

Inpatient Treatment

Data for all patients discharged from the YCPM between 1st April 2012 and 31st March 2013 were included in this report. In total **27** patients were discharged during this period.



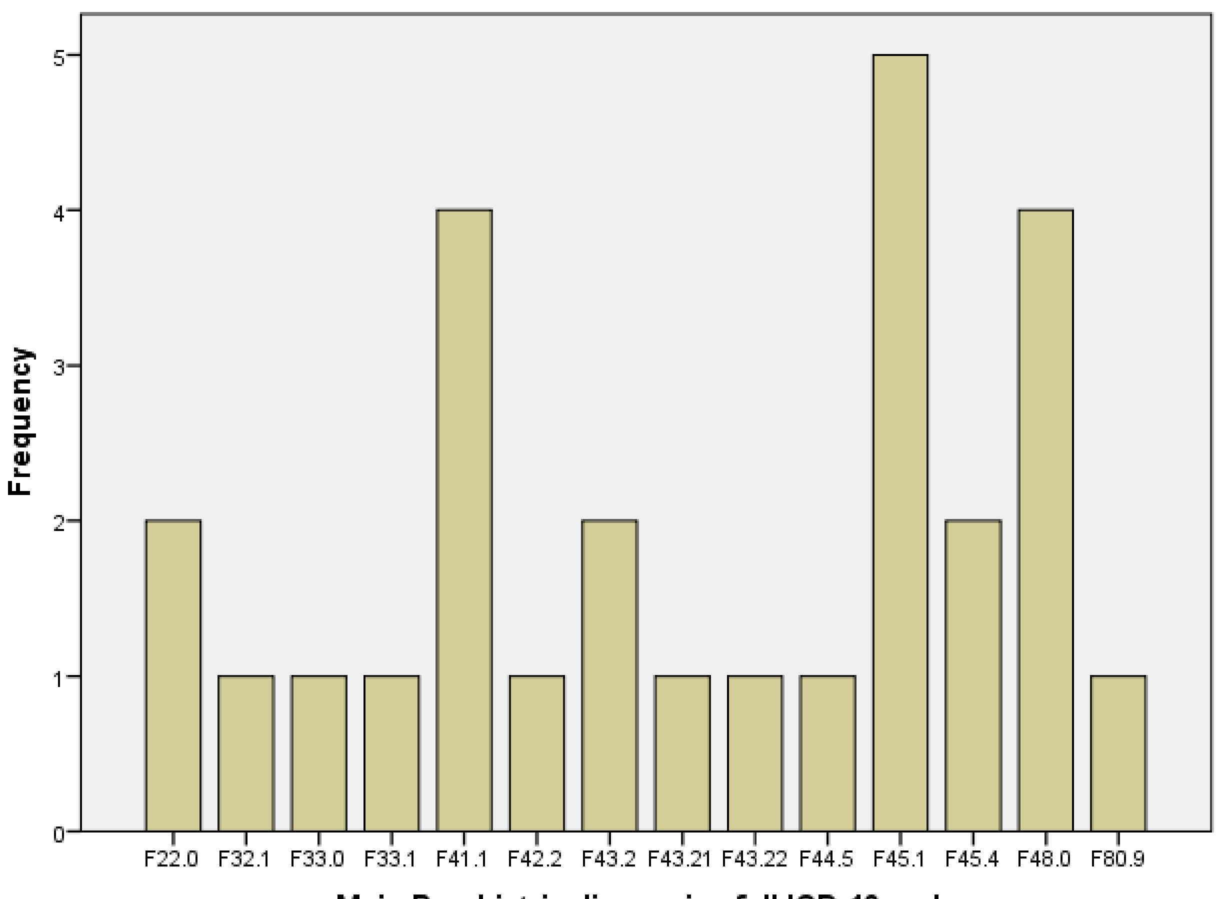
Female : Male ratio = 3.5 : 1

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:



Diagnoses:

F22.0 = Persistent delusional disorder

F32.1 = Moderate depressive episode

F33.0 = Recurrent depressive disorder, current episode mild

F33.1 = Recurrent depressive disorder, current episode moderate

F41.1 = Generalized anxiety disorder

F42.2 = Obsessive compulsive disorder – mixed obsessional thoughts and acts

F43.2 = Adjustment disorder

F43.21 = Adjustment disorder – prolonged depressive reaction

F43.22 = Adjustment disorder – mixed anxiety and depressive reaction

F44.5 = Dissociative convulsions

F45.1 = Undifferentiated somatoform disorder

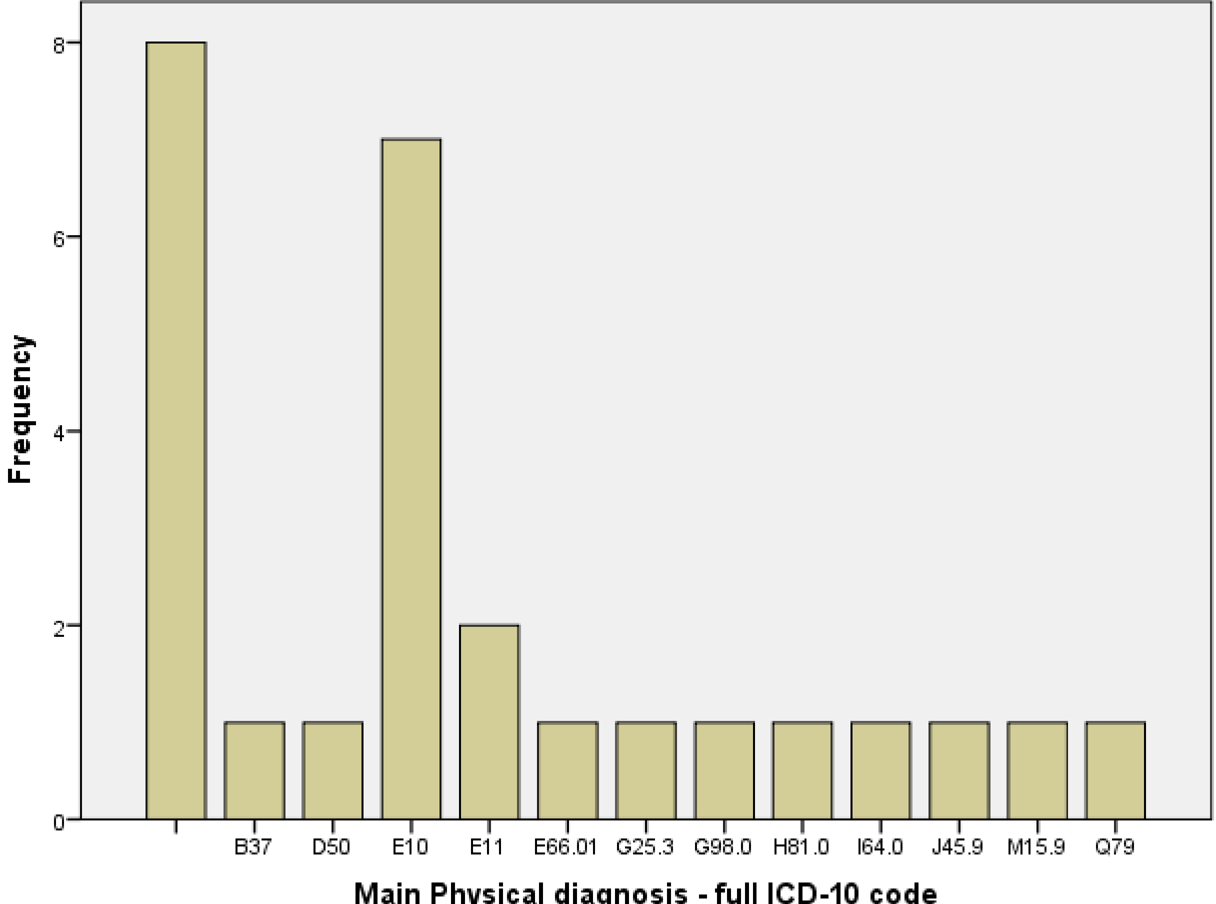
F45.4 = Persistent somatoform pain disorder

F48.0 = Neurasthenia / CFS/ME

F80.9 = Developmental disorder of speech and language

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:



Diagnoses:

