Minutes of the Derby Medical Society
Wednesday 16th October 2019

Apologies

Susie Hewitt
Mr Klezl
Alastair McCance
Dave Young
Shehla Imitiaz-Umer

Sharing Data and Making Patients Safer
Examples of Local and National Initiatives

Speaker
David Mullett
Champion for Quality improvement and Patient Safety at RCGP

David is the only RCGP Champion who is not a clinician.

He started by saying he was not going to talk about data extraction or Information Governance!

What is patient safety? - Avoiding harm to the patient caused by the care provided.

What is data?
An attempt to understand the real world and patient interactions that a computer can understand and process.
It is expanding and understanding “unknown unknowns”
There are many data sources in the NHS and outside in Social Care, ONS deaths and national demographic databases.

David leads a project on collaboration between the RCGP and Clinical Practice Research Datalink (CPDR), part of the MHRA.
The CPDR contains data from 1500 GP surgeries, hospital data, ONS deaths.
It aims to support quality improvement in Primary Care by focusing on prescribing and patient safety data. It monitors effects of licensed drugs and MHRA safety.

Reports produced
1. Heart and circulatory system and drugs prescribed with C/I for use in heart conditions
2. Valproate for people of childbearing age
3. Patients with Learning Disability or Autism and the prescription of psychotropic drugs

CPRD data sets are used in other safety studies.

Vaccine Safety

Herd immunity for MMR is reducing.
17 million lives saved by measles vaccine in the last millennium. Data shared by GP surgeries has helped to prove the safety of the vaccine.
90% of babies who died of pertussis in last 6 years were born to unvaccinated women.

Sharing of vaccination data has enable the JCVI (Joint Committee on Vaccination and Immunisation) to recommend that pertussis vaccination is offered to all pregnant women from 20 weeks gestation to reduce neonatal pertussis deaths.

RCGP Research and Surveillance Centre

This data set looks at data from 500 practices across England.
Public Health England (PHE) reviews this data to assess the occurrence of a flu pandemic.
When thresholds of incidence are reached this can help notify PHE to take further action. PHE also use laboratory and Acute Trust data.

National Reporting and Learning System (NRLS)

This is the mechanism for gathering data on patient safety incidents.
Last annual report documented 2 000 000 safety incidents in the year April 2018 to March 2019.
4568 deaths occurred from April 2018 to March 2019 among the reported safety incidents.
The reporting is not to apportion blame but to learn lessons and make changes to practice.
Practical guide has been produced for General Practice to look at safety incidents and look at how practice can change to reduce risks in the future.
"Swiss cheese model" of patient safety:

- Clinic design
- Administrative support
- Technical support
- Culture and leadership

Lots of areas could look at improvement to reduce the risk of errors.
Important to avoid blame and look at the system.

Linked Data Sets

Hospital, mental health and GP data was linked to look at: Predicting falls and when to intervene in older people.
Who was likely to be admitted with a hip fracture?
Common factors were found and allowed risk modelling to predict those at risk of falling and offer help before an injury occurs.

East Kent Local Hub has linked hospital and GP records to improve communication and alert relevant parties if a patient accesses care.

Sussex integrated data set links information to understand population health and support transformation.
6 main questions to answer using integrated data:

- Could Social Care have intervened and offered help earlier?
- What is the cost of a patient with diabetes and heart failure over a year?
- Is Social Prescribing a cost effective intervention in reducing health care use?
- What are the actual paths patients take when accessing healthcare?
- What would a population management perspective of mental health admissions look like?
- Where are the unwarranted variations in healthcare that we can address to improve patient outcomes?

Questions

The vulnerability of the elderly placed elsewhere after hospital discharge with a poor handover.

- Work is ongoing but poor handover is an issue.

CEPOD reviews and death analysis. Why do we look at failure and not success?

Non-medical sources of data via Apps, other databases.
There are plans to use health-app data but it is difficult to assess useful data among the volume of data sources

How are medication alerts disseminated

Thanks given by Dr Sarah Milner

Announcements

Annual Dinner
Final deadline for tickets is extended to 2nd November

Applications of the medical student elective Bursaries are open. Closing date is end of November 2019 and is open to current final year medical students.

Register

22 Members
10 Students
2 Guests

Key Learning Points

Collaboration between the RCGP and Clinical Practice Research Datalink (CPDR) has among other projects, enabled the JCVI (Joint Committee on Vaccination and Immunisation) to recommend that pertussis vaccination is offered to all pregnant women from 20 weeks gestation to reduce neonatal pertussis deaths. This is GP practices sharing data.

The National Reporting and Learning System (NRLS) last annual report documented 2 000 000 safety incidents in the year April 2018 to March 2019.
4568 deaths occurred from April 2018 to March 2019 among the reported safety incidents.
The reporting is not to apportion blame but to learn lessons and make changes to practice to improve patient safety.

Linked data sets work. Projects that linked Hospital, mental health and GP data looked at predicting falls and when to intervene in older people.
Common factors were found and this allowed risk modelling to predict those at risk of falling and offer help before an injury occurs.

Date of next meeting

6th November 2019