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National Inpatient Centre for Psychological Medicine

Annual Review 2019/20

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 inpatient 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.

Regular service evaluation projects are carried out and the results acted upon, eg baseline assessments of compliance with various NICE Guidance, such as that relating to CFS/ME, PTSD, IBS, and Multimorbidity.

The service has a CQC overall rating of Good (April 2018 inspection). For further details see page 35 of this Annual Review, or the NICPM service website: https://www.leedsandyorkpft.nhs.uk/our-services/services-list/nicpm/

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 eleventh 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.

Purpose

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

- Severe and complex medically unexplained physical 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.

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 2019-20

Activity

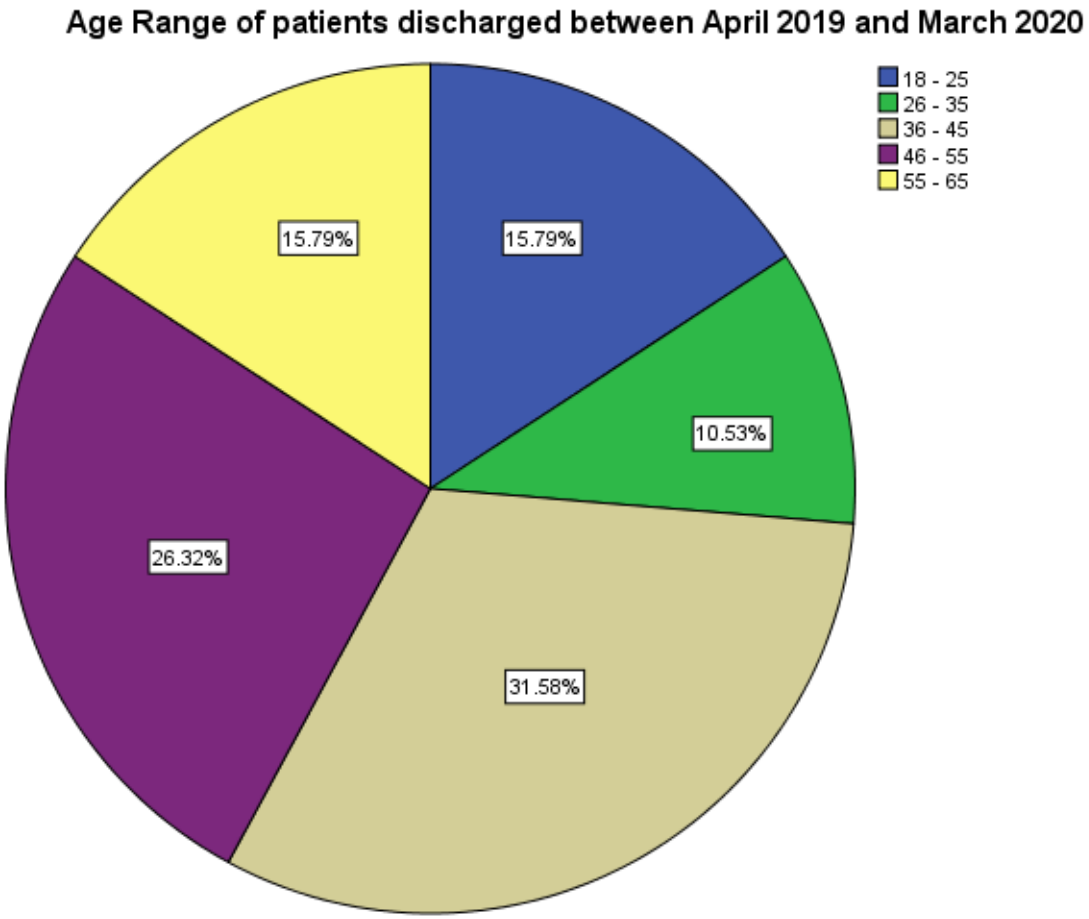
Inpatient Treatment

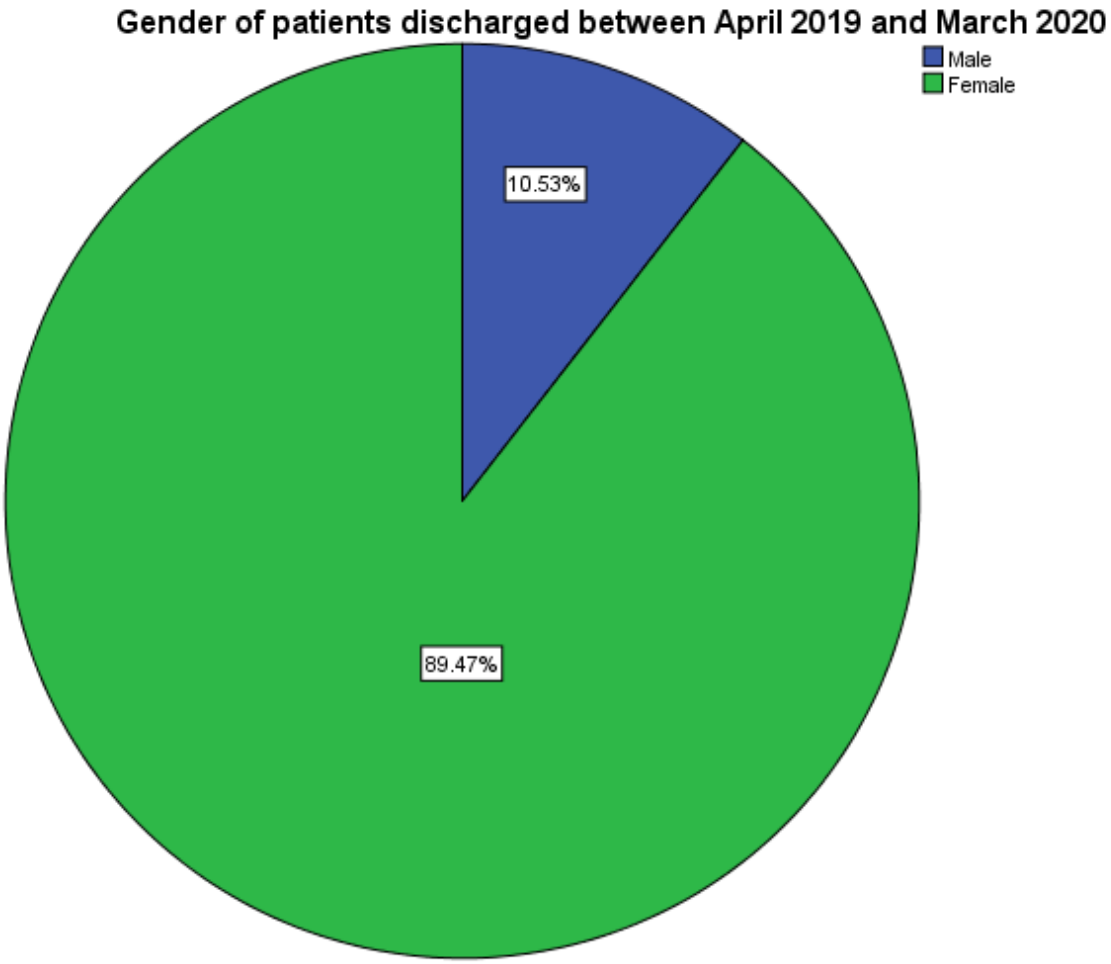
Data for all patients discharged from the NICPM between 1st April 2019 and 31st March 2020 are included in this report. In total:

- **19** patients were discharged during this period, which is a smaller number than in previous years. (This was due to some delayed discharges during the 2019/20 period, four of which were particularly prolonged, and because during February/March 2020 the unit was functioning at half the usual capacity due to the Covid-19 pandemic. In addition, and also in connection with the pandemic, one patient needed to be temporarily transferred home with a plan to return and continue their admission at an appropriate later point when the crisis had abated.)
- **16** had been on the unit for a full treatment admission (as opposed to assessment and opinion/advice only).
- **15** (93.8%) 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 **19.**

All other (ie outcome analysis) figures relate to the group of **15** with complete information.





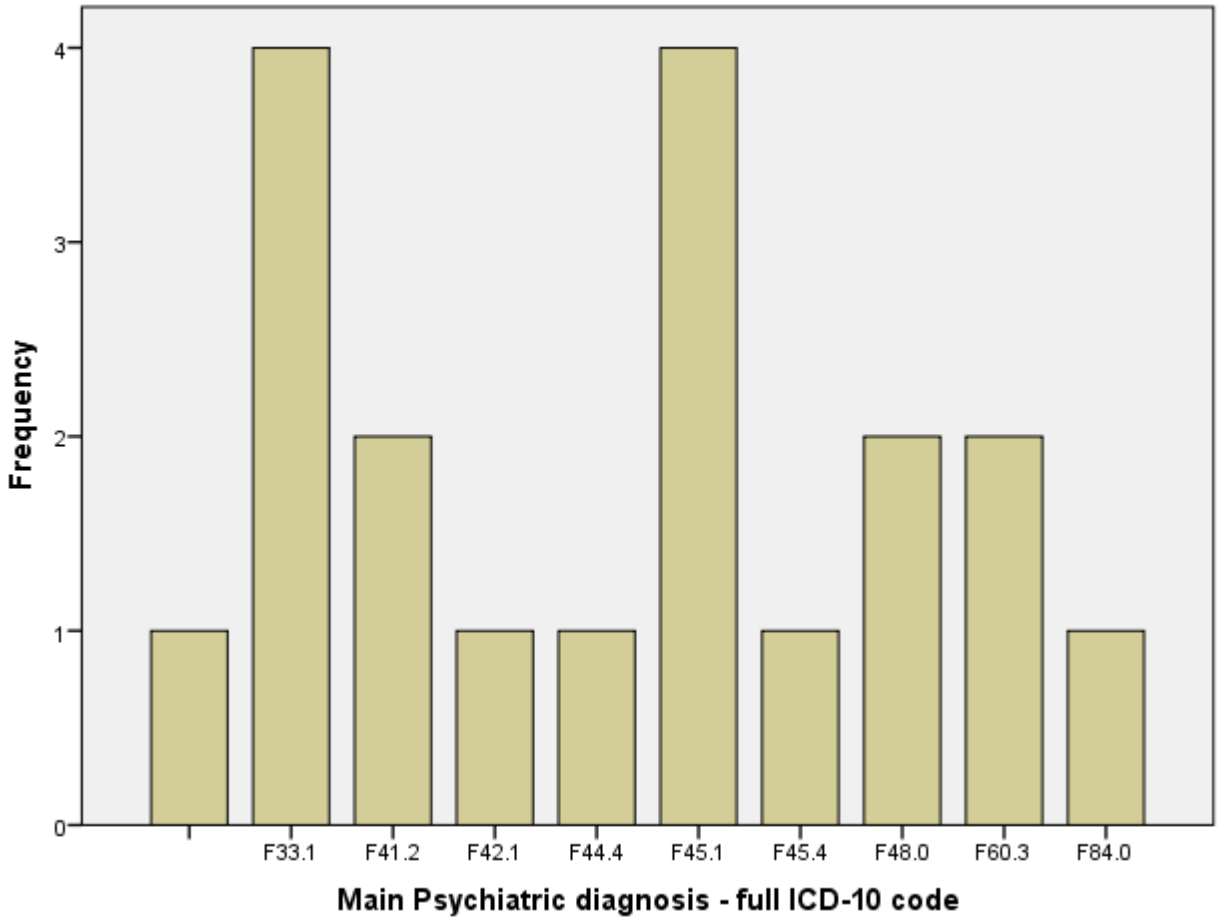
Female:Male ratio = 8.5:1

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

F33.1 = Recurrent depressive disorder, current episode moderate

F41.2 = Mixed anxiety and depressive disorder

F42.1 = Obsessive compulsive disorder

F44.4 = Dissociative motor disorders

F45.1 = Undifferentiated somatoform disorder

F45.4 = Persistent somotoform pain disorder

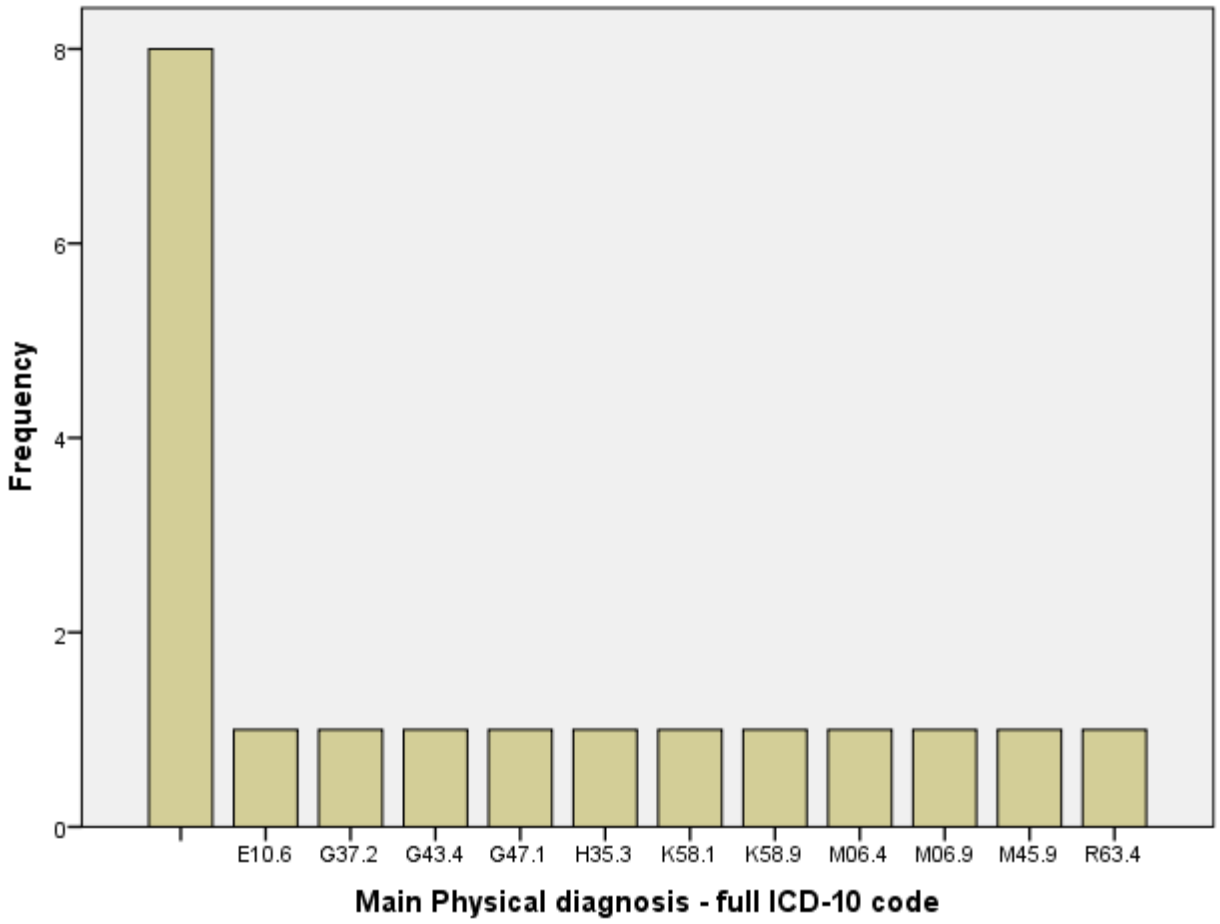
F48.0 = Fatigue syndrome (CFS/ME)*****

F60.3 = Emotionally unstable personality disorder / Complex PTSD

F84.0 = Autism

(*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. Five patients had one of their diagnoses as CFS/ME at discharge.)

