



ANNUAL CLINICAL REVIEW
SUMMARY OF REPORTS
2008

Introduction

It is pleasing that all clinical areas routinely collect data which provides valuable information on clinical activity for commissioners, future patients and families using our services and for clinical teams themselves to reflect on their effectiveness in a thoughtful and diligent manner. In a recently published compendium of outcome measures it was acknowledged that:

“...it is well recognised that implementing outcome measurement into regular practice can be a difficult process. A process arguably made more difficult by the growing number of instruments that have been developed which can lead some people to feel overwhelmed and uncertain where to start.”

(Department of Health, 2009, p.4)

The continuous improvement of mental health services is dependent on a range of factors including collaboration with patients and carers, the investment of appropriate resources, training for staff, and reflective practice built into everyday work. The latter requires the availability of meaningful and robust information about the experiences and outcomes of patients receiving mental health services, so that questions can be answered and improvements properly tracked and reviewed. Whilst this is only the second year that the Annual Clinical Review has been collated there is already evidence that such improvements are underway.

Specialist Adult Services

ACORN UNIT

Review of the Year

The core of established staff and new staff worked collaboratively with the patients and leavers to evolve the unique culture of the unit, and achieve a safe and therapeutic environment focused on recovery.

An Acorn Graduate reviews the year:

“Reflecting back on the year on Acorn, at times I find it quite incredible how it has helped me. In January 2008 even though I was fully committed to the programme and thought it could help I wasn't sure of the process. That is why going through the process is so important. It takes a lot of hard work on the part of both patients and staff, without the community (meaning staff and patients) I would not be looking forward to the rest of 2009. It is a difficult start to the year and I truly think that it is because I have been on the Acorn programme that I am getting through without resorting to harming myself and feel that I have the resources to survive.”

Service Model

The goal of the Acorn Programme is to help patients find a “Life worth living.” We want patients to be able to do the things that help them feel fulfilled and happy, and to be in relationships which are good for them. Part of this goal is to enable patients to take care of their own safety and make choices about how they live their lives. This is not a suicide prevention programme. There are no locked doors or observations. If a patient needs or wants others to take responsibility for keeping them alive, then this is not the programme for them.

The Therapeutic Community

In 2007 the Acorn Programme was the first Therapeutic Community to be accredited by the Community of Communities. We were reviewed again in 2008 and continue to meet criteria.

We encourage a ‘culture of enquiry’ in which everyone can question the conduct of any other individual or group of individuals, psychological processes (‘I wonder what made you do that’), and managerial issues. Such questioning is an important learning opportunity for those asking the questions and for those questioned.

Everything that happens in the community is open for discussion. We have a principle: ‘if you have a secret, you have a problem’. For many people the letting go of the need to keep parts of their lives hidden is a major part of their therapy.

Activity Information

Number of admissions	13
Number of discharges	13
Gender (all female unit)	13
Age (range)	21-56
Age (average)	36.3
Ethnicity	White British: 13

Waiting Time & Length of Admission

Average waiting time 32 weeks (range 11-130 weeks)

Patients are often assessed without funding and it can take some time for this to be confirmed. This is the main reason for lengthy delays in admission.

Average admission for patients completing the programme (includes both residential and day) (range)	51 weeks (33-57 weeks)
Average length of stay (range)	38.4 weeks (5-57 weeks)
Planned discharges	7
Unplanned discharges	6

In 2008 54% of patients completed the Programme to planned discharge. Two patients left immediately post-assessment but the remaining patients participated in the programme for more than three months. This is a slight improvement on 2007 when 50% of 12 admissions completed their admission to a planned discharge.

Examination of questionnaire data by year suggests that patients of 2008 were the most distressed and dissociated cohort since 2004 and most impulsive since 2005. There is therefore some support for the hypothesis that Acorn referrals have increased in complexity in recent years.

Employment

To our knowledge, one patient has become employed following discharge from the Acorn Programme. No patients were employed prior to admission.

FACE Risk Assessments on Acorn 2008

	Total	Mean
Number of CPA Reviews held	26	2
Number of FACE risk assessments completed	37	3

Each patient participates in a CPA review every 3-4 months, typically a total of three reviews during their admission.

Clinical Outcome Measures

We use a number of validated outcome measures on Acorn which are completed by patients themselves. We have chosen to focus on the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) and the Multi-Impulsivity Scale (MIS) as these questionnaires reflect the more immediate goals of the Acorn programme; to reduce self-defeating behaviour, risk and psychological distress. CORE-OM assesses psychological distress and risk in the last seven days. The MIS assesses impulsive feelings and behaviours (including self-harm and other self-defeating behaviours) in the previous two months.

