Rating providers for quality: a policy worth pursuing?

A report for the Secretary of State for Health

March 2013

About this report

This report outlines the findings and recommendations from an independent review conducted by the Nuffield Trust into whether the Government should introduce 'Ofsted-style' performance ratings for hospitals, general practices, care homes and other adult social care providers. The review was commissioned by the Secretary of State for Health, The Rt Hon Jeremy Hunt MP, in November 2012. It has sought to assess whether 'aggregate' ratings of provider performance should be used in health and social care and, if so, how best this might be done. The conclusions in the report are solely those of the Nuffield Trust. The report was presented to the Government on 22 March 2013, and an accompanying summary is available to download from **www.nuffieldtrust.org.uk/publications**.

Two main methods were employed to inform the review: engagement with policy-makers, professionals, the public and other key stakeholders; and reviews of relevant literature. The engagement process involved: a set of meetings with groups of stakeholders; an eight-week online consultation process; a series of three focus groups with the public, conducted by Ipsos MORI; and bilateral meetings with key individuals. More than 200 organisations and individuals contributed to the online consultation. These contributions have informed the conclusions and recommendations of the final report. The Nuffield Trust would like to thank those individuals and organisations again for their contributions.

A range of resources on the review are available from the Nuffield Trust website at **www.nuffieldtrust.org.uk/ratings-review**.

The Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK. We aim to help provide the evidence base for better health care through four key activities: conducting cutting edge research and influential analysis; informing and generating debate; supporting leaders; and examining international best practice.

Contents

List of tables and figures

List of figures

List of tables

Executive summary

Background

Should there be 'Ofsted-style' ratings for health and social care providers? This was the main question which prompted the Secretary of State for Health, The Rt Hon Jeremy Hunt MP, in November 2012 to commission this independent Review. The specific terms of reference were:

- To map the current system of assessing the quality and safety of care of providers of health and social care and the current system of accountability for quality of care.

- To identify the advantages and disadvantages of aggregate assessment of providers of health and social care.

- To identify in broad terms how best to combine relevant current and historic data on quality (safety, effectiveness, and user experience) and information from inspection to provide useful, credible and meaningful aggregate assessment for comparing the performance of organisations providing health care and social care. Key goals will be to use existing metrics, rather than require costly new data collection, and not to create extra burdens on providers.

- To suggest priorities for developing data and testing metrics in the short to medium term to allow better aggregate comparative assessment.

- To identify which organisation/s might be best placed to provide such aggregate comparative assessments.

In addressing the above we defined 'aggregate' assessment loosely, and it was assumed to mean assessment that is reported publicly. As shorthand for 'aggregate assessment' of performance we use the term 'rating' (despite the unhelpful connotations from the past).

We defined providers as being publicly or independently owned, and due to time constraints just considered the following broad groups: hospitals; general practices; and providers of adult social care – care homes (residential or nursing home providers) and domiciliary care providers.

Engagement process

To help gather intelligence we employed two main methods: engagement with key stakeholders; and reviews of relevant literature. The engagement process involved: a set of meetings with groups of stakeholders; an eight-week online consultation process; a series of three focus groups with the public; and bilateral meetings with key individuals (Appendix 1). We were struck by the generous contributions made by many and extend our thanks. The reviews of literature included grey and peer reviewed literature. We are grateful also to have been supported by an advisory group, the membership and terms of reference of which are shown in Appendix 2. The conclusions in the report however, are solely those of the Nuffield Trust.

History of provider ratings

There have been such ratings for providers before, in the period 2001–2009 in health care and 2008–2010 for social care, but these have been abolished. We outline the history in Chapter 2. The main observation is that there has been remarkable instability in the organisations doing the rating – instability which will have reduced the time for regulators to develop the system of ratings and to evaluate their impact. In health care, the rating with the longest shelf life was the Healthcare Commission's Annual Health Check (2005–9), which applied to NHS trusts. Over that period, there is evidence to show that the performance of NHS trusts did improve, against the measures in the rating. But it was difficult to find robust evidence of whether this was a result of the rating or other factors such as the system of performance management at the time, or indeed what happened to performance against aspects of care not included in the rating. More specifically, while the costs of the organisations doing the rating were known, the costs to the organisations rated were not. For social care there is even less evidence, as the ratings were produced over a shorter period. In other words, the added value of a rating relative to the costs over other activities to improve the quality of care in providers is not clear. Nor indeed is the potential for ratings to have an impact now and in the future if there were improvements in its design and use.

Addressing gaps in information for the public

In Chapters 3 and 4, to help answer the question what might ratings add now, we outline the main current initiatives to help improve quality of care in health and social care providers, external to what the providers may be doing themselves. In both sectors there is a lot of activity, and much that would be required to support a system of aggregate rating: developing standards; developing indicators and the data to measure standards against; inspections against standards; assessment of the quality of care of providers across a range of metrics; publication and presentation of that information publicly.

However there are two obvious gaps.

First, there is currently no independent, comprehensive assessment of quality across all providers (considered in this Review) across the full spectrum of performance. Current assessments by the Care Quality Commission (CQC) are independent but not comprehensive (they focus on essential standards only). In health care, current assessments by the commissioning system may be more comprehensive (using quality dashboards) but not independent, since commissioners select indicators through the NHS Commissioning Outcomes Framework, on which their own performance is also judged. Furthermore, the NHS Commissioning Outcomes Framework reflects priorities set in the NHS Mandate by the Government of the day, and may not necessarily translate into a set of standards and indicators that reflect comprehensively the quality of care of providers. For social care providers, current assessments by local authorities are variable in nature, may not give a comprehensive view of the care offered by providers. They do not cover all care homes (for example, those in which there are no local authority-funded residents) and are generally not published.

Second, although there is some information for the public on some aspects of the quality of care of providers available (more in health than in social care), comprehensive information is not available in one place, as is the case for schools, where this is provided by Ofsted. It is either not available or it is spread across a

number of sources, which may reduce its impact and use by the public. One aggregate, comprehensive rating of providers may provide more clarity and simplicity for the public, especially if it comes from one 'official' trusted source. Clearly a parallel market in supplying provider ratings from commercial independent organisations could exist, as it does now.

So if there is a gap, should it be filled?

The answer depends in part on what the main purpose of a rating is, as discussed in Chapter 5. There could be at least five purposes:

- to increase accountability to the public, users, commissioners of care, and (for publicly funded care) to Parliament

- to aid choice by users (their relatives and carers), and by commissioners of publicly-funded care (mainly NHS primary care trusts and the new NHS clinical commissioning groups, and local authorities)

- to help improve the performance of providers

- to identify and prevent failures in the quality of care

- to provide public reassurance as to the quality of care.

Our analysis suggests that a system of provider ratings could act to improve accountability for the quality of care, provided ratings were simple and valid, and were reported publicly, widely and accurately.

Ratings could aid choice among users and commissioners, but evidence suggests they have not been used much in the past, possibly because the information they contained was inadequate. In fact there is a big gap here: trying to choose in particular a care home, domiciliary care, or a general practice is not helped either by the confusing array of information from different sources, or more often a lack of information. This is a space that Ofsted helps to fill in the case of schools.

Perhaps as a result, individuals tend to rely on expert advice from trusted agents such as GPs, and informal sources such as family and friends. The public do not appear to use websites for information to make these choices, again possibly because the information they need is not available. The extent to which individuals (and those commissioning their care) might use information from ratings to choose providers is likely to depend on the availability of alternative providers to choose care from, and (for hospital care) more detailed information on the quality of clinical care in specific departments or specialties, again information that is either not, or not easily available. For users, ratings may be more useful for choosing providers that offer relatively simple and more homogenous services, for which they may have more confidence that their own experience can judge, such as general practices, care homes and domiciliary providers as compared to more complex care in hospitals.

As noted above, ratings have had a positive effect on improving the performance of providers (at least with respect to the indicators included in the rating) and have shifted the 'quality curve' upwards. In Chapter 5 we outline the ways this might occur. But ratings may also be associated with a number of important negative or perverse effects, such as weaker performance resulting from distraction of management time, and distortion of priorities as attention is focused on aspects of care that are measured

relative to those that are not. The more sanctions that result from a rating, the more this distortion is likely. In health care, it is important that a rating system should not be used as a new system of performance management: rather it should dovetail with a more supportive, albeit necessarily challenging, mechanism of improvement.

For hospitals, the focus on a 'whole institution' rating may prompt management to better performance, but quality of care for patients is delivered at a service level, say in departments or specialties or wards. Thus service level information has much more potential to engage clinical staff, and it will be important that an aggregate rating would include such information in the future. In developing this, information could be drawn from high quality local or national peer review activities.

Where might a ratings system be useful?

A comprehensive evaluation of the impact of ratings in health and social care has not been done, and so it is not easy to draw conclusions as to the overall benefit versus the costs. The impact of a rating on performance depends less on the rating *per se*, but rather the wider system in which it is embedded.

A rating by itself is unlikely to be useful in spotting lapses in the quality of care, particularly for services within complex providers like hospitals. It is here the analogy with Ofsted's ratings of schools breaks down: hospitals are large, with many departments and different activities, seeing large numbers of different people every day, carrying out complex activities, many 24/7, and in which people are sick and can die. Put another way, the risks managed by hospitals vastly outweigh those managed in schools. For social care providers the risks may be lower, but many are still dealing with frail, ill and otherwise vulnerable individuals. Indeed, unless there is a 'health warning' on a rating to clarify to the public what it can and cannot say about the quality of care, there is an inevitable risk that the rating (and the rating organisation) will be discredited, as lapses occur in providers scored as 'good' or 'excellent'. It may just be a question of time. And since an aggregate rating would be a measure of care across a whole provider, by the time it showed poor performance (particularly for clinical care), it would be too late. As a result, we conclude that any rating system must be closely linked to wider systems of surveillance to spot, investigate and remedy significant lapses in quality. If there are concerns about a provider that is being investigated, this would need to be appropriately signaled alongside the rating.

On public reassurance, the importance of linking a rating to an effective underpinning system of surveillance to try to spot failure has been noted. While the public would not expect the rating system to be infallible, reassurance is more likely to come about if the public were confident that a rapid and effective system of investigating and dealing with failure were more evident. This is where the proposed new 'inspector' of hospitals could have a role and be a public figure seen to describe and act on failure and explain to the public what remedy is being pursued and why. More generally, it could be that the existence of a rating does provide background reassurance to the public about the quality of care in providers, according to credible standards. However, in cases where there is little choice of provider other than one rated as poor or weak, public and patient confidence could be undermined.

How could a ratings system be designed?

So if a system of rating could be useful, particularly to improve accountability, aid choice, and help improve performance, there remains a question as to whether it could be designed for all three purposes. Chapter 6 discusses how best a rating might be designed, balancing the need for simplicity (e.g. for accountability) and the need for complexity (to have more detailed information on clinical care to aid choice and engage clinicians).

We conclude that the overall approach to ratings should allow complex organisations to be assessed at different levels, and promote service-specific ratings where possible, particularly in the case of hospitals. We suggest that any rating should include measures of safety, effectiveness, and user experience – a crucial element. They also have the advantage that they are common currency in the NHS, can apply equally well to social care and health sectors. There should not be undue reliance upon any one indicator – a rating should be made up of a range of indicators.

Alongside the three 'Darzi' domains of quality, we suggest that some measure of the quality of governance of providers, particularly large and complex providers, may be important to include in a rating. But, we do not suggest a rating for quality includes direct measures related to financial health and management. Bringing financial performance into a rating for quality might lead to a provider making inappropriate tradeoffs between financial issues and the quality of care. However, for hospitals, there might be room once a year to bring together a rating for quality with assessments on financial health and overall governance of providers as carried out by Monitor (for foundation trusts) and the NHS Trust Development Authority (for NHS trusts). In social care, because of the large number of private providers, assessing their financial health would be impracticable.

The information to support a rating, particularly if it were to cover areas of specific clinical care, would need to be developed over time. We suggest a 'road map' approach involving key stakeholders, including the public and patients, to help in the development of the rating system in this respect and the data needed to support it. Priority areas for the development of such information might include high-risk areas, for example care of the elderly, maternity care, care for people with learning disabilities, and care for people spanning more than one provider. In future, it would be desirable if a rating system could extend to assessing pathways of care for such groups of individuals.

To encourage use, the ratings should be updated regularly and made available in a timely way. To gain credibility, it is important that a range of key stakeholders, including groups representing the public and users, are involved in the construction of any rating, the contents and process of agreeing them should be made explicit and thresholds pre-defined in advance of assessment. While there is a legitimate role for national government (and local government in the case for social care) to influence priorities, the process should largely be sector-led including the public and users, with an agreed process for development which should focus on both the short and the medium term (five to 10 years).

There is strong evidence to suggest a rating should be based on a combination of indicators compiled from routinely available data, and information from inspections,

i.e. not just data alone (particularly in the case of social care). It should make use of already existing information on quality of care, and its design needs to align with pre-existing outcome frameworks and NICE standards where applicable. This is important because the impact of a rating is in part dependent on the wider system, and commissioners hold key levers for improvement (for example through contracting and payment mechanisms). However, the indicators in a rating might go wider than these existing frameworks.

There should be a transparent way of determining standards, indicators and the scoring of them in any new rating which should draw on the large amount of existing work already done, particularly under the auspices of the NHS Commissioning Board and should involve a wide range of stakeholders. Any disputes should be subject to a pre-agreed process for resolving these.

Which organisation should oversee any new system?

Chapter 7 picks up this issue, starting with which organisation might best do the rating and what might be some wider implications in the current health and social care systems?

We identify the key features needed in a rating organisation and conclude that the most obvious candidate would be the CQC. There are significant management challenges for the CQC already; changing its strategy to include the development and introduction of a rating, as well as any related work such as better targeting of inspections according to risk, would add to those management challenges. The CQC would need political support, support from the main national stakeholders, resources, and time to develop, as well as stability over a period of time, if a rating system were to be effective.

We also considered how a rating system might effectively co-exist with the wider system in health and social care for 'improvement' – i.e. activities designed to encourage and support providers to improve the quality of care provided. The key points here are that the rating system should synergise in particular with the commissioning system, and also encourage (not crowd out) local and national peer review activities for providers, particularly in health care. These activities are potentially very important in encouraging self-improvement for providers, and are underdeveloped.

Presenting information to the public

How exactly information should be presented to the public is also discussed. We conclude that although the rating should be continually refreshed throughout the year as new information came to light, there would be advantages in the publication of an annual 'verdict' that could promote greater accountability to the public. While the rating itself may not contain an element on the financial health of the provider, there may be merit in publishing an annual verdict at the same time by those organisations (in health care) which assess this, for example Monitor in the case of NHS foundation trusts and the NHS Trust Development Authority for NHS trusts. Such a move may help make clearer to the public in which organisations there are persistent dual concerns about quality and financial health. However, how best to present an annual verdict in a way that did not give inappropriate messages to the public or the media would need to be very carefully thought through, given the likely power of publication.

We suggest that more detailed work would need to be done on how best to present and market the information in a rating to the public for it to be understood properly and to allow greater use – a task beyond the scope of this Review.

If the value of the rating was in it being a single trusted independent source of aggregate information of performance across the spectrum, then there are implications, particularly in health care, as to how information from other 'official' sources are presented. For example, it might be confusing if there were an aggregate rating on quality produced by the CQC and another produced by the NHS Commissioning Board. The Department of Health has a role here to help co-ordinate strategies appropriately

We note the regrettable lack of evaluation of previous ratings systems, which is likely to have hampered their effective development. It would be important that any new system is fully evaluated to assess its benefits versus drawbacks. Consideration should be given to road-testing any new system, to avoid any unintended consequences or perverse effects.

Conclusion

So, in conclusion, is introducing a new rating system a policy worth pursuing?

Our analysis suggests that there is a clear gap in the provision of clearly presented, comprehensive and trusted information on the quality of care of providers which might properly inform the public and users about the quality of care, as well as improve the accountability of providers to the public.

The decision to go ahead will rest on a range of information, some outside the scope of this Review, for example the overall likely costs of introducing a rating system next to other priorities in both sectors. The overall costs could be reduced if a rating could be an adjunct to other similar activity (as described in Chapters 3 and 4) or replace it. These are properly political decisions.

From this analysis, the balance of cost and benefits may be more favourable for providers of social care and for general practices (given the potential for choice and nature of care). However, the benefits are less certain for hospitals, given the way that ratings were designed and used in the past. Indeed this was the main response from the participants in the engagement exercise carried out in this Review.

We conclude that the benefits of introducing a rating system will be much more likely if the following occurred as a minimum:

- Any extra burden that a rating might impose on providers (or commissioners of care), which might detract from front-line care, is assessed explicitly and minimised as a priority. To help, inspections by the rating organisation would need to be developed effectively to target providers by risk.

- The organisation doing the rating (we assume the CQC) is given the resources and time to manage and develop a new strategic direction, political support and support from other stakeholders, as well as stability from disruption over a period of time.

- The design and presentation of the rating is sector-led with groups representing the public and users of care meaningfully involved. This way the rating might reflect more what really matters to the public, and win the hearts and minds of staff attempting to improve care. There would need to be alignment with existing frameworks for assessing quality and a consensual process agreed to further development of the rating in future.

- For hospitals, the goal should be to introduce ratings that drill down to the level of individual departments and clinical services so that patients can have a much truer understanding of the quality of care provided in those departments.

- Further market research is undertaken to better understand how to communicate ratings to the public, particularly those in areas with limited choice of provider.

- There is clarity as to how the rating fits with wider activities to help support providers to improve, for example commissioning, and the work of other regulators.

- The rating system links closely with systems designed to spot, investigate and manage lapses in quality, and the rating signals appropriately and early, where there are concerns being investigated.

- An evaluation of the costs and benefits is undertaken from the very beginning.

- There is support for the development of ratings over the medium term (subject to evaluation results) by political and other key stakeholders, and a road map for indicator development is established over the next five to 10 years. The emphasis here should be to develop assessment of individual clinical services (particularly within hospitals) and for groups of patients most at risk.

There are potential benefits of ratings for quality, including for hospitals, but these will only have a chance of being realised if these steps are followed.

We were struck by the goodwill and thoughtfulness of all who took part, many of whom expressed willingness to help shape any new arrangements, which augurs well for the future. To those who contributed we express sincere thanks and hope that this review does some justice to their generous contributions.

1. Introduction

Should there be 'Ofsted-style ratings' for health and social care providers? If it is possible to identify excellent and poorly performing schools, why not in health and social care? Would such ratings be valuable to the public, to providers themselves and to others? Would they help encourage better performance? If so, how best should they be designed and implemented and which organisation is best placed to do this?

These were some of the questions which in November 2012 prompted the Secretary of State for Health, The Rt Hon Jeremy Hunt MP, to commission an independent body, the Nuffield Trust, to carry out a review on the subject. The specific terms of reference were:

- To map the current system of assessing the quality and safety of care of providers of health and social care, and the current system of accountability for quality of care.

- To identify the advantages and disadvantages of aggregate assessment of providers of health and social care.

- To identify in broad terms how best to combine relevant current and historic data on quality (safety, effectiveness, and user experience) and information from inspection to provide useful, credible and meaningful aggregate assessment for comparing the performance of organisations providing health care and social care. Key goals will be to use existing metrics, rather than require costly new data collection, and not to create extra burdens on providers.

- To suggest priorities for developing data and testing metrics in the short to medium term, to allow better aggregate comparative assessment.

- To identify which organisation/s might be best placed to provide such aggregate comparative assessments.

In addressing the above we defined 'aggregate' loosely. We defined providers as being publicly or independently owned, and due to time constraints considered the following groups: hospitals; general practices; and providers of adult social care – care homes (residential or nursing home providers) and domiciliary care providers. As an indication of numbers of providers in these groups, in the last year there were 291 NHS provider trusts registered with the Care Quality Commission (CQC), 1,227 independent health care facilities (only a very few of which will be hospitals) and 12,500 providers of adult social care, and 8,316 GP practices in England (Care Quality Commission, 2012).

As shorthand for 'aggregate assessment' of performance we use the term 'rating'.

To help gather intelligence we employed two main methods: engagement with key stakeholders; and reviews of relevant literature. The engagement process involved:

- a set of meetings with key groups of stakeholders

- an eight-week online consultation process

- a series of three focus groups with the public

- bilateral meetings with key individuals.

We were struck by the generous contributions made by many and extend our thanks. The engagement process with key individuals and stakeholders was highly iterative and this report hopefully reflects many of the issues raised. The process is described in more detail in Appendix 1. The reviews of literature included grey and peer-reviewed literature. We are grateful also to have been supported by an advisory group, the membership and terms of reference of which are shown in Appendix 2. The conclusions in the report are however solely those of the Nuffield Trust.

The breadth of the terms of reference, and the brevity of time available for the Review meant we focused on identifying key themes relevant to the questions posed. Also, because of time, the evidence used to support some themes is illustrative and not a thorough review. Nevertheless we believe that the Review sets out useful points to help policymakers reach a decision as to whether or not to introduce aggregate assessment of providers published as a rating.

The structure of this report is as follows. Chapter 2 covers a brief history of ratings in health and social care – what was their purpose, how were they constructed, what was their impact, and why they were abolished. Chapter 3 outlines the current policy landscape for promoting high-quality care in providers across the health system and asks, "What would a new system of rating add and to what extent is there support for its introduction?". Chapter 4 asks the same questions with regard to the social care system. Chapter 5 examines what might be the main purpose of a ratings system today. Chapter 6 examines how ratings might best be constructed, learning lessons from the past. Chapter 7 examines which organisation might best construct the ratings and why, and some implications of introducing a system of ratings in the current environment. Chapter 8 offers broad conclusions.

2. Ratings in health and social care: a brief history

In this chapter we outline previous systems of rating the quality of care for health and social care providers used since 1997 and their impact. Because of reference to the potential value in health care of Ofsted-style ratings (Department of Health, 2012a), a brief outline of how ratings work in the education sector is also included.

Performance rating in the NHS 1997 to 2000

Though performance indicators for public sector services have been around since the 1980s, we start our review in 1997 and the new Labour Government's first White Paper on the NHS *The New NHS, Modern, Dependable* (Department of Health, 1997), which stated that patients would be guaranteed national standards of excellence, along with new incentives and sanctions to improve quality and efficiency. Further detail was later set out in *A First Class Service – Quality in the NHS* (Department of Health, 1998a). This strategy focused on setting standards (through the National Institute for Clinical Excellence (NICE) and National Service Frameworks), delivering standards (through improved clinical governance) and monitoring standards locally (by health authorities and primary care groups) and nationally (by the NHS Executive) against a framework (Department of Health, 1998a). The NHS Performance Assessment Framework (PAF) (Department of Health, 1999) was introduced in 1999 to serve that purpose.

The PAF was envisaged as a single system for monitoring progress against a set of centrally determined objectives. This required some process for measuring, assessing and rewarding NHS performance, and was organised across six areas of care: health improvement, fair access, effective delivery of appropriate health care, efficiency, patient/carer experience and health outcomes of NHS care. Each area of care was underpinned by a set of NHS performance indicators[1] to allow comparison between health authority areas and in some instances between NHS trusts. Its purpose was twofold: both to assist in the improvement of services, and to assess performance across areas and providers (Department of Health, 1999).

From 2000, the Labour government relied heavily on centrally-driven performance management of the health services (Dixon and others, 2012) and across the public sector (Smith and Busse, 2009). The NHS Plan was published in 2000 and outlined the Government's vision for patient-centred care, a new delivery system for the NHS and changes between the NHS and the private sector. The NHS Plan endorsed the NHS PAF (Department of Health, 2000).

The NHS performance ratings (star ratings)

In September 2001, the NHS Executive issued all non-specialist acute NHS trusts with a performance rating (stars) on a four-point scale that reflected their performance

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1   Called high-level performance indicators (HLPIs)

during the 2000/01 financial year (Department of Health, 2001a). Ratings were based upon performance against key national targets (such as waiting times) and a broader range of indicators that formed the balanced scorecard (Department of Health, 2001a).

Trusts with the highest level of performance were awarded a rating of three stars and allowed (in theory) greater autonomy, greater capital investment and financial freedom regarding the NHS Performance Fund, and ability to apply for foundation trust status (Department of Health, 2002a).

Trusts that were zero-rated were required to produce a Performance Action Plan which was agreed with the Modernisation Agency and the trust's Regional Office (Department of Health, 2002a). In addition, the trust would be "named and shamed" as failing and the chief executive was at risk of losing their job. In 2000/01, the then Secretary of State for Health described the 12 zero-rated hospitals as the 'dirty dozen' and six of their chief executives were dismissed (Bevan and Hamblin, 2009). Therefore, the main purpose of the star ratings was apparently to improve performance of providers, in particular with regard to key national targets, rather than to inform choice for the public.

In 2001/02, the performance assessment was extended to cover all NHS trusts,[2] and the Commission for Health Improvement (CHI) clinical governance review was included in the framework, where available (Department of Health, 2002b).

The Commission for Health Improvement (2000–2004)

CHI was established in April 2000 following the Health Act (1999). At its inception in 1999, the then Prime Minister described CHI as an 'Ofsted' for the NHS, although there were doubts at the time that CHI could have a similar role to Ofsted, partly because of the political risk of naming a hospital as 'failing' was far greater than naming a school as failing, and partly because CHI's focus was on improvement and support compared to the then Ofsted's perceived 'big stick' deterrence model of inspection (Bevan and Cornwell, 2006). Nevertheless CHI was established at a time when the Government was placing significant investment into the NHS, coupled with strong performance management of commissioners and providers to deliver national targets.

In 2000, it was envisaged that CHI "would carry out local reviews to check that systems to monitor, assure and improve clinical quality [were] in place" to support the PAF (Department of Health, 1999). The remit was assessment of NHS provider trusts, not independent sector providers or general practices. CHI undertook a rolling programme of clinical governance reviews of providers aiming to cover all NHS trusts; the cycle was only just being completed on the demise of CHI (after four years, in 2004). The reviews spanned seven 'pillars' of clinical governance: risk management, clinical audit, research and education, patient involvement, information management, staff involvement, education, training and development. However, the assessments focused largely on the processes and organisation of care, rather than directly assessing quality and outcomes which was more difficult (Walshe, 2002). There was evidence that their inspections and reports were generally well received and acted on by trusts (Benson and others, 2004), although there were concerns by trusts about the burden of inspections. In addition, CHI undertook investigations into serious service failures in

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2 This included acute trusts, specialist trusts, ambulance trusts, primary care trusts, mental health trusts and trusts providing services for people with learning disabilities.

the quality of care within the NHS. Regulatory issues relating to financial management were the responsibility of the Audit Commission.

In 2002, the Department of Health transferred responsibility for the star ratings system to the CHI (following the Bristol Royal Infirmary Inquiry) and made it the independent regulator of NHS performance. In 2002/03 CHI published ratings for all NHS trusts[3] and improved the transparency of the ratings process by publishing in advance the confirmed lists of indicators and the technical specifications used to calculate them. CHI's findings from clinical governance reviews were included in the ratings and could modify a rating using a set of rules, known as the Finsbury Rules (Commission for Health Improvement, 2003a; 2003b).

CHI's name included the word improvement – and this was felt to be an important element in its mission. However the main improvement activity CHI undertook was in assessing performance and publishing results, rather than direct support of providers to improve care.

Impact of star ratings

The star rating system improved reported performance on key targets in the English NHS (e.g. the four-hour waiting time targets in A&E and eight-minute response time for ambulance trusts) (Bevan and Hood, 2006a), but they had their limitations. A review by Bevan and Hamblin (2009) identified numerous other studies that showed reported improvements in performance in England, but each highlighted common criticisms of star ratings. For example, there was criticism from managers about the scoring methodology, in particular the sensitivity of the ratings to small fluctuations in data (Barker and others, 2004).There was a widespread view among clinicians that national ratings distorted local priorities for clinical care (Mannion and others, 2005a). Participants in the review's engagement exercise gave examples of direct political interference in the star rating of trusts, which reduced confidence in, sector ownership of, and credibility of, the ratings system. Common criticisms were summarised by Bevan and Hamblin into six themes, as shown in Figure 2.1.

Figure 2.1: Common criticisms of star ratings – summary adapted from Bevan and Hamblin (2009)
Measure what matters: Often the most important aspects of performance cannot be measured and as a result it is necessary to use process indicators as proxies for clinical quality. Star ratings were criticised for being heavily focused on process measures, rather than outcomes.
Indicator selection: Which indicator to include in a rating is difficult to determine, especially when reflecting the complexity of a hospital setting. Regulation by targets assumes that priorities can be targeted, the part that is measured can stand for the whole, and what is omitted does not matter (Bevan, 2006).
Nature of measure: Performance indicators are often "tin openers" rather than "dials" – they do not give an answer but do prompt investigation and inquiry (Carter and others, 1995 from Bevan and Hamblin, 2009).
Methodology: Aggregation of indicators and league tables was so complex that it was difficult for an organisation to understand why its rating had changed – *not knowing what the providers were aiming for was difficult and the Health Commission was later praised for publishing the indicators and methods before reporting on performance.*
Unintended consequences (gaming): In some cases data may have been manipulated to achieve targets; in others, actions may have been taken at odds to the substantive goals behind those targets ("hitting the target, missing the point", or gaming).
Unintended consequences (morale): Publically inflicting reputational damage on hospitals damaged staff morale and affected staff recruitment (Horton, 2004; Mannion and others*,* 2005a; 2005b from Bevan and Hamblin, 2009).

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3 This included acute trusts, specialist trusts, ambulance trusts, primary care trusts, mental health trusts and trusts providing services for people with learning disabilities.

CHI was abolished in 2004. A review at the time made a number of recommendations for the future development of regulation of the quality of health care, namely that there should be a more targeted approach to regulatory processes, the consistency and reliability of inspections should be improved and the regulatory cycle should be short enough to ensure there are not fallow periods during which little progress is likely to be made (Benson and others, 2004).

The Healthcare Commission (2004–2009)

In April 2002, the Government announced plans for CHI to be replaced by a new body – the Commission for Healthcare Audit and Inspection (CHAI) – to be the authoritative, independent judge of both the quality and efficiency of health care. The Health and Social Care Act (2003), which established CHAI (later incorporated into the Healthcare Commission), and policies at the time, heralded a desired shift in the 'balance of power' in the NHS away from 'top-down command and control' to the concept of 'earned autonomy' where high-performing NHS trusts could enjoy more freedom to innovate. The rationale was that the new regulator, the Healthcare Commission, was to play an important role in:

- holding "autonomous bodies" to account for their performance

- publishing information to aid patient choice

- developing a risk-based regulatory system, making regulation targeted and proportionate (Healthcare Commission, 2009).

At this time the government also established NHS foundation trusts, with Monitor as their independent regulator. The Healthcare Commission brought together the regulation of the NHS with the regulation of the independent healthcare sector from the National Care Standards Commission (Dewar, 2002), the functions of the Mental Health Act Commission, and parts of the health care brief from the Audit Commission (mainly national value for money studies in health care). The Healthcare Commission was also required to work closely with the new regulator of social care, the Commission for Social Care Inspection (CSCI), which was developed in parallel.[4]

The Healthcare Commission had a statutory duty to complete annual performance assessments of providers and award an annual rating. It developed and published the inherited star ratings covering 2003/04 (Healthcare Commission, 2004) and 2004/05 (Healthcare Commission, 2005a) for acute, specialist, ambulance, mental health and primary care trusts (learning disability trusts were now excluded because the available indicators were insufficient). General practices were not included beyond their role in PCT assessments.

For 2003/04, some changes were made to the indicators and the methodology used, and improvements in the data to reflect patient experience (through patient surveys including users of mental health and ambulance services) (Healthcare Commission, 2004). For 2003/04, each provider was still awarded a star rating, but the underlying results were presented differently; achievement against the balanced scorecard indicators was summarised into a high, medium or low grading, and achievement against key targets summarised as pass/borderline/moderate/fail. In 2003/04 the ratings for primary care, mental health and ambulance trusts took into consideration

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4   CSCI brought together the Social Services Inspectorate (SSI), the joint review team of the SSI and Audit Commission, and the NCSC's role in relation to social care (see Chapter 4 for additional detail).

results from clinical governance reviews carried out by Healthcare Commission (and its predecessor CHI) but these were not considered for acute and specialist trusts (as many were no longer current).

For 2004/05 the performance ratings followed the format of the previous year, with one change – the decision to exclude the assessment score from all clinical governance reviews from the performance ratings. This decision was taken by the Healthcare Commission following feedback from the strategic health authorities and trusts (Healthcare Commission, 2005a) – the clinical governance reviews were thought to be very burdensome by some NHS trusts, not timely enough to be useful, and unfair (as not all trusts had had a review in the same year as the 'rating').

Annual Health Check

Background

In January 2005 the Healthcare Commission published the *Assessment for Improvement: The Annual Health Check* (Healthcare Commission, 2005b). This outlined a new system to replace star ratings, one with a broader assessment drawing in a wider range of information than star ratings. The objectives of the Annual Health Check (AHC) were to:

- provide assurance that NHS health care services in England were meeting essential quality and safety standards for everyone

- ensure that health care organisations were seeking to improve and provide value for money

- bring together information on the performance of health care services to make it available to the sector and members of the public to inform better decision making (Healthcare Commission, 2008a).

The first AHCs for NHS organisations were published for 2005/06, and performance was presented in a dashboard format supported by a written commentary on key areas of performance. Performance against core standards and existing national targets was graded as fully met, almost met, partly met, or not met. Performance against all other components and the overall rating was on the scale excellent/good/fair/weak. The four-point scale was selected to align with the approach used by the Audit Commission's assessment of the performance of local authorities under the comprehensive performance assessment (Audit Commission, 2002b; 2003). The AHC was published by the Healthcare Commission in October of each year for 2005/06, 2006/07 and 2007/08.

A change in approach towards health care organisation's responsibilities

The AHC, unlike star ratings, had to include an assessment of core standards covering seven domains of care.[5] The assessment was based on a combination of a public statement, a declaration by the board about compliance with these standards and a process of selective inspection. Self-declaration was considered a good way to hold boards to account and was consistent with other governance arrangements whereby boards were legally responsible for the performance of their organisations (Kennedy, 2008). Trust self-declaration would be checked by selective unannounced risk-based inspections, along with some random inspections (Healthcare Commission, 2005b).

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5   Safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, public health

Not all organisations could be inspected, so inspections were triggered by information indicating there were areas of concern with regard to the core standards – an "information-led, risk-based" system of regulation (Bardsley and others, 2009). This signalled a change in approach towards increasing the onus on health care organisations to ensure their own quality and efficiency, with the regulator as back stop.

The AHC also included other assessments, notably against old national targets (known as existing commitments), which were judged by a series of scored indicators. In the early years the score also included assessment from specific reviews, 'deeper dive' thematic or improvement reviews, targeted on specific topics: for example thematic reviews of services such as children's services (Healthcare Commission, 2008c) or acute hospital services (Healthcare Commission, 2008d). Though used in the earlier years, these were taken out of the scoring system.

At the same time, the Healthcare Commission had a system of specific investigations into serious service failure, which once completed could be used to moderate an AHC score.

Framework of assessment

In constructing the rating, the Healthcare Commission was able to decide upon the technical methodology, for example the actual indicators used and the rules to score and aggregate them, but the criteria for assessment needed sign-off by the Department of Health and the Secretary of State for Health. The AHC was essentially a retrospective assessment of NHS trusts and commissioners (primary care trusts[6]) compiled annually using information from inspection and data from a range of sources (Healthcare Commission, 2005b). Self-assessment and inspection methods were used to ascertain performance against core standards whilst indicators were used for national targets (measured in a similar way to the old star ratings) and the selected reviews of specific topics (thematic or improvement reviews). The AHC also included an element on financial management; this was based directly on assessment by either the Audit Commission or Monitor (Healthcare Commission, 2005b). The framework of assessment also tested ways to include more stretching 'developmental standards'. While there was aspiration to apply developmental standards and incorporate local targets, this proved too challenging to be implemented widely (Healthcare Commission, 2009).

Data collection

One of the constraints on both star ratings and the AHC was the idea that the elements used in an assessment had to be the same across all trusts. As far as possible the Healthcare Commission developed ways to exploit data from existing sources so as to reduce the 'perceived burden of regulation': the number of special collections of data to measure progress in meeting government priorities decreased by over 50 per cent since 2005/06 (Healthcare Commission, 2009). However, in some cases, for national targets and improvement reviews, the Healthcare Commission did explicitly require trusts to send in data from bespoke information requests.

The Healthcare Commission website became a repository for information about trust including the elements that underpinned the AHC, such as summary data on the risk profiles used to select trusts for inspection, inspection reports and surveys results. As

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6   This included all activities of primary care trusts (whether provided directly by the PCT, or commissioned from providers or independent contractors such as GPs) (Healthcare Commission, 2005b)

well as the AHC, the Healthcare Commission carried out several other functions (that did not always directly feed into a trust's overall performance rating).

Serious service failure

The Healthcare Commission, as did CHI before it, had a responsibility to undertake investigations into serious service failures, including making recommendations to Monitor and the Secretary of State for Health. The investigations were undertaken by a specialist team in response to serious concerns raised by whistle-blowers, referrals from the service itself or from Department of Health and government. There were relatively few full-scale investigations (17 during the existence of the Healthcare Commission), and examples include the management of hospital-associated infections at Maidstone and Tunbridge Wells NHS Trust, maternity services at Northwick Park and high mortality rates at Mid Staffordshire NHS Trust (Healthcare Commission, 2009).

From 2006, the Healthcare Commission developed a process whereby information could be used to initiate this escalation process, for example analysis of mortality rates in NHS trusts to detect outliers. This function was known as 'surveillance' and rested in part in spotting potentially worrying patterns from a vast array of information, routine and bespoke, hard data and softer intelligence. This 'surveillance science' was in the early stages of development during the existence of the Healthcare Commission and important in helping to spot and tackle failure in clinical care. The functions were highly relevant to support the rating system, since it was known that clinical failures could occur in a trust which appeared to be fair, good or excellent on an aggregate rating such as the AHC – as in the case of Mid Staffordshire NHS Foundation Trust in 2007/8. Indeed, as noted by Sir Ian Kennedy, Chair of the Healthcare Commission in his testimony to the Public Inquiry on Mid Staffordshire NHS Foundation Trust, an aggregate rating can, and did, mask pockets of poor performance in a Trust.

"[The Annual Health Check] was better able to identify compliance with standards... it was less able to identify certain areas of failure if they were – and I would hold to the view, if they were in certain areas of practice, which might be masked by the whole – the whole trust's performance." (Mid Staffordshire Inquiry, 2011)

However, finding an appropriate way to signal concerns about a provider spotted using surveillance and subsequently investigated (for example Mid Staffordshire NHS Foundation Trust) was not achieved prior to the demise of the Healthcare Commission.

Independent sector regulation

Unlike CHI, the Healthcare Commission also had some responsibility for the regulation of the independent sector provision, to provide assurance that independent providers could be only be registered if they met the National Minimum Standards for Independent Health Care (Department of Health, 2002c). This was viewed largely as a consumer protection role (Healthcare Commission, 2009). The assessment was different to that for the NHS although there were common elements including greater emphasis on self-assessment, supplemented by unannounced spot checks focused on pre-selected standards. Throughout its existence, there was a search within the Healthcare Commission to develop a "level playing field" between NHS and independent sector assessment.

