Leeds and York Partnership NHS
NHS Foundation Trust

The Yorkshire Centre for Psychological Medicine

Annual Review

2014/15

Contents

Introduction

The Yorkshire Centre for Psychological Medicine (YCPM) delivers biopsychosocial care for people with complex medically unexplained symptoms and physical / psychological co-morbidities. The YCPM is an eight bed specialist in-patient unit which was originally established 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 sixth YCPM Annual Report/Review. 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 doctors

Nursing

Occupational therapy

Physiotherapy

Cognitive behavioural therapy

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:

Medical / surgical teams within the general hospital system, across the full range of specialities

Psychosexual therapists

Outpatient CFS/ME team

Inreach and outpatient services

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 system, across the full range of specialities.

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 (at least weekly) 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 2014-15

Activity

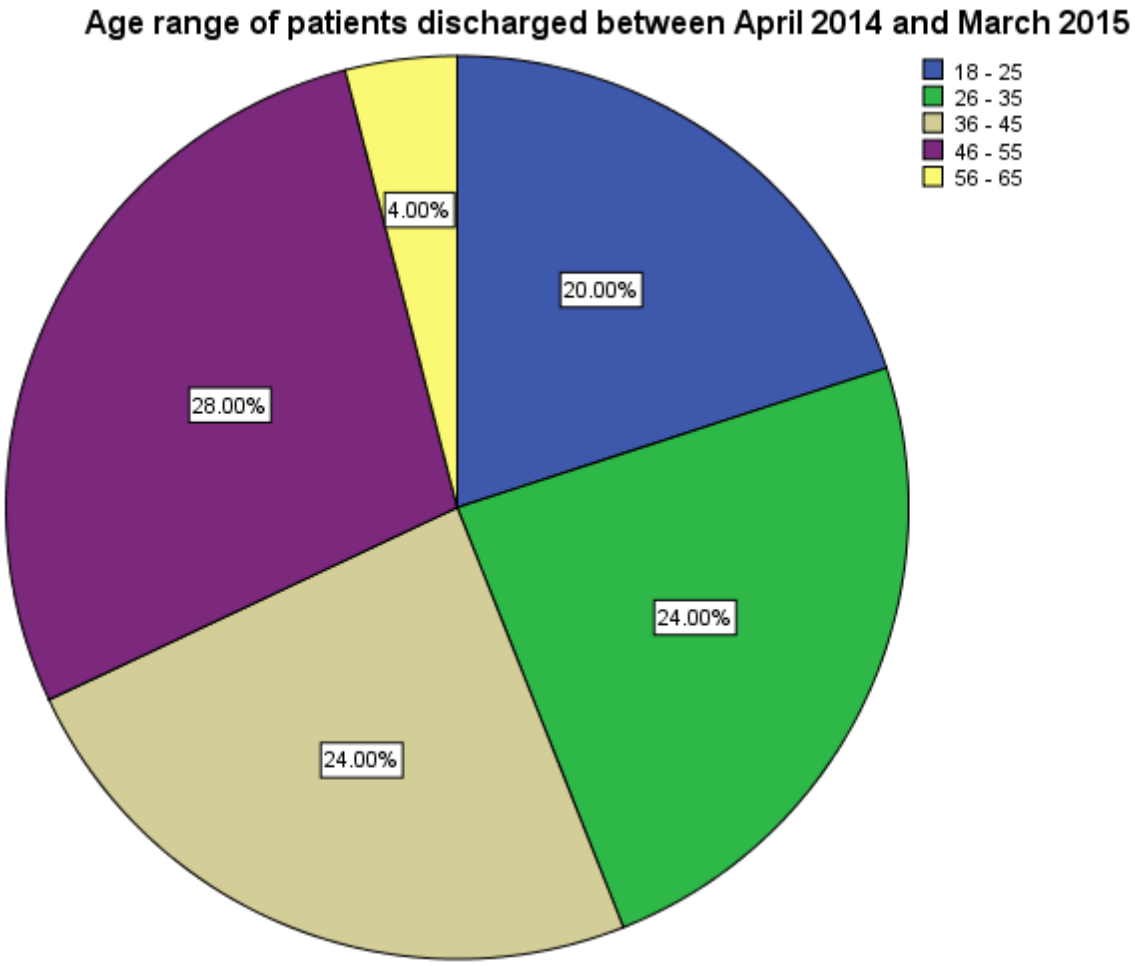
Inpatient Treatment

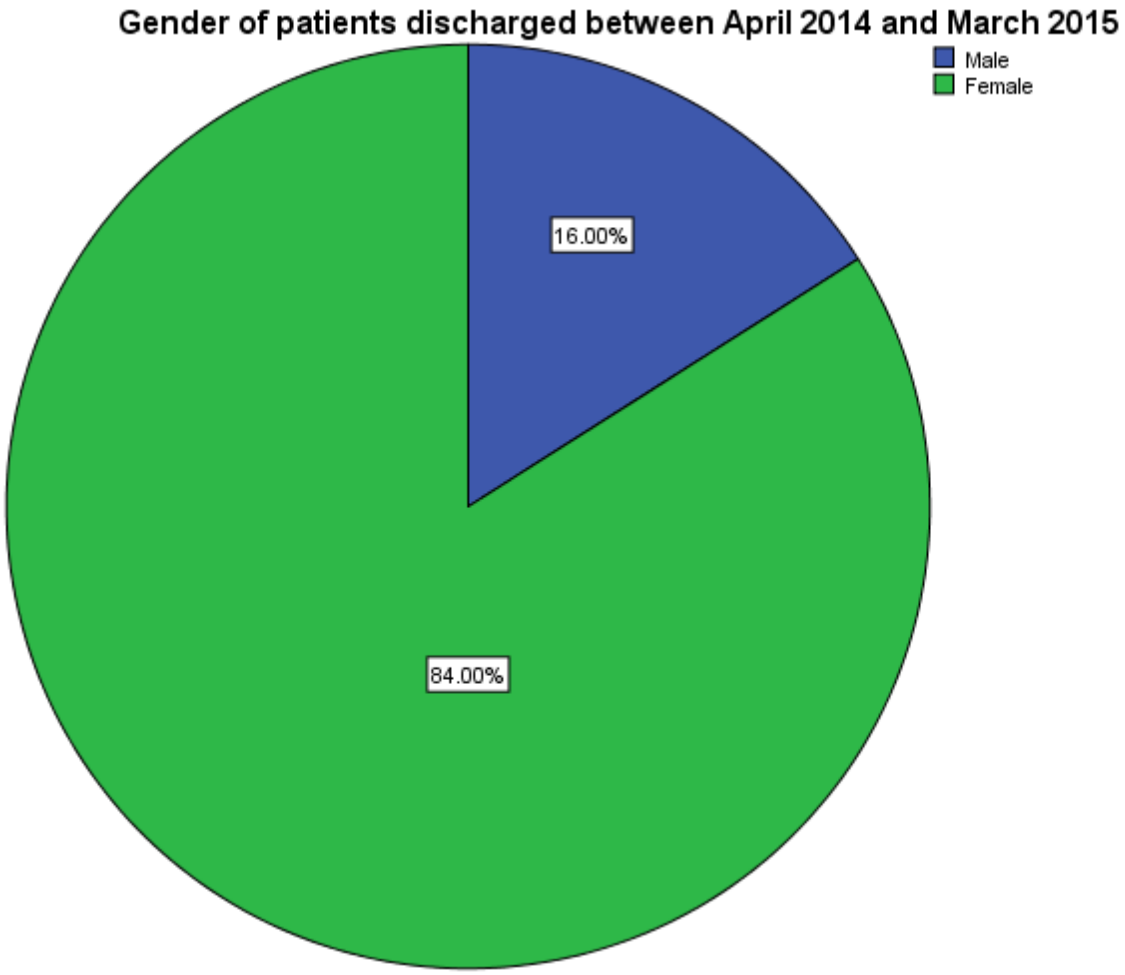
Data for all patients discharged from the YCPM between 1st April 2014 and 31st March 2015 are included in this report. In total:

- **25** patients were discharged during this period.
- **18** having been on the unit for a full treatment admission (as opposed to assessment and opinion/advice only).
- **17** of these being willing and able to complete all outcome measures, so forming the main group for the analysis.

Figures for **Age, Gender, Diagnoses** and **Length of stay (LOS)** relate to the whole group of **25.**

All other (ie outcome analysis) figures relate to the group of **17** with complete information.





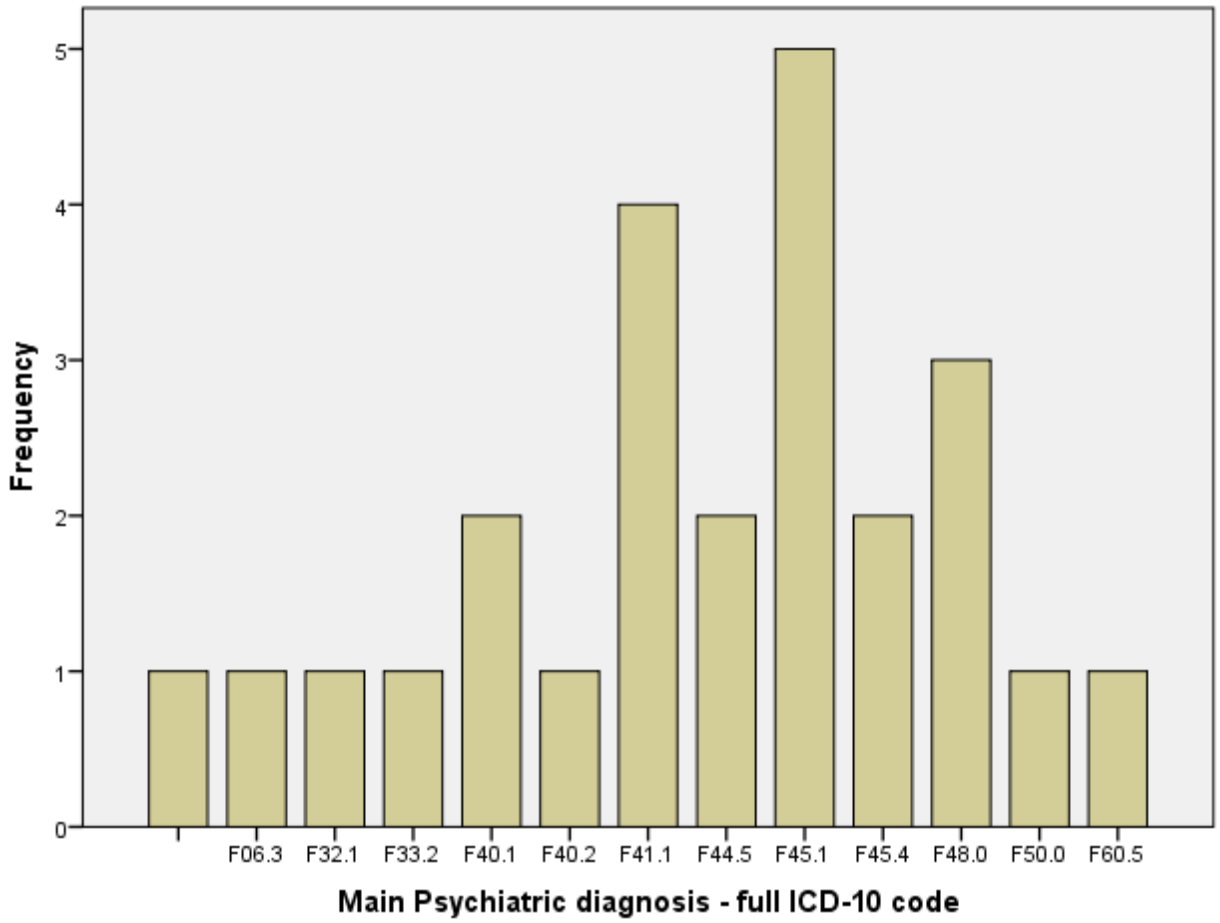
Female:Male ratio = approximately 5:1

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

- Severe and complex medically unexplained symptoms and illness.
- Physical and psychological comorbidities at a serious level of severity.
- 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:

Nil = no psychiatric diagnosis

F06.3 = Organic mood (affective) disorder

F32.1 = Moderate depressive episode

F33.2 = Recurrent depressive disorder, current episode severe without psychotic symptoms

F40.1 = Social phobia

F40.2 - Specific (isolated) phobia

F41.1 = Generalized anxiety disorder

F44.5 = Dissociative convulsions

F45.1 = Undifferentiated somatoform disorder

F45.4 = Persistent somatoform pain disorder

F48.0 = Fatigue syndrome (CFS/ME)*****

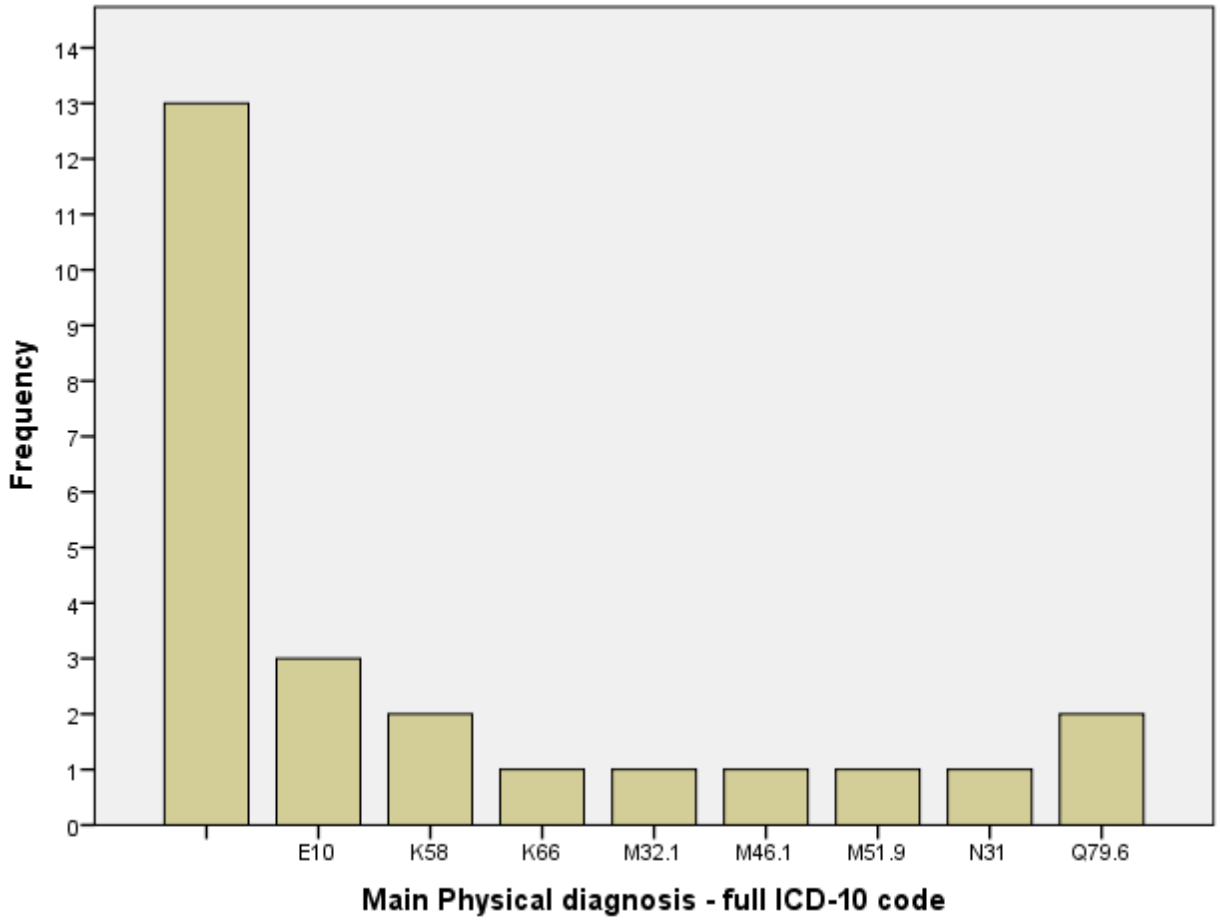
F50.0 = Anorexia nervosa

F60.5 = Anankastic personality disorder

(***NOTE:** CFS/ME is categorised in this section simply because, although far from ideal, the best fit within the system which we use for diagnostic classification (ICD-10) is F48.0. However, the YCPM team do not view CFS/ME as a mental disorder. People who suffer with CFS/ME have a physical illness, although generally without an identifiable organic pathology.)

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

E10 = Type 1 diabetes mellitus

K58 = Irritable bowel syndrome

K66 = Peritoneal adhesions (postprocedural)

M32.1 = Systemic lupus erythematosus

M46.1 = Sacroiliitis

M51.9 = Thoracic, thoracolumbar and lumbosacral intervertebral disc disorder

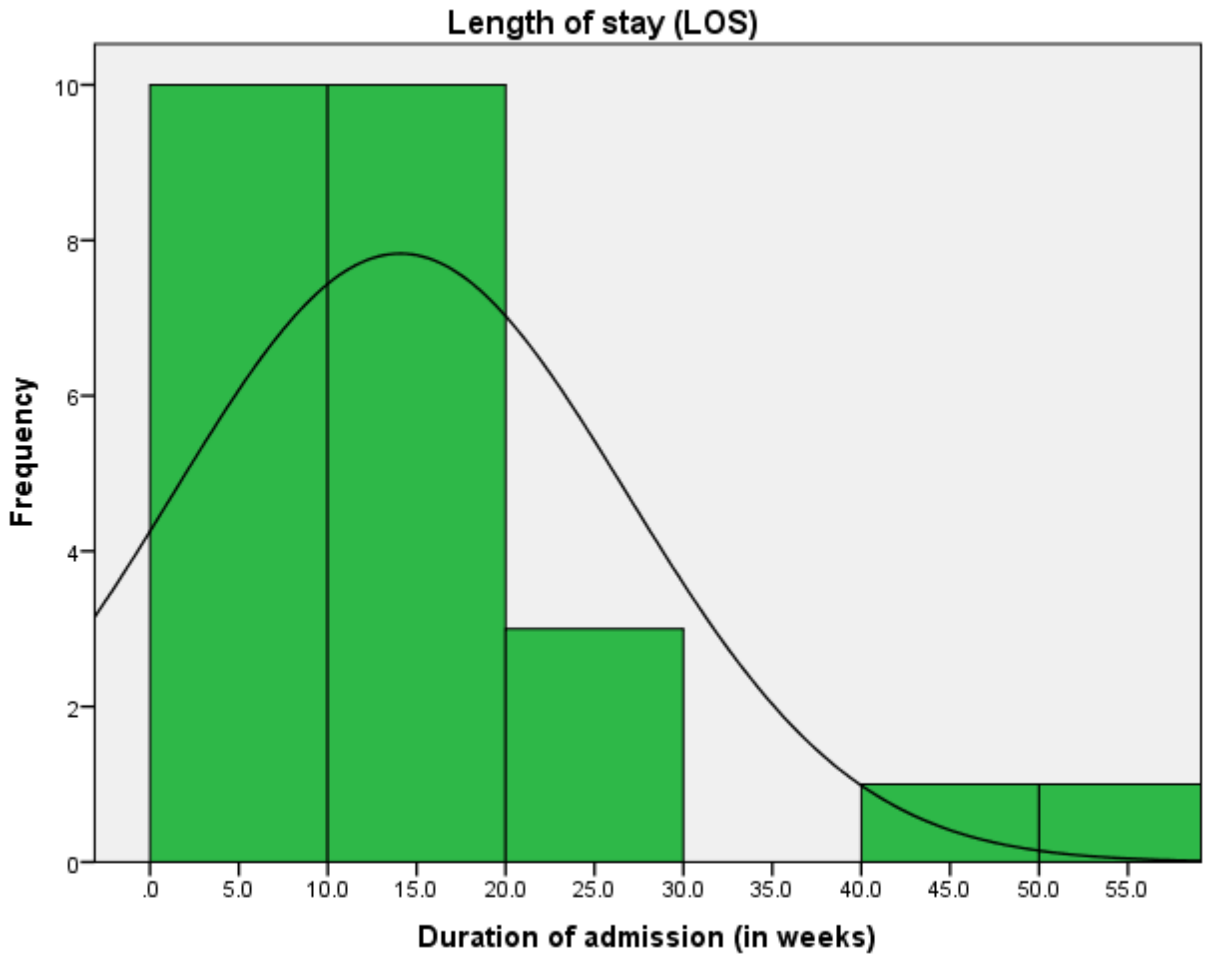
N31 = Uninhibited neuropathic bladder

Q79.6 = Ehlers-Danlos syndrome

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 2014 – March 2015



The figure above shows the length of stay in weeks for patients discharged between April 2014 and March 2015.

The duration of admission ranged from 0.5 to 53 weeks, with a whole group average of 14 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 34 weeks.

For the remaining 80% of patients the duration ranged from 0.5 to 19 weeks, with an average of 9 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 Improvement Scale (CGIS)

The proportions of patients showing **improvement** on the CGIS 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%)

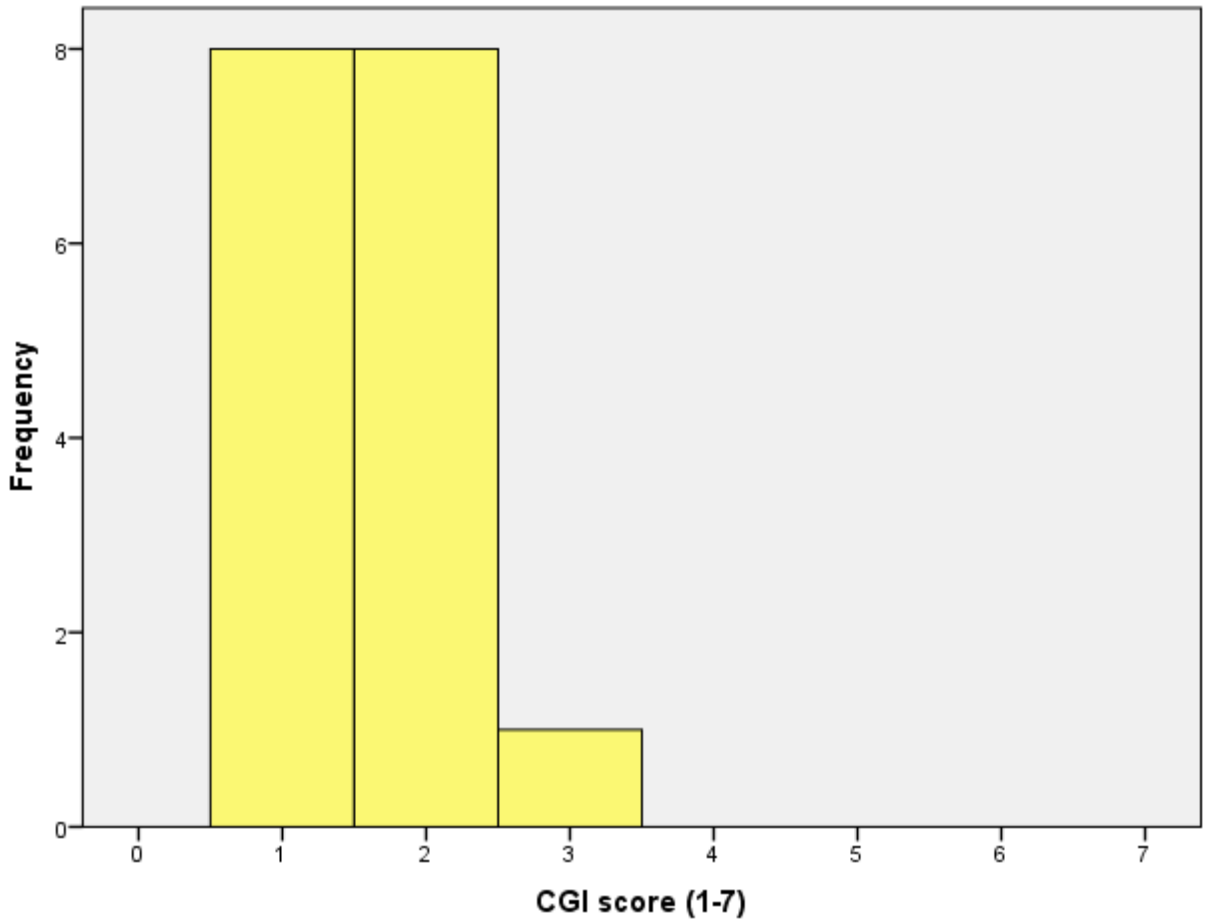
- **95%** in 2013/14

(Major improvement 26.3%, Moderate improvement 47.4%, Minor improvement 21.1%)

- **100%** in 2014/15

(Major improvement 47.1%, Moderate improvement 47.1%, Minor improvement 5.8%)

As shown in the chart below, 16 of the 17 patients (**94.2%**), in what is 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:

a) W: subjective well-being

b) P: problems/symptoms

c) F: life functioning

d) R: 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.)