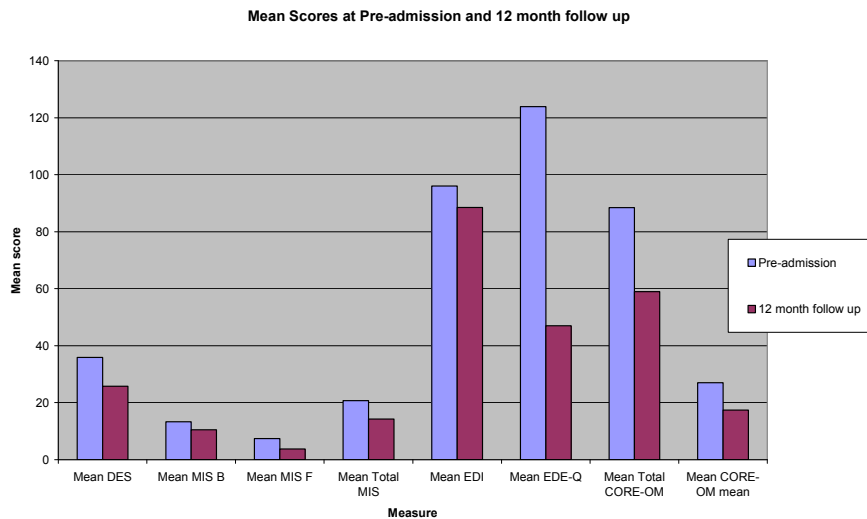


Figure 1: Mean scores for all questionnaires pre-therapy vs. 12 months follow-up

Patients (Figure 1) can be seen to have lower levels of dissociation (DES), impulsive behaviour & thoughts (MIS), eating disorder symptoms (EDI & EDE-Q) and psychological distress & risk (CORE-OM) one year after completing the Acorn programme.

Future Plans

- In 2009 all our patients will have electronic notes with paper back up of recent risk assessments.
- New edition of the Acorn Programme Handbook is due to be written in 2009.
- Acorn staff are developing a new outpatient DBT service in collaboration with the Tuke Centre.
- The IPA (Interpretative Phenomenological Analysis) evaluation of the Rookhow holiday is to be completed and submitted for publication in a professional journal in 2009.
- To plan a further therapeutic holiday. An Acorn patient writes;

“I attended the holiday in September last year. I had an amazing time in an atmosphere that was made safe and warm by both patient and staff members. There was a balance of laughter, tears and talking and acceptance of one another’s vulnerabilities at each given time. I think it was an eye opener to me just how well we can work as a therapeutic community.”

- Spring Lodge will open in April 2009. A patient writes;

“It can be difficult after spending long periods of time where there is 24 hour support on a daily basis to then move straight into independent living. Spring Lodge would be a great opportunity to gain experience in normal daily living skills and can help better prepare for discharge into the community and decrease risk of relapse.”

- The Neuroimaging research project is ongoing and we continue to scan new patients who consent to be involved. We have had our first Post-therapy repeat scan and look forward to presenting and publishing findings in 2010.

In conclusion, research and evaluation will remain pivotal to the development of our therapeutic model on Acorn. The research and service evaluation described in this report includes both qualitative and quantitative measures, reflecting our multi modality holistic approach. Community member collaboration in the collection of data is essential, and the information gained from the research is of most importance in the meaning ascribed to it by the community members in their journey of recovery.

NAOMI UNIT

Review of the Year

In 2008, Naomi continued with the development of a CBT service. This service introduced in 2007 has now well established training, supervision and evaluation systems. The evolution of the service has been sustained by the commitment of staff and patients to work in partnership towards a recovery orientated service.

Naomi has maintained high occupancy numbers consistently across the year, and this is not predicted to drop as referrals continue to arrive weekly.

The annual review 2007 described clear future plans and it has been interesting to reflect on these and notice that we have made changes from evaluation.

- CBT Supervision structure continues to be high profile with further changes to enable high attendance and improved recording.
- CBT specific groups have now been running for just over a year and feedback from the patients is continually received and has been positive.
- CBT training for staff has been completed, and has shown a more joined up delivery from across the staff group.
- High attendance of reflective practice facilitated by an external group analyst.
- FACE continues to be introduced and the familiarisation of new computer systems has been a challenge.
- Three new Senior Staff Nurse appointments successfully filled.
- Successful increase in Psychology Assistant time at the end of 2008.
- Spring Lodge development continues with planned opening in April 2009.

Naomi Outcome Measures for patients discharged in 2008

In 2008 the patient group in Naomi was all females, with age ranging from 19 to 53 with an average age of 29.39 and length of stay varying from 2 to 462 days with an average of 169.35 days per patient.

	Mean	SD
Age at discharge	29.39	10.63
Length of stay in days	169.35	127.13

Table 1: Table of mean and standard deviation for age and length of stay during 2008.

Weight (Kg)	Admission		Discharge		Difference	
	Mean	SD	Mean	SD	Mean	SD
Everyone (n= 21/23)	44.38	12.4	50.07	9.41	6.24	5.89
ED (n= 19/19)	44.13	13.05	50.49	9.85	6.86	5.90
AN (n= 15/15)	39.87	5.70	47.26	5.25	8.34	4.94
BN (n= 4/4)	60.12	20.93	61.8	14.53	1.67	6.73

Table 2: Table of mean and standard deviation for weight during admission and discharge for patients discharged in 2008.

BMI	Admission		Discharge		Difference	
	Mean	SD	Mean	SD	Mean	SD
Everyone (n= 21/23)	16.12	3.62	18.34	2.67	2.29	2.22
ED (n= 19/19)	16.08	3.81	18.55	2.73	2.52	2.23
AN (n= 15/15)	14.66	1.61	17.51	1.26	3	2.02
BN (n= 4/4)	21.37	5.27	22.21	3.53	0.84	2.33

Table 3: Table of mean and standard deviation for Body Mass Index (BMI) during admission and discharge for patients discharged in 2008.