Impact of the Annual Health Check

Performance

NHS performance (as measured by the Annual Health Check) and independent sector performance (as measured against National Minimum Standards) did improve over the years of the Healthcare Commission, and the Healthcare Commission considered that their assessments contributed to these positive trends (Healthcare Commission, 2008b; 2009).

There is evidence to suggest that performance against standards or targets improved over time. For example, the proportion of NHS trusts rated "excellent" or "good" increased from 46 per cent in 2005/06 to 60 per cent in 2007/08. The Care Quality Commission published a review of the four years 2006–2009 of the AHC to show the distribution of trusts (provider trusts and primary care trusts) by score category and how this had changed. The results on quality of care for acute and specialist providers are shown below in Figure 2.2.

Figure 2.2: Performance on overall quality according to the Annual Health Check for acute and specialist truct performance in England (2006–9)

Reproduced from Care Quality Commission (2009a)
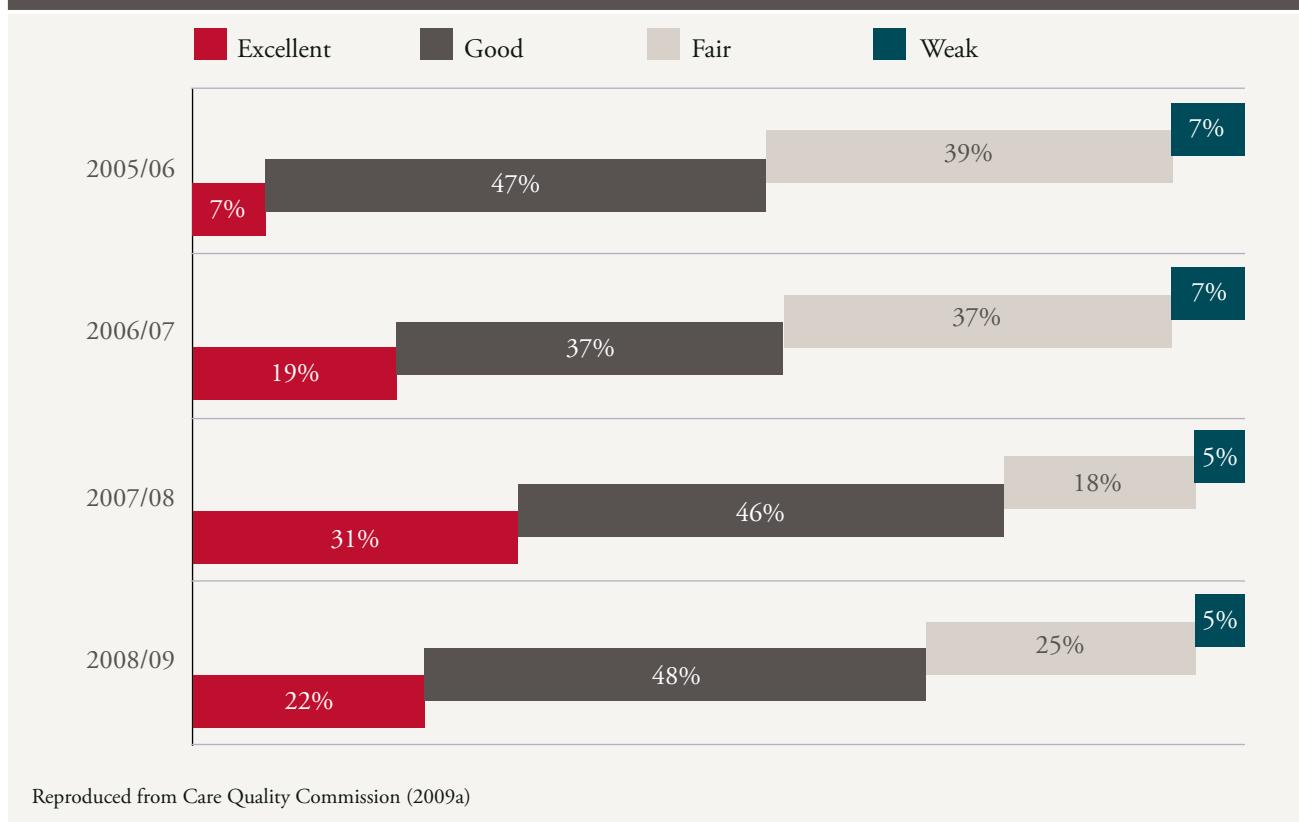
The results show a mixed picture, with performance generally improving over the four years but a dip in the number of trusts in the 'excellent' category in 2008/9. Performance against national priorities proved to be the most challenging of the three assessments that formed the overall quality score (Care Quality Commission, 2009a).

Some of this may have been due to trusts getting better at 'satisfying the regulator' but a number of standards and targets had become tougher over this period (Healthcare

Commission, 2009). However, improvement was not seen across all aspects of care, with some providers showing no improvement over the years of the AHC. Political pressures and strong performance management in the system may have resulted in greater progress against targets which were easily measured and managed, compared to others which may be more important, but were more difficult to measure (Healthcare Commission, 2009). There was also evidence of year-on-year improvements in NHS trusts' financial management from the Audit Commission's annual assessments, which fed into the AHC (Healthcare Commission, 2008b).

Whilst accusations of 'gaming' were common with regard to achievement of a relatively small number of indicators related to national targets, the Healthcare Commission suggested that it would be more difficult to game the system against the wealth of intelligence and information that the Commission was able to analyse.

Perceptions from NHS organisations

An evaluation of the AHC (2006/07) found that the majority of trusts considered it helpful for patient care, but that more could be done to reduce duplication with the work of other regulators. However, some providers were concerned about whether the AHC had produced a true reflection of their services (Healthcare Commission, 2008a). Participants in the Review's engagement exercise emphasised that the AHC, as with the star ratings system it replaced, focused management attention on the areas being rated. While this did lead to improvements, in some instances it led to perverse incentives, and skewed priorities, and encouraged a bullying style of management. For example, the Healthcare Commission highlighted that poor governance and leadership was a common theme from service failure investigations – with a tendency for boards to concentrate on other activities such as the delivery of targets at the expense of safety (Healthcare Commission, 2008b).

In carrying out the AHC, the Healthcare Commission had ongoing debates as to the extent to which it should try to drive improvement as well as publish ratings, debates which were not resolved. The Healthcare Commission had a legitimate service improvement function through its thematic reviews and investigations into services failures. Both aspects of the Healthcare Commission's work were well received by NHS organisations, suggesting the result had a positive impact for patients, and improved patient safety and the quality of care (Healthcare Commission, 2009).

Lessons learnt

The Healthcare Commission was abolished in April 2009. Lessons identified from the organisation's approach to regulation are summarised in Figure 2.3. Sir Ian Kennedy regretted there was not the time to develop the AHC further into a prospective rather than a retrospective system, to assess pathways of care and the clinical outcomes achieved, or to improve the way patient experience is incorporated (Kennedy, 2008).

Figure 2.3: Some recommendations from the Healthcare Commission's approach to regulation (2004–2009)

1. The regulatory system should include a range of regulatory tools and approaches which can be applied in relation to the risks in various sectors (provider, commissioner, health, social care)

2. Organisations should be held to account for the quality of services they provide – role of self-assurance

3. Sector led measures should be developed with clinical input and working with members of the public and patients to reflect what is important to them

4. Effective use must be made of existing information

5. Regulation needs to be aligned with other mechanisms and goals across the system

6. There should be robust intervention and investigation to tackle poor performance

7. Regulators should have the capacity to respond to requests to take further functions, and establish a local presence

Source: Healthcare Commission (2009).

Performance rating in social care 1999 to 2009

As with health, the Labour Government introduced a raft of reforms relating to social care quality in the late 1990's onwards. The *Modernising Social Services* White Paper (Department of Health, 1998b) set out that the Government would set new standards of performance and would publish annual reports on all council's performance; would introduce a Commission for Care Standards to regulate residential and domiciliary care and would strengthen the role of the Social Service Inspectorate, which had been set-up in 1985 as a professional division of the Department of Health. The Care Standards Act (2000) made provision for the establishment of the National Care Standards Commission (NCSC), regulation and registration of providers of social care services and established the General Social Care Council. The NCSC's role was to regulate statutory, voluntary and private sector social care services and relevant parts of the independent health care market. It inspected against national minimum standards determined by the Secretary of State. The Social Services Inspectorate (SSI) assessed how well each local council delivered their social services functions and supported them in improving their performance (Social Services Inspectorate, 2003).

In a speech to the Annual Social Services Conference in October 2001, the then Secretary of State, the Rt Hon Alan Milburn MP, announced the introduction of easily-accessible ratings for the public:

"Accessible information for the users of public services is essential if we are to design services around the needs of users. That is what we are doing with schools and hospitals. And it is what we must now do for social service." (Department of Health, 2001b)

Social Services Inspectorate rating of councils

The first ratings related to social care were published in May 2002 (Social Services Inspectorate, 2002a) by the SSI, for local councils with social services responsibilities. Star ratings were published annually and did not generally change in-year; however, if there were some serious concerns about a council's performance during the year, the rating would be adjusted to zero and special monitoring arrangements were put in place. The SSI had a role in service improvement through completing an Annual Review Meeting with each council to bring out strengths, areas for development and actions for the coming year. Summaries of these reviews were published alongside the star ratings of performance on the Department of Health's star ratings website.

Construction

The ratings were based on a set of performance indicators drawn from available performance data and inspections and monitoring information (including information from the Annual Review Meetings the SSI held with every council; joint Audit Commission/SSI reviews). The SSI made judgements on the performance of child and adult services reflecting current performance:

- Serving people well?: No / Most / Some / Yes

- Prospects for improvement: Poor / Uncertain / Promising / Excellent

and these were then aggregated into a single star rating. This was a subjective process but a set of descriptive benchmarks were produced to help guide inspectors. If adult or children's services were assessed to be failing, then the council was awarded zero stars, irrespective of how good the other services were. The worst-performing councils received zero stars and the best three stars – to reflect the presentation in use at the time for the NHS Performance Ratings. As with the NHS, councils performing well would receive greater freedoms, which were to be defined based on suggestions from the councils themselves. Councils with zero stars were required to produce an action plan explaining how they were going to improve performance, and provide regular monitoring information to SSI (Social Services Inspectorate, 2002b).

Comprehensive performance assessments

In December 2001, the local government White Paper *Strong Local Leadership, Quality Public Services* announced that the Audit Commission would work with specialist inspectorates to undertake comprehensive performance assessments (CPA) of all local councils in England (DTLR, 2001). The star ratings for social services subsequently became part of the CPA.

From 2002 to 2004 the Audit Commission carried out the CPA of single-tier and county councils, which spanned a wide range of services including education, social services (average of children's and adults' score), environment, housing, libraries and leisure, benefits and use of resources (Audit Commission, 2002a). The CPA assessment included reviewing available evidence on 'current performance' in core services, self-assessment on "judgement about the council's ability to improve services for local people and deliver positive change for their communities", and external 'corporate assessment' carried out by a small team, which included an auditor and inspector as well as officers and councillors from 'peer' councils (Audit Commission, 2002b). Councils were judged to be poor/fair/good/excellent. High-performing councils were rewarded with less ring-fencing and fewer, lighter-touch inspections, fewer planning requirements, and freedom to use income from fines. In April 2007, the responsibility for assessing children's services transferred to the Office for Standards in Education, Children's Services and Skills (Ofsted), and so social care star ratings from then onwards related to councils' performance on adults' social care only (Care Quality Commission, 2009b).

Commission for Social Care Inspection (CSCI) (2004–2009)

The Commission for Social Care Inspection (CSCI) was created by the Health and Social Care (Community Health and Standards) Act 2003 and became fully operational on 1 April 2004. CSCI incorporated the functions of the SSI together with

the social care responsibilities of the National Care Standards Commission and some functions of the Audit Commission. CSCI published its first performance ratings of all councils with social services responsibilities in November 2004 with the final set in November 2008 (Commission for Social Care Inspection, 2009a). During 2007, CSCI launched a new outcomes framework supported by a new self-assessment survey (Commission for Social Care Inspection, 2008). The methodology for the performance ratings of councils was developed by CSCI in consultation with councils and agreed with the Department of Health – because these ratings dealt with performance, they included some PSA targets and thresholds and were formally agreed with Ministers. CSCI's legacy document suggested that the council ratings were based on continuous, rigorous and structured assessment and that year-on-year council performance had improved in terms of addressing policy requirements for adult social care, with 87 per cent of councils in 2008 being judged to be delivering 'excellent' or 'good' outcomes for people who use social care (Commission for Social Care Inspection, 2009a).

Provider quality ratings

In May 2008, CSCI published quality ratings for all regulated adult social care services (including care homes, domiciliary care and adult placement (shared lives)) for the first time. The main aims of quality ratings were:

- to assist people using regulated care services, their families and carers to make informed decisions about which providers to use

- to make it easier for people using care services to assess a provider

- to encourage providers to improve their service

- to help stamp out bad practice (Commission for Social Care Inspection, 2009b).

The quality ratings were based on the national minimum standards but had various levels (1–3 stars), based on outcome descriptors developed with people who used services. The policy was agreed with the Department of Health but developing the content was very much left to CSCI. The quality ratings did not contain PSA targets as these targets did not apply to the independent sector.

Impact

In 2009, a review was commissioned by CSCI on the first year of the published star ratings. The review suggested the quality ratings were well received by members of the public, commissioners (local councils) and providers. The key benefits reported were that the ratings provided an indication of quality, allowed comparison between services, were easy to understand and helped inform choice. In addition, some councils used the ratings to help lever improvement in a competitive market, achieving better value for money (Commission for Social Care Inspection, 2009b). The analysis also showed that the ratings were used most by local authority commissioners of care, then by carers and relatives of those needing care, then the individuals themselves. CSCI's legacy document suggested that since the introduction of ratings there had been a significant reduction in the overall numbers of poor services (Commission for Social Care Inspection, 2009a).

Respondents to this Ratings Review engagement exercise were overall positive about the CSCI system of star ratings (though they admit they were not at the time CSCI was operating). The system was described as simple, consistent, accessible, reliable,

well accepted, extremely useful, having worked well and having been abolished prematurely. It was felt that ratings were used by the public and that there was now a gap in information available from trusted sources, particularly for self-funders. The CQC website was thought to have limited information in comparison. Many providers, in particular, were positive about the ratings; some chains of providers using ratings to compare their own care homes with each other and performance manage staff. The recent report from the Voluntary Organisations Disability Group and the National Care Forum reflects this and suggests that in the past, providers used ratings as an internal management lever and as a promotional tool whilst ratings also helped commissioners focus on driving improvement, not just deal with failure (Walden, 2013).

However, some drawbacks were also mentioned by participants in the Review's engagement exercise. Some of the problems were to do with issues such as the administrative burden, a focus on the wrong priorities, a lack of user involvement and the fact that the ratings had not always been timely. Some suggested that the quality ratings did not always measure what clients and their families valued most, were crude measures, and lacked depth. However there was a more positive view of the CSCI ratings relative to those carried out by the SSI, which were thought to be "too fierce and damning rather than balanced and informative". CSCI inspection data could become out of date very quickly due to publication lag. For example, findings were not updated in response to a change in management at a care home. Real-time data (quantitative and qualitative) would be critical in providing high-quality information.

CSCI was abolished in 2009.

Care Quality Commission (2009–ongoing)

The consultation document, *The Future Regulation of Health and Adult Social Care in England* (Department of Health, 2006) set out the Government's intention to establish an integrated health and social care regulator that would apply a consistent approach to regulation for all types of services through a new registration regime, requiring providers of health and adult social care services to be registered. The Health and Social Care Act 2008 created the Care Quality Commission (CQC), giving it the functions of the Commission for Healthcare, Audit and Inspection, the CSCI and the Mental Health Act Commission (which had monitoring functions with regard to the operation of the Mental Health Act 1983).

Care Quality Commission functions

The Health and Social Care Act 2008 sets out that the main objectives of the Commission, which are to:

- protect and promote health safety and welfare of people who use health and social care services

- perform its functions for the general purpose of encouraging the improvement of health and social care services, encouraging the provision of health and social care services in a way that focuses on the needs and experience of users and encouraging the efficient and effective use of resources in the provision of health and social care services.

The CQC forms part of the wider quality framework, having responsibility for:

- providing independent assurance and publishing information on the safety and quality of services

- registering providers of regulated activities (including NHS, adult social care and independent sector health care providers) and monitoring compliance with a set of registration requirements, using enforcement powers (where necessary) to ensure service providers meet requirements

- undertaking special reviews and investigations of particular services, looking across providers and commissioners of health and adult social care

- monitoring the use of the Mental Health Act

- helping manage the impact of regulation on service providers and commissioners (House of Commons Health Committee, 2011).

Registration of providers

The 2008 Act stated that all providers of regulated services (including health and adult social care) must be registered with the CQC and be compliant with the essential standards of quality and safety (Care Quality Commission, 2010a). There is a process of registration based on self-declaration of compliance against 16 essential standards according to the regulations set out in Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These standards, and the indicators associated with them, focus on a level of care below which a provider of regulated services is not expected to fall. The full list of regulated services is shown in Appendix 3 and the list of essential standards is shown in full in Appendix 4.

Concern was expressed early about the challenges the CQC would face in registering all providers of health and social care services. The House of Commons Health Committee concluded in 2011 that the timescale and resource implications of the legal requirement to introduce universal registration of primary and social care providers were not adequately analysed and that the registration process was not tested and proven before wider implementation (House of Commons Health Committee, 2011).

In the financial year 2009/10 the CQC registered all 378 NHS providers; by April 2011, the CQC was due to have registered 13,000 adult social care and independent health care providers, 8,000 dentists and 350 private ambulance services; and by April 2012 the CQC was required to have registered some 8,000 providers of primary care, including GP practices, out-of-hours primary care services and NHS walk-in centres (House of Commons Health Committee, 2011). On 12 August 2011, the Department of Health announced that CQC would be able to delay the registration of GP practices until April 2013 after 96 per cent of respondents to a consultation on the issue favoured postponement (Department of Health, 2011a).

Compliance against essential standards

After registration the CQC assesses compliance against the 16 essential standards using data and inspection. CQC had used a risk-based model of regulation in which it adjusted its use of regulatory interventions (like inspection) with providers based on an assessment of risk and performance, but has recently returned to a universal schedule of annual inspection in most sectors (Walshe and Phipps, 2013).

Most CQC inspectors use a tool called the Quality and Risk Profile (QRP). Data contained within the QRP are mostly populated by existing data sources and is intended to highlight gaps in data or areas of risk. It has been suggested that the QRP has a limited reliability because of patchy data collections and social care data is virtually non-existent (House of Commons Health Committee, 2011) – but as the QRP is about organising existing information the critcism seems misguided. More recently a review for CQC found that the QRP has not been used as intended and the predictive value of some of the data items has been questioned (Walshe and Phipps, 2013).

CQC inspections can be unannounced (focusing on a minimum of five national standards), responsive (unannounced and carried out to investigate specific concerns about poor care), or themed (focusing on a specific standard of care or services, such as dignity in care) (Care Quality Commission, 2011a). The CQC retains powers under the Health and Social Care Act 2008 to carry out investigations but unlike the Healthcare Commission, does not retain a specialist team to undertake this function (Care Quality Commission, 2011b).

If a service falls below this level, the CQC has a range of regulatory powers to enforce compliance. Thus, unlike its predecessors CHI and the Healthcare Commission, the CQC does not seek to define and encourage good performance, just assess against 'essential standards'. The CQC has been clear that it is not an 'improvement agency' *per se*, rather that the improvement it seeks to promote occurs as a result of its basic functions outlined above. Like CHI, the CQC covers quality in its assessments and not financial management.

Demise of performance ratings

The last AHC was published for 2008/09 under the CQC – the final publication of aggregated ratings in the NHS. Under the 2008 Act, the Care Quality Commission has powers to undertake periodic reviews of services provided or commissioned by PCTs, services provided by NHS trusts and foundation trusts and adult social services commissioned or provided by local authorities. The 2008 Act allows the CQC to publish a performance assessment (i.e. a rating) of NHS providers, PCTs and local authorities and this function can be extended to other registered service providers through regulations. As a result, the powers of periodic review under the 2008 Act are due to be repealed by the Health and Social Care Act 2012 in April 2013. The impact assessment accompanying the 2012 Act suggests that staff had been redeployed and there was no resource within the CQC to deliver this function (Department of Health, 2011a).

The CQC became responsible for regulating adult social care in April 2009. Councils were assessed against the seven outcomes of the White Paper *Our Health, Our Care, Our Say*. The CQC replaced the star ratings with an overall assessment of adult social care performance graded as performing excellently/well/adequately/poorly. Performance ratings for adult social care by councils were published by the CQC for 2008/09 and 2009/10 (Care Quality Commission, 2010b). The Care Quality Commission continued to award ratings for adult social care providers until June 2010.

The demise of performance ratings has been rejected across the social care sector. Participants in our engagement exercise generally thought that assessments based upon

minimum standards were an inadequate basis of measurement for the quality of social care. We have received a number of comments on the difficulties that people face having to choose a social care provider and the lack of information available to support them. The Voluntary Organisations Disability Group and the National Care Forum recently published a paper arguing that published, independent, ratings of the quality of care services would be a great help in distinguishing between services in adult social care and in driving improvement (Walden, 2013).

A number of private companies have emerged onto the market to fill this perceived lacuna in quality information with varying degrees of success and credibility. The BBC highlighted a number of councils who used external, ratings agencies assessments as a basis for quality payments. However, the BBC found that 14 out of 80 homes given a four or five star rating in the Sefton area were failing to meet one or more of the essential standards set out by the CQC (Barnes, 2012).

Broader impact of the Care Quality Commission

There have been significant concerns about the capability of the CQC (Department of Health, 2012b) and its strategic direction (House of Commons Health Committee, 2013). The Department of Health acknowledged that the CQC had, since 2009, brought together three organisations, developed a new regulatory model, brought 21,000 providers into the regulatory regime and carried out over 14,000 compliance inspections and reviews. However, the Department also found that the CQC's strategic direction was limited, with accountabilities unclear at board level (Department of Health, 2012b). The House of Commons Health Committee's concerns centre around strategic direction and governance, unclear roles and responsibilities, public and sector reputation. The minutes from the Public Board meeting of the CQC held on 7 February 2013 note that the Board commissioned Professor Kieran Walshe and Denham Phipps to produce an independent report into its regulatory model. The report finds that the CQC is currently configured as a 'safety-net' regulator but that a number of decisions around implementation have been made without good evidence (for example, the return to 12 monthly inspections or decision to inspect against a subset of the essential standards), making the model unsustainable. Walshe and Phipps concluded that the generic, regulatory model of the CQC is unusual as is its reliance on generalist inspectors and that the CQC should consider introducing greater differentiation between and within sectors (Walshe and Phipps, 2013).

Office for Standards in Education, Children's Services and Skills (Ofsted)

Given the parallels made by the Secretary of State for Health between Ofsted and potential ratings for health and social care providers, we include here brief details about this regulator, its broad approach to rating schools and impact.

Ofsted was founded in 1992 as the Office for Standards in Education, but given a wider remit and renamed Office for Standards in Education, Children's Services and Skills in 2007. The political issue that led directly to the introduction of Ofsted was the perceived unacceptable level of variation between the inspection regimes of different local education authorities. All of Ofsted's work is designed to improve outcomes for children and learners, with the aim of raising standards and improving lives while providing value for money (Ofsted, 2011).

The 2006 Education and Inspection Act created a revamped Ofsted and first Ofsted Strategic Plan. This plan, covering the years 2007 to 2010, focused strongly on Ofsted as a driver of quality in education. It gave paramount importance to a single priority: "better outcomes – an organisation with impact" (Ofsted 2007). Its 2011–15 successor, however, named "better outcomes" as just one of four priorities for Ofsted, alongside focusing on underperformance, ensuring stakeholder engagement and improving the organisation's own efficiency (Ofsted, 2011).

In 2010 a White Paper, *The Importance of Teaching* (Department for Education 2010), set out a radical reform programme for the schools system, with the intention to free schools from the constraints of central government direction and place teachers firmly at the heart of school improvement. There were also changes to school performance tables, Ofsted inspections and governance. The objectives were:

- to give parents, governors and the public access to much more information about every school and how it performs

- for performance tables to set out high expectations (every pupil should have a broad education and a firm grip of the basics)

- to use attainment and progress measures to create a more sophisticated minimum expectation for all schools

- to refocus inspection on schools' core educational purpose

- to release outstanding schools from all routine inspection (Department for Education, 2010).

A key intention was to make data on performance more accessible to both users (and parents) and to the schools themselves. The White Paper noted 'In the past, too much information has been unavailable to parents, too difficult to find or not presented comprehensibly'. The aim was to make publicly available information not only on the overall rating of a school, but 'data about attainment in specific subjects, trends over time, class sizes, attendance levels, the composition of the pupil body and financial information. The data will be published in a standardised format which allows anyone to access and analyse it' in an easily accessible online format. Parents will be able to choose the aspects of a school in which they are most interested, and search for or rank local schools against these priorities. Furthermore it was the intention to group similar schools in a region to provide detailed performance information which can be used by schools to identify other schools from which they can learn (Department for Education, 2010).

Plans were laid out to reduce drastically the number of criteria on which Ofsted based its overall rating of schools, from 27 to four. This was implemented for inspections in 2012. A new minimum, or 'floor' standard, was defined, which all schools were expected to meet. This standard was higher than in the past, so that minimum expectations would rise.

Yet the approach to 'improvement' was largely envisaged as being 'sector-led'. Schools had the clear responsibility for improvement. As the White Paper put it 'We will end the approach of trying to control improvement from the centre and make it easier for schools to learn from one another' (Department for Education, 2010). Nevertheless

there were important sources of national support to help schools and local authorities do this, in particular for underperforming schools such as those below the new floor standards, and those that were seriously failing, or unable to improve their results. For this group there was the possibility of conversion to Academy status. More details on the ratings system for schools are shown in Figure 2.4 below.

Figure 2.4: Assessing performance of schools by Ofsted

Ratings for schools

Ratings are given for the following four key judgements:

- achievement of pupils at the school

- quality of teaching in the school

- behaviour and safety of pupils at the school

- quality of leadership in, and management of, the school.

Four grades are available for each judgement. An overall effectiveness grade is formulated from these four key judgements. The descriptions below apply to the school's overall effectiveness (Ofsted, 2013).

Grade 1: Outstanding

An outstanding school is highly effective in delivering outcomes that provide exceptionally well for all its pupils' needs. This ensures that pupils are very well equipped for the next stage of their education, training or employment.

Grade 2: Good

A good school is effective in delivering outcomes that provide well for all its pupils' needs. Pupils are well prepared for the next stage of their education, training or employment.

Grade 3: Requires improvement (was 'Satisfactory' prior to September 2012)

A school that requires improvement is not yet a good school, but it is not inadequate. This school will receive a full inspection within 24 months from the date of the last inspection.

Grade 4: Inadequate

A school that has serious weaknesses is inadequate overall and requires significant improvement but leadership and management are judged to be Grade 3 or better. This school will receive regular monitoring by Ofsted inspectors.

A school that requires special measures is failing to give its pupils an acceptable standard of education and the school's leaders, managers or governors have not demonstrated that they have the capacity to secure the necessary improvement in the school. This school will receive regular monitoring by Ofsted inspectors.

Inspections

Ofsted is required to inspect all schools subject to section 5 of the Education Act 2005 within a specified period. Ofsted selects schools for inspection on a proportionate basis through a system of risk assessment. Those schools that Ofsted judge would benefit most are selected for more frequent inspection (Ofsted, 2013).

A school's senior leadership is encouraged to complete self-evaluation. School inspections last one to two days and notice of an inspection is given on the afternoon of the working day before it takes place. Inspection reports are generally available online three weeks after the date of the inspection (Ofsted, 2013).

Statutory powers with respect to schools

Ofsted has no statutory power in relation to schools. It is the local authority that has this power, although a grade 4 rating by Ofsted qualifies the school as "eligible for intervention". If the progress of a school towards removal of special measures is judged inadequate after a year, the Department for Education (DfE) will require the local authority to examine carefully the options available to it. It is therefore essential that, when a school has been in special measures for a year, Ofsted is able to report substantively on all issues for improvement as well as the school's overall progress since being made subject to special measures (Ofsted, 2012a).

Impact of Ofsted

An evaluation of impact in 2004 found that Ofsted had made a 'substantial contribution' to the improvement of education, and 'to a variable extent, alongside other factors – to education providers' (Matthews and Sammons, 2004). In 2009, an evaluation by the National Foundation for Educational Research (NFER) concluded that teachers found Ofsted inspections had helped to improve the performance of schools, in part through the quality of teaching. Although it was acknowledged that many other factors influenced the improvement of schools and it was difficult to attribute progress to any one source. In addition the researchers found that:

"although the majority of teachers felt that the focus on Ofsted recommendations had not led to a lack of attention elsewhere, nevertheless there was some limited evidence that concentrating attention in one area did in some cases lead to a reduction of standards elsewhere" (McCrone and others, 2009)

In 2012 Ofsted published figures on the overall effectiveness of schools since 2005/06 – shown in Figure 2.5 below.

Figure 2.5: Overall effectiveness of schools: trends in performance 2005/06 to 2011/12[1]

	Outstanding	Good	Satisfactory	Inadequate
1 Jan 2012 to 31 Aug 2012 (3,903)[1]	9	51	31	9
1 Sept 2011 to 31 Dec 2011 (2,236)	16	47	31	6
2010/11 (5,726)	11	46	38	6
2009/10 (6,171)[2]	13	43	37	8
2008/09 (7,065)	19	50	28	4
2007/08 (7,867)	15	49	32	5
2006/07 (8,323)	14	47	34	6
2005/06 (6,128)[3]	11	48	34	8
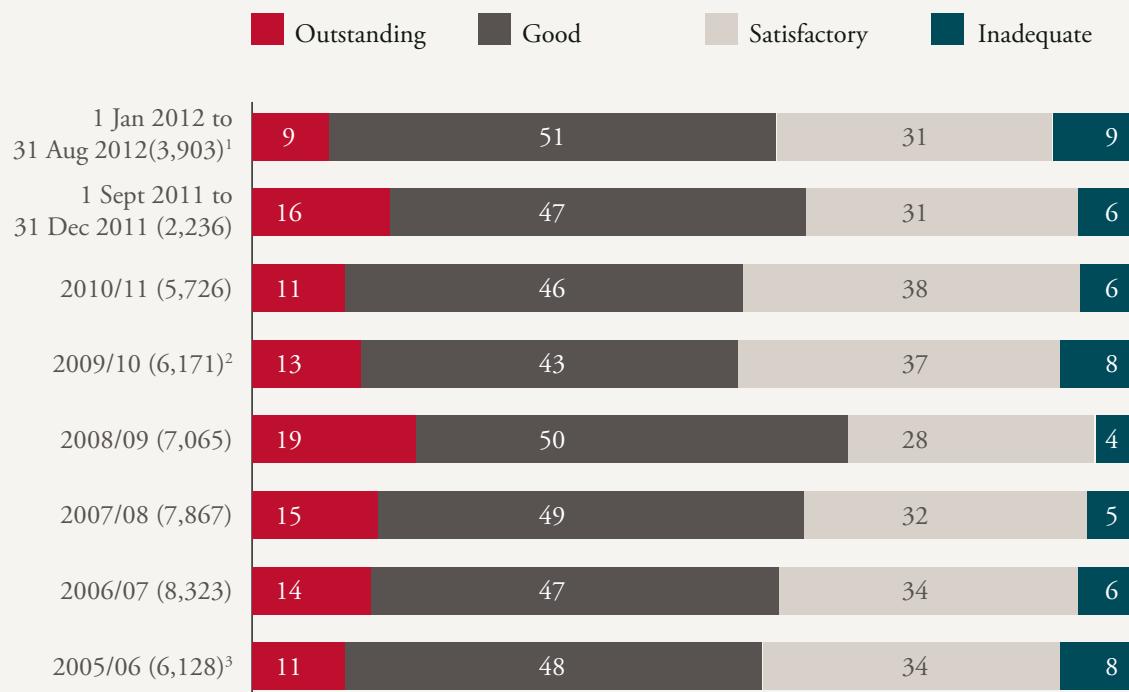
(Source: Ofsted, 2012b)

Percentages in the chart are rounded and may not add to 100
Based on Edubase at 3 September 2012

1. An amended section 5 inspection framework was introduced on 1 January 2012.

2. An amended section 5 inspection framework was introduced on 1 September 2009.

3. The section 5 inspection framework was introduced on 1 September 2005.

The figure shows a remarkably consistent distribution across the four grades over time. However figures between years are not strictly comparable because of changes to the inspection framework as noted in the table. For example since the introduction of the new framework in 2012 the profile of inspection judgements shifted, with a lower proportion of schools being judged outstanding and a higher proportion being judged inadequate.

Conclusions

This very brief outline of past experience raises many issues for any potential rating system in health care in future. These include, but are not limited to, the following, broad points which will be discussed in subsequent parts of this report.

The most obvious observation is the marked instability in the regulatory and previous rating systems since 2001 – instability which will have reduced the time for regulators to develop the system of ratings (and important associated supporting activity such as 'surveillance' and special investigations of failure) and extend them to more providers (such as primary care), and the time to carefully evaluate their impact. The instability also extends to providers, particularly NHS trusts, which have had to respond to a changing range of approaches, alongside other systems for scrutinising their performance for example as required by commissioners and by other regulators (such as Monitor). Figure 2.6 demonstrates just how complex the landscape was for health care organisations between 1999 and 2011.

Figure 2.6: A history of ratings in health care 1999–2011
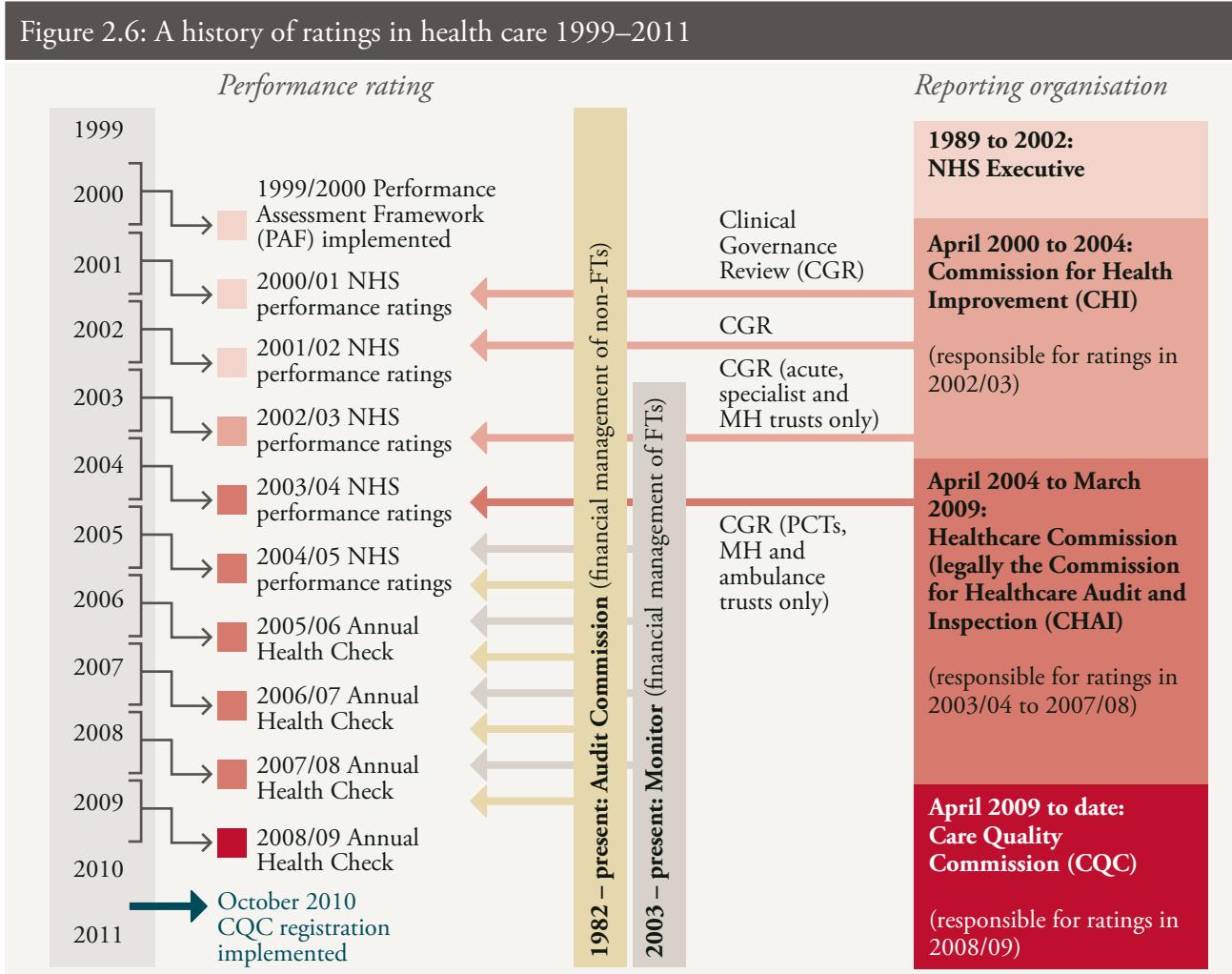
The main purpose of aggregate ratings appears to have been to help improve performance of providers with respect to quality of care. Ratings have been largely developed and implemented by independent regulators who have had a role in encouraging such improvement through assessment process, public reporting of performance as well as a range of regulatory powers to force providers to take remedial action on essential standards when performance is lacking. Regulators have generally held back from engaging in direct 'improvement' activities (measures aimed directly at helping to improve the performance of providers).

Publishing information to aid patient (and commissioner) choice of provider has clearly been an important but secondary purpose. Ratings have covered quality (in the case of CHI) and quality and finance issues (in the case of the Healthcare Commission), although the finance component was contributed by another regulator (the Audit Commission).

Ratings have been highly aggregated (for example star ratings, or the four categories of performance of the AHC), which in more complex providers (such as hospitals) can mask pockets of poor performance. Or, in the case of social care, it can mask pockets of good care, where the rating is given the minimum score irrespective of performance in the other areas.

Ratings have been largely retrospective and annual, and there have been concerns about timeliness. In the early days they relied on relatively few centrally driven target indicators in particular waiting times. These were scored using relative thresholds. Over time there has been a tendency to include a broader spread of information, including inspection findings where possible, and to have a fairer system of absolute pre-defined thresholds. There have also been attempts to make the rating responsive to 'real-time' inspections, for example through suspension of a rating where there are serious concerns being investigated. There remains much further work to do on how best to alert the public through a rating that there are concerns about a provider.

Ratings have generally been constructed using information from inspections and routine data, and have been limited by the availability of national sources on good quality data, in particular on outcomes. There have been prevailing concerns about the burden of inspection on providers, the quality of inspection, its frequency, and the timeliness of results in rating and as fed back to providers.

Ratings have had both a positive and negative impact, although on current evidence it is not possible to make conclusions on overall impact with confidence. The impact will depend not just on the rating system itself, but crucially on the prevailing set of policies and behaviours in play in health care, in particular the mechanisms used to encourage improvement. Some standards (and some indicators) contained within ratings have been set in health care centrally by government, although there is some evidence to suggest the more pressure on providers to achieve targets, the more perverse effects such as gaming occur.

