The fine line between Cool and Creepy: using regulatory data to assess/tackle risk

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Introduction – the GMC and the Data, Research and Insight hub (DRIH)

Using our data to assess and tackle risk: Pros

- - Improving regulatory efficiency/effectiveness
  - Improving training and training environments
  - Advancing ED&I agenda
  - Raising professional standards;

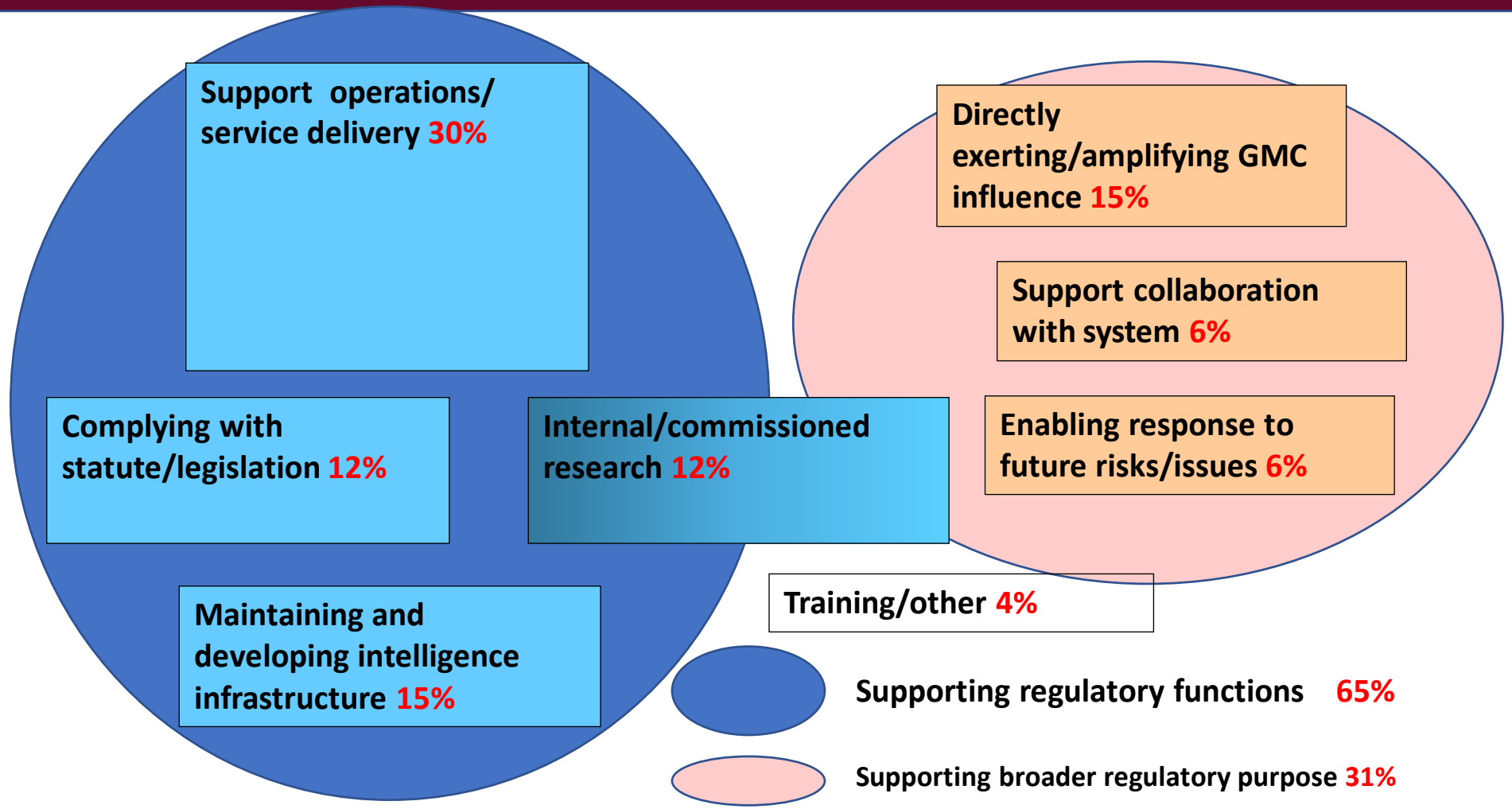
- - Influencing safer working environments
  - Supporting registrants more at risk
  - Improving registrant wellbeing

- - Improving workforce supply
  - Using data to have a 'seat at the table' in relevant system discussion/policy development

Regulatory Powers

Regulatory Purpose (Upstream)

DRIH current resources and capability
(percent of the 50 DRIH staff FTE)



We are reasonably well resourced so can both support the GMC's regulatory functions and explore ways of supporting broader regulatory purposes with our data

Using our data to assess and tackle risk: Cons

- Not being accurate; using ‘unproven’ data; going beyond risk appetite
- Only having partial view; seen as ‘naïve’
- Cultural difficulty within our organisations of dealing with probability rather than ‘proof’
- Identifying problems, but failing to identify solutions or evaluate interventions
- Unacceptability of risk profiling of individual registrants or health providers
- Registrant disquiet around using their personal data
- Stakeholders feeling regulator going beyond powers/remit
- Disproportionate use of our funds/resources

This presentation…

Some Experiences our Data, Research and Insight hub (DRIH) in trying to achieve benefits/mitigate risks that raise questions

- Horizon Scanning, qualitative data, early low-level risk indications
- New data sharing/collaboration approaches with the health system/other regulators
- The role of ‘targets’ in influencing
- Analytic models: ‘prediction’, ED&I in GMC processes; risk profiling
- The critical stuff we don’t have good data on
- From risk data to policy, intervention and evaluation
- Influencing safer working environment

… and discussion

Some questions for our discussion

- Does our collective experience to date suggest that data can actually lead to effective upstream (preventative) regulation?
- How can we use data more effectively to persuade ourselves and our regulatory partners to actually take action?
- What is the appropriate use of early data on potential future risk
- Is there a place for risk profiling?
- Can we get better at data collaboration within privacy constraints, our resources and remits and priorities?
- What is our overall risk appetite for using indicative data and for setting targets beyond our control to deliver entirely on own own?