CORE	Admission		Discharge		Difference	
	Mean	SD	Mean	SD	Mean	SD
Everyone (n= 14/23)	2.27	0.65	1.61	0.75	0.66	0.75
ED (n= 15/19)	2.19	0.70	1.61	0.75	0.66	0.70
AN (n= 12/15)	2.11	0.69	1.57	0.68	0.64	0.68
BN (n= 3/4)	2.51	0.79	1.76	1.13	0.75	0.93

ED= Eating Disorders, AN = Anorexia Nervosa, BN = Bulimia Nervosa.

Table 4: Mean and standard deviation of the total Clinical Outcome Routine Evaluation (CORE) score across patient groups.

The clinical cut-off point for the CORE is 1 and the severe cut-off is 2.5, ie participants/patients who score above this are considered to experience 'severe'/debilitating difficulties in one or more areas of the CORE subscales (e.g. social functioning and subjective well-being). The mean/average in the general population is 0.81, and 1.85 in the clinical population.

Looking at Table 4 it can be seen that the average Naomi patient scored just below the severe cut-off point at admission (2.23) and although on average the scores have improved by 0.66, the average mean at discharge remains above the clinical cut-off (1.61) but below the clinical mean (1.85).

EDE-Q	Admission		Discharge		Difference	
	Mean	SD	Mean	SD	Mean	SD
ED (n= 15/19)	4.6	1.51	3.28	1.74	1.32	1.64
AN (n= 12/15)	4.3	1.52	2.95	1.68	1.35	1.75
BN (n= 2/4)	5.95	0	4.75	1.48	1.19	1.19

ED= Eating Disorders, AN = Anorexia Nervosa, BN = Bulimia Nervosa.

Table 5: Mean and standard deviation of the total Eating Disorder Examination Questionnaire (EDE-Q) score across patient groups.

The mean/average score on the EDE-Q for young healthy females is 1.52. As can be seen in Table 5, the average score in the Naomi patients was 4.6 at admission and 3.28 at discharge, showing an average decrease in scores of 1.32 and subsequently an improvement of eating disordered thoughts and behaviours.

Future Plans For 2009

The skill of getting the balance right in continuing to provide a quality patient centred service alongside the recognition of needing to evaluate and move the service forward is always going to be a challenge. However if we do not hold this in mind we risk leaving team members behind and not joining up the service delivery. Therefore a more systematic and reflective approach will be taken this year.

- To use FACE outcomes more clinically.
- To work on developing a graded service, this works alongside the Naomi Pathways.
- Open Spring Lodge along with our Acorn colleagues.
- Manualise the CBT groups.
- Group training and develop staff confidence in groups.
- CBT training.
- Nurse Therapist appointment.
- Research and conference presentation at the Eating Disorder Conference.
- Environmental upgrades, to meet patient safety.
- Quarterly evaluation of qualitative information from service users and staff group.

HANNAH MILLS UNIT

Review of the Year

Achievements

- PSI Training amongst staff – trained staff working through BSc in psychosocial approach using CBT and family interventions.
- PSI training given to support workers.
- Dual Diagnosis training given by the University of York.
- Development of a new service – adding alcohol detoxification and an increased focus on dual diagnosis to take place on the newly developed area on the top floor.
- Incorporation of the on-line version of FACE into the working practice on the unit.

Reflections

The sense of community has developed over the year and this is reflected in the community meetings where problems can be raised and solutions discussed. Attendance at these meetings has improved with patients chairing the meetings.

It has been a good year with difficult work done well. There has been a focus on bringing in new skills and developing new ways of working. As one staff member reported; 'it feels as though we have got over the change and things are slotting into place'.

Service Development

By the end of 2008 we had four programmes in place and had extended this part of the service to 24 beds. The four programmes are:

- Complex Psychosis
- Dual Diagnosis
- Alcohol Detox
- Short-Term Admissions

The bed numbers will increase to 26 when we add in the cottage beds. Across the whole service we now have 45 beds. The programmes offer two strands to the process and work with the individual patient to ensure the level of the programme they join is appropriate.

Clinical Activity

This section will describe the clinical activity on Hannah Mills Unit, including the number of admissions, discharges, waiting time, length of stay, total number of CPA reviews and referral sources. Demographic information for people living on Hannah Mills unit (gender, age, ethnicity) has also be included.

Total number of admissions	10
Total number of discharges	12
- to other Retreat units	3
- to other inpatient units	2
- to a community unit	1
- into the community	7
Mean waiting time (days)	22.45
Total number of CPA reviews	41

Table 6: Measures of clinical activity in Hannah Mills unit (2008)

There were no unplanned discharges during 2008. Twelve people were discharged from Hannah Mills during 2008. The majority of these people (7 people, 63.6%) were discharged into community settings. All of these people had contact with a Community Mental Health or Assertive Outreach team. Hannah Mills has had a greater proportion of short-term admissions and during 2008 eight people (36.4% of the total) stayed for less than 6 months. The mean length of stay remains around two years.

There are a wide variety of people of different ages living on Hannah Mills and 26.1% (6 people) came from minority ethnic groups. None of those living were in paid employment during 2008.

Therapeutic Input

All those living on Hannah Mills unit participated in therapeutic interventions with their named nurse and other members of the team, as set out in individual care plans. For reasons of brevity it is not possible to include in detail every intervention with each patient, as these interventions take place on a continual, daily basis as part of the ongoing individual relationship with each person (according to the psychosocial interventions model).