Ratings have usually been at the organisational level – lacking the focus on individual clinical services, or even site of care (for example the specific hospital) that patients and many professionals would find more revealing and valuable.

If ratings for social care are to have more traction with the public and patients to aid choice, more work is needed both on what elements of care both groups most want to know, and how best to convey this information.

In the education sector, Ofsted has assessed the performance of schools using an assessment system for over ten years. While the distribution of performance appears to be stable over time, the standards that make up the assessment have changed. Information is clearly available publicly, not only on the overall effectiveness of a school, but on performance of different aspects in an easily accessible format. The information is aimed not only at users (or parents) but also at the schools themselves, and facilities comparing similar schools in specific areas are an important part.

3. Quality in health care

This section briefly outlines some contours of the current policy landscape across health care for promoting good quality care in providers, and asks what a new system of rating could add.

Broad roles and responsibilities in the health care system

The White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010a) and the Health and Social Care Act 2012 signalled a huge reform programme for the NHS in England. The advent of new organisations and functions represents a significant change to how health services are organised and run. These reforms have taken place alongside the QIPP (Quality, Innovation, Productivity and Prevention) agenda for the NHS, which aims to improve the quality of care the NHS delivers while making up to £20 billion of efficiency savings by 2014/15. In short, the quality landscape in the NHS is crowded, and getting even more so as organisations, following the 2012 Act, look to document where their roles and responsibilities lie. Furthermore, the Government's forthcoming response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013 (Francis, 2013), may herald further changes.

Central themes guiding the reforms include:

- the development of a culture that puts patients first above the interests of the health care system, and involves patients and user groups in shaping care

- being open and transparent

- actively promoting quality of care through a range of means

- collective leadership to improve quality

- allowing greater local freedoms with local accountability.

The National Quality Board

The importance of quality was highlighted in Lord Darzi's report, *High Quality Care for All*. The report defined high-quality care as having three dimensions: patient safety, patient experience and effectiveness of care[1], and made a number of recommendations to put "quality at the heart of the NHS" (Department of Health, 2008). The National Quality Board was established in 2009 in response to the report, to consider quality across the health care system and at the interface between health and social care. The National Quality Board brings together national organisations across the health system to:

- report to the Secretary of State on the state of quality in England using internationally agreed comparable measures, and oversee the work to improve quality measurement in the NHS

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1 Measured by mortality or survival rates, complication rates, measures of clinical improvement and PROMS (patient reported outcome measures).

- advise the Secretary of State on clinical priorities for quality improvement and the standards to be set by the National Institute for Health and Clinical Excellence (NICE)

- provide advice to the Advisory Committee on Clinical Excellence Awards[2] on how to strengthen the awards scheme to drive quality improvement

- provide advice on other schemes to drive quality improvement including Indicators for Quality Improvement (IQI)[3] and Quality Accounts.

In January 2013, the National Quality Board published a good summary of roles, responsibilities and behaviours to assure and improve quality of care. The report outlines:

- the nature and place of quality in the new health system

- the distinct roles and responsibilities for quality of the different parts of the system

- how the different parts of the system should work together to share information and intelligence on quality and to ensure an aligned and coordinated system-wide response in the event of a quality failure

- the values and behaviours that all parts of the system will need to display in order to put the interests of patients and the public first and ahead of organisational interests. (National Quality Board, 2013).

The National Quality Board report echoes the description of quality set out in *High Quality Care for All* (Department of Health, 2008), in defining high-quality care as having the three dimensions of patient experience, patient safety and clinical effectiveness, although not explicitly equity (that is, equal access to care for equal need). It also outlines the system's collective, twin objectives in relation to quality, namely to ensure that essential standards of quality and safety are maintained and to drive continuous improvement in quality and outcomes (National Quality Board, 2013). The report notes three levels of activity in promoting quality and acting to prevent failures, as outlined by the King's Fund: frontline professionals (both clinical and managerial); boards and senior leaders of health care providers; and external structures and organisations (Dixon and others, 2012). It notes that it is clearly providers who are ultimately responsible for the quality of care provided in the health care organisation (National Quality Board, 2013).

This chapter focuses on the roles and activities of external structures and organisations, particularly those with a national remit. The National Quality Board report presented a useful diagram – the quality curve – to help clarify the roles of these external organisations and structures (see Figure 3.1).

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2 The Advisory Committee on Clinical Excellence Awards advises health ministers on the making of clinical excellence awards to consultants working in the NHS as defined in guidance at: http://www.dh.gov.uk/health/about-us/public-bodies-2/advisory-bodies/accea/

3 Indicator for Quality Improvement (IQI) was launched by the NHS Information Centre in May 2009. Over 200 indicators have been chosen through partnership with strategic health authorities, the NHS Information Centre, and Royal Colleges.

Figure 3.1: The Quality Curve, reproduced from the National Quality Board (2013)
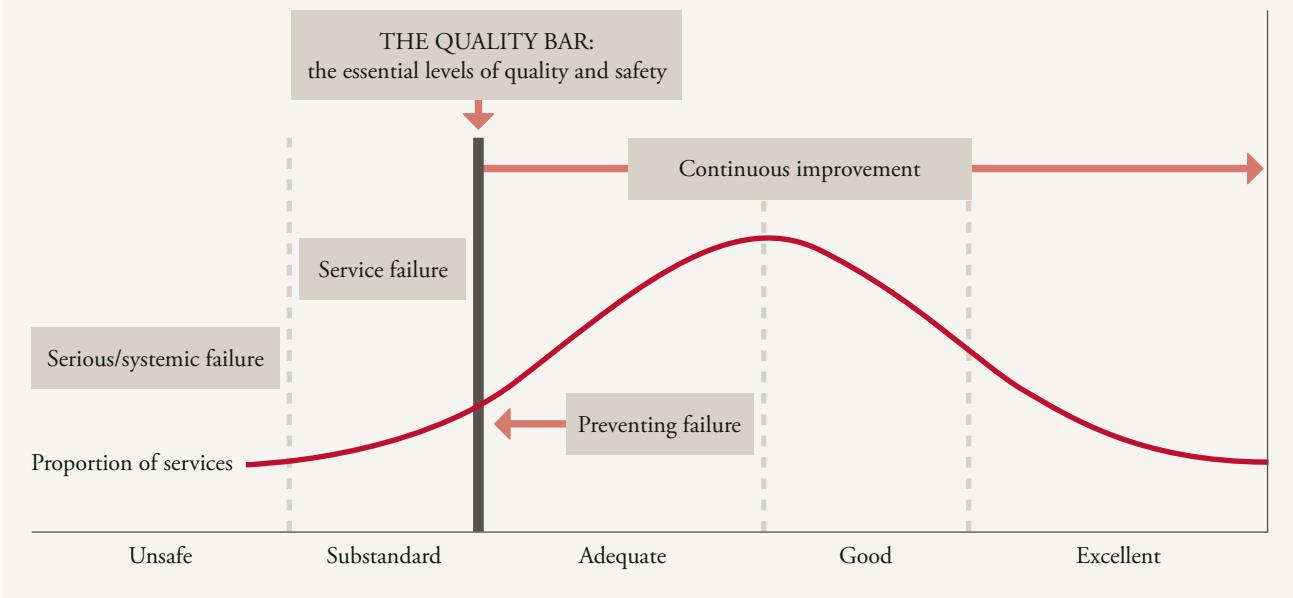
The National Quality Board report helps to clarify the systems for spotting and managing failure in the quality of care (that is care below the quality bar). The Care Quality Commission (CQC) regulates health and social care services in England against requirements described as the "essential standards of quality and safety" and set out in legislation (Care Quality Commission, 2010). The standards relate to 28 regulations and reflect the minimum level of care a service can provide to satisfy regulation. The current standards are generic and are used to assess the performance of a diverse range of providers. As a result, the system focuses on finding and dealing with poor performance.

Similarly, one of Monitor's functions is to assess financial risk at provider level in NHS foundation trusts. The financial risk ratings produced (a rating of 5 reflects the lowest level of financial risk and a rating of 1 the greatest) assess the risk of an actual or potential breach of the foundation trust's authorisation (Monitor, 2012a). In other words, Monitor is also assessing to see if a provider is falling, or is likely to fall, below a 'finance bar' (as CQC checks compliance against the quality bar), not where a provider might be above the bar. The assessment of NHS trusts by the NHS Trust Development Authority (NTDA) takes a similar approach.

Care above the quality bar

On quality above the bar, the National Quality Board report outlines that there should be "clear and accepted definitions of what high quality care looks like which patients, commissioners and providers can unite around" and mentions the NICE Quality Standards.

The NICE Quality Standards Programme was established in 2009 to manage the development of quality standards for health and social care topics (from April 2013). The topics for development are prioritised each year following input from the NHS Commissioning Board, the Department of Health and the Department for Education (NICE, 2012). Although the standards are not targets, they set out high-priority areas

for quality improvement that are "aspirational but achievable", and providers and commissioners should have due regard to the standards when planning and delivering services, as part of a general duty to secure continuous improvement in quality (NICE, 2012).

The National Quality Board report also highlights the need for "robust, relevant and timely information, transparently available on the quality of care at every level in the system" in order to drive quality improvement, and mentions one main source: the NHS Outcomes Framework. The purpose of the NHS Outcomes Framework is:

- to provide a national level overview of how well the NHS is performing, which the public and Parliament can use to hold the Government to account for progress

- to act as an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board and as part of the Mandate set for the Board

- to act as a catalyst for driving quality improvement and the measurement of outcomes throughout the NHS.

As well as the NHS Outcomes Framework, there is also a Public Health Outcomes Framework and an Adult Social Care Framework which "include complementary and shared outcomes, where improvement requires joint working across the sectors" (National Quality Board, 2013).

Based on the NHS Outcomes Framework, the NHS Commissioning Board is developing a Commissioning Outcomes Framework, drawing on NICE standards, to hold clinical commissioning groups (CCGs) to account for the outcomes they are achieving. Furthermore, the National Quality Board report notes that provider organisations and their clinical teams are expected to draw on a range of comparative quality indicators (including clinical audits) to drive improvement across all their services.

So the emphasis in the National Quality Board report, at least with respect to providers above the quality bar, is that the Commissioning Outcomes Framework should help to define standards for commissioners. Commissioners then transmit these priorities to providers and drive improvement using a commissioning contract based on the NHS standard contract and via payment incentives (NHS Commissioning Board, 2012a). The NHS Commissioning Board outlines its role in the system as 'primus inter pares' for driving improvement (NHS Commissioning Board, 2012b). There has been extensive work at a Strategic Health Authority (SHA) and national level to develop quality of care 'dashboards' for provider services (for example a series of indicators for specialised services) which reflect the priorities in the NHS Outcomes Framework and NICE guidelines, and can be used to help monitor progress in providers. Some of this information is published and available to the public on the NHS Choices website.

There is no suggestion in the National Quality Board report of the need for an assessment of quality of all providers above the 'quality bar', that is: (a) independent of the commissioning system, for example that use a national set of standards that may go wider than the priorities set out in the NHS Commissioning Outcomes Framework, or (b) presented in a highly aggregate form to the public, such as a simple rating (National Quality Board, 2013).

The lead role of commissioners in setting and assessing standards above the quality bar is also suggested by Robert Francis QC in his report on the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013). He suggests a set of standards that are:

- fundamental (minimum safety and quality)

- enhanced

- developmental (longer-term goals for providers).

He recommends that the Government 'through regulation' should achieve a wide consensus with stakeholders (including the public) on fundamental standards and that the NHS Commissioning Board together with CCGs should devise enhanced (and presumably developmental) standards. Failure to comply with enhanced standards "should be a matter for performance management by commissioners rather than the regulator" (Francis, 2013). Again, there is no suggestion of an assessment of provider performance, independent of commissioning. This is a gap which could be filled by a rating system, if it were thought valuable.

System landscape and initiatives

There are numerous initiatives and organisations which aim to develop increasingly comprehensive assessments on the quality of care (patient experience, safety and effectiveness) of providers. As Francis noted, "healthcare is not an activity short of systems intended to maintain and improve standards, regulate the conduct of staff, and report and scrutinise performance… yet none of them… appreciated the scale of the deficiencies at Stafford and, therefore, over a period of years did anything effective to stop them" (Francis, 2013).

If defining and assessing the quality of care in a consistent way for those providers above the 'quality bar' (Figure 3.1) was thought to be useful, there are a number of initiatives that suggest a new rating system might not be necessary.

There are several main sources driving these initiatives: the Department of Health (DH); the commissioning system (driven in part by the need to achieve against the NHS mandate and the outcomes frameworks); the regulatory system (institutions and professionals); other national bodies; professionally led initiatives (such as clinical audit, condition-specific peer review and accreditation); local service led initiatives (service peer reviews, benchmarking clubs); and independent or commercial initiatives (such as benchmarking). These sources are not mutually exclusive and some are coordinated by the National Quality Board.

Some of the main developments and plans are outlined below – the list is illustrative and not exhaustive.

Government and the Department of Health

The Secretary of State for Health has the ultimate responsibility for the provision of a comprehensive health service in England and to ensure the whole system works well together to respond to the priorities of communities.

The Health and Social Care Act 2012 requires the Secretary of State to act to secure improvement in the quality of services (Department of Health, 2012a). The DH is

responsible for the strategic leadership of both the health and social care systems, acting as a 'system steward'. This section does not attempt to list every policy originating from the DH but instead highlights a number of recent initiatives related to quality.

The NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England. It sets out patient and staff rights and responsibilities. The NHS Constitution commits to continuous improvement in the quality of service and the identification and dissemination of best practice in quality of care and treatments. The NHS commits to making information available on the quality of clinical services where there is robust and accurate information available to inform user choice (Department of Health, 2013a).

Mandate to the NHS Commissioning Board

In November 2012, the DH published the first mandate to the NHS Commissioning Board, which set out the outcomes and corresponding indicators that would be used to hold the NHS Commissioning Board to account for improvements in health outcomes (Department of Health, 2012b). These high-level national outcomes are set across five domains: (1) preventing people from dying prematurely; (2) enhancing quality of life for people with long-term conditions; (3) helping people to recover from episodes of ill health or following injury; (4) ensuring that people have a positive experience of care; and (5) treating and caring for people in a safe environment and protecting them from avoidable harm (Department of Health, 2012c). The mandate states that the NHS should measure and publish outcomes data for all major services by 2015, broken down by CCG as well as by provider and team (Department of Health, 2012b).

Quality Accounts

From April 2011, the DH required all providers of NHS services (excluding general practice, out-of-hours services, dentistry and pharmacy) to publish annual Quality Accounts. Quality Accounts are annual reports to the public from providers of NHS care about the quality of services they deliver (Department of Health, 2010b). Monitor incorporates the requirements for Quality Accounts into the requirements for Quality Reports that all foundation trusts must include in their financial reports. A key objective of this policy has been to place quality reporting on an equal footing with financial reporting (Department of Health, 2010b). Quality Accounts are required to be submitted to the Secretary of State and are published on the NHS Choices website so that they are available to the public. From April 2013, responsibility for the strategic direction of Quality Accounts will transfer to the NHS Commissioning Board and any future guidance will be jointly published with the DH (Department of Health, 2013b).

Review into the quality of care and treatment provided by 14 hospital trusts in England

In response to the publication of the Francis Inquiry Report, the Prime Minister announced on 6 February 2013 in Parliament (*Hansard* HC 6 February 2013 Column 282) that he had asked the NHS Medical Director, Professor Sir Bruce Keogh, to conduct an immediate investigation into the care at hospitals with the highest mortality rates. Supported by a National Advisory Group the review will comprise three stages:

- **Stage 1: Gathering and analysing the full range of information and data available within the NHS.**

- **Stage 2: Rapid Responsive Review** – a team of experienced clinicians, patients, managers and regulators will observe the hospital in action.

- **Stage 3: Risk Summit** – a separate group of experts will consider the report from stage 2, alongside other intelligence in order to make judgments about the quality of care being provided and agree any necessary actions. A report following each Risk Summit will be made publicly available (NHS Commissioning Board, 2013).

Review into bureaucracy

The Rt Hon Jeremy Hunt MP has asked Mike Farrar, Chief Executive of the NHS Confederation, to work with national bodies to look at how joint inspection and shared information could improve clinical outcomes and free up time. The objective of this work is to see if it would be possible to reduce bureaucratic burdens by one-third. Speaking to the *Health Service Journal*, Mike Farrar suggested that the review would start by looking at the reason for information collections and would look at whether technology could make information collection more efficient (Calkin, 2013). A previous review into bureaucracy in 2009 found the regulatory system to be complex, confused and over-reliant on prescriptive adherence to meeting detailed targets and performance measures (NHS Confederation, 2009). The findings are expected to be published at the end of March 2013.

Review of zero harm

The Prime Minister announced in response to the Francis Inquiry Report that he had asked Professor Don Berwick to lead a review on making zero harm a reality. He stated

"Quality of care means not accepting that bed sores and hospital infections are somehow occupational hazards – that a little bit of these things is somehow okay. It is not okay; they are unacceptable – full stop, end of story. That is what zero harm – the jargon for this –means. I have therefore asked Don Berwick, who has advised President Obama on this issue, to make zero harm a reality in our NHS."
(*Hansard* HC 6 February 2013 Column 281)

Professor Berwick is expected to report his findings to the NHS Commissioning Board and the DH at the end of July 2013.

A new Chief Inspector of Hospitals

The Prime Minister announced on 6 February 2013 that he had asked the CQC to create a new Chief Inspector of Hospitals to take responsibility for a new hospital inspection regime. The intention is for the new inspection regime to start in autumn 2013 and focus on whether a hospital is clean, safe and caring (*Hansard* HC 6 February 2013 Column 282).

Table 3.1: Quality initiatives: Government and the Department of Health	
Source	**Initiative**
Department of Health (DH)	**The NHS Constitution** sets out commitments from the NHS in relation to quality (Department of Health, 2013a).
	The DH published the **NHS mandate** to the NHS Commissioning Board (Department of Health, 2012b), underpinned by the **NHS Outcomes Framework** (Department of Health, 2012c).
	The DH requires providers to publish **Quality Accounts** (which include the mandatory DH core quality indicators).
	The Prime Minister announced **a review led by Sir Bruce Keogh** of the quality of care and treatment by hospital trusts with higher than expected mortality rates (NHS Commissioning Board, 2013).
	Rt Hon Jeremy Hunt MP asked Mr Mike Farrar CBE to lead **a review of bureaucracy** (Calkin, 2013).
	Prof Don Berwick was asked to lead a review of **zero harm** (*Hansard* HC 6 February 2013 Column 281).
	There will be a **Chief Inspector of Hospitals** (*Hansard* HC 6 February 2013 Column 282).

(See Appendix 5 for supplementary information)

Commissioning system

The NHS Commissioning Board

At a national level, the NHS Commissioning Board will provide strategic direction for quality within the NHS (from April 2013) in its direct commissioning and commissioning support roles. The Health and Social Care Act 2012 requires the NHS Commissioning Board to act to secure improvement in the quality of services (Department of Health, 2012a). It will lead a number of projects to provide clarity on the quality of care, ensuring openness and transparency in the system, and making use of available data to support commissioners at a local level (National Quality Board, 2013).

The NHS Commissioning Board also has a role in providing more information on quality to the public through NHS Choices and the development of a web-based platform for quality information. However, the NHS Commissioning Board does not have a monopoly on the provision of information. There are many commercial organisations that now benchmark information or offer a commercial rating such as Dr Foster Intelligence.

Clinical commissioning groups (CCGs)

CCGs will take on many of the functions of primary care trusts and will bring together a range of clinical professionals to commission the majority of NHS-funded health services. In commissioning these services, CCGs will be responsible for securing a comprehensive service to meet the needs of their local population. CCGs can commission any service provider that meets NHS standards and costs. However, they must be assured of the quality of services they commission, taking into account NICE guidelines and CQC essential standards. CCGs should be identifying the improvements they wish to secure in the quality of services they commission and using the commissioning process to drive continuous quality improvement (National Quality Board, 2013).

Table 3.2: Quality initiatives: commissioning system	
Source	**Initiative**
NHS Commissioning Board (NHS CB)	The NHS CB will develop national **'quality dashboards'**, e.g. for specialised services as part of quality improvement programme (NHS Commissioning Board, 2012a).
	The NHS CB will develop local **Quality Surveillance Groups** to facilitate information sharing on quality, and link to clinical audit data (National Quality Board, 2013).
	The NHS CB will publish **consultant level outcome** data covering mortality and quality for ten survival and medical specialties (NHS Commissioning Board, 2012a).
	The NHS CB is responsible for **NHS Choices**, which already contains some information on providers (including primary care) and is developing a **customer service-focused, web-based platform** providing information on care, providers and other services to the public (Department of Health, 2012d).
	Subject to regulations, the NHS CB will pay a **Quality Premium** in 2014/15 to CCGs that in 2013/14 improve or achieve high standards of quality against specific measures. (NHS Commissioning Board, 2012a).
	The NHS CB will **review the incentives, rewards and sanctions** available to commissioners to drive improvements in care quality in 2013/14 (NHS Commissioning Board, 2012a).
Clinical commissioning groups (CCGs)	CCGs will be able to use **Commissioning for Quality and Innovation (CQUIN)** payments to secure local quality improvements over and above the norm by agreeing priorities with their providers. It is set at a level of 2.5 per cent of the value of all services commissioned through the NHS Standard Contract.
Strategic Health Authorities (SHAs) – abolished from 1 April 2013	The SHAs established **Quality Observatories** which led the development of national 'quality dashboards' for: (1) all non-specialist acute trusts; (2) all mental health trusts; and (3) general practices on behalf of the Quality Observatory Network (Department of Health, 2008). The Quality Observatories have played a key role in the development of local quality indicators. For example, work in the North East Quality Observatory to develop local indicators for quality care following arthroplastic surgery in collaboration with local orthopaedic surgeons (North East Quality Observatory System, 2012).
	In some areas, **initiatives to making local information more accessible to the public**, e.g. www.myhealth.london.nhs.uk/ (London Health Improvement Board, 2012).

(See Appendix 5 for supplementary information)

Regulatory system

Care Quality Commission (CQC)

As set out in chapter 2, the CQC assesses health and social care services in England against registration requirements described as the "essential standards of quality and safety" (Care Quality Commission, 2010). The CQC is working to align the national standards of quality and safety with the NHS, Adult Social Care and Public Health outcomes frameworks (Care Quality Commission, 2012).

Monitor

Monitor currently assesses NHS foundation trusts against a Compliance Framework to ensure they are financially robust, well-governed, legally constituted (in accordance with the National Health Service Act 2006) and meet the required quality threshold (Monitor, 2012a).

Quality governance has been included in Monitor's Foundation Trust assessment process since 2010 and is embedded within the Compliance Framework (Monitor, 2012a)

Monitor's functions are changed by the Health and Social Care Act 2012 and all providers of NHS-funded services will be required to hold a licence (unless exempted through regulation). There will be a joint process with providers applying for a Monitor licence and CQC registration. Monitor will manage key aspects of health regulation, through regulating pricing, enabling integrated care, safeguarding choice and competition, and ensuring continuity of services (Monitor 2012b). As a result of the legislative changes, the Compliance Framework will be replaced with a new Risk Assessment Framework.

NHS Trust Development Authority (NTDA)

The NTDA will be fully operational from April 2013. The NTDA will be responsible for overseeing the performance management and governance of NHS trusts (including clinical quality) and managing their progress towards Foundation Trust status. The NTDA set out clear expectations on quality in their planning guidance for 2013/14, for example stating that trusts must deliver in full on any agreed CQUIN schemes and would be expected to measure progress against the NHS Outcomes Framework through the National Quality Dashboard (NHS Trust Development Authority, 2013).

NHS Litigation Authority

The NHS Litigation Authority (NHSLA) runs the Clinical Negligence Scheme for Trusts (CNST), alongside three other schemes to indemnify NHS bodies against negligence claims and property losses. The NHSLA has an important role in reducing negligence claims and does this through its risk management programme. There is a set of risk management standards for each type of health care organisation, incorporating organisational, clinical, and health and safety risks and the NHS. The NHSLA assesses organisation into three levels (one, two and three) with discounts of between 10-30% being applied to CNST contributions. Given the higher number of negligence claims arising from maternity services, there is a separate set of standards for maternity services which are assessed in the same way (NHS Litigation Authority, 2011). The NHSLA is currently reviewing the standards with a view to there being a greater focus on outcomes and that the assessment process being less burdensome (NHS Litigation Authority, 2012).

Professional regulators

Professional regulators such as the Nursing and Midwifery Council and the General Medical Council make assessments of individual competence through revalidation and registration, and investigation into complaints about individuals. Professional regulators have a range of powers to restrict or remove the right of practice of an individual (National Quality Board, 2013).

Table 3.3: Quality initiatives: regulatory system	
Source	Initiative
Care Quality Commission (CQC)	The CQC assesses compliance of registered services against **essential standards of quality and safety**, monitoring and inspecting providers against those standards. The CQC publishes results of inspection reports on their website. The CQC brings together a range of information on providers in the **Quality Risk Profile** to assess risks to quality of care and prompt further investigation. The CQC can undertake thematic reviews, themed inspections and specialist investigations into specific aspects of care.
Monitor	Monitor assesses foundation trusts against the **Compliance Framework**. Monitor uses a combination of financial and performance information as a primary basis for assessing the risk of a trust breaching their authorisation, and assigns two ratings: • **the quarterly financial risk rating** which is designed for regulatory purposes and not for performance • **the governance risk rating** which includes an assessment of the Board's statement against the 'Quality Governance Framework. (Monitor, 2012a). Monitor publishes the risk ratings on its website. Monitor is consulting on the **Risk Assessment Framework**, which will replace the Compliance Framework (Monitor 2013).
NHS Trust Development Authority (NTDA)	From April 2013 the NTDA's roles include: • **performance management of NHS trusts** • **management of the foundation trust pipeline** • **assurance of clinical quality, governance and risk** in NHS trusts • **appointments to NHS trusts**, e.g. of chairs and non-executive members. In assessing adherence to **quality governance** for non-foundation trusts, it expects NHS trusts to make use of quality dashboards and to produce quality accounts (NHS Trust Development Authority, 2013).
NHS Litigation Authority (NHSLA)	The NHSLA assigns a **risk rating** to each organisation with better scoring providers receiving discounts from their CNST contributions (NHS Litigation Authority, 2011).
Professional regulators	Professional regulators make assessments of individual competence through revalidation, registration and investigation into complaints about individuals (National Quality Board, 2013).
(See Appendix 5 for supplementary information)	

Other national organisations

Health and Social Care Information Centre

The Health and Social Care Information Centre is a major data hub for health and adult social care, and is involved in the development of indicators of quality, data collection and presenting information for commissioners and providers (NHS Information Centre, 2009). More recently, it has become involved in benchmarking investigations of compliance against NICE standards (NHS Information Centre, 2013).

Health Education England

From April 2013, Health Education England will provide leadership for professional education, training and workforce development, ensuring that this has the right capacity and capability. It will allocate education and training resources and oversee provider-led local allocation of resources. Local Education and Training Boards (LETBs) will lead workforce planning locally and commission high-quality education and training. Part of LETBs' responsibilities will be to secure quality and value from education and training providers (National Quality Board, 2013).

Healthwatch England

Healthwatch England will be part of a newly-established Healthwatch network from April 2013 acting as a 'consumer champion'. Local Healthwatch organisations will be more plugged-in to decision making at a local level and will be expected to develop relationships with local organisations including those representing specific user groups. Local Healthwatch organisations will ensure that the voices of people using care and support are heard by commissioners and care providers. Local Healthwatch organisations will have the power to enter and view providers, and to scrutinise and comment upon service quality, passing on information to the local authority, the CQC, or Healthwatch England for further action (Department of Health, 2012e).

National Institute for Health and Clinical Excellence (NICE)

NICE has a key role in the development of evidence-based service standards and indicators for health and, more recently, social care, but these are mainly process rather than outcome measures. NICE and the CQC have worked together to develop a dynamic relationship between CQC's national standards for regulating quality and safety (the essential standards) and NICE's quality standards for improvement. Although the standards are not targets, they set out high-priority areas for quality improvement that are aspirational but achievable, and providers and commissioners should have due regard to the standards when planning and delivering services, as part of a general duty to secure continuous improvement in quality (NICE, 2013).

Quality Surveillance Groups (QSGs)

Different parts of the health and care system will come together to share information and intelligence through Quality Surveillance Groups (QSGs). Membership is determined locally but should include all local commissioners, representatives from regulators, local Healthwatch organisations and representatives from the LETB. Membership is mirrored in the four regional QSGs, with the addition of professional regulators, Health Education England and Healthwatch England.

Table 3.4: Quality Initiatives: other national organisations	
Source	Initiative
Health and Social Care Information Centre	The Health and Social Care Information Centre develops the **Indicators of Quality Improvement** aligned to the NHS Outcomes Framework.
	The Health and Social Care Information Centre provides a **Quality Accounts** section within their indicator portal directing to the latest data for each indicator (Department of Health, 2013b).
	The Health and Social Care Information Centre collects data on **adult social care**[4] at local authority level and holds the National Audit Social Care Intelligence Service. It also completes a user's survey and is developing a survey for carers.
	The Health and Social Care Information Centre is the single central **national repository for clinical audit data** but holds no clinical audit data on general practice.
Health Education England	Health Education England will provide leadership for professional education. Local Education and Training Boards will lead workforce planning locally and commission high quality education and training (National Quality Board, 2013).
Healthwatch England	Healthwatch England will be part of a newly established Healthwatch network from April 2013 acting as a '*consumer champion*'.
	Local Healthwatch will have the powers to enter and view providers and to scrutinise and comment upon service quality, passing on information to the local authority, the Care Quality Commission, or Healthwatch England for further action (Department of Health, 2012e).
National Institute for Health and Clinical Excellence (NICE)	NICE develops **Quality Standards** for health and social care topics (NICE, 2012.). Each standard contains a concise set of quality statements and associated measures (NICE, 2013).
	Quality standards for the NHS will be reflected in the new Clinical Commissioning Group Outcome Indicator Set and will inform payment mechanisms and incentive schemes such as the Quality and Outcomes Framework (QOF) and the Commissioning for Quality and Innovation (CQUIN) payment framework (NICE, 2013).
	NICE develops evidence-based guidance on **clinical governance**, including the systems and processes which should be in place to implement NICE guidance in the correct way.
	NICE is developing an **'innovation' scorecard** which will show how quickly local organisations are providing NICE-approved treatments and drugs (NICE, 2012; NHS Information Centre, 2013).
Quality Surveillance Groups (QSG)	The QSG will act as a virtual team across a health and care economy, bringing together organisations and their respective information and intelligence gathered through performance management, commissioning, and regulatory activities to maintain quality in the system by routinely and methodically sharing information and intelligence (National Quality Board, 2013).

(See Appendix 5 for supplementary information)

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4   Children's social care is within the Department for Education.

Professionally-led initiatives

Clinical audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE, 2002). *High Quality Care for All* stressed that quality improvement including clinical audit was at the centre of improving the NHS (Department of Health, 2008). The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality improvement, and in particular to increase the impact of clinical audit in England and Wales.

HQIP hosts the National Clinical Audit and Patient Outcomes Programme (NCAPOP), which comprises 40 clinical audits. The audits are carried out largely by professional organisations, for example the National Cancer Intelligence Network (NCIN) and the National Institute for Cardiovascular Outcomes Research NICOR). Clinical audit can result in significant improvements in care.

The NHS CB is looking to generate professionally-led clinical indicators of quality which fit within each domain of the NHS Outcomes Framework (Department of Health, 2012c), drawing largely on national clinical audits and peer reviews. This might be achievable in some specialties by 2015 (breast cancer, cardiac, stroke, diabetes) and in others with development/investment (such as liver or child health).

Peer review

The National Cancer Peer Review is a well established programme which focuses on ensuring the delivery of high-quality cancer services, along with looking to improve services, and supports the development of leadership, self regulation and governance.

A number of the Royal Colleges already provide an ad hoc peer review service (for a fee) for providers at their request, and some share this information with the CQC (see Appendix 5). For example, the Royal College of General Practitioners (RCGP) has extensive experience in supporting GP practices in delivering high quality care. There are currently two quality initiatives – Practice Accreditation and the Quality Practice Award. CQC minimum standards are used as a base for both initiatives, with Practice Accreditation recognising teams who have demonstrated organisational good practice and the Quality Practice Award recognising practices who have demonstrated excellence in clinical and organisational practice in the delivery of primary care. Both initiatives are voluntary rather than compulsory (RCGP, 2013).

There are also a number of local initiatives which make use of peer reviews to improve the quality of services. For example, NHS Quest and the West Midlands Quality Review Service (see Table 3.5).

Table 3.5: Quality initiatives: professionally-led initiatives	
Source	Initiative
Healthcare Quality Improvement Partnership (HQIP)	HQIP leads the **National Clinical Audit and Patient Outcomes Programme**, coordinating 40 national clinical audits. HQIP funds condition-specific **peer review**, for example the National Review of Asthma Deaths (HQIP, 2012).
National Cancer Intelligence Networks (NCIN)	The NCIN is a UK-wide initiative working to drive improvements in standards of cancer care and clinical outcomes by improving and using information collected about cancer patients for analysis, publication and research (NCIN, 2013). The NCIN will be hosted by Public Health England from 1 April 2013.
National Institute for Cardiovascular Outcomes Research (NICOR)	Reports from the NICOR are disseminated to boards, commissioners and regulators (NICOR data are used to inform CQC risk-based investigations), and they are looking to move towards publishing for public audiences. Examples of current publications include cardiac surgical database (Bridgewater, 2010) and the adult cardiac surgery annual report (NICOR, 2012). Providers are benchmarked against each other and over time. They have interactive web-based methods of presenting the data.
National Cancer Peer Review (NCPR) programme	The NCPR programme focuses on ensuring the delivery of **high-quality cancer services**, along with looking to improve services, and support the development of leadership, self regulation and governance. The peer review programme now reviews the quality of 1,841 clinical cancer services/teams: 1,245 tumour multi-disciplinary teams and 273 tumour network groups, along with services for radiotherapy, children's cancer, cancer research networks, rehabilitation and complementary therapy (Department of Health, 2012f) In October 2012, the NCPR piloted a patient-friendly portal, *My Cancer Treatment*, which used routinely available data presented in a way to be understandable and informative to patients (Department of Health, 2012f).
Royal Colleges	A number of Royal Colleges provide a **peer review** service, e.g. the Royal College of General Practitioners practice accreditation schemes, the Royal College of Physicians' Stroke Peer Review and invited service reviews, and the Royal College of Obstetricians and Gynaecologists' External Clinical Advisory team review (see Appendix 5).
Local peer review	**NHS Quest** is the member-convened network for high-performing foundation trusts[5] who wish to focus on improving quality and safety. Each NHS QUEST member must host one site visit, the purpose of which is for peer learning "through offering personal and organisational insights, sharing experiences, and inviting open discussion". The visits are then 'evaluated' using the net promoter score pre/post visit, along with collating key themes from the day (Brotherton, 2012). **West Midlands Quality Review Service (WMQRS)** The WMQRS was set up on 1 April 2009 as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by: • developing evidence-based quality standards • carrying out developmental and supportive quality reviews – often through peer review visits • producing comparative information on the quality of services • providing development and learning for all involved (WMQRS, 2012).

(See Appendix 5 for supplementary information)

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5   Members invited from the top 20% performing foundation trusts in relation to quality and safety data (as defined by CQC rating, Dr Foster Safety Score, HSMR, infection rates, Monitor rating, patient and staff satisfaction scores).

Summary

It is evident, from the illustrative tables above and in Appendix 5 that there are numerous initiatives and organisations involved in defining and assessing quality in health. This raises questions as to whether the landscape could be made less complex and more streamlined over time, reducing duplication of roles and data requirements. Some have pointed to a lack of clarity and a confusing overlap with the respective roles of the CQC and Monitor in regulating against failure (for example as noted recently by the Health Select Committee; House of Commons Health Committee, 2013). There also appears to be an overlap between the NHS Commissioning Board and the CQC with regard to the investigation into mortality outliers. One might expect the CQC to be leading this investigation (and this role would appear to fit with the new Chief Inspector role), but on the 11 March 2013, the CQC issued a press release clarifying that they would be merely a key partner in the review (Care Quality Commission, 2013). Furthermore, the NHS Commissioning Board is working with the CQC to ensure that there is more alignment between the priorities in the NHS Outcomes Framework, and the CQC's essential standards of quality and safety.

The tables above suggest that initiatives broadly fall into the following categories: developing standards; developing indicators and the data to measure standards against; inspections against standards; assessment of the quality of care of providers across a range of metrics; publication and presentation of that information publicly; and tackling under-performance. Bar possibly the last, these are all activities that would be required to support a system of aggregate rating.

For example, NICE is clearly heavily involved in leading the development of standards, with the priorities in part reflecting the NHS Outcomes Framework. The Health and Social Care Information Centre is developing timely and accurate information sources and metrics that standards can be measured against. There is a strong push to develop information that can assess clinical outcomes for specific populations or health conditions through developing and linking routinely collected data and clinical audits, including developing sources of information about patient experience. With respect to inspections, apart from the CQC a range of peer review activities exist: nationally assessing care for people with specific conditions (such as the National Cancer Peer Review Programme); or regionally/locally assessing whole services (such as the WMQRS and NHS Quest), although there is incomplete coverage across the country. On assessment of quality of care; providers of NHS services must report a range of information in Quality Accounts (which are already posted on NHS Choices); quality dashboards have been developed by commissioners; and there are moves to develop and present quality metrics for general practices nationally. There is progress in presenting more information to the public, for example on NHS Choices, and much greater ambitions in that direction. A range of commercial organisations are busy collating indicators on quality, rating providers and presenting the results to the public, providers and other audiences.

What might a new national rating system add?

Most of the ingredients that would support a rating system for providers are already present and developing in health care in England – at least in providers of NHS-funded care. Given this, what might a new national ratings system for providers potentially add? There are at least two possible areas.

First, there does not appear to be an independent, comprehensive assessment of quality of care across all providers (relevant to this review) and the spectrum of performance in England. Such an assessment may help to define and identify excellent care and, especially if publicly reported, may help to prompt better performance in weaker performing providers. Current assessments by the CQC are independent but not comprehensive (they focus on essential standards only). Current assessments by the commissioning system may be more comprehensive (i.e. using quality dashboards) but are not independent, since commissioners select indicators through the Commissioning Outcomes Framework on which their own performance is also judged. Furthermore, the Commissioning Outcomes Framework reflects the priorities set out in the NHS mandate by the government of the day, which may not translate into a set of standards and indicators that fully reflect the quality of care of providers in important respects.

Second, although information is available for the public on some aspects of quality care on the NHS Choices and CQC websites, the information could be better presented and in one place to aid choice of provider, say a hospital or a general practice. One aggregate, comprehensive rating of providers may provide more clarity and simplicity for the public, especially if it came from one 'official' trusted source. Clearly the market in supplying provider ratings from commercial independent organisations should co-exist, as now.

Independent, comprehensive assessment, presented in aggregate and simply to the public and providers on one trusted 'official' site, covering a spectrum of performance, is currently available for schools through Ofsted – the example used in recent speeches by the Secretary of State for Health (Department of Health, 2012g).

These issues will be explored further in subsequent chapters of this report.

Would there be support for a new rating system?