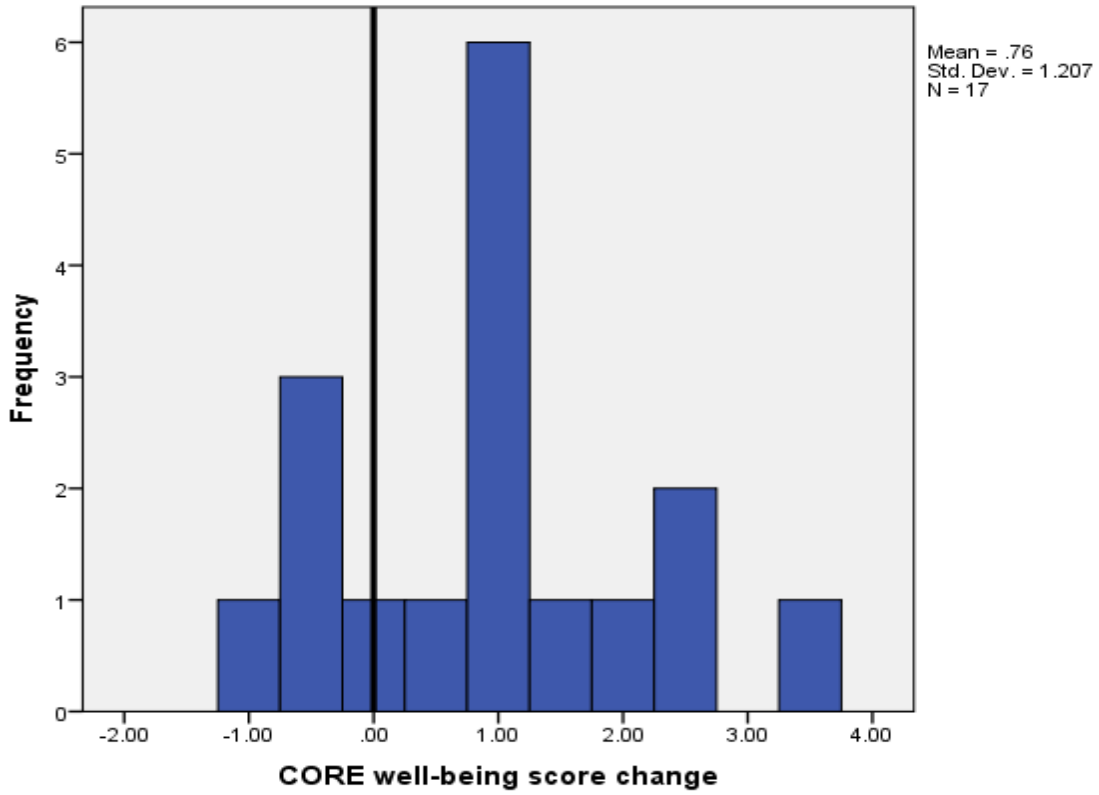
April 2014 – March 2015:

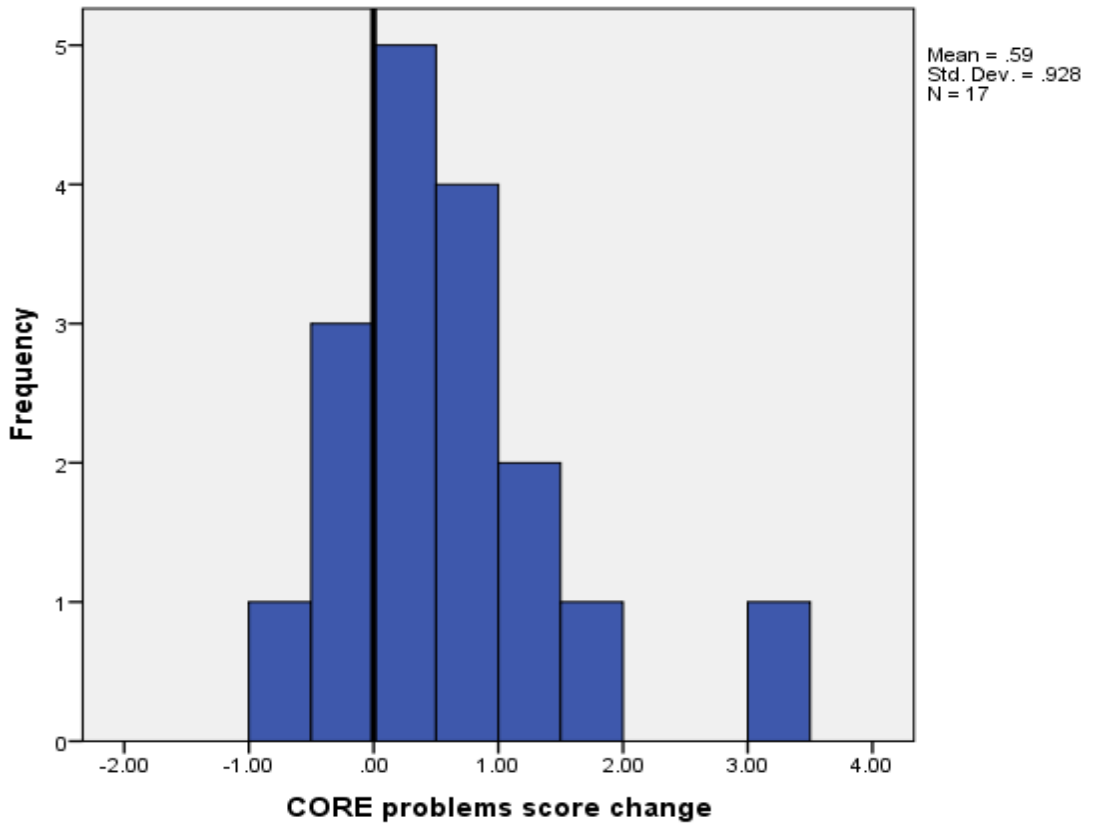
- Wellbeing subscale 70.1% improved
- Problems subscale 76.5% improved
- Functioning subscale 88.2% improved
- Risk subscale 41.2% improved (only 1 patient scored >1 at admission)
- **Total CORE scores** **76.5% improved**

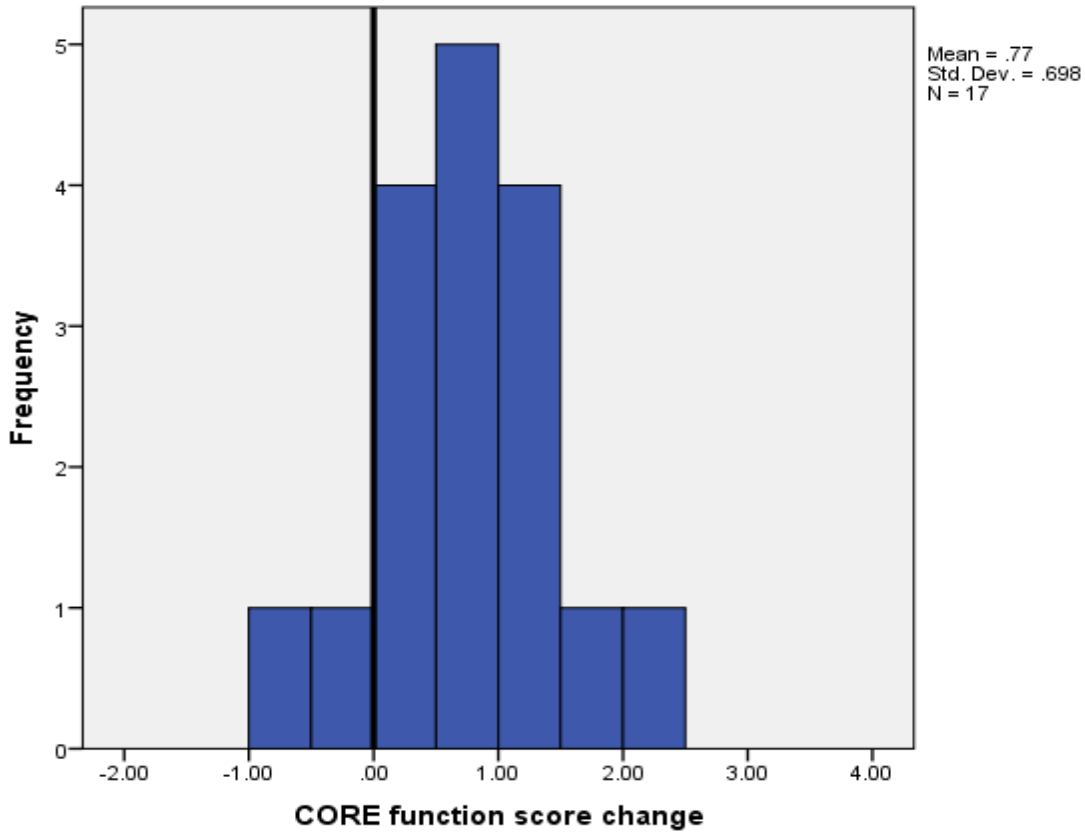
	Admission	**Discharge**
Mean CORE Total score	2.03	1.43

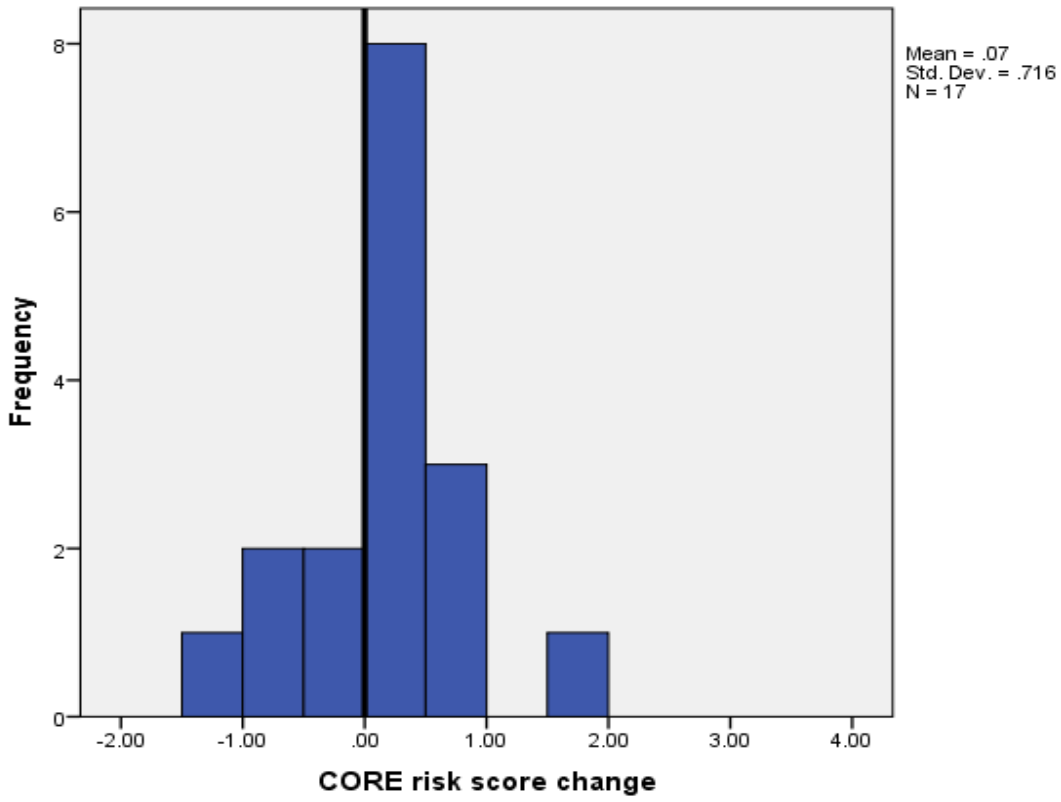
Data gathered on the CORE-OM forms is represented below.