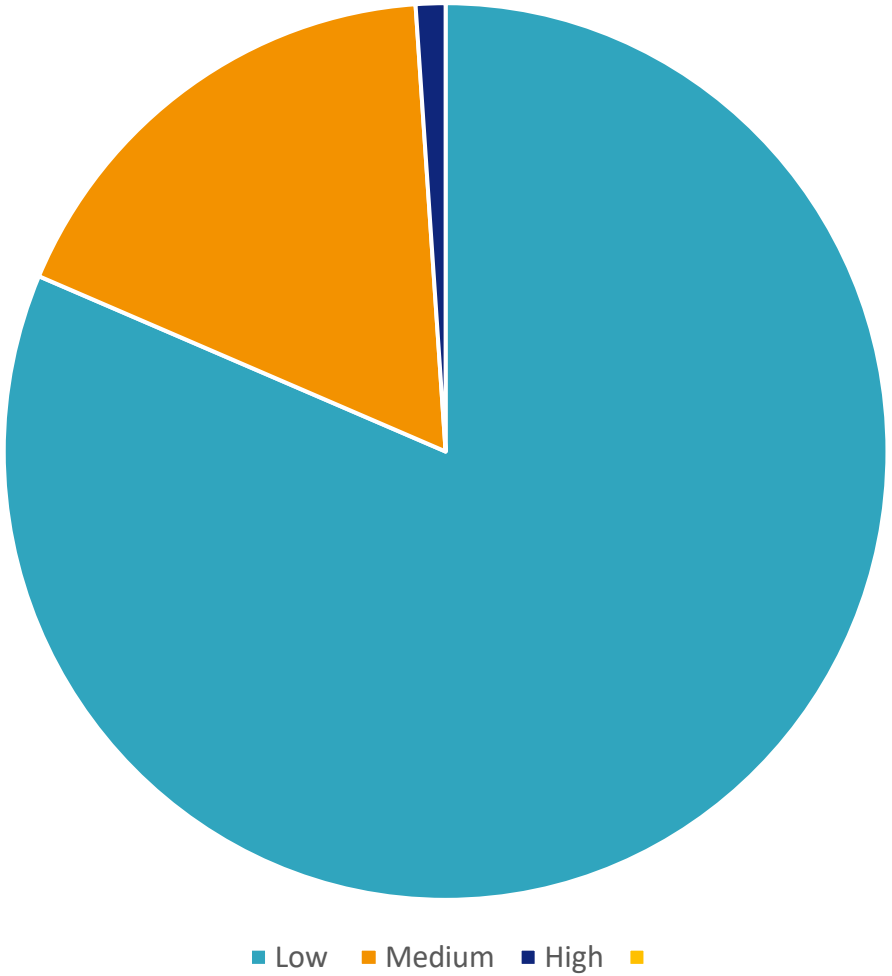
Horizon Scanning, qualitative data and early low-level risk indications

Capturing/structuring qualitative intelligence

- ***Records:***
- Date intelligence received
- Summary of details
- Where it relates to –
- Reliability of source and quality of information
- Dissemination permissions
- Severity and whether it is positive, negative or neutral

- ***Structures***
- Subject(s) codes, Searchable by these and/or aspects recorded
- ***Examples***
- XX NHS Trust (112 items)
- Last 2 weeks of August 2019 (115)
- Category eg induction (120)
- Free text search eg pensions (111)

Nature of qualitative intelligence



Low severity is defined as "soft intelligence added to knowledge base: forms part of the GMC intelligence resource, may require action if identified as relevant, but no urgent action or escalation is required"

Benefits of structuring qualitative intelligence

- Tracking emerging topics as they develop. Inputs into Horizon scanning scrum each fortnight.
- Faster and more auditable responses to internal/external enquiries
- Senior staff briefing on 'trending'/'emerging' topics on demand.
- Compare issues raised to different teams to identify common areas of concern, or unique areas spotted by each team.
- Assessing/tackling risk:
  - Identify 'high consequence' intelligence sources and spot what low-level issues are trending up.
  - See if topic affecting another location and what is being done there
  - Spot emerging topics/locations of concern/good practice

