National Inpatient Centre for Psychological Medicine

Annual Review 2017/18

The NICPM service is provided by Leeds and York Partnership NHS Foundation Trust

Contents

Introduction

The National Inpatient Centre for Psychological Medicine (NICPM) is a specialist inpatient psychological medicine unit, with a diverse and expert team delivering biopsychosocial care for people with severe and complex medically unexplained symptoms and physical/psychological comorbidities.

The NICPM 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' but since 2009 has been able to accept patients from across the UK.

The NICPM 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 NICPM 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 NICPM 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 ninth Annual Report/Review of the NICPM service. 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.

Note: this service was known as the Yorkshire Centre for Psychological Medicine (YCPM) until it became the National Inpatient Centre for Psychological Medicine (NICPM) in May 2017.

Purpose

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

- Severe and complex medically unexplained symptoms and illness
- Psychological difficulties affecting the management of long-term physical health conditions (physical / psychological comorbidities) at a serious level of severity
- Severe chronic fatigue syndrome (CFS/ME)
  (we provide the inpatient care for the Leeds and West Yorkshire CFS/ME service)

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

- Liaison psychiatry doctors
- Nurses
- Occupational therapists
- Physiotherapists
- Cognitive behavioural therapists
- Dieticians
- Pharmacists, and
- Administrators

We have a very experienced and expert team who, between them, have a broad range of specialist training, including in general/physical medicine, mental health, physical, occupational, and cognitive behavioural therapies.

We can also draw on expertise from other teams including:

- Medical and surgical teams within the general hospital system, across the full range of specialities
- Psychosexual and relationship therapists

Treatment Approaches

Patients referred to the NICPM 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)

A range of modalities and approaches are available, delivered on an individualised basis. Patients may also be referred into various groups as relevant to them and their needs.

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, etc.

Full range of cognitive behavioural and related approaches, mindfulness, compassion-focussed therapy, EMDR, etc.

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

Safety and 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 that the unit is ideally placed to help patients re-engage in normal activities in the wider community as and when possible and 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 NICPM is based at Leeds General Infirmary. Although this is a general hospital setting, the environment on the NICPM is specifically designed to provide a therapeutic environment for patients with mixed physical and psychological/emotional 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 2017-18

Activity

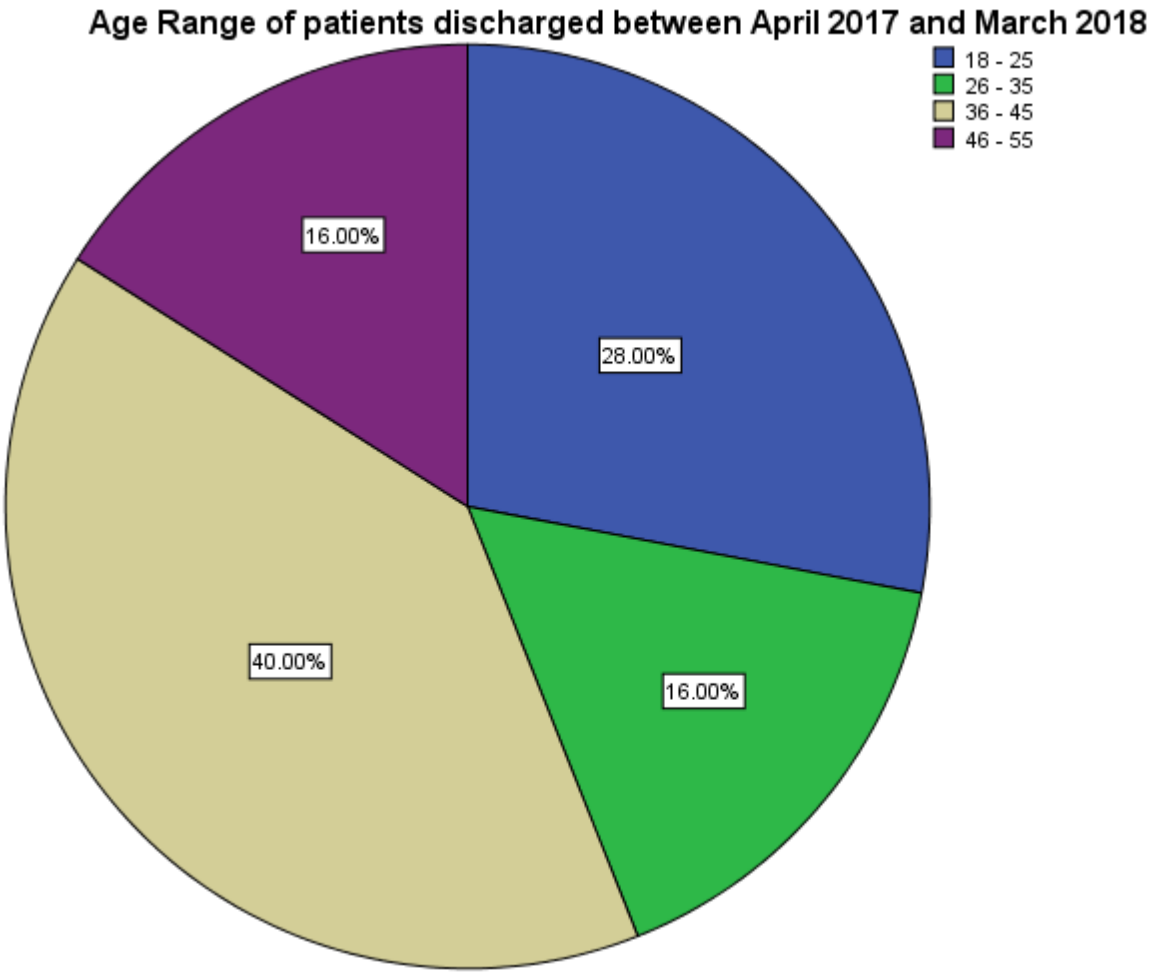
Inpatient Treatment

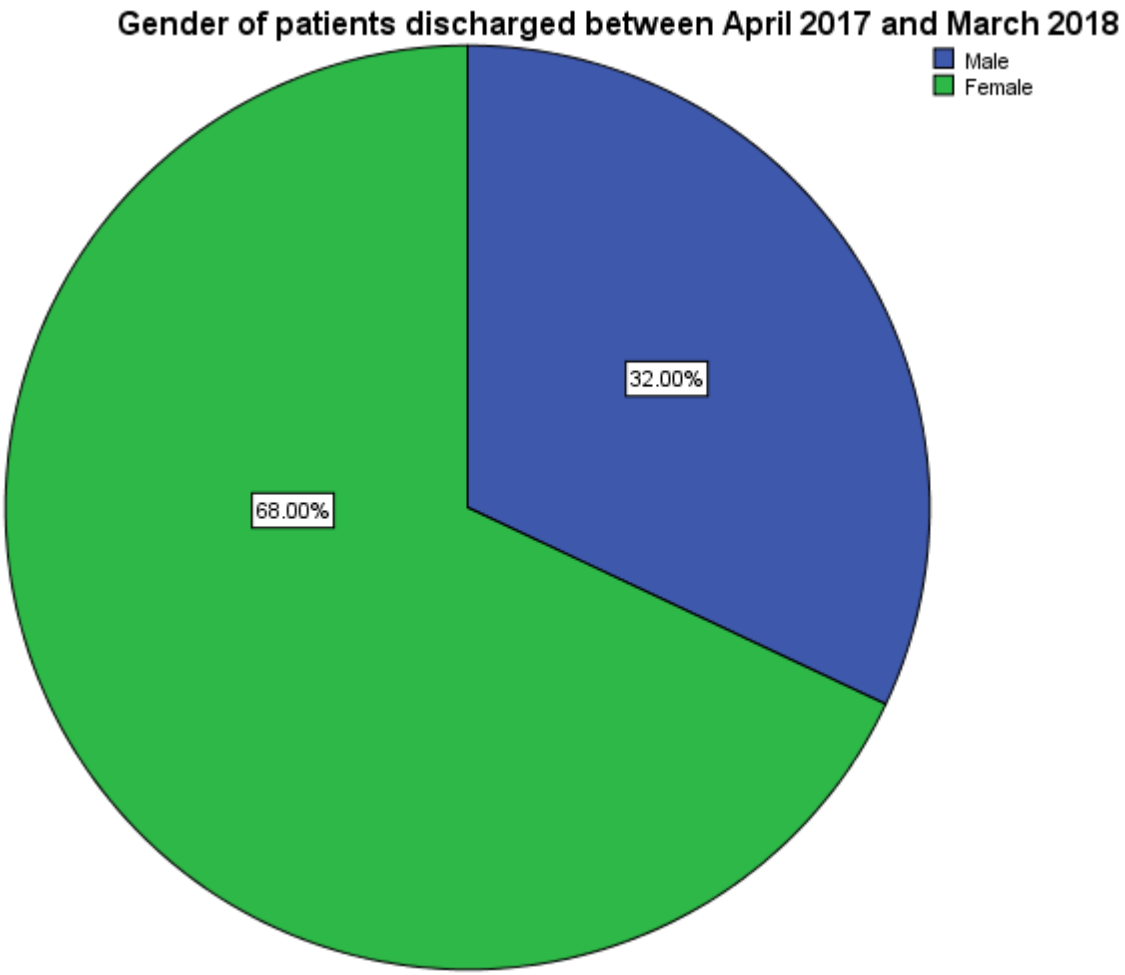
Data for all patients discharged from the NICPM between 1st April 2017 and 31st March 2018 are included in this report. In total:

- **25** patients were discharged during this period.
- **20** having been on the unit for a full treatment admission (as opposed to assessment and opinion/advice only).
- **20** (100%) 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 **20** with complete information - apart from EQ-5D-5L data which is for 17 people because 3 people did not provide two complete (ie both admission and discharge) EQ-5D-5L scores.





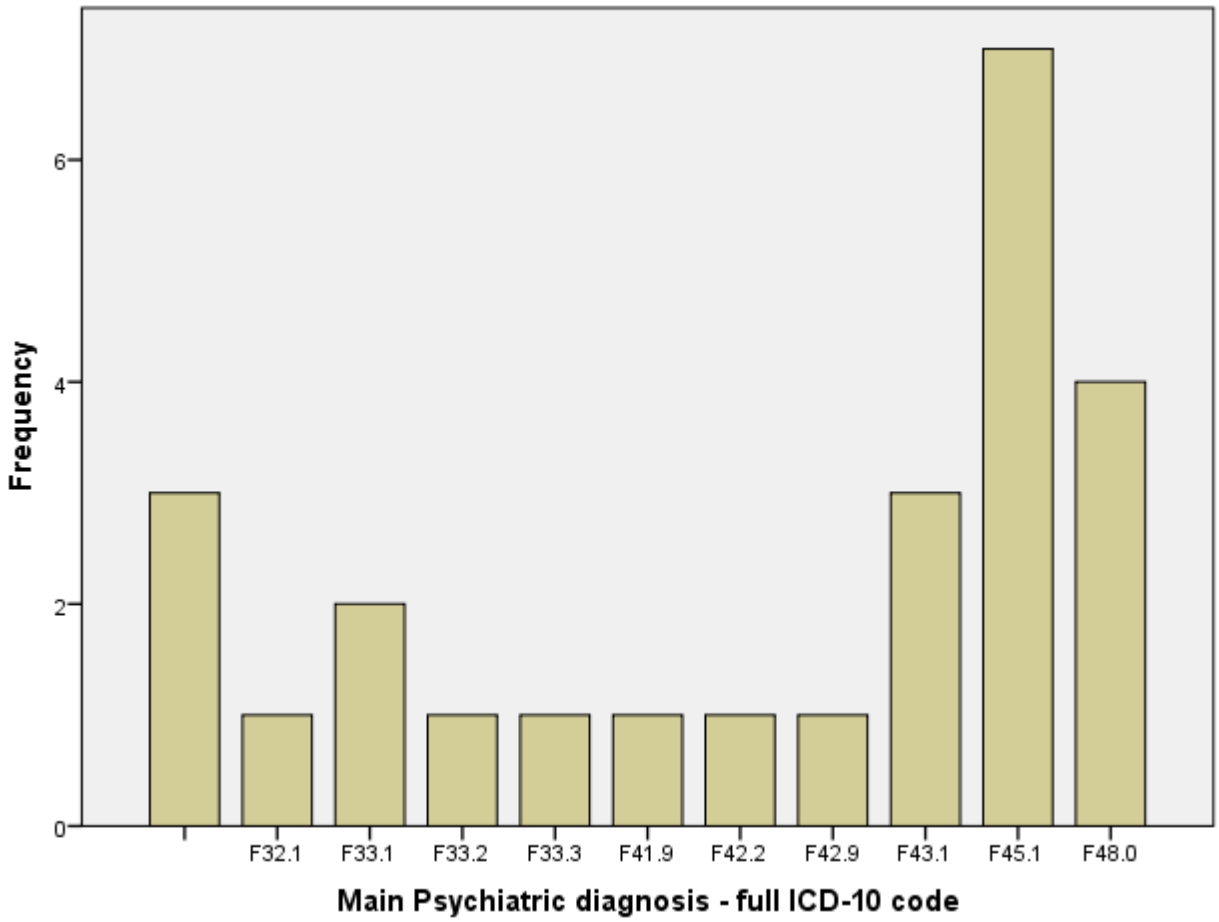
Female:Male ratio = approximately 2:1

Diagnoses

As mentioned earlier in this report, the NICPM 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 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

