NIHR | Yorkshire and Humber Patient Safety Translational Research Centre

Winter 2019-20 Newsletter

NIHR Yorkshire and Humber Patient Safety Translational Research Centre

Welcome to our Winter 2019-20 newsletter!

This edition intoduces you to one of our new researchers, George Peat, who has joined our Safe Use of Medicines theme. We have a project update from our health economics experts, Professor Chris Bojke and Dr Claire Sloan, who have taken a fresh look at the relationship between staffing ratios and incidents on mental health wards. We also tell you about the popular conference we co-hosted in October 2019: *Improving Patient Safety: New Horizons, New perspectives.*

Finally, we introduce you to our new project **'Patient and family involvement in serious incident investigations: Developing and testing national and local guiding processes'**. This exciting new research programme will use a process of co-design with stakeholders to guide the role of patients and families in serious incident investigations.

CONTACT: To find about more about us you can visit our website at **www.yhpstrc.org** or get in touch with us via email at **pstrc@bthft.nhs.uk** **or twitter @YH_PSTRC**

Meet our new Safe Use of Medicines Research Fellow

George Peat joined the Yorkshire and Humber Patient Safety Translational Research Centre in October 2019 as a Research Fellow. George is working on the 'deciding to deprescribe' project within the Safe Use of Medicines theme. His research interests include using phenomenological research approaches to uncover the experience of marginalised groups within healthcare, exploring notions of identity relating to living with a long term or life limiting condition, and identifying the mechanisms that patients use to support their psychological and social wellbeing. George has experience in using a range of qualitative methodology, and strives to develop new and innovative qualitative methods that attend to the needs of the participant. George's research background is in Psychology, having graduated with a BSc and MRes in Psychology from the University of Huddersfield. He is currently in the final stages of writing up his PhD thesis on the use of social media and gaming by young men with neuromuscular conditions. In his spare time George enjoys cooking, being outdoors, and growing vegetables with varying degrees of success!

Spotlight on: Patient-staff ratios and incidents on mental health wards

By Claire Sloan and Chris Bojke

Our analysis as part of the Health Economics Study Group (HESG) working paper series looks at the relationship between patient/nurse staff ratios and incidents on inpatient mental health wards. Although the issue of safe staffing is far more complicated than a simple patient/staff ratio, this metric has been the focus of much of the literature and incorrect results could exacerbate problems that mental health services are currently facing.

Last year, NHS digital reported that 23,686 mental health staff left the NHS between 2016-2017, with members of Unison citing less resources, a surge in patients, too few staff and rising stress among workers as key reasons for resignations. This can become a vicious cycle, as increased nurse stress leads to poor staff retention, and a survey of 1,000 mental health employees found that over a third of respondents felt that violent attacks had risen in the last 12 months, with a lack of staff being the most common reason given for the rise in incidents. As Anderson (2002) noted, nurses working in psychiatric wards already experience the highest risk for workplace violence, so it is important to ensure that staffing levels are decided with the safety of both patients and staff in mind.

Our motivation for this research was in part due to the lack of evidence on nurse staffing levels in a mental health setting. . In this study we used longitudinal data from a single trust over a period of 3 months (January 2016 – March 2016). In total, there were 9 wards which provided data on staffing, patient population and incidents. Staffing data were limited to Registered Nurses (RN), Health Care Assistants (HCA) or other and whether the staff or trust, bank or agency. Analysis of the data resulted in identifying different patient/staff ratios between wards that are not fully explained by observable patient characteristics. We concluded that variations in patient/staff ratios are likely to be endogenous, perhaps because more registered nurses would be systematically allocated to wards where there is an expectation of higher rates of incidents.

This challenges the conclusions of existing literature, which is dominated by The City-128 study (Bowers 2006, 2012) - an observational 6 month study of 136 acute psychiatric wards in 2004-05. The surprising conclusion from the study was that greater numbers of qualified nurses systematically lead to an increased probability of incidents, with a post-hoc rationalisation suggesting that junior staff are less likely to confront disruptive patients or deny their requests, which could in turn prevent patients' agitation escalating enough to cause an incident. However, we argue that the results observed within City-128 are more likely to be caused by a lack of consideration for how patient/staff ratios are

determined across wards. Given that the nature of patients' conditions differs between wards, some wards could be expected to have an increased risk of incidents which results in more registered nurses being allocated to them.