Horizon Scanning

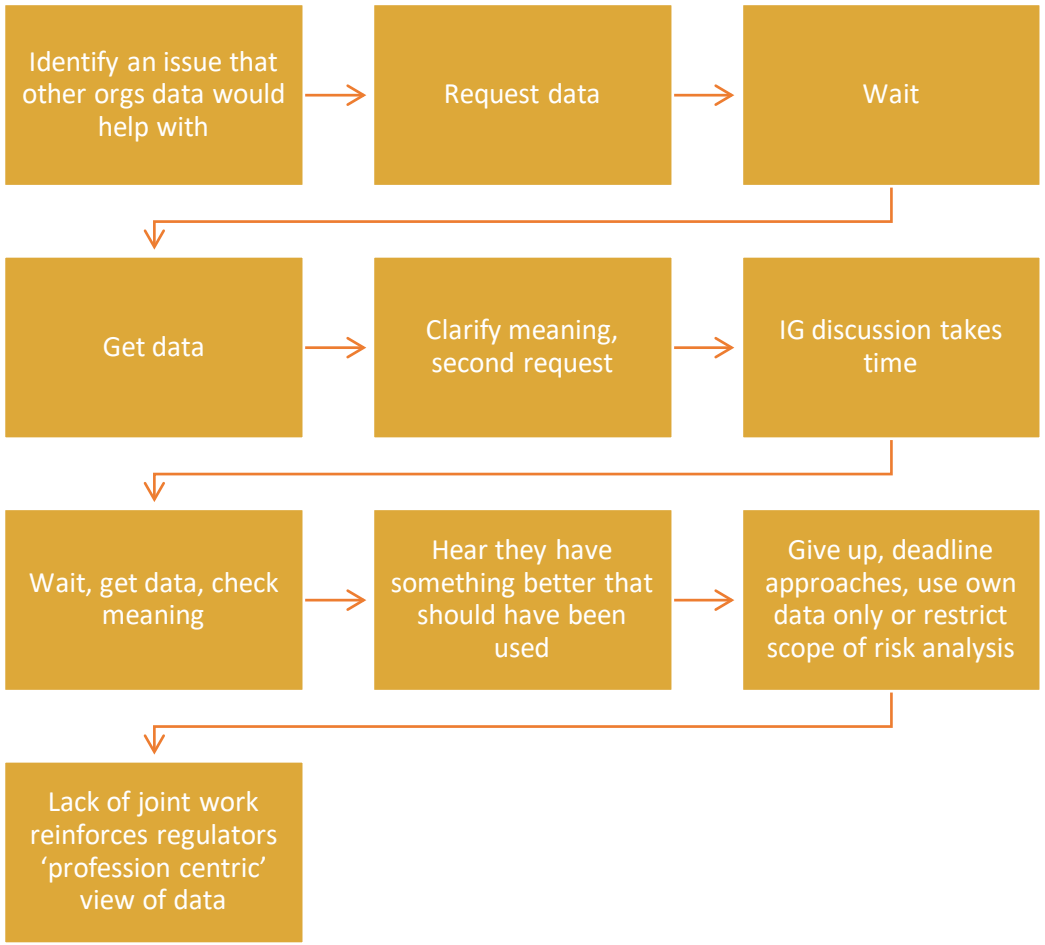
Horizon scanning is an art

- Fortnightly GMC Horizon Scanning Scrum
  - Same people spotting patterns over time
  - Intelligence Module + Externally facing people across GMC
    - Eg social media, Office of Chair and CE, call centre
  - Analysis and rapid scans between sessions
  - **Vital:** Interpreting risk data; panic reactions; strategic objectives
- Dashboard, scenarios → Long-term deep dives
- **Challenge**: Dissemination and motivating action

New data sharing/collaboration approaches with the health system and other regulators

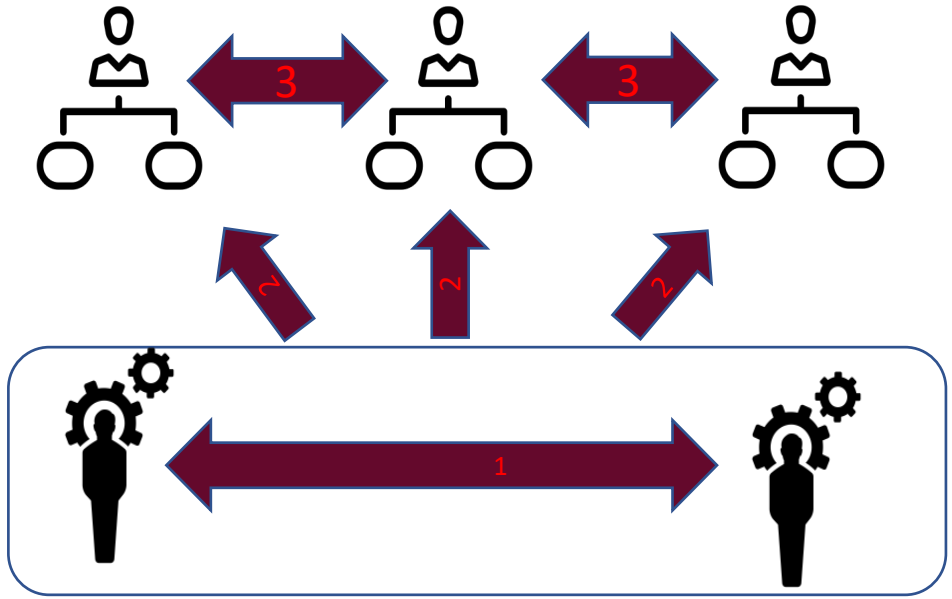
Data Collaboration: from this.....

