Interview Transcript[[1]](#footnote-1)

Subject 5: Public Health

I: [explaining project]

[1:25]

I: From what I understand you don’t necessarily make a whole lot of decisions based on natural hazards, but you do have some experience with risk regulation.

S: Yes. That’s correct. We find that things like disease prevalence, which, I’m assuming you’d define as a national hazard, we find that that doesn’t actually influence our model of regulation. So it is just risk-based regulation that we are moving towards. We’ve done it in the past and then we have moved away from it and decided to spend a couple of years inspecting every provider on our register and now we’re moving, having done that and having produced one single comprehensive baseline, we’re now moving towards a more risk-based approach.

I: Okay. And how does that look compared to what you guys used to do?

S: So the output of what we did before, and in fact in some sectors we’re still doing because we’ve got such a lot of locations to get around that we haven’t finished yet, but for what we call our comprehensive inspection it produces a rating so it’s a judgment on a four-point scale and so that feeds into the risk-based regulation. For example, if you’re a GP surgery, for example, and we have judged you as being good, which is the third point on the four-point scale, then you are less likely to be inspected in the next three years than if we deemed you to be on the first point, which is inadequate so that automatically puts you on a level, the frequency of your inspection is adjusted. And then the next stage is what inherent risks are present in the sector or the market. So in adult social care for example, what we’re likely to do from next year is to actually not move into a risk-based regulation, entirely. We will probably go around the entire sector again as a result of the fragility of the market and the lack of nationally available data on adult social care. That information asymmetry doesn’t give us confidence that we will be able to detect a risk when it emerges. Until that changes, we will continue to be confident that we’re at least visiting every care home once every couple of years. For hospitals, where the inherent risk is different, it’s riskier procedures, I mean the inherent risk in adult social care is that so much of the activity is either undertaken in someone’s own home or the individuals who are in receipt of the care are particularly vulnerable and isolated. In the hospitals, there’s obviously a cohort of people who do receive that care, but it tends to be the risk of mortality, the risk of complication, the risk of acquiring a hospital infection when you’re there that you didn’t arrive with and so there are known inherent risks within that provider group that we can anticipate and adjust the inspection frequency in accordance with that.

[5:34]

S: And then there are the last consideration is where we might anticipate risks which may emerge so they’re not necessarily inherent in the type of service that’s delivered, but we would want to continue to survey for that risk should it emerge. So for example, we know that a high-performing organization tends to have either a really stable leadership if we’re describing it in the [healthcare organisation] for example, but in adult social care, that takes the form of a registered manager. We know there’s a correlation between poor quality of care and a registered manager not being in place for 6 months or more so we know that as soon as a registered manager’s absence triggers a certain threshold, then that’s a live risk in that organization and we can respond accordingly and it’s not inherent to the service they provide, but it’s something that we need to be aware of when it occurs. There’s obviously a number of those that we examine at quite a granular level, particularly in the [healthcare organisation] because of the different nature of the, the multiple services that are delivered by a hospital versus a very generic offer that tends to be provided by a care home or a dentists for example.

I: Okay. When you’re identifying and figuring out these risks do you communicate those onwards or how do you quantify them?

S: So, how do we quantify them, so there’s, we tend to, if I take hospitals because that’s probably the easiest, even though there’s more data there, with hospitals, we will in collaboration with the sector, we developed a set of indicators so in acute [healthcare organisation] hospitals, we’ve come up with about 100 indicators that we think are reliable and we’ve been scanning them on a regular basis over the last couple of years and we’re replicating the same in mental health and adult social care and GPs to varying success in terms of do those indicators subsequently correlate with our quality findings when we go and inspect, it’s a mixed picture, but to a degree it starts with what information is available and then do those indicator shave a legitimacy when we present them back to the sector that we regulate. There’s an untapped resource in qualitative information and we’re doing some research of our own at the moment thinking about what are the best qualitative sources and what can that data tell us in a way that we haven’t really exploited it to date. We’ve got a crude indicator about ratio of positive and negative sentiment in codes that are published on a few websites, the sort of Trip Advisor-style healthcare websites, but it’s not, over the next sort of year that’s really where we want to build our capability. So it’s not all about quantifying it, I suppose is what I’m saying. I think there’s definitely an opportunity there in the qualitative space.

[9:20]

I: Okay. So then basically, you boil that down into the four point rating scales?

S: So if there’s….so we’re constructing a model whereby we could flag a concern at a corporate level or we could flag a concern at a more granular level. So our definition of quality is split into five domains. So we could have a, for example, a patient survey. We run the annual inpatient survey for the [healthcare organization], we could run that and there could be a flag that emerges from that exercise, which tells us that in caring, which is one of our five domains, there’s an issue and we respond to that, but equally there might be an issue with surgery, which is one of our core services. So we have eight core services and five domains, so you’ve got this forty box grid, so you might have a flag in one of those grids or in multiple grids, one of the columns or one of the rows, sorry have I explained that properly?

I: Yeah, that makes sense.

[10:34]

S: Our preference is to be as granular, so that we could be sort of more proportionate, but we’re limited by the data. We have tried to get data because of this, going back to the information estimatory point, because often, providers of health and social care hold quite a lot of information themselves because they know what their risks are and they tend to monitor them relatively well within them. So we’ve tried to tap into that, but it’s a very resource intensive exercise and we’ve not managed yet to find a way of doing that in a way that’s kind of proportionate to the benefit to us, which is why we always default to what’s centrally available.

I: Okay. Great. I can’t think of anything else at the moment. This has been very helpful seeing how things work in a completely different sector. Is there anything else that you think might be relevant and worth hearing?

[11:41]

S: I don’t think so. No. I think that’s it for the moment.

I: Great. Well thank you for taking the time to explain this to me. It’s been very helpful. And in the future, do you mind if we have further questions if we contact you again?

S: No, I’m really interested in the work that you’re doing so to be connected to it in some way and kind of get a feeling of where you’re going with it is incredibly helpful so I’m always happy to help when I can.

I: Great, well we’ll keep in touch definitely and thank you again for taking the time this afternoon.

S: Thanks, bye.

I: Bye.

1. The interviewer is denoted by “I” and the subject as “S” [↑](#footnote-ref-1)