F32.1 = Moderate depressive episode, without somatic symptoms

F33.1 = Recurrent depressive disorder, current episode moderate

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

F33.3 = Recurrent depressive disorder, current episode severe with psychotic symptoms

F41.9 = Anxiety disorder

F42.2 = Obsessive compulsive disorder - equal/mixed thoughts and acts

F42.9 = Obsessive compulsive disorder

F43.1 = Post-traumatic stress disorder

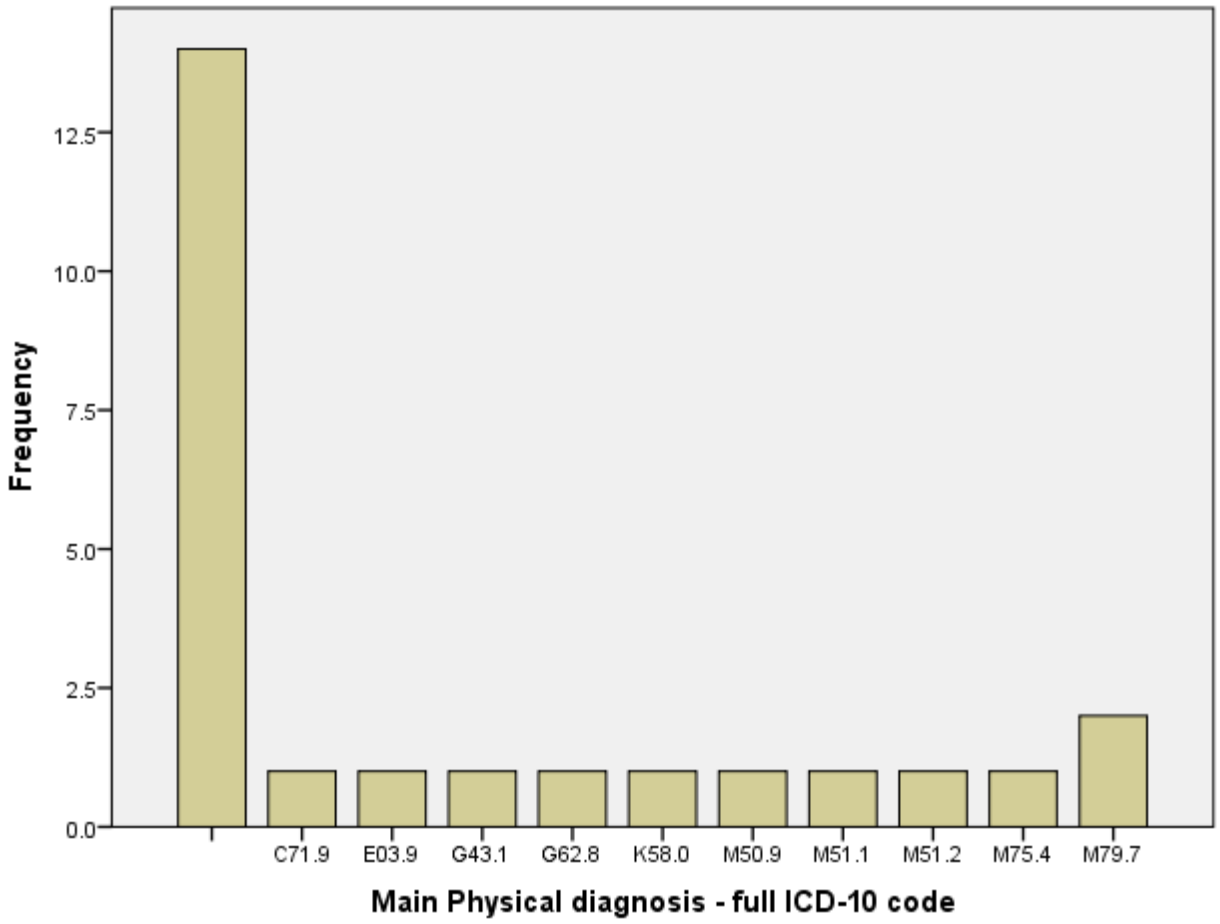
F45.1 = Undifferentiated somatoform disorder

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

(*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 NICPM 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

C71.9 = Malignant neoplasm of brain, glioma

E03.9 = Hypothyroidism

G43.1 = Migraine with aura

G62.8 = Polyneuropathy, small fibre neuropathy

K58.0 = Irritable bowel syndrome with diarrhoea

M50.9 = Cervical disc disorder

M51.1 = Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy

M51.2 = (Other) thoracic, thoracolumbar and lumbosacral intervertebral disc displacement

M75.4 = Impingement syndrome of shoulder

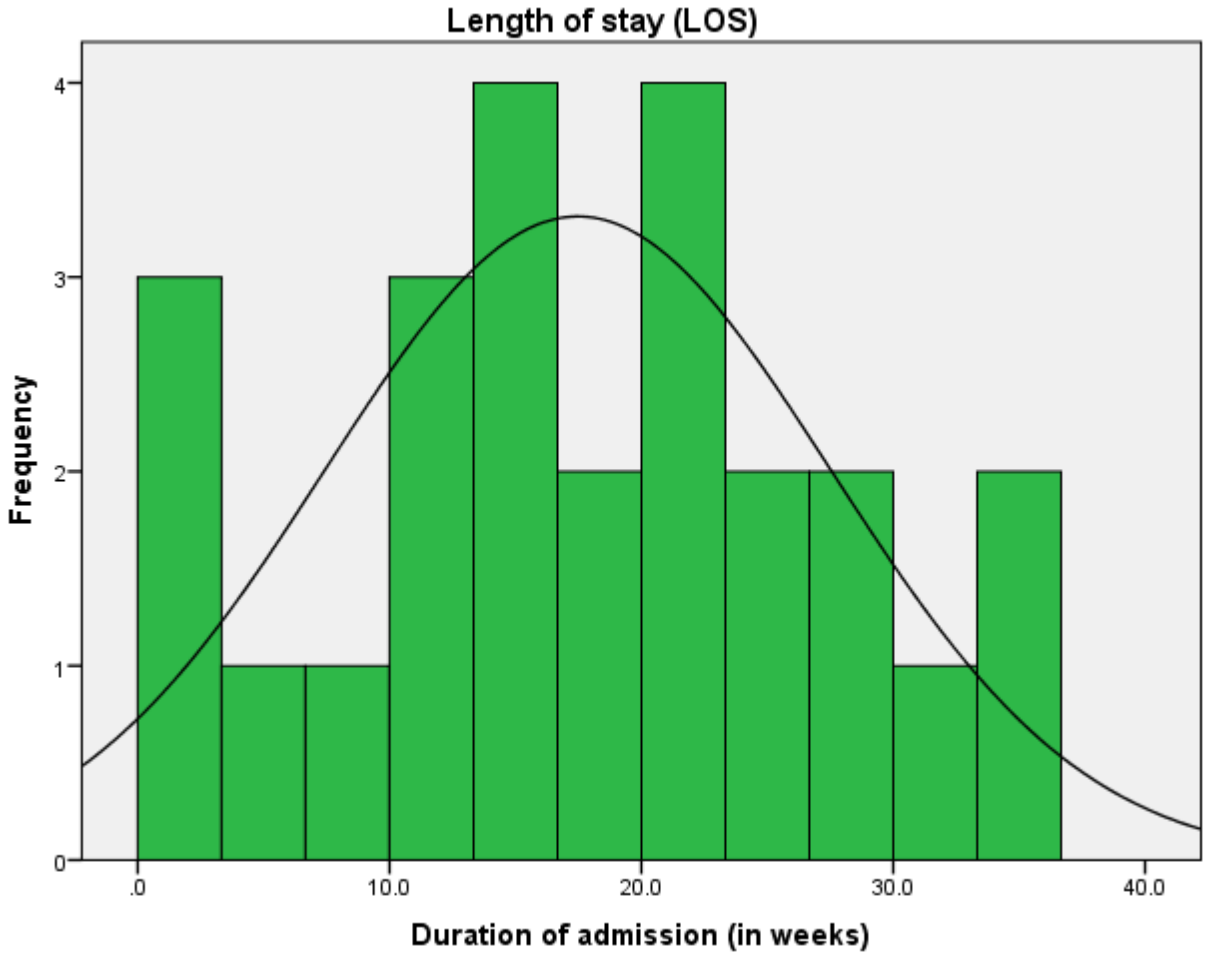
M79.7 = Fibromyalgia

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 NICPM 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 NICPM service are suffering with very complex presentations, involving combinations of multiple physical and multiple psychological symptoms and conditions.

(ALSO PLEASE NOTE: All of the diagnostic categories detailed above refer to those present at the point of discharge, not at admission. This is important because in some cases the discharge diagnoses are not the same as those at admission. This is due to people recovering to the point of no longer satisfying criteria for a particular diagnostic category, and has been the case in relation to various conditions, including some people coming to the unit with severe and complex CFS/ME.)

Length of stay, April 2017 – March 2018



The figure above shows the length of stay in weeks for patients discharged between April 2017 and March 2018.

The duration of admission ranged from 1 to 36 weeks, with a whole group average of 17.5 weeks.

80:20 split:

For the 20% of patients with the longest length of stay, duration ranged from 26 to 36 weeks, with an average of 30.9 weeks.

For the remaining 80% of patients the duration ranged from 1 to 25 weeks, with an average of 12.7 weeks.

Clinical Outcome Measures

The NICPM 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 NICPM. 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%)

- **100%** in 2015/16

(Major improvement 59.1%, Moderate improvement 36.4%, Minor improvement 4.5%)

- **100%** in 2016/17

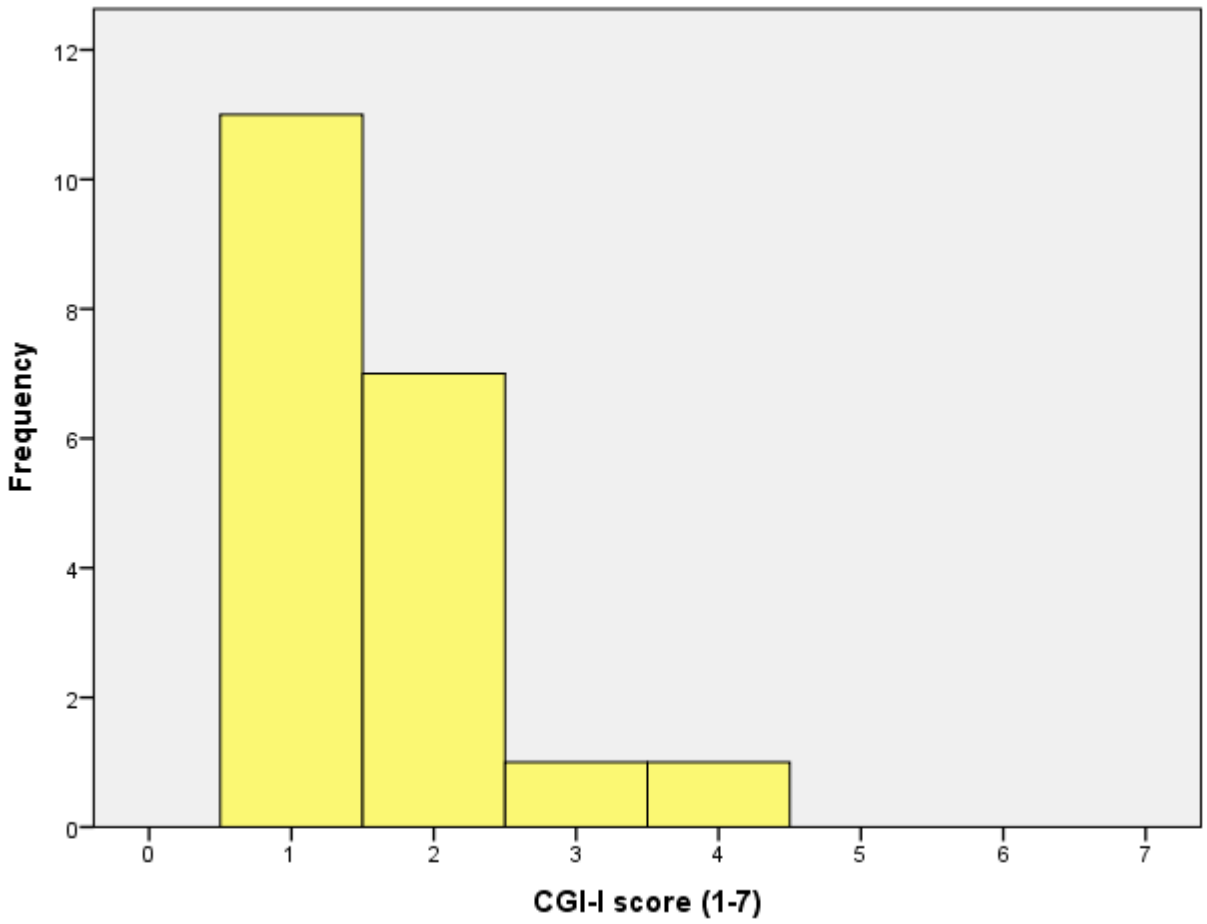
(Major improvement 61.1%, Moderate improvement 33.3%, Minor improvement 5.6%)