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

E10.6 = Type 1 diabetes mellitus with specific complications

G37.2 = Central pontine myelinolysis

G43.4 = Hemiplegic migraine

G47.1 = Hypersomnia

H35.3 = Degeneration of macula and posterior pole

K58.1 = Irritable bowel syndrome

K58.9 = Irritable bowel syndrome without diarrhoea

M06.4 = Inflammatory polyarthropathy

M06.9 = Rheumatoid arthritis

M45.9 = Ankylosing spondylitis

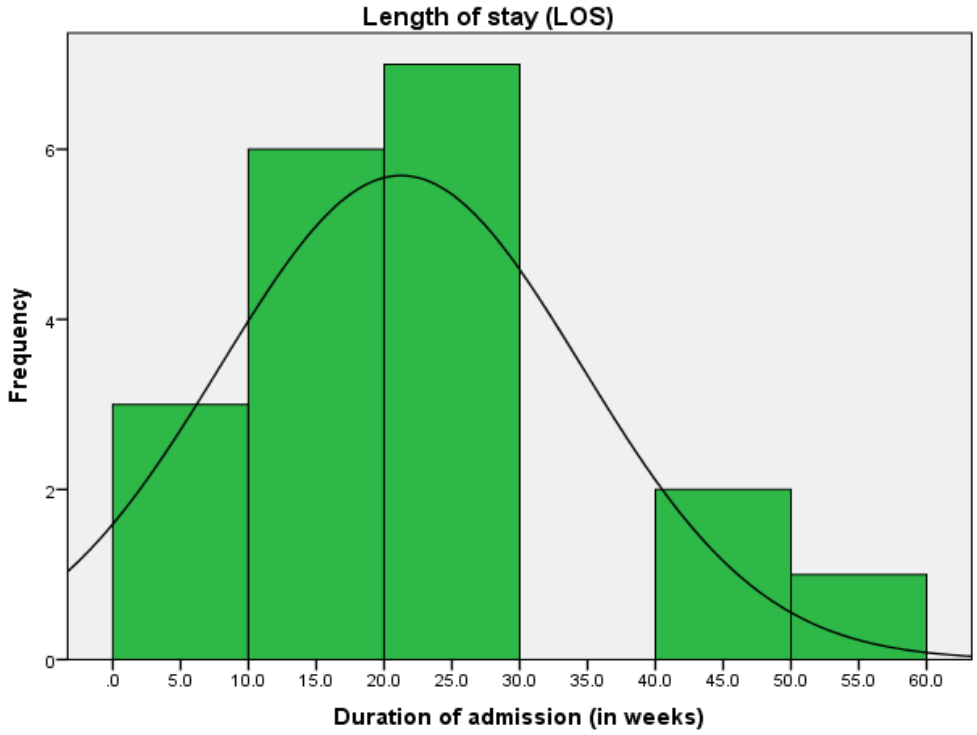
R63.4 = Abnormal weight loss

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.

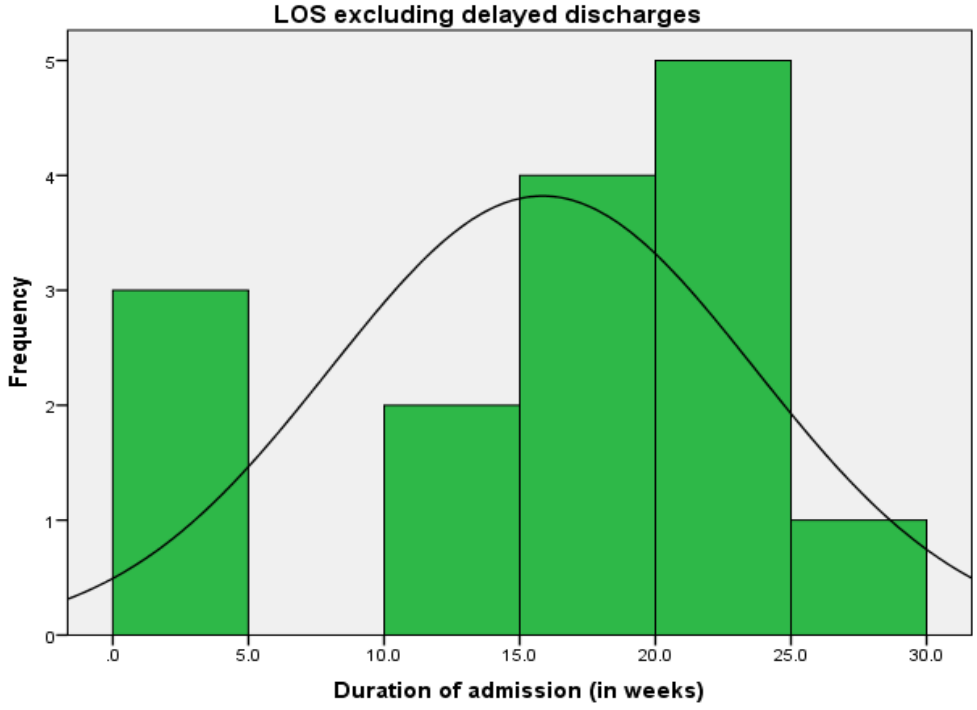
The result of all of this is that many patients being cared for by the NICPM service are suffering with very complex presentations, involving combinations of multiple physical and multiple psychological symptoms and conditions.

(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 2019 – March 2020



The whole group duration of admission (LOS) ranged from 0.5 to 51.6 weeks, with an average of 21.2 weeks. This is substantially longer than in any previous year of this service, and is in part due to four prolonged delayed discharges, representing 20% of the whole group and for whom the LOS ranged from 29.5 to 51.6 weeks, with an average of 41.5 weeks. If the figures for those patients are excluded from the analysis, the duration of admission for the remaining 80% ranges from 0.5 to 25.1 weeks, with an average of 15.8 weeks. The figure below represents that amended 80% group analysis:



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.

1. Clinical Global Impression (Improvement) Scale - CGI-I

The CGI-I score is established by consensus within the multidisciplinary team, at the point of discharge, according to a 7 point Likert scale with items as shown in the Key to the CGI-I chart below.

The proportions of patients showing **improvement** on the CGI-I 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%)

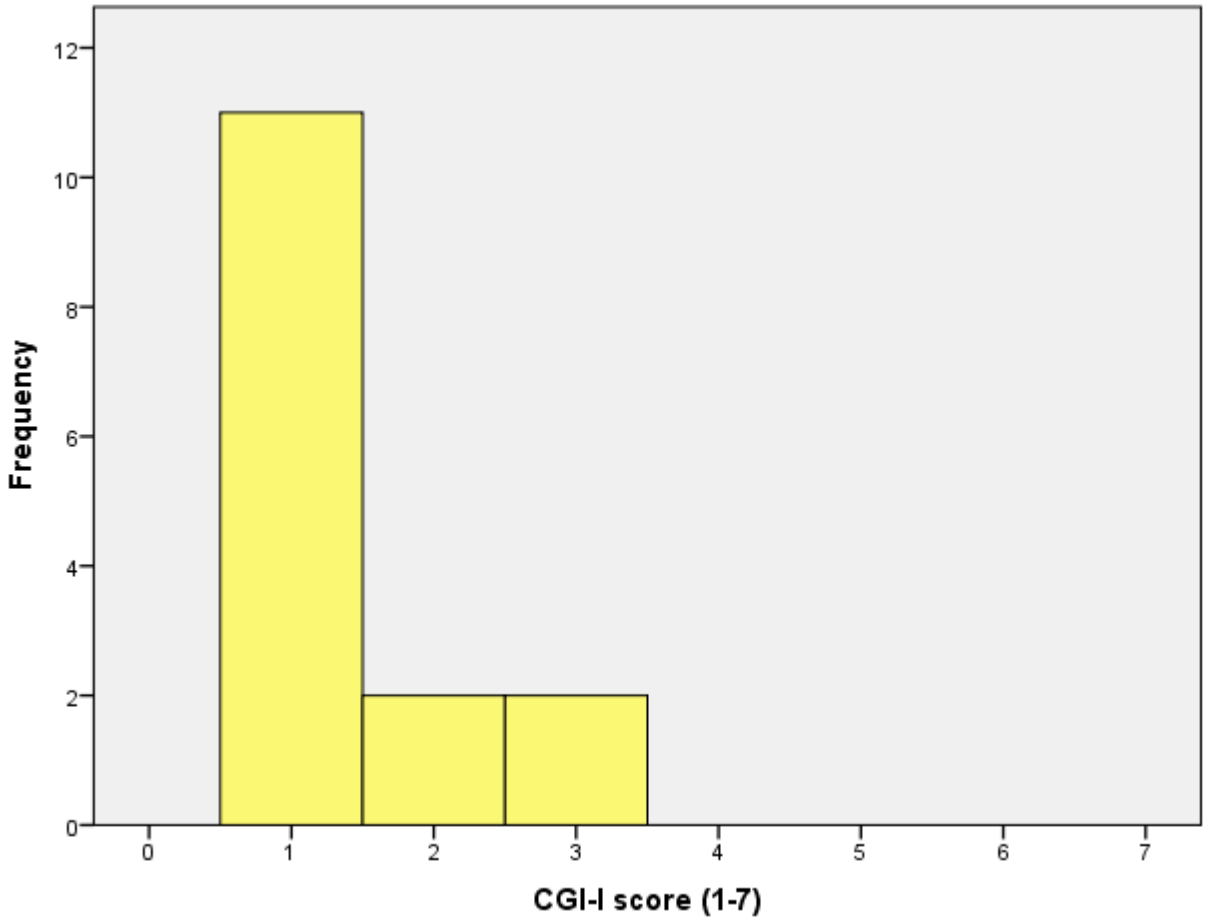
- **100%** in 2018/19

(Major improvement 64.7%, Moderate improvement 5.9%, Minor improvement 29.4%)

- **100%** in 2019/20

(Major improvement 73.3%, Moderate improvement 13.3%, Minor improvement 13.3%)

As shown in the chart below, 13 of the 15 patients (**86.6%**), in what is a highly selected group with severe and complex presentations, scored at either **Moderate or Major improvement** on the CGI-I Scale.



Key:

1 = Major improvement

2 = Moderate improvement

3 = Minor Improvement

4 = No change

5 = Minor deterioration

6 = Moderate deterioration

7 = Major deterioration

2. Clinical Global Impression (Severity) Scale - CGI-S

The CGI-S score is established at two time points: first at admission and again at discharge. This measure is based upon the following question and 7 point Likert scale:

“Considering our clinical experience with such conditions, how ill is the patient at this time point?”