Participants in the engagement exercise expressed mixed views about the prospect of re-introducing ratings in health care settings, with a particular concern about the prospect of a single, aggregate rating for complex organisations such as hospitals. The Ofsted analogy is not quite right – hospitals and schools operate under different levels of risk. There was concern from the health care sector that a single rating could be misleading. This was also reflected in our focus groups with members of the public. However, participants were more positive about the idea of a set of dials, allowing access to more granular information and would be willing to work towards a better, more differentiated set of national standards as long as there could be a reduction in bureaucracy in parallel.

4. Quality in social care

Background

There are some significant features of the 'social care landscape' that are very different to those pertaining to health care.

The majority of organisations providing social care to adults are privately owned or run by the voluntary sector. Local councils directly provide less than 10 per cent of residential care and 16 per cent of home care. Many providers are small – the overwhelming majority having fewer than 50 employees and many having four or fewer (Skills for Care, 2012). As of 31 March 2012, there were nearly 12,500 social care providers registered by the CQC to provide regulated services in over 25,000 locations. There were 13,134 residential care homes, 4,672 nursing homes and 6,830 agencies providing domiciliary care (Care Quality Commission, 2012).

The social care market is more developed than the market in health care – 45 per cent of care home places in England are now occupied by people who fund their own care (self-funders) and 20 per cent of people who receive care in their own homes are self-funders (Care Quality Commission, 2012).

Local authorities are the commissioners of publicly-funded social care. Of 152 local authorities with responsibility across England, 56 are unitary councils, 36 are district councils, 32 are London boroughs, 27 are county councils, and one covers the City of London (Department of Communities and Local Government, 2012). They are democratically-elected bodies responsible to their local electorate and have significant autonomy in their affairs. For example, with respect to adult social care, local authorities set the standards for quality of care in contracts with providers, the information required on quality from providers, the extent of monitoring of quality, the extent to which information about quality is publicly available, and the price they will pay for care.

Information taken from council administrative systems suggests that the number of people receiving state-funded services in 2011/12 was 1.5 million, of which 1.2 million received community-based services, 213,000 received residential care and 86,000 received nursing care (see Table 4.1). Adults aged 65 and over accounted for 68 per cent of the total number of service users, rising to 91 per cent of nursing care service users (Health and Social Care Information Centre, 2013).

Table 4.1: Number of service users receiving state-funded social care services during 2011/12 by service type and age group (Health and Social Care Information Centre, 2013)

Type of service	18-64	65 and over	All ages
Community-based services	429,000 (35%)	802,000 (65%)	1,231,000 (100%)
Residential care	46,000 (22%)	167,000 (78%)	213,000 (100%)
Nursing care	8,000 (9%)	78,000 (91%)	86,000 (100%)
Total number of services users receiving services 2011/12	**471,000 (32%)**	**991,000 (68%)**	**1,462,000 (100%)**

User autonomy and personalisation

The nature of social care services means that there has been much greater emphasis (than in health care) on putting individuals in control of decisions about care, and considering this as a key feature defining quality. An increasing number of individuals receiving local authority-funded social care do so through direct payments and personal budgets. Therefore, there is more emphasis on individual choice of provider and individual assessment of the quality of care provided.

Direct payments are cash payments made in lieu, either fully or partly, of services from local authority social services. The payment must be sufficient to enable users to purchase services to meet their needs, and must be spent on services to address that need (Gheera, 2012). Personal budgets are an allocation of funding given to users after a social services assessment of their needs. Users can either take their personal budget as a direct payment, or – while still choosing how their care needs are met and by whom – leave councils with the responsibility to commission the services. Or they can have a combination of the two (Gheera, 2012).

The total number of personal budgets delivered by councils across England was estimated to be 432,349 during 2011/12. As of March 2012, the percentage of eligible people in receipt of personal budgets (including estimates for non-responding councils) was 52.8 per cent, although there are wide variations between different local authorities in the degree of support offered to local people (National Audit Office, 2011). The amount spent on personal budgets in 2011/12 was £2.6 billion – 14.8 per cent of all direct spend on adult care and support services. The amount spent on personal budgets has increased by 57 per cent since 2010/11 (Association of Directors of Adult Social Services, 2012). There have been ongoing attempts to boost the take-up and use of personal budgets amongst older people and those with mental health problems (Routledge and Carr, 2013). Following favourable findings on the impact of direct payments and personal budgets (Hatton and Waters, 2011), the Government has committed to amending the legislation to allow everyone an entitlement to a personal budget and to pilot the use of direct payments for those living in residential care.

Local authorities as commissioners of adult social care would be expected to play a large role in monitoring and assuring the quality of care provided to local authority-funded users. However, in some areas of the country there are significant numbers of people who are ineligible for local authority-funded care and who are required to pay privately for their services. There is a strong regional variation in the proportion

of people who self-fund their care. For example, the proportion of private payers is estimated to be 55 per cent in the South East, compared to 22 per cent in the less affluent North East, Northern Ireland and the Isle of Man (Laing & Buisson, 2013). The mechanisms that local authorities employ to set standards, contract, monitor and improve the quality of care in areas with a high proportion of self-funders can be significantly limited or even absent. The CQC is the main external body actively assessing the quality of care according to essential standards across these providers. However, given the regional variation, providers in areas with a smaller proportion of self-funders are likely to be dependent on local authority contracts for their financial sustainability.

Rising demand for social care services

The UK population is ageing and is projected to continue ageing over the next few decades. Life expectancy at birth in the UK increased in each three-year period between 2004–06 and 2008–10, rising from 77.0 to 78.2 years for males, and from 81.3 to 82.3 years for females. Between 2004–06 and 2008–10, life expectancy at age 65 in the UK increased from 17.0 to 18.0 years for men and from 19.8 to 20.6 years for women (Office for National Statistics, 2011). In addition, it is estimated that the fastest population increases will be in the numbers of those aged 85 and over (Office for National Statistics, 2012).

The total number of people with dementia in the UK is forecast to increase to 940,110 by 2021 and 1,735,087 by 2051; an increase of 38 per cent over the next 15 years and 154 per cent over the next 45 years (Alzheimer's Society, 2007). The Alzheimer's Society suggest that in excess of 80 per cent of residents currently living in care homes have dementia or significant memory problems, and the move to support people in the community has contributed to a shift towards higher dependency among residents in care homes (Alzheimer's Society, 2007; 2013).

As a result, the number of people needing care is likely to increase significantly, placing pressure on the social care system. The Office for Budgetary Responsibility has estimated that, based on the current social care system, social care costs would rise from 1.1 per cent of gross domestic product (GDP) in 2016/17, to two per cent of GDP in 2061/62 (Office for Budgetary Responsibility, 2012). Recognising the urgency of social care reform, the Government committed to establishing a commission on long-term care in the Coalition Agreement (HM Government, 2010).

Recent initiatives and reforms

As in health care, there has been a focus on the need to reform social care services in order to achieve better quality care for the resources available given current and likely future demands (HM Government, 2012a). Some key initiatives relevant to this review are outlined below. As in the previous chapter, the account is not meant to be exhaustive, but illustrative.

Funding reform

The Commission on the Funding of Care and Support gave recommendations to the Government in July 2011 for a new funding system for social care. The report highlighted the need to reform the system of funding, citing the current system as unfair, unsustainable and difficult to understand. The Commission recommended a cap to an individual's lifetime contributions towards their social care costs of between

£25,000 and £50,000, as well as an increase to the means-tested threshold for support from £23,250 to £100,000 (Commission on Funding of Care and Support, 2011). In February 2013, the Government announced new measures based on the Commission's recommendations. The Government's original intention was that from April 2017, there would be a £75,000 cap (excluding a contribution towards general living costs) on the costs that an individual in England would have to pay to meet their eligible care and support needs and that there would be a change in the upper capital threshold for means-tested support to around £123,000 (Department of Health, 2013). However, the Chancellor George Osborne announced in March 2013 that Ministers would extend the means test for residential care costs from April 2016 rather than April 2017. The cap on care costs which was to be £75,000 will now be £72,000 and the £123,000 threshold for means tested support will be set at £118,000 (Pickover, 2013).

Broader social care reform

In 2011, the Government ran a consultation exercise called *Caring for our future: shared ambitions for care and support* as part of an engagement process to identify the key priorities for reforming care and support. Key themes emerging from the engagement exercise included:

- the need for reform of social care funding

- the importance of quality

- the key role of information and advice for service users

- the benefits of integration and prevention

- enabling users and carers to shape services

- the requirement to develop the social care workforce (Ipsos MORI, 2012).

In parallel, there has been a focus on legislative reform. The current legal framework for care and support dates back to 1948 and consists of a complex and confusing patchwork of legislation. In 2008, it was announced that the Law Commission would conduct a review of adult social care law. The Commission reported in 2011 and noted that that the "current framework for adult residential care, community care, adult protection and support for carers is inadequate, often incomprehensible and outdated" (The Law Commission, 2011). In 2012, the Government announced its intention to publish a draft Care and Support Bill to modernise the legislation for care and support in England, making it clear that law reform was a significant policy goal in its own right (Department of Health, 2012a).

In July 2012, the Government published the Care and Support White Paper with the aim of promoting wellbeing and independence in order to reduce the risk of people reaching a crisis point. The White Paper articulates a vision for a person-centered system where people have clear information to make good choices about care, can develop their own care and support plan, have the option to choose between a range of high-quality options or choose their own, and are listened to (HM Government, 2012a). The Government made commitments to:

- establish a new national information website to provide clear and reliable information on care and support

- work with a range of organisations to develop comparison websites to compare the quality of providers

- legislate to give people an entitlement to a personal budget

- improve access to independent advice to help people eligible for financial support from their local authority to develop their care and support plan

- develop, in a small number of areas, the use of direct payments for people who have chosen to live in residential care, to test the costs and benefits (Department of Health, 2012b).

Clearly the first two areas are most relevant to the issues examined in this review.

Quality in social care

On the definition of quality, the Care and Support White Paper suggests that good quality care does not have the same meaning for everyone because the user is at the heart of defining what good quality means to them (HM Government, 2012a). However, the White Paper references the three Darzi components of quality – effectiveness, experience and safety (Department of Health, 2008) and refers to their applicability in social care. The White Paper also offers some statements from individuals using care which would suggest a high-quality service (Figure 4.1).

Figure 4.1: Statements of high-quality adult social care services (HM Government, 2012a)

The Care and Support White Paper suggests that a high-quality service means that people should say:

- I am supported to **become as independent as possible**.

- I am treated with **compassion, dignity and respect**.

- I am **involved in decisions** about my care.

- I am **protected** from avoidable harm, but also have my **own freedom** to take risks.

- I have **a positive experience** of care that meets my needs.

- I have a personalised service that lets me **keep control over my own life**.

- I feel that **I am part of a community** and participate actively in.

- The services I use represent **excellent value for money**.

The draft Care and Support Bill places a duty on local authorities to promote diversity and quality in the provision of services. Under the current drafting, local authorities would need to promote the efficient and effective operation in its area of a market in services, ensuring that there is a variety of providers to choose from, a variety of high-quality services to choose from and that members of the public have sufficient information to make a decision on their care (HM Government, 2012b). However, the Care and Support White Paper makes it clear that the ultimate responsibility for providing high-quality care and support rests with the providers within the system (HM Government, 2012a).

Provider quality profiles

The Care and Support White Paper acknowledged the need for better information on provider quality and committed to ensuring that every registered residential or home care provider would have a quality profile on the NHS Choices website. Basic profiles have been accessible since July 2012, but from April 2013 they are expected

to include information about complaints, and users views (HM Government, 2012a). Providers will also have the option to include *Transparency and Quality Compact Measures* (Department of Health, 2013b). These measures were developed by a range of providers and stakeholders as part of a process to agree some basic metrics for voluntary inclusion in the provider quality profile. The metrics include:

- staff stability

- staff qualifications

- resolving complaints

- medication management (residential and nursing care only)

- pressure care management (residential and nursing care only)

- falls management (residential and nursing care only)

- scheduled homecare visits successfully undertaken (homecare only)

- scheduled homecare visits taking place on time (homecare only).

The Care and Support White paper made a commitment that the Government would enable open access to the data on the provider quality profile, to support the production of independent quality ratings and the development of a range of care comparison websites (HM Government, 2012a). There are now lots of individual commercial rating websites of varying degrees of quality and credibility. It can be extremely confusing for consumers if a website rates a service as good or excellent, whilst at the same time the regulator has concerns. Many of these sites are built around a user-feedback model, but participants in the engagement exercise were clear that many people in residential care (and their families) could be reluctant to leave feedback due to fear of reprisals. The low throughput of users and the volume of feedback on these sites means that it can be difficult to preserve anonymity.

The broader quality landscape

As is the case in health care, there are a large number of organisations and initiatives seeking to improve the quality of social care. The Department of Health has been working with the Think Local Act Personal (TLAP) partnership[1] to help those working in care and support to be clearer about what quality is, and to provide clarity on the different roles and responsibilities of organisations and groups in the social care sector. This was initially set out in a report *Bringing Clarity to Quality in Care and Support* (Department of Health, 2012c) and was updated as a suite of Quality Assurance Briefings in March 2013 (Think Local, Act Personal, 2013). In the paragraphs that follow, we highlight some key issues relevant to this review, and, in doing so, it may be useful to refer again to the quality curve shown in the previous chapter (National Quality Board, 2013) (Figure 4.2).

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1 Think Local, Act Personal is a national, cross sector leadership partnership focused on driving forward work on promoting personalised community-based social care.

Figure 4.2: The Quality Curve, reproduced from the National Quality Board (2013)

THE QUALITY BAR:
the essential levels of quality and safety

Continuous improvement

Service failure

Serious/systemic failure

Preventing failure

Proportion of services

Unsafe   Substandard   Adequate   Good   Excellent
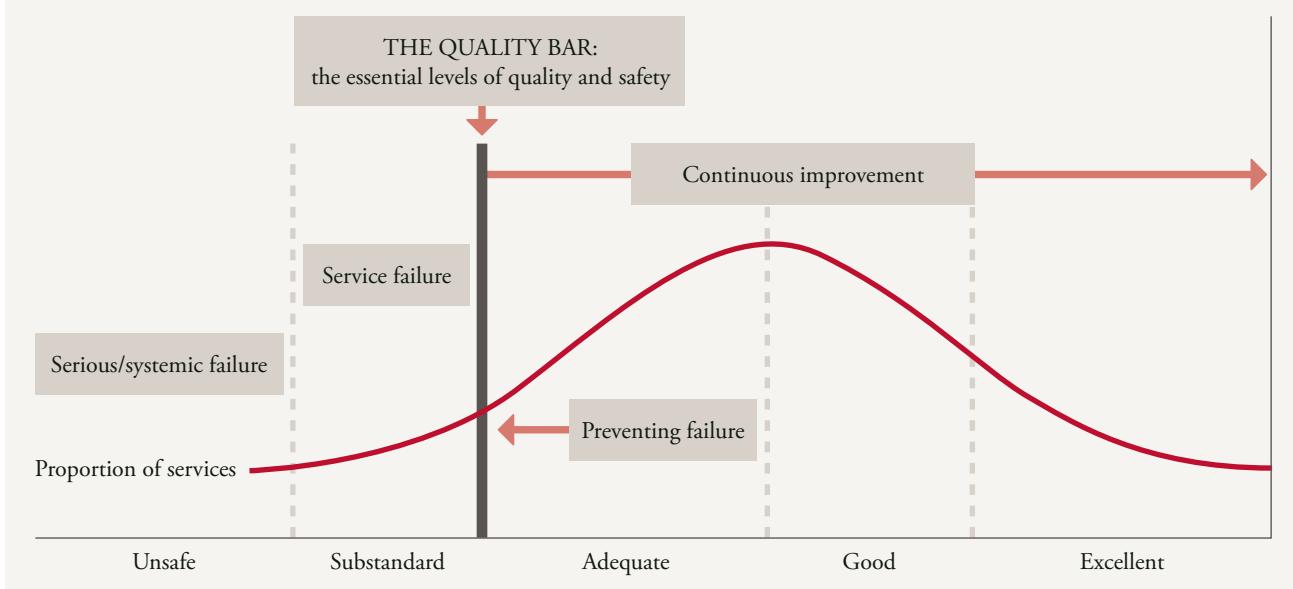
Care Quality Commission (CQC)

As set out in Chapter 2, the CQC is the key regulator of quality for adult social care providers, assessing them against essential standards, and using a range of enforcement powers in cases of non-compliance. In doing so, the CQC is focused on preventing providers from falling below the 'quality bar', as shown in Figure 4.2, and forcing those below to improve. In response to criticism about the limitations of focusing on compliance or non-compliance, the CQC launched a consultation on a proposal to launch a CQC-licensed excellence award for social care providers in 2011. The award would have been licensed by the CQC and delivered by third party organisations. The award was intended to be voluntary with a fee contribution. The consultation showed that although there was support for the concept of recognising quality, there was widespread disagreement amongst the sector regarding implementation. The main concerns are highlighted in Figure 4.3, all of which are important to consider in the context of ratings (Care Quality Commission, 2011).

Figure 4.3: Sector concerns in relation to the adoption of the proposed Excellence Award in Social Care (Care Quality Commission, 2011).

Costs to providers: It was widely felt that the potential costs may discourage applications for the award and disadvantage smaller providers.

Use of assessor bodies: There was widespread concern about the potential for inconsistency of assessments made by multiple awarding bodies.

Voluntary nature of the scheme: It was widely felt that a voluntary scheme would be confusing for the public and would not facilitate choice between providers who had applied for the award and those who had not.

Preference for a graded system: Many respondents felt that a scheme which recognises the stages in between essential and excellent would better enable choice and motivate providers to improve.

Proposed timeline: There was concern that the proposed timeline for implementation was unachievable.

Financial regulation

Local authorities have traditionally been responsible for managing the exit of providers from the market, but the financial difficulties faced by Southern Cross Healthcare in 2011 prompted further discussion as to whether additional mechanisms to oversee the social care market are sufficient when dealing with complex and large providers. Southern Cross was a large national care home provider that had nine per cent of the market nationally, and a greater share in certain areas such as the North East. In the early 2000s, the business was purchased by Blackstone, a private equity house. The company sold and leased back the property portfolio, thereby becoming highly leveraged (National Audit Office, 2011). In July 2011, the company announced the decision to transfer all of the company's homes to new operators. The National Audit Office recommended that the Government should develop a system to address serious provider failure where service providers were dominant or where service users were particularly vulnerable (National Audit Office, 2011). Considering the large number of providers across England, the proportion leaving and entering the social care market is small. During the year to April 2011, only 114 care homes were de-registered by the CQC and 133 homes were re-registered (Department of Health, 2012d).

At the time of writing this report, the Department of Health was in the process of consulting on market oversight proposals. The Department's preferred option is to strengthen and clarify the role of local authorities by imposing a duty to meet the needs for temporary care and support of any person (regardless of their eligibility for state funding) if they have urgent, unmet needs as a result of provider failure, and to offer additional oversight of those care and support providers that pose the greatest risk to the continuity of care. The Government would look to either the CQC or Monitor to take on this function (Department of Health, 2012e).

Adult Social Care Outcomes Framework

An Adult Social Care Outcomes Framework (ASCOF) has been operating since 2011/12 (Department of Health, 2011a). It has three main purposes. First, to provide robust and nationally comparable information on the outcomes and experiences of local people, allowing meaningful comparisons between councils (not individual providers) and to help identify local priorities for improvement. Second, to help councils report to the public progress on improving the quality of social care. Third, to support ministers in discharging their accountability to the public and to Parliament for the adult social care system, and to inform national policy development. The framework is not used to 'performance manage' councils in any way (Department of Health, 2012f). With the ASCOF, the attempt has been not only to provide comparative data across local authorities, but to develop more measures of outcomes and experience of care. The ASCOF uses measures that are shared, or aligned, with the NHS and Public Health Outcomes Frameworks, to facilitate joint working on common aims across sectors. Provisional results for the first year were published in September 2012 (Department of Health, 2012g). The Health and Social Care Information Centre has led a 'zero-based review' of adult social care data collections since November 2010. A consultation in 2012 among key stakeholders demonstrated the support for the collection of data on social care nationally (Department of Health, 2012g). However, in parallel, there has been a move to reduce the number of datasets local government are required to submit to the Department of Communities and Local Government. The Single Data List contains details of all of the data that local

government must submit to central government. If an indicator is not on the list, local government do not need to collect and provide it without receiving additional funding. Datasets have reduced by 56 since 2010 and, as of March 2012, stood at 156 datasets (Department of Communities and Local Government, 2013).

The unit of analysis in the ASCOF is the quality of the performance of the adult social care system as a whole, rather than the performance of individual providers.

Sector-led improvement at a local government level

In recent years, there has been a focus on encouraging sector-led improvement, with the Local Government Association playing a key role in supporting this process in social care, having developed enhanced programmes around children and adult's social services (Local Government Association, 2012). The National Children's Improvement Board (CIB) is a direction-setting and decision-making group that is responsible for the overall delivery of the Towards Excellence for Children programme and the development of sector-led improvement for children's services. Evaluation of the CIB 'Early Adopter Programme' for sector-led improvement shows that where local authorities had undertaken a peer challenge or review, they were positive about the potential benefits, but there was still a long way to go in securing widespread sector engagement and improvements for service users (Easton and others, 2006). The Towards Excellence in Adult Social Care Board (TEASC) is the partnership board established to oversee the development of the new approach to sector-led improvement in adult social care, aligned with the current personalisation agenda (Local Government Association, 2012).

National standards

From 1 April 2013, the remit of NICE will be expanded to cover social care. NICE will focus on the issuing of guidance and quality standards and implementation tools. In doing so, it will work with a range of stakeholders such as the CQC, the LGA, TEASC, and specifically with the Social Care Institute for Excellence (an independent charity supporting social care improvement which NICE has appointed to lead the National Collaborating Centre for Social Care to develop and disseminate NICE social care guidance). The intention behind this is to promote a consistent approach across health and social care, to tap into NICE expertise on quality standards and to exploit potential economies of scale (Department of Health, 2011b).

In 2011, the Department of Health asked NICE to run a pilot programme to develop social care quality standards relating to dementia care and looked-after children (to be published in April 2013). Standards in eight other areas are planned in social care, including medicines management in care homes. The programme is testing draft methods and processes, exploring the format and presentation of the quality standards in social care settings, and developing an approach to integrating related health and social care standards. At the time of writing, the Department of Health was seeking views on future topics for NICE guidance and quality standards in social care. The topics under consultation include falls, social isolation and medicines management in home-based settings (Department of Health, 2013c).

The Care and Support White Paper makes reference to the NICE standards, highlighting the opportunity to provide evidence-based descriptions of what good care and support should look like for commissioners and providers. These descriptions

could support carers and families to understand what to look for in a quality service (HM Government, 2012a). The standards are meant for providers and commissioners (both local authority commissioners and individual funders). For commissioners, the incorporation of NICE standards and guidance in contracts with providers will not be mandatory. For care providers, the White Paper offers a commitment to help develop and pilot a new, nationally-agreed, care audit to test themselves against best practice in national quality (HM Government, 2012a). The care audit pilot, led by the Healthcare Quality Improvement Partnership, will focus on the quality of dementia care in residential care settings, building on the evidence base set by NICE in this area. The pilot will be developed in consultation with providers and other stakeholders during 2012 and 2013, and audit tools made available free of charge for any residential care provider for use from the end of 2013. Participation will be voluntary and the results will not be collated or published nationally (Riley, 2012).

Local standards

Some local authorities have already developed comprehensive quality frameworks to assess the quality of adult social care. For example, Leeds City Council has recently completed a major piece of work to consider the cost, quality and dynamics of the residential and nursing home market in the city, with a view to establishing a quality framework that is fair to the provider and affordable to the Council[2]. A number of local authorities offer enhanced payment schemes for those providers who can demonstrate they meet certain criteria. For example, Tameside pays enhanced rates to care home providers if they can demonstrate that 85 per cent of staff are qualified to NVQ level 2 (equivalent) or above, the registered manager is qualified at NVQ level 4 (equivalent) or above, the home has completed certain accreditation schemes such as the 'Gold Standard Framework', or the home has achieved the Investors in People award to silver level or above.

Local authorities currently collect intelligence and surveillance data on social care providers to inform contract management – information that is generally not published. The extent and frequency of this monitoring is variable, and it is not clear how it links, if at all, with the assessments carried out by the CQC. Clearly local authorities have a key role in driving improvement using a range of means linked to commissioning. However, the extent to which local authorities see it as their responsibility to assess the quality of care in providers with which they do not contract is unclear.

In addition to the regulator and commissioners, there are a large number of other organisations who are active in this area, including the Social Care Institute for Excellence, The National Skills Academy and local Healthwatch organisations. For example local Healthwatch organisations will have the powers to enter and view providers and to scrutinise and comment upon service quality, passing on information to the local authority, the CQC, or Healthwatch England for further action (Department of Health, 2012c).

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2   Details of the scheme were sent in a personal communication to the Nuffield Trust as part of the engagement process.

Figure 4.4: Social care landscape
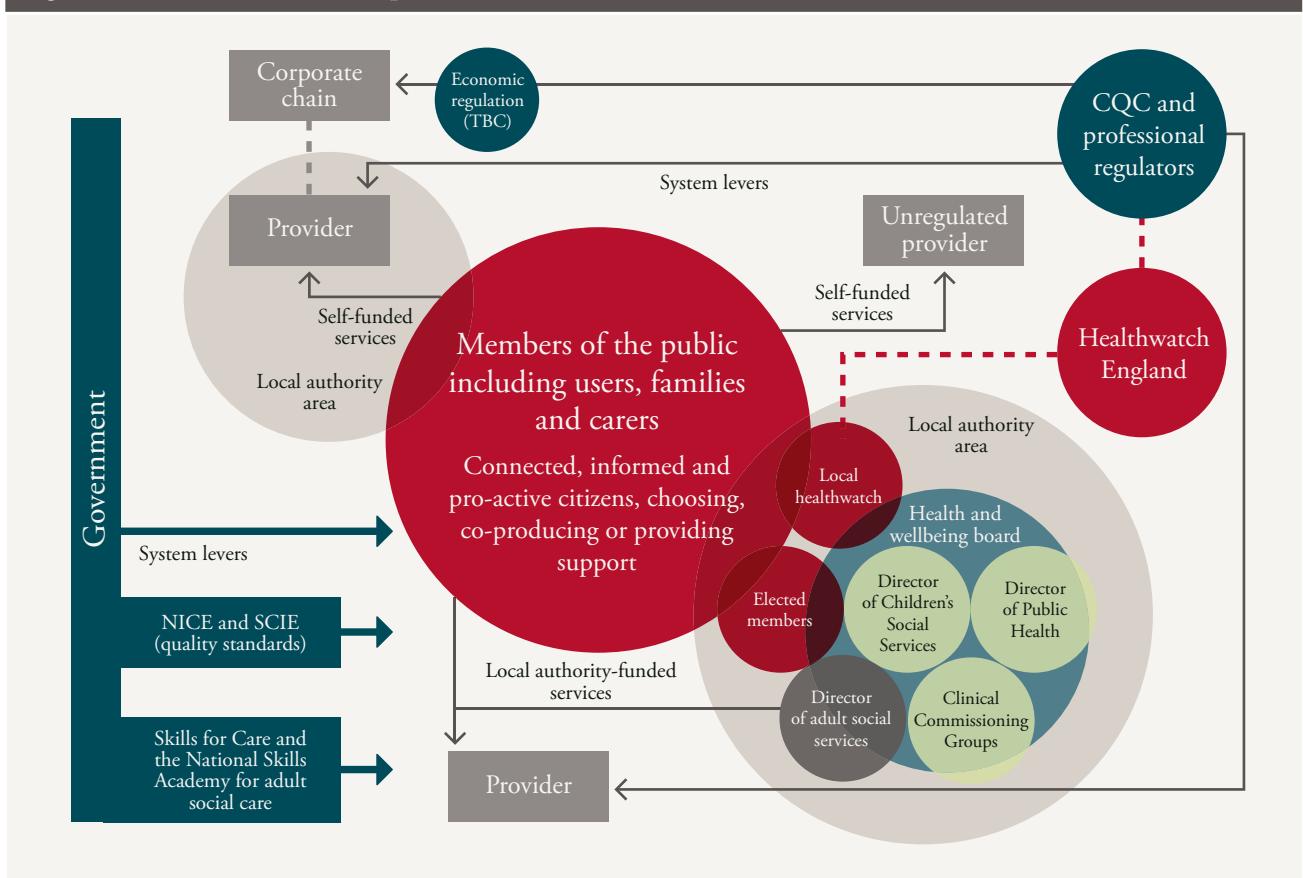
What might a new national rating system add?

The above brief and partial account demonstrates the complexity of the social care landscape (Figure 4.4) and the huge amount of activity required to improve quality in adult social care. In the previous chapter examining quality in health, key initiatives included: developing standards; identifying and developing indicators and the data to measure standards against; inspections against standards; assessment of the quality of care of providers across a range of metrics; and publication and presentation of that information publicly. There is activity in all these areas within social care as well.

As in health care, there is, as yet, no independent and comprehensive aggregate assessment of the quality of care across all providers (relevant to this review) and across the spectrum of performance in England. Such an assessment may help to define and identify excellent care and, especially if publicly-reported; help to prompt better performance in weaker performing providers; and promote user choice. Current assessments by the CQC are independent but not comprehensive (they focus on essential standards only). Current assessments by local authorities are variable in nature, and may not give a comprehensive view of the care offered by providers. They do not cover all care homes (for example those in which there are no local authority-funded residents) and are generally not published. Analysis of outcome measures taken from the ASCOF are a useful start but cover local authorities and not providers.

Second, although there is information for the public on some aspects of care quality available through the publication on NHS Choices of the provider quality profiles, and on the CQC's website, the information could be far more clearly and simply

presented to the public in one place. One aggregate, comprehensive rating of providers may provide more clarity and simplicity for the public, especially if it came from one 'official' trusted source. A useful market already exists in supplying basic information and ratings to the public on social care providers (chiefly care homes) from charitable and commercial organisations. These suppliers rely on users of care to record their experiences (which while useful may be limited as users may be reluctant to record dissatisfaction because of fear of reprisal). Furthermore, there is a plethora of these websites, which may be confusing for the public to use.

Is there support for a new rating system?

Overall, there was clear consensus from participants in the Review's engagement exercise that a system of aggregate rating, along the lines developed by the Commission for Social Care Inspection (CSCI) was valuable and was missing in the social care sector. The National Care Forum and the Voluntary Organisations Disability Group published a document calling for ratings to be re-introduced (Walden, 2013), citing the importance of publicly available information on quality. This view is supported by the market research commissioned by the CSCI to measure the impact of the star ratings on decision-makers (both members of the public and council commissioners). The study found that quality ratings were seen as a helpful factor in decision-making (Commission for Social Care Inspection, 2009).

Ratings were thought to be helpful for users, providers and commissioners. For users, they could be a trusted source of comprehensive information on the quality of providers, to aid choice. Ratings were thought to be a useful decision-making tool for commissioners and potentially would help to align the price paid for services with the quality of the provider (i.e the opportunity to pay a quality premium). For providers, a rating system could help to prompt better performance through competition and through having a clearer picture on the definition of good or excellence services. For large chains of providers, a rating might support the internal processes of performance management between individual providers and for senior staff. Some of these potential benefits were also apparent in the responses to the *Caring for Our Future* engagement process (Ipsos MORI, 2012).

As in health care, the main concerns related not to the concept, but to how a rating might be carried out. The main concerns were about: the potential cost to local authorities and providers ('no extra costs' was a very firm message), the worry of inconsistencies due to the subjective nature of inspections (it was recognised that because of a lack of data in social care, assessments would rely more heavily on inspection); a possible lack of experience of those doing inspections; lack of timeliness in assessments leading to ratings that were out of date and slow to refresh (possibly leading to severe business consequences for some providers); and worries about an increasing data burden on providers.

5. Purposes of a rating

Introduction

If the preceding chapters suggested that there might be a gap in the health and social care landscape that a system of aggregate ratings of providers might fill, and that there is some support among stakeholders (albeit qualified) to filling that gap, what might be the prime purpose of such a rating system? This is the question that participants in this Review's engagement exercise raised more frequently than any other. Finding an answer is important to shape the broad design of the rating system and how it would fit with other initiatives already operating (as outlined in Chapters 3 and 4).

The terms of reference for the Ratings Review did not specify the purpose of a rating system. On announcing the Review, the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, highlighted the following objectives: "Clear, simple results that patients and the public can understand – driving organisations to excel rather than just cover the basics," and "Greater certainty that poor care gets spotted and addressed before standards collapse" (Department of Health, 2012a).

The overarching goals of a rating system must be to help improve quality of care in providers for individual users. This chapter explores more specific purposes of rating which could include:

- **accountability:** promoting accountability for care to patients, the public and Parliament

- **choice:** facilitating choice of provider by individuals seeking care (as an end in itself) or by commissioners (for example, the NHS Commissioning Board, clinical commissioning groups (CCGs) local government)

- **performance:** helping to improve performance of providers

- **failure:** identifying or preventing failure

- **reassurance:** overall security/reassurance to the public that performance is credibly assessed and to a national standard.

Accountability

A key purpose of a rating could be to help promote accountability of providers via the public reporting of performance to the public and users of care, to local authority commissioners (for publicly funded providers of social care) and to NHS commissioners, and ultimately to Parliament (for NHS-funded health care). Clearly a great deal of information on the performance of providers is already in the public domain and available for scrutiny, and this is likely to increase in future. The key value of an aggregate rating of providers might be its simplicity and the fact that it could be communicated to a wide audience thus engaging more people in scrutiny. The last point is likely to be enhanced if there were an annual newsworthy 'verdict'.

The political desire for greater accountability is likely to have been prompted by high-profile failures in care for individuals funded through the public purse. This is by no means a British phenomenon.

In Australia, for example, a wave of new measures has been introduced in recent years towards providing more transparent information to the public in the wake of several scandals in health care involving individual consultants (Bentley, 2010), and wider lapses in patient safety at several hospitals (Faunce and Bolsin, 2004). The aim of these performance-rating efforts is to provide Australian users with data on the services available to them, to provide 'league table' comparisons for providers and to make providers more accountable to the public for the quality of care offered (Metherell, 2007). Both the MyHospitals[1] and MyAgedCare[2] websites were launched in response to the popular MySchools[3] website, which provides information on school outcomes. Prior to the launch of MyHospitals there existed no federal system of hospital performance reporting. This task was primarily the responsibility of each Australian State, with the Queensland department of health being acknowledged as an innovator in this area (Mulgan, 2012).

Similar initiatives, common across a selection of other countries, are summarised in Appendix 6, many of which refer to publishing performance data rather than publishing aggregate ratings.

The precise rationale for the introduction of the range of initiatives shown in Appendix 6 is not easy to identify. A summary of what appear to be the main reasons is shown below.

Table 5.1: Broad stated rationale for introducing public reporting systems in the areas of health and social care	
Country	Rationale(s)
Germany	• To support the broader trend of using market-mechanisms to steer quality • To enhance informed decision-making by users and to increase responsiveness of providers
Netherlands	• To enhance informed decision-making by users and to increase responsiveness and quality of providers
Finland	• To support the broader trend of using market-mechanisms to steer quality • To enhance informed decision-making by users and to increase responsiveness and quality of providers
Australia	• To increase accountability • To support the broader trend of using market-mechanisms to steer quality • To enhance informed decision-making by users and to increase responsiveness and quality of providers
Denmark	• To increase transparency and accountability, which will help to set high standards in the health care system • To provide patients with information they can use to make choices • To improve quality and safety, and prevent adverse events

Accountability, whether stated as an explicit purpose or not, is clearly an underlying purpose in countries such as those shown in the table where a large proportion of funding for health or social care comes from the public purse.

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1   http://news.smh.com.au/breaking-news-national/hospitals-website-launched-but-no-date-20100716-10dg2.html

2   www.agedcare.com.au

3   www.myschool.edu.au.

Choice

As shown in the table opposite, information to facilitate user choice is clearly a major purpose behind efforts to publicise data on the quality of care. We consider two main potential users of choice:

- **users of care**, including those who commission their own care, potential users of care, the friends, family and carers of those who use care, and their GPs

- commissioners of **publicly funded health care** (chiefly NHS primary care trusts and the new CCGs that replace them) and social care (local authorities).

Not considered here is how ratings might impact on the choices of the public, or groups representing them, with respect to more strategic planning decisions about the health care in their area.

Encouraging user choice of care provider is a key thrust of national policy in health and social care and an important end in itself. The right to choice within the NHS is clearly outlined in the NHS Constitution which states that "you have the right to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs" (Department of Health, 2013a). The current Government has outlined its intention to put patients and the public at the heart of the NHS through greater information, choice and control (Department of Health, 2010a). While there is no similar constitution for social care services, promoting greater choice is a central theme of current policy and initiatives in social care as outlined in the Care and Support White Paper (HM Government, 2012).

Choosing a health care provider

The public and patients

With respect to the public and patients, some key questions relevant to this Review are: 'Is choice wanted?'; 'Are choices of health and social care possible and being made?'; and, if so, 'Would a rating help aid those choices?'

To help, the Nuffield Trust commissioned Ipsos MORI to research public attitudes towards ratings (Ipsos MORI, 2013). Three focus groups of eight people were conducted with the general public between the 4 and 6 March 2013. A slide pack summarising the results of this research will be published alongside this report. Participants were recruited based on a number of criteria including: social grade (two groups at ABC1 and one C2DEs[4]); having primary-school-aged children; having experience of choosing a care home in the last 12 months; or having experience of non-emergency hospital treatment. Given the very small scale of the research, it cannot claim to be representative of the wider population but identifies some useful themes and areas for further research.

Generally speaking, participants had made use of the internet for seeking out comparative information on consumer goods and services. For schools, there was a high awareness of Ofsted and its role in regulating the education sector. Most people who had recent experience of choosing a school had used Ofsted ratings or inspection reports. However, none of the participants relied solely on Ofsted ratings. Word of mouth and personal experience were key factors in choosing public services in general.

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4   Classifications assign a social grade based on occupation. ABC1 (higher, intermediate and junior managerial/professional occupation) and C2DE (skilled and semi-skilled manual workers, pensioners, casual workers and unemployed).

Participants thought ratings in health and social care could be useful as a point of reference but not as a primary factor in decision-making.

The perception of the usefulness of ratings was inextricably linked with the perception of choice: where choice was possible, ratings were thought helpful. Where choice did not exist, participants thought that ratings could actually undermine confidence and increase concern about care, for example, in the case where hospital services in an area were inadequate and the user was unable to travel. Generally, participants did not consider that they had a choice of health services under the NHS. There was also an assumption that hospital services in particular should provide a consistent level of quality (and, as such, choice should not necessarily be needed).

There was a perception that ratings would be more useful for simpler, homogenous services (rather than the complex, heterogeneous hospitals). Other research has in fact found the opposite; that choice was seen as more relevant to choosing hospitals than choosing a GP practice (Owen-Evans, 2011a). Ratings of hospitals were thought to be less useful if there was an informed and trusted mediator to support decision-making (such as a general practitioner). Ratings for individual GPs were thought to be more useful than ratings for general practices at an organisational level. As users, ratings for whole hospitals were thought less useful than ratings for the department or specific services needed. Interestingly, participants thought ratings for private healthcare providers were more useful as it was perceived that the consumer had more power to make choices.