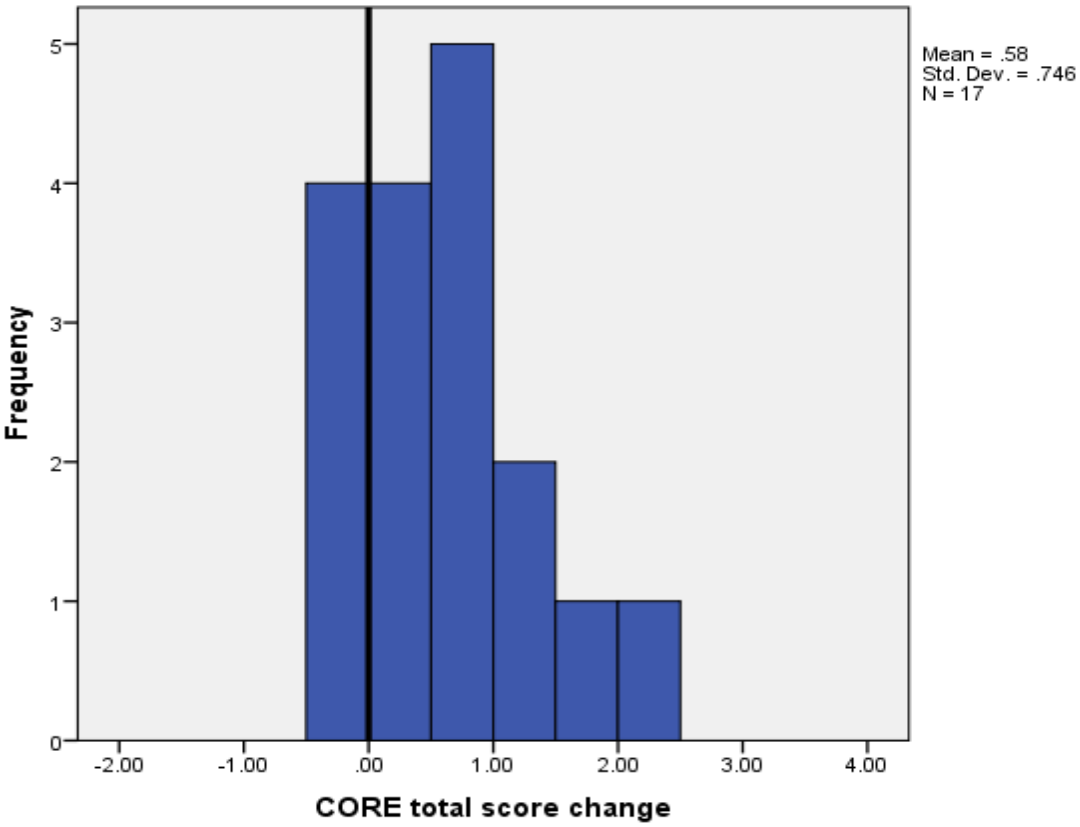
(**NOTE**: on this measure, and the construction of the charts shown below, a positive change in subscale and total CORE scores (ie above the zero line on the bottom axis) is desirable and is evidence of improvement / reduced distress.)


Mean = .76
Std. Dev. = 1.207
N = 17
Frequency
0
1
2
3
4
5
6
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE well-being score change


Mean = .59
Std. Dev. = .928
N = 17
Frequency
0
1
2
3
4
5
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE problems score change


Mean = .77
Std. Dev. = .698
N = 17
Frequency
0
1
2
3
4
5
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE function score change


Mean = .07
Std. Dev. = .716
N = 17
Frequency
0
2
4
6
8
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE risk score change


Mean = .58
Std. Dev. = .746
N = 17
Frequency
0
1
2
3
4
5
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE total score change

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".

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

April 2014 – March 2015:

Of those people who initially scored at the level of experiencing severe or extreme problems (ie a score of 4 or more) in each particular domain, the proportion of those scoring themselves as improved during the admission was as follows:

- **Mobility** improved in **87.5%** of patients
- **Self-care** improved in **100%** of patients
- **Usual activities** improved in **63.6%** of patients
- **Pain / discomfort** improved in **62.5%** of patients
- **Anxiety / depression** improved in **100%** of patients

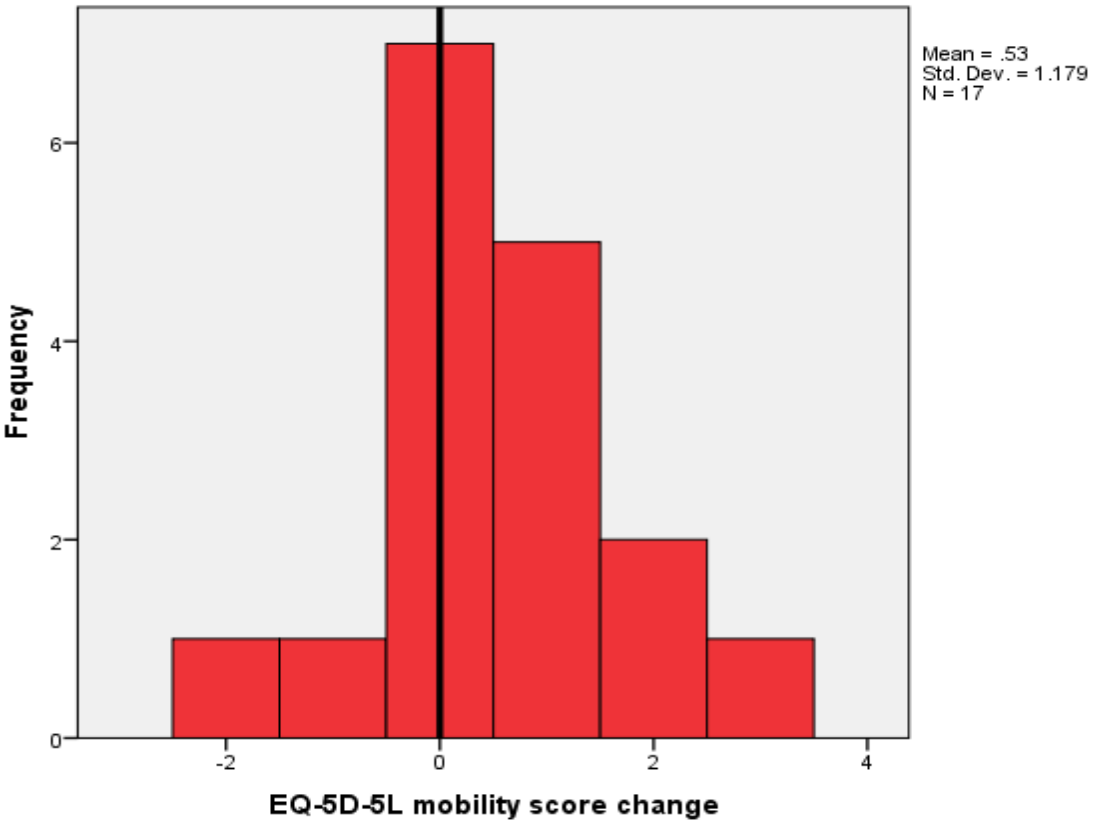
Also, across the whole patient group of 17 people:

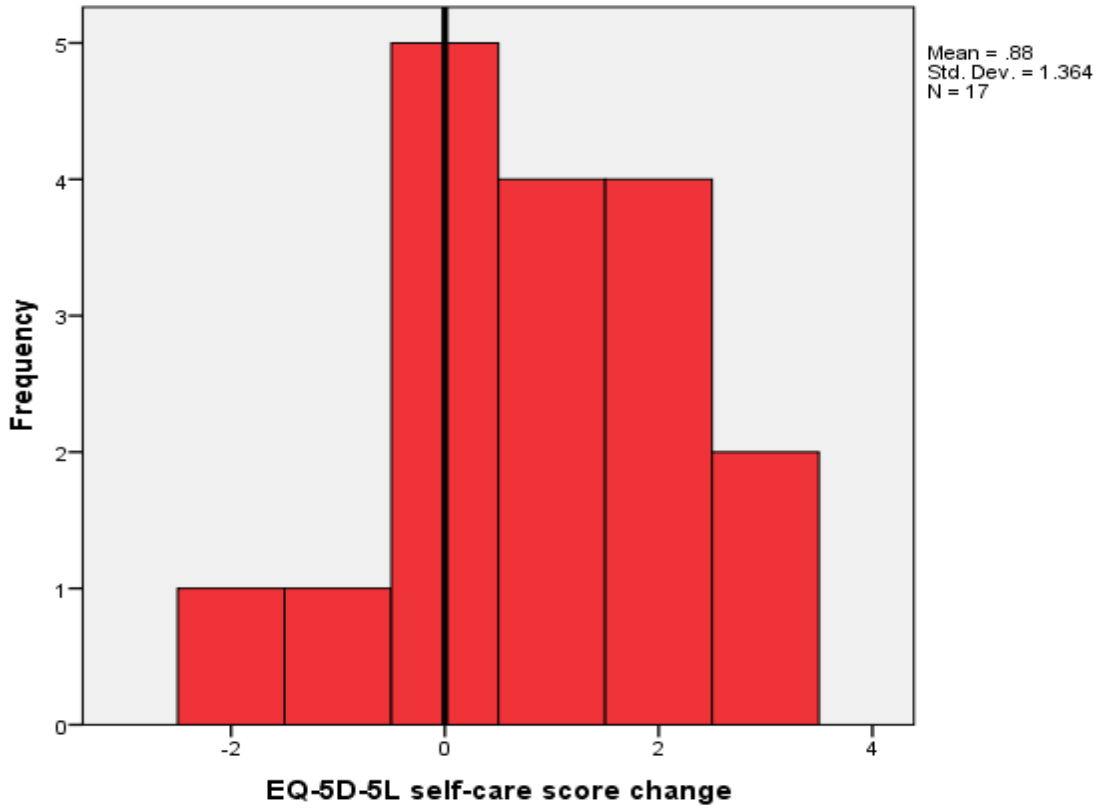
- **At least one domain** improved in **82.4%** of patients
- **Overall health score on VAS** improved in **64.7%** of patients

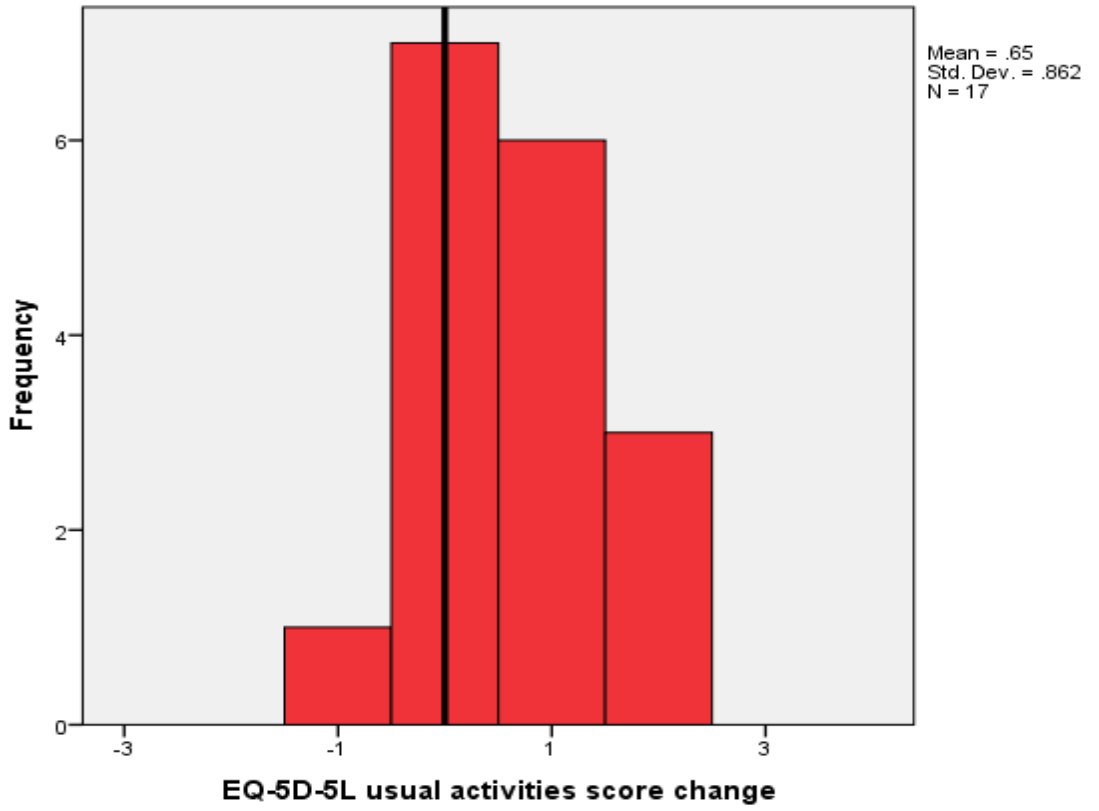
NOTE:

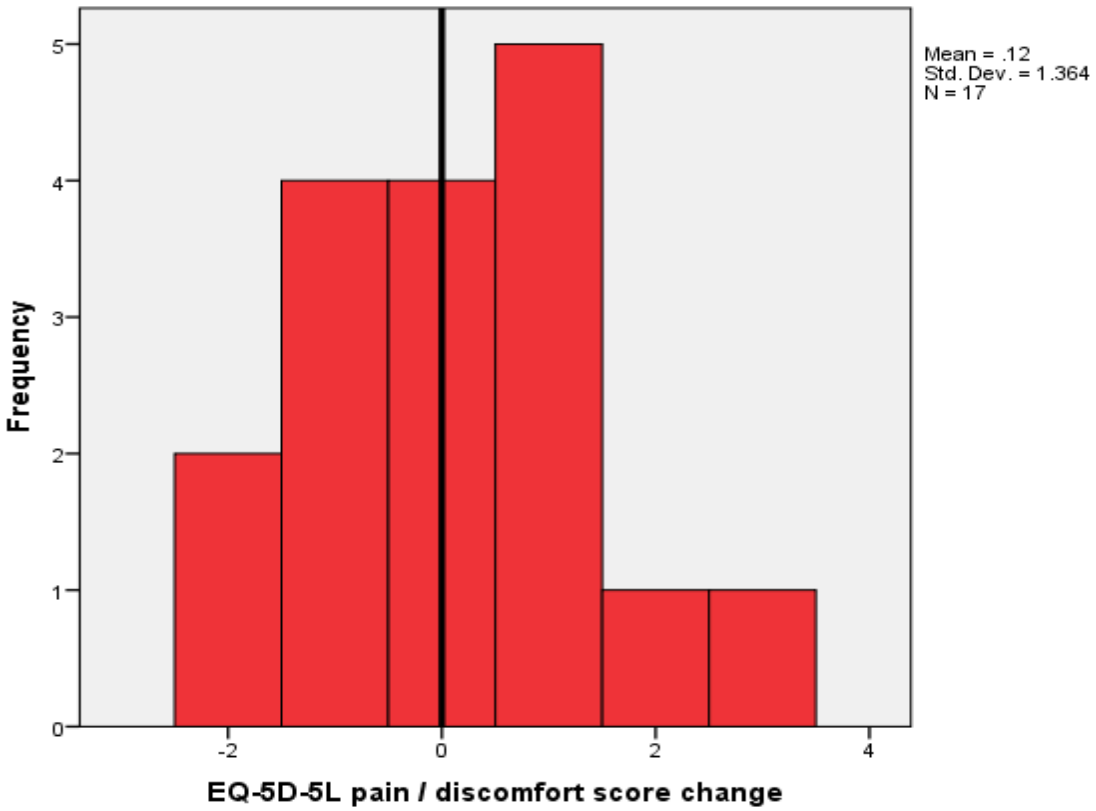
- The charts which follow have been constructed using the EQ-5D-5L data from the whole patient group of 17 people, regardless of initial score level.
- In the construction of the first 5 of these charts, a positive change in the X axis (ie an increase in score by 1, 2, 3 or 4 steps, calculated as score at Admission minus score at Discharge) 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.

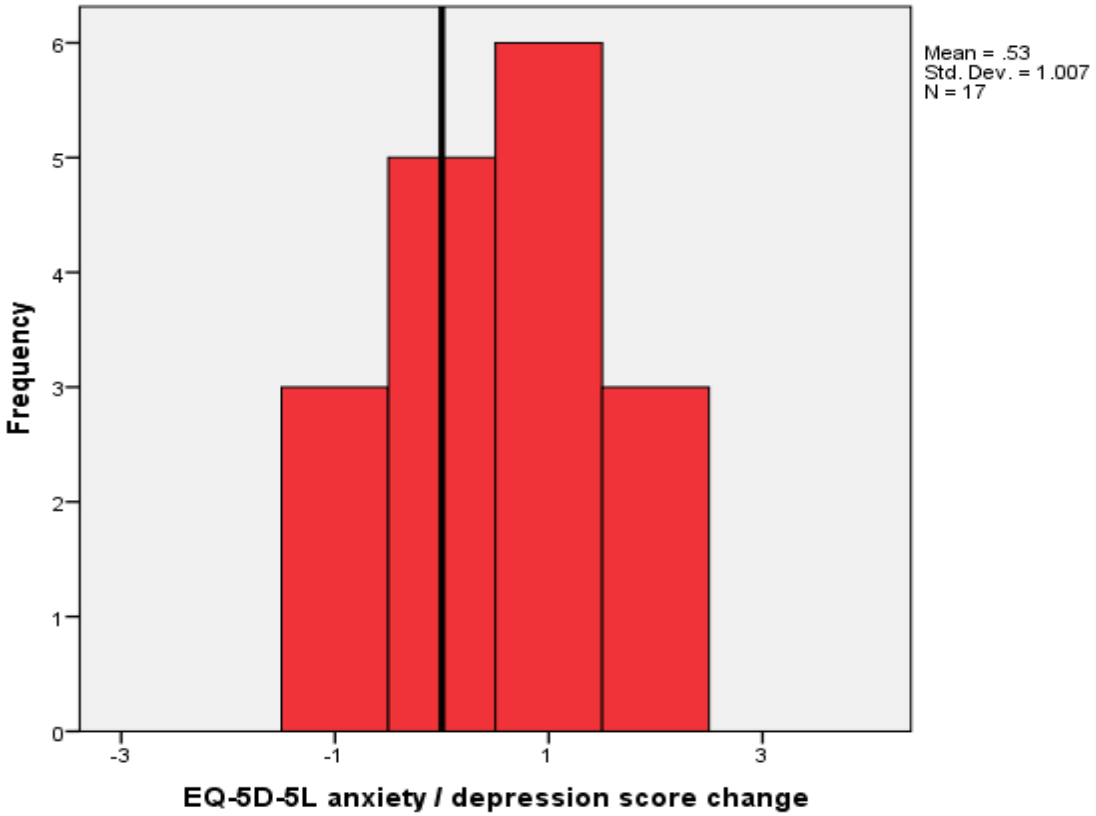
- Similarly in the 6th chart, which illustrates Overall Health Score Change, scores are taken from the 100 point EQ-5D-5L Visual Analogue Scale (albeit in this case as score at Discharge minus score at Admission) and a positive change is again desirable as evidence of improvement, as indicated by the score change columns to the right of the reference line on the bottom axis.

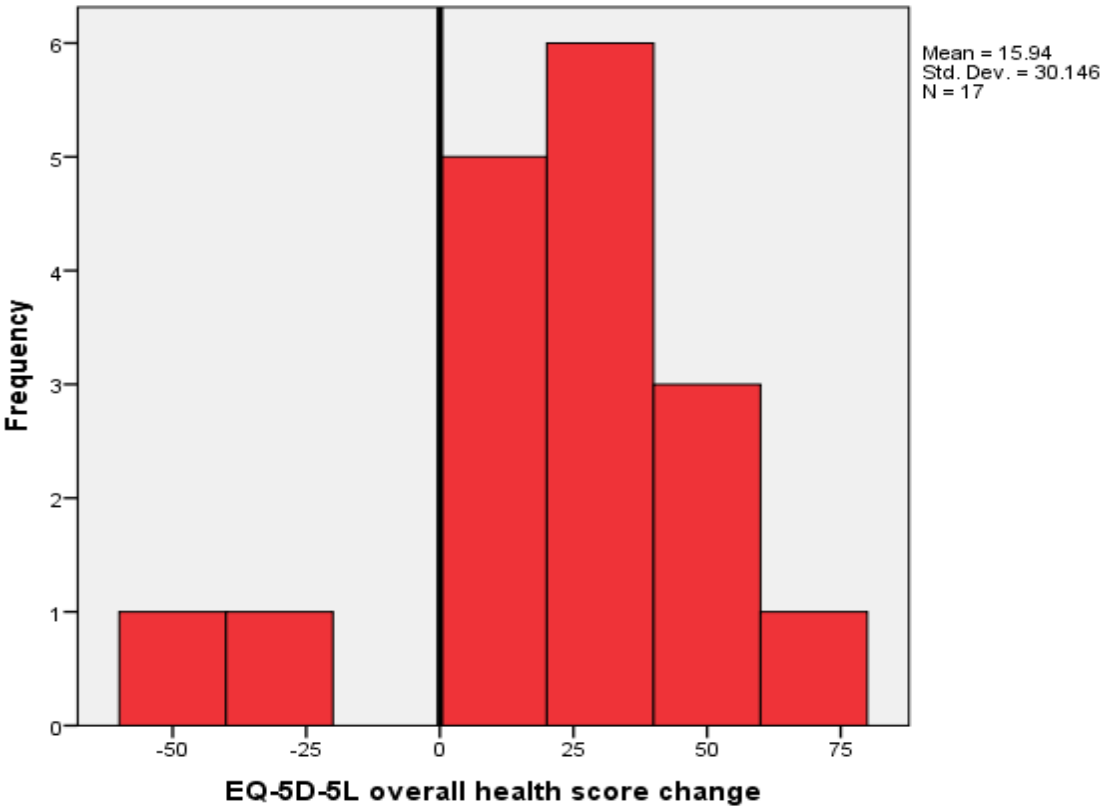



Mean = .88
Std. Dev. = 1.364
N = 17
Frequency
0
1
2
3
4
5
-2
0
2
4
EQ-5D-5L self-care score change


Mean = .65
Std. Dev. = .862
N = 17
Frequency
0
2
4
6
-3
-1
1
3
EQ-5D-5L usual activities score change


Mean = .12
Std. Dev. = 1.364
N = 17
Frequency
0
1
2
3
4
5
-2
0
2
4
EQ-5D-5L pain / discomfort score change


Mean = .53
Std. Dev. = 1.007
N = 17
Frequency
0
1
2
3
4
5
6
-3
-1
1
3
EQ-5D-5L anxiety / depression score change


Mean = 15.94
Std. Dev. = 30.146
N = 17
Frequency
0
1
2
3
4
5
6
-50
-25
0
25
50
75
EQ-5D-5L overall health score change