1 = Not at all ill

2 = Borderline ill

3 = Mildly ill

4 = Moderately ill

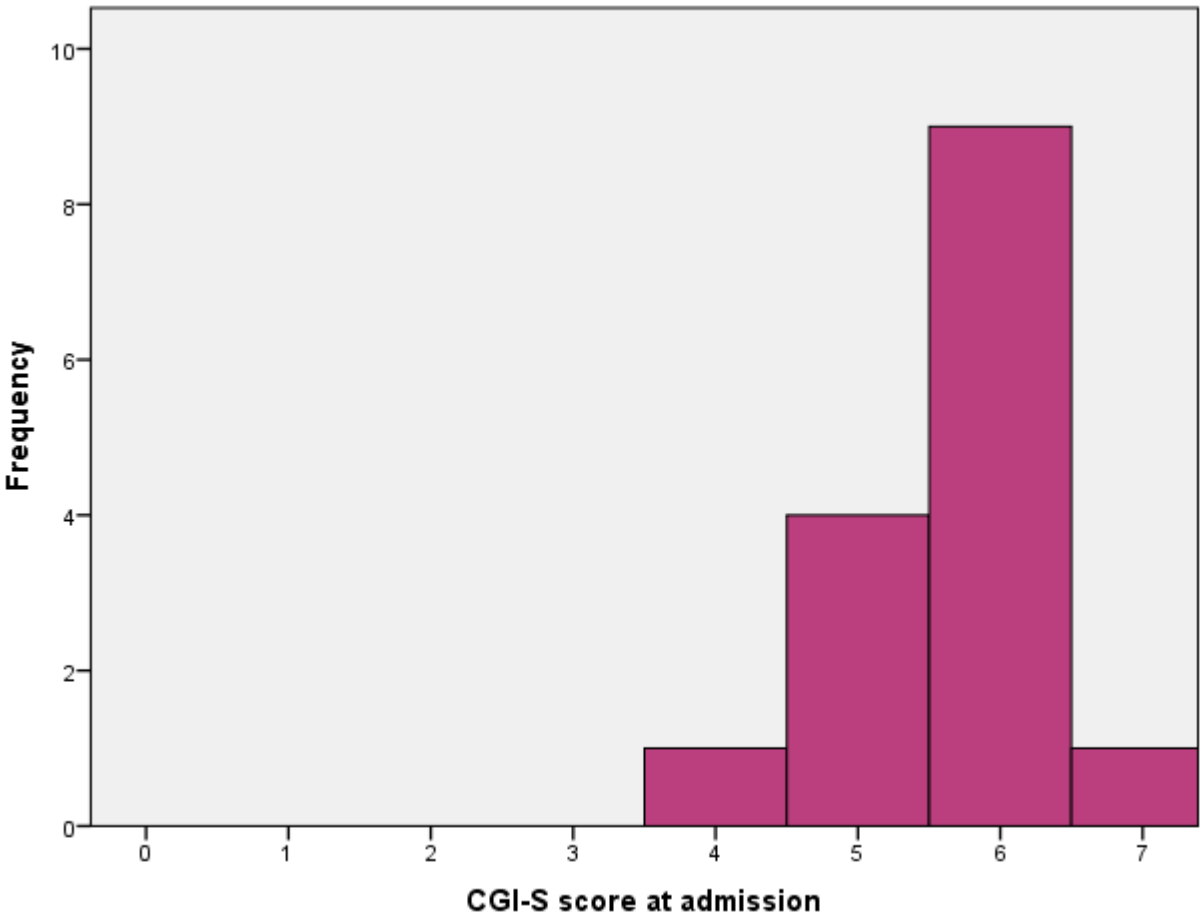
5 = Markedly ill

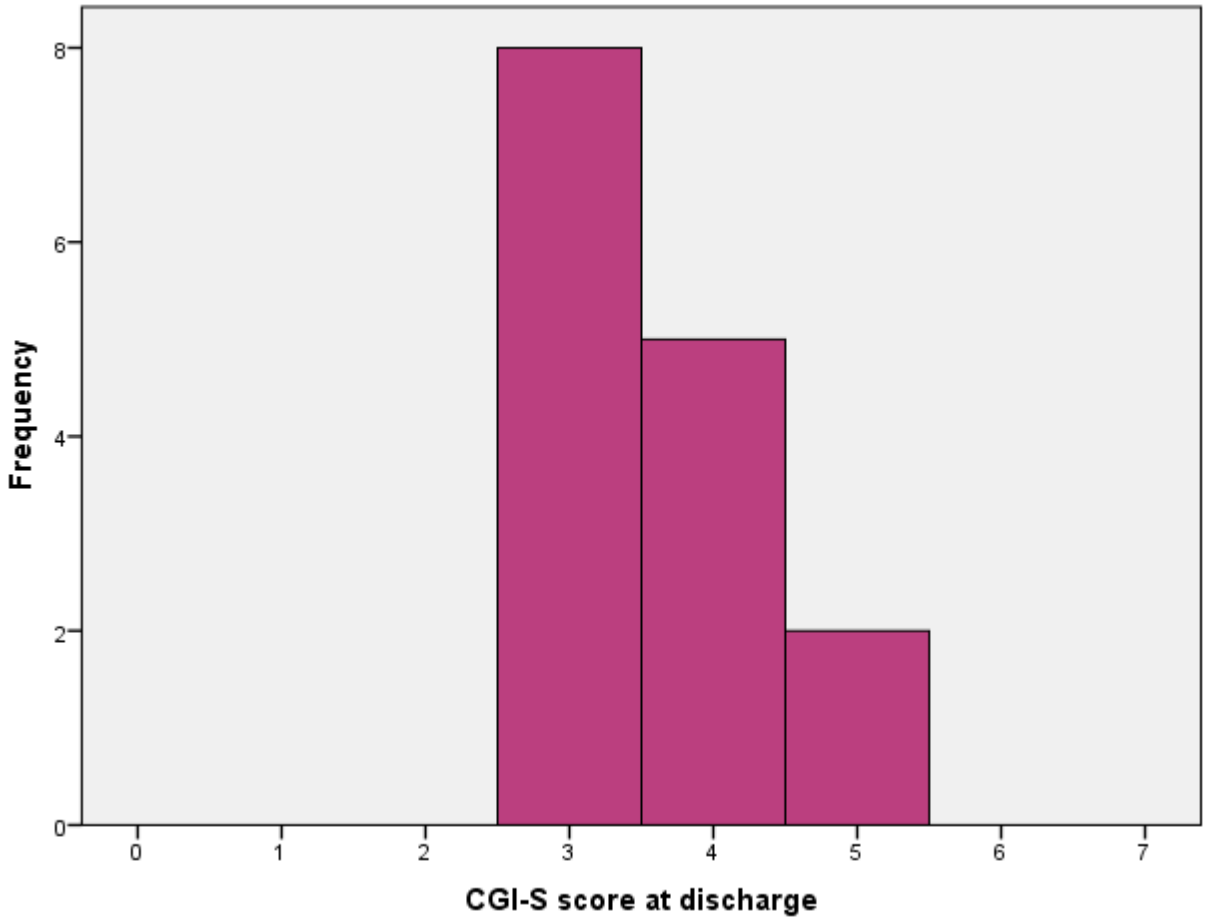
6 = Severely ill

7 = Among the most extremely ill patients

At admission, 100% of patients scored either (4) Moderately, (5) Markedly, (6) Severely, or (7) Extremely ill.

At discharge, the category (score) had changed (reduced) for 14 (93.3%) of patients, ie for all but one patient, categorised as moderately ill at admission.





3. 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.

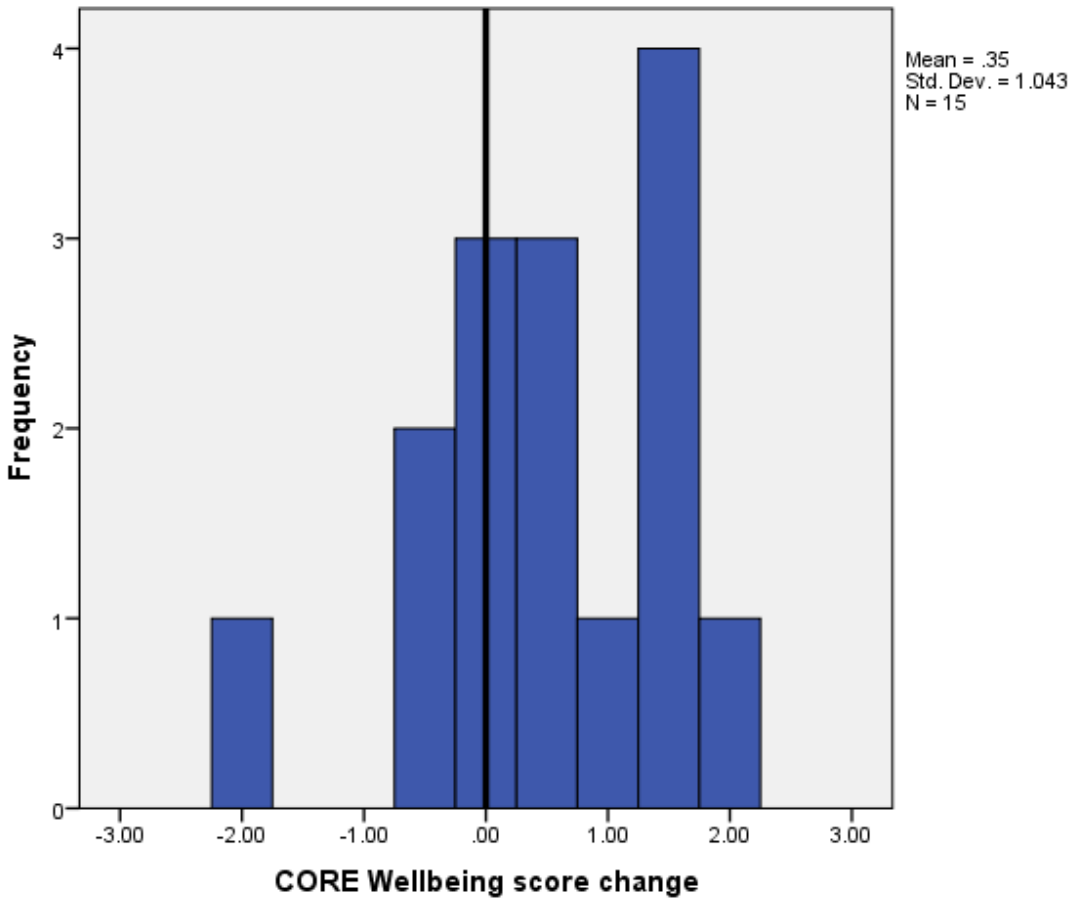
(Patients who are admitted only for a brief period of assessment are not asked to complete a CORE-OM questionnaire on discharge.)

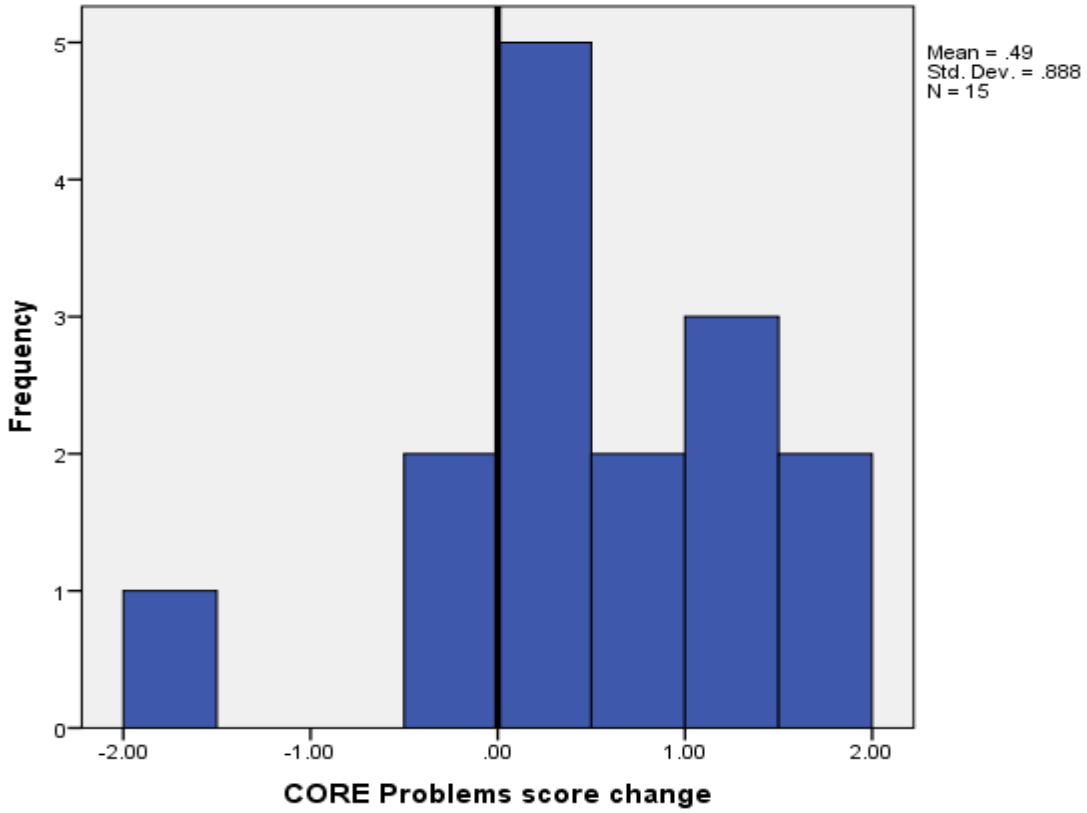
April 2019 – March 2020:

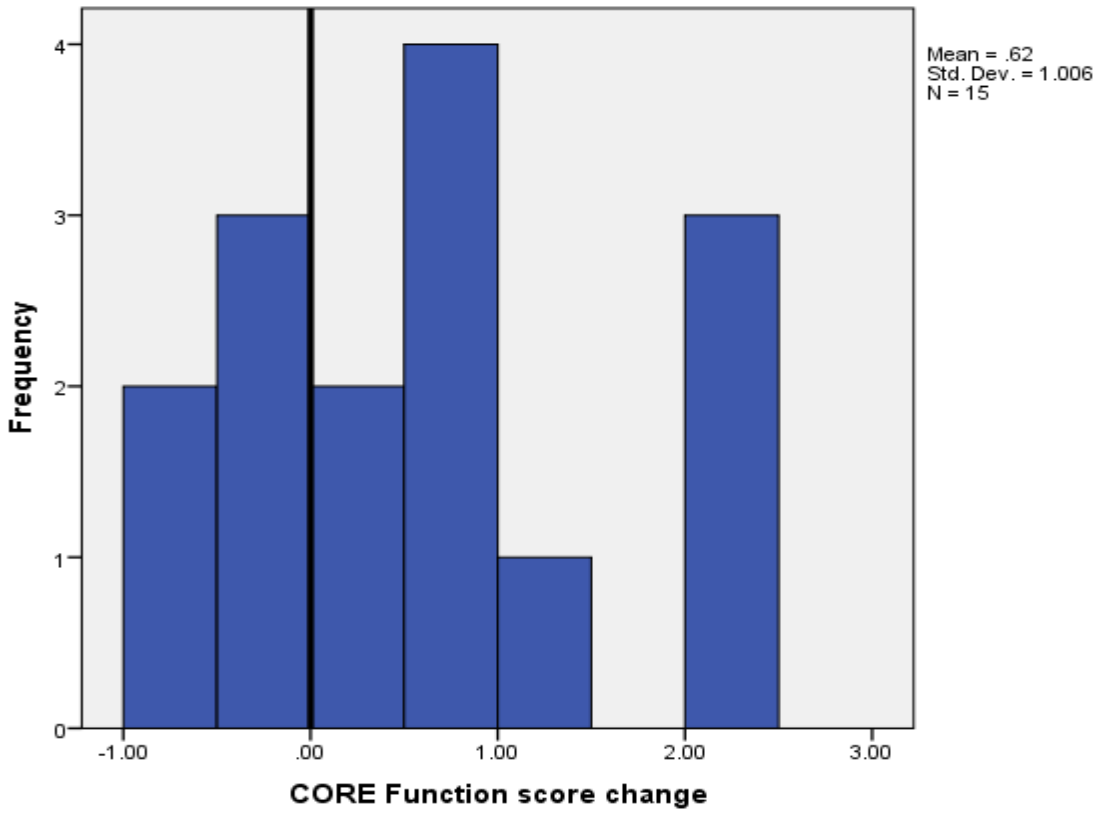
- Wellbeing subscale 73.3% improved
- Problems subscale 80.0% improved
- Functioning subscale 66.7% improved
- Risk subscale 60.0% improved

