National Institute for Health Research

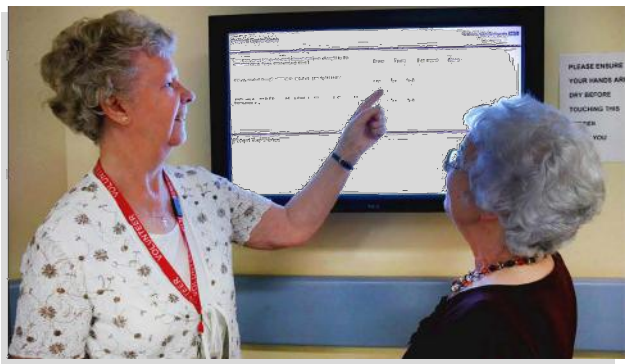
Newsletter

Autumn 2018

NIHR Yorkshire and Humber Patient Safety Translational Research Centre

Welcome to our update about the National Institute for Health Research (NIHR) Yorkshire and Humber Patient Safety Translational Research Centre (PSTRC). Since we were commissioned in August 2017 our research teams have been working to develop ideas, methods and research projects to meet our PSTRC mission: to deliver research to make healthcare safer. Our newsletters showcase our current projects as well as the work we have in development. This edition has two articles about our work to explore low-value safety practices that may be carried out 'in the name of safety' and we also highlight our work around service user and carer involvement in mental healthcare safety and deprescribing (or reducing) medicines for older people. We are keen to know what you think about our work and to hear how you could work with us. If you are a researcher, healthcare professional, patient or business in the region we would be pleased to hear from you. You can contact us by emailing pstrc@bthft.nhs.uk

WHAT IS A PSTRC?



NIHR Patient Safety Translational Research Centres (PSTRCs) work to apply advances in research to patient safety topics. There are three PSTRCs commissioned by NIHR and our PSTRC is a partnership between Bradford Teaching Hospitals NHS Foundation Trust and the University of Leeds, working in collaboration with colleagues at the University of Bradford, University of York and the UK's largest independent, not-for-profit repository for online patient feedback, Care Opinion.

OUR RESEARCH IS ORGANISED INTO FOUR MAIN THEMES:

- Patient Involvement in Patient Safety, aiming to create and test tools that support patient and carer involvement across the pathway of care.
- Workforce Engagement and Wellbeing, working with health professionals and other staff to co-produce and develop the evidence around interventions to enhance workplaces for a positive impact on healthcare safety.
- Safe Use of Medicines, aiming to develop interventions to reduce the prescribing of medicines that are no longer needed and to increase the involvement of patients and carers in decisions about their care.
- Digital Innovations for Patient Safety, working to develop digital solutions that address threats to patient safety and designing and evaluating targeted interventions.

