To note

Patient Safety Intelligence Forum: July 2015 update

Issue

1. At its meeting on 13 February 2014, the Strategy and Policy Board agreed to establish the Patient Safety Intelligence Forum.

2. We have committed to provide a biannual review of the Forum’s work to the Board. Accordingly, this paper provides an overview of our work over the past six months and presents the key findings of a rapid internal review of the function and impact of the Forum.

3. Building on the key learning points from this, we propose a forward programme of work to further develop the capability of the Forum over the next 12 months. The proposed actions have previously been considered by Directors and are therefore presented here as a below the line paper.

Recommendation

4. The Strategy and Policy Board is asked to note the progress made to date and our plans for the next 12 months.
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5 The Patient Safety Intelligence Forum (PSIF) was established in February 2014. Its purpose is to coordinate information that may demonstrate concerns about patient safety or medical practice and ensure the appropriate response. It is supported by the Regulation Policy Team (RPT).

6 Drawing on a review of PSIF over the previous 12 months, this paper identifies priority areas for development over the coming year.

Progress to date

7 We provided our last PSIF update to the Strategy and Policy Board in October 2014. We committed to undertake further action to improve the process for referring and presenting information to the forum, and to clarify the levers available to PSIF when action is required.

8 Over the past six months, we have:

a Revised the PSIF template to better track emerging issues (see Annex A).

b Introduced a cross-directorate triage group to inform decision making by PSIF with regard to the sufficiency of proposed regulatory actions.

c Piloted a provisional risk assessment tool to review issues referred to the triage group and formulate a suitable recommendation for PSIF’s consideration.

d Developed draft escalation criteria to inform future referrals to PSIF.

9 The challenge remains to clarify the levers that are available to PSIF and the circumstances in which these should be employed. While we have taken some initial steps to address this point, this will now be considered as part of an cross-directorate project, led by the Office of the Chair and Chief Executive (OCCE), to clarify the GMC’s regulatory protocols (and how these interrelate with the powers of other relevant organisations).

10 Since our last update, a Significant Event Review (SER) has been held into the handling of events surrounding the publication of external reports into the quality of care at Aberdeen Royal Infirmary (NHS Grampian). This recommended that PSIF clarify its purpose and the type of issue that should be referred to it (as well as reiterating the need for formal escalation criteria and defined regulatory levers). We have committed to reporting back to the Audit and Risk Committee in November 2015, in the context of the report of the ongoing audit of our use of intelligence which the Committee will consider.
In addition, the SER concluded that PSIF is not equipped to handle rapidly developing situations. The SER suggested that smaller ‘SWAT’ style teams could provide closer management and co-ordination of information flows as events unfold. Over the coming months we will develop draft criteria for determining when such groups should be established and their governance once in place.

Rapid Internal Review

To inform our programme of work for the next 12 months, we have undertaken an analysis of supporting PSIF documentation (the PSIF template and accompanying decision log) for the 10 meetings held between March 2014 and April 2015. The analysis identified 107 discussions (one per site) covering 28 separate sites.

The key findings were:

a. As of April 2015, 10 sites had been closed for consideration at PSIF and 18 were still open (an additional nine sites were subsequently closed or deferred at the May 2015 meeting). At the time of this review, seven of these sites have been open since the first PSIF meeting in March 2014.

b. A range of issues prompted consideration at PSIF – of which the three principal reasons were issues relating to clinical quality, systems concerns, and quality of training (see figure 1 in Annex B).

c. The most frequent sources of concern for referral to PSIF were the Employer Liaison Service (ELS), the Education and Standards directorate, and external reports/indicators (see figure 2 in Annex B). It is interesting to note that our primary patient safety indicator – Fitness to Practise data – served as a prominent source of concern in only five cases.

d. Of the 107 discussions, 10 recommended closure of the case and 97 recommended continued monitoring (of these, 36 discussions had no specified follow up action).

e. Where actions were specified, these were grouped into two categories – either a request for internally held information or a request for external action (for example, engagement with the relevant Deanery, engagement with the relevant Responsible Officer, Chief Executive discussion with national bodies/senior leadership of health providers, deferral of revalidation recommendations) (see figures 3 and 4 in Annex B).

In conclusion, the length of time taken to close cases coupled with the tendency to ‘continue monitoring’ might suggest one of two things. Either we do not have the appropriate regulatory interventions to tackle the types of risk that these cases present or our regulatory interventions are not producing the desired effect. It may also suggest a lack of clarity over why we have referred an issue to PSIF and the challenge to identify an appropriate remedial action as a result.
15 However, given that externally reported system concerns are one of the three key reasons for PSIF referrals, it seems more likely that we are referring issues that go beyond the remit of the GMC. This may also explain why the majority of actions taken to date have been relatively soft in nature (for example, request for engagement, Chief Executive contact) as opposed to utilising our more formal regulatory levers.

16 In addition to the analysis referred to above, we have surveyed the views of PSIF members, the triage group and supporting data teams to provide a baseline measure of performance and to identify areas for improvement.