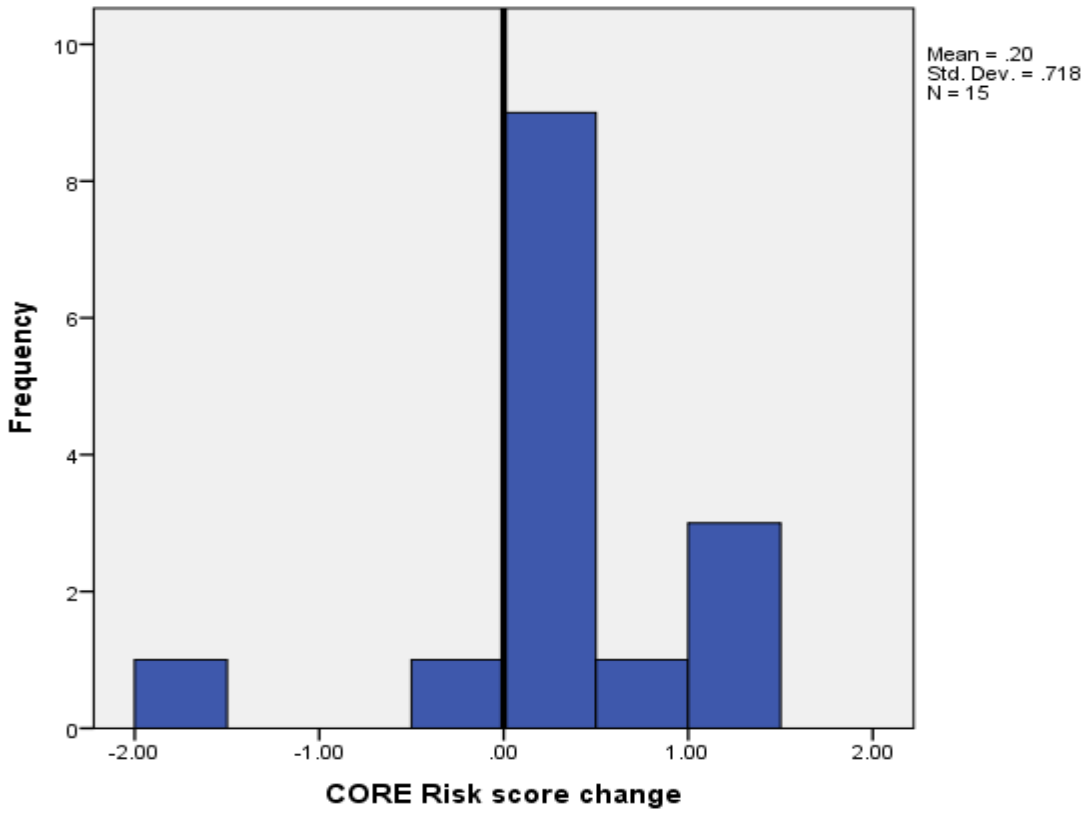
Data gathered on the CORE-OM forms is represented below.

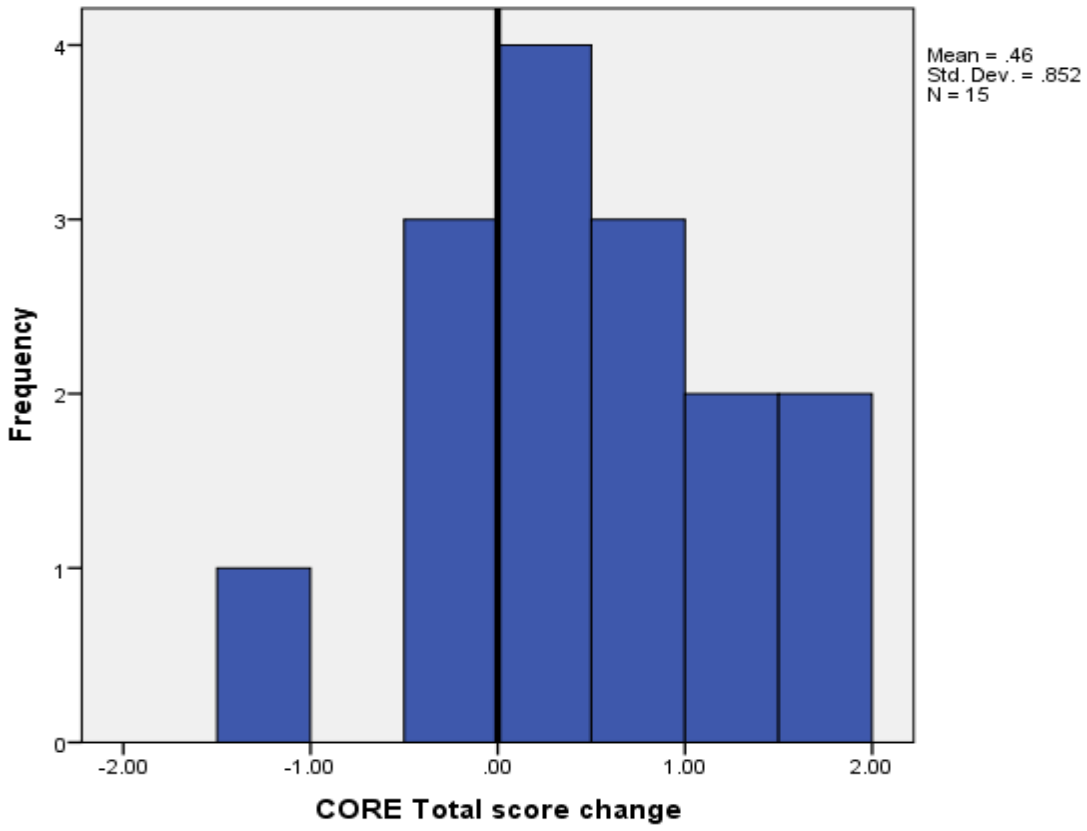
(**NOTE**: on this measure, and the construction of the charts shown below, a positive change in subscale and total CORE scores (ie above the zero line on the bottom axis) is desirable and is evidence of improvement / reduced distress.)




Mean = .49
Std. Dev. = .888
N = 15
Frequency
0
1
2
3
4
5
-2.00
-1.00
.00
1.00
2.00
CORE Problems score change


Mean = .62
Std. Dev. = 1.006
N = 15
Frequency
0
1
2
3
4
-1.00
.00
1.00
2.00
3.00
CORE Function score change


Mean = .20
Std. Dev. = .718
N = 15
Frequency
10
8
6
4
2
0
-2.00
-1.00
.00
1.00
2.00
CORE Risk score change


Mean = .46
Std. Dev. = .852
N = 15
Frequency
4
3
2
1
0
-2.00
-1.00
.00
1.00
2.00
CORE Total score change

4. 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".

April 2019 – March 2020:

Of those people who initially scored at the level of experiencing significant problems in each particular domain (ie score 3 = moderate, 4 = severe, or score 5 = extreme problems), the proportion of those scoring themselves as improved during the admission was as follows:

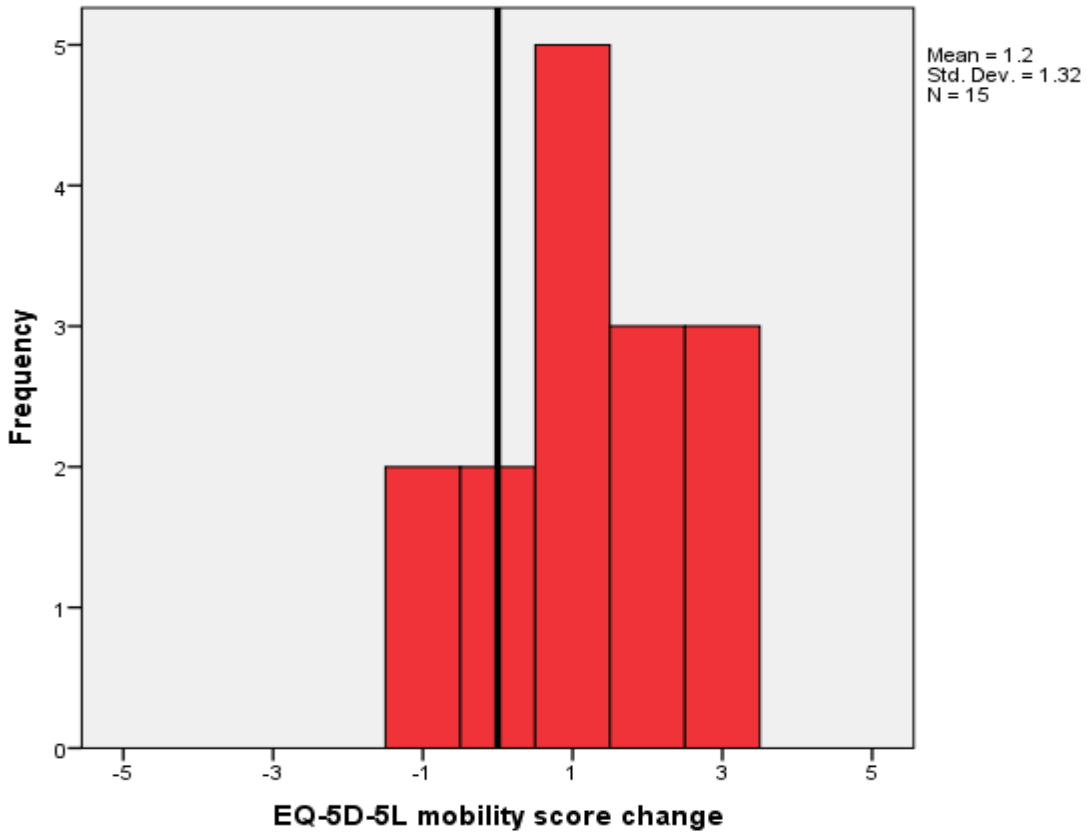
- **Mobility** improved in **84.6%** of patients
- **Self-care** improved in **76.9%** of patients
- **Usual activities** improved in **78.6%** of patients
- **Pain / discomfort** improved in **66.7%** of patients
- **Anxiety / depression** improved in **62.5%** of patients

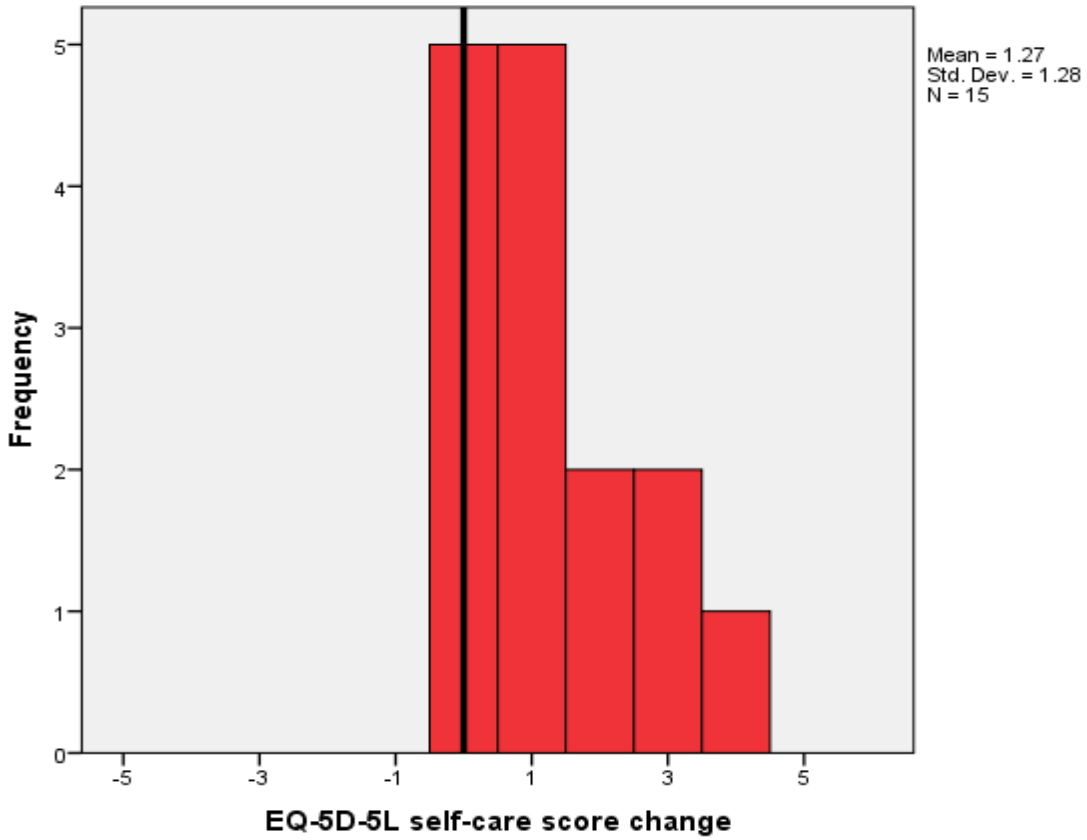
Also, across the whole patient group:

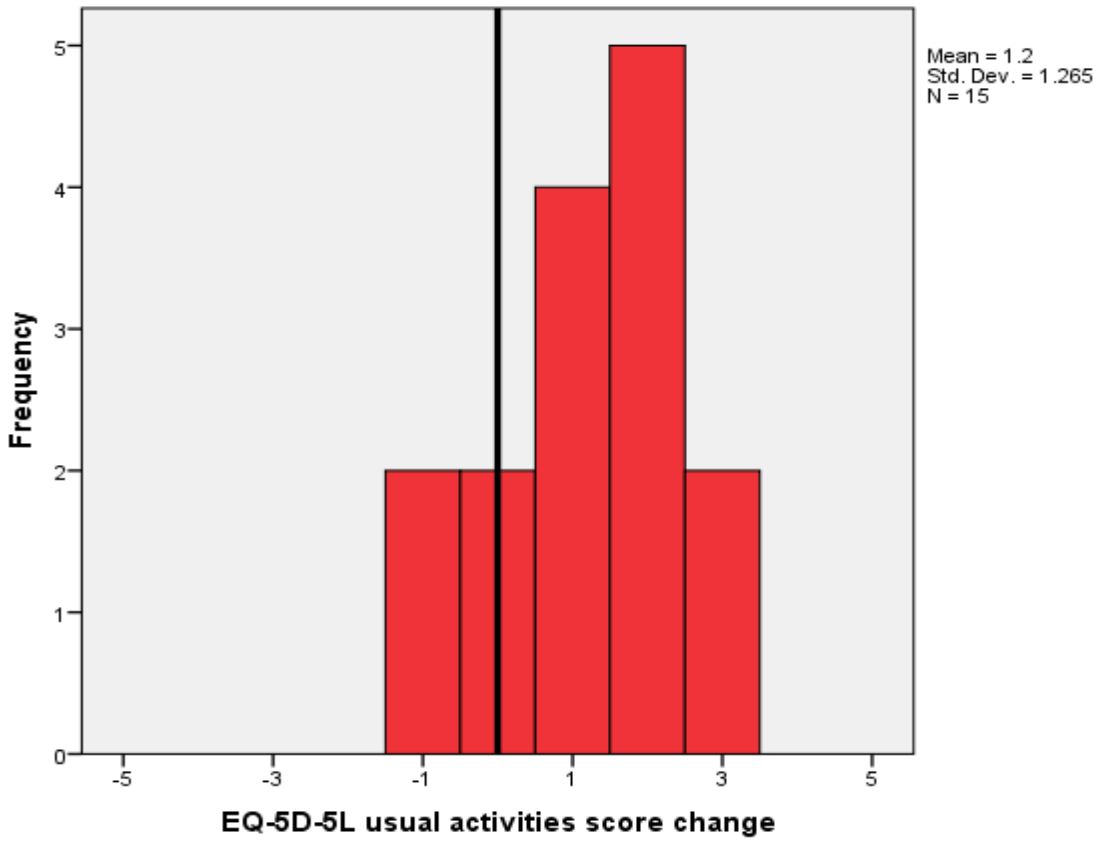
- **At least one domain** improved in **93.3%** of patients
- **Overall health score on VAS** improved in **93.3%** of patients

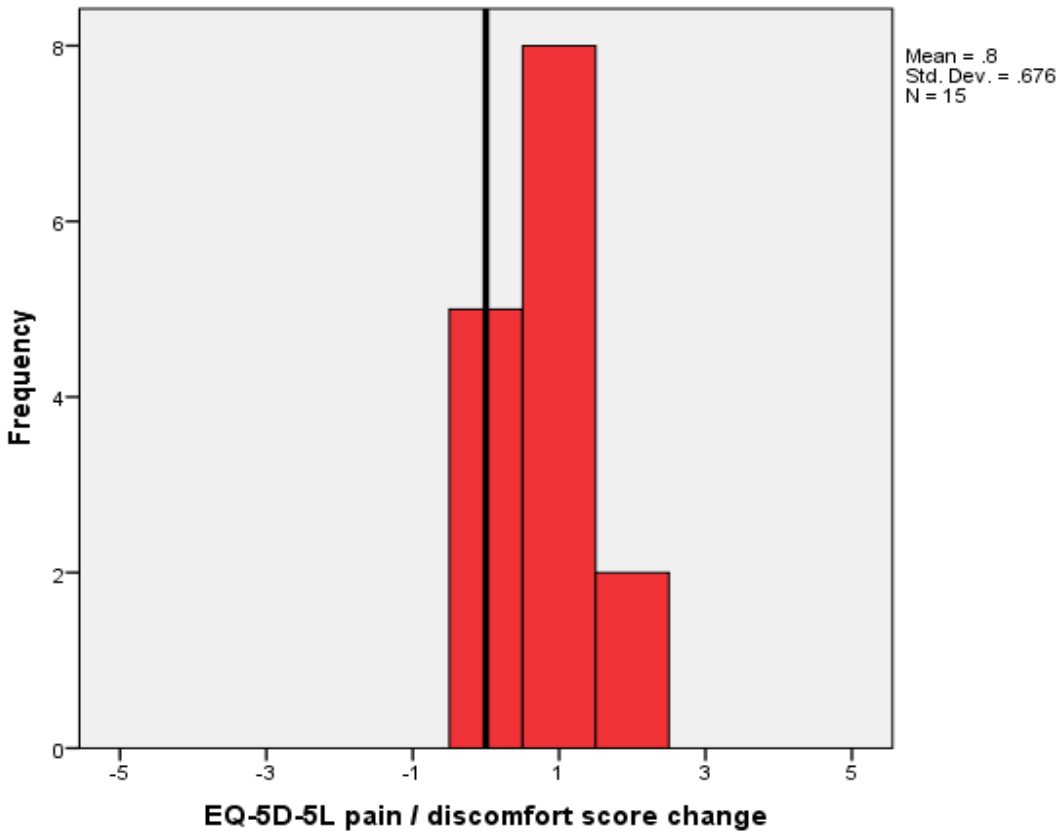
NOTE:

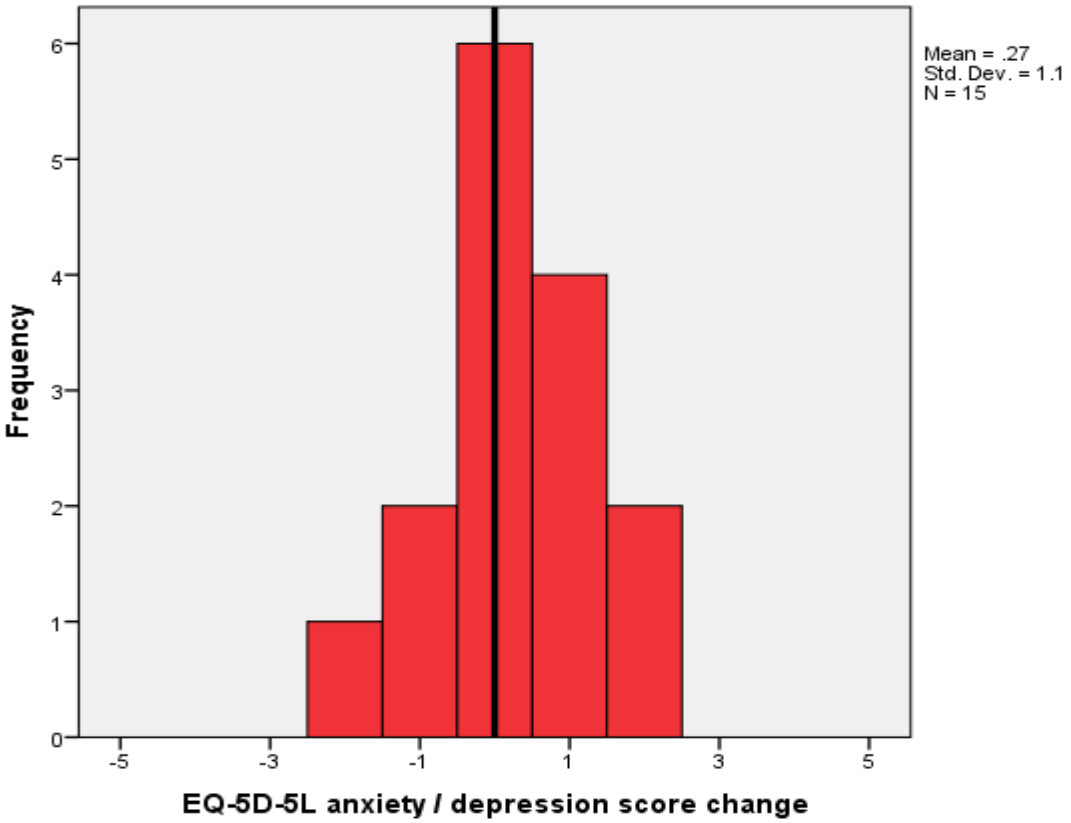
- The following charts have been constructed using the dataset of the whole patient group of 15.
- In the construction of the first 5 of these charts, a positive change in the X axis (ie an increase in score by 1, 2, 3 or 4 steps, calculated as score at Admission minus score at Discharge) is desirable 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.


Mean = 1.2
Std. Dev. = 1.32
N = 15
Frequency
0
1
2
3
4
5
-5
-3
-1
1
3
5
EQ-5D-5L mobility score change

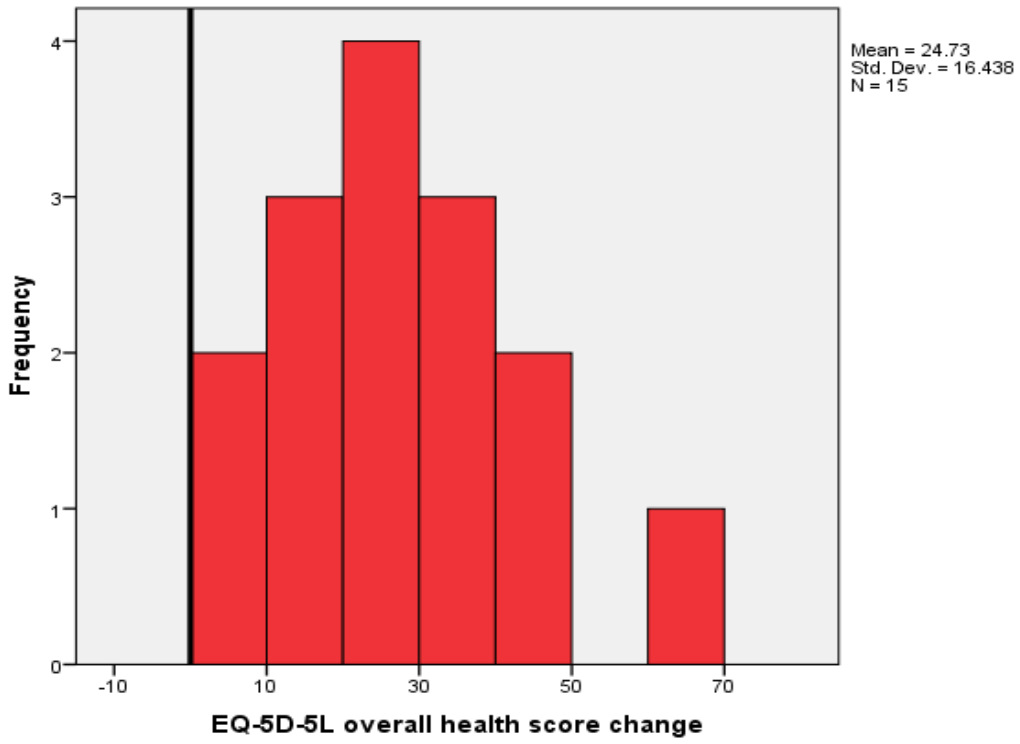

Mean = 1.27
Std. Dev. = 1.28
N = 15
Frequency
0
1
2
3
4
5
-5
-3
-1
1
3
5
EQ-5D-5L self-care score change


Mean = 1.2
Std. Dev. = 1.265
N = 15
Frequency
0
1
2
3
4
5
-5
-3
-1
1
3
5
EQ-5D-5L usual activities score change


Mean = .8
Std. Dev. = .676
N = 15
Frequency
0
2
4
6
8
-5
-3
-1
1
3
5
EQ-5D-5L pain / discomfort score change



Similarly, in the chart below illustrating Overall Health Score Change (ie using the scores from the 100 point EQ-5D-5L Visual Analogue Scale) a positive change is desirable as evidence of improvement, as indicated by the columns to the right of the reference line on the bottom axis.



5. 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

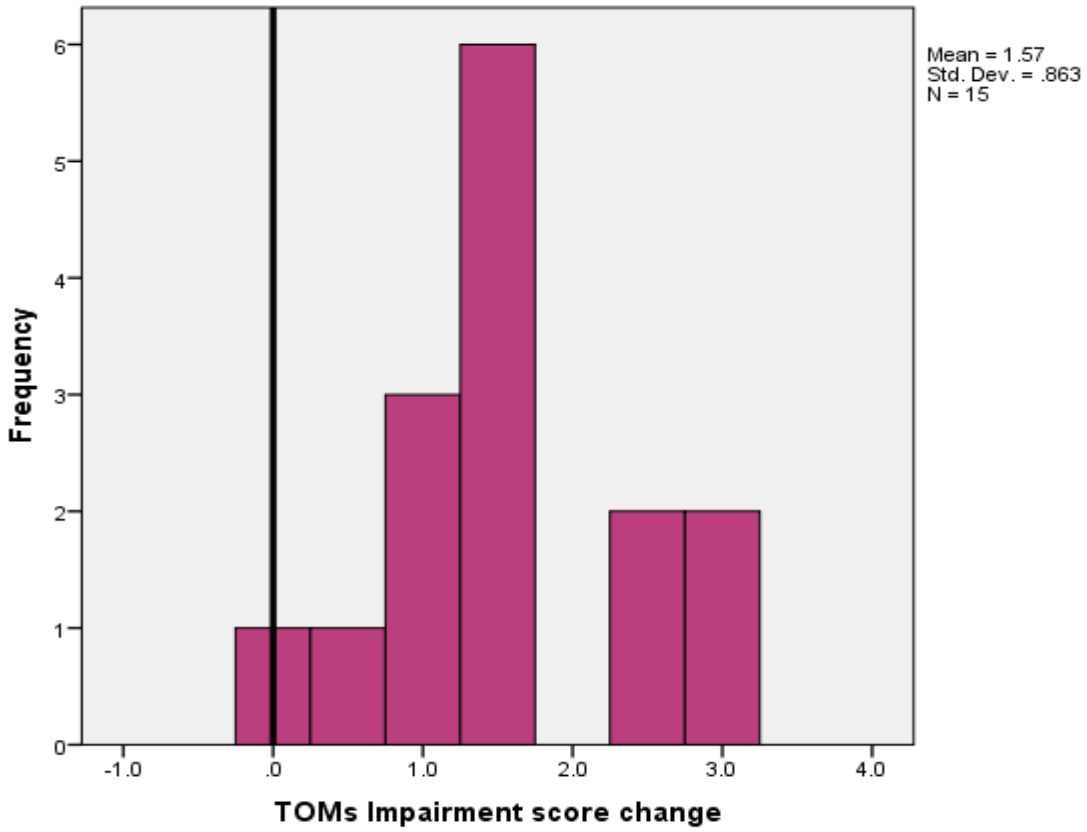
This is a measure which has been validated and used very widely within healthcare services, particular those with a significant Occupational Therapy component. The figures given here relate to use of the standard version of TOMs.