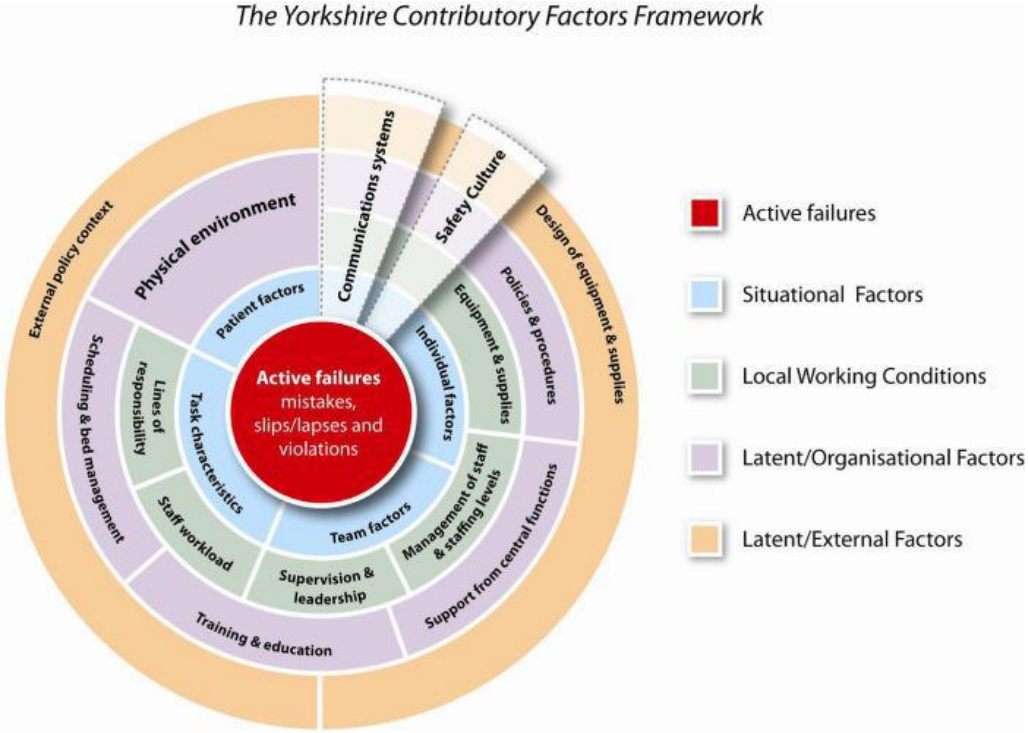
THE PATIENT SAFETY TRANSLATIONAL RESEARCH CENTRE PHD FORUM

PhD students from across the three NIHR Patient Safety Translational Research Centres (PSTRCs) are gearing up to present their work at the first cross-PSTRC PhD network forum on 5th February 2019. The PhD network is a new collaborative initiative between Imperial, Greater Manchester and Yorkshire and Humber PSTRCs and it aims to offer development activities to PhD students from the three Centres, and facilitate them to network and disseminate their research. At the event our PhD students will showcase their patient safety projects and gain feedback from experts from across the PSTRC infrastructure.

The network is co-ordinated by Dr Abigail Albutt and Dr Thomas Mills, research fellows at Yorkshire and Humber PSTRC. Students can register by visiting http://yhpstrc.org/contact/phd-network or by emailing: abigail.albutt@bthft.nhs.uk

SERVICE USER AND CARER INVOLVEMENT IN MENTAL HEALTHCARE SAFETY

NIHR Yorkshire and Humber PSTRC are excited to be collaborating with John Baker and Kathryn Berzins from the Mental Health Research Group at the School of Healthcare, University of Leeds. In 2012, the Yorkshire Quality and Safety Research (YQSR) Group published an empirically based framework of factors contributing to patient safety incidents in hospital settings—the Yorkshire Contributory Factors Framework (YCFF) (Lawton et al 2012). Our collaboration has built on this earlier research, and modified the framework to include important factors in mental healthcare (see Berzins et al 2018a). Two additional factors 'Social environment' and 'Service process' were added to form the YCFF-MH.



SOCIAL ENVIRONMENT:

Concerns about the social aspects of the service environment, for example, lack of activities and other patients' behaviour

SERVICE PROCESS:

Both gaining access to and discharge from services, for example, not being able to access crisis care or being discharged from hospital before feeling suitably recovered

Our ***Patient Involvement in Patient Safety*** theme has been working with John and Kathryn to help us move forward in our understanding of service user and carer involvement in mental healthcare safety. A survey of 185 UK service users, carers and health professionals explored the ease of raising concerns about safety and the potential for service users and carers to be involved in safety interventions (see Berzins et al 2018b).

KEY FINDINGS:

- 77% of service users and carers reported finding it very difficult or difficult to raise concerns
- Services do not listen; concerns about repercussions; and the process of raising concerns, especially while experiencing mental ill health—were frequently cited barriers
- Universal support from health professionals for service user and carer involvement in safety interventions
- Over half the service users and carers supported involvement, primarily due to their expertise from experience.

We are pleased to share that our paper was the subject of a recent blog by Alison Faulkner (@AlisonF101) *'Whose Safety is it Anyway? Service user and carer involvement in mental health care safety'* which was published on Twitter via The Mental Elf (@Mental_Elf). The link to the blog is: https://www.nationalelfservice.net/populations-and-settings/patient-safety/whose-safety-is-it-anyway-service-user-and-carer-involvement-in-mental-health-care-safety/

WHAT NEXT?

We are currently exploring funding opportunities to take this work forward, and we would like to extend a warm welcome to our new PhD student Mary Smith who joined the team in October 2018. Mary's PhD will study the experience of patients and families raising complaints and safety concerns within acute inpatient mental health settings.