4. TOMs (Therapy Outcome Measures)

The TOMs is a clinician-rated outcome measure which is used, as part of a therapeutic approach, as many times as required and helpful during the admission (this varies depending upon the individual patient and their needs). Results for this annual report are taken from the TOMs scores at admission and then at discharge, providing a comparison of scores covering the following 4 subscales:

a) Impairment

b) Activity

c) Participation

d) Well-being

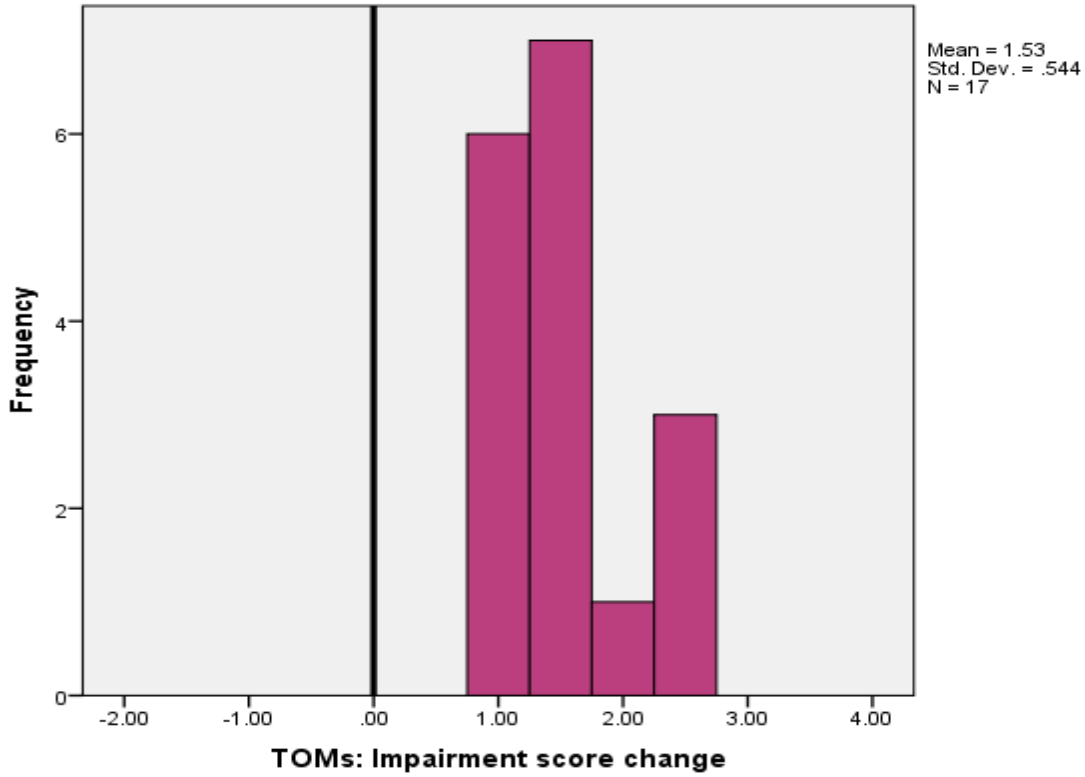
This is a measure which has been validated and used very widely within healthcare services, particular those with a significant Occupational Therapy component. The figures given here relate to use of the standard version of TOMs.

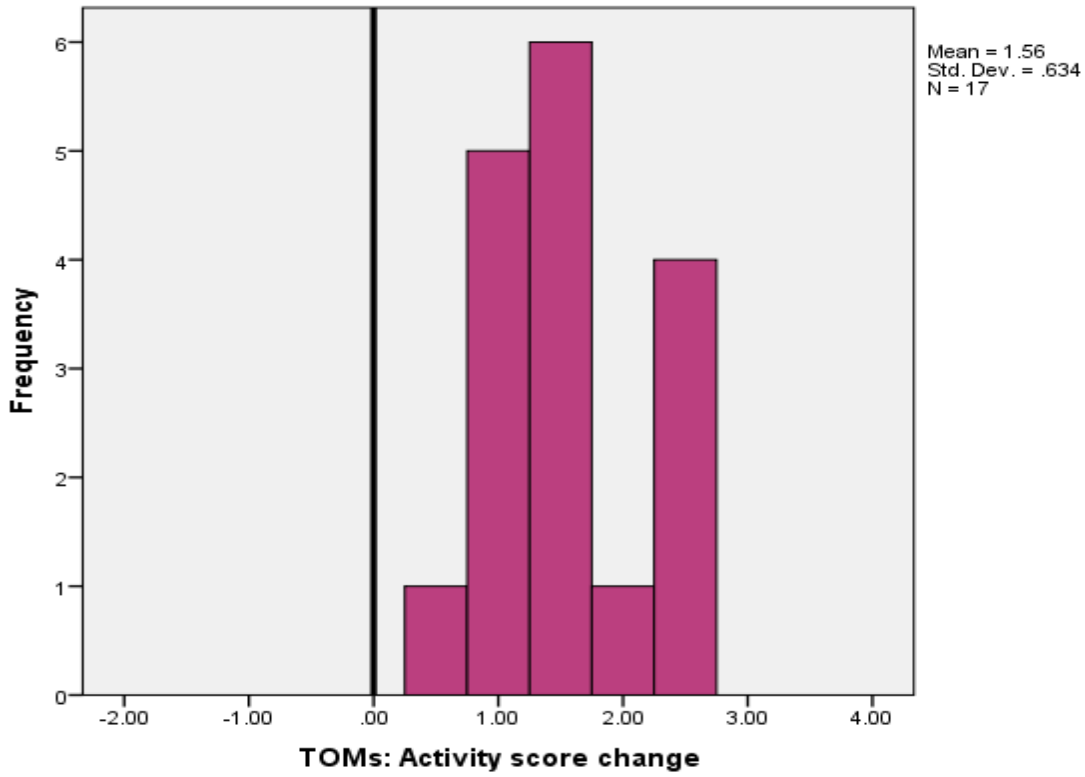
April 2014 – March 2015:

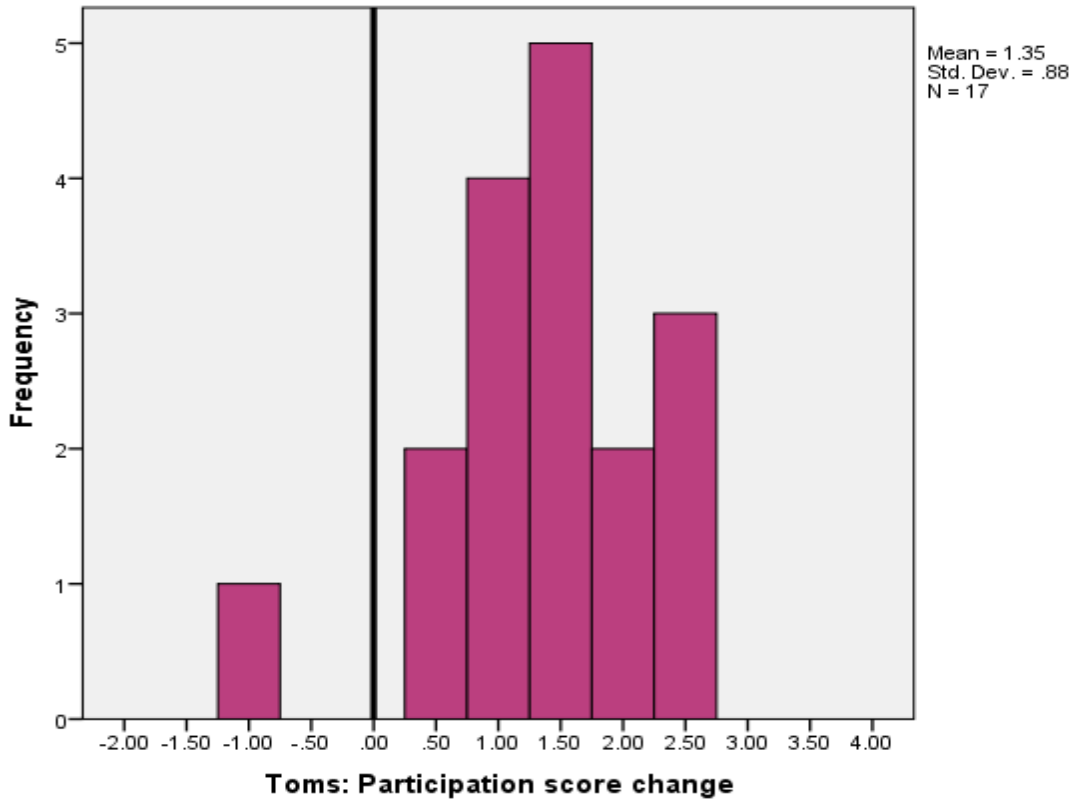
In each particular domain, the proportion of those showing an improvement of at least 1.0 points score change during the admission was as follows:

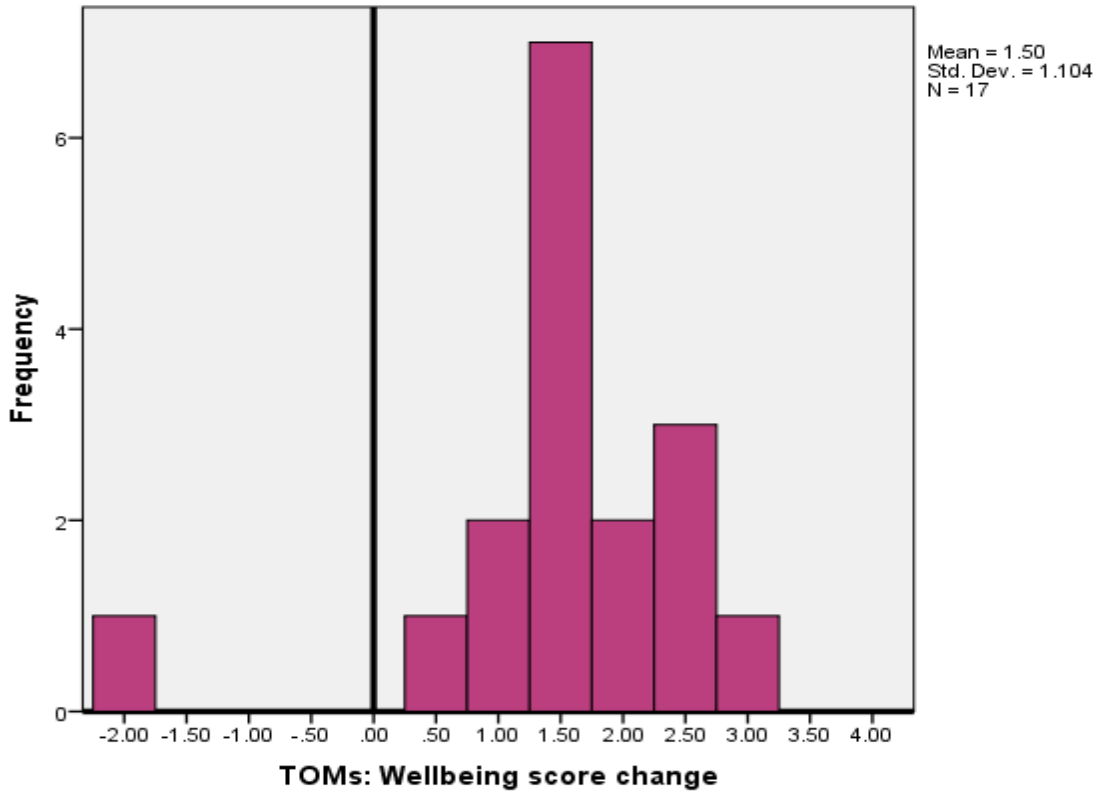
- **Impairment** improved in **100.0%** of patients
- **Activity** improved in **94.1%** of patients
- **Participation** improved in **82.4%** of patients
- **Well-being** improved in **88.2%** of patients

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


Mean = 1.53
Std. Dev. = .544
N = 17
Frequency
0
2
4
6
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
TOMs: Impairment score change


Mean = 1.56
Std. Dev. = .634
N = 17
Frequency
0
1
2
3
4
5
6
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
TOMs: Activity score change


Mean = 1.35
Std. Dev. = .88
N = 17
Frequency
0
1
2
3
4
5
-2.00 -1.50 -1.00 -.50 .00 .50 1.00 1.50 2.00 2.50 3.00 3.50 4.00
Toms: Participation score change


Mean = 1.50
Std. Dev. = 1.104
N = 17
Frequency
0
2
4
6
-2.00 -1.50 -1.00 -.50 .00 .50 1.00 1.50 2.00 2.50 3.00 3.50 4.00
TOMs: Wellbeing score change

5. Chalder Fatigue Scale

This measure asks the scorer (patient) to answer 11 questions which cover physical and mental fatigue (including one item on subjective memory function). The questionnaire is given to all patients at admission and at discharge, ie including but not only those patients with a diagnosis of CFS/ME.