Nil = no organic pathology / no physical diagnosis

B37 = Oral candidiasis

D50 = Iron deficiency anaemia

E10 = Type 1 diabetes mellitus

E11 = Type 2 diabetes mellitus

E66.0 = Obesity

G25.3 = Myoclonic jerks

G98.0 = Nervous system disorder, NOS

H81.0 = Meniere's disease

I64.0 = Stroke – CVA, NOS

J45.9 = Bronchial asthma

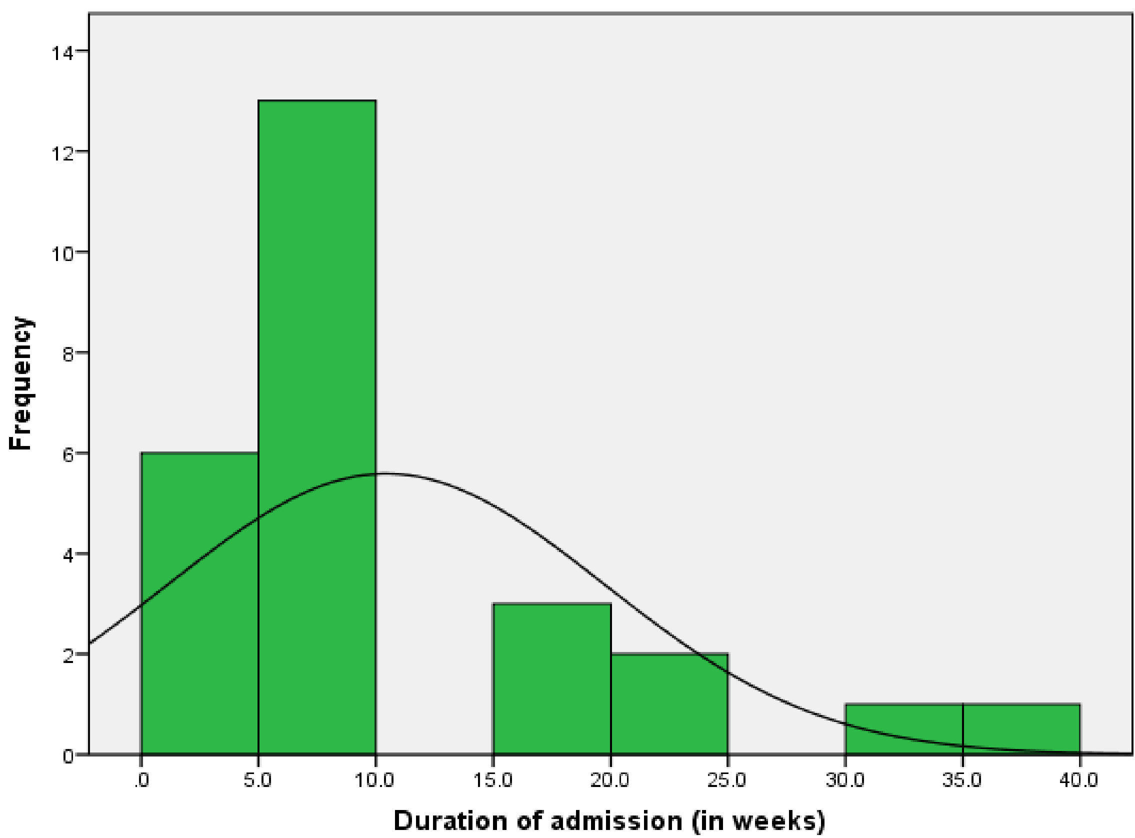
M15.9 = Osteoarthritis

Q79 = Congenital diaphragmatic hernia

NOTE: for ease of presentation and interpretation the tables above only show the MAIN psychiatric and physical diagnoses for each person – many patients admitted to the YCPM have multiple psychiatric and multiple physical diagnoses as comorbid presentations.

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 2012 – March 2013



The figure above shows the length of stay in weeks for patients discharged from April 2012 to March 2013.

Whole group:

The duration of admission ranged from 1 to 38 weeks, with a whole group average of 10.4 weeks.

80:20 split:

For the 20% of patients with the longest length of stay, duration ranged from 17.5 to 38 weeks, with an average of 26.5 weeks.

For the remaining 80% of patients the duration ranged from 1 to 16.7 weeks, with an average of 6.6 weeks.

Clinical Outcome Measures

The YCPM provides a unique service for the broad range of people suffering with severe and complex MUS. Outcome measurement takes place routinely, providing evidence of clinical effectiveness in what is a highly selected group of very complex cases. Many of these cases have previously been found to be intractable or untreatable by other services, hence the referral to the YCPM. In the context of the severe and complex nature of these cases and the difficult nature of this work the outcome figures are good.

Outcome measures currently in use:

1. Clinical Global Impression (CGI)

The proportions of patients showing **improvement** on the CGI are:

- **81%** in 2009/10

(Major improvement 22%, Moderate improvement 34%, Minor improvement 25%)

- **90%** in 2010/11

(Major improvement 33%, Moderate improvement 33%, Minor improvement 24%)

- **89%** in 2011/12

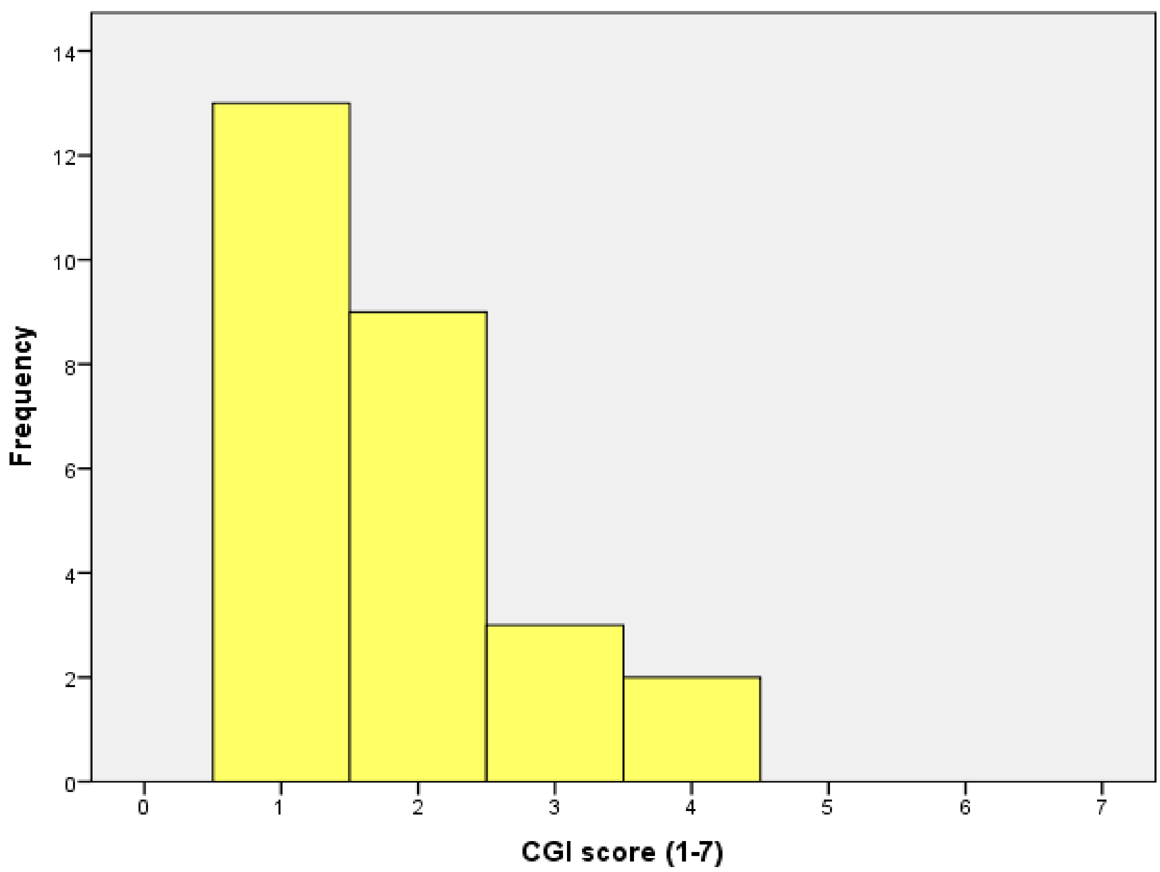
(Major improvement 48%, Moderate improvement 33%, Minor improvement 7%)

- **93%** in 2012/13

(Major improvement 48%, Moderate improvement 33%, Minor improvement 11%)

Of the 27 patients discharged in the 2012/13 period, Clinical Global Improvement ratings were carried out for all 27 of them.

As shown in the chart below, 22 of the 27 patients (**81.5%**), in a highly selected group with severe and complex presentations, scored at either **Moderate or Major improvement** on the CGI Scale.



Key:

1 = Major improvement

2 = Moderate improvement

3 = Minor Improvement

4 = No change

5 = Minor deterioration

6 = Moderate deterioration

7 = Major deterioration

2. 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.

(Patients who are admitted only for a brief period of assessment are not asked to complete a CORE-OM questionnaire on discharge.)