For further information please contact: Dr Gemma Louch Gemma.Louch@bthft.nhs.uk
or **Dr Kathryn Berzins** K.M.Berzins@leeds.ac.uk

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IN THE NAME OF SAFETY? - IDENTIFYING AND LETTING GO OF LOW-VALUE SAFETY PRACTICES

BY GILLIAN JANES, LAURA PROCTOR, REBECCA LAWTON

Our ***Workforce Engagement and Wellbeing*** theme is working on an innovative project to identify working practices that are done 'in the Name of Safety' but are perceived by staff to be of limited value. The NHS is characterized by a tendency to add more initiatives to make care safer. Evidence suggests that as much as 25% of healthcare is unnecessary (Grol and Grimshaw, 2003). Staff are overwhelmed as 'the work of healthcare has become undo-able.' (Sinsky and Privitera, 2018).

Story so far….

The Choosing Wisely campaign promotes care that is: supported by evidence, non-duplicative, free from harm and truly necessary. To date, it has focused on removing health technologies and clinical practices that offer little benefit to patients (see Haas et al 2012; Bekelis et al 2017). 'In the Name of Safety' applies similar principles to the removal of non-clinical procedures (Norton et al 2017). Phase 1 involves crowd-sourcing specific examples of practices, perceived to add little or no value to patient safety, from front-line healthcare professionals. This will continue until December 2018.

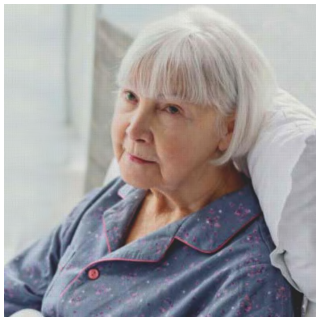
A recent TweetChat @WeNurses shared early findings with the wider healthcare community and provided opportunity to debate and understand some of the challenges surrounding the 'letting go' of currently accepted practices. You can read a summary of the TweetChat here: http://www.wecommunities.org/tweet-chats/chat-details/5226

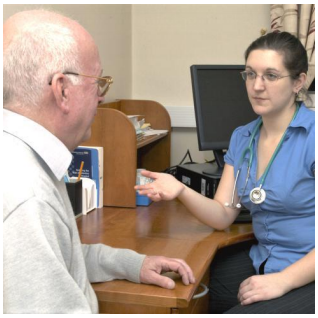
And add your own suggestions for so-called patient safety practices to stop here: https://www.surveymonkey.co.uk/r/7BWHW5H

NEXT STEPS

Caption: Our team planning the #WeNurses tweet chat

We have now secured funding from THIS Institute for a PhD Fellowship to take this work forward. A prioritization exercise will determine which low value safety practices to focus on but the best way to approach this 'mindful forgetting' (Coiera, 2017) in healthcare is unclear (Niven et al 2015; Bekelis et al 2017). Stopping may be more difficult for staff than the adoption of new innovations (Ubel et al 2015). Behaviour change approaches will be used to develop and test interventions to support 'letting go' of low- value practices in the workplace. Ultimately this should improve safety for patients, staff well-being and optimize stewardship of NHS resources.





For further information please contact: Dr Gillian Janes gillian.janes@bthft.nhs.uk

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WHAT PRICE SAFETY? THE HEALTH ECONOMICS OF DIS-INVESTING IN LOW-VALUE SAFETY

BY SILVIYA NIKOLOVA AND CHRIS BOJKE

The 'In the Name of Safety' project will identify non-clinical safety practices which are believed to provide either little or no benefit to patient safety. Following identification it is natural to question whether such practices should be dropped in a process of disinvestment. The underlying rationale and methods developed for the economic evaluation of new technologies are, in principle, appropriate to aid such decisions: if a safety practice delivers no or marginal Health Related Quality of Life (HRQoL) benefit at a sufficiently large cost, then freeing up that money for other use in the NHS could be used to obtain better patient outcomes overall. Adopting the National Institute for Health and Care Excellence reference case evaluation framework and decision rules - if the Incremental Net Health Benefit of a safety practice is below zero, then it would be optimal to cease that activity and use the money elsewhere to more effective means.

Early-stage economic modelling based on available data can be used to help identify which of a potentially long list of practices should be short-listed for consideration. Application of Value of Information techniques can supplement these early models to identify whether it is optimal to make definitive judgments on disinvestment decisions with current evidence or whether further information is required. If disinvestment of a particular practice is subject to uncertainty which means it is unclear regarding the impact on HRQoL and/or costs and the practice uses up a relatively large amount of NHS resource, then this identifies it as a priority for future research.