- **95%** in 2017/18

(Major improvement 55.0%, Moderate improvement 35.0%, Minor improvement 5.0%)

As shown in the chart below, 18 of the 20 patients (**90%**), 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 NICPM 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 2017 – March 2018:

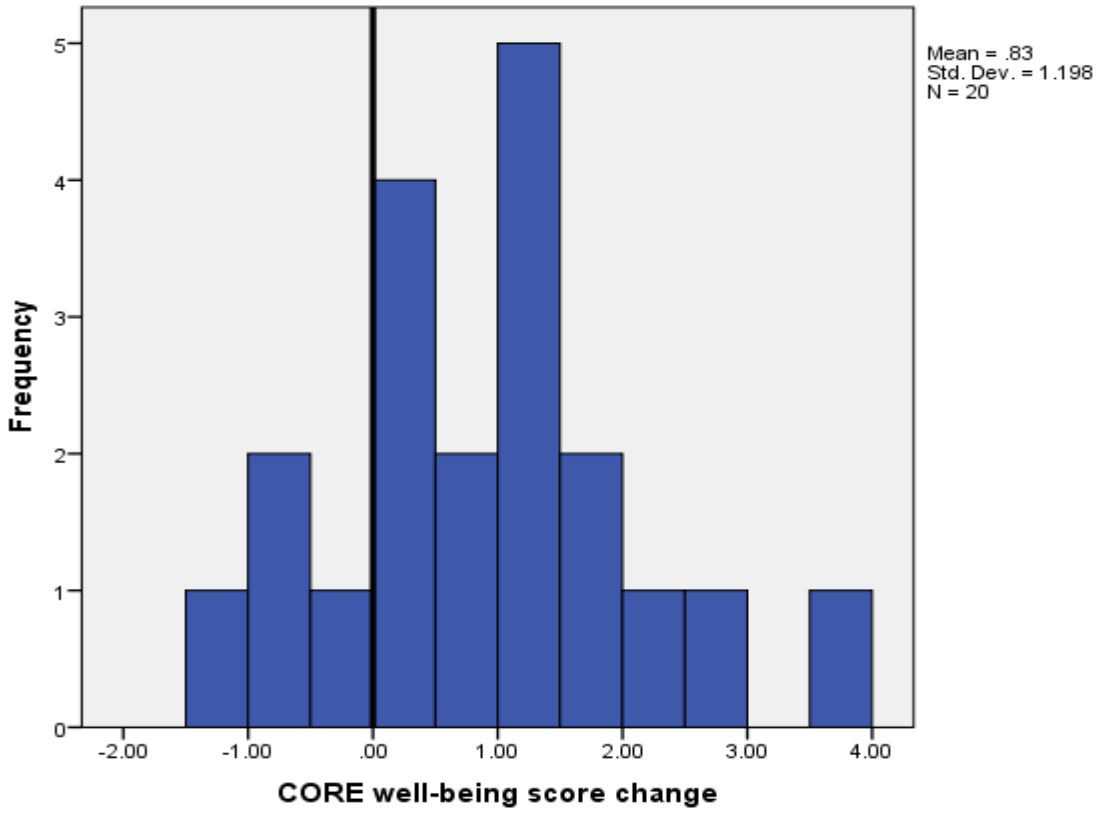
- Wellbeing subscale 70.0% improved
- Problems subscale 60.0% improved
- Functioning subscale 90.0% improved
- Risk subscale 40.0% improved *****

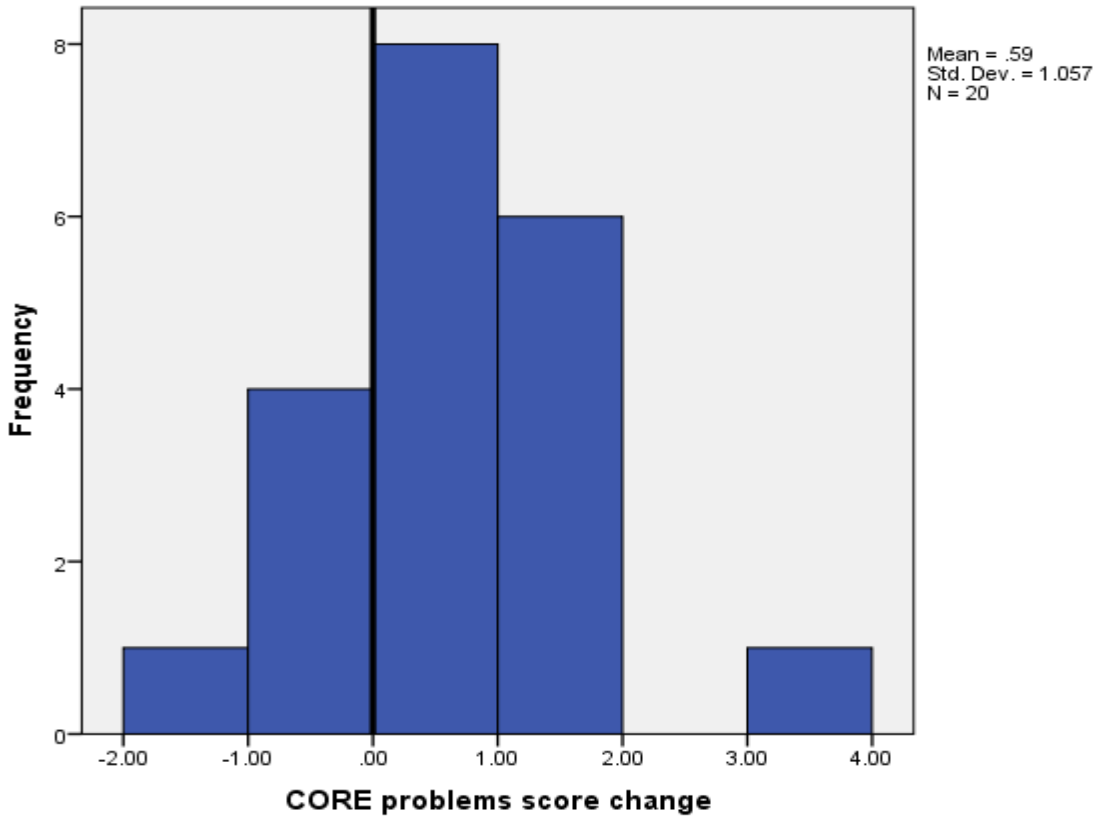
***** (Note: 90% of the group had very low CORE Risk scores at admission (ie scoring 1 or less), with 35% scoring zero, so limiting the potential improvement)

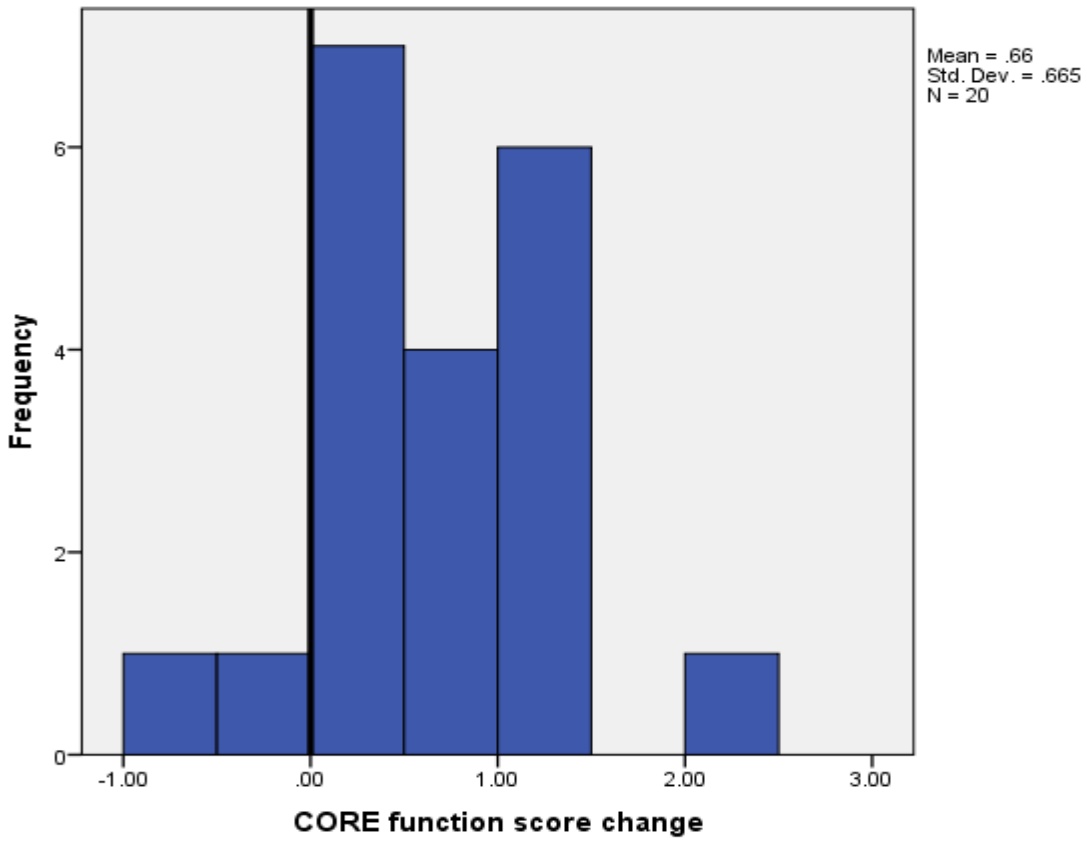
	Admission	**Discharge**
Mean CORE Total score	2.12	1.57

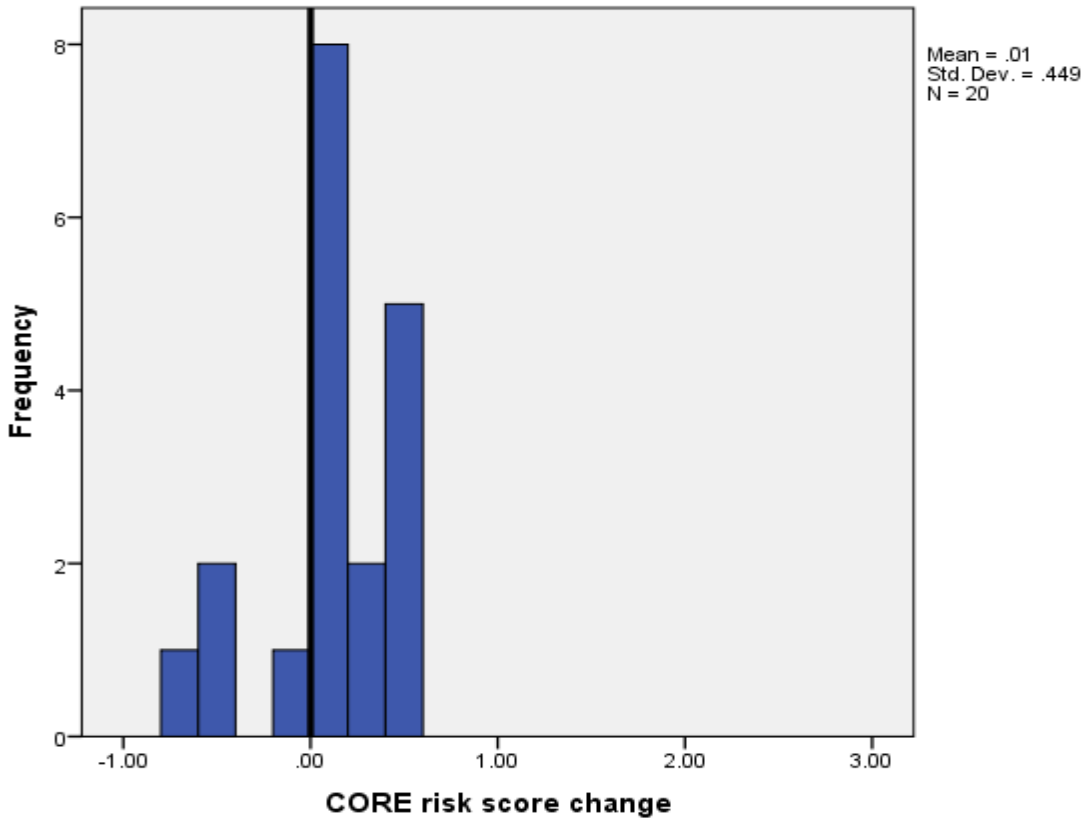
Data gathered on the CORE-OM forms is represented below.