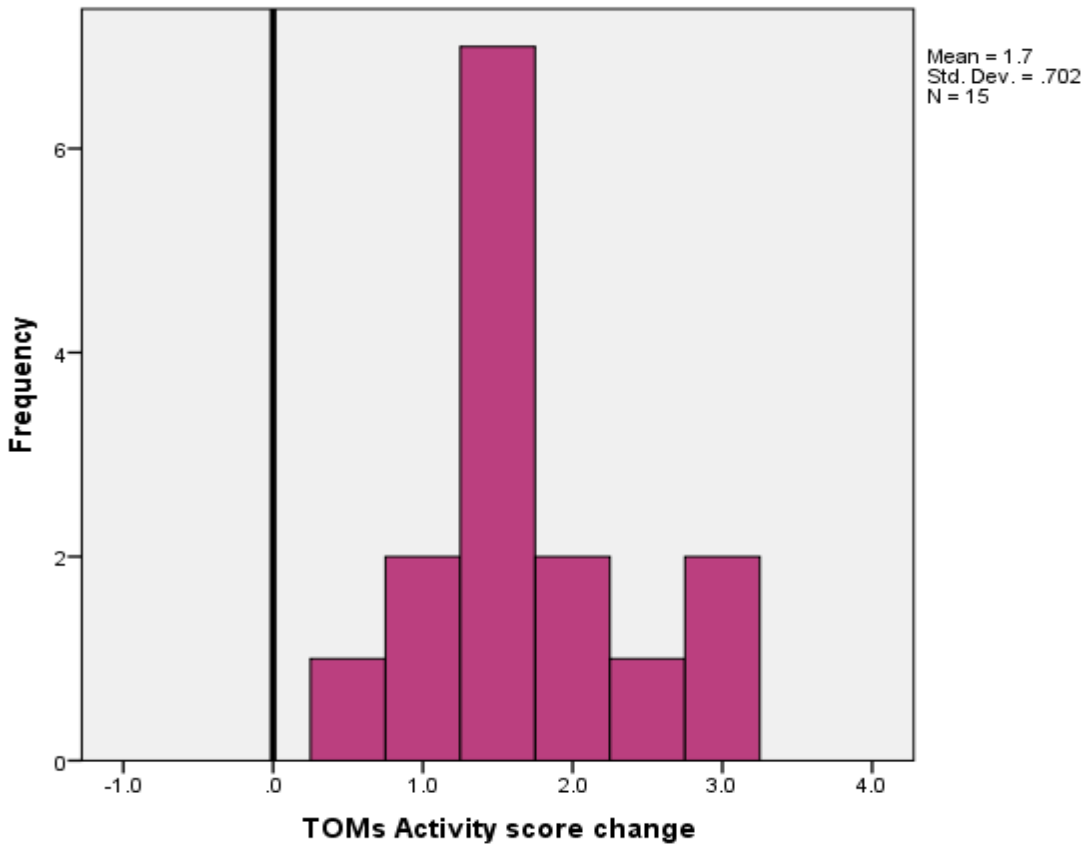
April 2019 – March 2020:

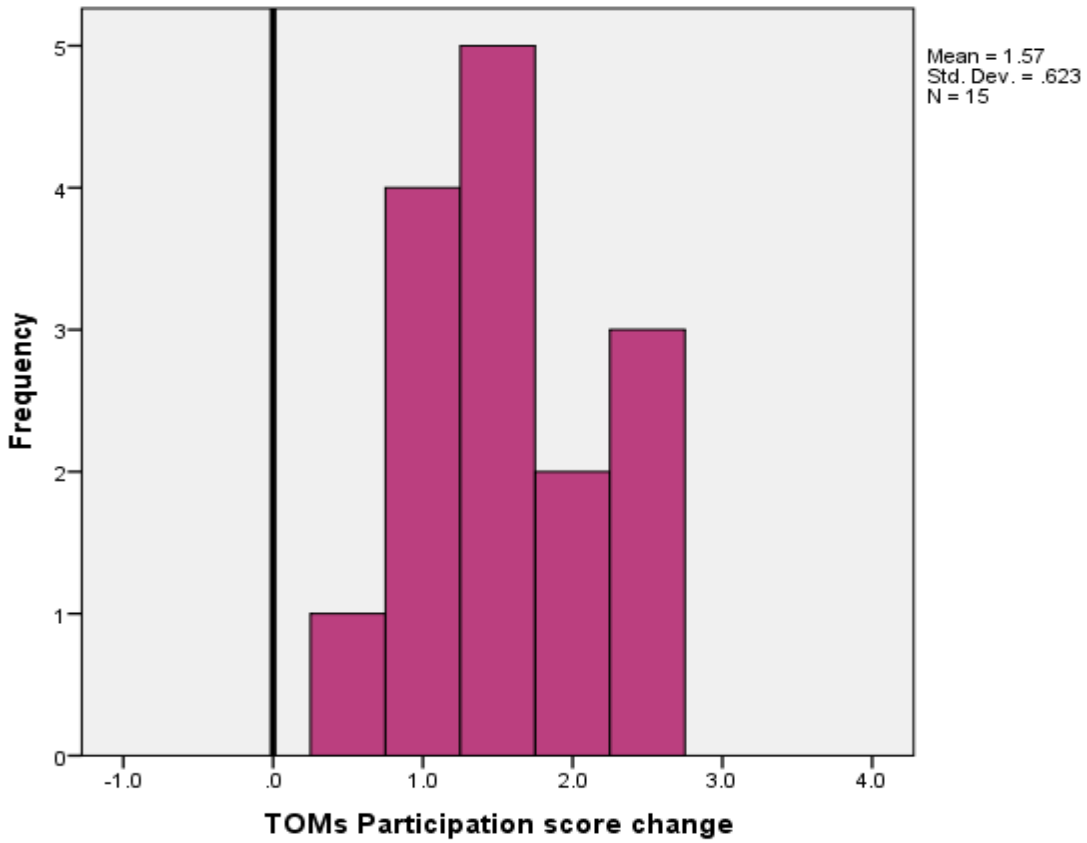
In each particular domain, the proportion of those showing an improvement of at least 1.0 points score change during the admission was as follows:

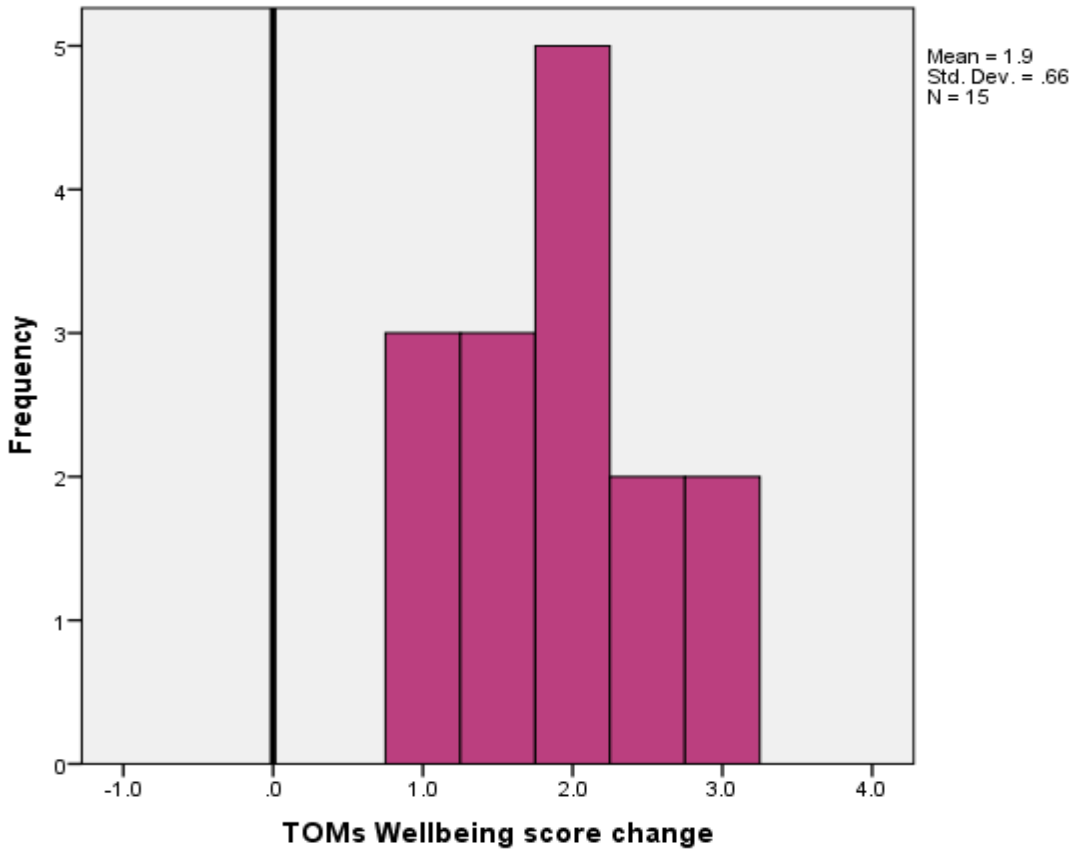
- **Impairment** improved in **86.7%** of patients
- **Activity** improved in **93.3%** of patients
- **Participation** improved in **93.3%** of patients
- **Wellbeing** improved in **100%** of patients

(**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 = 1.57
Std. Dev. = .863
N = 15
Frequency
0
1
2
3
4
5
6
-1.0
.0
1.0
2.0
3.0
4.0
TOMs Impairment score change


Mean = 1.7
Std. Dev. = .702
N = 15
Frequency
0
2
4
6
-1.0
.0
1.0
2.0
3.0
4.0
TOMs Activity score change


Mean = 1.57
Std. Dev. = .623
N = 15
Frequency
0
1
2
3
4
5
-1.0
.0
1.0
2.0
3.0
4.0
TOMs Participation score change


Mean = 1.9
Std. Dev. = .66
N = 15
Frequency
0
1
2
3
4
5
-1.0
.0
1.0
2.0
3.0
4.0
TOMs Wellbeing score change

6. Chalder Fatigue Scale

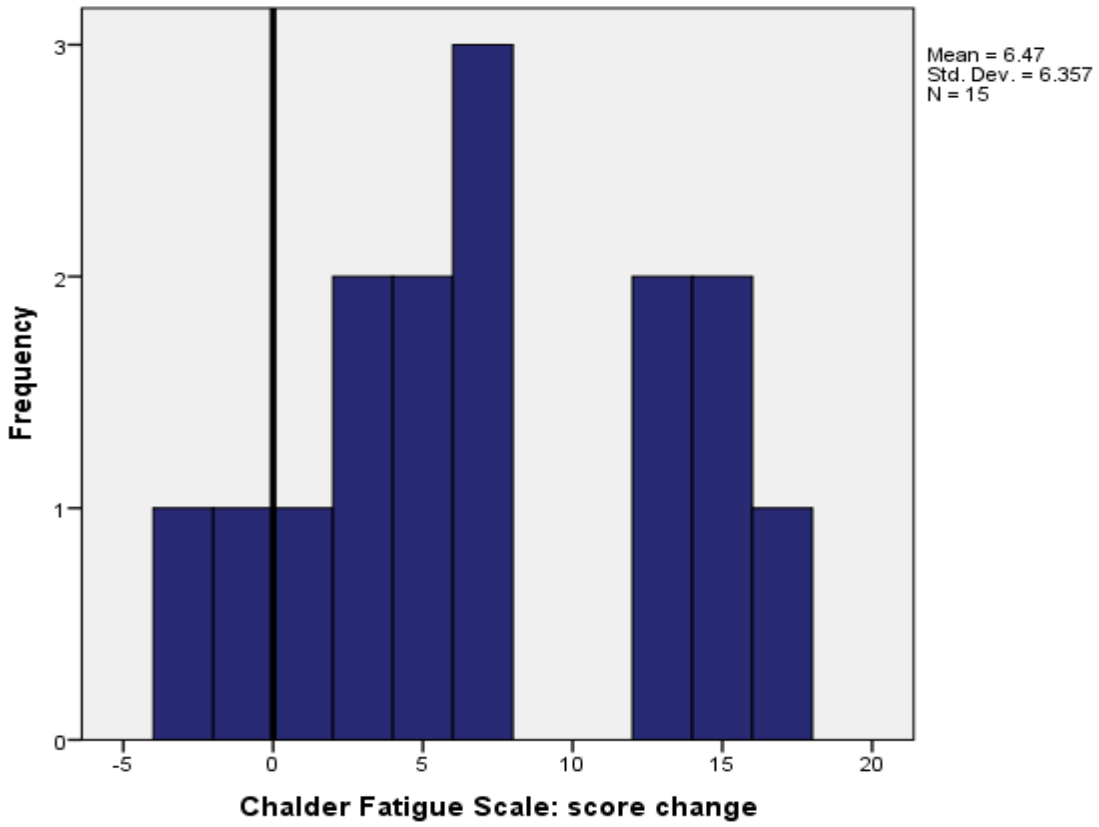
This measure asks the scorer (patient) to answer 11 questions which cover physical and mental fatigue (including one item on subjective memory function). The questionnaire is given to all patients at admission and at discharge, ie including but not only those patients with a diagnosis of CFS/ME.

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 2019 – March 2020:

- **85.7%** (6/7) of patients admitted with CFS/ME showed a reduction (improvement) in their fatigue score
- **80.0%** of the total patient group showed a reduction (improvement) in their fatigue score:
    - 1 patient showed no change in fatigue score
    - 2 patients showed a slight worsening in fatigue scores (an increase of 2 and 3 points respectively)

(**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.)