The focus groups present a mixed picture: on the one hand choice was thought valuable and was exercised for relatively simple services and goods; on the other hand the groups appeared more sceptical about exercising choice of provider in the NHS. This could be for a range of reasons, for example: a lack of alternative provider; a lack of information available; a lack of information clearly presented; the lack of confidence in making a decision on health care because of its complexity and the risks of making a wrong decision (hence the reliance on trusted 'agents' such as GPs); lack of time to choose, particularly in an emergency situation; and normative views that choice was irrelevant – good care on the NHS should be available to all.

A number of studies have confirmed that for patients offered choice, one of the most important sources of information to help choose a hospital for treatment was their GP (Department of Health, 2010b: Dixon and others, 2010; Hildon and others, 2012).

Figure 5.1 shows the sources of information on choice from the last National Patient Choice survey. Relevant to the issue of rating, only a tiny minority appear to use websites when choosing a hospital for care (Department of Health, 2010b). On choosing a general practice, *Which?* found that patients relied heavily on subjective and informal sources including word of mouth and reputation with virtually no use of, or access to, more objective measures (Owen-Evans, 2011b). Work by the King's Fund found that while patients placed a high value on the quality of care, they rarely used objective measures of performance to help them choose a hospital (Dixon and others, 2010).

Figure 5.1: Most important source of information when patients choose their hospital, February 2010 (Department of Health 2010b)
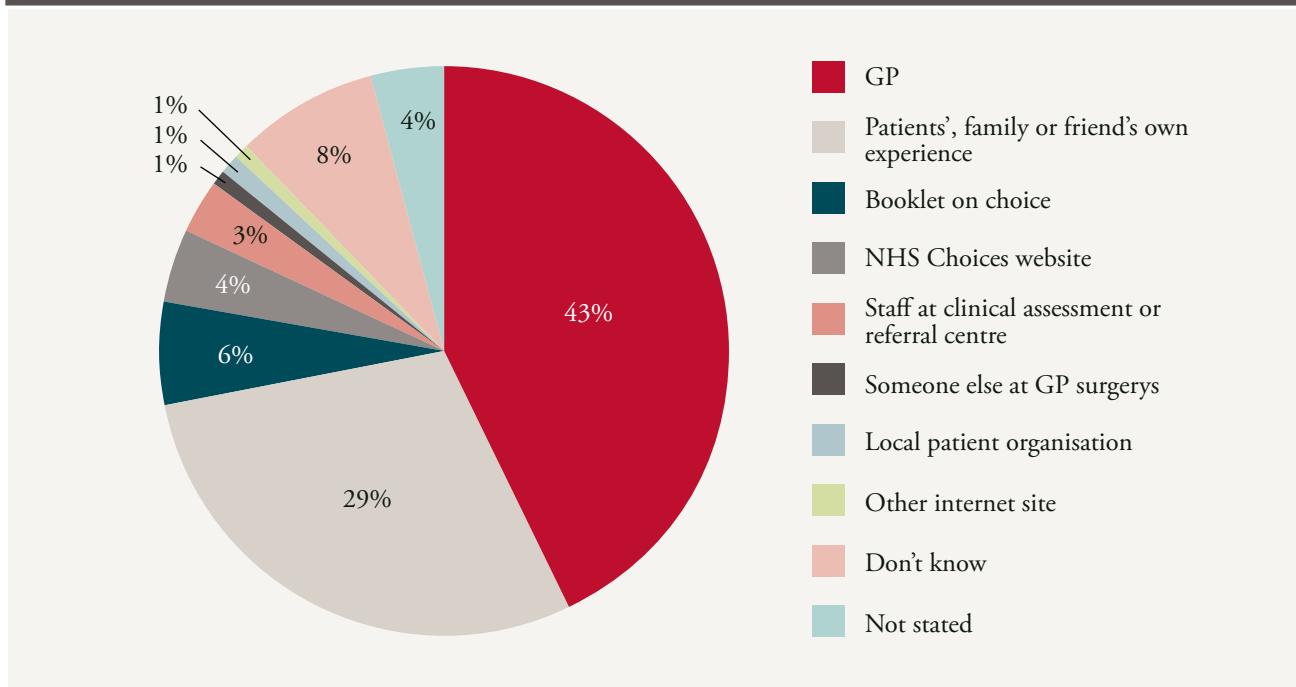
Various studies point to the importance of convenience as a factor in a patient's choice of provider (Department of Health, 2010b) and other factors such as cleanliness, information about infections, waiting times, hospital food, privacy and visiting times (Ipsos MORI, 2006; Owen-Evans, 2011b; Hildon and others, 2012).

The factors people choose as important are likely to be different according to their particular health needs. Those looking to make a more considered decision on their hospital provider might base a decision on wanting to see a particular consultant, or condition-specific requirements. But for routine more minor operations, cleanliness and convenience is very important (Owen-Evans, 2011b). Similarly, we know from other studies that patients' preferences (in other words, what aspects of quality are important to them) are inconsistent. For example, the King's Fund inquiry into the quality of general practice in England showed that while some patients put great value on speed and convenience of access, others put greater value on continuity of care with the same doctor (Goodwin and others, 2011). This could suggest that individuals need help to make good quality choices (Dixon and others, 2010) or that patients may prefer to see and select a range of aspects of quality specific to their needs rather than be given a single summary assessment of quality.

The Healthcare Commission did see one of its roles as being a source of information for the general public about care. Its website appeared to be well used, with approximately 140,000 visitors each month. However, it is not possible to tell the extent to which visitors were members of the public (or commissioners) seeking information from the Annual Health Check to make care choices (Healthcare Commission, 2009).

More difficult to find is evidence on the extent to which people are exercising choice, and in particular if they are switching to different providers. For hospital care, the King's Fund found that most patients would choose their local provider, and GPs

described their patients as loyal to their local trust and reluctant to consider travelling further (Dixon and others, 2010). However, more recent evidence shows that, following national policies to increase choice, there are changes in the flows of patients to different providers for elective care which could indicate that patients (or their GPs) are exercising more choice, in part because more options are available (Kelly and Tatlow, 2012). The proportion of people changing general practice is quite variable around the country and between population groups (movers are often younger and healthier) but on average is less than 10 per cent a year. However, many in this group will be changing because of moving location of residence rather than actively switching from a practice because of quality of care issues (Bardsley and Dixon, 2011).

Insofar that there is any hard evidence of people exercising active choice of provider, it is difficult to assess the role that ratings may have played in these decisions, relative to concurrent initiatives promoting choice or other factors. Anecdotal evidence was cited in the Review's engagement exercise with respect to ratings of maternity services, which were published by the Healthcare Commission in 2008 following a number of high-profile investigations into poor maternity services at individual trusts (including North West London Hospitals NHS Trust in 2005). The assessment focused on the whole of the pathway of maternity care, drawing tougher information from trusts delivering the services, staff and patient surveys. The Review relied heavily on the views of women using the service (Healthcare Commission, 2008). Trusts were scored against 25 indicators covering clinical care, 'women-centred' care, and efficiency and capability, and aggregated into a single overall statement on performance. In total, 148 trusts providing obstetric maternity services, and four trusts that provided just midwifery-led services were reviewed. A total of 26 per cent of the organisations scored as 'best performing', 32 per cent as 'better performing', 22 per cent as 'fair performing' and 21 per cent as 'least well performing' (Healthcare Commission, 2008). Reports on individual trusts were made available for public and professionals.[5] In London, 19 out of 27 maternity providers were graded as 'least well performing'. Engagement participants reported a temporary surge in demand in maternity care from units with more favourable ratings, leading to problems managing the extra capacity.

International evidence of publicising information on the performance of providers also shows low use by the public and the overall impact is inconclusive (see Appendix 7).

Overall, the influence of publicly reported ratings on user choices is clearly an under-researched area. The findings from our focus groups highlight the need to conduct further research to explore how a ratings system could be constructed and presented to the public to optimise its usefulness.

Commissioners

It is not clear the extent to which primary care trusts (PCTs) used the Annual Health Check ratings produced by the Healthcare Commission to select where and how much care was commissioned. It is likely that the Annual Health Check was one of a range of items used in these decisions. From April 2013, CCGs replace PCTs and begin operating across England to commission approximately £65 billion NHS care on behalf of the populations they serve. The attitudes of CCGs to the usefulness of provider ratings for quality of care are largely unknown. However, there are clues from some participants in the engagement exercise, principally GPs. The prevailing view

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5   www.birthchoiceuk.com/BirthChoiceUKFrame.htm?http://www.birthchoiceuk.com/HCSurvey.html

was that ratings for hospitals could be useful if they contained the right information, in particular more granular information as to the quality of medical care for specific conditions. More aggregate ratings (for example, one summary score for a trust) were thought to be far less useful.

Choosing a social care provider

Participants of the three focus groups commissioned as part of this Review were more positive about the use of ratings to aid choice of social care provider. A care home was seen as a longer-term commitment and often a personal financial contribution was involved. Participants noted similarities between care homes and schools – every aspect of a care home would be experienced by a resident but the same would not be true of a hospital.

While the focus groups were positive as to the value of ratings for social care, in its impact assessment to the Care and Support White Paper, the Department of Health found that there was inadequate provision of information to both state-funded care users and, in particular, to people funding their own care (Department of Health, 2012b). The Care and Support White Paper also made it clear that there is a desire for people to compare different care providers easily (HM Government, 2012). The Personal Social Services Adult Social Care Survey, England 2011–12 found a relationship between information provision and satisfaction and personal control suggesting that information provision can be important in determining high-quality services. Of those who found it very easy to find information and advice, 84 per cent were extremely or very satisfied with their care services and 53 per cent felt that they had as much control over their daily life as they wanted. In contrast, of those who found it very difficult to find information and advice, only 37 per cent were extremely satisfied or very satisfied with their care and only 16 per cent felt they had as much control over their daily life as they wanted (Health and Social Care Information Centre, 2012).

A survey of 5,257 people on behalf of *Which?* in 2012 found searching for a care home to be the least enjoyable of all choices the public make in consumer markets or public services: 63 per cent of respondents said they did not enjoy making a decision about choosing a care home provider (62 per cent for home care services). This compares to 53 per cent who did not enjoy making a decision about a bank and 42 per cent did not enjoy making a decision about renting a property. The research found that members of the public are ill-equipped for making a decision as a consumer. Only 43 per cent of those who had experience of arranging care said they felt knowledgeable as a consumer when choosing a care home. This was even lower (37 per cent) in relation to home care services (Moran, 2012).

The Equality and Human Rights Commission Report into homecare found a lack of suitable information on different processes and options for obtaining care and on quality. Some older people and their families felt overwhelmed with choosing a home care provider and in some cases they were only given a long list of providers without additional information. The Commission noted that some older people gave evidence that the previous 'star rating' system was helpful in selecting care providers (Equality and Human Rights Commission, 2011).

Similarly the Alzheimer's Society surveyed 1,139 family members of people with dementia across the UK and found high use of more informal sources of information to aid choice of a care homes:

- care homes directly – 59 per cent

- social workers and other health and care professionals – 40 per cent

- local regulator – 23 per cent

- local council – 21 per cent

- Alzheimer's Society Services – 21 per cent (Quince, 2013).

These broad findings are confirmed by a report by the Commission for Social Care inspection (CSCI) on its quality ratings of social care providers (CSCI, 2009a). The most important sources of information in choosing a care home were preferences by friends and relatives, information from local authority social services staff, visits and chats with staff at the care home and feedback from residents. Only 21 per cent of relatives and one per cent of individual users obtained information from CSCI's website (which published the star ratings). The public did, however, report that they found the CSCI quality ratings easy to use, and that ratings had helped them to make decisions about which care service to use. Awareness of the rating however was highest among care home residents and lowest among people using home care services. Both the CSCI ratings and fuller inspection report were helpful to make decisions about care, although more to relatives of the individual concerned rather than the individuals themselves (CSCI, 2009a). Despite this, there is a large market for web-based ratings for care homes, although it is difficult to find robust evidence on the extent to which these are used.

Commissioners (local authorities)

The best evidence on the use of ratings for choice by commissioners again comes from CSCI's market research report (CSCI, 2009a). Councils almost universally had awareness of the CSCI ratings and thought they were a good idea, being useful and simple to use. The report showed that the ratings were used far more by local authority commissioners in selecting care providers to contract with, rather than users and relatives, particularly for domiciliary care. Sixty-four per cent of councils surveyed said that the CSCI inspection report was the most useful source of information, although it is not clear specifically how important the aggregate rating was as part of that fuller inspection report. Some councils had used ratings to offer higher fees to higher quality providers to encourage improvement across a wider set of care providers (CSCI, 2009a).

The same report found that commissioners and users had slightly different priorities. When asked which factors were considered the most important when assessing which case services to use, local authorities placed the highest value on "the providers' ability to meet the changing needs of a resident in their care", whereas residents and their families looked at the overall quality of a service regarding hygiene, activities and friendliness (CSCI, 2009a).

Performance

Perhaps the strongest claims of the benefits of a system for rating providers are that it would prompt an improvement in performance of providers. It may be important to distinguish here between a publicly reported aggregate rating on performance (a rating), publicly reported data that are not aggregated (a range of individual performance indicators, possibly brought together in a balanced scorecard approach or 'dashboard') and unpublished comparative data on performance (for example, through voluntary benchmarking systems).

Examples of ways in which a rating might prompt better performance with respect to quality of care are shown in Figure 5.2.

A rating might have some generic effects on providers. The mere fact of defining good care might be helpful in identifying to providers what to aim for. Similarly, knowledge of what might be good practice (in the providers identified as high performing) might stimulate improvement. The process of assessment itself might prompt reflection and change particularly if there were timely feedback.

Public reporting of performance clearly has important effects on the performance of providers in health (Shekelle and others, 2008). It is not clear where these effects are felt within providers and whether the source of improvement initiative is the Board, managers, or clinical staff. Some research suggests the impact is felt more at the level of the provider than in specific areas of clinical care and that there is a trade off between providing summative measures of performance (such as ratings) and more granular data such as specific-treatment data (Pearse and Mazevska D, 2010). The fewer the indicators which directly relate to patient care, then presumably the lower level of involvement by front-line clinical staff.

Public reporting might prompt action by organisations external to the providers, for example: greater competition from other providers; enforcement action by regulators; more stringent contract specifications by commissioners; reward for performance through financial incentives (such a quality premium on prices); for chains of private providers (particularly in social care), direct performance management from headquarters to improve; or it may prompt local benchmarking and peer-review activity.

The public reporting of a performance rating may also prompt attention internal to the provider itself: direct activity to improve performance; more regular self-assessment; closure of particular services or activities; or merger with other services or providers.

Figure 5.2: How a rating system might result in improved performance of providers

Generic

- A trusted source defining good standards and practice (thought especially useful to small isolated providers in social care)
- Reporting examples of good practice
- Through the process of assessment

Public reporting prompting external action

- Commissioners: may be able to reduce oversight of providers; may act on results of ratings to encourage improvement (for example, through contract specifications)
- Financial incentive (price in social care but could link to Commissioning for Quality and Innovation/pay for performance schemes in health)
- Competition (reputation and market)
- Regulatory action
- Direct performance management (for example, by NHS Trust Development Authority for NHS Trusts, by the corporate headquarters of independent sector provider chains)
- Development of further peer review/benchmarking systems

Public reporting prompting internal attention

- Affirmation of good practice (which might be especially valuable for small isolated providers in social care)
- Regular self-assessment
- Direct performance improvement activity (institution or department, managerial or clinical)
- Closure/merger

Participants in the Review's engagement exercise were clear that all these mechanisms might work to benefit the public, and had a number of examples to illustrate this. The mere presence of a publicly reported aggregate provider rating was thought to be a powerful spur on management, although less so on clinicians.

In fact, there is a wealth of evidence in the UK and worldwide to show the positive impact of public reporting of performance data (although not necessarily an aggregate rating) on the quality of care (Shekelle and others, 2008). Many countries, as noted above, are requiring health care providers to do this, although some, such as Germany, have encouraged an approach which is more professionally led and with less public transparency (see Appendix 8).

Figure 2.2 in Chapter 2 showed that in health care one impact of the Annual Health Check rating was a reduction in the proportion of acute and specialist providers rated as weak, and (apart from the final year) an increase in the proportion rated as excellent. It is also true, however, that a number of providers remained consistently in the 'weak' category over time.

There is no evidence of this impact using the CSCI system of ratings in social care, in part because of their short history. However, as noted in Chapter 2, CSCI's legacy document suggested that since the introduction of ratings there had been a significant reduction in the overall number of poor services (CSCI, 2009b).

A major initiative internationally is the Nursing Home Compare launched in the United States by the Center for Medicare and Medicaid Services (http://medicare. gov/NHCompare) as described in Appendix 9. Again, while there was little evidence to suggest that consumers used the rating to choose a social care provider, there is evidence to suggest that the information led to quality improvements in the social care sector, but in higher rather than lower performing providers (Werner and others, 2012).

But as participants in the Review's engagement exercise also pointed out, there could be a mixed or negative impact of ratings on performance, as noted in Chapter 2. Examples are outlined in Figure 5.3. One potentially negative consequence of a rating is the effort and cost of disputing the rating. It is difficult to obtain figures on the extent to which NHS Trusts disputed the judgments in previous ratings systems. At present if a provider does not agree with a Care Quality Commission (CQC) judgment (to impose, vary or remove a condition of registration, or to suspend or cancel a registration), they can make representations to the CQC against its enforcement decisions, and if they are not content after the representation process, they can take their case to a First-Tier Tribunal (Care Quality Commission, 2011a). At present, there have been very few appeals to the Tribunal – 18 between January 2011 and January 2012[6] and none before 2011. Up until that time CQC judgments had not been subject to judicial review (Public Accounts Committee, 2012).

In social care, participants in the Review's engagement exercise noted that the reputational damage caused by a poor rating could be devastating for a small provider, potentially pushing it out of business very quickly.

The acceptance of mediocrity was also an important issue which came up in the Review's engagement exercise, and highlighted in a recent speech by the Secretary of State for Health with respect to NHS trusts (Department of Health, 2013b). While participants accepted that there may be 'middling' performance in NHS trusts which a rating might help to improve, critical was whether or not NHS trusts saw the standards and indicators (and other assessments which made up an indicator) as truly reflecting the quality of care for patients.

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6   Five were appeals against the cancellation of a registration; ten were against CQC's refusal to register the provider; two were against imposed conditions on the provider; and one was against an urgent cancellation of registration.

Figure 5.3: Potential negative impact of ratings on quality

Weaker performance

- *Risk of demoralisation:* following a poor rating or inaccurate media reporting of the rating, making it harder to attract staff. This could particularly be the case if the rating is poor because of circumstances largely beyond the control of the provider, for example if local primary care and social care services are inadequate.

- *Risk aversion:* leading to lack of innovation.

- *Harm:* inappropriate attention on the measured relative to the unmeasured. The risk of harm may be greater in providers offering more complex care such as hospitals, or for users who need complex care across a range of providers who need to collaborate.

- *Distraction:* finance and management time diverted from frontline care, for example, on responding to the assessment process needed by the rating, and on managing external reputation after publication of a rating (for example, disputing the rating, possibly through judicial review) rather than managing poor performance.

- *Tension between management and clinical staff:* in the past, ratings were seen as primarily engaging management rather than clinicians, which may lead to conflict over priorities for patient care.

- *Spiral of decline* (with possible adverse impact on surrounding providers) and exit.

Perverse effects

- *Gaming the assessment:* generating misleading data, avoiding certain types of needed care or user groups if that impacted adversely on the rating.

- *Impact of rating on other providers:* the performance of a good-quality provider A may weaken if a neighbouring provider B has a poor rating and demand in provider A increases excessively; or the merger of a weak performer with a good performer may pull down the ratings of the good.

No impact

- *Weak follow up actions:* if a rating is not respected and there is no follow up (for example, if weak or there is no relevant action from regulator, rater or commissioner) or if the follow-up actions of these bodies are misaligned, providers may be happy to accept middling performance on a rating (for example, because of an acceptance of mediocrity, or because a rating is not seen to assess the most important aspects of quality).

Participants in the engagement exercise suggested that a broad range of timely indicators reflecting quality (experience, safety and effectiveness of care) would be important. There were concerns about undue reliance upon one or a small number of indicators, for example, TripAdvisor type indicators of user experience, the Friends and Family Test, and hospital level mortality rates. At the same time, as Mike Farrar CBE, Chief Executive of the NHS Confederation, suggested: "we have got to have a degree of sophistication but we've got to avoid it being so complex nobody can understand it" (Calkin, 2013a).

Through the engagement process, there was some discussion as to whether information on finance and financial management should be part of a rating either as an indicator of the likely quality of care or as a separate domain in itself (eg as a measure of quality governance and management). There were very mixed views. In the NHS, there was uncertainty about the link between financial health and quality of clinical care, and worries about the feasibility of collecting adequate information on providers in the independent sector. In social care, it was generally thought to be unfeasible because of the large number of providers and the fact that most were private businesses.

Others recognised that a rating was not going to be "a 100 per cent perfect summary assessment" of performance and that it might take many years to develop. Given concerns about data quality, they felt that a relative assessment of performance against

peers could still be somewhat beneficial. Respondents were of the opinion that it was important to "engage with rather than oppose" an assessment system in order to help shape its development. Robert Francis QC also noted the importance of engagement, highlighting that trusts and clinical staff who were engaged in selecting indicators would have a sense of ownership over them (Francis, 2013) and add validity to their value.

Other topics relevant to professional engagement include (i) the extent to which indicators cover important aspects of quality at a department, service, ward or treatment level – reflecting both process and outcome measures; (ii) development of indicators over time alongside progress on the routine collection of electronic data on clinical care[7]; and (iii) the extent to which indicators should become more challenging and encourage improvement. We return to these points briefly in Chapter 6.

In the NHS, participants in the Review's engagement exercise gave testimony that some of the effects in Figure 5.3 did occur, and (as noted in Chapter 2) were more likely to occur when central pressure was put on trusts through performance management to achieve specific national targets (which made up some of the indicators in the Annual Health Check). Useful analyses in this area were published by Bevan and Hood with respect to the impact of targets and strong performance management (2006a; 2006b). There were particular worries that a focus of ratings on discrete providers may distract attention away from the collaboration needed across providers, particularly for the care of vulnerable groups because of gaps at the point of transition between settings. It was thought important that a rating could help encourage integrated care.

Several participants in the engagement exercise insisted that the costs of any new system of rating should be fully and transparently funded, and that it would be critical to make sure that any extra burden on providers or on commissioners of publicly funded health and social care, be recognised and minimised. Using existing sources of information, rather than requiring new collections was thought to be important in this respect. Participants from the NHS were frustrated by the amount of time wasted with reorganisations, feeding external requests for information related to performance management, and dealing with endless initiatives, "all of which gets in the way of the core job". A review of the burden of information requirements on NHS organisations and how they might be minimised is currently under review led by the NHS Confederation (Calkin, 2013b).

While the costs of the national bodies carrying out previous ratings systems can be quantified, the overall impact of the previous ratings systems, in particular the Healthcare Commission's Annual Health Check and CSCI's ratings, was not evaluated with respect to the range of issues in Figures 5.2 and 5.3. If ratings were reintroduced, their impact would need to be carefully evaluated from the start.

This suggests that the overall impact of a rating on the performance of providers will depend not just on how it is constructed, implemented and presented, but the physiology of the system in which it operates. A review of international experience of using a wide range of performance measures in health care noted that even with technically credible measures, many initiatives have failed to have a material impact on performance because measurement (and publishing that measurement) alone is not sufficient to achieve desired change (Smith and others, 2009). In particular, what are

7   Professor Mike Richards at the Department of Health and NHS Commissioning Board is currently reviewing the feasibility of developing ratings of individual hospital teams/services, as requested by the Secretary of State for Health.

the consequences of a poor rating, or incentives for a good one? How effective are the wider mechanisms for improving performance in the health and social care systems (the persistence of a group of trusts being rated as 'weak' was noted in the Annual Health Check) and how aligned are they with the standards assessed in the rating system? We return to these issues of how ratings might work best within the existing health and social care systems in Chapter 7.

Failure

A potential purpose of a system to assess and rate the quality of care in providers is that it might provide, in the words of the Secretary of State for Health The Rt Hon Jeremy Hunt MP: "Greater certainty that poor care gets spotted and addressed before standards collapse" (Department of Health, 2012a).

Health care

There have been some very serious and high-profile failures in the quality of care in providers in recent years, not least at Mid Staffordshire NHS Foundation Trust (Francis, 2013) and Winterbourne View hospital – a private hospital owned by Castlebeck Care Limited (Department of Health, 2012c). There have also been very critical reports on failures produced by the Commission for Health Improvement and the Healthcare Commission including investigations in Maidstone and Tonbridge Wells, Cornwall and Northwick Park hospitals. Investigations are currently underway into serious failings in maternity care at University Hospitals of Morecambe Bay Foundation Trust, and 14 NHS trusts which have higher than expected mortality rates (on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Indicator or the Hospital Standardised Mortality Ratio (see Appendix 5)).

The poor quality of care provided at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 has been the subject of multiple inquiries, most recently an independent inquiry set up in 2009 chaired by Robert Francis QC, and the Public Inquiry set up in 2010, also chaired by Robert Francis QC, which reported in February 2013. At the time of writing, the Government is about to publish its response to the 290 recommendations arising from this second inquiry.

The problems at Mid Staffordshire NHS Foundation Trust were first brought to light by patients and staff at the trust. But they were then identified by the Healthcare Commission – not through the Annual Health Check but by a detailed analysis of mortality rates.

Partly prompted by these scandals, there has been a significant amount of analysis, particularly in the NHS, as to the reasons for failure and the systems for spotting it. Prompted by the Healthcare Commission's report into the serious failings at Mid Staffordshire NHS Foundation Trust, the National Quality Board has published two useful reports setting out the roles and responsibilities at every level of the health system for safeguarding quality – the first a review of early warning systems (National Quality Board, 2010) and the second, a report into how the new health system will work to maintain and improve quality in the light of the extensive NHS reforms resulting from the Health and Social Care Act 2012 (National Quality Board, 2013a).

In both reports the primary responsibility for spotting and preventing failures in the quality of care is clarified as being the provider itself. The second report cites work by The King's Fund, which set out three lines of defence against serious quality failure in health care (Dixon and others, 2012):

- **The first line of defence** is front-line professionals, both clinical and managerial, who deal directly with patients' carers and the public and are responsible for their own professional conduct and competence for the quality of care they provide.

- **The second line of defence** is the boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations. They are ultimately accountable when things go wrong.

- **The third line of defence** is the structure and systems that are external to individual for assuring the public about the quality of care. These are often national organisations (such as regulators or the NHS Commissioning Board), but may also be regional or local activity such as peer-review activity.

The National Quality Board then set out the main roles and responsibilities in the third line of defence and how they would collaborate together more effectively to spot early signs of failure. A key new feature is a system of Quality Surveillance Groups, set up at local and regional level, to act as a collaborating 'virtual team' across the health economy to share a wide range of intelligence and any concerns about providers in the area. They would consist of a large range of all major stakeholders, core members include local HealthWatch groups, the CQC, Monitor and the NHS Trust Development Authority. Concerns would be escalated into a 'risk summit' for further investigation (National Quality Board, 2013a). They will be chaired and supported by the NHS Commissioning Board and further details on their membership and functions have recently been published (National Quality Board, 2013b). The broad approach is on a wide range of organisations external to providers meeting regularly, sharing data and softer intelligence as a way to spot concerns early, and escalating concerns where relevant.

The second inquiry into care at Mid Staffordshire also focused on (but was not restricted to):

… to examine the operation of the commissioning supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken. (Francis, 2013)

As part of this, there was extensive examination of the system of regulation that was run by the Healthcare Commission at the time. Francis writes: "the system of regulation which the Healthcare Commission was given to run failed to prevent or detect over three quarters of its lifetime what has been described as the biggest scandal in NHS history."

He assumed that the Annual Health Check was designed to spot lapses in care by saying: "At the heart of the failure to detect or prevent the appalling events at Stafford sooner was the concept of core standards and the means of assessing compliance: the Annual Health Check (AHC)."

He thought there may be a problem with the AHC because the core standards were largely set centrally *'by Government'*, and in his view there should be a more obviously inclusive and transparent process to gain more acceptability and validity among patients the public and the staff who work to them.

When giving evidence to the Public Inquiry on Mid Staffordshire, Sir Ian Kennedy, the chairman of the Healthcare Commission 2004 to 2009 said that the Annual Health Check:

… was a mechanism that was able to paint a picture about an organisation by reference to the standards handed down. It was not able to identify always what might be pockets of failure, the existence of which would be hidden in the total organisational performance. (Mid Staffordshire Inquiry, May 2011).

When asked whether the ratings system came with adequate warnings to reflect that concern, and whether the rating risked giving false reassurance to the public, Sir Ian responded:

"Well, what it said it would do would be to do what the legislation required, which was to produce an annual rating, pursuant to general standards which had been laid down. And that's what it did." (Mid Staffordshire Inquiry May 2011).

In addition to Mid Staffordshire, it is also worth noting that earlier ratings systems had not predicted service failures indentified in major investigations by HC. In fact, in some cases, an over-emphasis on achieving ratings had been seen to be one of the causes of management teams ignoring issues of quality (Healthcare Commission, 2007).

Francis' and Kennedy's comments suggest several issues relevant to the potential purpose of ratings with respect to spotting serious lapses in quality. First, that the Annual Health Check as constructed patently failed in that respect in the case of Mid Staffordshire. Second, core standards as centrally defined may have reduced desired engagement from staff, patients and the public. Third, a rating, by its very nature of being an aggregate assessment at the level of the provider (not of individual departments, wards or treatments for people with specific conditions), may be insufficiently granular, and thus mask pockets of poor performance. As noted earlier, healthcare is highly complex and not an activity often provided by a whole 'institution' (as rated), but by individual services within it. Fourth, that if the desired purpose of an aggregate rating is to spot lapses in quality, the rating risks providing false reassurance to the public.

Many of these issues were brought up by participants in the engagement exercise, particularly those from the NHS in relation to hospitals. There was a wide consensus that a rating could not necessarily spot failure, or if it did 'it would be too late' because the failure must have escalated to institutional proportions to have impacted upon a rating and thus be noticed.

Financial failure in hospitals was thought much easier to spot in the NHS, since the unit of analysis is appropriately the institution, for which the assessment of data and institutional competence (such as Board governance) would be easier to assess, and a range of financial information is available. Spotting financial failure in private providers (such as in social care) would be far more difficult, not least because of their sheer number and lack of access to information.

But spotting failures in the clinical care for individuals below a whole hospital level was more difficult and would require a different approach. Lapses could occur at several levels, for example:

- **at the institutional level**, for example, weak overall clinical governance, institution wide weakness in addressing cleanliness, hygiene or complaints about care

- **at the level of clinical specialties or departments**, for example, dysfunctional medical and nursing leadership and management, and low morale

- **at ward level**, for example, poor hygiene and care in part due to rapid turnover of staff

- **for groups of patients with specific conditions**, for example, poor teamwork and substandard clinical and nursing care

- **for individuals**, such as rare sentinel events due to medical or nursing error. These could be one-off errors, or could be more systematic across a number of individuals.

Participants in the Review's engagement exercise were clear that it was very difficult for any system, external to the hospital, to spot lapses at every level with confidence, and again confirmed the responsibility of the provider to do this. While a great deal of information is routinely available on hospital care, there are still significant gaps in what is available nationally for external scrutiny.

However it was this type of scrutiny – of data on mortality rates measured at hospital level – by the Healthcare Commission and by a commercial company, Dr Foster Intelligence, that triggered concern about Mid Staffordshire by external bodies. While there is fierce and unresolved debate about the value of mortality indicators at hospital level (Lilford and Pronovost, 2010; Bottle and others, 2011), these indicators are being used as noted above to focus investigations in 14 specific hospitals of concern (NHS Commissioning Board, 2013), and to assess whether there are indeed lapses in quality or not.

In the case of Mid Staffordshire, surveillance by the Healthcare Commission was followed up by a special investigation. As Francis put it:

[the HC] was the first organisation out of the plethora with the relevant responsibilities to identify serious cause for concern, and to take the action which led to the full exposure of the scandal. This success was due to an eventual willingness to take the only action available to establish the true level of concern, namely a thorough and challenging investigation of facts on the ground. (Francis, 2013)

In the Healthcare Commission, this function of surveillance of all NHS trusts in England was different to that of rating using the Annual Health Check. Surveillance involved looking at a very large array of data and other intelligence and using a range of statistical techniques to spot worrying patterns that could be followed up by further investigation. The development of surveillance of this type was in the early stages before the Healthcare Commission was abolished, and its true potential to spot real concerns for follow up remains unknown, in particular at deeper levels within a hospital. There are also gaps in the routinely collected data that provide information on the quality of some aspects of clinical care, which may make surveillance more effective at these deeper levels.

But as Sir Ian Kennedy further noted in his evidence, in regulating health care it is likely that no one activity can be relied upon to spot failure. The Healthcare Commission used other means such as special indepth reviews of particular types of care, for example for vulnerable patients, special investigation of areas of concern, and surveying staff. As noted above, new systems for spotting failure are being structured, many set up by the National Quality Board, for example, Quality Surveillance Groups. As outlined in Chapter 3, another initiative, by the NHS Commissioning Board is to make far more information on care and its quality publicly available, as part of the Government's transparency agenda. And like its predecessor, the CQC also pursues a range of approaches, for example developing of the quality risk profiles (QRP) to support risk-based inspection and as background information for inspectors, and special reviews, for example on the dignity and nutrition of patients.

So in addition to the summary ratings surveillance is needed specifically aimed at identifying specific service failures and triggering further enquiry. For this predictive process, different information sets need to be used in different ways. The intelligence used may be circumstantial and speculative, and it is not used to make judgment but to trigger some form of regulatory enquiry. Such systems are more sensitive to 'false positive signals', where an alert turns out to be a false alarm. In recent years, the Healthcare Commission developed such a programme looking at mortality outliers (an area where measures were often ambiguous), but the approach should be developed. Though unexpectedly high mortality rates may suggest service failure, they might not be statistically significant. We believe that key to improved surveillance systems would be the ability to use early information from staff and patients that might indicate a service was going wrong. This cycle of surveillance and response needs to be as speedy as possible.

Social care

The surveillance function outlined above for health care is largely missing in social care given the lack of available national data. However, in many ways, users of social services are particularly vulnerable to a failure of care. This can be particularly true where isolated and vulnerable members of the public are using care services. The issues highlighted by the Mid Staffordshire Inquiry (Francis, 2013) are not limited to health services. The Residents and Relatives Association has called for any changes in response to the Mid Staffordshire Inquiry to include the improved regulation of care homes, including more frequent and more specialist inspections (Relatives and Residents Association, 2013).

There are particular difficulties with spotting 'failure' in a home-care setting as the care provided is less visible. The Equality and Human Rights Commission found that while many older people were highy satisfied with their home care, in the worst cases, they heard of older people not being fed, or being left without access to food and water, or in soiled clothes and sheets. In numerous other instances, older people were ignored and stripwashed by care workers who talked over them (Equality and Human Rights Commission, 2011).

Last year, there was a high-profile case featured on the BBC Panorama programme. Secret filming showed that Maria Worroll, a resident at Ash Court care home was slapped six times by her care worker and other workers were feeding Mrs Worroll too quickly, manually rolling her over and hauling her roughly into bed. Mrs Worroll suffers from Alzheimer's disease and arthritis, and requires around-the-clock care

(BBC, 2012). Before the abolition of quality ratings in 2010, Ash Court received an 'excellent' rating. In June 2011, the London Borough of Camden was alerted to safeguarding concerns. The CQC carried out an inspection four days later, finding that the home was meeting all the essential standards of quality and safety (although noting that some improvements were required to maintain this level). This inspection report was not published until October 2011. While the report references a safeguarding concern, Ash Court was found to be fully compliant against the outcome 'Safeguarding people who use services from abuse' (Care Quality Commission, 2011b). This report makes no attempt to second-guess the CQC's judgments in this case, but it could be suggested that there was a lack of transparency about the process for investigation and communicating the extent of the abuse suffered by Maria Worroll to other residents and members of the public at that time.

Public reassurance

Many participants in the engagement exercise thought that a rating (over and above existing information) might offer an additional level of reassurance to the public about the quality of health and care services they receive. Some of the extra value lay in the aggregation of information in a clear and easily understandable way and in one place (rather than across multiple websites, for example), as well as information on performance beyond the basics (in other words, compliance against essential standards). However, if people have little choice than to receive care in a provider rated as poor or weak ratings might serve to undermine public confidence.

Additionally, the extent to which there should be a 'health warning' on a rating is a key issue given the rating itself is not necessarily helpful in spotting failure in complex providers, such as care homes.

Again, participants in the engagement exercise supported this to provide clarity to the public and patients. In the focus groups commissioned for this Review, there was recognition that a rating would not be a guarantee of quality and that mistakes could still happen in 'outstanding' hospitals. There was general acceptance that there was no such thing as a perfect service. Participants seemed to be relatively forgiving of mistakes as long as action was seen to be taken quickly to rectify any issues or concerns – this was important to reassure the public that standards were being protected.

A separate but related issue is the extent to which information on known consistently poor performing NHS trusts, for example in the quality of care provided and the financial health of the organisation, should be published in one place rather across the separate websites of various national monitoring bodies. It could be accompanied by an agreed 'narrative' to alert the public as to the nature of the concerns, as well as the proposed plan of remedial action.

There is the further question of the extent to which any rating should indicate when there are concerns about a particular provider which are under review, and if so when in the process of investigation, and how best to alert the public. Should the rating be 'suspended', or should it be qualified in some way? This also relates to the question of to what extent should a 'rating' be linked to wider activities to spot failure, such as surveillance? If the rating system were not linked in any way to these systems, then, as participants told us in the engagement exercise, the rating (and organisation doing the rating) could quickly become discredited if a significant failing occurred in a hospital if it were rated as 'excellent', 'good' or 'OK'. Participants in the engagement exercise were

worried that many concerns might turn out to be unfounded ('false positives'), and a warning notice on a rating might inappropriately undermine public confidence. There was little time in the Review to explore this in more detail, but we return to the issue briefly again in the next chapter.

Conclusion

There could be at least five main purposes of provider ratings: to increase accountability to the public, users, commissioners of care, and (for publicly funded care) to Parliament; to aid choice by users (their relatives and carers), and by commissioners of publicly funded care (mainly NHS primary care trusts and the new NHS CCGs, and local authorities); to help improve the performance of providers; to identify and prevent failures in the quality of care; and to provide public reassurance as to the quality of care.

This very brief analysis suggests that a system of provider ratings could act to improve accountability for the quality of care, provided ratings were reported publicly, were simple and were valid.

Ratings could aid choice among users and commissioners. The ratings may be more credible and useful for choice of providers that offer relatively simple and more homogenous services, such as general practices, care homes and domiciliary providers as compared to more complex care in hospitals. For the latter, the usefulness of previous ratings in aiding choice appears to have been limited by a lack of more detailed information on the quality of clinical care in specific departments or specialties, the level of complexity on care needs which require individuals to rely on expert advice from trusted agents such as GPs, and the availability of alternative providers from which to choose care.

In social care, provider ratings appear to have been more useful to aid choice for local authority commissioners than the public, although were valued by the latter in particular the relatives of individuals needing care in helping to make choices. With providers offering less complex services than hospitals, it may be that the aggregate rating is more credible to aid choice. The views of family and friends and other informal sources of information appear more important than formal sources in aiding choice of provider.