Clinical Outcomes – FACE

Risk Profile

FACE Risk Profiles were completed at six monthly intervals for those living on Hannah Mills during 2008. Risk Profiles were repeated more frequently if clinically indicated. Mean risk scores decreased in relation to four of the seven areas measured by FACE (violence to others, suicide, deliberate self-harm and severe self-neglect). Risk scores increased in three areas (accidental self-harm, abuse/exploitation by others and risk related to physical condition).

There are a number of possible explanations for these findings. For example, it is possible that the needs of the patients in question changed over time. Equally, it is possible that initial interventions focussed more on the first four areas, as these areas of risk (particularly violence to others and suicide) may have been considered the greatest clinical priority.

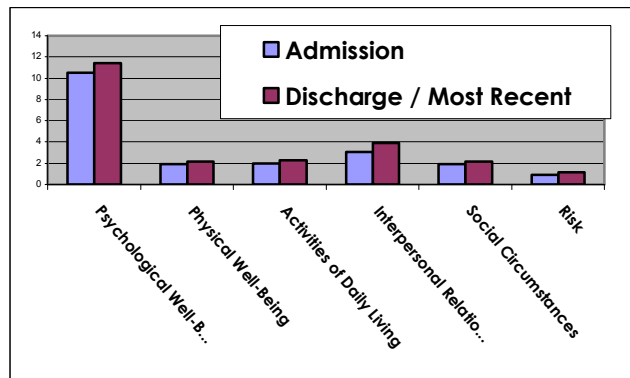


Figure 2: Bar chart illustrating the mean number of key problems from first to most recent administration of the FACE CORE assessment

Clinical Outcomes - Recovery Measures

The Mental Health Recovery Measure (MHRM, Young and Bullock, 2003) was chosen as a measure of recovery. Individuals were asked to complete the MHRM in the weeks before their CPA meeting, so that results could be discussed in the wider clinical context during the meeting.

Patients were also originally asked to complete the Social Functioning Scale (SFS) in addition to the MHRM. Data were collected for eight patients during 2008. However, during the year, it became apparent that the SFS was better suited to collecting in-depth information about a particular area of functioning (social contact) rather than being used as a more global measure of recovery.

Recovery Data

Of the 14 patients approached before their first CPA in 2008 (time 1) 11 (78.6%) completed the MHRM. Table 7 illustrates in detail responses to the MHRM questions.

The data have been presented for each individual question for the MHRM. Looking at the data in this way was described as clinically useful by the teams, in addition to looking at overall 'scores'.

For example, one of the questions asks individuals whether or not they agree with the statement "I am in control of my life". Whilst 45.5% of the people asked agreed or strongly agreed with this statement, 54.5% were not sure or strongly disagreed. This could provide significant information to the team, particularly if issues around control have been highlighted as a clinical issue.

Similarly, another MHRM question asks whether "My quality of life will get better in the future" and 54.6% of the people asked agreed or strongly agreed with this statement, 44.6% were not sure or disagreed. Again this can be very useful information for the team about the individual's level of hopefulness and belief in positive change.

The questionnaire can also open up different areas of discussion. For example, the questions "The way I think about things helps me to achieve my goals" or "My religious faith or spirituality supports my recovery".

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I work hard towards my mental health recovery	0	0	9.1%	45.5%	45.5%
Even though there are hard days, things are improving for me	0	0	18.2%	63.6%	18.2%
I ask for help when I am not feeling well	0	0	27.3%	54.5%	18.2%
I take risks to move forwards with my recovery	0	9.1%	27.3%	27.3%	36.4%
I believe in myself	0	9.1%	18.2%	54.5%	18.2%
I have control over my mental health problems	27.3%	0	27.3%	18.2%	27.3%
I am in control of my life	9.1%	0	45.5%	27.3%	18.2%
I socialise and make friends	0	9.1%	9.1%	54.5%	27.3%
Every day is a new opportunity for learning	0	0	27.3%	45.5%	27.3%
I still grow and change in positive ways despite my mental health problems	0	9.1%	0	54.5%	36.4%
Even though I may still have problems, I value myself as a person of worth	0	9.1%	18.2%	45.5%	27.3%
I understand myself and have a good sense of who I am	0	18.2%	9.1%	45.5%	27.3%
I eat nutritious meals everyday	18.2%	0	18.2%	54.5%	9.1%
I go out and participate in enjoyable activities every week	0	18.2%	36.4%	27.3%	18.2%
I make the effort to get to know other people	0	27.3%	0	36.4%	36.4%
I am comfortable with my use of prescribed medications	9.1%	0	18.2%	45.5%	27.3%
I feel good about myself	0	9.1%	36.4%	27.3%	27.3%
The way I think about things helps me to achieve my goals	0	18.2%	27.3%	45.5%	9.1%
My life is pretty normal	9.1%	9.1%	18.2%	36.4%	18.2%
I feel at peace with myself	18.2%	0	9.1%	54.5%	18.2%
I maintain a positive attitude for weeks at a time	3	9.1%	9.1%	36.4%	18.2%
My quality of life will get better in the future	0	9.1%	27.3%	36.4%	18.2%
Every day that I get up, I do something productive	0	18.2%	0	45.5%	36.4%
I am making progress towards my goals	0	0	27.3%	63.6%	9.1%
When I am feeling low, my religious faith or spirituality helps me feel better	9.1%	9.1%	18.2%	18.2%	45.5%
My religious faith or spirituality supports my recovery	18.2%	9.1%	18.2%	18.2%	36.4%