Our current model in UK has problems



…to this, piloted in relation to maternity services…

Moving towards a new model in UK



Shared data platform

Share data and insight

Identify and escalate issues in common

Agree common action

General Medical Council

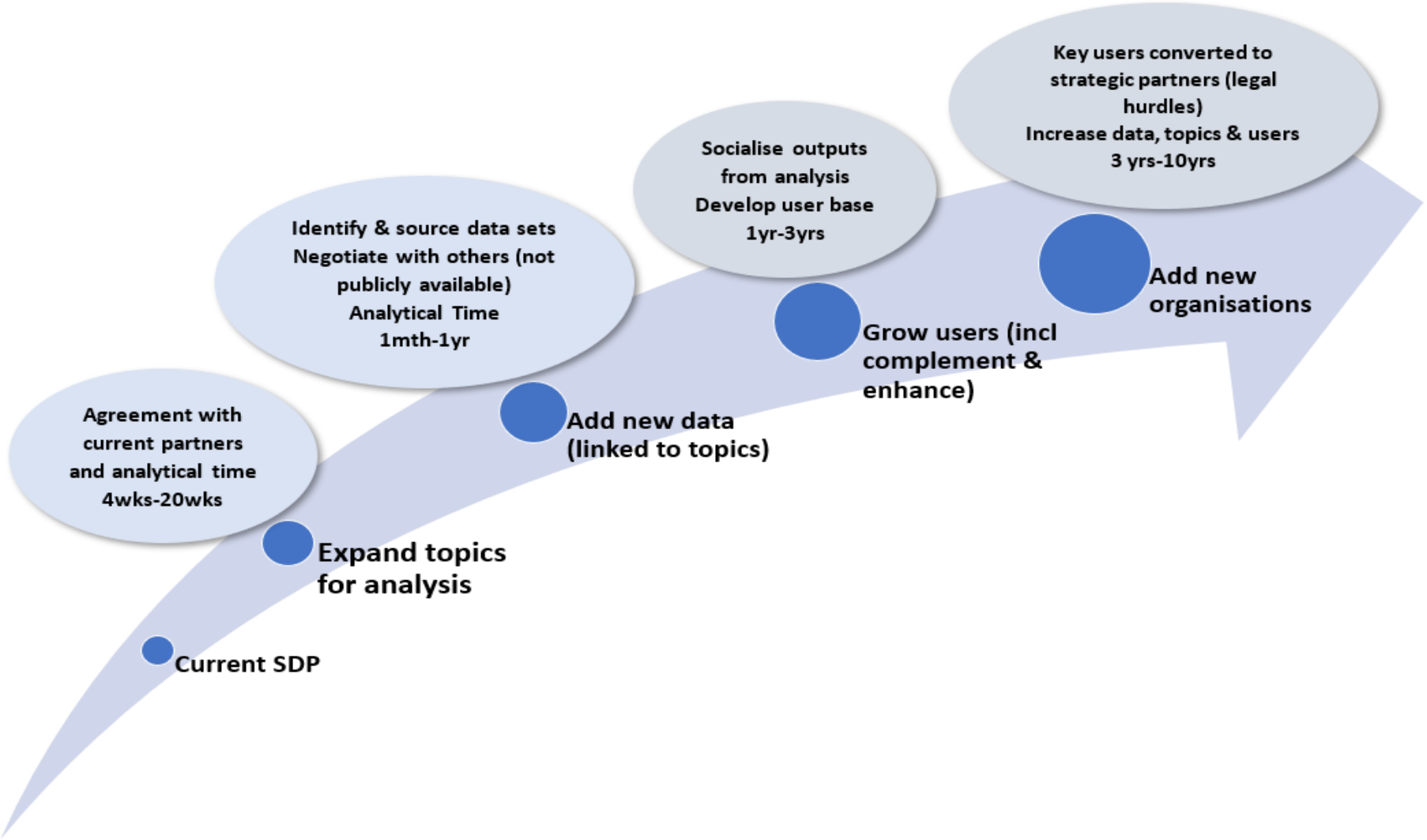
Nursing & Midwifery Council

CareQuality Commission

Two measures to contribute to NHS risk architecture

- **Complaints:** GMC/NMC maternity specific FtP normalised by activity
- **Staffing levels:** CQC maternity survey and the safe staffing theme

….and this in the future



The role of ‘targets’ in influencing

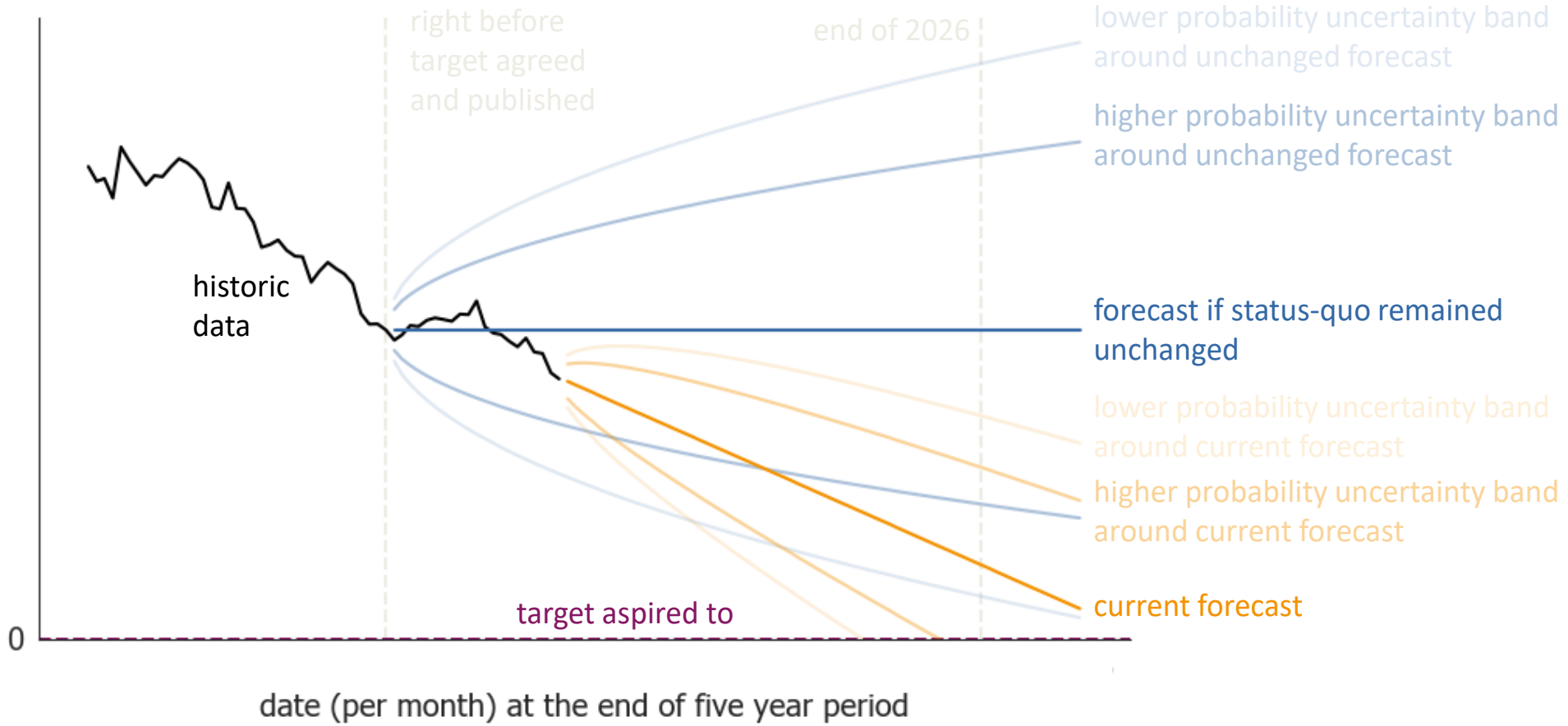
Setting targets that cannot achieve ourselves

In February 2021 we **committed to eliminating**:

- **disproportionality in fitness to practise referrals** from designated bodies based on ethnicity and place of primary medical qualification (PMQ) by 2026
- **differences in key index measures of fairness in medical education and training** by 2031 (‘Fairer training cultures’)

% of providers (DBs) with disproportional referrals

FER KPI1:
% of active DBs with referrals disproportionate about ethnicity or PMQ region



Analytic models: ‘prediction’ models; ED&I in our own processes; risk modelling

Fitness to Practice data modelling summary

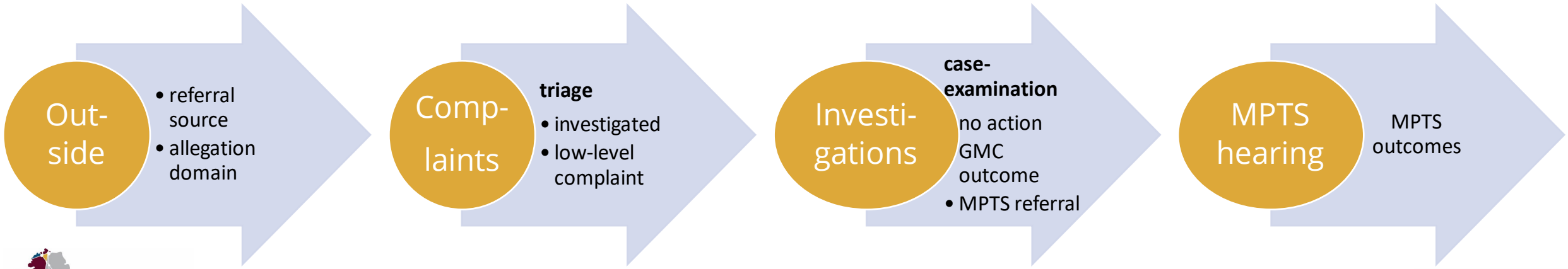
FtP proportionality analysis:

What factors relate to FtP? ~70 mature models of transitions in arrows

16 models: complaints, sources, and allegations

mature

15 models MPTS



Examples of factors related to more complaints or investigations

Related to getting more complaints

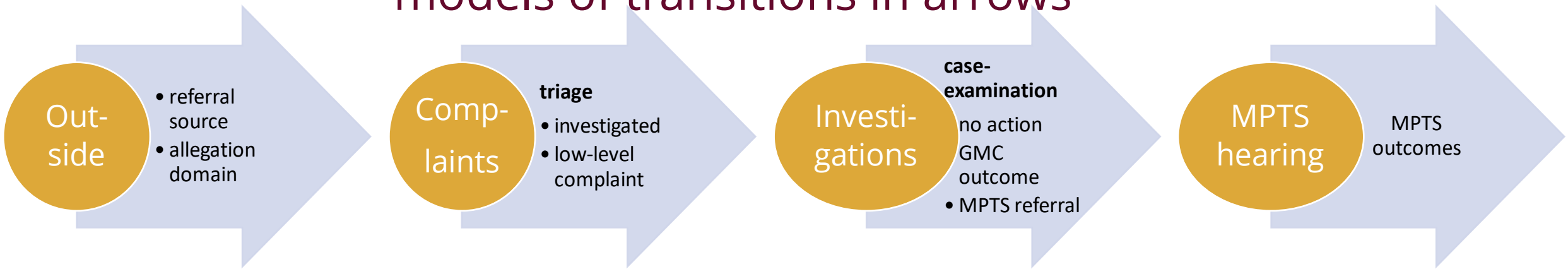
- Being **male**
- DB connection (NHS base)
  - **Non-NHS**
  - **Unconnected**
- **Deprivation** (current doctor location)
  - Workplace locality of the doctor
  - During childhood
- Having sat **IELTS**
- **Visibility of area of practise**

Unrelated to getting more complaints

- **Age**
- **Ethnicity**
- **PMQ**
- Having sat **Professional and Lingusitic Assessment Board**

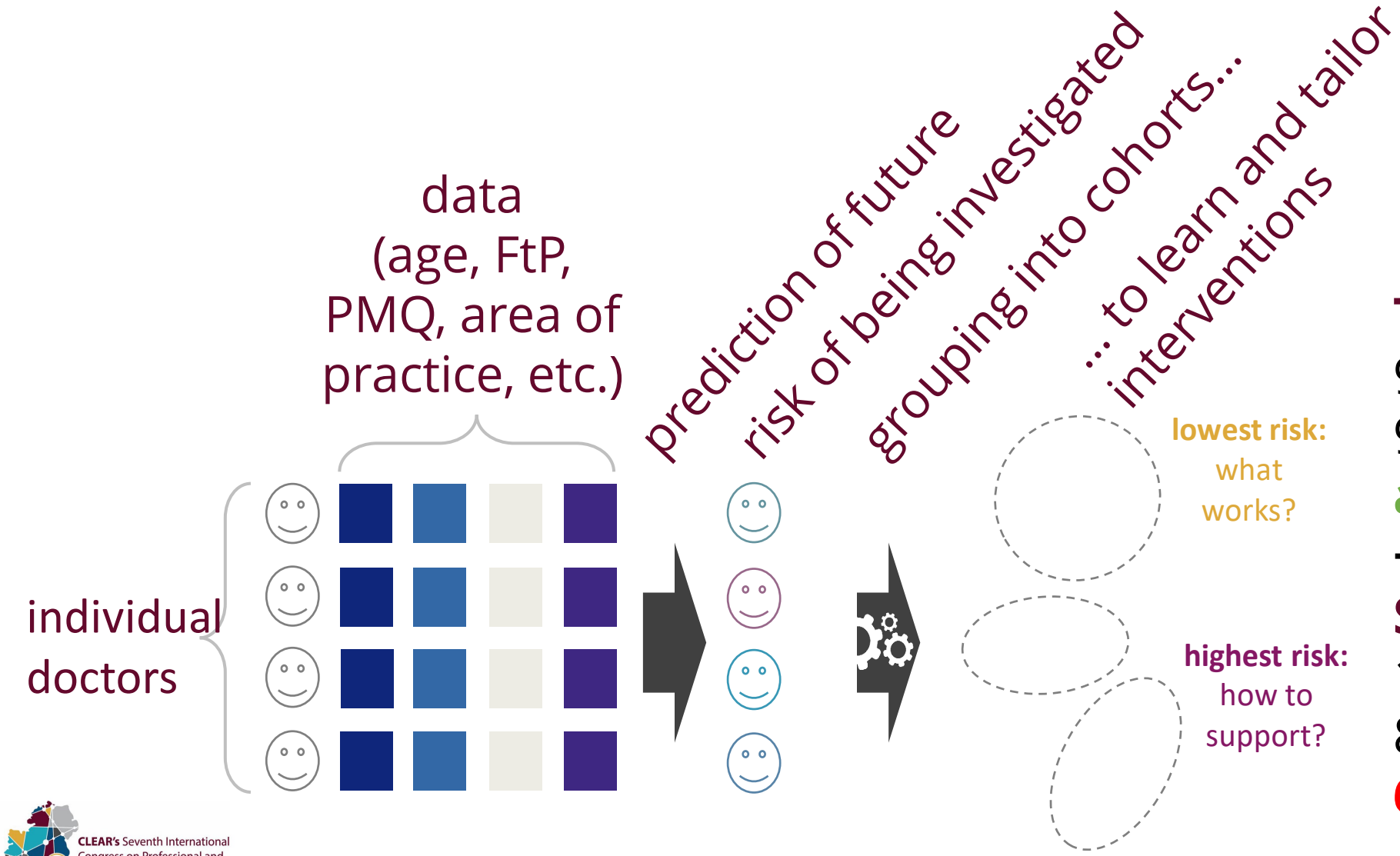
Fitness to Practice data modelling summary