There are however issues within the evaluation framework that should be considered before application to disinvestment in safety practices. For example, is the default £30,000 per Quality Adjusted Life Year (QALY) threshold used by the NICE in decisions of adoption relevant for decisions of disinvestment? Arguably not, the current threshold contains ad-hoc valuations of 'innovation' which does not exist in disinvestment decisions. Furthermore is the value of safety practices wholly captured by HRQoL and/or is the assumption of risk-neutral patients tenable; could we undervalue practices by ignoring attitudes towards risk? In applying established economic concepts to aid better decision-making in disinvestment we will also seek to address these broader methodological issues.

SPOTLIGHT ON DEPRESCRIBING MEDICINES

With the UK's ageing population, the use of medicines has become more prominent in recent years. And although drug therapy is necessary to improve health and quality of life, it is known that patients who have to take multiple medicines often struggle to understand what each medicine does or even how to take them correctly. Also, the more medicines patients have to take, the more difficult it becomes to understand how medicines interact with each other, or identify which medicines are still appropriate.

People on multiple medicines, particularly those who are older, face other challenges. For example, they are not always sure of why they were started on some medicines, or fail to recognize the benefit of continuing to take them as prescribed. Healthcare professionals try to detect these problems by reviewing patients regularly, and identifying medicines that are no longer appropriate has become a priority in these reviews. The process of tapering, stopping, discontinuing or withdrawing medicines, known as deprescribing, has become a prominent strategy to reduce problematic prescribing, ease patient burden, increase adherence to treatment and quality of life. However, stopping medicines can be an emotional and even difficult experience, particularly if patients have been on medicines for a long time and do not understand the reasons for stopping them.

Our ***Safe Use of Medicines*** research theme is focusing on how we can stop medicines safely. Specifically, we are interviewing patients, healthcare professionals, and informal carers to investigate how medicines are stopped in primary care, what helps or hinders this process, and how patients and healthcare professionals feel and experience these consultations. These investigations will help us increase the safe use of medicines through the development of processes that ensure patients receive the information and support they need when medicines are stopped, and play a central role in these discussions and decisions.

If you have any questions about our deprescribing research contact: Dr Janice Olaniyan J.O.Olaniyan@bradford.ac.uk **or Dr Iuri Marques** I.Marques@bradford.ac.uk

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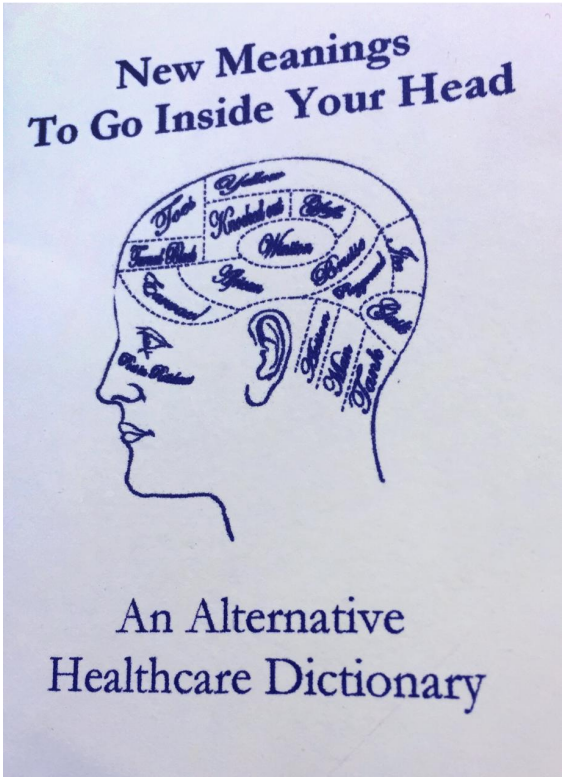

We have been working with our Citizens' Participation Group to pilot methods to develop easy-to-understand definitions for patient safety research concepts. Local poet Winston Plowes @WinstonPLowes and our Patient and Public Involvement team piloted a workshop method to explore what patient safety means to people so we can improve our communication about patient safety topics and create a new patient safety mini-dictionary. See our next newsletter for more information.

Read more about our Patient and Public Involvement and Engagement strategy on our website: http://yhpstrc.org/about-the-pstrc/patient-involvement/

Contact us

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