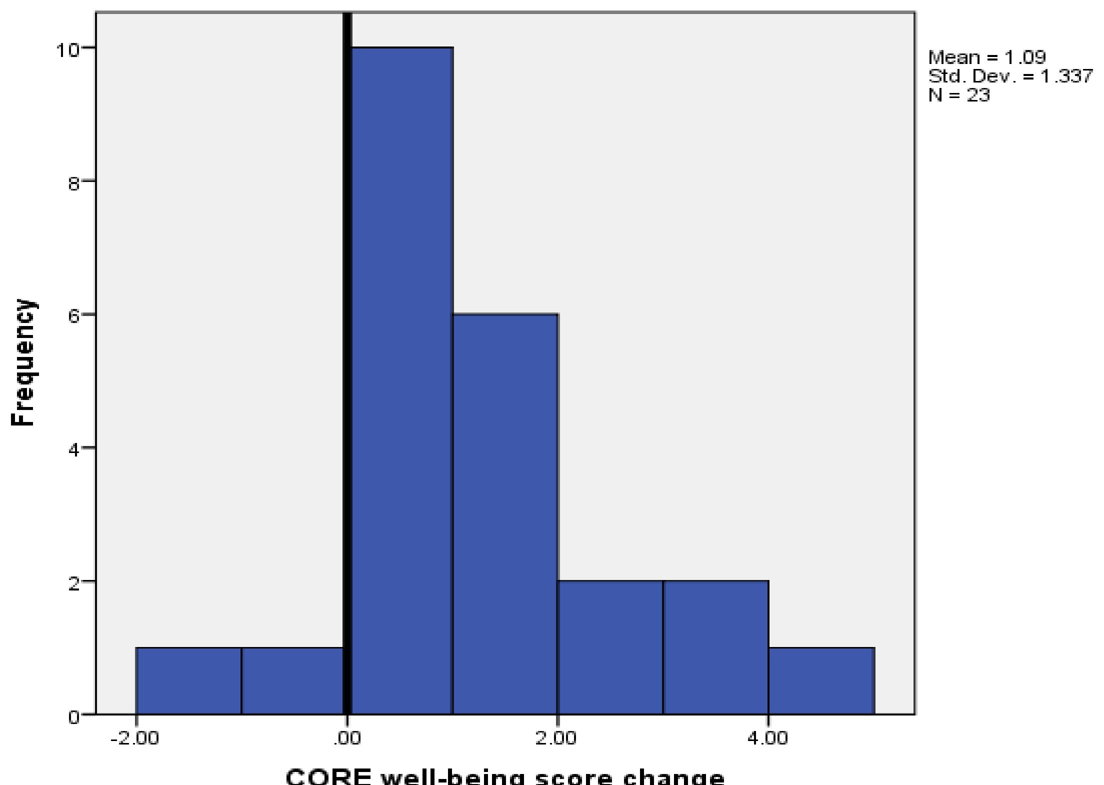
April 2012 – March 2013:

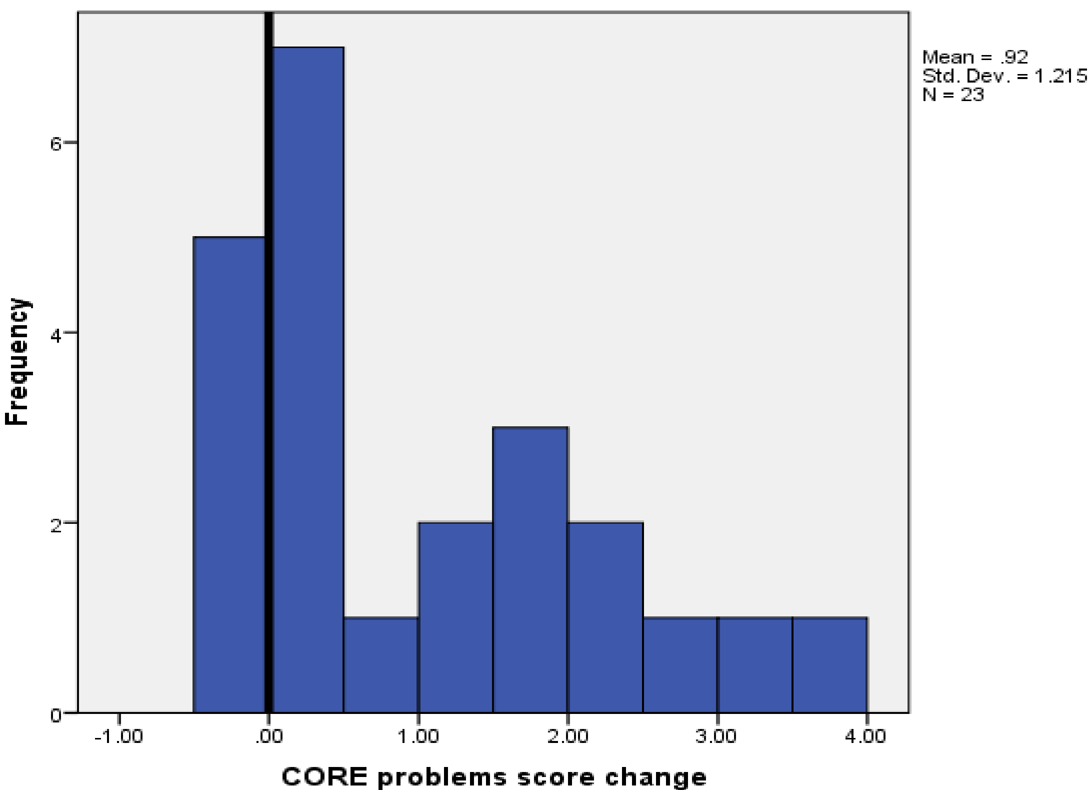
- Wellbeing subscale 91.3% improved
- Problems subscale 78.3% improved
- Functioning subscale 87.0% improved
- Risk subscale 82.6% improved
- **Total CORE scores 78.3% improved**

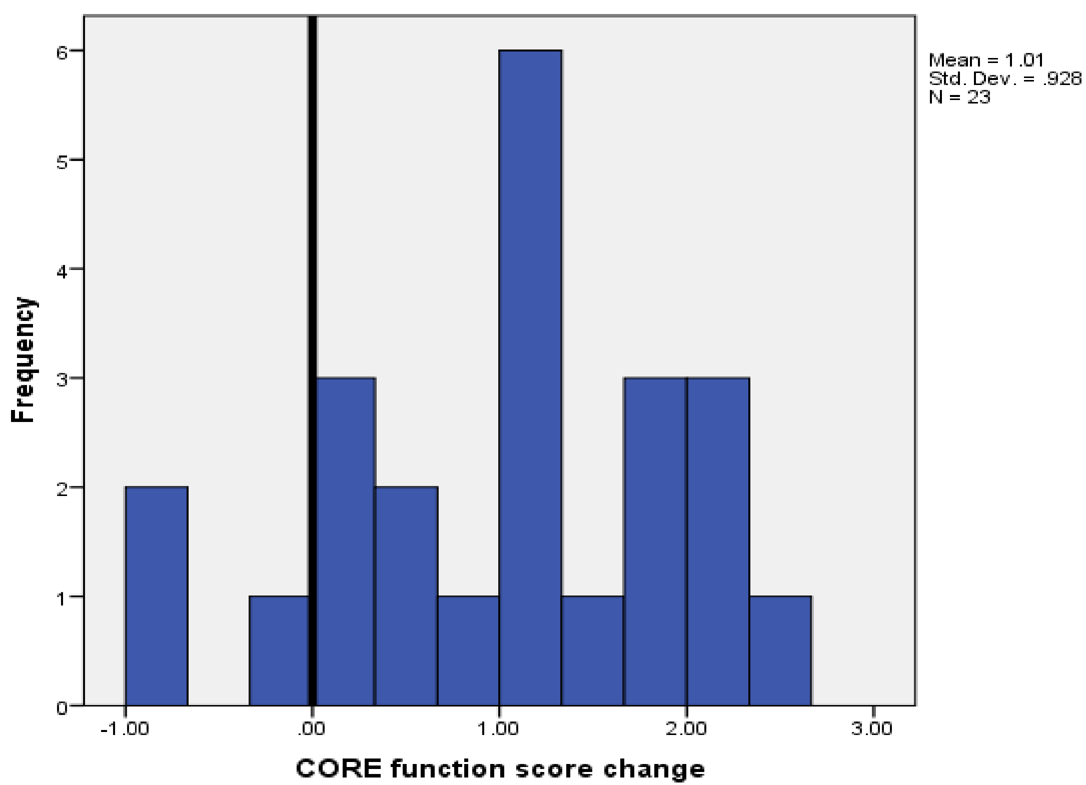
Mean CORE scores	Admission	Discharge
Wellbeing subscale	2.79	1.70
Problems subscale	2.54	1.62
Functioning subscale	2.21	1.21
Risk subscale	0.57	0.28
Total CORE scores	2.08	1.29