FtP proportionality analysis:
What factors relate to FtP? ~70 mature models of transitions in arrows



investigation forecasting model*: *Who will be investigated?* (lists of doctors at high/low risk

Example of how an investigations-forecasting model might work



Top risk cohort:
9k doctors
99.7% investigation risk
all investigated
++++++++++++++++++++
Second top cohort:
14k doctors
80% investigation risk
63 % not investigated

Tricky route from models to intervention

Follow-up

- Interviews/focus-groups with randomly selected doctors from highest- and lowest-risk cohorts
- Design potential intervention

survey

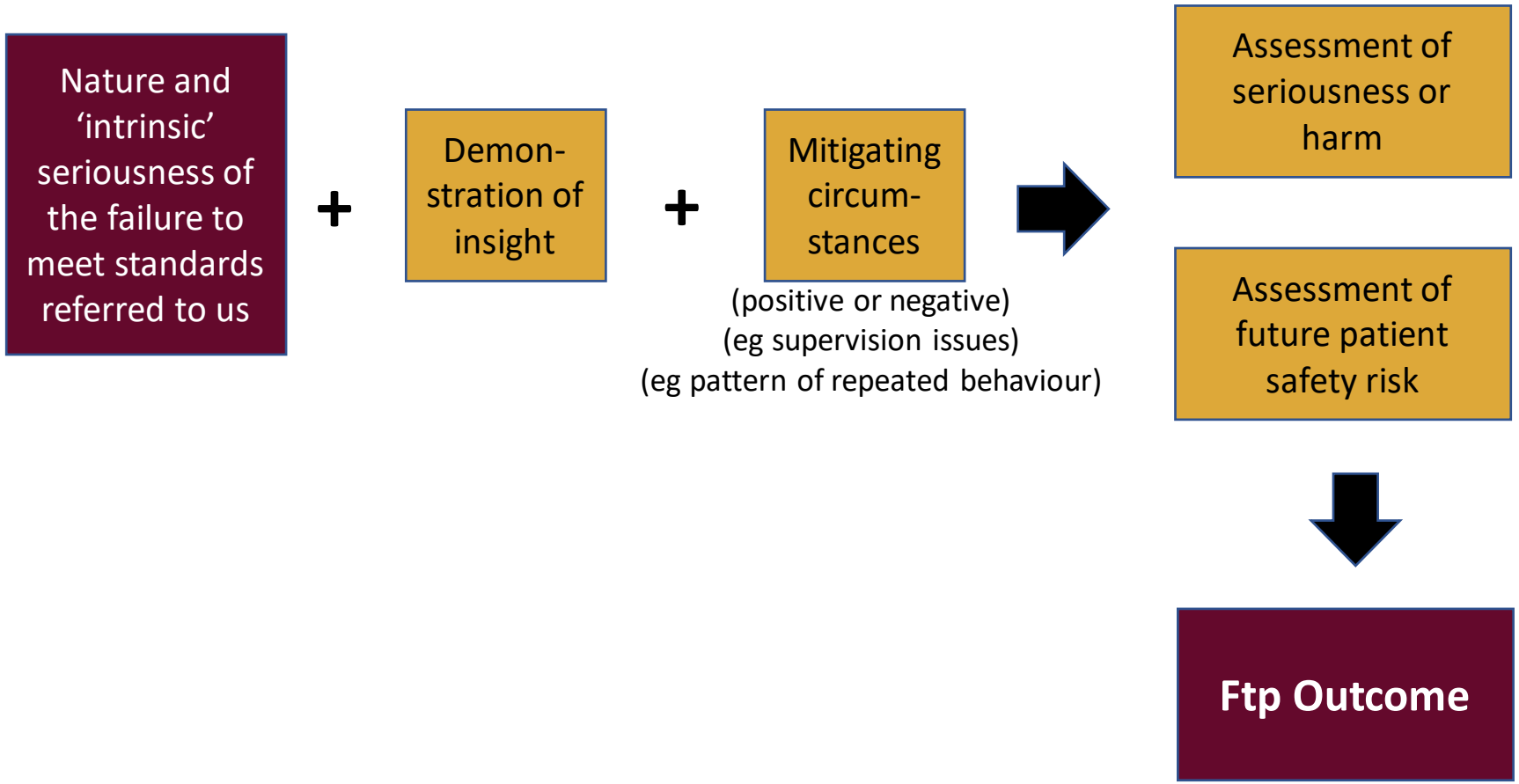
- Pilot intervention
- Analyse and tune

Launch

- Tuned general intervention
- Continuous run and measure long-term effect
- Continuous improvement

The Critical stuff we don't have good data on

Ideally…


Nature and 'intrinsic' seriousness of the failure to meet standards referred to us
+
Demon-stration of insight
+
Mitigating circum-stances
(positive or negative)
(eg supervision issues)
(eg pattern of repeated behaviour)
Assessment of seriousness or harm
Assessment of future patient safety risk
Ftp Outcome

…but

Little data for concepts such as seriousness or insight

Nature and 'intrinsic' seriousness of the failure to meet standards referred to us

+

Demon-stration of insight

+

Mitigating circum-stances

(positive or negative)
(eg supervision issues)
(eg pattern of repeated behaviour)