There are two main ways to score this tool and analyse the results. At the YCPM the 4-point Likert scoring approach is used (0,1,2,3).

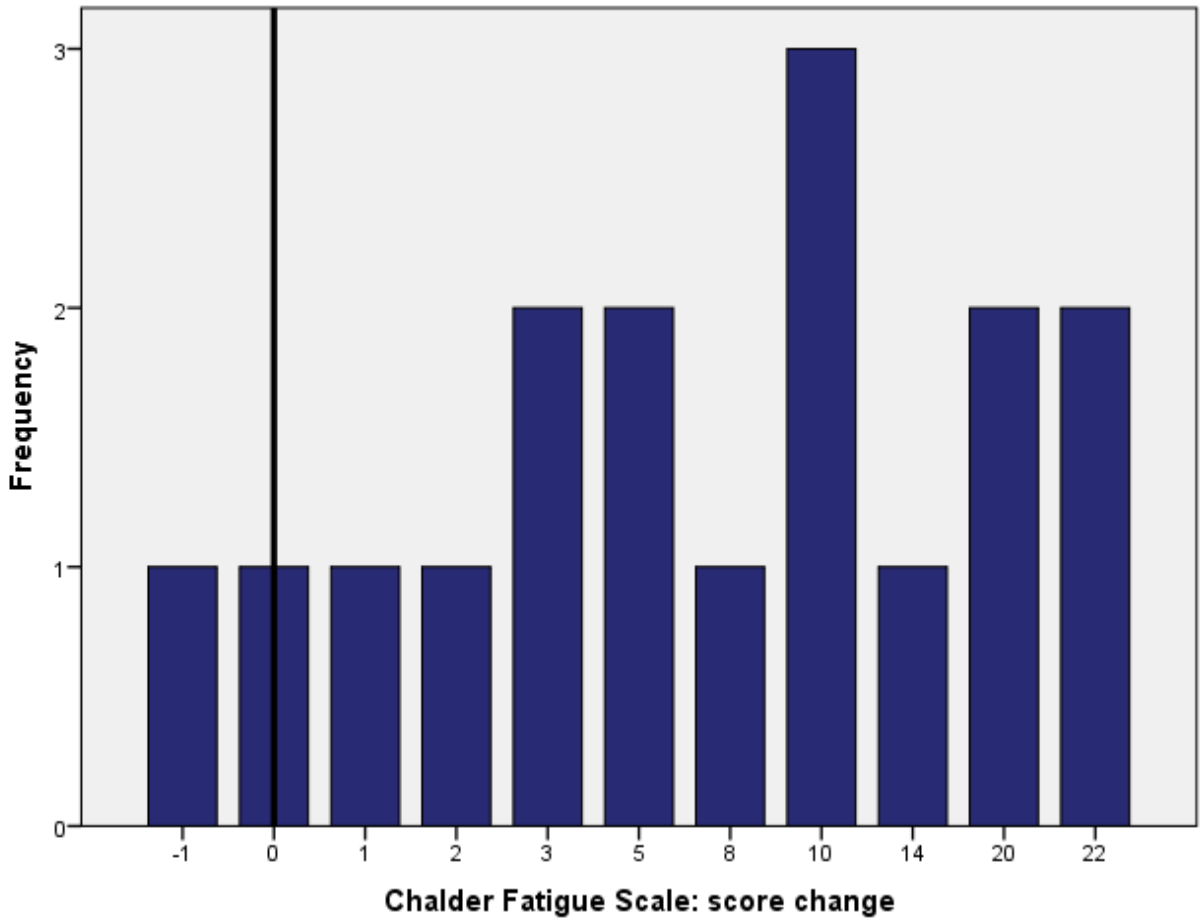
April 2014 – March 2015:

- 100% of patients with CFS/ME showed a reduction (improvement) in their fatigue score

- 88.2% of the total patient group showed a reduction (improvement) in their fatigue score
- Of the total patient group:
    - 5.9% (1 patient) showed no change
    - 5.9% (1 patient) showed a slight worsening (increase in fatigue score), from a total score of 12 to a total score of 13
    - Neither of these patients had a diagnosis of CFS/ME or any fatigue state

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

Chalder Fatigue Scale results



6. 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+.

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 2014 – March 2015

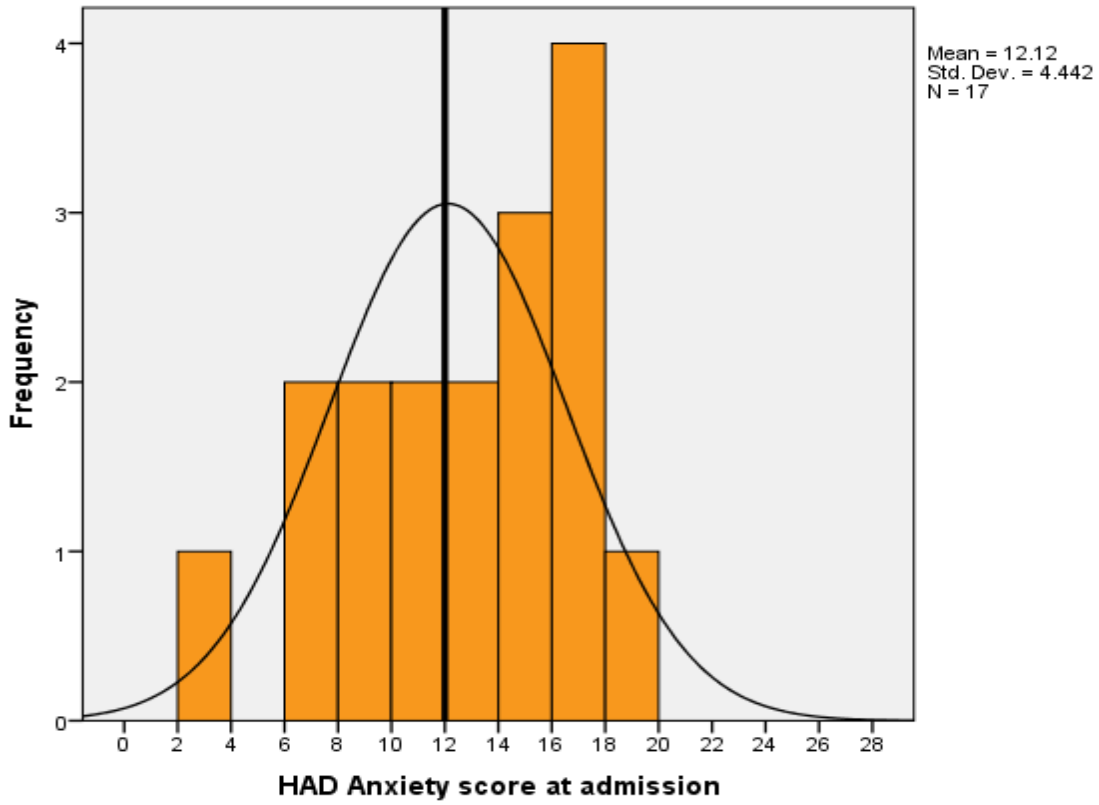
HAD-A:

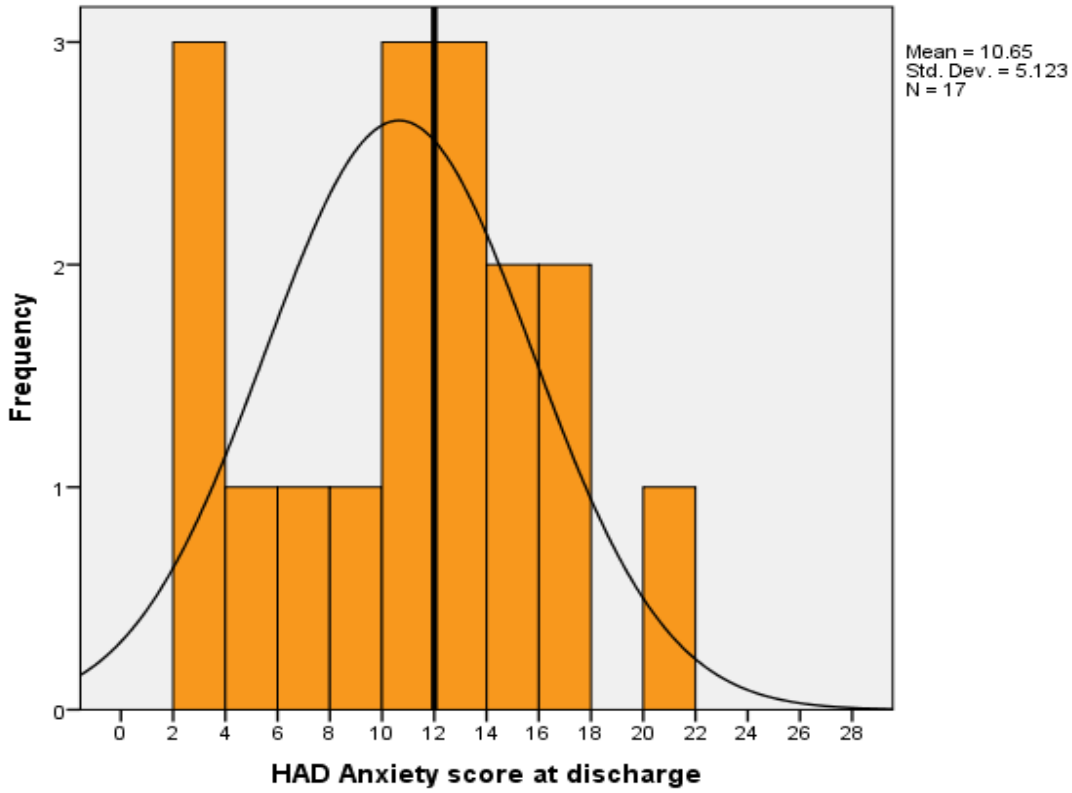
- Ten people (59% of patients admitted) scored 12 or more on HAD-A at admission
- Of these, seven (70%) showed a reduction in score by the time of discharge
- The scores in four (57%) reduced to below threshold

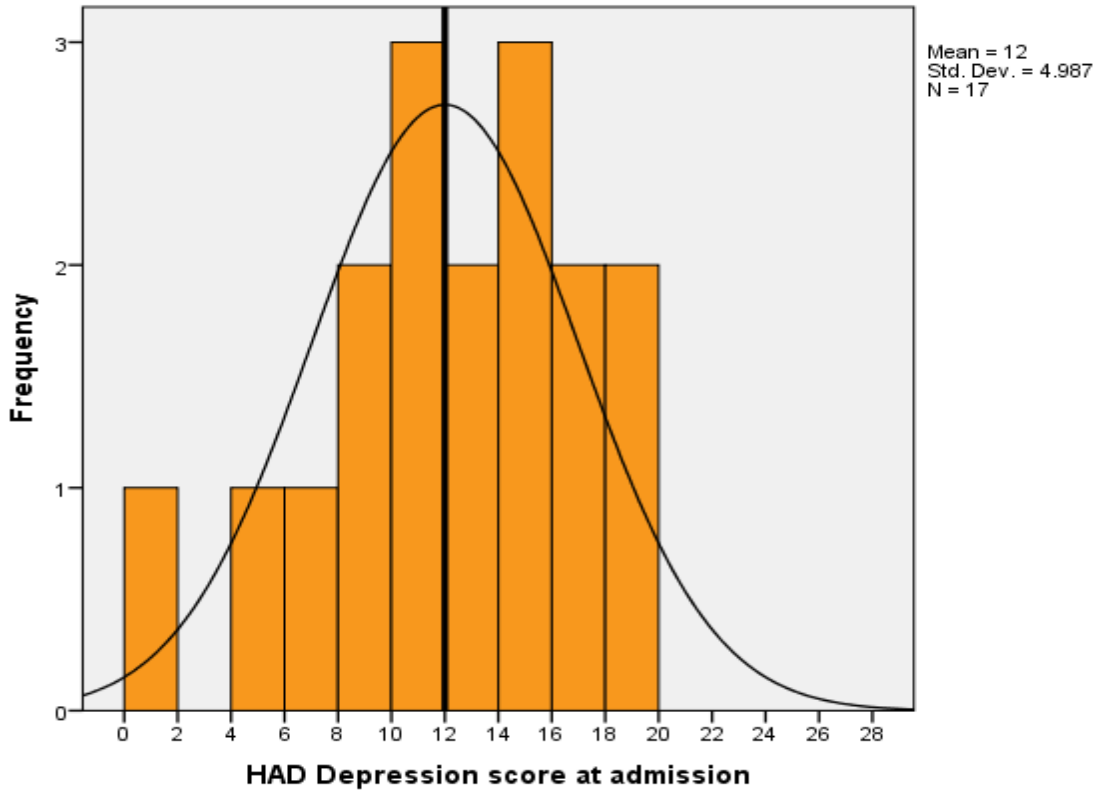
HAD-D:

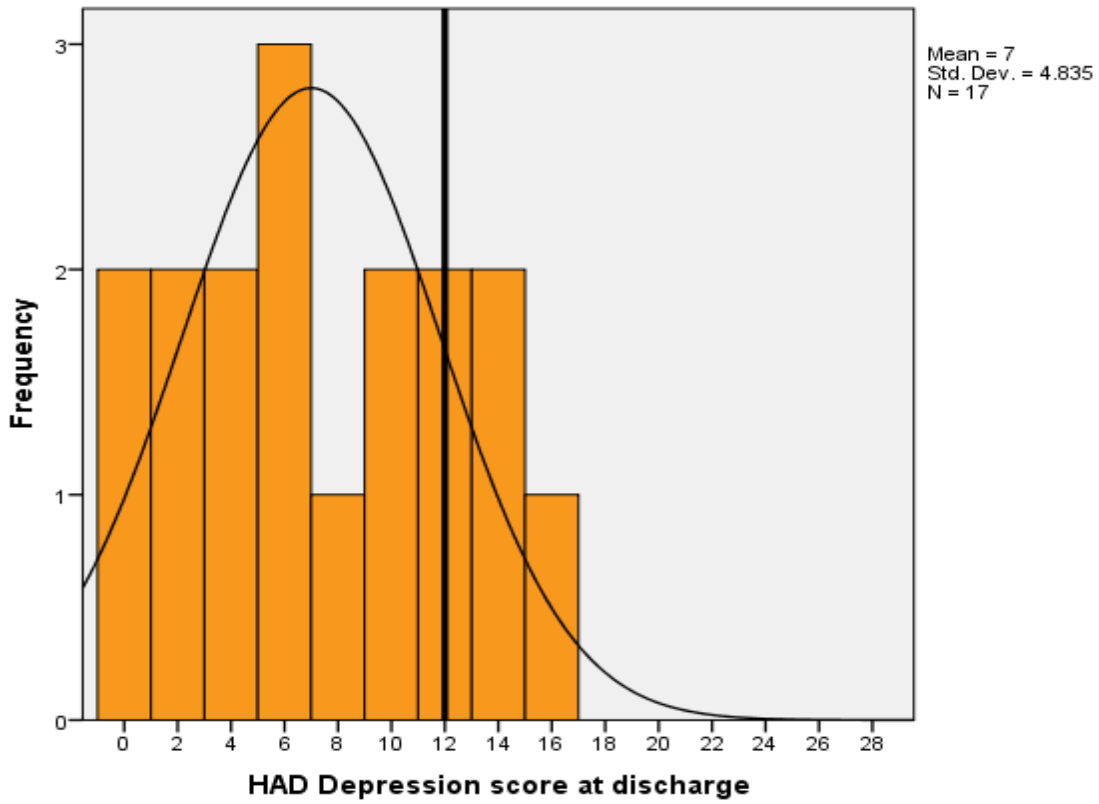
- Nine people (53% of patients admitted) scored 12 or more on HAD-D at admission
- Of these, eight (89%) showed a reduction in score by the time of discharge
- The scores in six (75%) reduced to below threshold

(**NOTE**: comparative charts below include scores at admission and at discharge. The bold line at "12" on the bottom axis indicates the clinical cut-off / threshold point, as described above.)


Mean = 12.12
Std. Dev. = 4.442
N = 17
Frequency
HAD Anxiety score at admission


Mean = 10.65
Std. Dev. = 5.123
N = 17
Frequency
HAD Anxiety score at discharge


Mean = 12
Std. Dev. = 4.987
N = 17
Frequency
HAD Depression score at admission


Mean = 7
Std. Dev. = 4.835
N = 17
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 and York Partnership 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 patients in their last week of admission and collected on discharge.

April 2014 – March 2015:

- 100% of patients reported that when they were first admitted they were made to feel welcome and were given enough information about the ward.
- 59% reported that they were "always provided with copies of their care plans" (plus 29% "most of the time").
- 88% of patients rated the service as either "excellent" or "good"
- (0% rated the service as poor or very poor)
- 100% of those who had identified family/carers involved reported that the support/advice received by their family/carers was "excellent" or "good"
- (0% rated the support/advice received as poor or very poor)

Some examples of patients' written feedback (2014/15):

"Lots of opportunities to talk to staff about any problems I've had. Lots of support and understanding."

"Best things: support from staff and always having someone to talk to or help you. Having own personal involvement in decisions about treatment and care plans."

"Being somewhere with knowledge of ME. Getting some medical help and CBT. Related things with pacing and being taught about resting, with staff quickly adapting and aware of rapid changes in care plans".

"They saved my life."

"It was nice being with others going through/managing hard times".

“All staff have made themselves available if/when I have needed extra support, or even just to talk. It has been a very pleasant change to have health professionals just listen”.

“I have been involved with my care progress from the very beginning and it has been very carefully thought out at all stages. The staff have given a very supportive network at all levels.”

“Awesome key nurse. Always felt she would have a constructive answer if I brought a problem to her.”

“Conversations with the Senior OT were always informative, invaluable and this was one of the kingpins around which I was able to progress. I learnt new ways of looking at anxiety and energy which have stuck with me and I use all the time.”

“The MDT process made me feel very involved in my care.”

“The encouragement, physio and groups have helped a lot. CBT helped a lot, and getting involved with other patients.”

“Care & nursing staff excellent.”

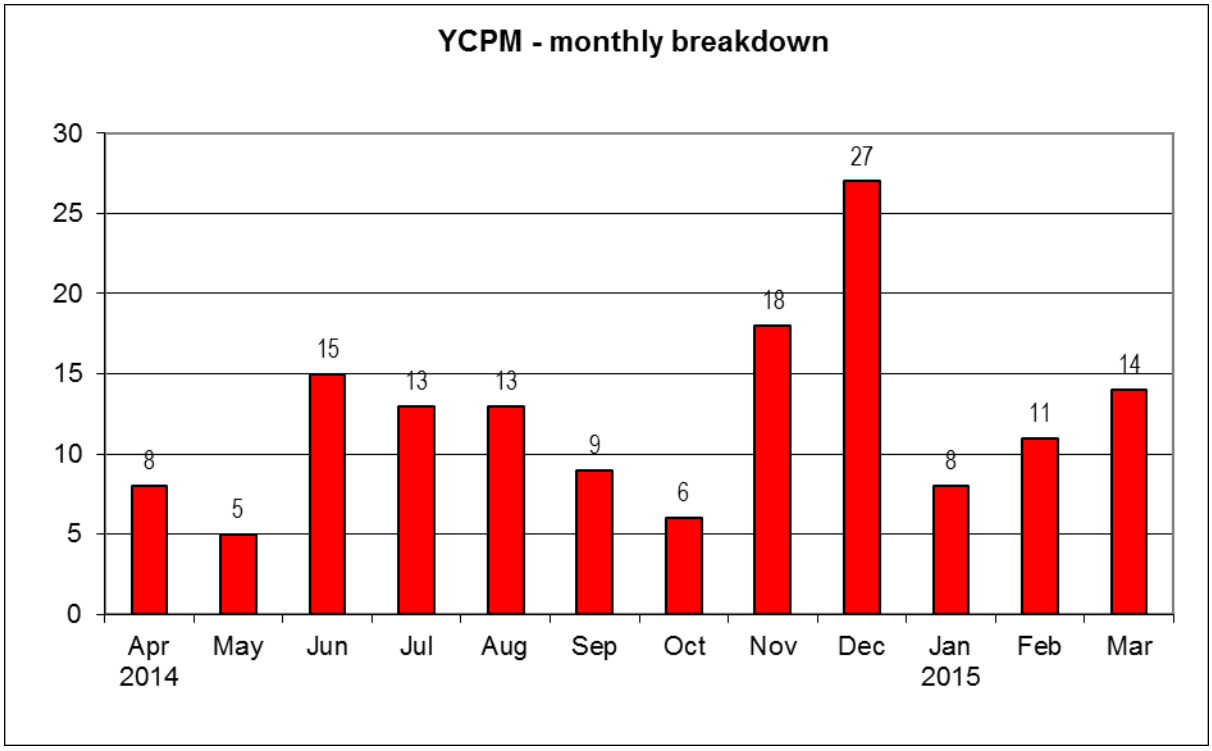
“Overall the service has been more than I could have dreamed of. The willingness and enthusiasm of staff, and being treated as a person rather than a number or just another patient. The ability to form a community with other patients on the ward - the ward is homely within the constraints of being a hospital.”

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 three level 3 ratings as detailed.

In total, 147 incident forms were completed within the period to which this report relates, as detailed below.

Incidents reported April 2014 – March 2015



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

Severity:	1	2	3	4	5	Total
Apr 2014	8					**8**
May	3	2				**5**
Jun	10	4	1			**15**
Jul	12	1				**13**
Aug	11	2				**13**
Sep	7	2				**9**
Oct	6					**6**
Nov	13	4	1			**18**
Dec	26		1			**27**
Jan 2015	8					**8**
Feb	11					**11**
Mar	14					**14**
Totals:	**129**	**15**	**3**			**147**

Severity 3 incidents:

1. Joint dislocation (known condition causing this patient to experience spontaneous and multiple dislocations).
2. Vomiting during severe asthma attack.
3. Episode of severe anaphylaxis requiring (successful) cardiopulmonary resuscitation.

Key:

Trust Severity Rating Criteria		NPSA Ratings	
1	No injuries, very minor financial loss, and/or service interruption	**1**	**No harm** ▪ *Impact prevented:* any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to person(s) receiving NHS-funded care ▪ *Impact not prevented*: any patient safety incident that ran to completion but no harm occurred to the person(s) receiving NHS-funded care
2	First aid treatment, minor financial loss, minor service interruption	**2**	**Low** (Minimal harm - patient(s) required extra observation or minor treatment)
3	Medical treatment required, moderate financial loss, service interruption	**3**	**Moderate** (Short-term harm - patient(s) required further treatment, or procedure)
4	RIDDOR reportable, significant loss of service capability, major financial loss, legal consequences	**4**	**Severe** (Permanent or long-term harm)
5	Death, huge financial loss, permanent/ semi-permanent loss of service, threat to achievement of Trust's objectives, legal consequences	**5**	**Death** (Caused by the patient safety incident)

Incidents by category / type

Accident	
Accident - no injury	3
Contact with hazard	1
Fall	10
Handling injury	2
Accidental injury	2
Clinical	
Care of patient	9
Placed self on floor	1
Patient found on floor	7
Patient information incorrect	1
Pt collapsed	2
Medical devices & equipment	1
Medication	77
Other	1
Potential hazard	1
Confidential	
Patient information	2
Other	1
Other	
Building/maintenance work/problem	5
Complaint	1
Poor housekeeping/potential safety risk	2
Other	3
Unwell/illness - patient	4
Property	
Personal property loss/damage	1
Other	2
Trust property loss/damage	1
Security	
IT security breaches	1
Self harm	
Actual self-harm	1
Verbal abuse	
Accusations/allegations	2
Verbal abuse	2
Violence	
Aggressive behaviour	1
Total:	**147**

(1 patient involved in 6 falls/found on floor incidents,1 patient involved in 4 falls/found on floor incidents, 1 patient involved in 12% of total incidents (i.e. 17 incidents across the year), 1 patient involved in 8% of total incidents (i.e. 12 incidents across the year).)

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