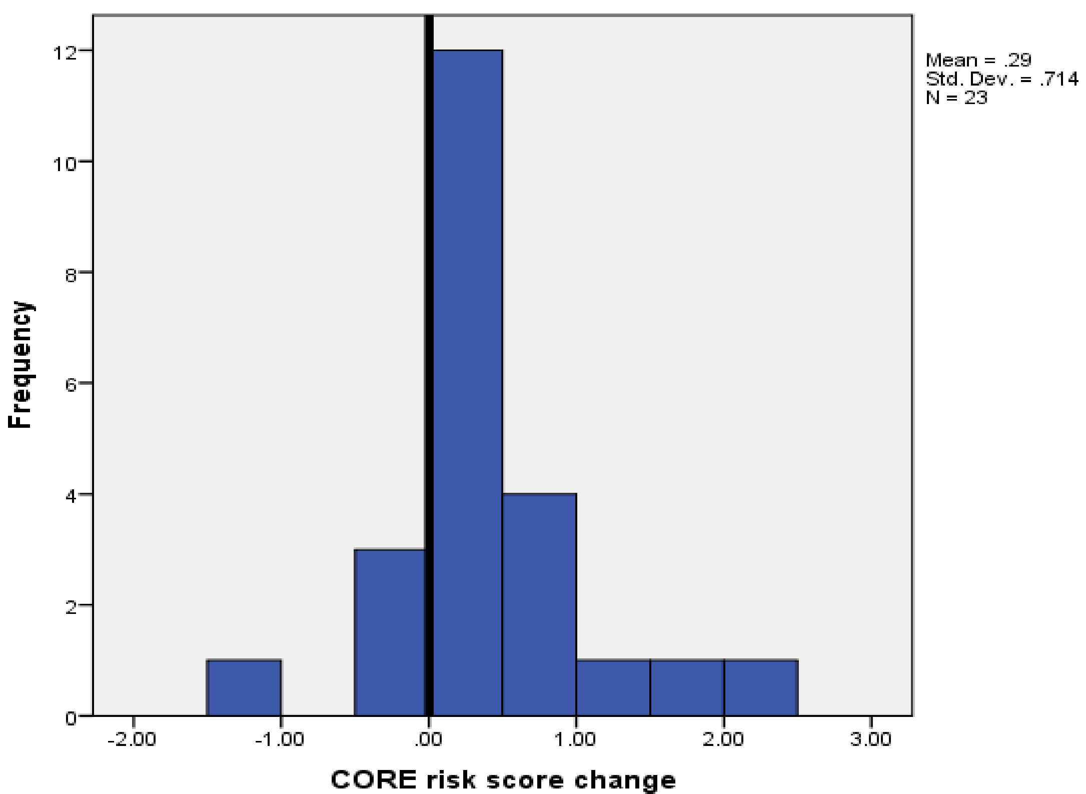
Data gathered on the CORE-OM forms is represented below.

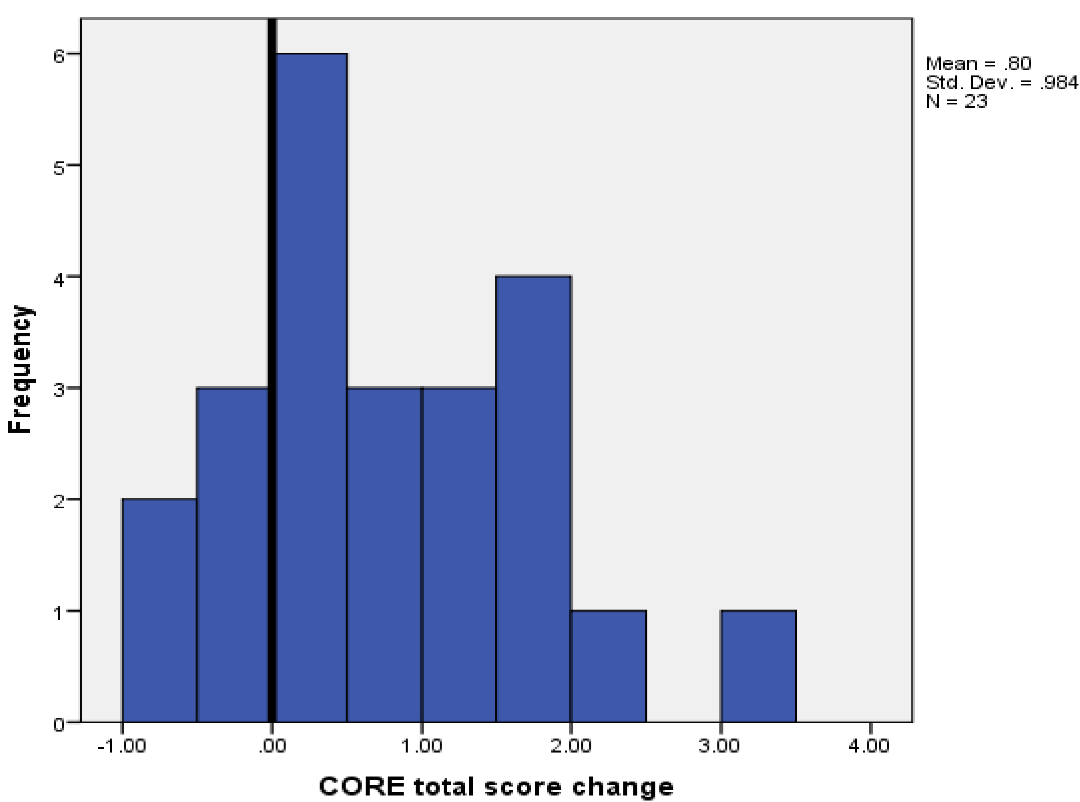
(**NOTE**: on this measure, and the construction of the charts shown below, a positive change in subscale and total CORE scores (ie above the zero line on the bottom axis) is desirable and is evidence of improvement / reduced distress.)


Mean = 1.09
Std. Dev. = 1.337
N = 23
Frequency
10
8
6
4
2
0
-2.00
.00
2.00
4.00
CORE well-being score change


Mean = .92
Std. Dev. = 1.215
N = 23
Frequency
6
4
2
0
-1.00
.00
1.00
2.00
3.00
4.00
CORE problems score change


Frequency
6
5
4
3
2
1
0
-1.00
.00
1.00
2.00
3.00
CORE function score change
Mean = 1.01
Std. Dev. = .928
N = 23


Frequency
12
10
8
6
4
2
0
-2.00
-1.00
.00
1.00
2.00
3.00
CORE risk score change
Mean = .29
Std. Dev. = .714
N = 23



3. EQ-5D-5L

This measure asks the scorer to rate against 5 levels across 5 domains:

a) Mobility

b) Self-care

c) Usual activities

d) Pain / discomfort

e) Anxiety / depression

Plus a 100 point Visual Analogue Scale (VAS) to indicate overall “how good or bad your health is”.

In the context of the experience of providing this service this approach has a naturally close fit with the work of the unit, both intuitively and with regard to the face validity of the measure.

(Patients who are admitted only for a brief period of assessment are not asked to complete an EQ-5D-5L questionnaire on discharge.)

April 2012 – March 2013:

Of those people who initially scored at the level of experiencing Moderate problems or worse (ie a score of 3 or more) in each particular domain, the proportion of those showing improvement during the admission was as follows:

- **Mobility** improved in **50.0%** of patients
- **Self-care** improved in **54.5%** of patients
- **Usual activities** improved in **68.8%** of patients
- **Pain / discomfort** improved in **37.5%** of patients
- **Anxiety / depression** improved in **78.6%** of patients

Also, across the whole patient group:

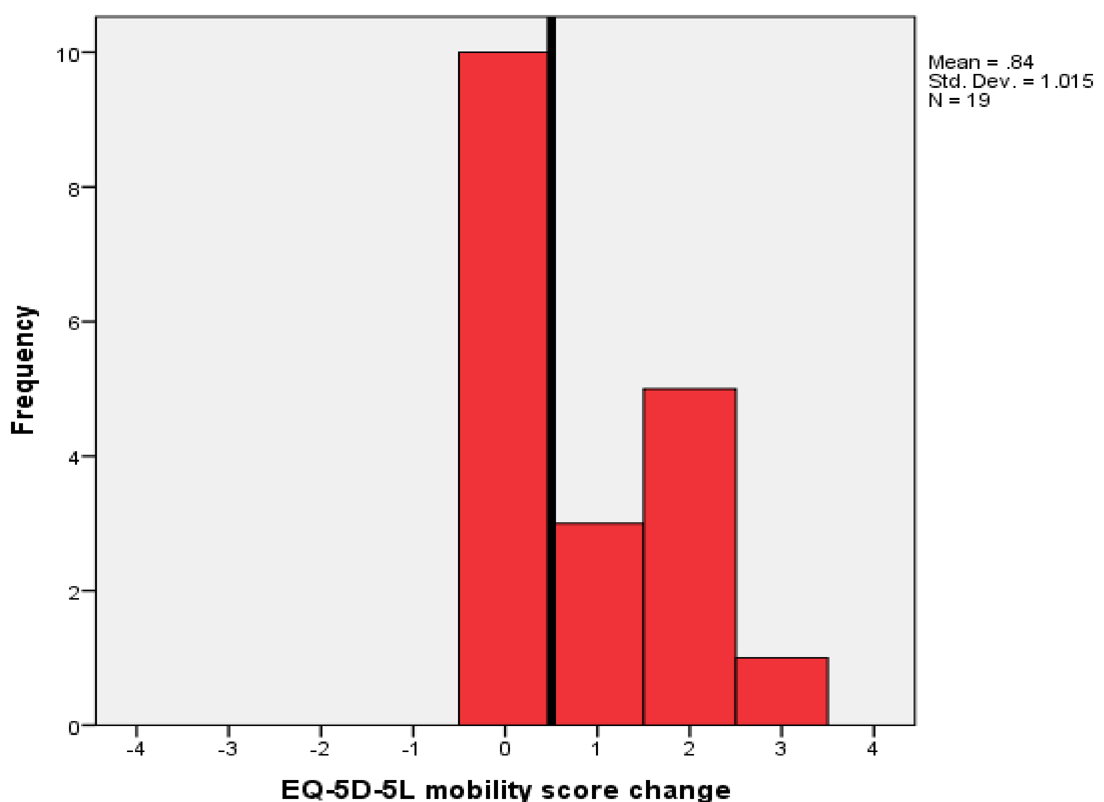
- **At least one domain** improved in **84.2%** of patients
- **Overall health VAS** improved in **73.7%** of patients