For both health and social care, the extent to which the public or users of care use web-based information in making choices currently appears very small.

The publication of aggregate ratings in health care under the Annual Health Check was associated with improved performance across acute and specialised trusts over time (2005–09), although some NHS trusts remained 'weak' throughout. The impact of CSCI star ratings in social care is less known given their short history.

But ratings may also be associated with a number of important negative or perverse effects, such as weaker performance resulting from distraction of management time and as attention is focused on aspects of care that are measured relative to those that are not. A comprehensive evaluation of the impact of ratings in health and social care has not been done, and so it is not easy to draw conclusions as to the overall benefit versus the costs. Furthermore, in the case of complex providers such as hospitals, it may be that a simple aggregate rating has more impact on management than clinical

staff, yet it is the latter that are critically important in helping to improve quality of care. It would be important for front-line staff in providers (managers and particularly clinicians) and patients to help identify the standards (and indicators) that make up a rating for it to have validity, credibility and traction and have impact on front-line care. The impact of a rating on performance depends critically on the wider system in which it is embedded.

A rating *per se* may not necessarily be able to spot serious failures in the quality of care, particularly in hospitals. A rating may therefore need to have a 'health warning' to clarify to the public what it can and cannot say about the quality of care. Similarly, if there were concerns about a provider that was being investigated, this would need to be appropriately signalled alongside the rating.

Many participants in the engagement exercise thought that a system of rating the quality of providers might provide reassurance to the public and patients. However, in cases where there was little choice than a provider rated as poor or weak, public and patient confidence could be undermined.

So if a system of rating could be useful, particularly to improve accountability, aid choice, and help improve performance, there remains a question as to whether it could be designed for all three purposes. Respondents to the Review's engagement exercise were sceptical. The discussion in this chapter already points to some possible tensions: between the need for simplicity (for accountability, for example) and the need for complexity (to have more detailed information on clinical care to aid choice, and engage clinicians).

6. Designing a rating

The following chapter looks at some of the issues that need to be considered when designing and implementing a rating system. The rating methodology needs to satisfy a wide range of criteria – it has to be valid, credible, consistent and transparent, and clearly communicated so that people know what the results portray. To do this, a rating needs to strike a balance between oversimplification and complexity. This is not an especially easy task. It is important to emphasise that our role is not to design the rating system, but rather suggest high-level principles and to identify the key features of a good-quality rating. We also express some views on which elements we think lead to a better rating system.

Who designs the rating?

One of the central questions concerns who decides which elements go into the rating. In the past these have tended to be centrally driven with standards and indicators set by the Department of Health or the CQC; the targets set by ministers. The Francis Report noted that:

…generic standards were formulated not by the regulator, but by the Government, thereby inhibiting the engagement with standards of those working in the system and therefore the effectiveness of the regulator. While there was a consultation period and the manner of assessing compliance was left to the HC, the fact is that the standards were formulated and handed down by the DH. This must have contributed to the impression that the process was government controlled and thereby reinforced the disengagement of front-line clinicians from a concept, which if it was to work, demanded their involvement and endorsement.
(Francis, 2013)

In the past there have been elements of rating that are purposely built upon measurement against a set of national targets or policy goals. Given that this represents a legitimate democratic underpinning to the choice of a measure, it seems entirely reasonable given two provisos. First, there needs to be recognition that these only assess part of a wider definition of quality; and second, once established, these targets and measurements are free from political interference. There needs to be some mechanism for agreeing the methods initially but also safeguards against short-term and ad hoc interference.

It is important that the approach to developing and agreeing care standards, and in particular how they can be measured, is a transparent process which has credibility with some key groups:

• patients, users and care services

• the professional groups that provide the care who will often know how best to measure quality

• system regulators including the CQC, NICE and NHS CB.

Such a process should set standards and find appropriate ways to assess them in each area – building on work already undertaken by many others, aligning as appropriate with existing standards such as those developed by NICE. There are value judgments involved, therefore the process should be evidence-based, transparent and led by professionals and members of the public.

Constructing a rating

A rating can be constructed in a number of different ways and, as discussed in earlier chapters, they have taken a variety of different forms. At its heart a rating is just a summary of one or more (often many) different aspects of the quality of care in a provider. The rating represents an overall statement of how well the provider is performing – a judgment. That judgment is limited in its scope and is built up from small assessments based on evidence usually in the form of indicators, an inspection or peer-reviewed findings.

While others have looked at the relationships between past ratings and external measures related to performance or quality (Gravelle, 2012), there is no 'right' answer. As one participant in the Review's engagement exercise noted:

"There is no uniquely correct way of choosing which indicators to use – i.e. which elements of an organisation's performance is taken into account and how it is measured, or of combining the various elements to calculate a summary measure."

Though a rating aspires to measure some overarching attribute of an organisation, such as the quality of care, in reality, the rating is merely an aggregation of smaller assessments and measurements. Each of these will have strengths and weaknesses. The process of building a rating is about combining these in a way that makes most sense from the perspective of the rater: the rater applies values to decide which elements are included and how they are weighted in the overall scheme. As this is subjective, transparency in the process of selection is crucial.

A good-quality rating, like a good performance indicator, has to satisfy a demanding range of requirements. Table 6.1 gives an example of some criteria for good performance indicators. In practice, rating systems have to balance these different elements.

Table 6.1: Criteria for good performance indicators (Audit Commission, 2000)	
1. Relevant	One way of helping to ensure the relevance is to relate the performance indicators to the strategic goals and objectives of the organisation or of a specific service area.
2. Clearly defined	A performance indicator should have a clear and intelligible definition in order to ensure consistent collection and fair comparison. Vague descriptions can lead to misinterpretation and confusion.
3. Easy to understand and use	It is important that indicators are described in terms that the user of the information will understand, even if the definition itself has to use technical terminology.
4. Comparable	Indicators should ideally be comparable on a consistent basis both between organisations and over time.
5. Verifiable	The indicator also needs to be collected and calculated in a way that enables the information and data to be verified. The indicator should allow aggregation and disaggregation of the data.
6. Cost-effective	Balance the cost of collecting information with its usefulness.
7. Unambiguous	It should be clear whether an increase in an indicator value represents an improvement or deterioration in service.
8. Attributable	Service managers should be able to influence the performance measured by the indicator (that is, it should either be totally within their control or at least open to significant influence).
9. Responsive	A performance indicator should be responsive to change. An indicator where changes in performance are likely to be too small to register will be of limited use. This can be the case particularly with qualitative (yes/no) indicators, as progress towards achieving a 'yes' is not captured.
10. Avoid perverse incentives	It is important to consider what behaviour an indicator ought to encourage. Indicators that might encourage counter-productive activity should be avoided if possible.
11. Allow innovation	The definition of an indicator ought not to deter organisations from developing innovative processes or coming up with alternative methods, systems or procedures to improve service delivery.
12. Statistically valid	Performance indicators based on a small number of cases are likely to show substantial annual fluctuations.

The process of building a rating is typically one of identifying:

- the structural framework and scope of a rating – deciding which elements of care are sufficiently important to be rated

- the level of assessment (for example, the trust, department or condition-specific level)

- the individual components to include in a rating, how to assess them, including considering the role of inspection and expert judgment

- the methods for scoring, combining and weighting individual elements (including setting thresholds for good or bad performance, for example, 95 per cent of cases waiting over 18 weeks, non-compliant on any care standards)

- the frequency of rating

- strategies to minimise gaming

- how to best present the findings including how frequently to publish the results

- the relationship between the final score and the implications of that for the organisation.

The following sections explore these stages in more detail.

Structural framework and scope of a rating

There are many different ways in which quality of care or organisational performance can be categorised. Donabedian's scheme of structure/process/outcome has always been popular (Donabedian, 1966). Broader definitions of quality were later developed by Maxwell (Maxwell, 1984), and Leatherman in *The Quest for Quality* (Leatherman, 2008). The CHI used the seven 'pillars' of clinical governance in its reviews (risk management, clinical audit, staffing, education, governance, environment and patient involvement). In the 2004 model of core standards a variant was used (safety, access, environment, governance, effectiveness, public health and patient focus; Department of Health, 2004).

More recently, we have seen three simple arms of quality described by Darzi (effectiveness, patient experience and safety) which have been used to form the five domains of the NHS Outcomes Framework (see Table 6.2; Department of Health, 2008; 2011).

Table 6.2: The domains of the NHS Outcomes Framework (Department of Health, 2011)		
Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	**Effectiveness**
Domain 3	Helping people to recover from episodes of ill health or following injury	
Domain 4	Ensuring that people have a positive experience of care	**Patient experience**
Domain 5	Treating and caring for people in a safe environment, and protecting them from avoidable harm	**Patient safety**

For ratings in social care, the CSCI approach was based on standards that varied by care type (Department of Health, 2009). For example, for care homes for adults (18 to 65 years old) there were 43 standards covering topics including choice of home, individual needs (service user plans, decision-making), lifestyle, personal and health care support, concerns, complaints and protection, environment, staffing, conduct and management of the home. While for domiciliary care there were 27 standards covering user-focused services, personal care, protection, managers and staff, organisation and running of the business.

In practice, the choice of topics for grouping and classification makes little difference in the end. All these frameworks show recurrent themes that are important to the delivery of care. While we do not have any views on whether one scheme is better than any others, we do believe that the simplicity of the Darzi approach has advantages. We suggest that these be used as an overarching framework that can be populated with individual measures. They have the advantage that they are common currency in the NHS, can apply equally well to social care and health sectors, and are relatively simple.

Finance and overall governance

The Darzi dimensions of quality do not explicitly include assessments specifically related to overall governance of a provider and financial performance. Throughout this Review there was consensus among participants in the engagement exercise that the overall governance of a provider was deeply linked to the overall quality of care provided. But there were more mixed views on how the overall financial health of

a provider might be linked with quality of care provided. It was thought that poor financial health would eventually impact on the quality of care. However, it was also recognised – particularly in hospitals – that poor care may occur in financially robust providers.

Thus, while there was support that a measure of governance should be included in the rating, alongside the three Darzi domains of quality (experience, safety and effectiveness), there was less support to include direct measures relating to financial health and management. There were worries that bringing financial performance into a rating might lead to a provider making inappropriate trade-offs between financial issues and the quality of care. In social care, because of the large number of private providers, assessing financial health was thought to be impracticable. However, in part because the high-profile case of the collapse of Southern Cross and its impact on the quality of care, the CQC is considering how to monitor some aspects of financial health of large chains of social care providers, and the Department of Health is consulting on this issue. Monitor, as financial regulator, is strengthening its approach to monitoring quality governance of NHS foundation trusts. As noted in Chapter 2, a finance element was included in star ratings, but in the Annual Health Check the Healthcare Commission created a separate rating score based directly on findings of the Audit Commission (for NHS trusts) or Monitor (for NHS foundation trusts).

We return to this issue in the next chapter.

What are we rating (the level of assessment)?

Our brief in this report was to consider providers of health and social care, yet this still begs questions of what forms the unit of assessment.

Social care ratings have historically focused on individual care providers at site level – something that makes sense for people who want to choose between care services. Yet many such sites sit within wider organisational chains – and some elements of quality might better be described at the broader organisational level.

In health services, the opposite is often the case: an acute care trust may be the object of a rating – yet most patients would prefer information about their local hospital. It is not uncommon for the facilities at one site within a trust to be very different from other sites.

For a complex organisation such as an acute hospital, it might be argued that even the hospital is too wide ranging and that people will want to know about the individual departments, services or even wards, as confirmed by our focus groups. We believe that, for the health sector, ratings should aim to present information by service type where possible. While some elements may be operating in an overarching way across a whole provider, ratings could be focused on specific services.

We suggest that ratings for complex large organisations move towards a system which is capable of operating at different levels, for example:

- **trust level** – to include general strategic management issues such as clinical governance processes, risk management and safety, and overall experience (staff and user surveys)

- **departments/specialties level** – to include areas such as access, the environment of care, safety and user experience (mainly safety and experience of care)

- **care group or condition-specific level** – to include clinical measures and outcomes.

These developments are much more likely to be possible in the NHS, than in the independent sector in health care. Nevertheless, there is useful progress in the independent sector to develop data.

For social care providers, we believe the development of a rating is more straightforward as there is relatively little information that can be considered. There are recent initiatives to develop shared information in this sector, however, which show promise.

Throughout this Review we have been reminded of the limitations of focusing purely on a single provider, when very often care spans different organisations in different sectors. For example, much of the performance of a hospital with regard to rates of readmissions or emergency care may be much more related to the characteristics of primary care, community services, social care, local commissioning and factors other than internal issues under the control of the hospital's clinicians or managers. There may be an argument in some cases for giving an organisation the responsibility for improving performance across the whole of the pathway.

Which components to include in a rating?

First, we need to emphasise that measuring the quality of care is not straightforward because quality is complex. More specifically it:

- is multi-dimensional and can encompass sometimes conflicting perspectives of what is good

- can sometimes only be understood by very detailed knowledge of what care is provided, for example, appropriateness of prescribing a particular drug

- can mean different things to different care users

- will vary between areas where services are provided, and vary over time

- may not be immediately visible – user outcomes resulting from good or bad quality care may take years to accumulate

- can require skilled judgment to assess – for example, how to balance the protection of a 'confused' and frail care user, with a respect for a person's basic rights and freedoms

- encompasses both a care user's perspective, and their friends and relatives, and a professional view.

Assessing quality therefore is not simple or straightforward. Ratings have to be carefully constructed from a range of individual elements or assessments drawn from a range of sources. The early star ratings relied on a relatively small set of quantitative indicators – with a strong emphasis on a limited set of national targets. In contrast, the CSCI ratings of social care providers were dominated by inspection findings. Others included both quantitative data and inspection – something we believe is the right approach.

Table 6.3 shows the types of intelligence that might be used to assess standards. It is clear that the range of information varies by care sector. There is much less information on social care and independent provision in general compared to NHS organisations. Because of this, inspection is likely to have a stronger role to play in any rating system in social care, and individual and carer/relative reports of experience of care would be very important. Yet within the health sector there tends to be more information about acute services than community, although there is an increasing amount of data becoming available on primary care. The most challenging area of all is probably for the many, often small, providers of home care services. For some of these, the rarefied debates over indicators and weighting may seem rather distant.

Similarly, debates over whether to use process or outcome measures may be arid – the obvious answer is you need both: outcomes because they capture what is important to patients and service users – the primary recipients of care. Yet outcomes can be long term, and difficult to measure and understand. Often, good indicators are built on more reliable measures of process – which have known links to eventual outcomes or where the process itself has some legal or ethical imperative, for example, reporting of serious untoward incidents.

Table 6.3: Examples of different information sources that can be used in ratings	
Information sources	**Example indicators**
Computerised hospital records	Hospital admissions for effective procedures, for example, cataracts
	Hospital-specific standardised mortality ratios
Office for National Statistics deaths and births	Condition-specific mortality
	Peri-natal mortality
General Practice data sets	Quality and Outcomes Framework indicators
	Achievement of clinical targets such as HbA1c control
Aggregate information about general practices	Waiting times to see a GP
Specific care registers/databases	Hospital acquired infections, for example, Clostridium difficile
	Surveillance Scheme Registries, for example, National Cancer Registry, National Joint Registry, National Venous Thromboembolism Registry, Renal Registry
	Radiotherapy data sets
	Clinical audit data sets, for example, Myocardial Ischaemia National Audit Project, National Audit of Dementia
Adverse events/incidents reporting	Serious untoward incidents, National Reporting and Learning System reports,
	Complaints, for example, Independent Sector Complaints Adjudication Service
	Notifications to CQC
Aggregate returns to DH, CQC or Information Centre	Numbers of theatres
	Delayed transfers of care
	Staffing levels
	Estates indicators (estates return information collection)
	Immunisation coverage statistics, for example, COVER, HPV vaccination uptake
	Uptake of cancer screening
Collected only to measure performance (aggregate)	Waiting times, for example, cancer waiting time data
	Reoperation after cancellation
	Local authority indicators on social care provision
Other user reports	Hospital level monitoring systems, NHS choices sites, Iwantgreatcare etc.
	Local surveys
	Healthwatch
	User-reported outcome measures
User surveys	Inpatient surveys, general practice surveys, social care users surveys, community mental health services survey, cancer patient experience survey
Staff surveys	GMC surveys of trainees doctors and trainers
	Survey of NHS staff – would you recommend the trust as a place to receive treatment?
Other peer reviews/ inspections	CQC
	Royal Colleges/training
	Cancer peer review
	Endoscopy peer review
	Patient Environment Action Team/Patient-led Assessments of the Care Environment
Accreditation schemes	Imaging Services Accreditation
	Physiological diagnostic accreditation
	A series of accreditations run by the Royal College of Psychiatrists at ward level (other Royal Colleges may also complete accreditation in their fields, too)
Other regulatory findings (using one of the methods above)	Clinical Negligence Scheme for Trusts
	NHS Litigation Authority
	Ombudsmen reports
	Auditors statements
	Health and Safety Executive notifications
Self-assessment	CQC registration data
	Monitor Quality Governance Assessment
	National Cancer Peer Review (self-assessment component)

We would stress the importance of exploiting the range of information sources that currently exist. The range of assessments available to the rating is likely to be informed by work currently underway described in Chapter 3 (in particular the review of bureaucracy and review of zero harm).

There are some areas where the nature of existing information limits the scope of what is possible. Yet we know there are examples of individual care organisations, or professional groups that have managed to develop much more sophisticated information systems to give a much better assessment of the quality of care. For example, the clinical audits for cardiac surgery or the trust information systems at University Hospital Birmingham. While we recognise that improvement in local information systems should be driven by the needs of individual organisations and practitioners to improve the care they provide, it is clear that better information will also yield better comparative data that can be used to develop more robust ratings.

We do not believe that the requirements for a summary rating should necessarily drive data collections, however, there are areas where more detailed data are important to assess the delivery of basic care and we would urge the NHS to consider how it can improve the quality and depth of information available in areas such as:

- clinical markers of quality that extend beyond the basic information in hospital episode statistics

- information about patient outcomes, measured through patients themselves or through clinical proxies

- information that spans a patient's journey through care sectors, teams and services[1]

- more complete information about patients' experiences of care

- information in care settings outside of the large hospitals.

In recent years, there have been developments in the way that patients' views of services can be captured. There are examples where people can contribute their views on web forums as in TripAdvisor, for example, NHS Choices includes free text comments directly from service users. There is clearly interest in developing ways that such intelligence can be used as part of rating, though there also has to be some caution in using evidence that can be very powerful, but also very selective. We believe it is important to invest in further research into the ways to use and develop these types of data sets within structured rating systems.

The role of inspection and expert judgment

The assessments undertaken as part of an inspection or peer review process can form an important element of the evidence used in creating a summary rating. The term inspection itself is used rather loosely – a tradition continued here in referring to an assessment that is made on site. Proper inspection is not a process of just walking round a care home but is a process of structured enquiry – seeking evidence around key themes. Inspectors need to have clarity of purpose and guidance on assessment and evidence. While unannounced inspection is often favoured as a way of seeing what really happens – it has its down sides when looking at aspects of care that need some preparatory material.

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1 Professor Mike Richards has been asked by the Secretary of State for Health to examine the extent to which ratings for the quality of individual hospital teams or services can be developed.

Inspection findings are important in that they:

- can encompass complex judgments of quality

- address elements of quality that cannot be measured remotely through information

- are able to observe directly care users/patients and talk to them

- can provide structured feedback on areas of strength and weakness, as well as a summary statement.

Against these are the challenges of inspections:

- Inspectors can only report on what they observed, usually for only part of an organisation and for a limited time.

- Some elements of quality are just not visible, for example, the appropriateness of treatment.

- They are relatively expensive and have to be done sparingly – as a consequence you cannot inspect all places all of the time. In many cases the last inspection may have been some time ago.

- They require special skills and/or training to deliver judgments that are robust and reliable. There are also issues around the inspectors themselves. Some respondents questioned how good any inspectors would be and whether or not they would be unintentionally biased. In addition, concerns were raised about the consistency of the application of ratings criteria by inspectors.

- They may interfere with the care provided by an organisation. There is often criticism from care providers of the burden of regulation – and the problems of the multiple different regulatory regimes that have to be addressed. These burdens are felt to be especially acute during an inspection.

We believe that it is important to continue to develop the style of inspection and the range of approaches that may be used. Good inspection programmes need to be responsive to signs of problems, and proportionate in their approach. If the frequency of inspection is too rigid, there are likely to be problems at the top and at the bottom of the distribution curve. For example, staffing changes can have a significant impact on the culture of an organisation.

The use of peer reviews, as outlined in Chapter 3, is an important alternative to a formal regulatory inspection. These have the advantage that they can provide sufficient expertise to undertake reviews, and be seen to have specific value to the professional groups being reviewed.

Methods for scoring, combining and weighting indicators

Scoring

Usually every element within the rating will have some form of scoring system to say what is good or bad. An assessment that is ambiguous or context-dependent does not add to a process that needs to simplify judgments into crude scales. This means that indicators have to be calibrated such that they provide a simple verdict on good or bad without caveats and additional clauses. For example, a measure based on the number of complaints received is difficult to interpret; a high value may mean poor-quality care or

could mean it is easier to complain – a sign of good practice in transparency and user involvement within the organisation.

For every indicator or assessment there needs to be some way of identifying a threshold – the line between good or bad. In inspections this is built into the individual standards and evidence used during the inspection. For indicators, a cut-off needs to be specified. In some systems, including early star ratings, the sense of what was good or bad on indicators was determined by an organisation's position in a distribution. So, for example, the bottom five per cent of NHS trusts may score badly and the top five per cent well. This approach was simple to use and to maintain an even balance of scores. However, we do not recommend this approach as it has serious flaws:

- It does not recognise how good or bad an organisation is against an absolute standard – for some indicators being in the bottom five per cent may be perfectly acceptable.

- It is not possible for an organisation to set itself a target of what to achieve for a good score – as its score depends on what other organisations do.

- The scoring can only be applied once all data are collected.

Such relative measures also create a problem that is seen with any ranking process whereby small and insignificant changes in a score may lead to large changes in a rank (Goldstein, 1996). Ranking is not a good way to score indicators. The rank of any one provider can vary by a large amount as a result of small changes in the method of calculation or of small change in performance on any one element.

Instead, we suggest that the scoring needs to be explicit and agreed beforehand – in effect this becomes an explicit statement of what the rater considers to be good quality for that particular indicator.

A second issue in scoring is the extent to which statistical uncertainty enters into measurement. For example, ratings based on surveys generate a score that is drawn from just a sample of users – so there is an inherent uncertainty about that score. Standard statistical methods exist for taking this into account to ensure that only statistically significant differences in practices are scored. In some cases this does mean that superficially different scores are not counted as such.

Finally, when creating thresholds it is important to remember that these can be created in different ways – they do not have to be the national average. An assessment or indicator might be judged good or bad relative to:

- an absolute statement of values

- historic scores/values

- international comparative benchmarks

- groupings of similar organisations

- a local target/aspiration.

Combining and weighting

Having scored individual indicators or assessment – there usually needs to be some way of combining or aggregating scores. The aggregation process is necessary for the sake of simplicity, yet it may also create its own problems. The most obvious one is that 'information' is lost in the process of aggregation so that a good and a bad indicator may cancel each other out.

When assessments are aggregated, the relative weighting given to each element should reflect its contribution to the overall rating. Though there will be differences of views about what is important, in the end this is a judgment that has to be made by the organisation doing the rating. Their views may not necessarily always accord with the views of either service users or care providers, though a rating organisation needs to take these into account.

For example, in the star ratings system which preceded the Annual Health Check in health care, achievement of waiting times targets was considered to be most important and so was weighted higher than a balanced scorecard of measures – a reflection of the importance of national targets to the DH (Bevan, 2006a). However, it may be very difficult to come to a view that one indicator is more or less important than another. In these circumstances it is usually best to weight indicators evenly, and make explicit that this has been done.

Though some aggregation is inevitable in rating, there is still the question of how the final score(s) are presented. So should there be a single score, or a series of scores against each underlying component (like GCSE results), and/or summary descriptive statement? Many participants in the Review's engagement exercise felt that a single summary score, while undoubtedly adding impact and simplicity, ran the risk of oversimplification – lumping together activities and dimensions of care that really should be seen as different.

There are occasions when the aggregation process can use sets of rules. Figure 6.1 gives an example of how sets of rules were used to add findings from Clinical Governance Reviews (CGR) to the star ratings – at least for one year. Though to the outsider rules may appear unclear, they do represent a statement of the value that the rating organisation places on individual elements within its overall score.

Figure 6.1: The Finsbury rules. Example of rules and ratings (Healthcare Commission, 2004)

The Finsbury rules are the rules for incorporating the Healthcare Commission's CGR assessment levels into star ratings. They are:

- A trust will be zero-star if it fails the Healthcare Commission's criteria on the key targets or CHI's CGR zero-star threshold. For CHI's CGR threshold, a trust receives 0 stars if it scored I in five or more components.

- For a trust to be eligible for three-star status it needs to pass both the Healthcare Commission's criteria on the key targets and the balanced scorecard and score III for one or more of its CGR components and not score I for any of the components.

- If a trust is borderline two/three star on the key targets and the balanced scorecard, it is promoted to three stars if, in its CGR, it scored III for three or more of its components and did not score I for any component.

Frequency of rating

In the past, CHI, Healthcare Commission and CSCI ratings have been constructed on an annual cycle – a retrospective assessment of performance in the previous year. Such an approach was deemed necessary for two reasons: first, if the rating relied on data that were collected specifically for rating and then only once a year; second, it was felt that an annual event maximised the publicity that was available, and made it easier for providers to publicise their scores.

Yet the annual cycle also had drawbacks: the most important being that ratings became detached from the present day. At the extremes a rating may have described something two and half years earlier: ratings became out of date easily. Additionally, when evidence of a failure came to light, there was not always a way to update the rating.

We believe that the information flows and technology available today make it possible for ratings to be something that should be much more up to date – refreshed as new information emerges or on a regular monthly or quarterly cycle. This would provide a much more immediate link between the quality of care, the way organisations are managed to improve quality and the rating. There may be opportunities for annual reviews of ratings over the past year to help disseminate messages about the ratings (see Chapter 7), but these would be in addition to the basic system.

Gaming

Within the rating systems there is always concern about the potential for gaming – that is an organisation seeking to inflate its rating without really improving the quality of care it offers – or 'achieving the target but missing the point'. There are examples of this happening in the past (Bevan and Hamblin, 2009) and it is likely that it will always be a possibility (Bevan, 2006b). Moreover, the greater the pressure an organisation is under to achieve a rating, the greater the temptation for gaming.

Clearly, a rating system should seek to reduce the extent to which gaming occurs and there are a number of strategies that have been used:

- direct observation by an independent agency – such as an inspection

- technical validation checks on quantitative measures that values conform to the patterns that you might expect, for example, patterns of diagnostic coding, or the distribution of ambulance waiting time

- external validation – use of say audit findings on information collection

- direct checks – for example, through inspection

- public declarations – an approach used by both CSCI and the Healthcare Commission in which local stakeholders come together to potentially challenge an organisation's declaration of its performances

- clear penalties for wilful deception.

Presenting and reporting

The complexity of the elements within a rating and its scoring is intimately linked to the ways that information is presented – and for whom. The presentation of information to the public, providers and commissioners of care is clearly important and is an area where there are no simple answers.

As noted in the previous chapter and the next, for public accountability purposes, there may be merit in publishing a simple aggregate rating. But for individuals using care, and the staff in providers, it is important to represent the individual elements of the rating separately. This is recognition of the complexity of services that are being described and of the limitations of aggregation as outlined above. It may be that ratings in health care – hospitals and GPs – are best developed as a series of related measures, a set of dials, capturing different aspects of performance. A good example of this with respect to the quality of care in general practice is myhealthlondon – an online dashboard of information about the quality of care in general practices in the NHS London region which makes use of a locally developed General Practice Outcome Standards Framework (www.myhealth.london.nhs.uk/). NHS London reports that myhealthlondon received approximately 2,670 visits weekly as of August 2012. Two-thirds of general practices in London had accessed this information, either by actively engaging with their own practice website or by registering for the risk-alert dashboard, which has had 2,109 logins in the three months since it went live (August 2012).

The challenge with an approach that includes a series of dials is that users might find this confusing. The London School of Economics and Political Science used seven focus groups to explore the types of quality information that people valued, their preferences for different types of information and their understanding of different measures of quality. The study concluded the ordering of information is important as more attention is paid to the indicators presented first. Clear labels, consistent formats and summative measures are likely to reduce the cognitive burden of comparing different indicators for those who are less numerate (Fasolo, 2010). The King's Fund built on these findings and conducted online experiments to compare how different scorecard designs affected choice. The research identified that people find it difficult to make trade-offs between quality, safety, patient experience and location, and advised caution in relation to the ability of patients to make complex decisions without support (Dixon, 2010); finding echoed by *Which?* in its response to the Draft Care and Support Bill. *Which?* suggested that more must be done for social care users who lack computer literacy, noting that even those who are computer literate would need more support to filter and interpret information (*Which?*, 2012).

In social care the range of assessments available are limited and the services more homogenous – though not completely. Moreover, as noted in earlier chapters, the role that a social care rating can play within a market for care means that the function of the rating is more important to tell potential purchasers and users about quality – as one of respondents to our evidence gathering noted:

"Choosing a care home is a 'distressed purchase', so a single rating would help. When choosing a care home, even an imperfect rating is better than trawling through a CQC report."

Therefore, in this case we believe a simple summary rating is possible and most appropriate. Again there would need to be a transparent and inclusive approach for developing the rating.

We would suggest that some important criteria in developing the reporting processes are that they are:

• simple and understandable

- transparent so that the underlying methods, decisions and value are clear

- capable of drilling down into degrees of detail

- up-to-date.

We recognise that it is difficult, if not impossible, to fulfil all these criteria. One of the most challenging is to balance the presentation and content that gives professional users the information they need to improve performance – yet is also accessible to the general public.

Though web-based reporting is clearly better at handling complex information we have to recognise that for some users access to websites is not easy and these groups will need to be considered when generating outputs.

We suggest that the presentation style be developed by a group with expertise in this area and should consider issues such as:

- using sets of dials for multiple ratings

- presentations that are refreshed and updated often (and can include some trends over time)

- approaches to showing provisional scores

- ways to summarise the direction of travel (with respect to performance)

- using a range of presentation formats including short statements and phrases to summarise complex information.

Developing ratings in future: a road map

The challenges of creating a rating system cannot be underestimated. Computerised NHS performance indicators have been around for over 30 years and they are constantly evolving as the breadth and quality of information improves. We suggest there needs to be a strategy for the next decade which pursues the application of better information.

One of the most important elements of this will be to improve the use of clinical measures to show patient health status and ultimately patient outcomes over time. Such information should be important in the delivery of care and indeed there are many examples around the country of where such information is collected which could be piloted for inclusion into a national rating.

The key elements of the future strategy will be:

- moving towards more routinely collected indicators for specific clinical conditions, thus shaping the information priorities of the NHS Information Centre and refining tools for capturing key data sets flowing from developments in operational IT systems, for example, bedside handheld data capture

- improvements in the methods to disseminate information for both public and professional audiences

- improvements in the way information from care users and the general population is collected and used within a ratings framework. A key priority for the future is the development of user-reported metrics capturing health status for common chronic health conditions

- further work on using data sets which link care records across sectors and over time. These are important in understanding the contribution of individual care providers (for example, in better risk stratification) but also in improving our understanding of the long term outcomes of care

- in social care, considering whether more work could be done on developing basic data to allow national comparisons, and reducing information requirements on social care providers (particularly coming from different local authority commissioners)

- developing ratings which look beyond simple organisations to consider the pathways of care

- undertaking regular piloting and evaluation

- development of a ratings system which is closer to real-time information.

We recognise that if the road map involved the continuing development of a rating, there is the potential loss of comparability of performance over time. We believe this is an unfortunate but necessary price to pay for improving our ability to measure and improve quality in both health and social care.

Summary

In summary, drawing on the lessons learnt from different approaches to ratings taken in the past, and respondents' views aired during this consultation process, we can make a number of suggestions on how a rating might be constructed.

First, the overall approach to ratings should allow complex organisations to be assessed at different levels, and promote service-specific ratings where possible. Ideally the ratings could be updated regularly, and be able to react to robust information about changes in quality as it emerges.

Second, there is strong evidence to suggest a rating should be based on a combination of indicators and inspection data, and as much as possible, make use of already existing information on quality of care. The design of the rating system and the framework used need to align with pre-existing frameworks where possible. Any rating scheme should also recognise the need for continuing improvement in data collection and indicator development across health and social care, and should shape such initiatives in the future.

Third, a transparent approach should be taken in the construction of any rating. The content of any rating should be made explicit (thus avoiding the use of relative measures and ranks), and thresholds pre-defined in advance of assessment. The correct statistical measures must be applied, and there needs to be flexibility within the system to allow choice of comparators and to set thresholds.

7. Which organisation? Some implications of introducing a rating system

This chapter addresses the question that if a rating system were to be introduced, which organisation might best do it? What might be some wider implications of introducing a new system? The task here for the Review is not to carry out a full examination of these issues, that is a task for policy-makers, but rather to point up a few key themes for consideration.

Which organisation(s)?

As noted in Chapter 2, over the past decade regulatory bodies have constructed ratings for assessing the quality of care – the CHI and the Healthcare Commission for NHS (with the Audit Commission and Monitor supplying the financial element of the Annual Health Check), and the CSCI making quality assessments for all regulated social care services. During the course of this Review we have considered the key desirable features for an organisation charged with constructing ratings for health and social care providers. These are summarised in Figure 7.1, below.

Figure 7.1: Key features of an organisation charged with constructing ratings for health and social care providers
• Independent
• Credible, trustworthy
• Robust knowledge of health and social care sector
• Significant capacity to handle and analyse large datasets
• Significant capacity to carry out inspections
• Capacity to combine information from data and inspections
• Can link effectively to systems to spot failure: such as surveillance, thematic review
• Authority to engage stakeholders and lead development of a rating system now and in the future
• Ideally would cover all providers to be rated: in health and social care; public and independent providers
• Minimises additional cost and duplication of functions

Participants of the Review's engagement exercise thought that the independence of the rating organisation(s) was important. This meant independence of the rating organisation from national government, and from public commissioners of care (local government in the case of social care, the NHS CB and CCGs in the case of health care). Particularly in health, independence from national government was thought essential because of worries that a rating system might turn into another system of 'targets' with strong performance management (the drawbacks of this were noted in Chapter 5), Moreover, the rating system needs to be free from ad hoc changes to

the underpinning measures that might erode the credibility of the rating with the public. This could in turn impair the effectiveness of the rating in stimulating change for the better. In the past, while the DH has sought extensive input from a range of stakeholders in identifying standards, some Central Government targets remained, for example, in the Healthcare Commission's Annual Health Check. While it was thought legitimate for there to be such priorities, too many skewing a rating may result in a less complete picture of quality. A widely agreed and transparent process for designing and developing the components of a rating, as noted in the previous chapter, was thought essential.

The need for independence of the rating organisation from public commissioners of care was strongly felt in social care: it was thought local authorities, being the direct commissioner of care, would be conflicted if they were judging the quality of providers from which they chose to commission. This was similar to the view held in the NHS, with respect to the NHS CB. However, it was recognised that any new system of rating should be aligned with the NHS Outcomes Frameworks as far as possible as this would drive the priorities of commissioners. Providers should not have to compromise between serving commissioners and achieving a good rating due to contradictory objectives.

The importance of linking the rating to organisations undertaking inspection is especially important for social care, in part because of the nature of care and in part because of the lack of data on quality of care. There is clearly a need to inspect social care providers regularly. With approximately 25,000 care homes and domiciliary care providers in England, that is a very challenging task, currently carried out by the CQC. But in health care, too, respondents recognised that analysis of data alone may not be enough to assess quality of care, and inspection was needed. The need for a rating to link effectively with methods to spot and investigate potential failure, as discussed in Chapter 5, is also critical.

Throughout the engagement exercise for this Review, respondents across health and social care were consistent that, if a rating system were to be introduced, the burden on providers should be minimal, and there should be no duplication with other systems of monitoring (for example, by commissioners). In health care, for example, as noted elsewhere in the report, many participants from NHS trusts were concerned about the volume of data requests from external bodies and the number of inspections by a range of agencies, to the extent that it distracted from the core purpose of caring for patients. It was thought that much of the data elements required for a rating should already be routinely available, and that inspections could be minimised through targeting them (based on risk). Particularly for trusts, there was a call for a review of data requirements and the number of inspections, which as noted in Chapter 3 is currently underway, led by Mike Farrar, Chief Executive of the NHS Confederation.

Many of the features in Figure 7.1 point to the CQC as being the obvious organisation to construct a rating, and indeed that was the majority view of those in the engagement meetings held during the Review.

Some implications of introducing a rating system

Role of the CQC

If the CQC were to take on this role, it would have to expand its current regulatory focus on compliance with essential standards, towards assessing a wider spectrum

of performance. There has been concern expressed about the capability of the CQC to carry out its current large role and its broad regulatory approach (Department of Health, 2012; House of Commons Health Committee, 2013). As a result, the CQC is currently carrying out a strategic review of its approach following the employment of the new Chief Executive, David Behan, and Chair Sir David Prior. One conclusion of a paper commissioned by the CQC for this purpose advised that: 'the CQC could within its existing legislative and regulatory framework create a more differentiated, demanding and service specific set of standards, and it could consider making more use of standards developed in or with the sectors it regulates' (Walshe and Phipps, 2013).

In parallel, the development of a credible rating system would require significant investment of time and resources. It would be important to include commissioners centrally in this task, and to ensure alignment not only with the NHS Outcomes Framework (Department of Health, 2012b) but as appropriate with the Adult Social Care Outcomes Framework (Department of Health, 2012c) and Public Health Outcomes Framework (Department of Health, 2012d). As outlined in the previous chapter – there is a need to develop a medium-term plan or 'road map' to develop the indicators in the ratings, which across both health and social care are limited by the extent to which routine data are available.

We suggest that in developing better measures of quality, high-risk areas could be prioritised, for example, care of the elderly, maternity care and care for people with learning disabilities, as could the development of assessment of the care people receive across different providers (in health care, and across health and social care). For social care, there might be a similar task. A key aim might be to shape the information routinely collected towards gaining a better comparative picture of the quality of care in providers across authorities without involving extra burdens of data collection.

Developing and agreeing a set of standards and the ways to measure them in a rating would need to involve key groups including those representing the public, the Health and Social Care Information Centre, the NICE, the NHS CB, local government, professional groups and a range of public and private providers or their associations. As noted in Chapters 2 (history), 3 (health landscape) and 4 (social care landscape), a great deal of work has been done to date, particularly in the NHS and continues to be done to develop standards and indicators to assess quality across a range of domains. This work could be borrowed, not duplicated, as a starting point to further development.

The introduction of a rating system may also have implications for the frequency of inspection of providers, particularly in health care. A paper commissioned by the CQC as part of its strategic review noted that:

… [the] CQC had used a risk-based model of regulation, in which it adjusted its use of regulatory interventions like inspection with providers based on an assessment of risk and performance, but has recently returned to a universal schedule of annual inspection in most sectors.

and

We find that even modestly proportionate or risk-based regulation requires a strong and stable database of performance data which has clear predictive validity, and a graduated range of regulatory interventions short of full inspection. (Walshe and Phipps, 2013)

As noted at several points in this Review, the link between the rating, and systems to spot high risks of failure is very important and the CQC would therefore need to play a central role in the new system of spotting and preventing failure as described by the National Quality Board. However, a more fundamental issue for the core role of the CQC is the extent to which it develops the systems of surveillance,[1] particularly for NHS trusts and for general practices, which was begun by its predecessor the Healthcare Commission.