Despite caution from the authors against using the results for lower staff numbers, subsequent studies have gone on to find low-staffing options to be the most cost-effective (Kartha and McCrone, 2019). This is concerning as such findings could be used by policy-makers to justify low-staffing options when considering the NHS budget. Mental health services are particularly expensive to fund, as the average UK cost of an acute inpatient stay in a psychiatric unit is £11,500 per patient (McDaid, 2016). This can explain the reluctance for policy-makers to increase the number of staffing and beds in mental health wards, despite the evidence from the Care Quality Commission (2018) that more is needed to cope with the increasing demand for services. It is our hope that with more research highlighting the pressures faced by mental health wards, better decisions concerning the volume and composition of staff levels can be made to improve staff retention and rates of incidents.

References

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Improving Patient Safety: New Horizons, New perspectives

In October 2019 the PSTRC, along with colleagues from the Improvement Academy, NIHR CLAHRC and the Partners at Care Transitions programme team, hosted a two-day national patient safety and quality improvement conference in Leeds. Improving Patient Safety: New Horizons, New Perspectives was attended by over 200 delegates and brought together clinicians, academics and policy makers to discuss the latest patient safety research and quality improvement projects and methods. The conference trended on Twitter as delegates shared their responses to the talks and workshops during two packed days of keynotes, breakout sessions and workshops.

Director, Rebecca Lawton, opened the event and introduced the first keynote speaker Suzette Woodward, from the Department of Health and Social Care, who got the conference off to an energetic start. Suzette's talk focussed on joy, positivity, gratitude and wellbeing, motivating the audience to be part of more positive and courteous workplaces. Philip Lewer, Chairman, Calderdale and Huddersfield NHS Foundation Trust, offered reflections on the conference at the end of its first day and offered tips on communicating clearly about safety systems, giving each member of the audience a pair of socks to help emphasise the key message.

Professor Bryony Dean Franklin, UCL School of Pharmacy

Tessa Richards, Senior Editor, The British Medical Journal, urged us to share ideas, decisions and power with patients and the public.

On day 2, Mary Dixon-Woods' powerful keynote talk outlined the history of and implications around voice and safety in healthcare.

Adam Kay, comedy writer and former doctor, emphasised the importance of supporting staff who experience errors and trauma in healthcare, as well as keeping the audience laughing with highlights from his bestselling book "***This is Going to Hurt***".

In addition to the headline talks, the conference offered a programme of interactive workshops and breakout sessions. Topics ranged from supporting safety at transitions for older people to the safety of digital innovations in the NHS. Poster sessions allowed in-depth discussion about ongoing research and improvement projects.

We have been overwhelmed by the positive feedback from delegates who particularly appreciated the mix of patient/public, clinical, academic and policy delegates which enhanced the quality of conversations. They commented on the collaborative and friendly atmosphere. Some have shared what they have learnt with colleagues and are already planning new related projects.

Delegates can still access presentation slides by visiting the conference website: **https://improvementacademy.org/training-and-events/2019/10/15/impsaf-conference/**

We also invited delegates from other professions to take part. You can read how veterinary delegates who ran a workshop with PSTRC researchers, benefited from the event by reading their blog here: **http://rcvskblog.org/improving-patient-safety-new-horizons-new-perspectives/**

If you would like to register to receive information about future events please email **impsaf2019@bthft.nhs.uk**

Mary Dixon-Woods, Director, The Healthcare Improvement Studies (THIS) Institute

Olivia Joseph, Research Fellow, Bradford Institute for Health Research

Dr Michael McCooe, Bradford Institute for Health Research/BTHFT, congratulating the poster winners

Patient and family involvement in serious incident investigations: Developing and testing national and local guiding processes

Summary of research

This project sits within the Patient Involvement in Patient Safety theme. The research runs from November 2019-February 2023 and is funded by the National Institute for Health Research. The research aims to co-design processes and resources to guide the role of patients and families in serious incident investigations at a national and local level, and to test these processes to understand their impact upon experience, learning and likelihood of seeking legal recourse.

Who is involved?

The research is led by Dr Jane O'Hara (School of Healthcare, University of Leeds) with support from other PSTRC members (Professor Rebecca Lawton, Dr Gemma Louch, Professor John Baker), and collaborators from Sheffield Hallam University and the Universities of York, Birmingham, and Nottingham.

Why is this project important?