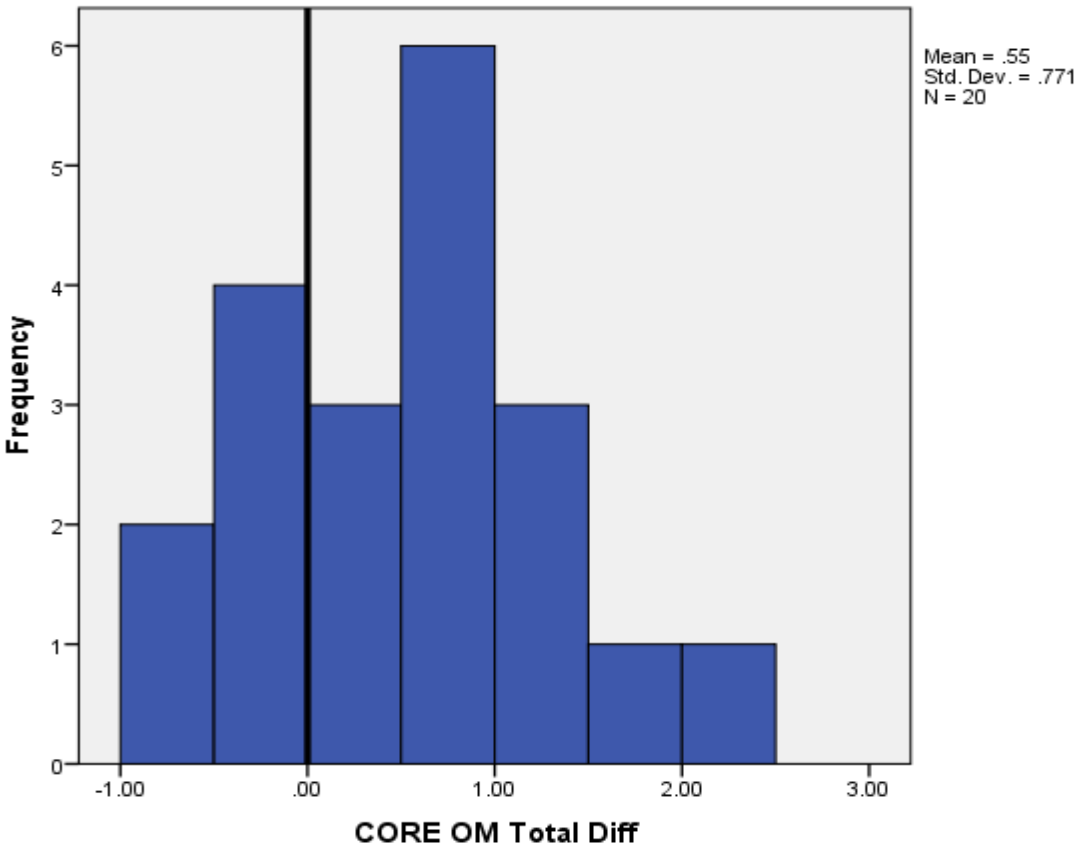
(**NOTE**: on this measure, and the construction of the charts shown below, a positive change in subscale and total CORE scores (ie above the zero line on the bottom axis) is desirable and is evidence of improvement / reduced distress.)


Mean = .83
Std. Dev. = 1.198
N = 20
Frequency
0
1
2
3
4
5
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE well-being score change


Mean = .59
Std. Dev. = 1.057
N = 20
Frequency
0
2
4
6
8
-2.00
-1.00
.00
1.00
2.00
3.00
4.00
CORE problems score change


Mean = .66
Std. Dev. = .665
N = 20
Frequency
0
2
4
6
-1.00
.00
1.00
2.00
3.00
CORE function score change


Mean = .01
Std. Dev. = .449
N = 20
Frequency
0
2
4
6
8
-1.00
.00
1.00
2.00
3.00
CORE risk score change


Mean = .55
Std. Dev. = .771
N = 20
Frequency
0
1
2
3
4
5
6
-1.00
.00
1.00
2.00
3.00
CORE OM Total Diff

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 2017 – March 2018:

Of those people who initially scored at the level of experiencing particularly significant problems in each particular domain (ie score 4 = severe, or score 5 = extreme problems), the proportion of those scoring themselves as improved during the admission was as follows:

- **Mobility** improved in **50%** of patients
- **Self-care** improved in **100%** of patients
- **Usual activities** improved in **57%** of patients
- **Pain / discomfort** improved in **67%** of patients
- **Anxiety / depression** improved in **86%** of patients

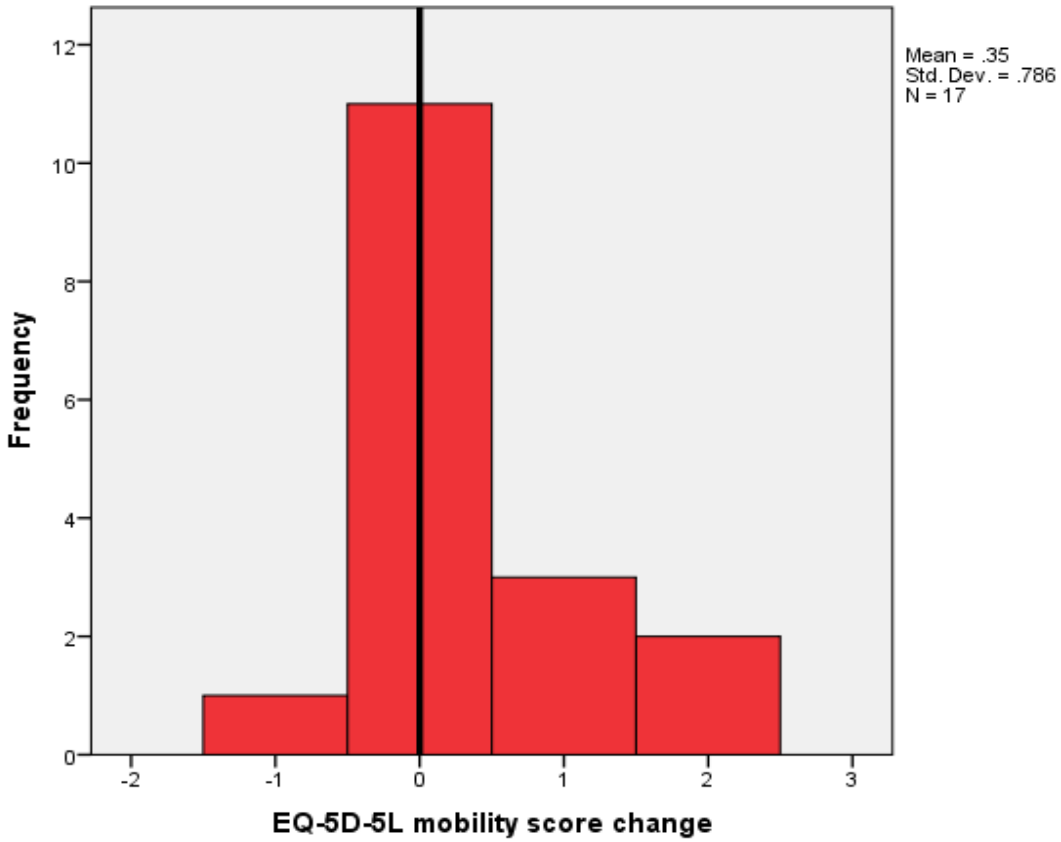
Also, across the whole patient group of **17** people (ie because 3 people did not provide EQ-5D-5L scores at both admission and discharge):

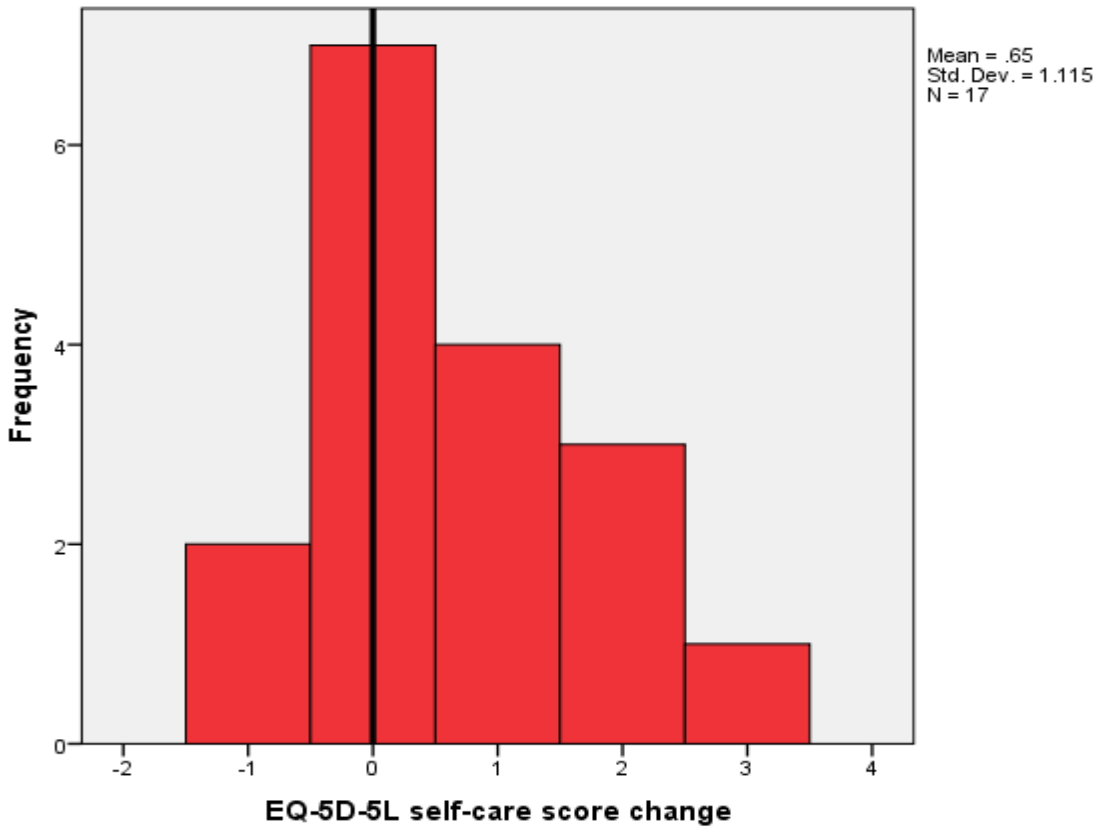
- **At least one domain** improved in **88.2%** of patients
- **Overall health score on VAS** improved in **82.4%** of patients

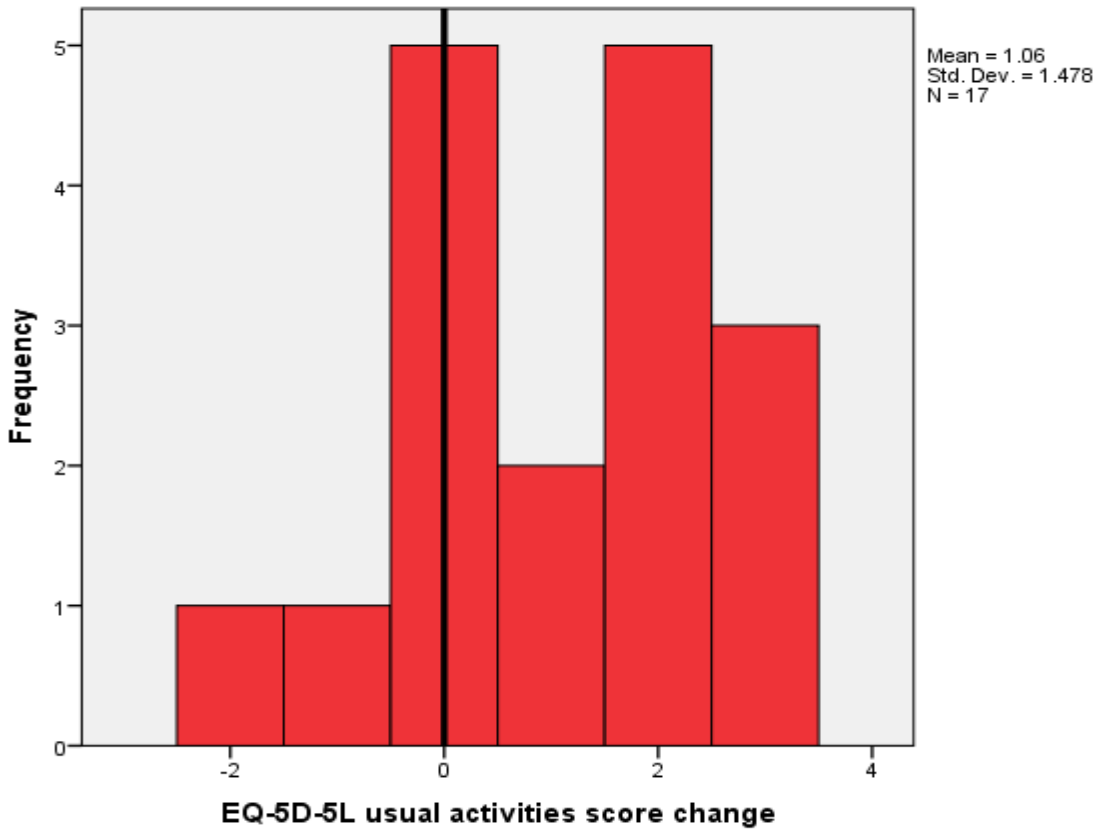
NOTE:

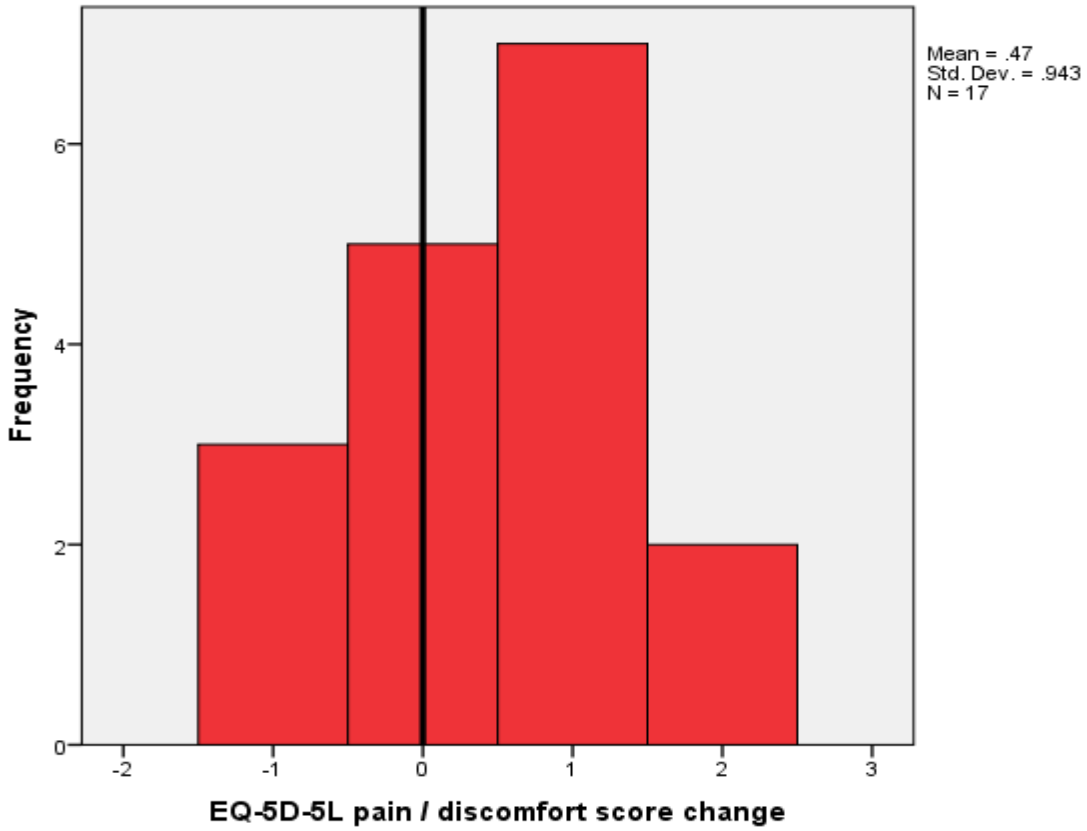
- The charts which follow have been constructed using the dataset of the whole patient group with complete EQ-5D-5L data, ie **17** people, regardless of initial score level.
- In the construction of the first 5 of these charts, a positive change in the X axis (ie an increase in score by 1, 2, 3 or 4 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.

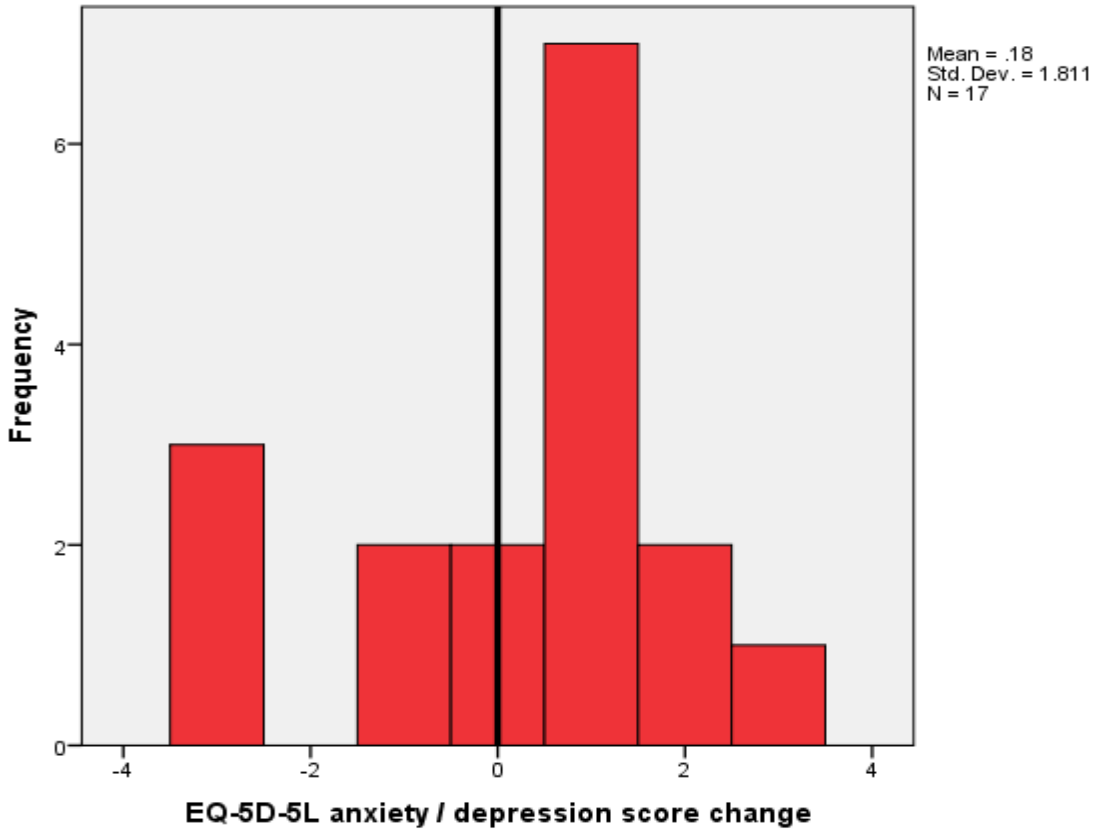
- Similarly in the 6th chart, which illustrates Overall Health Score Change, scores are taken from the 100 point EQ-5D-5L Visual Analogue Scale (albeit in this case as score at Discharge minus score at Admission) and a positive change is again desirable as evidence of improvement, as indicated by the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

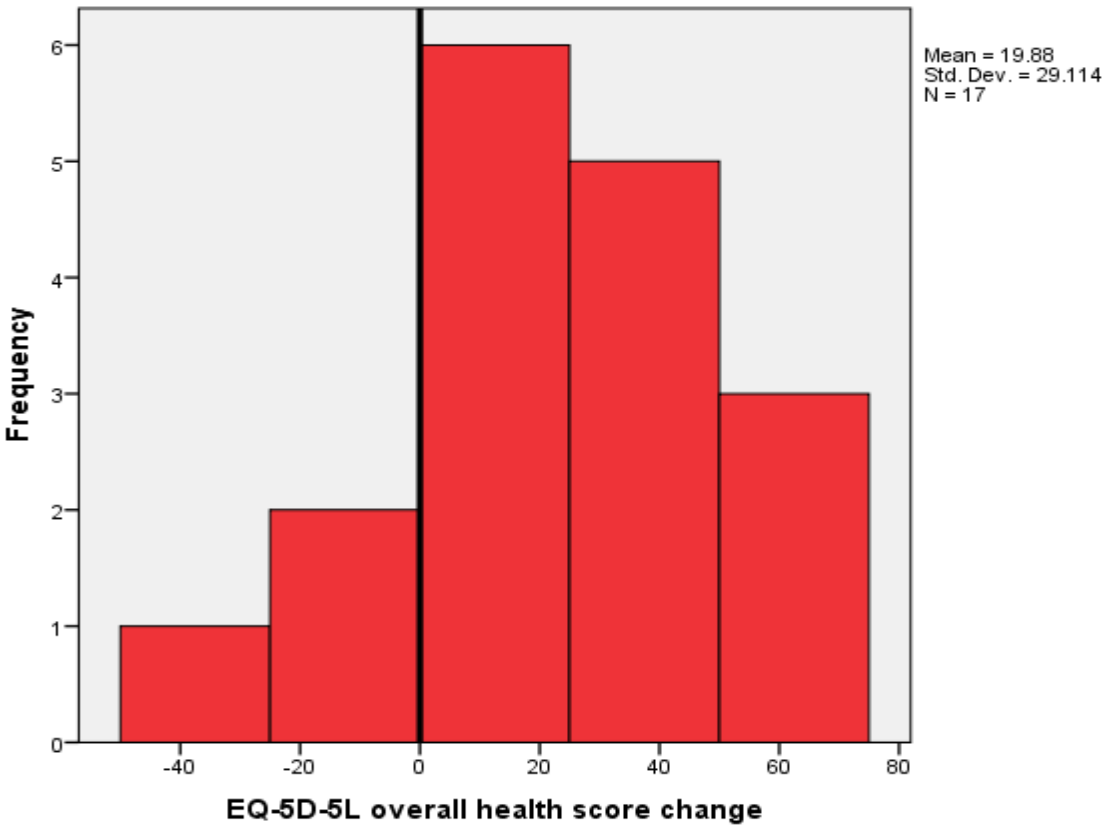



Mean = .65
Std. Dev. = 1.115
N = 17
Frequency
0
2
4
6
-2
-1
0
1
2
3
4
EQ-5D-5L self-care score change


Mean = 1.06
Std. Dev. = 1.478
N = 17
Frequency
0
1
2
3
4
5
-2
0
2
4
EQ-5D-5L usual activities score change


Mean = .47
Std. Dev. = .943
N = 17
Frequency
0
2
4
6
-2
-1
0
1
2
3
EQ-5D-5L pain / discomfort score change


Mean = .18
Std. Dev. = 1.811
N = 17
Frequency
0
2
4
6
-4
-2
0
2
4
EQ-5D-5L anxiety / depression score change


Mean = 19.88
Std. Dev. = 29.114
N = 17
Frequency
0
1
2
3
4
5
6
-40
-20
0
20
40
60
80
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

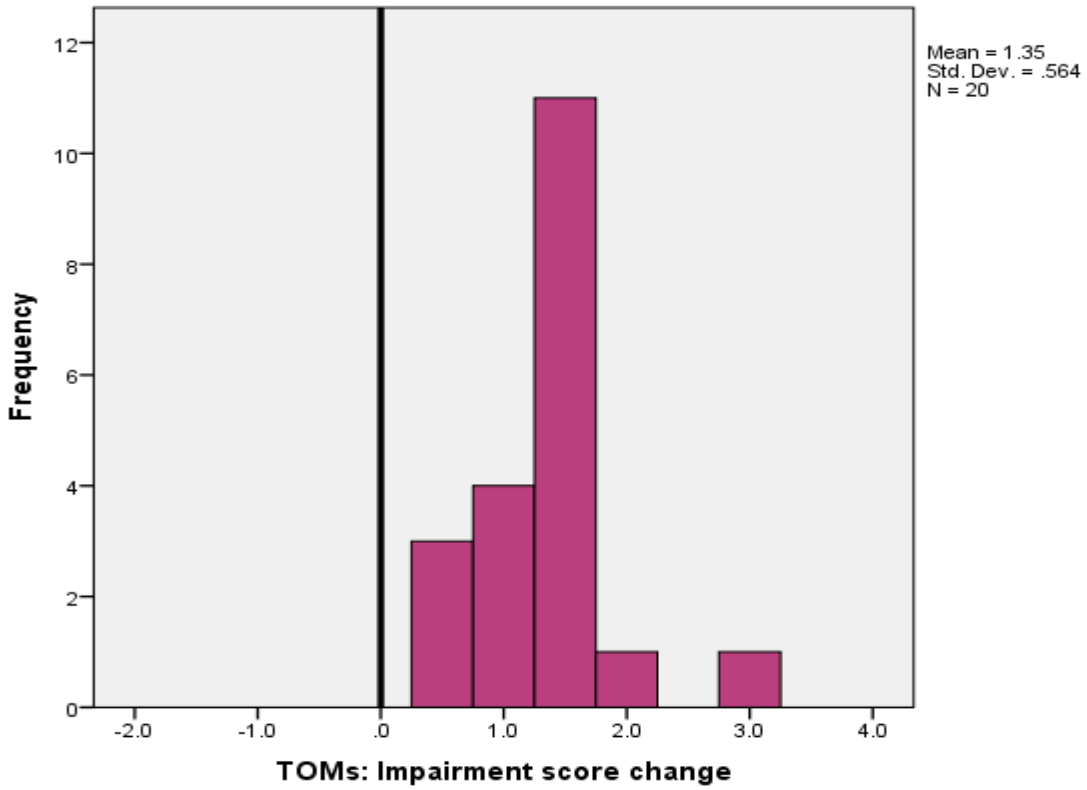
This is a measure which has been validated and used very widely within healthcare services, particular those with a significant Occupational Therapy component. The figures given here relate to use of the standard version of TOMs.