17 Respondents acknowledged that real progress had been made in bringing about increased coordination to our data, helping to break down historical silos in the process. However, this was balanced by a sense that PSIF is still maturing and hasn’t yet realised its full potential. Respondents felt that PSIF would therefore benefit from action in the following areas:

a Clarifying the purpose of PSIF and addressing the perceived overlap between PSIF and operational decision making (therefore clarifying the added value of PSIF). Suggestions for improvement included repositioning PSIF as a strategic function tasked with articulating and overseeing the delivery of a corporate harms reduction strategy, refocusing PSIF’s attention on issues where a cross-directorate response is required and better articulating the tools available for intervention.

b Articulating clear criteria for referring sites to PSIF and communicating the reason for referral to teams supplying data (there was a sense that PSIF was not always considering the ‘right’ sites and secondly that additional relevant intelligence could be identified if the rationale for referral was more explicitly conveyed).

c Improving our understanding of the supporting data to better identify the nature of the problem and the type of intervention that might be applied. Suggestions included developing a weighting system to inform analysis of intelligence and developing ‘provider profiles’ to establish baseline characteristics for benchmarking.

d Taking steps to improve the transparency of PSIF. Suggestions for improvement include developing external lines on the role of PSIF and clarifying our process for notifying external organisations if referred (and considering what it means, from a practical business perspective, to designate a provider as a ‘PSIF site’).

18 The full report of the survey can be found at Annex C – and more detailed consideration will be given to the findings at the next meeting of PSIF.

Future development of the Forum

19 Much of PSIF’s focus to date has been reactive in nature – for example, responding to a critical external report or the removal of trainees from an institution. It has not yet addressed the risk of such events occurring.
Adopting a risk-based intelligence led model will help to situate PSIF’s focus further upstream and, through focusing on the risks of such events occurring, will allow us to consider how these can be mitigated through intervention (bringing about increased alignment with our work on prevention). Therefore, to help deliver this, our focus over the coming year will be on supporting the development of a GMC intelligence model (to be led by the Intelligence Unit).

The model will involve commissioned research to identify leading quantitative indicators of risk at both cohort and site level (albeit focusing on areas of GMC interest – for example, areas at risk of referral to Enhanced Monitoring and areas at risk of serious and sustained breaches of Good medical practice). While focusing on cohort level risks will promote greater alignment with our statutory functions, it will also provide additional options for intervention and, when overlaid with site based information, will provide a richer picture of risk at this level.

As part of the scoping exercise, the Intelligence Unit will consider how the model can support the identification of patterns and trends in concerns that are referred to us – to understand the common factors that characterise cohort risk, the moderating impact of systems factors and the contributory factors that underpin specific ‘harms’. In the medium to longer term, the model will capture emerging concerns and ‘regulatory noise’ concerning issues of interest, with a digest prepared for PSIF’s consideration where particular risks warrant a policy or communications based response.

We anticipate that a feasibility study for developing the model will be completed by early 2016. This will aim to identify a subset of leading indicators for both cohort and site level risk and consider how these might be combined. In addition, it will set out a roadmap for completing the leading indicator work (incorporating qualitative information) and enabling automated detection of risk through the Data Strategy.

Secondly, and acknowledging that this may never provide a complete failsafe mechanism for detecting risk, we will take interim steps to facilitate information sharing at an operational level to ensure that referrals to PSIF are jointly formulated and considered, and derived from more meaningful and accessible information.

To support this, we will recommend a requirement for regional leads and teams to discuss and triangulate local concerns prior to PSIF referral, building on initial work in the London region. We will develop a proforma to support this process, improving the consistency of referred information, focusing attention on areas of interest (which may include reputational risks and policy based issues in addition to site and/or cohort level risks) and reducing reliance on anecdote and subjective impressions.

These steps should help to address the issues identified in paragraphs 14-17 and provide greater clarity on the purpose and scope of PSIF. We will review the Terms of Reference in light of the proposed changes and, will seek the Board’s approval should amendments be required.
Supporting information

How this issue relates to the corporate strategy and business plan

27 Strategic aim 1: to make the best use of intelligence about doctors and the healthcare environment to ensure good standards and identify risks to patients.

How the issues support the principles of better regulation

28 The proposed development of a GMC intelligence model will support the delivery of a risk-based, and therefore more targeted, approach to the selection and discussion of cases at PSIF. Using our reported findings as a baseline, we will repeat the evaluation in 12 months’ time to assess the impact of these changes.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

29 This paper draws on a post implementation review of PSIF undertaken by the Assistant Director - Audit and Risk Assurance, an analysis of PSIF meeting outcomes undertaken by a Clinical Fellow, discussions with the Senior Management Team and the outcome of the NHS Grampian SER.

30 Following this meeting of the Strategy and Policy Board, we will develop an internal communications article to socialise the Forum to staff across the organisation, focusing primarily on the purpose of the Forum and our future plans for development.

How the issues differ across the four UK countries

31 For the immediate future, and to pilot our processes, PSIF has agreed to focus on acute secondary care institutions across the UK. Therefore, we have not yet considered any NHS primary care institutions, despite the Care Quality Commission rating a number of general practices as inadequate.

32 Furthermore, variations in the collection of data across all four countries present a challenge to fulfilling our duties at PSIF. Where there are gaps in data availability, we should look for opportunities to use our influence to address this.

What equality and diversity considerations relate to this issue

33 As the Forum begins to consider looking at ‘themes’ or ‘issues’ rather than geographies, we must be mindful of the equality and diversity requirements in responding to different groups of doctors.

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* These contact details were updated on 31 July 2015 due to a staffing change