For social care there is far less routinely collected data available on the quality of care in care homes and domiciliary care providers, and analysis nationally is hampered by different data collections across local authorities for individuals receiving publicly-funded social care. Clearly, in addition, the rise in self-funders means that there is a large proportion of service users who have no contact with the local authority. This is likely to hamper attempts to develop a data-driven method of risk assessment, leading to a reliance on information from inspections. Through the Review's engagement exercise we did not detect a strong push for fewer inspections, rather the consensus was more for an annual inspection for all providers.

For the management of the CQC, the implications of the above – if it were to come about – are very significant. Accordingly, the CQC would clearly need time, political support and support from key national stakeholders, and extra resources to develop and carry out these tasks. As noted in Chapter 2, and indeed in the second Francis Report (Francis, 2013), there has been profound disruption in the way of rating and regulating of providers over the last 15 years. It is critical to create stability over the next decade.

Improvement in health and social care

In Chapter 5, one main purpose of a rating system was identified as to help improve the performance of providers. Figure 5.2 suggested some broad mechanisms, external to the providers themselves:

- commissioners may act on results of ratings to encourage improvement through contract specifications, for example financial incentives (price in social care but could link to pay for performance price incentives in health care)

- regulatory action

- competition (reputation and market)

- behavioural/reputational incentives (professionals are most strongly motivated by peer perceptions)

- direct performance management (for example, by NHS Trust Development Authority for NHS trusts, by the corporate headquarters of independent sector provider chains)

- development of further peer review/benchmarking systems.

If a rating system were introduced, it would be important to the health and social care sector to clarify which organisations, outside the providers themselves, might have key roles in these mechanisms at different points of the 'quality curve' (shown in Chapters 3 and 4). In health it was thought important that a rating system should not be used as

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1   The systematic country-wide monitoring of information about providers and statistical analysis of trends and outliers

a new system of performance management, but rather a more supportive mechanism of improvement.

Health care

If the unit of analysis in this figure is the *whole provider* (which is what would be scored by an aggregate rating), then a new system of rating would help to define broad performance across the spectrum and measure against it. As regards improvement, the regulator would have a role below the quality bar. Above the quality bar, possibly the major force driving improvement would be the commissioning system (the NHS CB and CCGs), for example, using contracting mechanisms and payment incentives. Monitor will also have roles, for example, in regulating financial health and reducing anti-competitive activity in line with its current mandate. Sector-led peer review activities, as outlined in Chapter 3, are clearly very important and encourage the health sector to help promote a culture of improvement and compassion (Francis, 2013). Academic Health Science Networks and Strategic Clinical Networks should have an important role in helping raise the bar and achieve spread of best practice. But as noted in Chapter 5, clinical lapses in quality can also occur in hospitals that perform above the quality bar.

If commissioners have a key role in driving improvement, then as noted above it will be critical that the standards and indicators in the rating align with existing frameworks such as NICE Quality Standards and the indicators set out in the NHS Outcomes Framework (Department of Health, 2012b) and related quality dashboards (NHS Commissioning Board, 2012), and as appropriate with the Adult Social Care Outcomes Framework (Department of Health, 2012c), and Public Health Outcomes Framework (Department of Health, 2012d). Related to this, participants in the engagement exercise were clear that significant effort should be put in to provide a whole system perspective on performance metrics. More integrated service delivery was seen to be key; both to raising quality standards and meeting the financial challenges. They repeatedly pointed out that any new performance rating system should have an emphasis on integration and using whole system measures to assess the performance of a range of stakeholders within a community. There should be continual monitoring of, and engagement with, best practice internationally in the development of indicators and standards.

The rating system may, however, contain a wider set of information than the mandate-driven NHS Outcomes Framework. The NHS CB is, therefore, a key stakeholder in helping design the rating. In case of disagreement between the NHS CB and the CQC (if it is the rating organisation) over the standards to be included, an arbitration process with pre-agreed and transparent criteria to guide decisions should be established.

More specifically, it will be important to identify how support for improvement and development should be linked to any publication of performance metrics. There may be useful lessons from existing initiatives in England such as the 'Spread Model' from NHS North West's Advancing Quality initiative.[2] This seeks to align robust evidence and metrics to the identification of clinical and managerial champions, opportunities for peer-to-peer spread, the use of robust improvement methods, and the development of both reputational and financial incentives.

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2   Advancing Quality Initiative www.advancingqualitynw.nhs.uk/index.php

Social care

In the social care sector, the main driving force for improvement is through sector-led improvement. Imposing a solution centrally without extensive engagement is unlikely to be effective. However, there may be a role for the DH to do more in mandating data collection to support benchmarking and local improvement initiatives.

Compared to the health sector, there are fewer national bodies operating in the quality improvement sphere. It will be important to ensure that key organisations such as the Local Government Association, the Social Care Institute for Excellence and provider bodies are involved in the development of indicators in conjunction with service users and their families.

Presentation

A big question remains as to exactly how the ratings are best presented: some more technical aspects were discussed in the previous chapter.

If as we suggest, the value of a rating comes from there being a single, trusted source of information, it follows that information about quality should come primarily from the rating organisation. However, there should still be a role for other organisations to present that information themselves, provide that this did not generate confusion for the public.

For social care, there are a range of commercial sources of information about the quality of care homes and domiciliary care, but with the demise of the CSCI, there is currently no other official source of aggregate ratings so the risk of confusion with another 'official' source is less.

Given the relatively low use of websites by the public in seeking information to aid choice of provider in both health and social care sectors, a new ratings system may need significant marketing in its first few years, if an important purpose of it is to aid choice, and promote accountability.

In health care it was thought valuable to have a regularly refreshed set of 'dials' covering different domains of care on each provider as well as a summary statement. Beneath this it might be possible to build functionality on a website to allow users to choose which domains they thought were valuable and enable them to construct their own bespoke aggregate rating for providers to allow comparisons in preferred areas of quality, for example, as in the case in the information on the quality of general practices in London in myhealthlondon. Where possible it should thus be tailored to individual preferences, both in terms of what aspects of quality are important to them, but also to their preferred way of viewing information and their cognitive and numeric ability. In social care the number of domains would be smaller and could not be refreshed so regularly, because so much of the rating would depend upon an annual assessment. At whatever time of year there could be an ongoing aggregate rating for providers, with access to further information underpinning it, for example, inspection reports.

The potency of having a publicly-reported rating at one point in the year to allow comparisons and media scrutiny, was clearly acknowledged by participants in the Review's engagement exercise. Such a rating could come with a simple summary statement. This could act to increase accountability, as noted in Chapter 5. However,

there was some worry about inappropriate reporting in the media, leading to questions about how key stakeholders such as MPs, local authorities and others could be engaged early so that any new system of performance measures were properly understood and used to secure improvement rather than blame.

Clearly, how best to present the rating given the above would need significant market research, a task beyond the scope of this Review.

Monitor and the NHS Trust Development Authority (NTDA)
Monitor

As noted in Chapter 3, in health care one role of Monitor is to assess NHS foundation trusts against a Compliance Framework. Monitor uses a combination of financial and performance information as a primary basis for assessing the risk of a trust breaching their authorisation for foundation trust status; assigning two ratings:

- **the quarterly financial risk rating**, which is designed for regulatory purposes and not for performance

- **the governance risk rating**, which includes an assessment of the Board's statement against the Quality Governance Framework (Monitor, 2012).

Monitor publishes the risk ratings on its website. Monitor is currently consulting on the Risk Assessment Framework which will replace the Compliance Framework (Monitor 2013).

There are at least three implications for Monitor if a new ratings system were to be developed and implemented by the CQC. The first is the extent to which information on overall governance and, separately, on the financial risk rating, should be elements of a new aggregate rating of the quality of care. As outlined in the previous chapter, there was greater support for Monitor's assessment of overall governance to be included, but not the financial health or risk rating.

The second is if, as suggested above, there were an annual publication of quality ratings that was designed to increased the public profile of the rating and accountability, to what extent should these be published with a similar set of ratings on finance and governance? Would there be value in an annual summary statement by the CQC and Monitor at the same time? This could be a useful way of highlighting persisting concerns as well as excellence. At present, information on known consistently poor performing NHS trusts, for example, in the quality of care provided and the financial health of the organisation, is published across the separate websites of various national monitoring bodies, and could be easier to track. It could be accompanied by an agreed 'narrative' by Monitor and the CQC to alert the public as to the nature of the concerns, as well as the proposed plan of remedial action.

But as noted in the previous chapter, there will be some trusts with weak performance on financial matters that at the same time may be rated as 'excellent' overall on clinical care. Again, a clear narrative to the public as to why may be helpful.

The third is that Monitor uses clinical indicators to help compile its assessment of overall governance in NHS foundation trusts. It would be worth reviewing these clinical indicators to see if they do indicate a measure of quality of governance, especially if the CQC developed a new set for a ratings system. Monitor (or the

NTDA for NHS trusts) could use information from the CQC on quality and clinical governance insofar as it is relevant to finance and overall governance, and the CQC could use information on overall governance from Monitor (or the NTDA) in its assessments insofar as it might indicate quality.

Adult social care is currently outside Monitor's statutory remit, although there are provisions in the 2012 Act to allow the Secretary of State, subject to approval by Parliament, to extend specific functions by Monitor to providers of such services. All providers of NHS-funded services will be required to hold a licence from Monitor, unless they are exempt under regulations that will be made by the Secretary of State for Health. The proposed exemptions include providers whose turnover from supplying NHS services is less than £10 million a year and providers of primary medical and dental services under contracts with the NHS CB from the requirement to hold a licence (Department of Health, 2013).

NHS Trust Development Authority (NTDA)

From April 2013, the NTDA's roles include:

- managing the progression of NHS trusts to foundation trust status where possible

- assurance of clinical quality, governance and risk in NHS trusts

- performance management of NHS trusts.

In doing this, it is developing similar measures to those used by Monitor in assessing the financial health and risk of NHS trusts. And in assessing adherence to **quality governance** for non-foundation trusts, it expects NHS trusts to make use of quality dashboards and to produce quality accounts (NHS Trust Development Authority, 2013).

The implications for the NTDA may be similar to those for Monitor outlined above: the possibility of using information from a new rating system to assess the quality of clinical care and clinical governance; to the extent that the NTDA assesses overall corporate governance using similar methods to Monitor, to offer information to add into an annual rating; and possibly to publish information annually alongside a new rating system.

Developing a rating system

It is clear from the analysis in this Review that in the past there has been limited evaluation of previous ratings systems, which has hampered their future development. There would be distinct benefits if any proposed new system of performance measurement and ratings of providers could be 'road tested' with a broad cross-section of key stakeholders in advance and evaluated. Key stakeholders should include providers, commissioners, patient and user groups, boards, clinicians and other health and care professionals, the media, local politicians and others. This would allow any unintended consequences or perverse incentives to be identified and develop a deeper understanding of what the measures are actually saying about the quality of providers in health and social care.

Conclusions

If a rating system were to be introduced, the most obvious candidate to do it is the CQC. However, it faces significant management challenges and changing its strategy to include the development and introduction of ratings would add to those challenges. The CQC would need significant support and stability over a period of time in order to ensure the success of any rating system. The rating would need to be aligned with NICE Quality Standards, Quality Accounts, the NHS Outcomes Framework (Department of Health, 2012b) and as appropriate with the Adult Social Care Outcomes Framework (Department of Health, 2012c) and the Public Health Outcomes Framework (Department of Health, 2012d). If there were no alignment with existing outcomes frameworks, there is a risk that providers may be required to work to even more objectives, some of which may be contradictory. There should be a transparent way of deciding on standards and indicators in the new ratings that should draw on the large amount of existing work already done, and involve a wide range of stakeholders. Any disputes should be subject to a pre-agreed process for resolving them.

While it is legitimate for the Government to have a say in priorities, an agreed and transparent process should be designed so that a rating is not vulnerable to ad hoc requests for inclusion of any specific indicator. In health it was thought important that a rating system should not be used as a new system of performance management, but rather a more supportive mechanism of improvement.

If the value of the rating is in it being a single, trusted, independent source of aggregate information, then there are implications in health care as to how information from other 'official' sources is presented. For example, it might be confusing if there were an aggregate rating on quality produced by the CQC and another produced by the NHS CB.

How exactly information should be presented to the public, in particular how aggregated the rating would need to be, would require market research – a task beyond the scope of this Review. Apart from a rating that might be refreshed during the year as new information came to light, there would be advantages in the publication of an annual verdict. In health care, there may be merits in publishing at the same time as assessments of governance and financial risk by Monitor and the NTDA, although this may not be possible for social care providers.

Also important, as noted elsewhere in this Review, is the extent to which concerns about quality (for example, arising from surveillance work) might appropriately be signalled alongside a rating.

The absence of evaluation about previous ratings systems is likely to have hampered their development. It would be important that any new system is fully evaluated to assess its benefits versus drawbacks. Consideration should be given to road testing any new system to avoid any perverse effects.

8. Concluding remarks

Now more than ever, it is important that there is accountability for the quality of health and care services and that the public can be reassured that there is a continued focus on improvement.

The approaches taken to this task and the opportunities available are different by care sector.

In the NHS there are a large number of initiatives to do this, as outlined in Chapter 3. These include the public reporting of a wide range of information about the performance of providers across England. As Robert Francis recently put it in the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: "Healthcare is not an activity short of systems intended to maintain and improve standards" (Francis, 2013). There is far less information publicly available on the quality of independent health care, beyond the critical assessment of how providers perform against essential standards, as assessed by the CQC.

The adult social care sector is different from health, and many people pay for their own care. There are a large number of small independent care homes and domiciliary care providers. The number of people receiving state-funded services in 2011/12 was 1.5 million and the information on care received by this group is very limited. The findings from CQC reports on compliance against essential standards are critical in this sector. Currently, there are attempts to assess the quality of adult social care at a national level through the Adult Social Care Outcomes Framework, and publication of provider quality profiles, but again, national data collection is significantly limited. There are mainly sector-led initiatives for improvement (as outlined in Chapter 4).

Despite this, there is a clear gap in the availability of a clear, comprehensive, aggregate assessment of the quality of care for health and social care providers across England from an independent and trusted source. Although the CQC offers an independent and systematic assessment of compliance against essential standards, this is limited to looking for lapses in basic care and does not give an idea as whether a provider might be good or excellent, or beyond basic standards. This is in contrast to the summaries produced by Ofsted for the performance of schools (as outlined in Chapter 2).

In health care, there is a great deal of information, but it is not easily available in one place. In social care, there is little information on the quality of care across all providers of adult social care, a gap which the provider quality profile is an early attempt to fill.

So if there is a gap, should it be filled with a new 'Ofsted style' rating, given all the other initiatives going on?

The answer in part lies in what the intended main purpose of the rating is. Chapter 5 outlines five potential purposes: increasing accountability; aiding choice; improving performance; spotting failure; and reassuring the public. We note from the past that a rating is seldom limited to just one focused objective.

Of these five purposes, the public reporting of an aggregate rating will clearly have an impact if done in the right way: providers will not want to be reported as weak. Aggregate ratings using the Annual Health Check (2005-09) for NHS trusts was associated with a shift in the performance curve towards better performance on the points on which they were rated. This benefit should not be underestimated, although the full impact of the rating (for example on areas not included) is unknown. In social care, the CSCI's provider quality ratings were in existence for only one year, so it is difficult to draw conclusions on overall impact. Critical to the impact of a rating is not the rating itself, but the activities in place in the wider health and social care system to improve care, internal or external, to providers. Nevertheless, a public prompt in and of itself could be a powerful spur to better performance.

On choice, perhaps unsurprisingly it seems as if ratings may have more impact where there is greater choice of providers, that is in social care and possibly for primary care, rather than hospital care. For hospitals, aggregate ratings may well not show the information that patients need to make a choice, in particular the quality of care in specific departments or specialties or for particular conditions. It would be important that any system of assessment which produces a rating can include this more detailed information, as is the case with Ofsted on school performance.

In social care homes and domiciliary care, providers offer far fewer and less complex services, so the presentation of information, and the validity of an overall assessment or rating is greater. But for health and social care, it seems that users do not tend to use websites (where a rating is likely to be presented) or ratings as a major source of information to select a provider, opting for more informal means, or in the case of hospital care, their GP. The extent to which this is because the information they need is not clearly available (as it would be in a rating), rather than other factors, is not clear.

As we have noted, a rating per se is unlikely to be useful in spotting lapses in the quality of care, particularly for services within complex providers such as hospitals. It is here where the analogy with Ofsted's ratings of schools particularly breaks down: hospitals are large, with many departments and different activities, carrying out complex activities, seeing large numbers of different people every day, and in which people are sick and can die. Put another way, the risks managed by hospitals vastly outweigh those managed in schools. Indeed, unless there is a 'health warning' on a rating, there is a danger that the rating will be discredited, as lapses will occur in hospitals scored as 'good' or 'excellent'. For social care providers, the risks may be lower, but many are still dealing with frail, ill and otherwise vulnerable individuals.

A rating might provide reassurance to the public and patients over and above that derived from existing information sources. Some of the extra value is likely to arise from information coming from a trusted source, and being in a simple format. However, ratings might serve to undermine public confidence if people had little choice than to receive care in a provider rated as poor or weak.

So the strongest reasons for a rating appear to be to promote greater accountability (assuming the rating accurately reflects the quality of the provider), to aid choice (mainly for people needing social care), and to prompt improvement in the performance of health and social care providers (although the full impact on improvement has not been fully assessed). But if a rating were introduced for the final purpose, there would need to be a concurrent increase in the capacity to spot lapses in the quality of care, particularly for hospitals, which may be a higher priority.

The design of the rating system should be an inclusive process to gain widespread support and 'buy-in' from providers themselves. In particular, the design should recognise the complexity of some providers (particularly hospitals) and a medium-term 'road map' is needed to guide future development, not least the inspections and data collections needed to increase acuity on quality, particularly of clinical care. Such a 'road-map' may prioritise the care of particularly vulnerable groups, or high-risk areas of care, for example for older people, maternity care, emergency care, or care for people with multiple, long-term conditions. For some of these groups, there is a need to move away from assessments of institutions, or services within them, to assessments of pathways of care which individuals experience across a range of settings in health and social care.

There would be costs of introducing a new rating, although these might be minimised if an existing organisation took on the task. The most obvious body is the CQC, as it demonstrates the key features likely to be necessary: however, the management task of doing so is significant alongside the large responsibilities the CQC currently has. The CQC already carries out many tasks which would support a rating, for example inspection and data analysis, but would have to orientate itself towards measuring performance across a spectrum and not be confined to assessing compliance against essential standards. To do this successfully, the CQC would need resources, significant support over a period of time and a forgiving timetable that would allow the development needed to accomplish these tasks appropriately, given the complexities and pitfalls associated and noted in this report. To rush will risk failure. Of all the potential pitfalls, the highest is the risk of a rating system, however good, being discredited by a lapse in care in a provider rated as 'good' or 'excellent', as noted above. To reduce that risk, the systems used for surveillance also need to be developed, not least within the CQC and, as noted above, an appropriate 'health warning' clearly presented with the publication of the ratings.

There would be costs to providers themselves and it would be critical that these are kept to a minimum given, particularly in health care, the weight of external requests for information and inspections. The review of this burden by Mike Farrar is to be welcomed (Calkin, 2013).

From this analysis, the cost and benefits of introducing ratings may be more favourable for social care, possibly for general practices (given the potential for choice and nature of care) and are more finely balanced for hospitals. Indeed this was the main response from the participants in the engagement exercise.

If the decision is to go ahead and introduce ratings, this report helps to point to how it could be done better by learning from the past. In particular, the need for wide engagement in how the rating is constructed and presented, a clear view as to how the rating fits with wider activities to help support providers to improve and spot failures (and effective wider activities), a clear ongoing evaluation of costs and benefits, learning from international good practice, and a departure from the notable experience of the past 15 years of regular disruption of these activities through the abolition or merger of regulators.

We were struck by the goodwill, attention and experience of all who took part, many of whom expressed willingness to help shape any new arrangements, and hope that this review does some justice to their contributions.

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Appendix 1: Engagement process

In considering whether aggregate ratings of provider performance should be used in health and social care, the review team has looked at lessons from past experiences of developing and using aggregate performance ratings in health and social care, from other relevant areas of the public sectors and internationally. The emphasis has been on engaging a wide group of local and national stakeholders in a dialogue, to try, as far as possible, to build consensus on this issue.

Engagement approach

Where possible, the Nuffield Trust followed the Cabinet Office guidance on consultation principles,[1] although this was not required of us by the Department of Health. Traditionally, a 12-week consultation period has been the norm for Government consultations but the guidance allows for consultation timeframes to be proportionate and realistic. The Review was announced on 28 November 2012, with a report required to be published by the end of March 2013. Given the short timescales for the Review, it would not have been feasible to conduct a formal consultation over a 12-week period. A formal consultation exercise was launched on 18 December 2012 and closed on 15 February 2013. Taking into account the Christmas period, this constituted eight working weeks. However, informal engagement with key stakeholders took place throughout the review process. On Friday 14 December, a letter was sent to over 100 relevant stakeholders from Dr Jennifer Dixon, Chief Executive, Nuffield Trust, advising them of the Review and the engagement process.

Online engagement

An important way that organisations and individuals contributed to the review was by responding to a series of questions we posed in an online consultation – this was available to access from the Citizen Space website (an online platform for consultation and citizen engagement). The consultation came to a close on Friday 15 February 2013. The online consultation was open to anyone that wished to contribute, and we are grateful for the responses received. We wanted to give the opportunity for free comment and decided against the production of a consultation document. The online consultation asked nine key questions.

1. Do you think a single, summary score (rating) for a care provider is a good idea? Please explain why you think it is/is not a good idea.

2. If there were such a rating, how should it be used, who should use it and why?

3. What might be the key advantages of having a rating?

4. What might be the key disadvantages of having a rating?

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1 Cabinet Office (2012) Consultation Principles: guidance (July 2012)

5. How should ratings best be presented or reported?

6. What can we learn from previous experience of ratings in health and social care?

7. What can we learn from experience in other countries?

8. What can we learn from experience in other sectors?

9. Is there anything else we should be aware of?

There were 220 responses received through the website. Of these, there were four tests and three people responded twice. Therefore, 213 different people responded online. A further 10 responses were received via email, and one response was received as a hard copy, meaning that **the total number of responses was 224**.

Broader engagement

As part of the wider engagement process we have spoken to a large number of organisations and individuals. We are particularly grateful to those organisations who arranged 'roundtable' events or visits on our behalf, enabling us to reach a wider range of individuals and organisations than we could have achieved alone. The following organisations submitted consultation responses or met with us during the course of the engagement process.

- Academy of Medical Royal Colleges
- Alzheimer's Society
- Association of Directors of Adult Social Services
- Association for Real Change
- Barchester Healthcare
- British Medical Association
- Bupa
- British Dental Association
- British Standards Institution
- Care Quality Commission
- Care Providers Alliance
- Care UK
- Centre for Public Scrutiny
- Cerner
- Clifton St Anne's PCS Ltd
- Department of Health
- Douglas Macmillan Hospice

- English Community Care Association
- ENS Recruitment Limited
- Foundation Trust Network
- General Medical Council
- Greensleeves Homes Trust
- Healthcare Quality Improvement Partnership
- Healthwatch England
- Health and Social Care Information Centre
- Hindu Forum of Britain
- Hospedia
- Jewish Care
- King's Fund
- Leicester City Council
- Leicestershire AIDS Support Service
- Linkage Community Trust
- Local Government Association

- Marie Curie Cancer Care

- Monitor

- Mosaic: shaping disability services

- National Association of Primary Care

- National Institute for Health and Clinical Excellence

- New Century Care

- NHS Alliance

- NHS Commissioning Board

- NHS Confederation

- NHS Litigation Authority

- NHS Midlands and East

- NHS Partners

- NHS South of England

- NHS Trust Development Authority

- Norfolk County Council

- Ofsted

- Orchard Care Homes

- Parliamentary & Health Service Ombudsman

- Patients Association

- ReallyCare CIC/ www.bettercareguide.org

- Royal College of Anaesthetists

- Royal College of General Practitioners

- Royal College of Midwives

- Royal College of Nursing

- Royal College of Obstetricians and Gynecologists

- Royal College of Physicians

- Royal College of Radiologists

- Relatives & Residents Association

- Registered Nursing Home Association

- Salisbury NHS Foundation Trust

- Shelford Group

- Skills for Care

- Somerset Partnership NHS Foundation Trust

- Stonehaven (Healthcare) Ltd

- The Queen's Nursing Institute

- University Hospitals Birmingham NHS Foundation Trust

- United Kingdom Accreditation Service

- United Kingdom Homecare Association

- Voluntary Organisations Disability Group

- Wandsworth LINk

- Yourcarehome.co.uk

Roundtable engagement

The engagement process with key individuals and stakeholders was highly iterative, meaning that the discussion was two-way and built on emerging findings and points raised.

Prior to a roundtable event, a tailored list of questions was circulated to participants for information. The events commenced with an overview presentation which detailed the background to the review, important issues and emerging themes. As the Review went on, the emerging themes changed. The roundtable events allowed free discussion and debate around a range of issues.

Engagement with staff who had worked in the former regulators

To help gather intelligence from past experience of ratings, we organised two seminars and a number of bilateral meetings with former staff of the Commission for Social Care Inspection, the Commission for Health Improvement and the Healthcare Commission to discuss their previous experiences of ratings. One seminar was held on health and the other on social care. It is clear that in developing the detailed metrics of any rating system, former staff should again be consulted to ensure maximum learning.

Individual contribution

We were struck by the generous contributions made by numerous individuals who approached the Nuffield Trust to share knowledge or experiences of ratings.

Webinar on emerging findings

On 27 February 2013, the Health Service Journal and the Nuffield Trust hosted an audio webinar on the emerging findings from the review. Chaired by Alastair McLellan, Editor, *Health Service Journal*, panellists included review lead Dr Jennifer Dixon, Chief Executive, Nuffield Trust; Jeremy Taylor, Chief Executive, National Voices; Sandie Keene, Director, Adult Social Services, Leeds City Council; and Dr Roland Valori, National Clinical Director for Endoscopy.

Ipsos MORI research findings – public attitudes towards health and social care ratings

As part of the review process, the Nuffield Trust commissioned Ipsos MORI to research public attitudes towards health and social care ratings. Three focus groups of eight people were conducted with the general public between 4 and 6 March 2013. One discussion group was conducted in London, and two in Sittingbourne, Kent. Participants were recruited based on a number of criteria including:

- social grade (two groups at ABC1 and one at C2DEs[2])

- having primary school-aged children

- having experience of choosing a care home in the last 12 months or having experience of non-emergency hospital treatment.

Qualitative research is not designed to be representative of the views of the public in general, but to provide insight into the perceptions, feelings and behaviours of participants in the groups. Analysis was carried out through detailed moderator analysis sessions, during which fieldwork notes were analysed and findings debated. Sessions took place during and after the fieldwork period. Given the small scale of the research, it cannot be claimed to be representative of the wider population, but it identifies some useful themes and areas for further exploration.

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2   Classifications assign a social grade based on occupation: ABC1 (higher, intermediate and junior managerial/professional occupation) and C2DE (skilled and semi-skilled manual workers, pensioners, casual workers and unemployed).

Appendix 2: Advisory Group

Terms of Reference of the Ratings Review Advisory Group

1. To help develop the analytical framework of questions to be covered by the Review.

2. To suggest literature to review, and experts and groups to contact relevant to the Review.

3. Where possible and appropriate, to attend meetings with key stakeholders and take part in webinars.

4. To help synthesise the main messages from literature, stakeholder meetings and consultation responses.

5. To advise the Nuffield Trust on drafts of the final report.

6. To give a view on communications and handling of the final report.

7. To attend working group meetings.

In total, the Advisory Group met four times during the review process, with members providing additional support such as participating in engagement events or making contacts on our behalf. During the engagement process, there was some criticism that there was not a provider representative. The Group was never intended to represent a full spectrum of interests in this work but instead to provide peer challenge and debate.

The overall shape, quality and conclusions of the work are the responsibility of the Nuffield Trust. We gratefully acknowledge the support of Advisory Group in the work of this Review. The external members of the Group were:

- **Dr Paul Aylin**, Clinical Reader in Epidemiology and Public Health and Assistant Director of the Dr Foster Unit, Imperial College.

- **Professor Nick Black**, Professor of Health Services Research, London School of Hygiene and Tropical Medicine.

- **Professor Martin Knapp**, Professor of Social Policy; Director of LSE Health; Director, NIHR School for Social Care Research; Director of Personal Social Services Research Unit, London School of Economics and Political Science.

- **Professor Sheila Leatherman**, Research Professor at the School of Public Health, University of North Carolina, and Trustee, Nuffield Trust.

- **Andy McKeon**, Adjunct Professor, Centre for Health Policy, Institute for Global Health Innovation, Imperial College London; Non-executive Director, National Institute for Health and Clinical Excellence (NICE); Non-executive Director, Egton Medical Information Systems (EMIS); Trustee, Nuffield Trust.

- **Professor Peter Smith**, Professor of Health Policy, Imperial College Business School and Co-Director, Centre for Health Policy.

- **Andrea Sutcliffe**, Chief Executive, Social Care Institute for Excellence (SCIE).

- **Jeremy Taylor**, Chief Executive, National Voices.

- **Matt Tee**, Managing Director, Reputate; from February 2013, Chief Operating Officer, NHS Confederation.

- **Professor Charles Vincent**, Professor of Clinical Safety Research, Department of Surgical Oncology and Technology, Imperial College London.

Appendix 3: Care Quality Commission's regulated activities

Providers are required to register for each of the regulated activities that they undertake. Regulated activities are listed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activities

1. **Personal care** – This consists of providing personal care for people who are unable to provide it for themselves because of old age, illness or disability, in the place where they are living.

2. **Accommodation for persons who require nursing or personal care** – This consists of providing accommodation together with personal care (for example, a care home) or nursing care (for example, a care home with nursing).

3. **Accommodation for persons who require treatment for substance misuse** – This consists of residential accommodation for people together with treatment for substance misuse.

4. **Accommodation and nursing or personal care in the further education sector** – This consists of providing accommodation together with personal care provided in an institution in the further education sector.

5. **Treatment of disease, disorder or injury** – This covers a treatment service provided by a care professional, social worker or team, and applies to the treatment of disease, disorder or injury in any setting, for example hospitals, clinics, hospices, ambulances, community services, and care homes.

6. **Assessment or medical treatment for persons detained under Mental Health Act 1983** – This relates to the treatment of people who are detained in, or recalled to, hospital for assessment and/or medical treatment under the Mental Health Act 1983.

7. **Surgical procedures** – This covers procedures if they are for the purpose of treating disease, disorder or injury; or cosmetic surgery; or for religious observance (e.g. circumcision), and are carried out by a health care professional.

8. **Diagnostic and screening procedures** – This includes a wide range of procedures related to diagnostics, screening and physiological measurement.

9. **Management of the supply of blood and blood derived product**s – This covers the supply of blood, blood components and blood-derived products for transfusion; the supply of tissue or tissue-derived products for transplant, grafting or use in surgery; and the matching and allocation of donor organs, stem cells or bone marrow for transplant or transfusion.

10.   **Transport services, triage and medical advice provided remotely** – This covers transport (ambulance) services, and remote clinical advice.

11.   **Maternity and midwifery services** – This covers maternity and midwifery services where they are carried out by, or under the supervision of, a health care professional.

12.   **Termination of pregnancies** – This covers the termination of pregnancies by surgical or medical methods.

13.   **Services in slimming clinics** – This covers services provided in a slimming clinic, which could be advice or treatment and include the prescription of medicines for weight reduction. These must be provided by, or under the supervision of, a registered medical practitioner.

14.   **Nursing care** – This covers nursing care, where it is not part of another regulated activity. This includes the provision of care, or the planning, supervision or delegation of the provision of care with the exception of services that do need to be provided by a nurse.

15.   **Family planning services** – This involves services for the insertion or removal of an intrauterine contraceptive device by, or under the supervision of, a health care professional.[1]

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1   Source – Care Quality Commission Regulated activities. www.cqc.org.uk/organisations–we–regulate/registering–first–time/regulated–activities . Accessed 15.03.2013

Appendix 4: Care Quality Commission's essential standards

The Care Quality Commission (CQC) outlines essential standards based on regulations contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The standards relate to the 28 regulations contained in the legislation governing CQC's work. When checking compliance against essential standards, the CQC focuses on one or more of the 16 standards that most directly relate to the quality and safety of care. Each of the standards has an associated outcome and providers must have evidence that they meet these outcomes. The other 12 regulations relate more to the routine day-to-day management of a service.

16 key essential standards

Outcome 1: Respecting and involving people who use services

- People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.

Outcome 2: Consent to care and treatment

- Before people are given any examination, care, treatment or support, they should be asked if they agree to it.

Outcome 4: Care and welfare of people who use services

- People should get safe and appropriate care that meets their needs and supports their rights.

Outcome 5: Meeting nutritional needs

- Food and drink should meet people's individual dietary needs.

Outcome 6: Cooperating with other providers

- People should get safe and coordinated care when they move between different services.

Outcome 7: Safeguarding people who use services from abuse

- People should be protected from abuse and staff should respect their human rights.

Outcome 8: Cleanliness and infection control

- People should be cared for in a clean environment and protected from the risk of infection.

Outcome 9: Management of medicines

- People should be given the medicines they need when they need them, and in a safe way.

Outcome 10: Safety and suitability of premises

- People should be cared for in safe and accessible surroundings that support their health and welfare.

Outcome 11: Safety, availability and suitability of equipment

- People should be safe from harm from unsafe or unsuitable equipment.

Outcome 12: Requirements relating to workers

- People should be cared for by staff who are properly qualified and able to do their job.

Outcome 13: Staffing

- There should be enough members of staff to keep people safe and meet their health and welfare needs.

Outcome 14: Supporting workers

- Staff should be properly trained and supervised, and have the chance to develop and improve their skills.

Outcome 16: Assessing and monitoring the quality of service provision

- The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

Outcome 17: Complaints

- People should have their complaints listened to and acted on properly.

Outcome 21: Records

- People's personal records, including medical records, should be accurate and kept safe and confidential[1].

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1   Source: Care Quality Commission *The Essential Standards* www.cqc.org.uk/organisations-we-regulate/registering-first-time/essential-standards . Accessed 15.03.2013

Appendix 5: Health care landscape and quality initiatives

Government and the Department of Health	
Organisation	Initiative
Department of Health	**The NHS Constitution sets out commitments from the NHS in relation to quality (Department of Health, 2013a)** The NHS Constitution establishes the principles and values of the NHS in England. It sets out patient and staff rights and responsibilities. The NHS Constitution commits to continuous improvement in the quality of service and the identification and dissemination of and best practice in quality of care and treatments. The NHS commits to making available information on the quality of clinical services where there is robust and accurate information available to inform user choice (Department of Health, 2013a).
Department of Health	**NHS mandate to the NHS Commissioning Board to improve health, patients experience of care and to reduce harm (Department of Health, 2012a), underpinned by NHS Outcomes Framework (Department of Health, 2012b)** In November 2012, the DH published the first mandate to the NHS Commissioning Board, which set out the outcomes and corresponding indicators that would be used to hold the NHS Commissioning Board to account for improvements in health outcomes based around the five domains of the NHS Outcomes Framework (Department of Health, 2012b). Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve, namely: (1) Preventing people from dying prematurely; (2) Enhancing quality of life for people with long-term conditions; (3) Helping people to recover from episodes of ill health or following injury; (4) Ensuring that people have a positive experience of care; and (5) Treating and caring for people in a safe environment; and protecting them from avoidable harm (Department of Health, 2012c). The Mandate states that the NHS should measure and publish outcome data for all major services by 2015 broken down by clinical commission group (CCGs) as well as by provider and team level (Department of Health, 2012b).

Government and the Department of Health	
Organisation	**Initiative**
Department of Health	**The DH requires providers to publish quality accounts (which include the mandatory DH core quality indicators)**
	From April 2011, the DH required all providers of NHS services (excluding general practice, out of hours services, dentistry and pharmacy) to publish annual Quality Accounts. Quality Accounts are annual reports to the public from providers of NHS health care about the quality of services they deliver (Department of Health, 2010). Monitor incorporates the requirements for Quality Accounts into the requirements for Quality Reports that all foundation trusts must include in their financial reports. A key objective of this policy has been to place quality reporting on an equal footing with financial reporting (Department of Health, 2010). Quality Accounts are required to be submitted to the Secretary of State and published on the NHS Choices website so that they are available to the public. From April 2013, responsibility for the strategic direction of Quality Accounts will transfer to the NHS Commissioning Board and any future guidance will be jointly published with the DH (Department of Health, 2013b).
	The quality account consists of both requirements set in regulation (part 1 and 2)[1] and locally derived priorities (part 3).
	• **Part 1:** Statement from the Board summarising the quality of the organisation.
	• **Part 2:** (a) Priorities for quality improvement (minimum of 3 with details of how progress will be made and reported) and (b) series of statements from the board relating to quality of the NHS services provided (including reviewing and engagement in cross-cutting initiatives which link strongly to quality improvement, CQUINS, data quality improvement, clinical audits).
	• **Part 3:** Review of quality of services in the organisation, alongside statements from the commissioner (e.g. PCT) (Department for Health, 2010).

1   National Health Service (Quality Accounts) Regulations 2010 can be found on the Office of Public Sector Information website: www.opsi.gov.uk

Government and the Department of Health	
Organisation	Initiative
Department of Health	**The Prime Minister announced a review led by Sir Bruce Keogh into the quality of care and treatment by hospital trusts with higher than expected mortality rates (NHS Commissioning Board, 2013a)** In response to the publication of Robert Francis' inquiry into Mid Staffordshire NHS Foundation Trust, the Prime Minister announced on the 6 February 2013 in Parliament (*Hansard* HC 6 February 2013, Column 282) that he had asked the NHS' Medical Director, Professor Sir Bruce Keogh, to conduct an immediate investigation into the care at hospitals with the highest mortality rates. That day, five hospitals were named: • Colchester Hospital University NHS Foundation Trust • Tameside Hospital NHS Foundation Trust • Blackpool Teaching Hospitals NHS Foundation Trust • Basildon and Thurrock University Hospitals NHS Foundation Trust • East Lancashire Hospitals NHS Trust. On 11 February 2013, an additional nine hospitals were named, making a total of 14 trusts under investigation[2]: • North Cumbria University Hospitals NHS Trust • United Lincolnshire Hospitals NHS Trust • George Eliot Hospital NHS Trust • Buckinghamshire Healthcare NHS Trust • Northern Lincolnshire and Goole Hospitals NHS Foundation Trust • The Dudley Group NHS Foundation Trust • Sherwood Forest Hospitals NHS Foundation Trust • Medway NHS Foundation Trust • Burton Hospitals NHS Foundation Trust.[3] The investigations will seek to: • determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these trusts • identify whether existing action by these trusts to improve quality is adequate and whether any additional steps should be taken • identify whether any additional external support should be made available to these trusts to help them improve • identify whether any areas may require regulatory action in order to protect patients (NHS Commissioning Board, 2013a). Supported by a National Advisory Group, the review will comprise three stages: • **Stage 1** – gathering and analysing information and intelligence • **Stage 2: Rapid Responsive Review** – a team of experienced clinicians, patients, managers and regulators will observe the hospital in action • **Stage 3: Risk Summit** – a separate group of experts will consider the report from stage 2, alongside other intelligence, in order to make judgments about the quality of care being provided and agree any necessary actions. A report following each Risk Summit will be made publicly available (NHS Commissioning Board, 2013a).