Assessment of seriousness or harm

Assessment of future patient safety risk

Ftp Outcome

+

Quality of evidence

+

(Possible) Bias

Tricky to get objective measure of seriousness

	Average seriousness of allegations				
	v. low (1-87)	low (88-174)	Mid (175-260)	high (261-347)	v. high (-434)
Probity…	minor motoring offences; other offences	drunk and disorderly; (serious) motoring offences; driving without tax/insurance/license; breach of the peace; criminal damage; resisting arrest; soliciting; public disorder; cruelty to animals; cause unnecessary suffering to dog	driving under alcohol/drugs; failure to provide a specimen; regulations breach home/clinic; possessing an offensive weapon; minor offence (dishonesty); coercive controlling behaviour	fraud; threats to kill; harassment; controlled substances offences; wilfully abandoning child <16; perverting course of justice	(attempted) murder; manslaughter; (attempted) rape; female circumcision; sexual/indecent assault; indecent images of children; child porn; indecent exposure; breach of non-molestation order; voyeurism; terrorism; assisting suicide; abortion offences; assault (GBH, ABH, common); theft; arson; firearms offences; affray; perjury
Honesty…	fail to cooperate with complaint process; encouraging gifts/donations; pressurising patients; fail to maintain trust-social med; fail to inform participant's doctor; fail to justify decision; inappropriate IT use; inappropriate canvassing; fail to properly inform patient; unjustifiable comments (teaching/supervision); private dispute; fail to say - fees to other doctor	unjustifiable claims; fail to provide info about fees; inappropriate use info in research; maladministration nursing/resident home; fail prioritise -clinical need; fail to respond to complaints; inappropriate provision of care; false/misleading advertising; undeclared interest in-home/other/in-hospital; fail to make reasonable adjustments; fail to verify before signing	fail/delay to advise GMC re: conviction/charge/other-offence; fail to clarify own limits; treating/prescribing self/family/friends; fail to provide name/GMC ref; unfairly ending relationship; impaired by barring decision; misuse of funds; inappropriate use medical records; coercion of possible participants; breach of confidentiality in social media; fail to advise about caution; fail advise GMC caution; fail to pay fees to other doctor	false/misleading evidence; false/dishonest/misleading reference/appraisal/report; dishonesty; research/drug-trial fraud; ethical approval not obtained; use of inappropriate participants; financial deception; offering/accepting inducements; interests affect patient care; fail to declare financial interest; false claims to membership; fail/delay tell (other)employer/patient restriction; discrimination colleagues//inquiry/inquest; no indemnity/insurance; forgery	indecent behaviour; work when suspended by IOT/IOP; fail tell patient restriction; dishonesty with patient/colleague; false certifications; improper alteration of records; false claims to experience/ qualifications/regulatory-status
doctor's health		diabetes mellitus with complications	fail to seek investigation/treatment/ independent-advice; fail to change practice; fail to protect patients/colleagues (hepatitis B, other); tuberculosis; abuse hallucinogens/ opioids/cocaine/stimulants/sedatives/hypnotics/alcohol/solvents/cannabinoids/tobacco/multiple; schizophrenia;		
clinical comp.	fail to optimise pain relief; fail to ask appropriate advice/information; unclear re: responsibilities	delay in diagnosis; lack of further investigation; prompt/suitable action not taken; fail to get 2nd opinion; refuse patient 2nd opinion; fail to arrange alternative; not consulting colleagues; lack of further investigation	suitable action not taken; fail to recognise own limits; failure to diagnose; inappropriate/irresponsible prescribing; prescribing without adequate history; inadequate follow up; prescribing without examination	misdiagnosis; substandard treatment; inadequate assessment/history-taking; failure to examine; inadequate examination/assessment; internet prescribing; withholding treatment/referral; fail to refer when appropriate; inappropriate referral; inappropriate delay in providing care	
Prof. perf.	no information/evidence folder; accidental breach info security; accidental disclosure; illegible medical records; delay in providing report/documentation; fail to understand principles; inefficient use of resources	inadequate leadership; incomplete medical records; other fail to follow GMC guidance (consent); breach of information security	intentional breach information security; intentional disclosure; fail to remedy deficiencies; fail to follow GMC guidance; regulation breach re homes/clinic; inadequate knowledge of law/codes; fail to get necessary training; inaccurate medical records; inadequate participation in med education	working when suspended from perf list; inadequate knowledge base; inadequate clinical skills	practising without license
communication	fail to respect advance wishes; fail to share appropriate info; fail to offer apology; fail to explain error/issue; fail to respond to concerns; no assessment of patient's priorities; fail to respect patient's views; fail to listen to patient; insufficient info treatment/research/ screening; not	fail to arrange ongoing care; delegation to inappropriate doctor/other; rough handling of patient; no handover clinician/team; fail to arrange adequate cover; fail to rectify harm; verbal abuse towards patient; fail respect patients dignity/views; failure to visit; no alt offered-conscien.	chaperone not present	no consent treatment/screening; inappropriate expression of beliefs; inadequate knowledge English language; fail to meet language needs; not accessible when on duty; fail to comply with language assessment	improper relationship with patient; inappropriate examination
safety systems	fail to assist, possible abuse (communication); fail to reflect on practice; fail to offer appropriate help responding to risks; fail to provide relevant info about systems; fail to participate in review/QA; fail to approp audit/review; poor reaction, adverse event; inadequate practice arrangements; poor response to audit/review	fail to ensure basic care; fail to respond, possible abuse (safety); fail raise concern patient safety; delay in reporting colleague; fail to provide adequate systems; fail to report inadequate-systems/risk; inadequate practice arrangements; health & safety breach; fail to participate in audit	fail to report adverse reaction; fail to report colleague	fail to offer appropriate help in emergency	
work w others	poor relations with colleagues; inaccurate/poor reference/appraisal/ assessment; fail to support colleagues; causing employment issues; poor teaching; fail to be objective; fail to respect others' skills; lack of commitment; fail to provide relevant info in reference/report	ignoring colleagues' advice; inappropriate personal comments; fail to appropriately supervise		harassment; poor communication skills; fail to take up post; leave post early/without-notice	bullying colleague physically/verbally