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I advocate for the rights of myself and others with mental health problems	0	18.2%	18.2%	36.4%	27.3%
I engage in work or activities that enrich myself and the world around me	0	0	18.2%	45.5%	36.4%
I cope effectively with stigma associated with having a mental health problem	0	0	18.2%	63.6%	18.2%
I have enough money to spend on extra things or activities that enrich my life	0	27.3%	9.1%	63.6%	0
<i>Total number of responses</i>	<i>4.9%</i>	<i>8.2%</i>	<i>18.9%</i>	<i>43.3%</i>	<i>24.7%</i>

Table 7: Responses to the Mental Health Recovery Measure at Time 1 (before 1st CPA in 2008)

Beyond Questionnaires

In addition to the use of psychometric techniques, there are a number of other avenues through which individuals can discuss what is important to them with the staff team and where the staff team can discuss outcomes for individual patients.

Community Meetings

These are held daily on Hannah Mills unit. Those attending describe their plans for the day, how they are currently feeling and any issues / concerns they want to raise with the community. Attendance at the community meetings has increased significantly through 2008 and this forum has been used throughout the year to discuss life on the unit.

Future Plans

As part of compiling this report, the team were asked for their feedback in using the outcome measures through 2008. The following themes emerged from conversations with team members.

- The Recovery Measure provides useful information about how the person perceived him or herself, particularly in terms of their future hopes and expectations.
- It seemed particularly useful to think about responses to individual questions (e.g. “my quality of life will get better in the future”) as well as using the overall score.
- It would be useful to link the outcome measures more closely to CPA meetings, so that they are part of broader clinical discussions. Although recovery measures were timed to coincide with CPA meetings, in practice it was often difficult to ensure someone was present at the meeting to report the findings.
- It could also be difficult to complete the recovery measure with patients, with a number of people choosing not to complete a questionnaire. It is likely that the effects of active or acute psychotic experiences will influence the completion of recovery measures. However, whilst it is important to address this issue it should also be noted that the majority of people living on Hannah Mills completed at least one recovery questionnaire during 2008.

BLAIR ATHOLL

Review of the Year

Increased Patient Involvement

Achieved through:

- Patient collaboration with named nurse in development of recovery and well being plans.
- Daily community meetings providing a venue for patients to plan, raise issues, steer change and for peers to address challenges that may have a negative influence on the community.
- High returns on outcome measures and patient survey.
- Patient inclusion at workshops, presentations and in-house training.

Group Programme

This has developed considerably over the past twelve months. There is now at least one organised group, in addition to the community meeting held within the unit each weekday.

Team Effectiveness

- High achievements in both mandatory and additional training have been attained.
- All staff appraisals have now been completed in accordance with the new, more structured format. This process has encouraged more debate, enquiry and measurement of performance.
- Consistently low sickness levels.

Clinical Supervision

All trained nurses are now in receipt of either individual or group supervision.

Audit

Blair Atholl achieved 82% overall compliance with the standards outlined by NICE for use of atypical antipsychotic drugs for the treatment of schizophrenia.

Appointment of Chefs

Patients are now enjoying home-cooked food on a daily basis. This has been a welcome change from the previous arrangement of cook-chill. Patients have played an active role in devising menus and revising these on a three-monthly basis.

Environmental Improvements

Blair Atholl has undergone substantial environmental improvements over the past year, including: a redesign of existing rooms resulting in a new ladies' lounge, men's lounge, multi-user room and second staff office. The kitchen and main office have also been upgraded. In addition, the purchase of new furniture has resulted in a more fresh and coordinated environment.

Service Model

In line with the wider service, Blair Atholl has at its heart the PSI model and a real sense of the recovery process. Blair Atholl is very much an integrated aspect of community life and, combined with the therapeutic programme, offers a real opportunity for people who may have longer-term needs.

Service Development

The Care Quality Commission, supported by our Statement of Purpose, have removed the age restriction from the service, which was a significant move and supports a unit which continues to develop.

Activity Information

In 2008 three people were admitted to Blair Atholl and four were discharged.

As the majority of admissions were from other Retreat units the waiting time was typically very short (longest waiting time was two days).

		Number (Percentage)
Gender	Male	9 (45%)
	Female	11 (55%)
Ethnicity	White British	18 (90%)
	White Other	2 (10%)
Age	Mean	68.6 yrs
	Range	51-87 yrs
	50-59	4 (20%)
	60-69	7 (35%)
	70-79	7 (35%)
	80-89	2 (10%)

Table 8: Demographic information for people living in Blair Atholl unit

It can be seen that although the mean age is 68.6 there is a relatively large range, with 20% of patients aged under 60. Due to the average age and continuing care status, none of those living at Blair Atholl were in paid employment during 2008. The mean length of stay is four years.

Clinical Outcomes – FACE

Risk Profile

The FACE risk scores across the different domains have remained stable over time which reflects the relatively stable needs and risks of populations in continuing care settings.

Clinical Outcomes - Recovery Measures

In 2008 Blair Atholl decided to review the clinical outcome measures used on the unit. A number of recommendations were made (described in the previous 2007 clinical review) with the new measurement system beginning in January 2008.

Two measures (the Challenging Behaviour Scale and DREEM recovery markers scale) were completed at six monthly intervals before each person's CPA meeting. Information from the outcome measures was then fed back to the meeting.