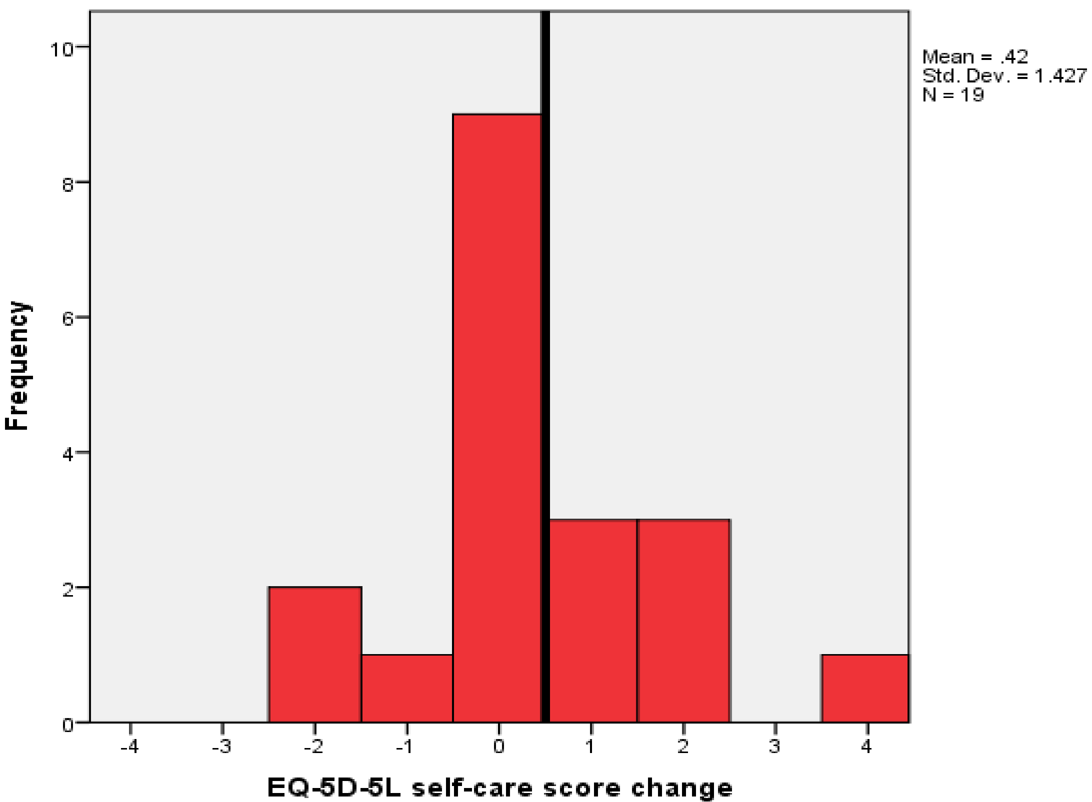
Scores from the EQ-5D-5L can be converted into Health Valuations (otherwise known as Index Values). Using the "crosswalk value set for the UK", for 2011/12:

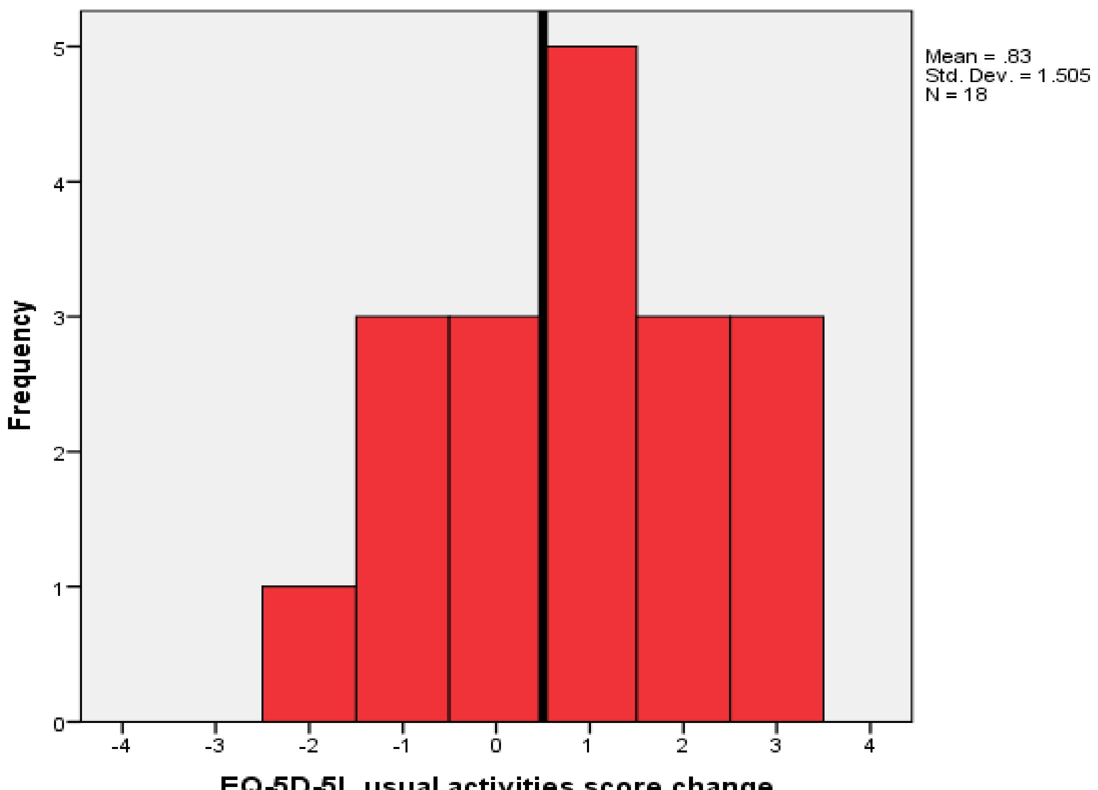
- **72.2%** of patients showed an increase (improvement) in overall Health Valuation score

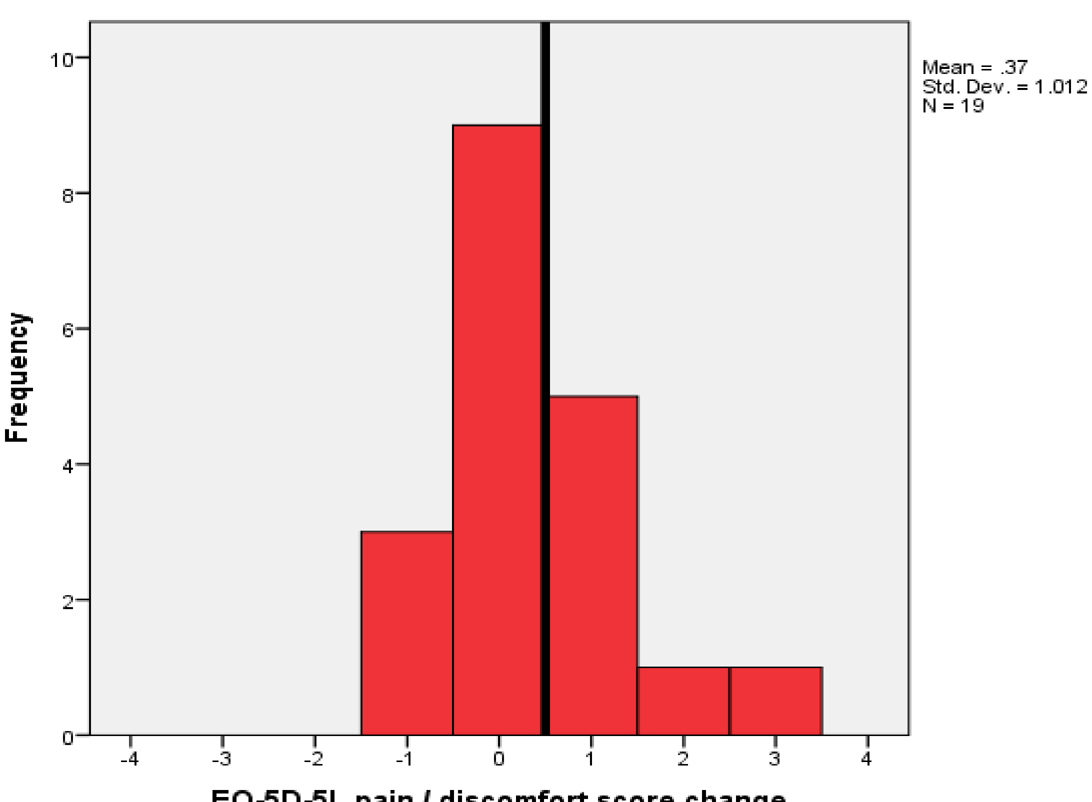
NOTE:

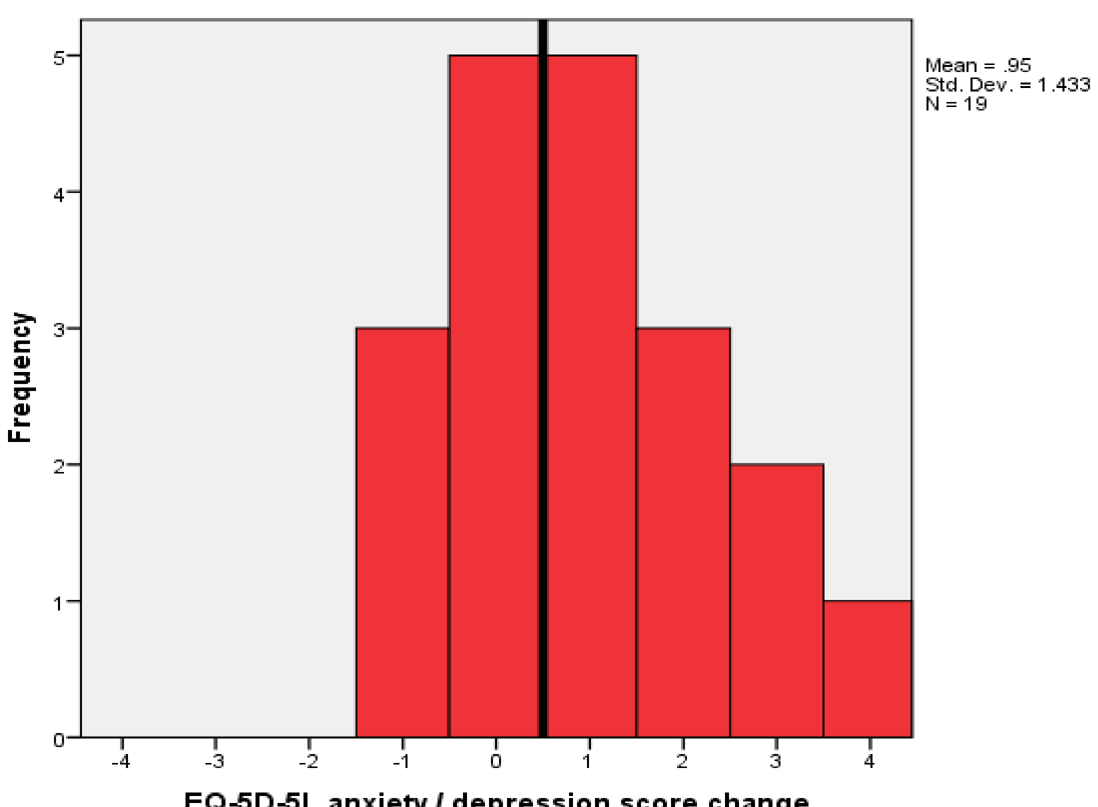
- On the EQ-5D-5L measure, and in the construction of the 5 charts which follow, a positive change in EQ-5D-5L subscale (ie an increase in score by 1, 2, 3 or 4 steps) is desirable as evidence of improvement in functioning, etc., and is indicated by the score change columns to the right of the reference line on the bottom axis.
- Similarly in the 6th chart, which illustrates Overall Health Score Change, scores are taken from the 100 point EQ-5D-5L Visual Analogue Scale (score at Discharge minus score at Admission) and a positive change is desirable as evidence of improvement, as indicated by the score change columns to the right of the reference line on the bottom axis.

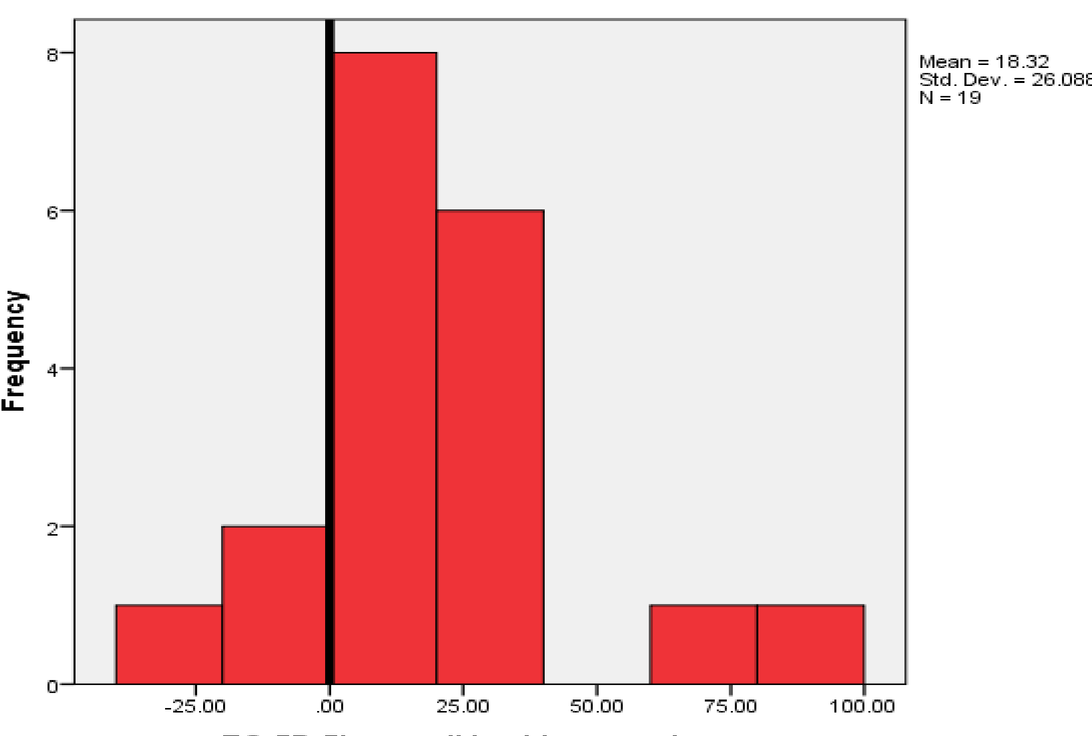

Mean = .84
Std. Dev. = 1.015
N = 19
Frequency
EQ-5D-5L mobility score change


Mean = .42
Std. Dev. = 1.427
N = 19
Frequency
EQ-5D-5L self-care score change


Mean = .83
Std. Dev. = 1.505
N = 18
Frequency
EQ-5D-5L usual activities score change


Mean = .37
Std. Dev. = 1.012
N = 19
Frequency
EQ-5D-5L pain / discomfort score change


Mean = .95
Std. Dev. = 1.433
N = 19
Frequency
5
4
3
2
1
0
-4
-3
-2
-1
0
1
2
3
4
EQ-5D-5L anxiety / depression score change


Mean = 18.32
Std. Dev. = 26.088
N = 19
Frequency
8
6
4
2
0
-25.00
.00
25.00
50.00
75.00
100.00
EQ-5D-5L overall health score change

4. HAD (Hospital Anxiety and Depression) scale

This 14 item measure consists of 7 items rating Anxiety (giving the "HAD-A" score) and 7 items rating Depression (giving the "HAD-D" score). For each of these subscales the cut-off score (threshold) which indicates a person is likely to be suffering with a case of clinical anxiety or depression is a score of 12 or more.

The HAD-A results reported here are for people who scored at or above the threshold of 12 at admission on the Anxiety subscale and, similarly, the HAD-D results are for people who scored at or above the threshold of 12 at admission on the Depression subscale.

April 2013 – March 2013

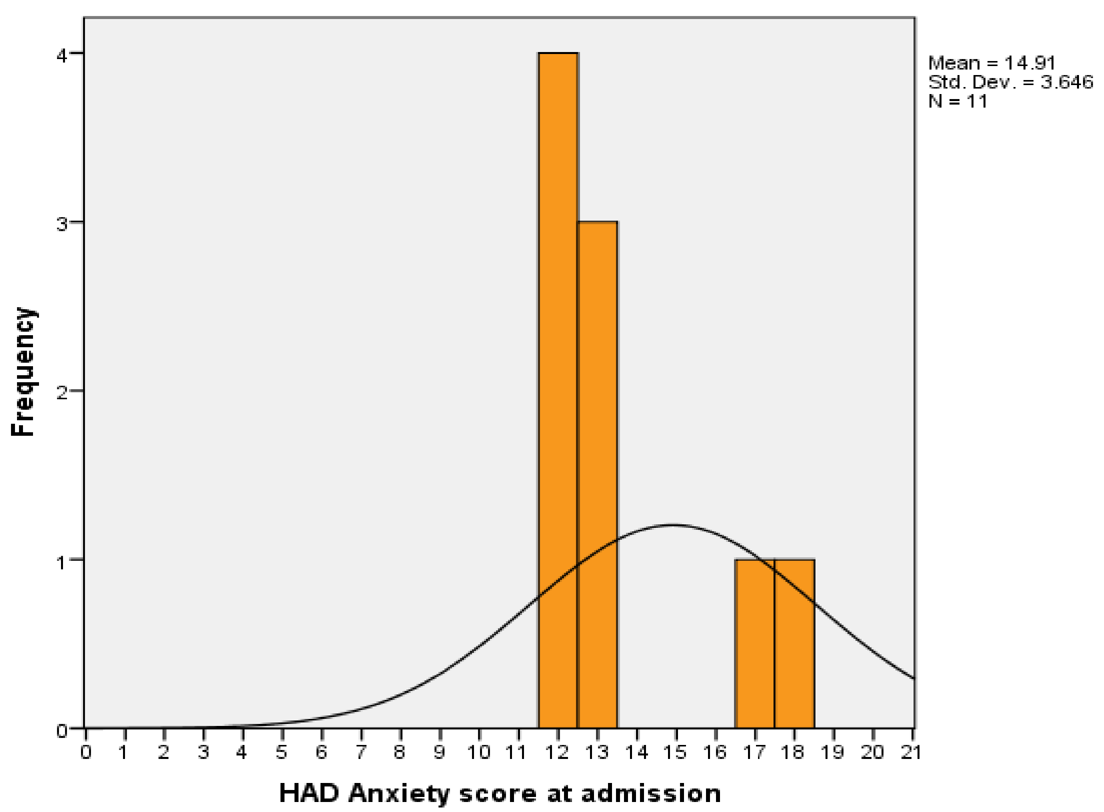
HAD-A:

- 11 people (41% of patients admitted) scored at or above 12 on HAD-A at admission
- All (100%) showed a reduction in score by the time of discharge
- The scores in 10 (91%) reduced to below threshold
- In the remaining 1 (9%), the score had reduced from 17 at admission to 13 at discharge

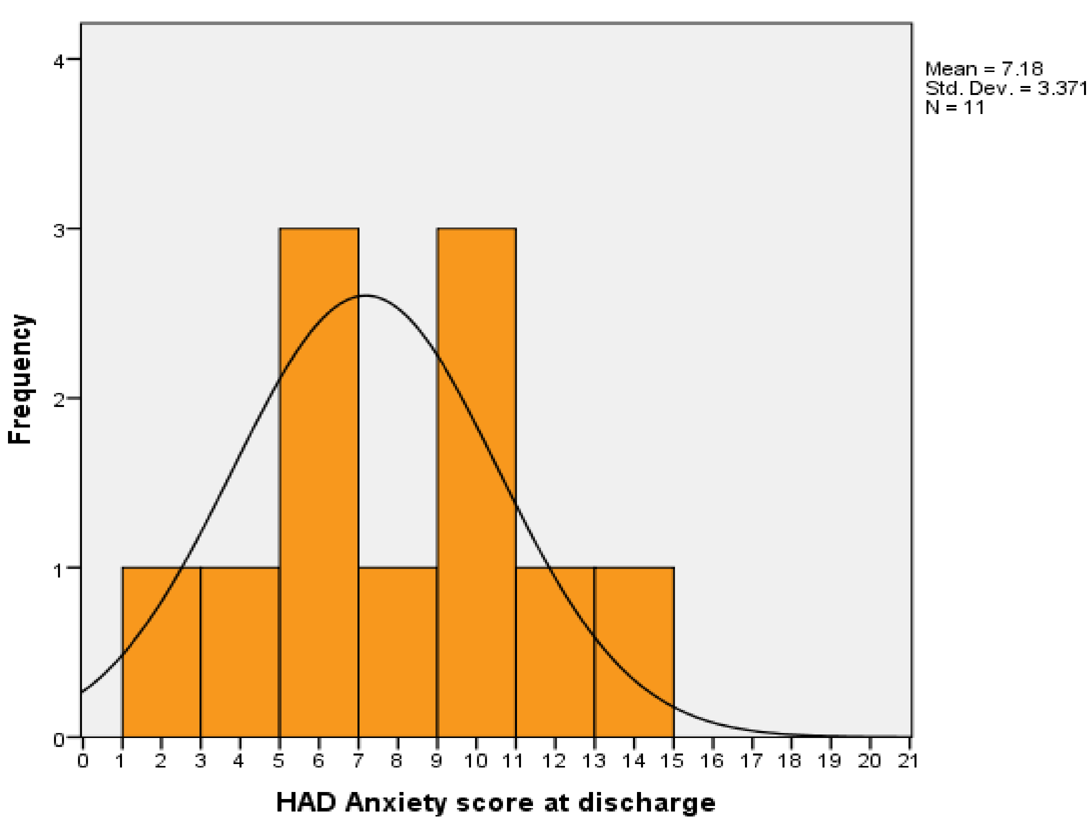
HAD-D:

- 13 people (48% of patients admitted) scored at or above 12 on HAD-D at admission
- Scores reduced in 12 (92%) by the time of discharge
- In the remaining 1 person the score was 12 at admission and still 12 at discharge
- The scores in 6 (46%) reduced to below threshold
- In the remaining 7 (54%), although the scores had reduced in all of them they remained at 12 or above at discharge

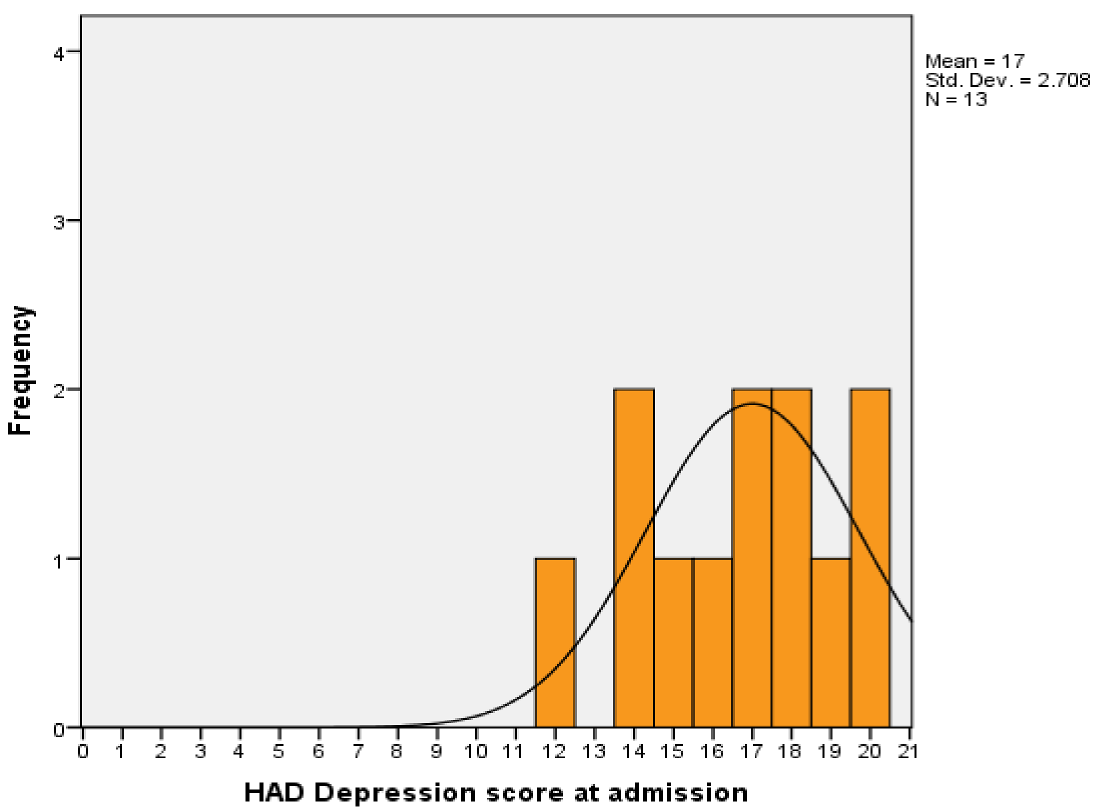
(**NOTE**: comparative charts below include mean scores at admission and discharge.)