7. HAD (Hospital Anxiety and Depression) scale

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

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

April 2019 – March 2020:

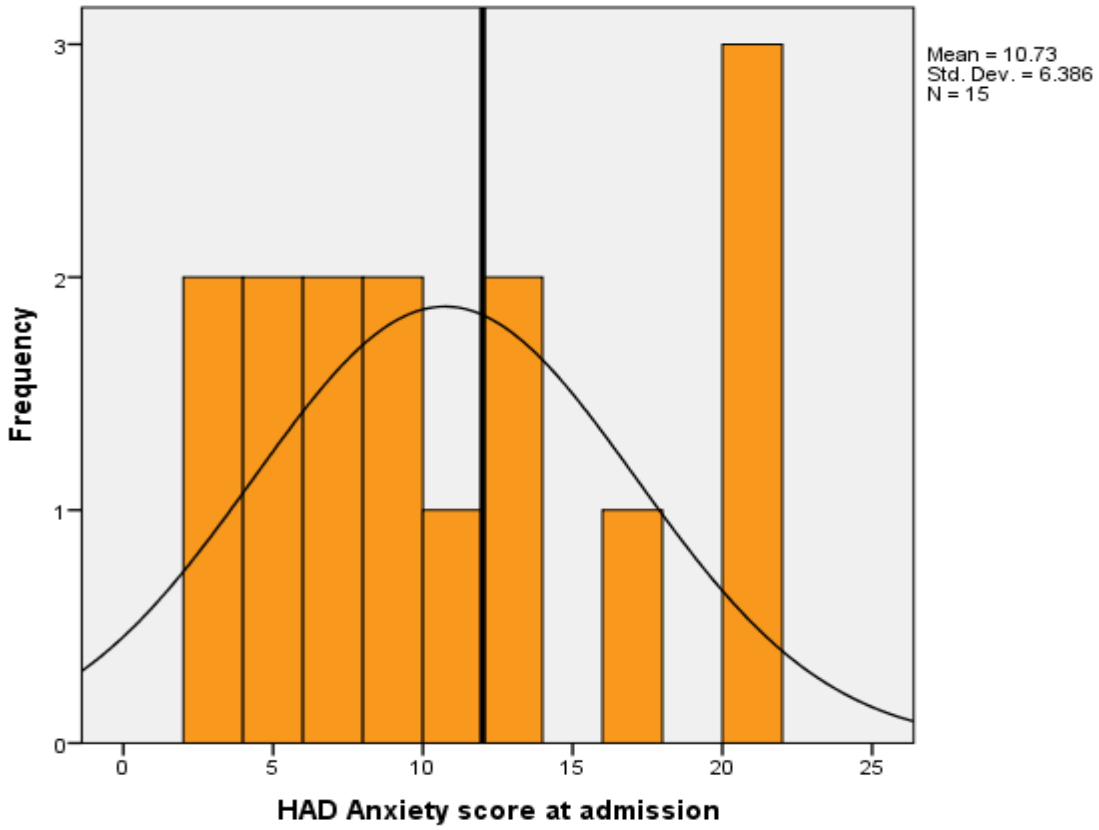
HAD-A:

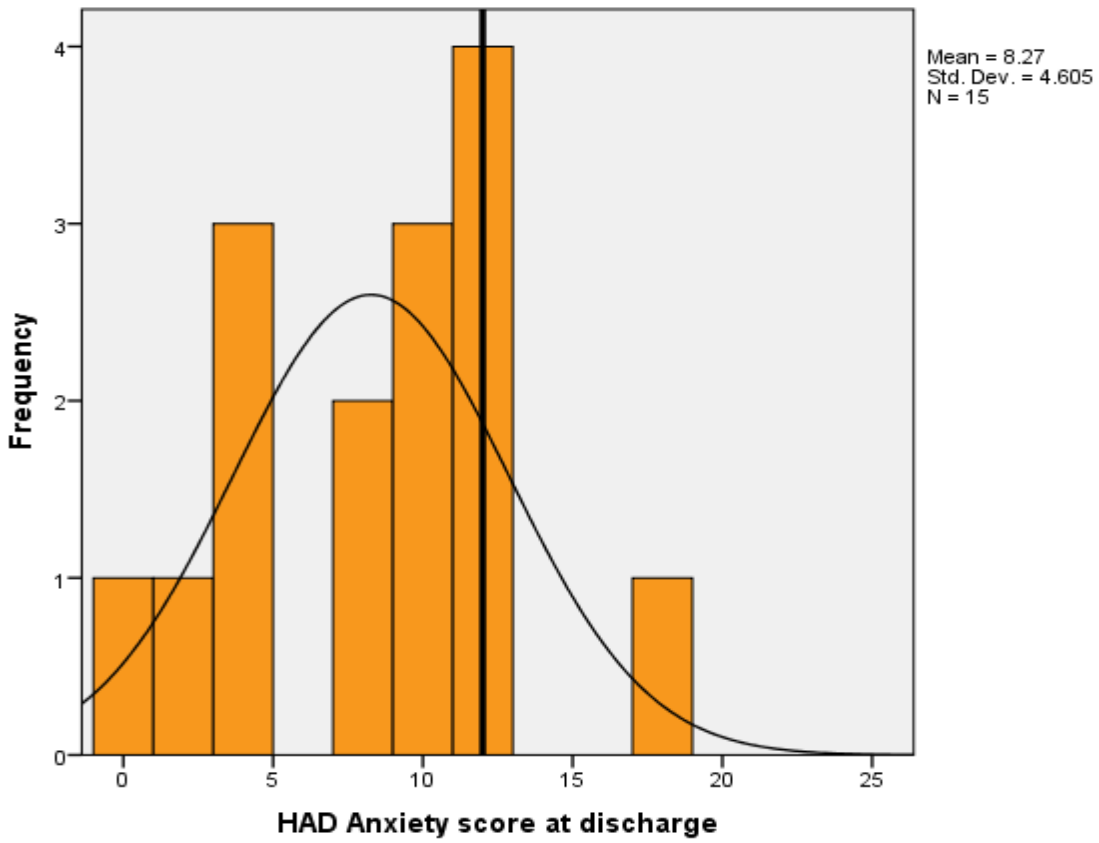
- 40.0% of patients admitted scored 12 or higher on HAD-A at admission
- Of these, 83.3% showed a reduction in score by the time of discharge
- The scores in 100% of those reduced to below threshold

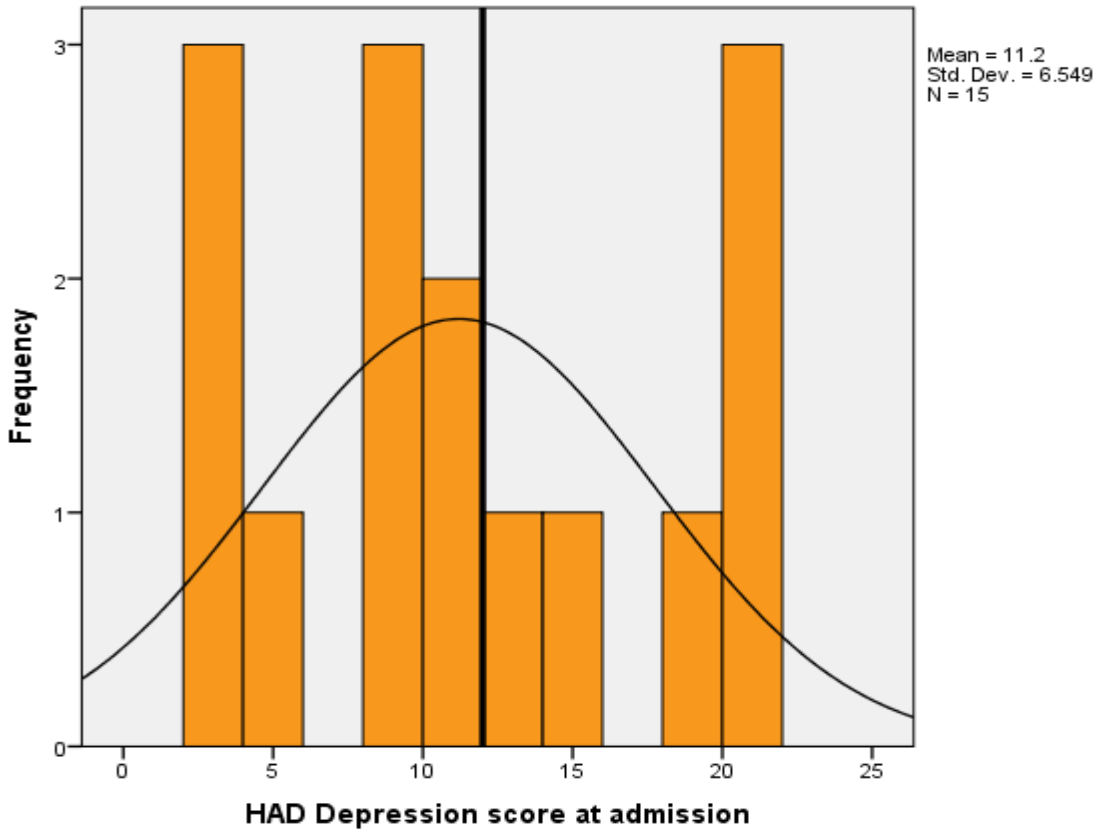
HAD-D:

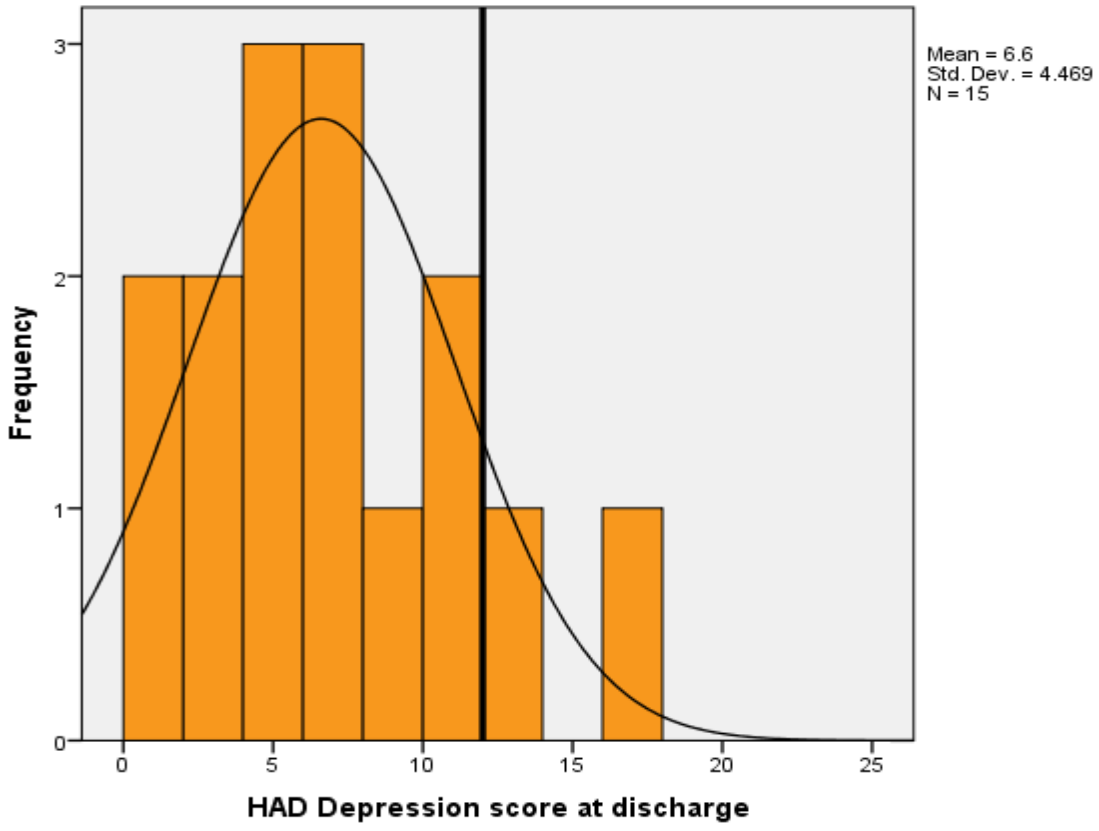
- 40.0% of patients admitted scored 12 or higher on HAD-D at admission
- Of these, 83.3% showed a reduction in score by the time of discharge
- The scores in 80.0% of those reduced to below threshold

(**NOTE**: the following charts have been constructed using the dataset of the whole patient group of 15. They 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 = 10.73
Std. Dev. = 6.386
N = 15
Frequency
HAD Anxiety score at admission


Mean = 8.27
Std. Dev. = 4.605
N = 15
Frequency
HAD Anxiety score at discharge


Mean = 11.2
Std. Dev. = 6.549
N = 15
Frequency
HAD Depression score at admission


Mean = 6.6
Std. Dev. = 4.469
N = 15
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.

April 2019 – March 2020:

- 100% of patients reported that when they were first admitted they were made to feel welcome and were given enough information about the ward.
- 100% reported that they were provided with copies of their care plans always or most of the time.
- 100% of patients rated the NICPM service as either "excellent" or "good"
- 78% 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 2019 – March 2020:

- 100% of carers who responded rated the NICPM service as either "excellent" or "good"
- 75% of carers reported that communication by the NICPM was either "excellent" or "good"
- 86% also rated the support/advice they had received as either "excellent" or "good"

Some examples of patients' written feedback (2019/20):

- "The staff are very approachable, there is a good and positive attitude of staff for both the patients and between staff members. The inquisitive nature of team members was highly appreciated."
- "I have been treated as a person and actually listened to, instead of a doctor seeing the diagnosis as depression and then assuming anything that is wrong with me was due to that. I cannot fault the service at all."
- "Open mindedness of staff. I have felt judged by other services, but the NICPM team is not opinionated – open to anything."
- "What has been good? Everything! Staff are professional and friendly."
- "Having a multidisciplinary team to work with to cover all aspects of treatment and rehab."
- "I feel my health issues have been addressed and that my OT in particular has helped me to do day to day tasks which I will need for home."
- "Excellent care and support from the doctors. Weekly MDT meetings. OT and physio support. Support from key worker."
- "In my honest opinion nothing can be improved. The team already go above and beyond."
- "You got me walking and I've gained a lot of confidence through my time here."
- "Even with no voice, you always took time to talk to me which I find quite overwhelming as it's not always the case in the outside world. Grateful for that."
- "Very attentive key workers, beneficial work with physiotherapist. Very thorough input from OT, good social opportunities. Feeling that I have been listened to."
- "Best things: the groups, 24/7 support, 1:1 time, being around other people around my age, emotional support from staff, the conservatory space."
- "The staff are friendly and welcoming. It is clear that they work well together as a team."
- "Communication and trust - I have learnt to trust the medical profession again, and felt listened to."
- "Staff are helpful and supported me and understood even when I can't explain."
- "The care, support and understanding. The "shoulders to cry on" and make you feel better. Getting back to a daily plan with hope for the future."