DREEM – Recovery Markers

A literature review of recovery measures identified the DREEM (Developing Recovery-Enhancing Environments Measure; Ridgway, 2004; Allott et al, 2006) as a useful measurement tool. The National Institute for Mental Health in England (NIMHE) cited this as a promising recovery-sensitive measure (REE; Campbell-Orde et al, 2005).

It was hoped by using this scale it would be possible to gain a sense of the individual's perspective of their current situation as well as their expectations and hopes for the future.

Of the 18 patients approached before their first CPA in 2008, 15 (83.3%) completed the DREEM. Table 9 illustrates in detail responses to the DREEM questions. The data has been presented for each individual question for the DREEM. This is because this is how the information is typically used in the CPA meeting. Thus, whilst a number is applied to an individual's overall recovery "score" it is the specific response to particular questions that may be most clinically useful.

For example, one of the DREEM questions asks individuals whether or not they agree with the statement "My living situation is safe and feels like home to me" (shown in bold on Table 9). Whilst 33.3% were neutral or disagreed with this statement 66.7% of those asked agreed or strongly agreed. A number of clinical discussions during CPA meetings have focussed on an individual's sense of safety and belonging.

Similarly, the DREEM is able to reflect individual levels of:

- self-esteem "I like and respect myself"
- optimism "I feel hopeful about my future"
- levels of motivation "I have reasons to get out of bed in the morning"

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Did not answer
My living situation is safe and feels like home to me	13.3%	6.7%	13.3%	40.0%	26.7%	
I have trusted people I can turn to for help		26.7%		53.3%	20.0%	
I have at least one mutual (give-and-take) relationship	6.7%	13.3%	13.3%	53.3%	13.3%	
I am involved in personally meaningful productive activities	13.3%	20.0%	26.7%	26.7%	13.3%	
My distressing symptoms are under control	13.3%	13.3%	13.3%	53.3%	6.7%	
I have enough income to meet my needs	13.3%		20.0%	46.7%	20.0%	
I'm not working but see myself working within 6 months	13.3%	26.7%	20.0%		20.0%	20.0%
I am learning new things that are important to me	6.7%	20.0%	6.7%	53.3%	13.3%	
I am in good physical health	13.3%	26.7%	20.0%	40.0%		
I have a positive spiritual life/ connection to a higher power	13.3%	20.0%	6.7%	40.0%	20.0%	
I like and respect myself	13.3%		20.0%	46.7%	20.0%	
I'm using my personal strengths, skills and talents		13.3%	33.3%	40%	13.3%	
I have goals I am working to achieve	6.7%	13.3%	13.3%	53.3%	6.7%	6.7%
I have reasons to get out of bed in the morning	6.7%	6.7%	6.7%	73.3%	6.7%	
I have more good days than bad	13.3%	6.7%	26.7%	46.7%	6.7%	
I have a decent quality of life	6.7%	6.7%	26.7%	40.0%	20.0%	
I control the important decisions in my life	6.7%	13.3%	20.0%	40.0%	13.3%	6.7%
I contribute to my community		26.7%	20.0%	40.0%	13.3%	
I am growing as a person	13.3%	20.0%	6.7%	46.7%	13.3%	
I have a sense of belonging	6.7%	6.7%	20.0%	60.0%	6.7%	
I feel alert and alive	6.7%	13.3%	13.3%	53.3%	13.3%	
I feel hopeful about my future	13.3%	13.3%	20.0%	40.0%	13.3%	
I am able to deal with stress	6.7%	26.7%	6.7%	46.7%	13.3%	
I believe I can make positive changes in my life	6.7%	13.3%	26.7%	46.7%	6.7%	

Table 9: Responses to the DREEM – Recovery Markers Scale at Time 1 (CPA meetings held between 01/01/08 and 30/06/08)

The DREEM also contains a number of open-ended questions. It has been useful throughout the year to get individuals' views in their own words. As can be seen from the quotes below there was considerable variation in responses to the questions. The second question ("what are the most important things you've learnt on your journey of recovery?") seemed to produce the most variation.

Quotes from DREEM Responses

What are the most important things you've learned so far on your journey of recovery?

"Exist more"

"Keep up with friendships"

"It's important to stay in contact with people"

"Get well as soon as I can"

"Change your life"

"There's different things"

"Talk to staff."

"A good home, plenty of food and a bed."

"To try keep going forward and not thinking back to the past; but it isn't easy"

"I haven't learnt anything. I haven't been ill so I haven't had anything to recover from"

"What recovery?"

"Get strength from helping others"

"Allow yourself to be helped when necessary"

"They make me speak more and I stick up for myself more"

Using the Challenging Behaviour Checklist the majority of Blair Atholl patients were classified as having severely challenging behaviour (94.4% described as having moderate or severely challenging behaviour at Time 1, 92.4% at Time 2). It is important to consider why the level of challenging behaviour remained high at both time points. Given that Blair Atholl is a "continuing care" environment, it is possible that there is a stable high level of such behaviour (this being one of the reasons patients remain in a hospital rather than community setting).

In future years it is likely that the population of people living at Blair Atholl will include a greater proportion of younger people with more active psychiatric problems. It will be important to ascertain whether this level of challenging behaviour continues into 2009.

Beyond Questionnaires

In addition to the use of psychometric techniques, there are number of other avenues through which people living at Blair Atholl can discuss what is important to them.