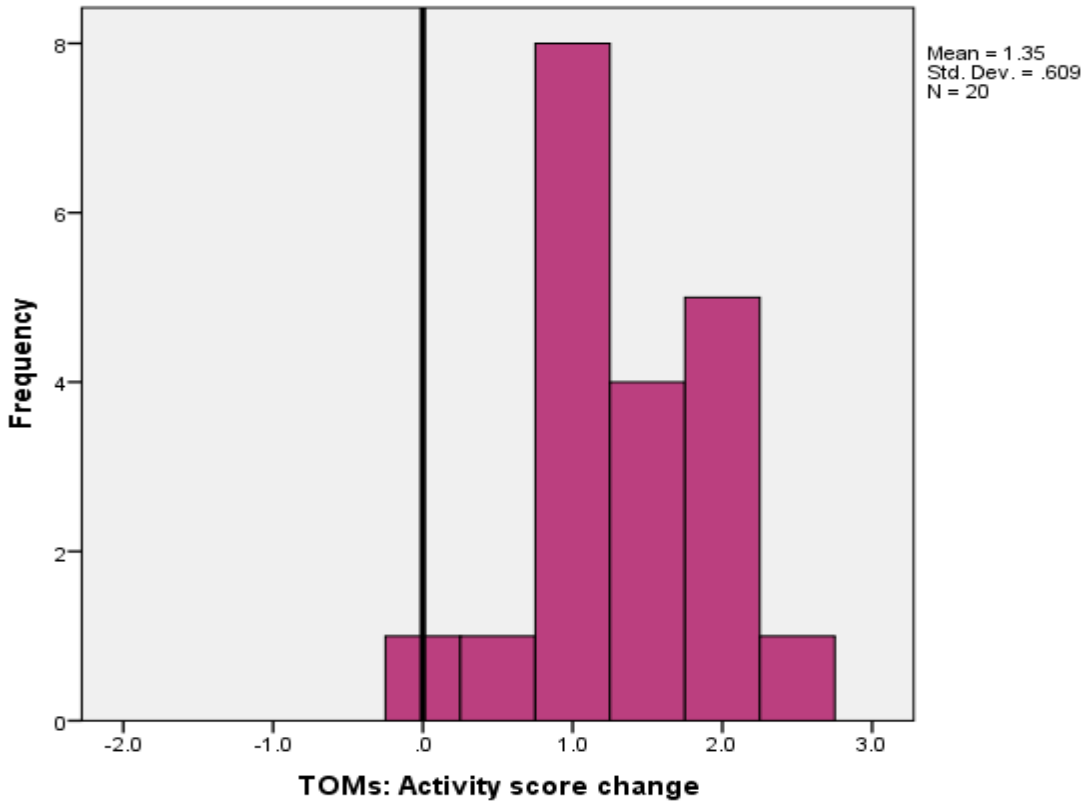
April 2017 – March 2018:

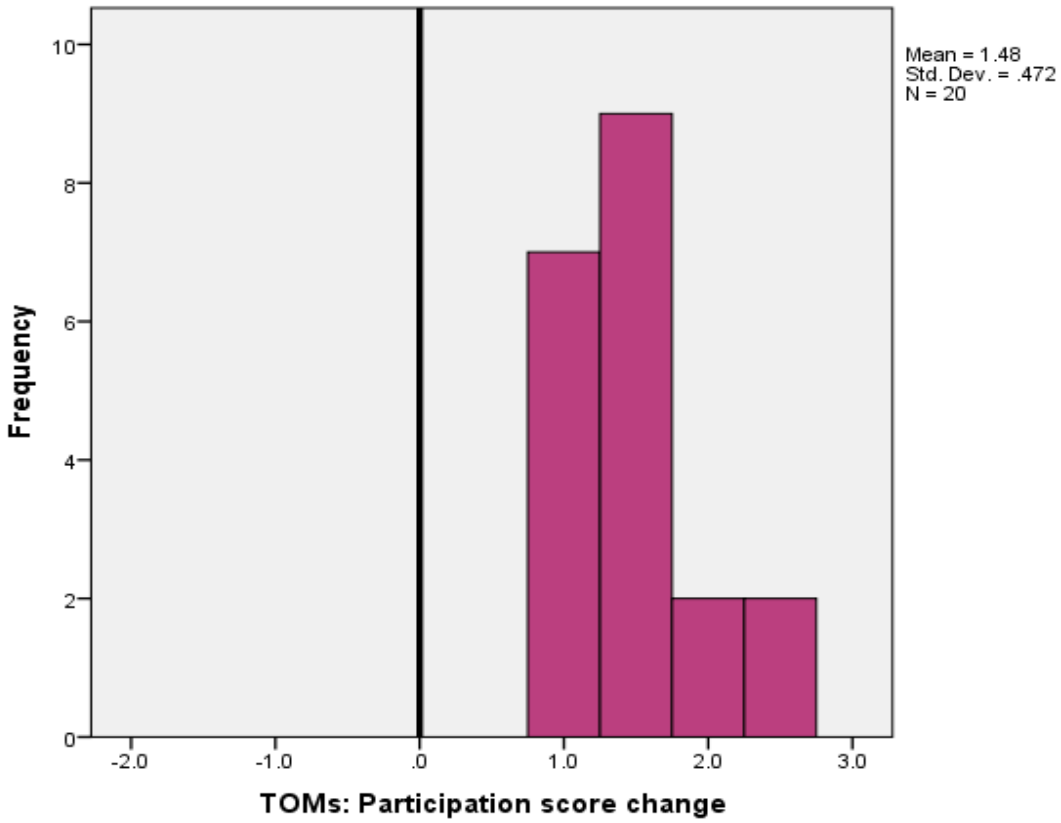
In each particular domain, the proportion of those showing an improvement of at least 1.0 points score change during the admission was as follows:

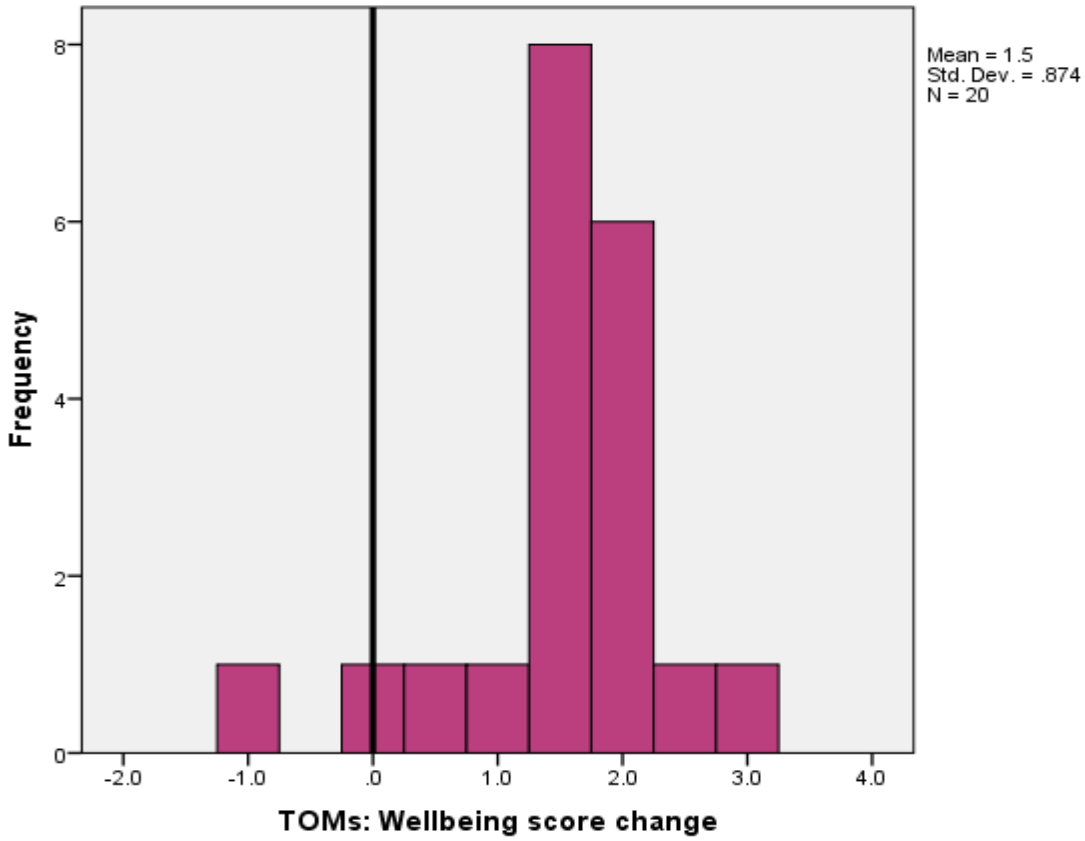
- **Impairment** improved in **85%** of patients
- **Activity** improved in **90%** of patients
- **Participation** improved in **100%** of patients
- **Well-being** improved in **85%** of patients

(**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 = 1.35
Std. Dev. = .564
N = 20
Frequency
12
10
8
6
4
2
0
-2.0
-1.0
.0
1.0
2.0
3.0
4.0
TOMs: Impairment score change


Mean = 1.35
Std. Dev. = .609
N = 20
Frequency
8
6
4
2
0
-2.0
-1.0
.0
1.0
2.0
3.0
TOMs: Activity score change


Mean = 1.48
Std. Dev. = .472
N = 20
Frequency
TOMs: Participation score change


Mean = 1.5
Std. Dev. = .874
N = 20
Frequency
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 NICPM the 4-point Likert scoring approach is used (0,1,2,3), so with a maximum possible score of 33.

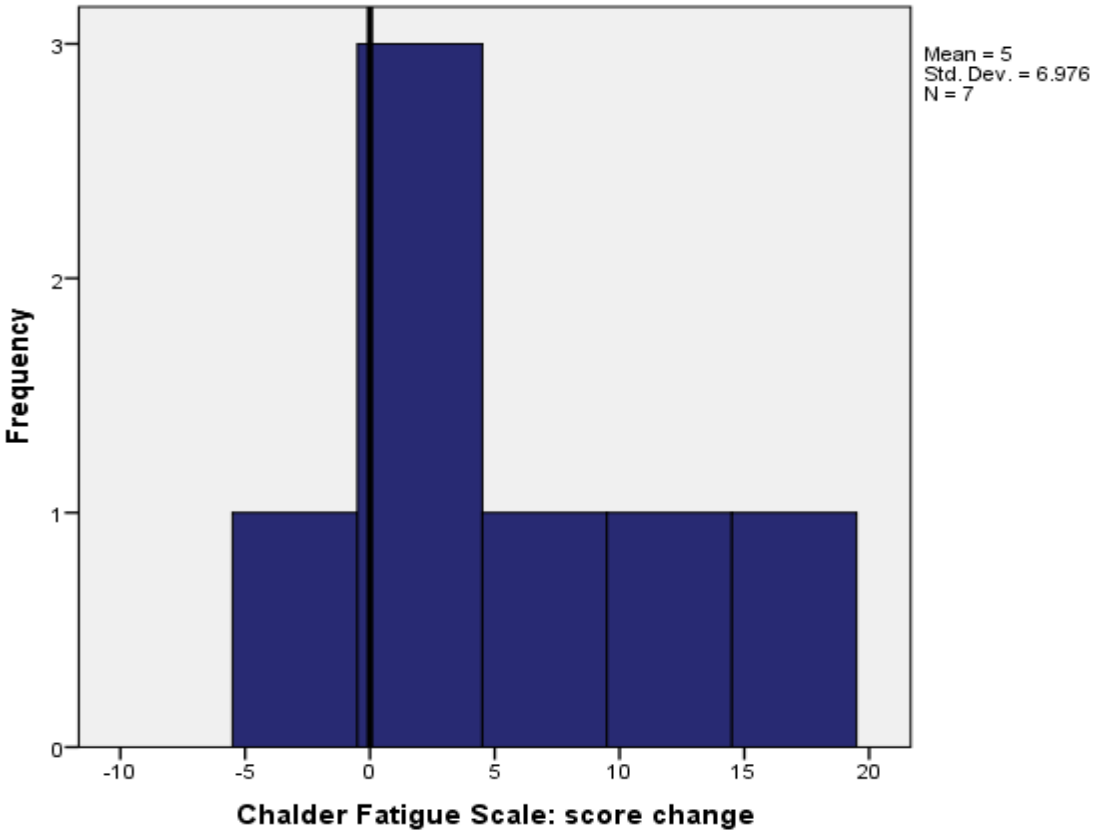
April 2017 – March 2018:

- **71.4%** of patients admitted with CFS/ME showed a reduction (improvement) in their fatigue score
    - 1 patient showed no change in fatigue score
    - 1 patient showed a slight worsening in fatigue score (increase of 3 points)

- **83.3%** of the total patient group showed a reduction (improvement) in their fatigue score
    - 3 patients showed no change in fatigue score
    - 3 patients showed a slight worsening in fatigue score (increases of 2, 3 and 4 points respectively)
    - 1 patient showed an increase of 7 points (from a score of 19 to 26), in the context of a neurological CNS disorder

(**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 2017 – March 2018:

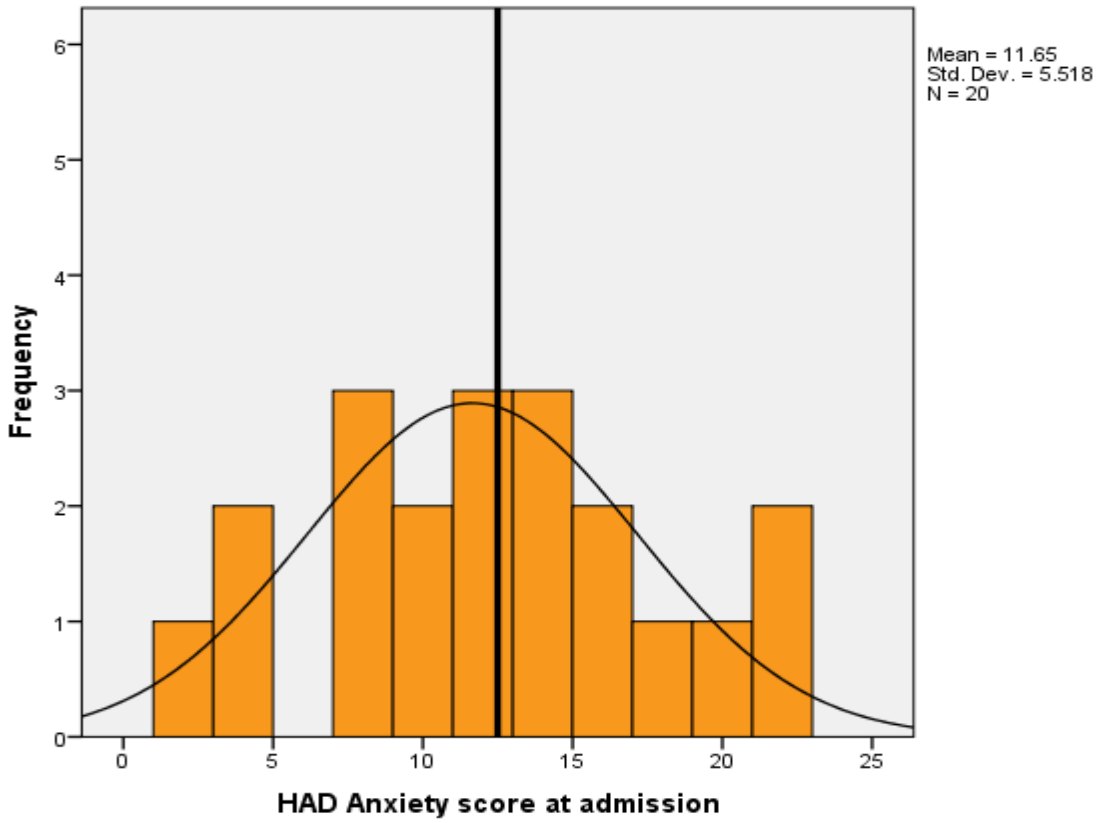
HAD-A:

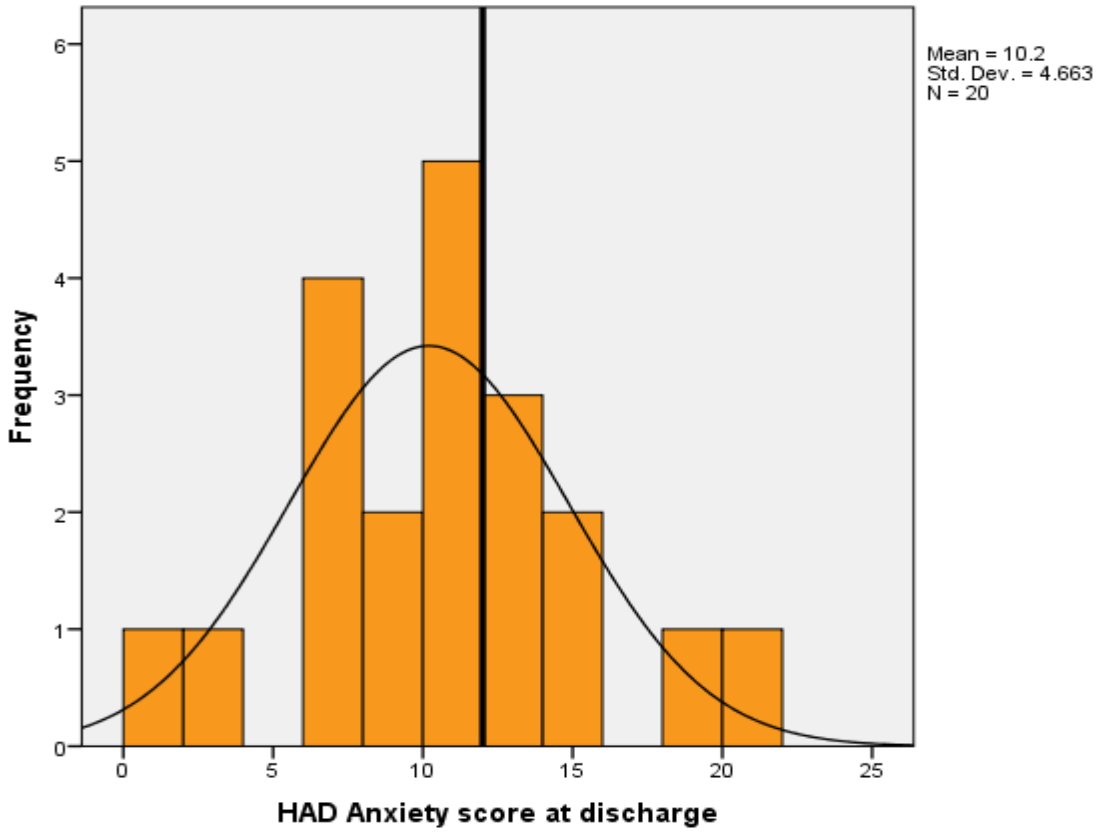
- 50% of patients admitted scored 12 or more on HAD-A at admission
- Of these, 90% showed a reduction in score by the time of discharge
- The scores in 78% of those reduced to below threshold

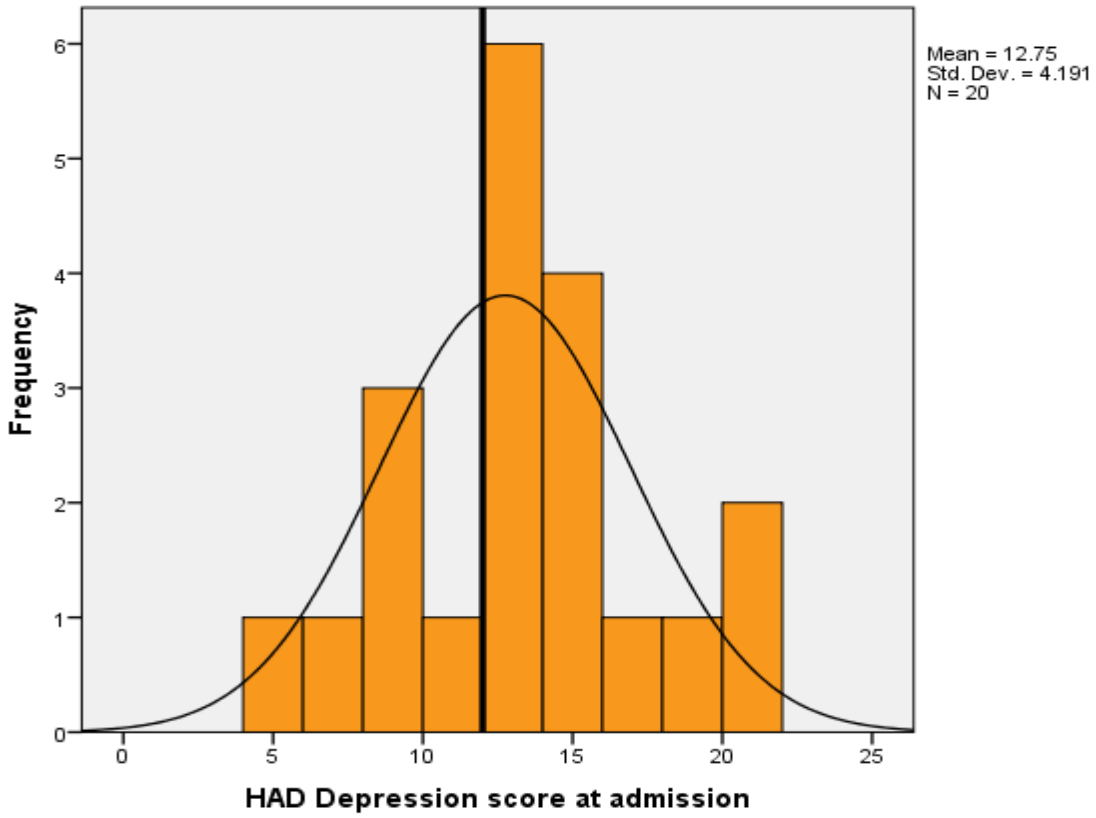
HAD-D:

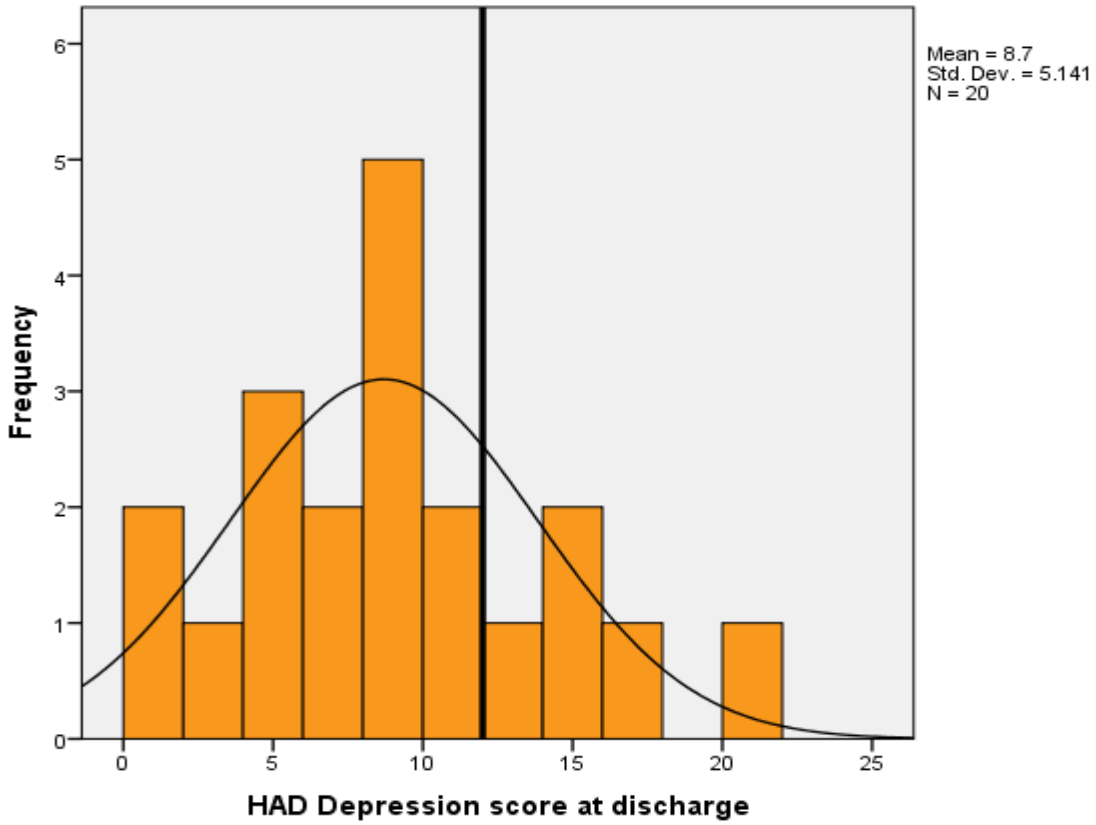
- 70% of patients admitted scored 12 or more on HAD-D at admission
- Of these, 71% showed a reduction in score by the time of discharge
- The scores in 90% of those reduced to below threshold

(**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 = 11.65
Std. Dev. = 5.518
N = 20
Frequency
HAD Anxiety score at admission


Mean = 10.2
Std. Dev. = 4.663
N = 20
Frequency
HAD Anxiety score at discharge


Mean = 12.75
Std. Dev. = 4.191
N = 20
Frequency
HAD Depression score at admission


Mean = 8.7
Std. Dev. = 5.141
N = 20
Frequency
HAD Depression score at discharge

Patient experience / feedback

The Patient Discharge Questionnaire was created by the NICPM team based on the guidance set out by Leeds and York Partnership NHS Foundation Trust. It is designed to collect both qualitative and quantitative data from inpatients regarding their care on the unit. The team at NICPM feel it is 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. In the period of this review,

April 2017 – March 2018:

- 90% of patients reported that when they were first admitted they were made to feel welcome and were given enough information about the ward.
- 80% reported that they were "always provided with copies of their care plans" (plus 20% "most of the time").
- 85% of patients rated the NICPM service as either "excellent" or "good"
- 75% of those who had identified family/carers involved reported that the support/advice received by their family/carers was "excellent" or "good"

Carer experience / feedback

The Carer Satisfaction Questionnaire was also created by the NICPM team. It is designed to collect both qualitative and quantitative data from the identified main carers of inpatients at the NICPM, regarding their view of care provided on the unit and their experience of contact with, and support from, the NICPM team.