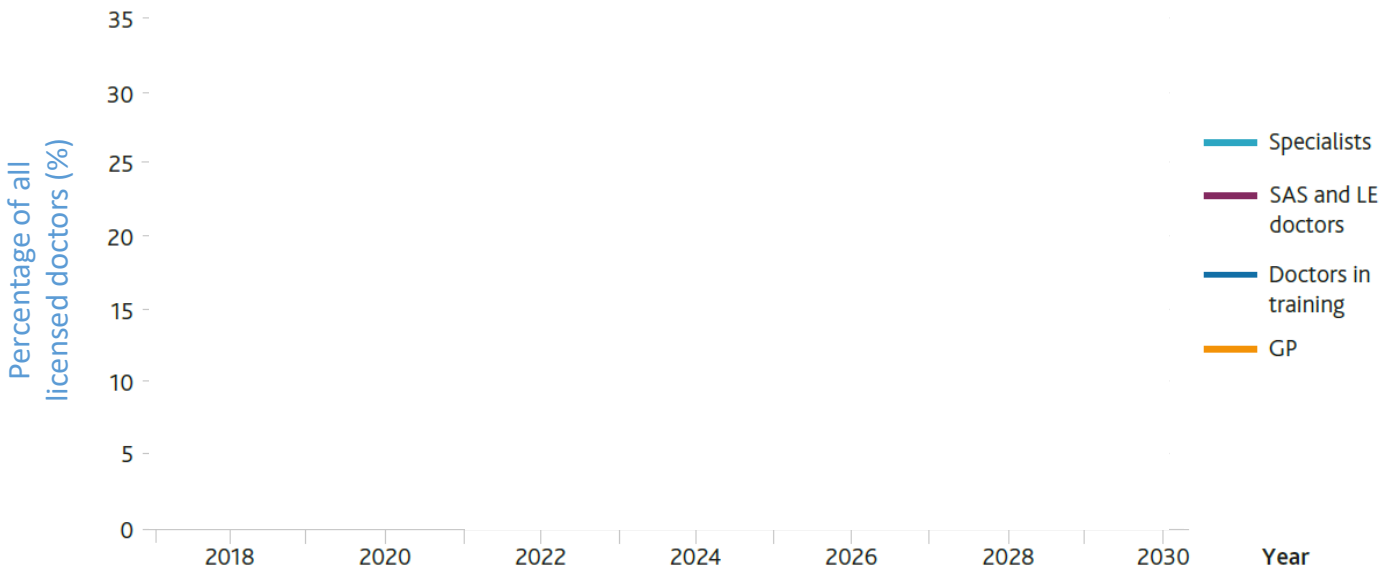
From risk data to policy, intervention and evalulation

Growing dependence on doctors from abroad

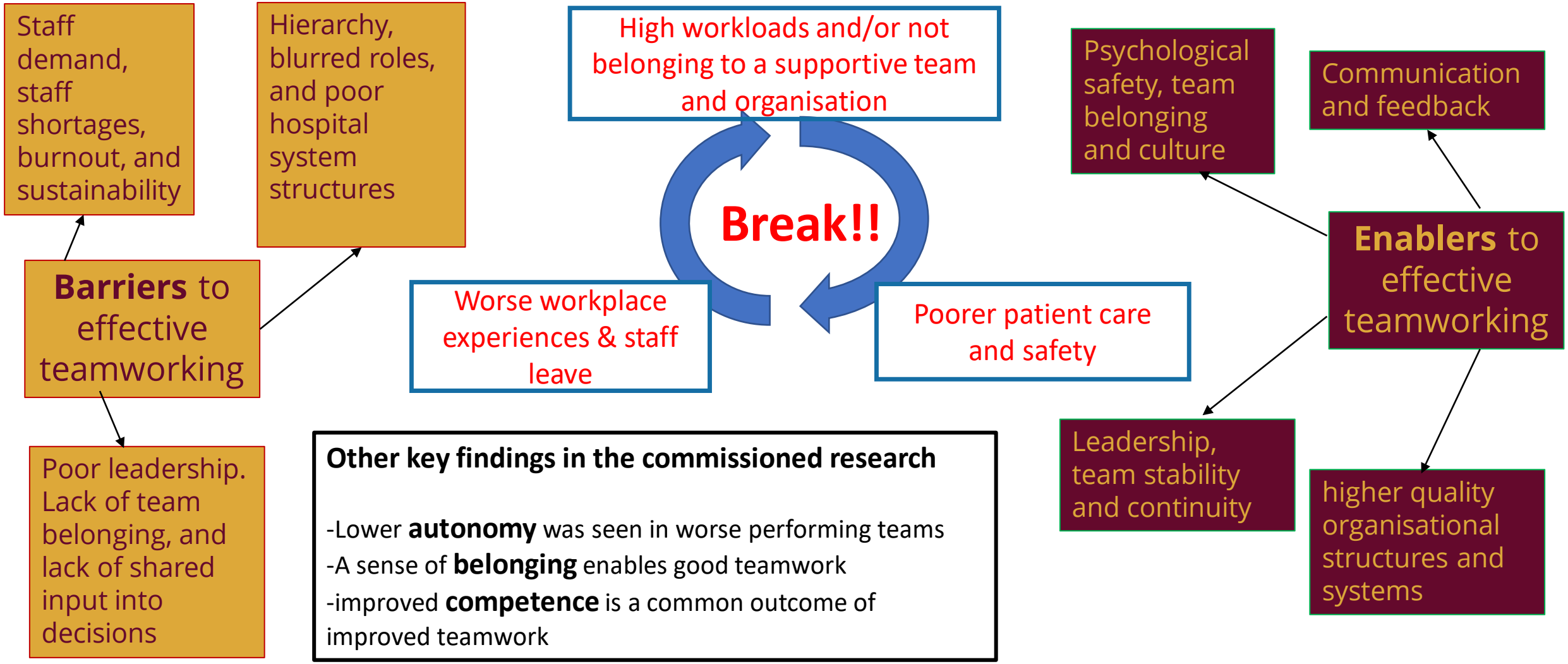
Growth in proportion of SAS/LE doctors

Licensed doctors	2017
Doctors in training	59,851
SAS and LE doctors	45,578
GP	60,690
Specialist	75,282
Total	**242,642**

- Over the last five years, the SAS and LE doctors group has grown at the fastest rate of all register groups
- The specialist, and especially GP, register groups have been far slower
- If current trends continue, SAS and LE doctors would be the largest register group by 2030



Break the vicious circle



Other key findings in the commissioned research

-Lower **autonomy** was seen in worse performing teams
-A sense of **belonging** enables good teamwork
-improved **competence** is a common outcome of improved teamwork

Discussion


The OLD STOREHO
OLD STOREHOUSE
SKATEBOARDS
LONGBOARDS
CRUISERS
ROLLERBLADES
SCOOTERS
AND SPARES

Some Discussion Questions

- Does our collective experience to date suggest that data can actually lead to effective upstream (preventative) regulation?
- How can we use data more effectively to persuade ourselves and our regulatory partners to actually take action?
- What is the appropriate use of early data on potential future risk
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Thank you

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