Community Meetings

Reflections on all of these strategies for eliciting outcome information are explored in the following section.

Future Plans

The team noted that there had been some concerns before the process started that it could become a “box ticking” exercise. However, there was a general consensus by the end of the process that the measures had been clinically useful. We tried to explore what had helped in this; the following factors emerged.

User-Friendly Questionnaires

It was felt by the team that the questions were non-threatening and well-received by patients. This may have contributed towards the high response rate recorded (83.3% at time 1, 92.9% at time 2). In particular, there was positive feedback from patients about the open-ended questions at the end of the measure, when the person could say anything they wanted to about the service and their view of recovery.

360 Degree Appraisals: Patients Appraising Staff

Work on this initiative has commenced and is planned to be completed by the end of March 2009.

Recovery Workshop

This will focus predominantly on the language styles and written words we utilise, and how we as a team address this in a more recovery-focused way.

OLDER PEOPLE’S SERVICES

Review of the Year

2008 has proved to be a significant year in the development of the Older People’s Services – Katherine Allen and George Jepson.

Satisfaction among our patients and carers has remained consistently high throughout the year with carers in particular taking the time to praise our service. The actress Sheila Hancock has praised our service while addressing Members of Parliament about the need for adequate care provision for people with dementia who are terminally ill. The demand for our service has remained high throughout the year with only one period of referral inactivity.

Service Model Description

During 2008 we took the opportunity to rewrite our service model to reaffirm our beliefs and commitment to recovery and the future development of our service for people over the age of 60 years. Our model is evidence based and person centred. The key elements of our service model are:

- An emphasis on recovery and rediscovery
- Bio-psychosocial well being
- Valuing each individual, their life history and their experiences
- Promotion of optimism

- Promotion of choice
- Encouraging positive risk taking while maintaining the safety and dignity of each patient
- Supporting our patients in maintaining their lifestyle preferences
- Working closely with families and carers
- Focussing on the strengths and skills of our patients rather than their problems
- Thinking creatively about how we relate to our patients

Activity Information

Admissions and Discharges during 2008

Waiting times are influenced by bed availability and the average length of stay on the units. The longest waiting time was eight months with the majority falling between 4 and 12 weeks for a place to become available. The ethnicity of our patients is as follows:

George Jepson unit has 13 White British and 1 Arab States

Katherine Allen unit has 14 White British

There have been two planned discharges during 2008 with one patient moving to a local care home and one moving back to their home area.

Average Length of Stay

George Jepson unit: 6 years

Katherine Allen unit: 4 years 6 months

Total Number of CPA Reviews During 2008

George Jepson unit: 25

Katherine Allen unit: 29

Clinical Outcome Measures – George Jepson unit

FACE Risk Assessment

The mean FACE risk scores for each of the 15 patients on George Jepson unit during 2008 are presented below. Each patient's risk status is measured across 12 categories of risk and scored 0-4:

- 0 - no apparent risk
- 1 - low apparent risk
- 2 - significant risk
- 3 - serious risk
- 4 - serious and imminent risk

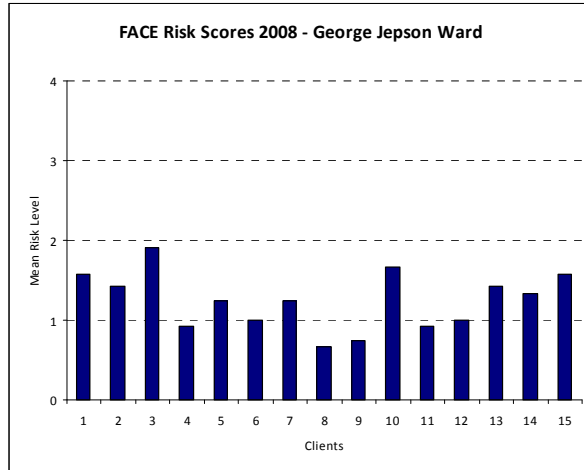


Figure 3: FACE Risk Scores 2008 - George Jepson unit

Figure 3 shows that all of the patients' mean FACE risk scores are lower than level 2, suggesting that most of the patients were not considered to be a 'serious risk' to themselves or others for any significant period of time during the year. The most important point illustrated by this comparison is that, in general, the patients' risk levels have decreased between 2007 and 2008.

FACE Core Assessment

The patients' mean scores on each of the five FACE Core subscales ('Psychological well-being', 'Physical well-being', 'Activities of daily living', 'Interpersonal relationships' and 'Social circumstances'). The subscale 'Activities of daily living' was the most problematic on the unit, which could be expected as many of the patients are physically unable to complete daily activities without assistance from staff.

Other Measures

Several other outcome measures have been used on George Jepson unit since late 2007, including the *Challenging Behaviour Scale* and the *Geriatric Depression Scale* (GDS). Figure 4 presents the mean data from the 10 patients for whom the scale was completed during 2008.