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2 On the basis that they have been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Indicator or the Hospital Standardised Mortality Ratio.

3 www.commissioningboard.nhs.uk/2013/02/11/final-outliers/

Government and the Department of Health	
Organisation	Initiative
Department of Health	**Rt Hon Jeremy Hunt MP asked Mr Mike Farrar CBE to lead a review into bureaucracy** Secretary of State for Health Jeremy Hunt has asked Mike Farrar, Chief Executive of the NHS Confederation, to work with national bodies to look at how joint inspection and shared information could improve clinical outcomes and free up time. The objective of this work is to see if it is possible to reduce bureaucratic burdens by one-third. Speaking to the Health Service Journal, Mike Farrar suggested that the review would start by looking at the reason for information collection and would look at whether technology could make information collection more efficient (Calkin, 2013). A previous review into bureaucracy in 2009 found that the regulatory system to be complex, confused and over-reliant on prescriptive adherence to meeting detailed targets and performance measures (NHS Confederation, 2009). The findings are expected to be published at the end of March 2013.
Department of Health	**Prof Don Berwick was asked to lead a review into zero harm** The Prime Minister announced in response to the Mid Staffordshire Public Inquiry report that he had asked Professor Don Berwick to lead a review on making zero harm a reality. The Prime Minister stated: "Quality of care means not accepting that bed sores and hospital infections are somehow occupational hazards – that a little bit of these things is somehow okay. It is not okay; they are unacceptable – full stop, end of story. That is what zero harm – the jargon for this – means. I have therefore asked Don Berwick, who has advised President Obama on this issue, to make zero harm a reality in our NHS" (*Hansard* HC 6 February 2013 Column 281). Professor Berwick is expected to report his findings to the NHS Commissioning Board and the Department of Health at the end of July 2013.
Department of Health	**There will be a Chief Inspector of Hospitals** The Prime Minister announced on 6 February 2013 that he had asked the CQC to create a new Chief Inspector of Hospitals to take responsibility for a new hospital inspection regime. The intention is for the new inspection regime to start this autumn and will focus on whether a hospital is "clean, safe and caring" (*Hansard* HC 6 February 2013, Column 282).

Commissioning system	
Organisation	Initiative
NHS Commissioning Board	**National quality dashboards**
	National 'quality dashboards' will be developed as part of the quality improvement work programme, and will to be linked, in some areas, to clinical audit data. Quality dashboards incorporate outcome measures, patient experience, service effectiveness and efficiency, and can be used to monitor performance. It is hoped that dashboards for specialised services will provide a strong focus to facilitate discussion between commissioners, the provider organisation, and the clinical team to focus on interventions that make a measurable change to care quality (NHS Commissioning Board, 2013c).
	The dashboards have been developed in three phases: firstly, **Quality Measures** have been defined by clinicians with commissioners and public health professionals; secondly, **Quality Databooks** define the measures in enough detail that all providers will be reporting the same data item; thirdly, the **Quality Dashboard** is a graphical display with a data entry spreadsheet for providers to submit the data. Databooks and data entry tools have been developed for a range of services including major trauma, burn care and cystic fibrosis.[4] A quality dashboard to identify service failures in providers has also been announced (NHS Commissioning Board, 2013b).
NHS Commissioning Board	**Consultant-level outcome data**
	The NHS Commissioning Board will publish consultant-level outcome data covering mortality and quality for ten survival and medical specialties. The NHS Commissioning Board will work with the Healthcare Quality Improvement Partnership (HQIP) to develop methodologies for casemix comparison and, in conjunction with NHS Choices, publish activity, clinical quality measures and survival rates from national clinical audits for every consultant practising in the following specialties:
	• adult cardiac surgery
	• interventional cardiology
	• vascular surgery
	• upper gastro-intestinal surgery
	• colorectal surgery
	• orthopaedic surgery
	• bariatric surgery
	• urological surgery
	• head and neck surgery
	• thyroid and endocrine surgery (NHS Commissioning Board, 2012a)
NHS Commissioning Board	**Development of NHS Choices**
	The NHS Commissioning Board is responsible for **NHS Choices**, which already contains some information on providers (including primary care) and is developing a **customer service-focused web based platform** providing information on care, providers and other services to the public (Department of Health, 2012d). Results from the friends and family test will be presented on NHS Choices, from April 2013, for all acute inpatient A&E (type 1 and 2), and from October 2013, for all maternity services.
NHS Commissioning Board	**Development of a 'quality app'**
	The NHS Commissioning Board is developing a '**quality app**' which will bring together information from official sources, such as complaints and patient satisfaction feedback and unofficial sources, such as conversations about services on Twitter, and Google searches (published from April 2013). The tool will provide members of the public with real time information on care, providers and other services (Illman, 2013).

4   www.specialisedservices.nhs.uk/info/specialised-services-quality-dashboards

Commissioning system	
Organisation	**Initiative**
NHS Commissioning Board	**Quality Premium** Subject to Regulations, the NHS Commissioning Board will pay a **Quality Premium** in 2014/15 to clinical commissioning groups that in 2013/14 improve or achieve high standards of quality against specific measures (NHS Commissioning Board, 2012). The NHS Commissioning Board will **review the incentives, rewards and sanctions** available to commissioners to drive improvements in care quality in 2013/14 (NHS Commissioning Board, 2012).
Clinical Commissioning Groups (CCGs)	CCGs will be able to use **CQUIN**; this presents an opportunity for commissioners to secure local quality improvements over and above the norm by agreeing priorities with their providers. It is set at a level of 2.5 per cent of the value of all services commissioned through the NHS Standard Contract (NHS Commissioning Board, 2012).
Strategic health authority (to be abolished April 2013)	**Quality observatories** Quality Observatories helped support the development of quality indicators as a tool for quality development and supporting clinical leaders to act on quality information to drive improvements in care. Their functions extend from a local level (providing analytical advice, supporting the development of local quality indicators for Quality Accounts and CQUIN arrangements), through regional (development of regional indicators and the analysis and publication of regional quality data), to a national level (supporting the development of the national quality indicators sets) (Department of Health, 2008). Regional Quality Observatories have had an important role in the development of quality indicators relevant to the local populations, working in collaboration with local clinicians in the area. For example, North East Quality Observatory System developed local indicators for quality care following arthroplastic surgery in collaboration with local orthopaedic surgeons. They used the data to compare performance across all units which carried out arthroplastic surgery in the North East and the results encouraged clinicians to work towards reducing unexplained variations in outcomes (North East Quality Observatory System, 2012). **Quality dashboards:** Lord Darzi envisaged a system in which "every provider of NHS services should systematically measure, analyse and improve quality". He suggested one suitable tool would be the use of clinical dashboards which present a set of comparable national metrics alongside locally determined metrics of quality, in a simple format to help drive quality improvement (NHS Networks). Following a successful pilot in 2008, the programme has been developed into the QIPP Urgent Care Clinical Dashboard programme within primary care hosted by NHS Networks. The Quality Observatories had a key role in the development of quality dashboards which benchmark performance against a number of quality indicators selected by a professionally led review panel. **Acute Trust Quality Dashboards** (led by East Midlands Quality Observatory) and the **Mental Health Trust Quality Dashboards** (led by Quality Intelligence East), provide an assessment of quality across the five domains of the NHS Outcomes Framework, with an additional domain created to focus on "organisational context". Indicators reflecting quality of care in acute trusts were selected largely from the 2011/12 NHS Operating Framework following input from many individuals and organisations[5]. Indicators for mental health were developed following a review of existing mental health indicators and input from an advisory group and mental health clinicians. The mental health indicators were first published in May 2012 and it is hoped that they will be available biannually (Quality Intelligence East, 2012).

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5   www.emqo.eastmidlands.nhs.uk/welcome/quality-indicators/acute-trust-quality-dashboard/

Commissioning system	
Organisation	**Initiative**
Strategic health authority (to be abolished April 2013)	**General Practice Profiles** were generated through consultation with general practitioners and commissioners, by building on existing dashboards and tools centred around the NHS Outcomes Framework. Each metric was considered based on whether it was a good measure of quality, its potential to drive quality improvement, and its purpose (e.g. benchmarking, examining over time, as a proxy measure). The dashboards draw on data from hospital episode statistics (HES), Secondary Uses Service (SUS), NHS Comparators, GP Patient Survey and Quality and Outcomes Framework (QOF) to provide an assessment of quality across the five domains of the NHS Outcomes Framework, with an additional domain created to focus on "organisational context". The dashboards were first published in March 2012, and will be produced quarterly on NHS Local websites (East of England Public Health Observatory (2010). There are additional profiles in development, for example clinical commissioning group profiles (Midlands and East Quality Observatory, 2012); and Community profiles produced jointly by West Midlands QI, Yorkshire and Humber Quality Observatory and North East Quality Observatory.[6] **SHAs in some areas have been working to make local information more accessible to the public** e.g. www.myhealth.london.nhs.uk/ (London Health Improvement Board, 2012).

Regulatory system	
Organisation	**Initiative**
Care Quality Commission (CQC)	The Care Quality Commission (CQC) assesses health and social care services in England against registration requirements described as the "essential standards of quality and safety" (Care Quality Commission, 2010). CQC is working to align the national standards of quality and safety with the NHS, Adult Social Care and Public Health outcomes frameworks (Care Quality Commission, 2012a). The CQC assesses compliance of registered services against **essential standards of quality and safety**. The standards relate to the 28 regulations set out in Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. Once registered, CQC continues to monitor compliance against these minimum standards and investigate where services are failing. When CQC checks providers' compliance with the essential standards, they focus on one or more of the 16 that most directly relate to the quality and safety of care. All acute, community, mental health, ambulance, dental and adult social care providers are registered with the CQC, and from April 2013 all primary care providers must also be registered. The CQC brings together a range of information on providers in the Quality Risk Profile (QRP) to assess risks to quality of care and prompt further investigation. The QRP is not publicly available. The CQC can undertake **thematic reviews**, themed inspections and specialist investigations into specific aspects of care. Examples of **thematic reviews** include *Dignity and nutrition* (Care Quality Commission, 2011) and *Health care in care homes* (Care Quality Commission, 2012b).

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6   www.wmqi.westmidlands.nhs.uk/wmqi-portal/community-profiles/

Regulatory system	
Organisation	Initiative
Monitor	Monitor currently assesses NHS foundation trusts against a Compliance Framework to ensure they are financially robust, well-governed, legally constituted in accordance with the National Health Service Act 2006 and meet the required quality threshold (Monitor, 2012a).
	Monitor's functions are changed by the Health and Social Care Act 2012 and all providers of NHS-funded services will be required to hold a licence (unless exempted through regulation). There will be a joint process with providers applying for a Monitor licence and CQC registration. Monitor will manage key aspects of health regulation such as regulating pricing, enabling integrated care, safeguarding choice and competition, and ensuring continuity of services (Monitor, 2012b). As a result of the legislative changes, the Compliance Framework will be replaced with a new Risk Assessment Framework.
	The **Foundation Trust Compliance Framework** has two components:
	• **Financial risk rating** (rated 1 to 5, where 1 represents the highest risk and 5 the lowest). These risk ratings consider achievement of plan, underlying performance, financial efficiency, and litigation; these are designed for regulatory purposes and not for performance. The financial risk rating is based on five weighted metrics.[7]
	• **Governance risk rating** (rated red, amber-red, amber-green or green) includes an assessment of the Board's statement against the Quality Governance Framework. Service performance is assessed against five categories (1) CQC concerns, (2 and 3) delivery of national measures (National access and outcome targets from the operating framework); (4) third party reports (e.g. NHS Litigation Authority) and (5) failures to comply with board statements. In the case of an NHS foundation trust failing to meet the corporate governance standards, the CQC will liaise with Monitor and, taking account of their respective powers, Monitor and the CQC will work together to ensure these requirements are met (Monitor, 2012a).
	The current **Risk Assessment Framework** consultation describes Monitor's approach to assessing the risk of NHS providers failing financially and overseeing the governance of foundation trusts (Monitor, 2013).
	Financial risk: The current financial risk rating will be replaced by the **Continuity of services** risk rating and based on two metrics (liquidity days and capital service capacity). It will change from a five- to a four-point scale. It will remain assessed quarterly and annually. Rather than being carried out for all services, this will only be applied to those defined by the **Commissioner Requested Services**.
	Governance risk: The current governance will be replaced by a new framework based on six categories to trigger a governance concern – the five original and the addition of quality governance metrics (staff and patient surveys and trends in 'never events').
NHS Litigation Authority	The NHS Litigation Authority (NHSLA) runs the Clinical Negligence Scheme for Trusts (CNST) alongside three other schemes to indemnify NHS bodies against negligence claims and property losses. The NHSLA has an important role in reducing negligence claims and does this through its risk management programme. There is a set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health and safety risks and the NHS. The NHSLA assesses organisations into three levels (one, two and three) with discounts of between 10-30% being applied to CNST contributions. Given the higher number of negligence claims arising from maternity services, there is a separate set of standards for maternity services which are assessed in the same way (NHS Litigation Authority, 2011). The NHSLA is currently reviewing the standards with a view to there being a greater focus on outcomes and a less burdensome assessment process (NHS Litigation Authority, 2012).

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7   EBITA margin (25%), % of plan EBITDA margin delivered (10%), I&E surplus margin (20%), net return on capital (20%), liquidity days (25%).

Regulatory system	
Organisation	Initiative
NHS Trust Development Agency	The NHS Trust Development Authority (NHS TDA) will be fully operational from April 2013. The NHS TDA will be responsible for overseeing the performance management and governance of NHS trusts (including clinical quality) and managing their progress towards foundation trust status. The NHS TDA set out clear expectations on quality in their planning guidance for 2013/14, for example stating that trusts must deliver in full on any agreed CQUIN schemes and would be expected to measure progress against the NHS Outcomes Framework through the National Quality Dashboard (NHS Trust Development Authority, 2013).
Professional regulators	Currently, there are nine regulators of individual health professionals, covering a range of professions including general practices, dentists, and pharmacists.[8] Professional regulatory bodies set and uphold the professional codes and standards individual health care providers must meet including competence, conduct and ethical practice. Professional regulators can launch an investigation following concerns about the fitness of a health professional to practice and have the power to demand the release of information and carry out inspections. The investigation could lead to sanctions on practice, suspension or removal from the register (National Quality Board, 2013).

Other national organisations	
Organisation	Initiative
Health and Social Care Information Centre	The Health and Social Care Information Centre is a major data hub for health and adult social care, involved in the development of indicators of quality, data collection, and presenting information for commissioners and providers (NHS Information Centre, 2009). More recently it has become involved in benchmarking investigations of compliance against NICE standards (NHS Information Centre, 2013). The Health and Social Care Information Centre develops the **Indicators of Quality Improvement** aligned to the NHS Outcomes Framework. The Health and Social Care Information Centre provides a **Quality Accounts** section within their indicator portal directing to the latest data for each indicator (Department of Health, 2013b). • The Health and Social Care Information Centre collects data on **adult social care**[9] at Local Authority level and holds the National Audit Social Care Intelligence Service. It also completes a user survey and is developing a survey for carers. It is the single central **national repository for clinical audit data** but holds no clinical audit data in general practice.
Healthwatch England	Healthwatch England will be part of a newly established Healthwatch network from April 2013 and will act as a 'consumer champion'. Local Healthwatch organisations will be more plugged-in to decision-making at a local level and will be expected to develop relationships with local organisations including those representing specific user groups. Local Healthwatch will ensure that the voices of people using care and support are heard by commissioners and care providers. Local Healthwatch will have the powers to enter and view providers and to scrutinise and comment upon service quality and to refer providers to the Commission, or Healthwatch England, for further action (Department of Health, 2012e).

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8 General Chiropractic Council; (ii) General Dental Council; (iii) General Medical Council; (iv) General Optical Council; (v) General Osteopathic Council; (vi) General Pharmaceutical Council; (vii) Health Professions Council; (viii) Nursing and Midwifery Council; and (ix) Pharmaceutical Society of Northern Ireland.

9 Children's social care is set within the Department for Education.

Other national organisations

Organisation	Initiative
NICE	NICE develops **Quality Standards** for health and social care topics (NICE, 2010). Each standard contains a concise set of quality statements and associated measures (NICE, 2013).
	The NICE **Quality Standards** Programme was established in 2009 to manage the development of quality standards for health and social care topics (from April 2013). Topics are prioritised each year following input from the NHS CB, DH and DfE. (NICE, 2013). There are currently 25 NICE quality standards published covering topics such as dementia, stroke and venous thromboembolism. A further 24 are in development, including standards for social care (e.g. (i) care of people with dementia, and (ii) health and wellbeing of looked-after children).
	The quality standards development process is evidence based (such as NICE guidance or NICE-accredited guidance), with professional input supported from the Quality Standards Advisory Committee[10] and external experts, alongside patient and public involvement, a process which can take up to 42 weeks. The final quality standard is composed of two parts:
	1. Six to eight *quality statements* which are clear, measurable and concise and describe high-priority areas for quality improvement (aligned to the NHS and Adult Social Care Outcomes Frameworks).
	2. *Quality measures* accompany each quality statement. The majority of quality measures are process related "because few outcome measures can be attributed to a single quality statement or be used at local level to reliably assess the quality of care or service provision and allow comparisons between providers" (NICE, 2013).
	Quality standards for the NHS will be reflected in the new Clinical Commissioning Group Outcomes Indicator Set and will inform payment mechanisms and incentive schemes such as the Quality and Outcomes Framework (QOF) and Commission for Quality and Innovation (CQUIN) Payment Framework (NICE, 2013).
	NICE develops evidence based guidance on **clinical governance**, including the systems and processes which should be in place to implement NICE guidance in the correct way.
	NICE is developing an "**innovation scorecard**", which will show how quickly local organisations are providing NICE-approved treatments and drugs (NICE, 2012; NHS Information Centre, 2013).
Quality Surveillance Groups (QSG)	The QSG will act as a virtual team across a health and care economy, bringing together organisations and their respective information and intelligence gathered through performance management, commissioning, and regulatory activities to maintain quality in the system by routinely and methodically sharing information and intelligence (National Quality Board, 2013).

Professionally-led initiatives

Organisation	Initiative
Healthcare Quality Improvement Partnership (HQIP)	HQIP leads the **National Clinical Audit and Patient Outcomes Programme**, coordinating 40 national clinical audits.
	HQIP funds condition specific **peer review,** for example the National Review of Asthma Deaths (HQIP, 2012).
National Cancer Intelligence Networks (NCIN)	The NCIN is a UK-wide initiative, working to drive improvements in standards of cancer care and clinical outcomes by improving and using the information collected about cancer patients for analysis, publication and research (NCIN, 2013). The NCIN will be hosted by Public Health England from 1 April 2013.

10 Membership includes commissioners, GPs and other primary care professionals, experts in quality measurement, social care experts, local authority representatives, lay members, secondary care providers and public health practitioners.

Professionally-led initiatives	
Organisation	Initiative
National Cancer Peer Review Programme	**Quality Indicators:** The review includes an annual self-assessment process supported by a targeted visit programme. The review also considered a qualitative assessment of indicators relating to the whole system of quality and safety in relation to patient and carer experience.
	Methods: All services must submit an internally validated annual self-assessment against the criteria set out in the Manual for Cancer Services. Compliance with the measures is appraised as yes, no or not applicable according to the evidence available. If evidence is not available then the measures will be considered as not met.
	Each year the zonal cancer peer review teams complete a desktop-based exercise to validate a sample of self-assessments, so that every team/service is externally verified at least once every five years.
	Peer review: In addition, there are a number of risk based peer reviews completed within targeted sites. Sites are pre-warned and are prioritised based on a number of criteria including new teams/services; teams/services which have not implemented the Improving Outcomes Guidance; immediate risks identified at previous peer review visits; or requests from organisations.
	The peer review visit examines compliance against the quality measures, and wider issues relating to the delivery of patient care. The zonal coordinating team invites nominations of reviewers from the cancer networks. The peer review teams are multidisciplinary, working in the same discipline as the people they are reviewing.
	Action: Following the peer review process, the cancer network and its organisations should agree on actions to be taken to address areas for improvement. The cancer peer review will be supportive of follow-up, but they recognise that approval and follow up of agreed actions is primarily a function of clinical and corporate governance systems and not a function of the peer review process (National Cancer Action Team, 2008).
Royal College of Physicians (RCP)	**Stroke Peer Review** has been implemented since 2006, in a collaboration between the British Association of Stroke Physicians, the Stroke Association and the Royal College of Physicians. A multidisciplinary review team (up to ten members) is invited in by the trust to examine a component of stroke care. The team make a one-day visit to the trust and report initial findings back in two weeks, with a full report within three months. The aim is to implement good practice and facilitate quality improvement in stroke care. A fee is charged to the trust.
	Invited Service Review (ISR) ISRs may be requested by trusts in relation to a range of issues for which independent advice is sought. A multidisciplinary team (including representation from the patient and carer network) led by medical director, analyse the situation via interviews. Summary feedback is provided at the end of the review, and the full report with recommendations is produced and issued to the trust. A fee is charged to the trust. The ISR is seen as incremental and developmental, to support staff and management in care improvement. The RCP has only recently decided to share this information with the CQC.[11]

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11 From Nuffield Trust Ratings Review engagement exercise.

Professionally-led initiatives	
Organisation	**Initiative**
Royal College of General Practitioners (RCGP)	**Practice accreditation** is funded by individual practices or in some cases primary care trusts (as the system currently stands) and it recognises teams who have demonstrated organisational good practice. It is estimated that approximately 280 practices are involved in the accreditation scheme (have signed up) but that 267 practices are actively involved. The initial findings look encouraging as the roll-out of accreditation progresses. Only one practice has received accreditation to date but the ultimate goal would be to publicise those practices who had received accreditation and the Quality Practice Award (only 220 practices have received this to date).[12] As part of the accreditation process, practices submit evidence online to the RCGP which is looked at by assessors (can be practice managers or GPs but to date all assessors are practice managers). There may be a subsequent visit by the RCGP. The RCGP gives practices a logo to display highlighting accreditation status. The RCGP does not complete regular practice reviews as problems with general practice would be dealt with by the GMC, CQC or the medical director of the Local Area Team of the Commissioning Board depending on the issue.
Local peer review	**NHS Quest** is the member-convened network for high-performing foundation trusts[13] who wish to focus on improving quality and safety. Each NHS Quest member must host one peer site visit, the purpose of which is for peer learning "through offering personal and organisational insights, sharing experiences, and inviting open discussion." The visits are then evaluated using the net promoter score pre/post visit, along with collating key themes from the day (Brotherton, 2012). **West Midlands Quality Review Service** The West Midlands Quality Review Service (WMQRS) was set up on 1st April 2009 as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by: • developing evidence-based quality standards • carrying out developmental and supportive quality reviews – often through peer review visits • producing comparative information on the quality of services • providing development and learning for all involved. **Quality Indicators:** Once a clinical area has been selected for review, the WMQRS develops **quality standards** that measure structures and processes (rather than outcomes) along patient pathways. The standards are developed from national guidance such as NICE, Medical Royal Colleges and Department of Health standards, and are cross-referenced to the Care Quality Commission (CQC) registration requirements so that organisations can use the findings for their self-assessments and CQC registration submissions. Quality review visits are then organised which involve specialist review teams (consisting of providers in the region, expert patients and lay members) visiting sites. The team walks the wards, examining documentation and treatment and can take six months to cover the region. All the findings are made available in the public domain on their website (apart from some specially commissioned programmes). **Risk identification:** Following a review, the service is awarded a colour-coded risk score (red, amber, yellow, green). Any immediate risks will be reported to the provider and commissioner and, if necessary, taken up with the Strategic Health Authority (SHA). The SHA then passes the information onto the CQC.

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12 From Nuffield Trust Ratings Review engagement exercise.

13 Members are invited from the 20 per cent top-performing foundation trusts in relation to quality and safety data (as defined by CQC rating, Dr Foster Safety Score, HSMR, Infection rates, Monitor rating, patient and staff satisfaction scores).

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Appendix 6: Examples of initiatives in selected countries to improve the availability of publicly reported data on the quality of health care

Country	Information collection/availability
USA	• Internet-based consumer ratings of physicians and hospitals have gained interest from the private sector (e.g. Rate MDs.com, consumerreports.org).
	• CMS Medicare Medicaid provides reviews of plans, hospitals and particular facilities to their users.
	• Some states provide report cards rating quality of hospitals and individual physicians (e.g. New York and Pennsylvania State Report Card, Michigan Quality Counts).
	• Various research institutions make performance information publicly available at the state, region and even hospital level – utilising different data sources including information collected through claims data and/or surveys (e.g. Commonwealth Fund, Dartmouth Atlas).
	• There exist various accreditation agencies (such as the Joint Commission, the Accreditation Commission for Health Care and others) which collect information on quality performance from providers.
	• The Agency for Healthcare Research and Quality (ARHQ) has developed a number of quality indicators that make use of readily available hospital inpatient administrative data. These are made available to programme managers, researchers and other stakeholders at the State and Federal level. The aim is to use these indicators to highlight potential quality concerns, identify areas that require further investigation and track changes over time.
France	• Information on hospitals is available on the website of Haute Autorité de Santé (HAS), although it concerns only the outcome of the accreditation process.
	• Other sources of information include a yearly star ranking of hospital departments in newspapers and magazines. For example, *Le Point* magazine usually provides a star ranking of public and private hospital wards for a variety of medical and surgical specialties in its September issue.
	• The National Agency for the Evaluation of Health and Social Care (www.anesm.sante.gouv.fr) and the MOBIQUAL programme (mobiqual.fr) are also voluntary programmes which provide quality benchmarks for residential facilities.

Country	Information collection/availability
Germany	• Each hospital is obliged to publish biannual performance reports addressing patients and their relatives but also at referring practitioners and the general public. All hospitals contracted within the statutory health insurance system have to make these reports available to the sickness funds for online publication, and to their visitors as hard copies. • The Joint Federal Committee of the BQS (Bundesgeschäftsstelle Qualitätssicherung) undertakes performance benchmarking of health care institutions. Benchmarks are produced in the following way: (1) All hospitals have to document particular data for specific patient groups and send these data to BQS; (2) BQS subsequently analyses the data according to agreed methods; (3) The results are made available to hospitals in reports and recommendations. Hospitals can see their level of performance in comparison with the other hospitals and receive concrete suggestions on how to improve quality. Conspicuous results are analysed together with the hospitals. The hospitals implement the agreed improvement activities. • Each sickness fund requires some quality information on institutional care (82 PIs) and home care (49 PIs) to be collected (www.mdk.de). • The German Network for Quality Development in Nursing publishes information on expert standards in seven areas (www.dnqp.de). • The 2008 Enhancement Act led to changes in external quality control in terms of yearly inspections, and the creation of a public reporting system. Upon finalisation, the reports are published on the websites of the state associations of LTC funds and on the website www.pflegelotse.de.
Netherlands	• The Government provides information through the internet. The National Institute for Public Health and the Environment (RIVM) has published a website (www.kiesbeter.nl), which helps consumers choose between different health care providers and health insurers. The site offers general information, for example on which services are available, on prices, on waiting lists and also on the quality of services. • There are also independent websites which offer information on quality, waiting lists, prices and patient satisfaction, all collecting their information through different methods. • The Dutch Health Care Inspectorate (www.igz.nl) publishes the Consumer Quality Index for social care (as well as health care) which comprises quality scores in different areas.
Sweden	• The public release of information regarding quality of care started with information about waiting times in the 1990s (www.vantetider.se). Moreover, in the 1990s, a national population survey (Vårdbarometern) was initiated regarding attitudes towards health care performance. The design makes it possible to compare developments in different county councils. • The most important source of data for the regional comparisons are the national quality registers, but also information about waiting times and comparison of expenditures/costs. The focus is on comparison and ranking across county councils for each indicator. Results are shown for hospitals for some 50 indicators, but without rankings. • A recurrent National Patient Survey (Nationella Patientenkäten) is administered to all health care providers in primary care (since 2009) and specialised hospital care (since 2010) in participating county councils and conducted every two years. All county councils and regions were expected to participate in the 2011 survey on primary care. The information generated through this survey focuses on patient satisfaction and quality of care. Since 2010 the results have been public with the main purpose of guiding people in their choice of provider. • The National Board of Health and Welfare develops standards, undertakes supervision and maintains official statistics. The local authorities collaborate to monitor 31 quality measures.

Country	Information collection/availability
Denmark	• In 2006, the National Board of Health and the former Ministry of the Interior and Health launched the website www.sundhedskvalitet.dk. The aim of the website is to communicate information on quality and service at different hospitals. • The National Indicator Project, which serves both professionals and the general public, takes the form of an web portal (www.sundhed.dk) where citizens can, by using a digital signature, view their own medical record (treatment at hospitals) and the prescription medication they have purchased. • In January 2004, a national reporting system for adverse events was established. The purpose of the system is to improve patient safety and health care. The National Board of Health runs the register for adverse events. After receiving the analysed and anonymized reports from the regions, they published an annual report on overall issues and results. All publications are available on the website www.dpsd.dk.
Canada	• The Canadian Institute for Health Information (CIHI), a "not-for-profit, independent organisation dedicated to forging a common approach to Canadian health information" evaluates health system performance at the national, provincial and territorial level. In the past decade, CIHI has teamed up with Statistics Canada to be able to provide more detailed performance information to the public at the hospital level. This online comparisons tool was made publicly available in 2012. • Other local government and not-for profit organisations within the provinces/territories also provide ratings of hospitals (e.g. myhospitalcare.ca, run by the Ontario hospital association).
Australia	• *MyHospitals* is an Australian Government initiative to inform the community about hospitals by making it easier for people to access information about how individual hospitals are performing. • *MyAgedCare* is an Australian Government initiative to provide access to government and non-government information and services and to help people make informed decisions about aged care options for themselves and their family members. • Most states and territories have performance reporting schemes set up which permit performance comparisons for public hospitals within the state (eg. The Victorian Health System Performance page http://performance.health.vic.gov.au/Home.aspx). However the initiatives differ amongst the states and territories in terms of the type of information published as well as its frequency.

Appendix 7: Using performance information to make choices in health care: lessons from abroad

Despite the proliferation of performance information being released into the public domain, little is known about how this information is used and to what extent such reporting leads to quality improvement by changing the behaviour of health care consumers, providers and purchasers (Ketelaar and others, 2011).

Systematic reviews carried out in countries where performance information on individual health care providers is available show that the evidence of their impact on patient choice and health outcomes is inconclusive or small (Ketelaar and others, 2011; Shekelle and others, 2008; Fung and others, 2008). Across countries, evidence suggests that patients are more likely to base decisions about where to receive care on recommendations from a GP or information from family and friends. Moreover, research indicates that the existence of multiple and often conflicting public reports confuses patients and may deter them from using this information to make choices (Rothberg and others, 2008).

Most research in this area has focused on the publication of health performance information in the United States, such as the adoption in New York and Pennsylvania of initiatives related to coronary bypass surgery (Bentley and Nash, 1998), Cleveland's survey of patient experiences in hospital (Rosenthal and others, 1997), and the Quality Counts survey of Wisconsin hospitals (Hibbard and others, 2003). Results across studies suggest that some improvements in health outcomes as well as greater efforts by providers to secure performance improvements can be detected as a result of publication. However, these effects are not found to be driven by patient feedback or choice, but rather through naming and shaming or reputational effects (Hibbard and others, 2003).

Similar results have been found from studies in the Netherlands, where evidence suggests that members of the public remain largely uniformed (Grol and Faber, 2007; Lako and Rosenau, 2009). Estimates from these studies suggest that around 14 to 18 per cent of the population mention looking for information on hospital quality as a basis to make decisions regarding provider. However, results continue to suggest that the publication of data encourages quality improvement efforts by providers, particularly in instances where the media raises awareness (Meijer, 2007).

Despite the increasing use of the internet for all age groups and the rise in the use of health information online, evidence suggests that the public finds it challenging to make use of information for treatment decisions (Marshall and McLoughlin, 2010;

Woolf and others, 2005). There are various theories outlined by the academic literature indicating why take-up might be so low, highlighting barriers that range from the cognitive and emotional challenges patients face when making complex decisions of this sort to the amount and order of indicators provided.

However, public reporting holds the potential to become a powerful agent for quality improvement. Patients maintain that they would use mortality data in making decisions; yet despite the wide availability of mortality reports, few patients actually use them, and even the best public reports do not seem to affect market share or consumers' choices. This may change as consumers become more aware of the rating services and in areas where price is more of a consideration – such as in long-term care.

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Appendix 8: Lessons from performance benchmarking in Germany

From 2001, the BQS (*Bundesgeschäftsstelle Qualitätssicherung GmbH*, National Institute for Quality in Health Care) has been responsible for the development of clinical performance measurement in German hospitals commissioned by the Joint Federal Committee. The initial remit of the BQS was to improve inpatient care by benchmarking hospitals confidentially on a number of performance indicators. Participation in the benchmarking project is mandatory for all German hospitals. Hospitals that fail to collect data as required by law face financial penalties. If they report fewer than 80 per cent of cases (determined through the number of respective reimbursed cases), payment is cut (Busse and others, 2009).

In 2001, this exercise began with the measurement of 12 tracer conditions. Today, quality information is collected for 289 clinical indicators across 30 areas (which consist of 20 per cent structure, 20 per cent process and 60 per cent outcome indicators). Clinical indicators are collected from each hospital by a BQS project office in each Land and sent to a national office. Of these indicators 182 are made publicly available (anonymously in aggregate format). These are independently validated and benchmarked. They are assessed (by BQS) and assigned an assessment ranging from 'require national level intervention' to 'excellent'. The results are made available to hospitals in reports and recommendations so that hospitals can assess their relative performance as well as receive concrete suggests on how to improve quality. Any outliers identified by the national office are analysed together with the hospital. As a first step, hospitals are required to fill out a questionnaire accounting for why these outliners exist. Finally, each project office organises regional meetings with all hospitals to discuss the performance results and potential performance improvements.

Thus, the quality assurance process has served as an intra-professional tool for physicians that can be used to help them determine their own relative performance with respect to implementing standard treatment processes and identifying important complications. There has been some independent research which has attempted to evaluate the impact the BQS has had on quality of care. Reiter and others (2011) evaluated the instrument used for the selection of quality indicators and concluded that it contributed substantially to the collection of proper information, thus ensuring high transparency in a very sensitive context. However, other articles investigating the quality of data in specific clinical areas, including breast cancer (Neuschwander and others, 2007) suggest that the quality of data is poor and that benchmarking hospitals in these areas cannot inform discussions on quality of care.

In a review of quality assurance programs in Germany, Busse and others (2009) outline the advantages and disadvantages of the BQS system. The main advantages are

that physicians can examine the relation of a possible complication to the performed procedure (or treated disease) during the data collection process and thus learn from the quality indicators. The disadvantages identified are that the efforts put into the collection of separate quality data above the administrative data is too great, and the detection of quality problems relies heavily on participants' honesty. If the information is used for public benchmarking, there is a strong incentive for manipulation, which can easily be done by omitting complications or by not documenting certain cases at all. Finally, outcome information is mostly restricted to the inpatient episode. Follow-up cannot be widely established because of the enormous effort needed. It also would be prone to loss of cases because of under-reporting and reporting bias.

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Appendix 9: Nursing Home Compare – evidence of using information on facilitating choice and improving performance

The Centres for Medicare & Medicaid Services (CMS) Nursing Home Compare (www.medicare.gov/NHCompare) is a web-based nursing home report card initiative which was designed with the goal of improving consumer information in the area of nursing home quality. Nursing Home Compare was initially introduced in October 1998, where it included reports of deficiencies, but CMS has increasingly expanded the quality information available on the website. In 2002, the Nursing Home Quality Initiative (NHQI) introduced quality indicators (QIs) to the Nursing Home Compare website. As of December 2008, the website added a new "five-star" reporting system with an overall star rating as well as specific star ratings based on the inspections, staffing, and quality of care (Grabowski and Town, 2011).

Evidence of patient choice

In an attempt to measure knowledge and familiarity with the Medicare Star Quality Rating System in 2011, Harris Interactive – on behalf of Kaiser Permanente – conducted a study of Medicare-eligible seniors by phone (Harris Interactive, 2011). The results suggested that there is not universal familiarity with the system, and less than one third of those who had heard of the system were using it to make decisions about their own health plans. Although only two per cent of seniors could report their own plan's rating, more than one quarter of the sample reported they knew how to find information about the rating system. Similarly, a recent study by Werner and others (2012) found that only a very small (though statistically significant) amount of people responded to Medicare's Nursing Home Compare website when making consumer decisions.

Performance improvements

A number of studies in the US have examined the impact on quality of Nursing Home Compare, and despite the little evidence suggesting that consumers use the rating to make choice, evidence does suggest that the rating has led to quality improvements. In examining the initial report card effort (before the NHQI), Stevenson (2006) found little effect of reported staffing and deficiencies on facility occupancy rates. However, a later study by Zinn and others (2005), which examined trends in post-acute and long-stay quality measures following the national release of the NHQI, found mixed findings. Some measures exhibited improvement, while others showed little change.

One study (Werner and others, 2009a) suggested that both reported and unreported measures of post-acute quality improved following the introduction of Nursing Home Compare in 2002. However, their findings also suggested that improvements were found in those facilities that were medium- to high-scoring – with low-scoring facilities experiencing no change or a worsening of their unreported quality of care – thus widening the quality gap even further. Conversely, findings by Clement and others (2012) showed that lower-quality providers tended to increase their prices in order to invest in quality improvements, although mid-level and high-quality nursing homes did not significantly increase self-pay prices nor consistently change quality after NHC was introduced. In a follow-up article, Werner and others (2009b) used a sample of the 15 percent of small nursing homes that were not subject to public reporting as a control group and found that the introduction of the federal report card effort improved two out of four post-acute measures of nursing home quality when examining mean impacts over a three-year window.

In order to better understand the reaction of nursing home administrators to Nursing Home Compare, Mukamel and others (2007) surveyed a random sample of roughly 700 nursing homes. Of their sample, 69 per cent of administrators reported reviewing their quality scores regularly and many reported taking specific actions to improve quality – with those scoring worse on quality scores more likely to take action following publication of the report card. In a follow-up study, Mukamel and others (2008) linked the actions taken by the nursing home administrators in response to Nursing Home Compare with five reported quality measures using a pre-/post-study design. They found that two of the five measures showed improvements. Finally, Grabowski and Town (2011) found very little evidence to suggest that the staggered introduction of the NHQI report card measures led to increased patient demand or better long-stay quality. However, homes in more competitive areas were more likely to increase their quality, although it is unclear whether public reporting was the cause.

As noted by Clement and others (2012), a challenge for researchers in this area has been to identify where changes in quality do occur. While it is relatively straightforward to identify changes in price, changes in quality are harder to track due to the number of different measures and the longer lead time needed for an impact to be observed.

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