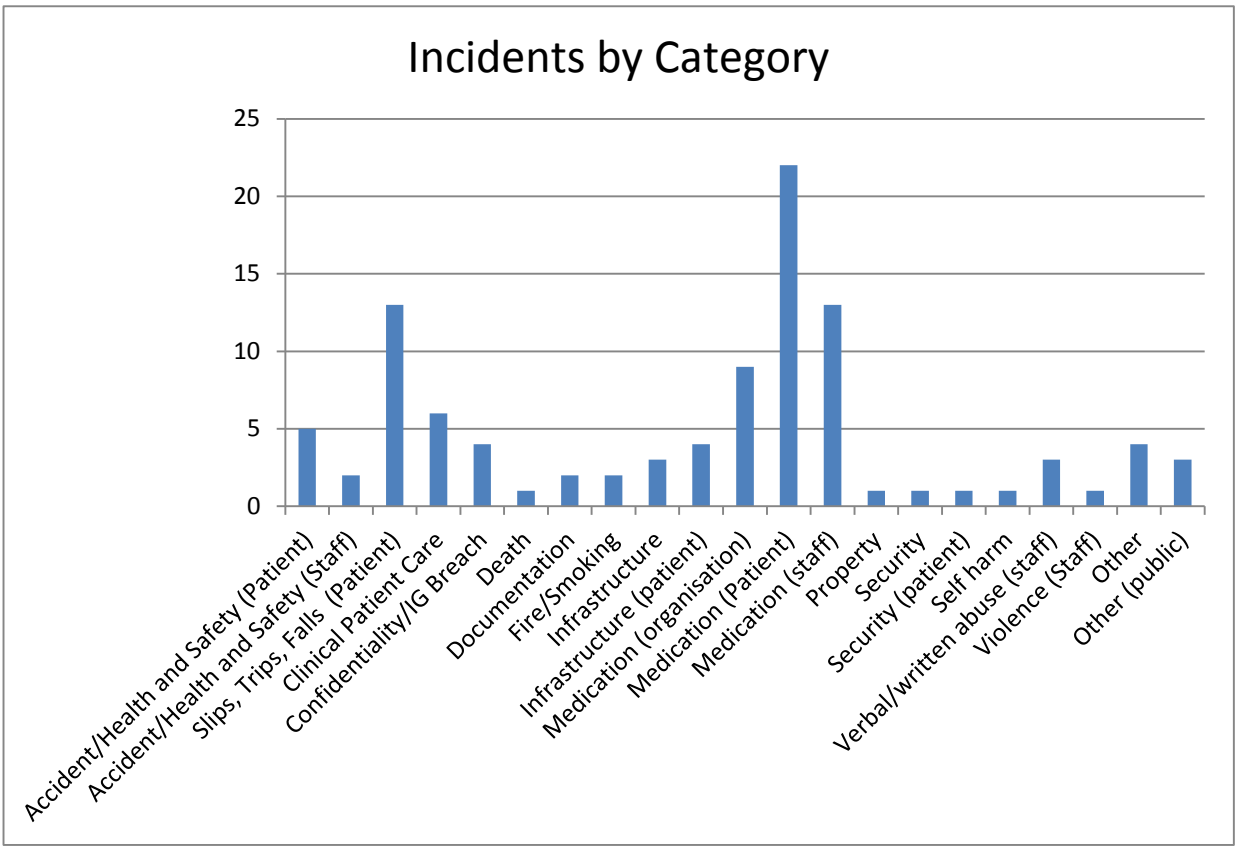
Incidents

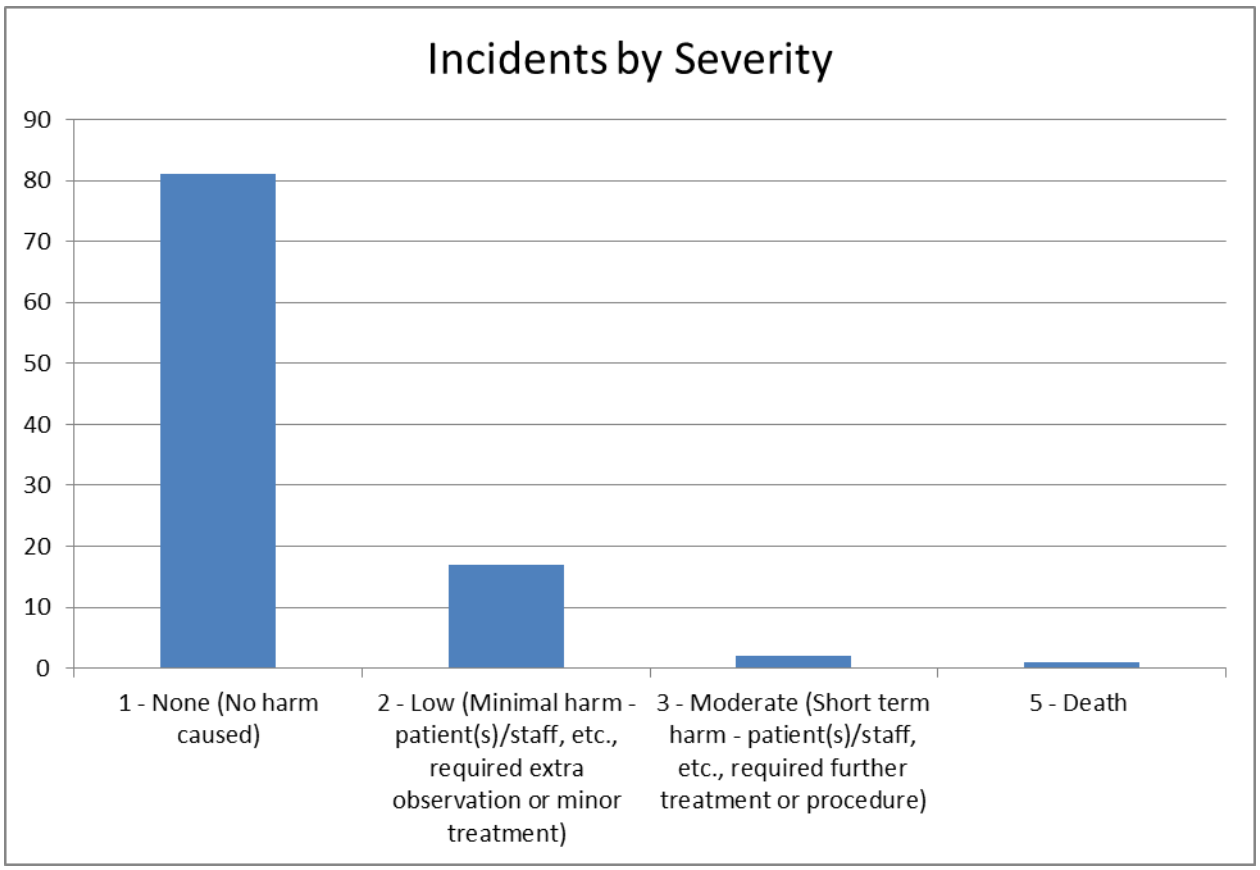
In line with the general approach across the Leeds and York Partnership NHS Foundation Trust, and with what is considered to be a sign of a mature service and team, the NICPM has a relatively low threshold for reporting incidents. As a result, the numbers are not small but, importantly, the incidents seen are almost all of low severity or risk.

As mapped against the National Patient Safety Agency (NPSA) ratings for levels of harm, the incidents during the period of this report (2019-20) were all level 1 ('no harm') or level 2 ('minimal harm'), apart from two at level 3 ('moderate harm') and one logged incident at level 5 ('death'). The latter was the death of a patient before they had been admitted to the unit, ie while on the waiting list for admission.

In total, 99 incident forms were completed within the period to which this report relates, as detailed below.

Incidents reported April 2019 – March 2020





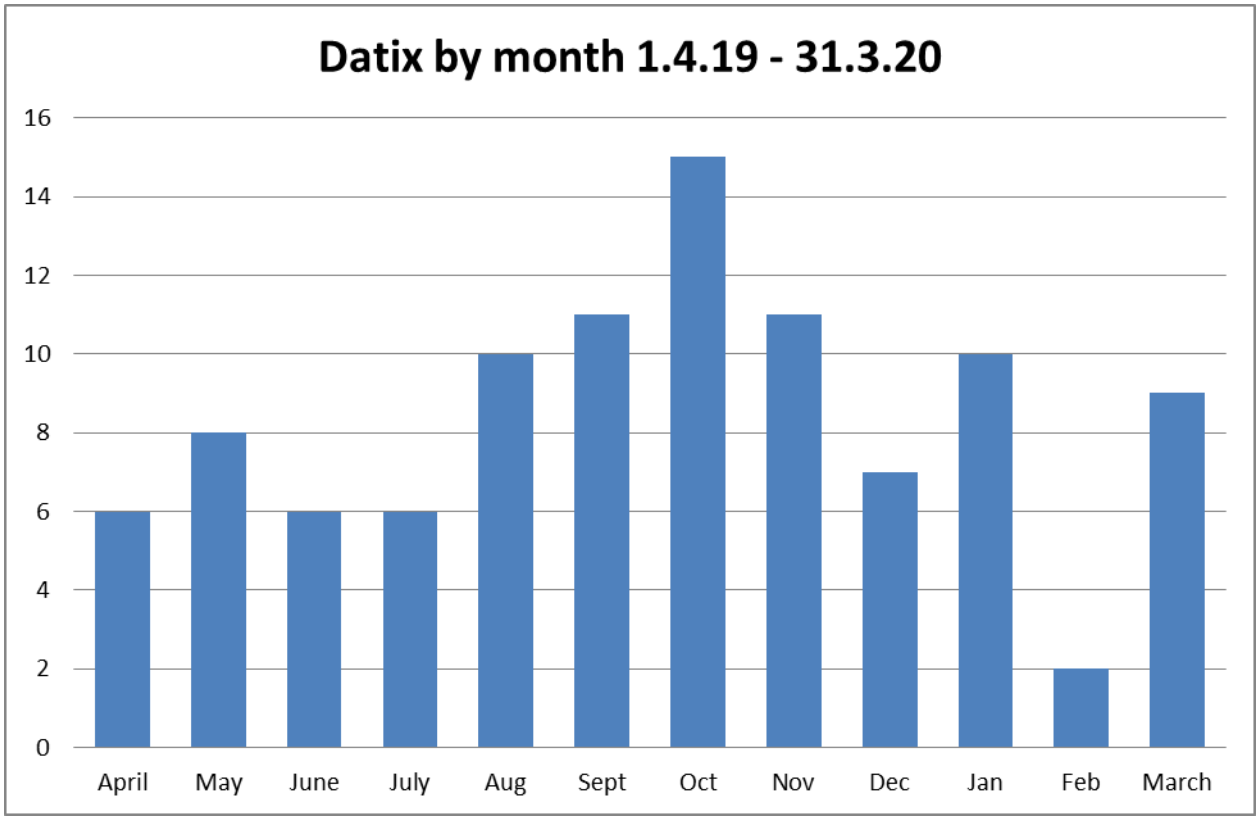
Key:

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 5 incident

Incident date	Description
xx/xx/xxxx	**(Relates to a patient who had not yet been admitted to the NICPM unit.)** The patient was on the waiting list for admission. Upon checking PPM it was noted that patient had passed away, with cause(s) of death listed as Bronchopneumonia and Metastatic breast cancer. DATIX was required to be completed.

Breakdown by month



CQC Rating (April 2018 inspection)

The ratings which the NICPM service and team received from the 2018 CQC inspection were as follows, and we have included some relevant quotations from the CQC Report which help to explain the ratings:

Overall Rating: Good

"The service provided care, treatment and support that was based on the best available evidence and achieved good outcomes for patients. The outcomes exceeded the expectations of patients and made a real difference to the quality of their lives. Patients were fully involved in decisions about their care and treatment and all patients had clear discharge plans. The service had a strong, visible person-centred culture. Staff respected their relationships with people who used the service and empowered patients to be partners in their care. Care plans were personalised and contained meaningful goals for individual patients. Feedback from people who used the service was consistently positive and we observed staff that were kind, caring, respectful, and compassionate. Staff felt proud to work at a service where managers were visible and supported their learning and development needs. Senior staff were knowledgeable and understood the issues the service faced and continued to take action to address the challenges."

Safe: Good

"All patients and staff told us they felt safe on the ward. Staff ensured that the ward environment, and the equipment they used, was safe, clean, and well maintained. The service always had enough regular staff with the right skills, experience, or competencies to fill all shifts."

Effective: Outstanding

"The service had a truly holistic approach to assessing, care planning, and delivering care and treatment. Staff completed care plans with individual patients that were detailed and highly person-centred and reviewed them regularly. All patients knew about and had copies of their care plans. The service provided patients with high quality care that was nationally recognised and based on the best available evidence. Patients told us how the care and treatment they received exceeded their expectations."

Caring: Outstanding

"Patients and carers were consistently positive about the care staff provided. Patients felt that staff did all they could to help them in a respectful, caring and compassionate way. Carers felt the support from the service was excellent and had improved the lives for patients and their families. There was a strong, visible person-centred culture of care where staff worked collaboratively with patients as active partners in their care and protected patients' privacy and dignity. Staff were highly motivated to ensure that patients' needs and preferences were always reflected in decisions about their care and treatment."

Responsive: Requires Improvement

The CQC had some concerns about the current ward facility, but not about the performance or effectiveness of the team. The CQC said "whilst the managers recognised the limitations of the environment, and the difficulties to secure a long-term estates strategy remained on the Trust risk register, the Trust still had no timescale or confirmed plans for the proposed new location for the

service." This is why the rating in this category was "Requires Improvement". These concerns are being actively addressed, with plans now in place to build a new unit in 2020.

The CQC also said "however, the service was specifically tailored to meet each patient's individual needs and preferences. Staff planned, supported, and prepared patients and their families before admission, and patients and their families felt welcomed by the service. The service had a clear admission and assessment process that was entirely recovery-focused and supported patients with a successful discharge."

Well-Led: Good

"The service had a strong culture of patient- centred care that was in keeping with the Trust vision and values. The service proactively involved patients as partners in their care and was committed to achieving positive outcomes for patients and their carers. The ward had a clear model of care and a defined care pathway that fully supported patients' individual needs from referral to discharge. The service was recognised as a national service and staff focused on continuous learning and development to improve their skills and provide high quality care."

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May 2020