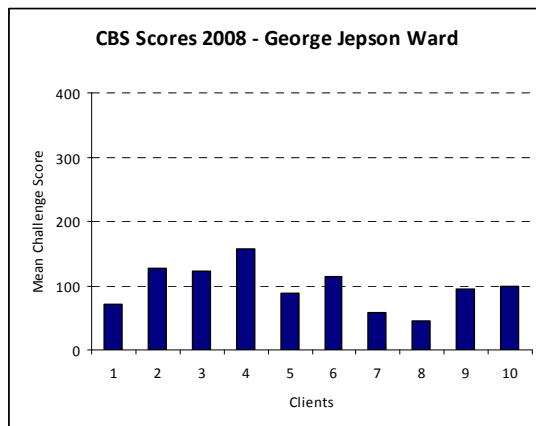


Figure 4: CBS Scores - George Jepson unit

Katherine Allen unit Clinical Outcomes

FACE Risk Scores

Figure 5 displays the mean scores for each patient's FACE Risk assessment. Due to the relatively low turnover of patients on Katherine Allen unit it is not possible to obtain comparative data from admission and discharge in 2008. For most individuals on the unit the FACE Risk assessment is completed annually, therefore for the purposes of this report 'start of year' and 'end of year' scores are compared. In some cases (marked *) a complete data set was not available.

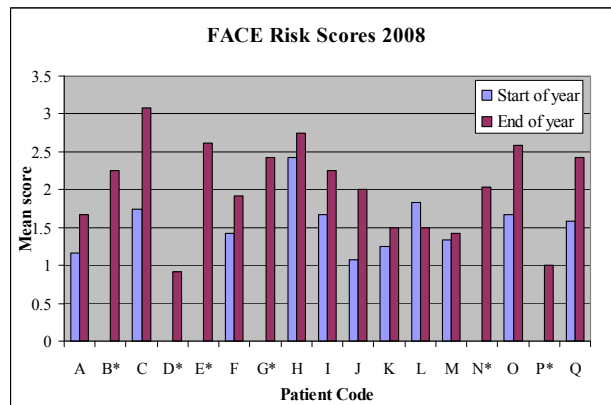


Figure 5: Mean FACE Risk assessment scores at the start and end of 2008. * indicates limited data available

As shown in Figure 5, the overall risk scores of patients on Katherine Allen unit appear to have increased during 2008. The final item on the FACE CORE assessment provides summary information, measuring overall change in state and impact of difficulties on quality of life.

Figure 6 shows most individuals have remained relatively stable over 2008, with the exception of patients C & E experiencing an overall worsening state, and patient F experiencing an overall improvement in the impact difficulties have on their quality of life.

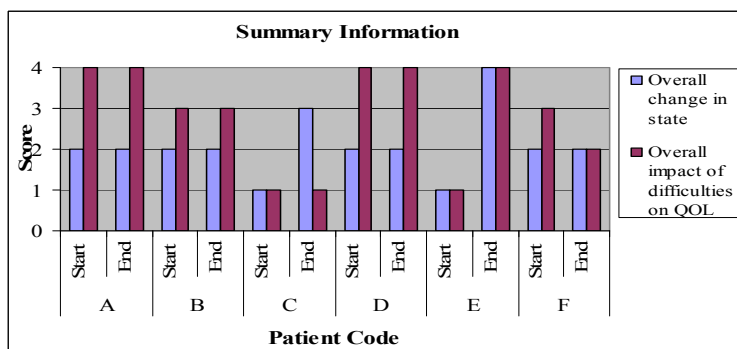


Figure 6: Summary information for six patients at the start and end of 2008.

Outcome Measures

During 2008, the most frequently used measures to assess clinical outcomes were the Challenging Behaviour Scale (CBS), and the Clinical Outcomes in Routine Evaluation (CORE) assessment. These measures are deemed most central to therapy aims and are carried out on an approximate quarterly basis.

Challenging Behaviour Scale (CBS).

The CBS assesses two main components of challenging behaviours: Frequency and Level of Challenge to Staff (i.e. management difficulty on the unit). The frequency component is displayed in Figure 7 in a sample of six patients.

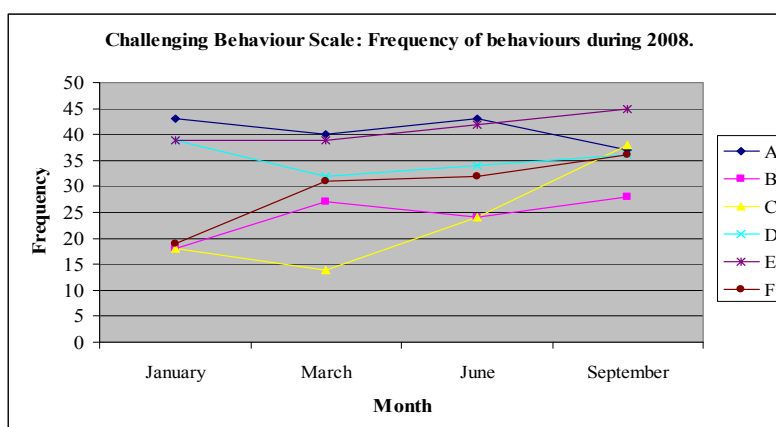


Figure 7: Frequency of challenging behaviours in 2008

Future Plans

Both units will be developing staff in order to provide specialist care in the following:

- Palliative care
- Nutrition
- Cognitive Behaviour Therapy
- Dementia Care

George Jepson unit

The unit will shortly benefit from the creation of a single en-suite room, new office and clinical room. This will allow single room accommodation for all patients on the unit. With the creation of a new office/work station staff will be able to implement FACE documentation.

Katherine Allen unit

Work will start in mid 2009 to redesign and refurbish the unit. This will ultimately entail reducing the available beds from 16 to 12. In addition, a separate planning application will be made to apply for a balcony area to enable all patients to access fresh air.