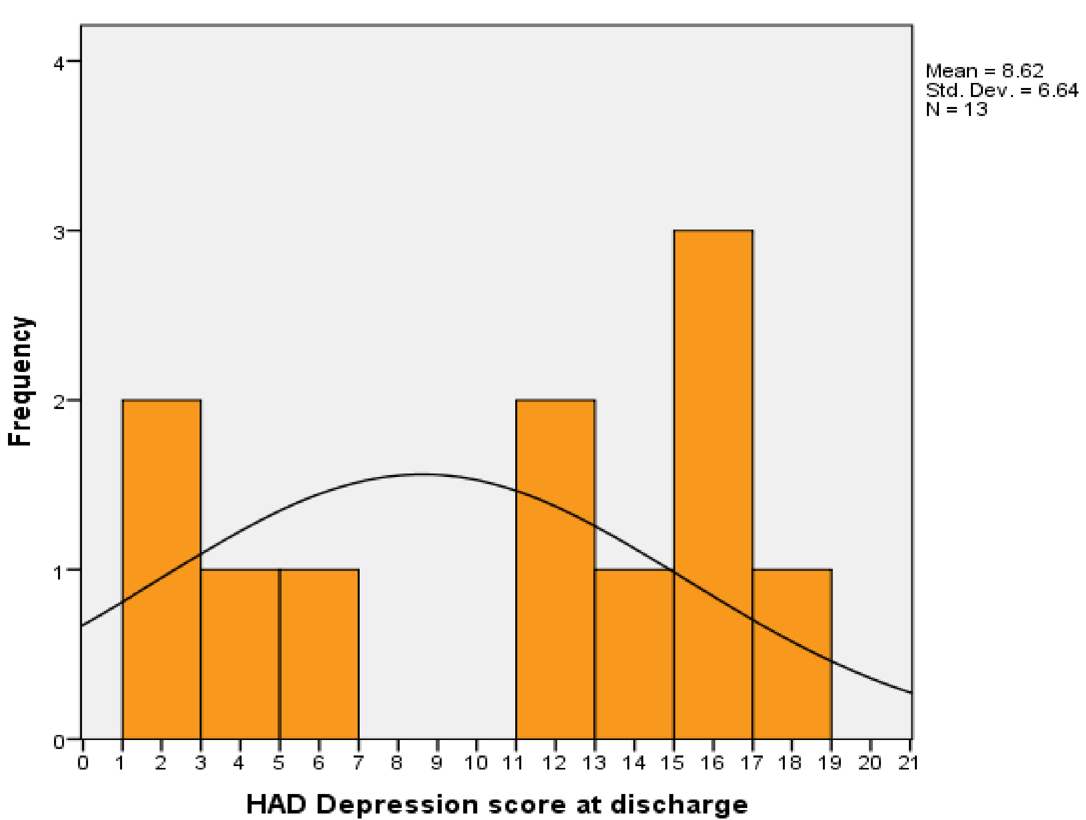


Mean = 14.91
Std. Dev. = 3.646
N = 11
Frequency
HAD Anxiety score at admission



Mean = 7.18
Std. Dev. = 3.371
N = 11
Frequency
HAD Anxiety score at discharge


Mean = 17
Std. Dev. = 2.708
N = 13
Frequency
HAD Depression score at admission


Mean = 8.62
Std. Dev. = 6.64
N = 13
Frequency
HAD Depression score at discharge

Patient experience / feedback

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 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 collated and reviewed regularly in order to continuously improve and provide the best possible service to our patients. The questionnaire is given to patients in their last week of admission and collected on discharge. Following feedback and discussion with patients and members of the YCPM team it has recently been amended and updated, including a reduction in the number of questions.

April 2012 – March 2013:

- 81% of patients rated the service as either "Good" or "Excellent"
- 80% reported that they were "always provided with copies of their care plans"
- 93% reported that the support/advice received by their family/carers was "excellent" or "good" (the remaining 7% reported "average")

NOTE: These outcomes are in a highly selected group of people many of whom, at the point of admission, tend to want more medical tests and investigations and not to engage in any psychological or psychosocial work.

Some examples of patients' written feedback (2012/13):

"My key team members have been excellent. They could not have been more supportive and always made time to catch up to discuss difficulties / concerns of the week, or even just life in general. They made time to let me know that if I wanted or needed to talk that they were there for me, which I very much appreciated, as well as all the assistance with leisure facilities. Immense gratitude to them all."

"Staff were very good at teaching relaxation and distraction."

"All staff have been so helpful and caring."

"Everybody has been helpful. Less restrictions than a general ward."

"! was made to feel at ease and it was the right decision to come here. I feel a lot more positive about my life and future."

"Support from staff helpful, especially with stoma care. Increase in antidepressant helped. Environment - TV large, comfortable."

"The one to one sessions were extremely helpful, with my sleep and other problems."

“Friendly and helpful staff always available for support and encouragement. Positive environment with social opportunities and many activities which aid the rehabilitation progress. Involved in care, listened to, and opinions considered. Problems always effectively dealt with.”

“Caring staff with time for me which gave me the possibility to express my concerns and have them addressed accordingly and in an expedite manner.”

“Ward setting was more casual and comfortable than typical hospital wards. Staying on the ward gave me a better chance to listen to my body and put myself first and not think about jobs and things you would have to do at home.”

“Very good key team really nice and understanding staff who have listened to me and not judged me.”

“All staff were very professional and polite and helpful at all times.”

”Everyone is really friendly.”

“I felt as if I was accepted for me and not because I had an illness. The staff and patients were very friendly.”

“I have been consulted at every stage of my care and have found staff’s approach consistent. Staff were always understanding, positive, calm, friendly, but maintained the utmost professionalism.”

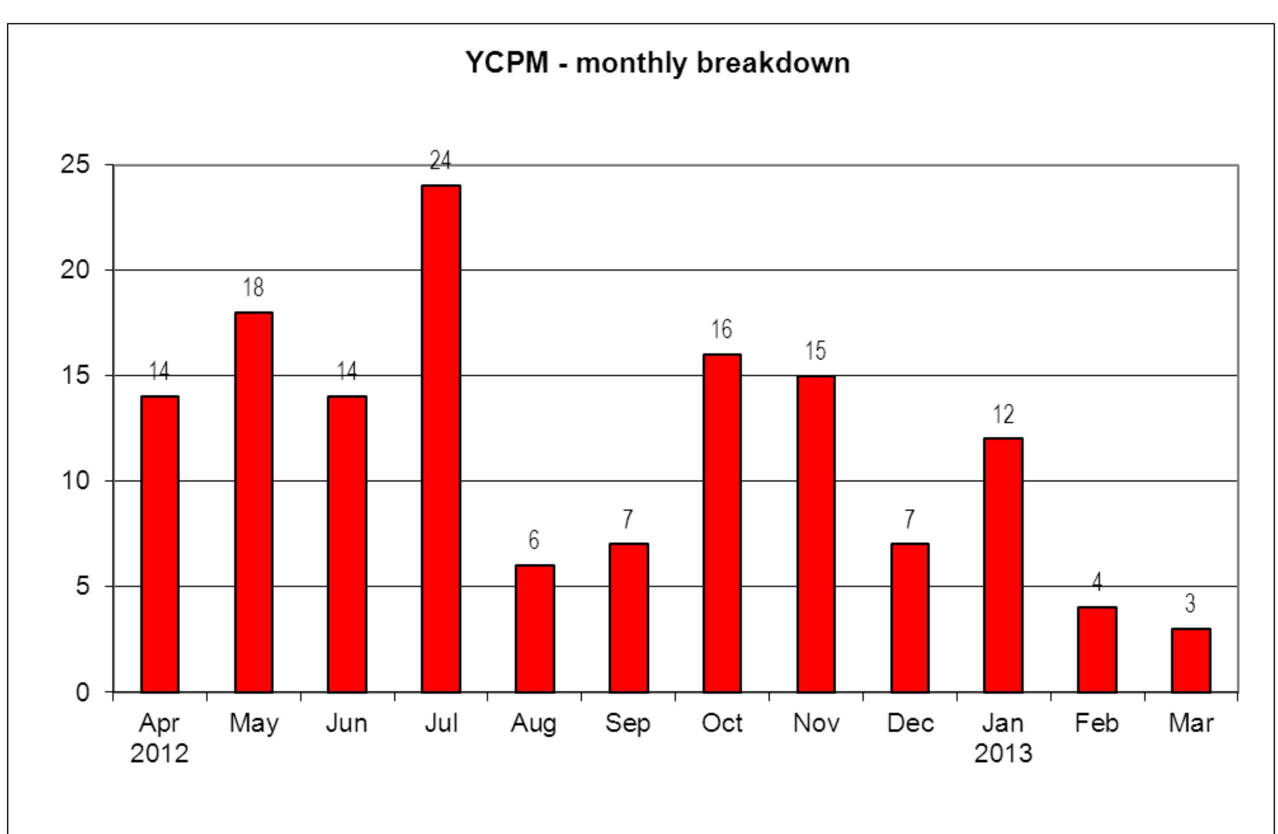
Asked “what has been good about the service you have received?”:
“The holistic approach to treatment. The opportunity to meet with the entire team at weekly MDTs. The opportunity for one to one sessions when required e.g. relaxation, and to ventilate feelings and thoughts re: anxiety and low mood.”

Incidents

In line with the general approach across the Leeds and York Partnership 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) ratings for levels of harm they are all level 1 ('no harm') or level 2 ('minimal harm'), apart from one level 3 rating as detailed.

In total, 140 incident forms were completed within the period to which this report relates, as detailed below.

Incidents reported April 2012 – March 2013



NPSA severity ratings of these incidents (ratings 1 – 5)

	Severity Rating					
	1	**2**	**3**	**4**	**5**	
Apr 2012	12	2				**14**
May	14	4				**18**
Jun	13	1				**14**
Jul	18	5	1			**24**
Aug	6					**6**
Sep	6	1				**7**
Oct	13	3				**16**
Nov	14	1				**15**
Dec	7					**7**
Jan 2013	12					**12**
Feb	3	1				**4**
Mar	3					**3**
Totals	**121**	**18**	**1**			**140**

Severity 3 incident: Housekeeper closed the kitchen door and the handle came off. The handle fell onto housekeeper's foot. Attended A & E – fracture to foot confirmed.

KEY:

NPSA Ratings

1 = No injuries, very minor financial loss, and / or service interruption.

2 = First aid treatment only, 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.

Incidents by category / type

Type and category	Number
Accident	30
Accident - no injury	2
Accidental injury	2
Contact with hazard	1
Contact with hot liquid/surface	6
Fall - accidental	14
Handling injury	2
Needlestick injury	1
Potential hazard	2
Clinical	78
Patient found on floor	3
Fall due to dizziness	3
Patient collapsed	2
Medication	48
Missing patient	1
Other	1
Confidential	2
Patient information	2
Fire	6
Smoking in non-designated area	6
Other	10

Accidents falls:
One patient involved in five falls.
One patient involved in four falls (also two incidents of *found on floor*).

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