It is estimated that ten thousand cases involving harm or death are reported in the NHS every year. There is a need to improve the process of learning from such serious incidents to reduce occurrence and the associated trauma. A key to understanding these cases lies with the patients and families that have been through a serious incident since this group are experts by experience, with crucial knowledge about care failures that the health service can learn from. Although indications suggest that greater involvement of patients and families leads to better learning from these incidents which then minimizes occurrence, there is currently no UK-based evidence to guide organisations in meaningfully involving patients and families in serious incident investigations. In order to improve care for patients the system must improve how it learns from past care failures.

PFI-SII

Involving Patients and Families in Serious Incident Investigations

What are we doing?

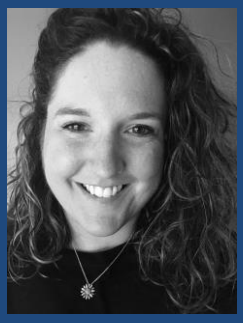
Over the course of the project the research team will work collaboratively with patients, families and healthcare staff (key stakeholder groups) to design guidance for NHS trusts and the national independent investigations agency for healthcare – the Healthcare Safety Investigation Branch. Through a process of co-design with stakeholders, resources will be developed to guide the role of patients and families in serious incident investigations.

Ultimately it is anticipated that this guidance will help healthcare services to work sensitively and transparently with patients and families after serious safety events, to learn together about what has gone wrong, and what might help prevent future recurrences.

Follow us on Twitter: **@PfiSii**

Meet the PFI-SII Research Team

Siobhan McHugh



Siobhan joined the PSTRC in November 2019 as a Research Fellow on the PFI-SII project (Patient and Family Involvement in Serious Incident Investigations). Although new to the PSTRC, she has been a PhD student in the Yorkshire Quality and Safety Research group since October 2016, and is currently in the final stages of writing up her PhD. Her PhD work focuses on the use of video-reflexive ethnography to improve teamwork and communication in the multi-disciplinary clinical handover, specifically within maternity services. Siobhan graduated with a BA (Hons) in Natural Science, and then went on to complete a BSc (Hons) in Psychology and an MSc in Health and Exercise Psychology. In her spare time, (when not writing up!), she can normally be found at the side of a rugby pitch shouting instructions, playing the piano, watching netflix or enjoying a good book.

Katherine Ludwin

Hello! I joined the study team at the end of 2019 as a Research Fellow and am really excited to be working on such an important and methodologically innovative project. A sociologist by background, I have over ten years of qualitative research experience, most recently in a health studies context. My PhD was rooted in gender studies and focused on social expectations about what it means to live a 'normal' family life. I subsequently worked on several research studies at the University of Bradford related to the lived experience of dementia, using adapted approaches to interviewing and ethnographic methods as a way to explore issues in-depth. During my time at the university I taught on the dementia studies undergraduate and postgraduate programmes, working with care home staff and nurses to improve practice in relation to dementia care. During my spare time, when I'm not hanging out with my kids, I might be watching a documentary or deconstructing the odd soap opera!

Ruth Simms-Ellis

I will officially join the team as Programme Manager in April 2020. I'm a work psychologist and have spent many years as a consultant, helping organisations at individual, team and strategic levels to reduce stress, build resilience and enhance functioning. At the University of Leeds I guest lecture on the topics of work and health psychology at undergraduate and postgraduate levels. Through my career, I've focused particularly on supporting people exposed to traumatic events. In the banking industry, I helped establish a peer-debriefing system for teams involved in armed robberies and developed a national anticipatory anxiety programme to boost team resilience in the event of a robbery. I also worked clinically, assessing and treating military personnel with Post-Traumatic Stress Disorder for the Ministry of Defence within their Department of Clinical Psychology at Catterick Garrison, North Yorkshire. More recently, within the NHS I've been involved in numerous projects to support the "second victims" (i.e. healthcare professionals) of patient safety incidents or adverse events. These include: (i) a national second victim website resource (https://secondvictim.co.uk/) to support NHS staff with adverse events, (ii) a proactive, psychological intervention to help NHS staff cope after involvement in adverse events, (iii) an intervention to help staff disclose adverse events to patients and families. I'm also on the Steering Group for the 'Just Culture' Network, led by the Improvement Academy. For futher information please click here. In my spare time I love singing, going to gigs and weekend getaways – especially to Edinburgh where my daughter's studying.

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