European Partnership for Supervisory Organisations in Health Services and Social Care

EPSO Working group Effectiveness

Agenda London 25th April 2017 and further

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Introduction

EPSO has convened two meetings for the Working Group Effectiveness. The last meeting was during the EPSO meeting in Stockholm, September 2016. This meeting ended with stating two priorities for future meetings:

- Framing the effectiveness of supervisory authorities
  e.g. how to make complex risks manageable and identify relevant supervisory actions to decrease these risks;
- Setting goals for the results/effectiveness of supervision/inspection
  e.g. how to determine an attainable effect and assess whether this effect has been achieved.

Proposed theoretical framework

At the meeting in London we would like to discuss whether the following theoretical framework on what regulation entails, can help find answers to the questions above. For regulation to be possible, these elements must be defined (as concrete as possible, aimed at a specific regulatory theme):

1) The overarching mission of the regulatory agency (what is its goal and jurisdiction and the work distribution between state and providers, etc);
2) The risk, or problem, to focus on – and how to frame this;
3) The behavior expected from healthcare providers (norms, rules, regulations, self-monitoring etc);
4) The addressee (who/what needs to show the expected behavior);
5) The goal (what effect does the regulator hope for);
6) The intervention (what will the regulator do to achieve the goal);
7) The effect (how to assess the consequences of intervention);
8) How to distribute the knowledge gained in the process;

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Proposed next steps for the Working Group

A) London, April 2017: Discuss whether the theory above resonates ;
B) Tallinn, July 2017: Before the meeting each member chooses a current issue they are struggling with and tries to fill out the 8 elements for this issue. At the meeting, we will discuss point 7 (the effect) of these examples. The goal of this discussion is to try make the intended effect explicit and achievable. We will try and plan more time than usual for this meeting, so we can really go in depth.
C) 2018: we reconvene and discuss progress on the issues we discussed in July.

EXAMPLE

Learning from adverse events (AEs) in Dutch hospitals:

1) The overarching mission of the regulatory agency (what is its goal and jurisdiction etc)
   The Dutch Healthcare Inspectorate want to supervise the learning capability of hospitals
2) The risks, or problems, to focus on
   The risk is that a hospital experiences an adverse event and does not take adequate improvement measures, thus sustaining the safety issues that made this AE possible
3) The behavior expected from healthcare providers (norms, rules, regulations etc)
   We expect hospitals to execute a proper AE investigation, leading to improvement measures
4) The addressee (who/what needs to show the expected behavior)
   The hospital's board of directors and their AE investigation committees
5) The goal (what effect does the regulator hope for)
   Each Dutch hospital can execute a proper AE investigation (eg Root Cause Analysis)
6) The intervention (what will the regulator do to achieve the goal)
   We will measure the quality of *AE investigation reports, give specific feedback on inadequate items and track the quality of these reports over time*
7) The effect (how to assess the consequences of intervention)
   The difference in quality score for AE investigation reports over time
8) How to distribute the knowledge gained in the process
   Publish the results, use the results in one-on-one discussions with hospital boards to reflect on the quality of their learning process compared to peers