April 2017 – March 2018:

- 100% of carers who responded rated the NICPM service as either "excellent" or "good"
- 71% reported that communication by the NICPM was either "excellent" or "good"
- 86% of carers rated the support/advice they received as "excellent" or "good"

Some examples of patients' written feedback (2017/18):

"Best things?... Lovely staff and well trained. Flexibility and care for each patient as an individual. Good range of activities. Allowing home leave. Good range of therapies. Good Qualified Doctors and Nurses. Easy accessible bathrooms."

"Support with my physical and psychological needs delivered swiftly at all times. The staff felt like friends and social activities were always a pleasure to attend."

"A very positive experience for me. Very helpful. The whole package has been brilliant."

"A wide range of professionals that communicate effectively and work together in providing a suitable care plan that has helped me progress."

"The staff have been consistently caring and willing to listen. Everything has been incredibly personal & individually helpful to me when it comes to my care."

"Physio and kindness from staff. Food and cleanliness also been very good."

"I have received excellent care and support from multiple professionals, which enabled me to get back on my feet."

"The expertise, care, and dedication by all the staff is outstanding."

"Very caring & dedicated team."

"The staff have made me feel human again. So cheerful no matter what time day or night."

"Whole holistic approach. Having more contact with specialities than I would in the community. Core strength improved. Confidence has improved, less anxious when in public."

"Everything has been good & all the services I have been offered have all helped with my progress."

"I really liked the MDT meetings to make sure everyone was on the same page and knew the next plan of action surrounding my treatment."

"Getting such clear, concentrated care on all fronts physical, psychological, social."

"Excellent nursing & holistic services. Kind, caring, considerate staff at all levels."

"Everyone was clear on the agreed plan and executed with the highest standards you could ask for. Not a single staff member ever half-arsed anything, they put in 100% of their care & concentration."

"Things that have gone undiagnosed for years are now under treatment. I am no longer shut-in. I can walk so much more. Every member of staff is dedicated, kind and friendly. Thank you NICPM."

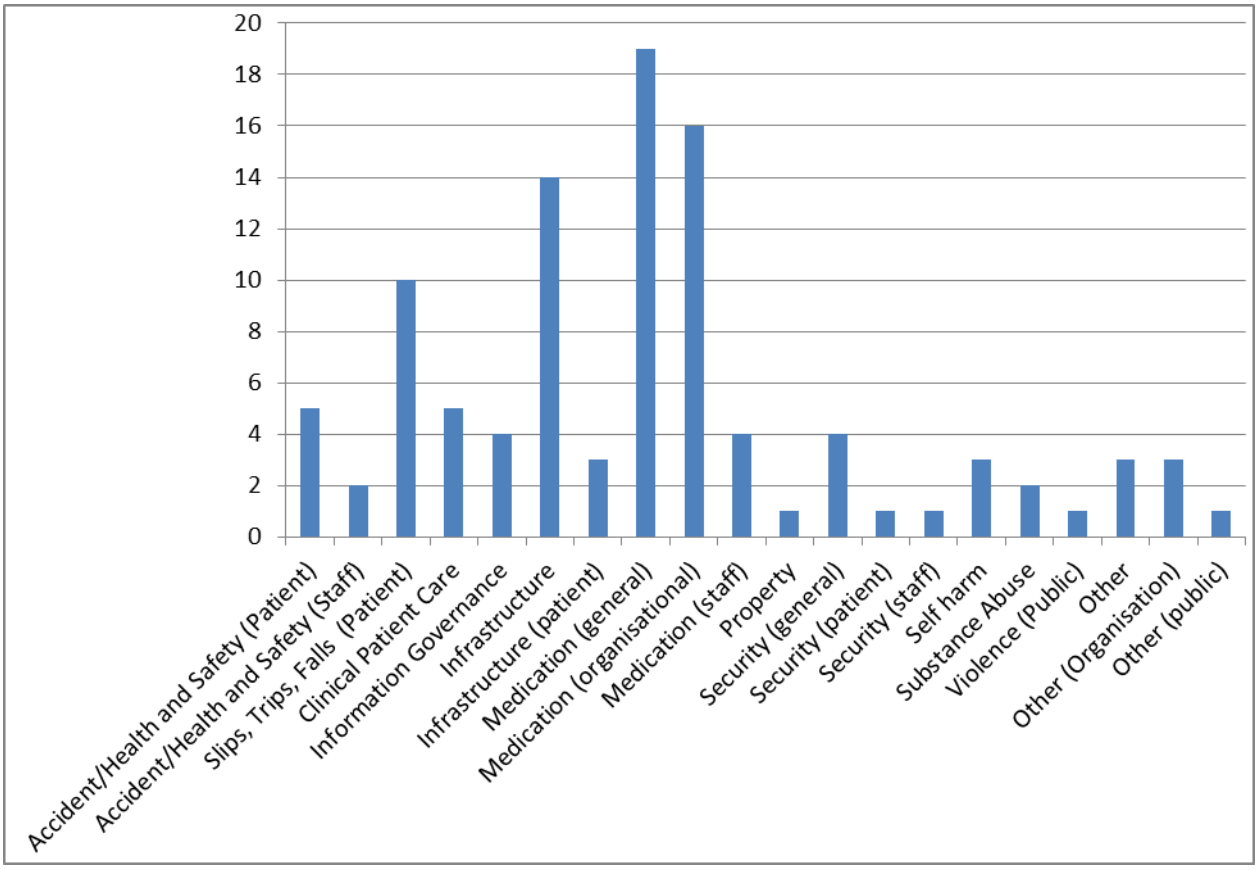
Incidents

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 NICPM 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 incident at level 3 ('short-term harm').

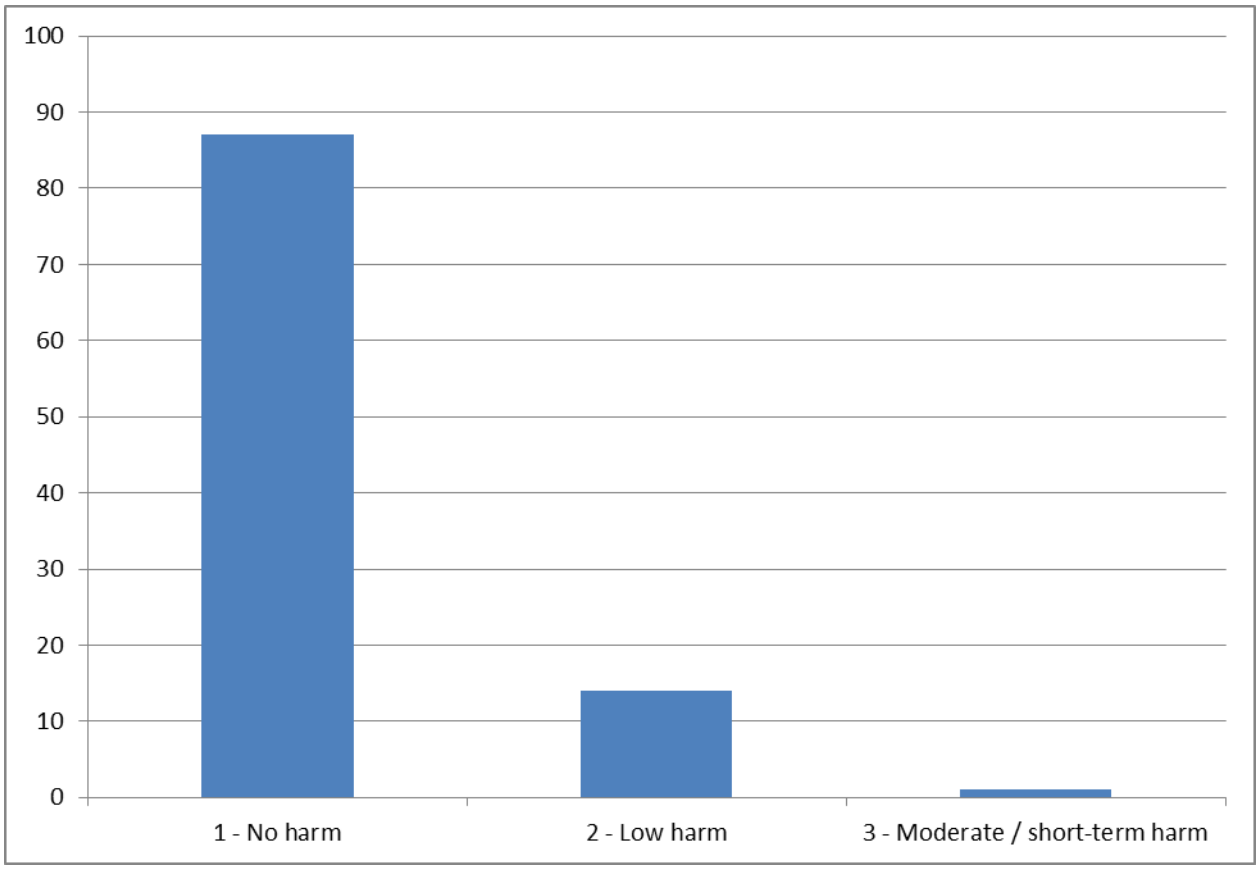
In total, 102 incident forms were completed within the period to which this report relates, as detailed below.

Incidents reported April 2017 – March 2018

By category:



By severity:



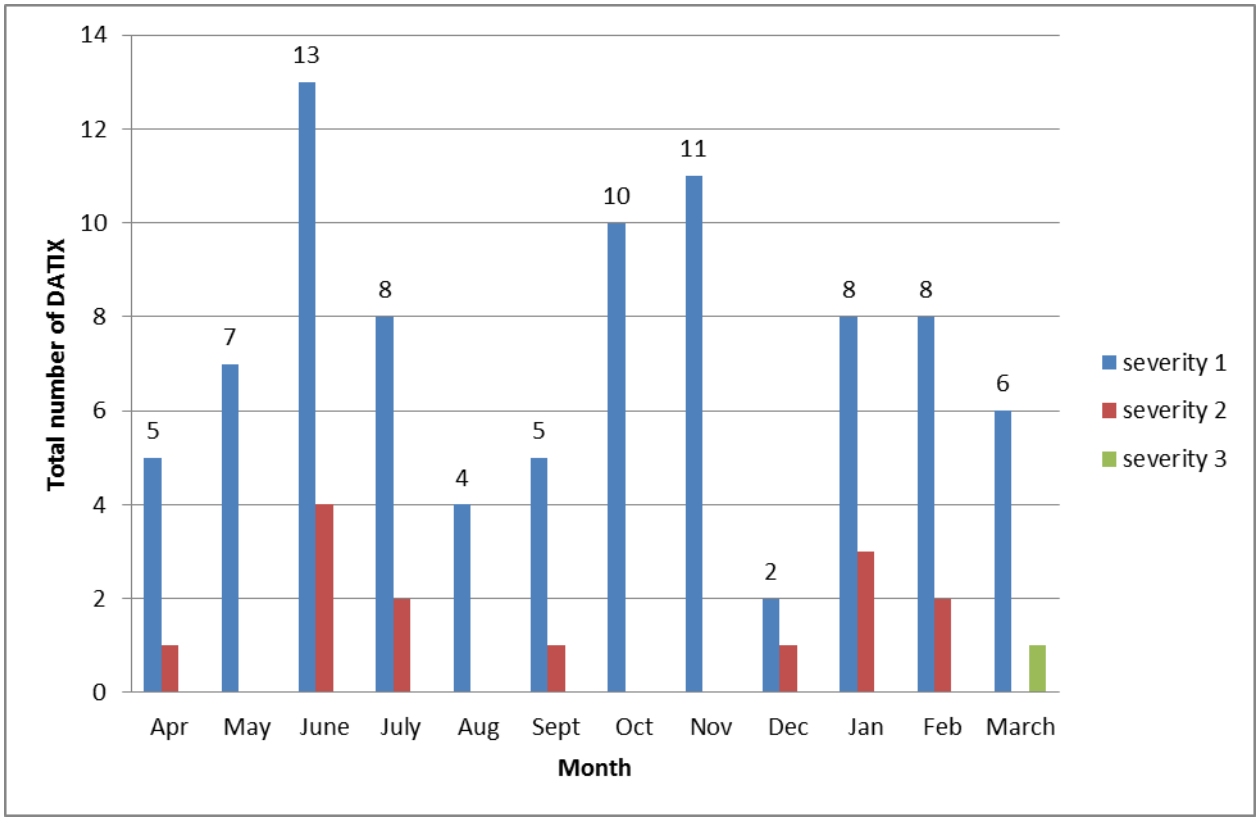
Key:

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)

Severity 3 incident

Incident date	Description
21/03/2018	The NICPM team responded when a member of the public collapsed outside the hospital on the street (cardiorespiratory arrest). The person was successfully resuscitated and then transferred and admitted for coronary care at the LGI.

Breakdown by month (April 2017-March 2018)



Authors

Dr Peter Trigwell

Consultant and Clinical Lead

National Inpatient Centre for Psychological Medicine

Mrs Kairon Eustace-Tyson

Clinical Team Manager

National Inpatient Centre for Psychological Medicine

Leeds and York Partnership NHS Foundation Trust

May 2018