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Rating providers for quality: a policy worth pursuing?

A report for the Secretary of State for Health: summary

March 2013

The Nuffield Trust has conducted a major independent review into whether the Government should introduce 'Ofsted-style' performance ratings for hospitals, general practices, care homes and other adult social care providers. The Secretary of State for Health, the Rt Hon. Jeremy Hunt MP, commissioned the review 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. A final report, *Rating providers for quality: A policy worth pursuing?*, was presented to the Government on 22 March 2013. This paper provides a summary of the main report.

Terms of reference

The specific terms of reference for the independent review 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 on the review, we considered the following broad groups only: 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 key groups of stakeholders
- an eight-week online consultation process
- a series of three focus groups with the public conducted by Ipsos MORI
- bilateral meetings with key individuals.

More than 200 organisations and individuals contributed to an online survey; these contributions have informed the conclusions and recommendations of the final report. 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 outlined in the main report and available to view on the Nuffield Trust website at www.nuffieldtrust.org.uk/ratings-review. 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 2001–09 for health care and 2008–10 for social care, but these have been abolished (the history is outlined in Chapter 2 of the main report). The main observation is that there has been remarkable instability in the organisations doing the ratings – instability which will have reduced the time for regulators to develop the system of ratings and evaluate their impact.

In health care, the rating with the longest shelf life was the Healthcare Commission's Annual Health Check (2005–09), which applied to NHS trusts. Over that period, there is evidence to show that performance of NHS trusts did improve against the measures in the rating. However, 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

To help answer the question "What might ratings add now?", Chapters 3 and 4 of the main report 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.

> There is currently no independent comprehensive assessment of quality across all providers

For social care providers, current assessments by local authorities are variable in nature, may not be a comprehensive view of the care offered by providers, 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 available for the public on certain aspects of the quality of care (more so for health than for social care providers), it is neither comprehensive nor available in one place. One aggregate, comprehensive rating of providers may provide more clarity and simplicity for the public, especially if it comes from one 'official' trusted source, as is the case for school ratings provided by Ofsted. Clearly a parallel market in supplying provider ratings from commercial independent organisations could exist, as now.

> One aggregate, comprehensive rating of providers may provide more clarity and simplicity for the public

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 of the main report. 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 (and 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 by either a confusing array of information from different sources, or more often a lack of information altogether. 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. To date, 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 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 (Chapter 5 of the main report outlines 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 that sanctions 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.

> Service-level information has much more potential to engage clinical staff, and it will be important that an aggregate rating would include such information

For hospitals, the focus on a 'whole institution' rating may prompt management to better performance, but quality of care for patients is delivered at more of a service level, for example in departments or specialties or wards. Thus service-level information on quality 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 on 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 that 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 that the rating (and the rating organisation) will be discredited, as lapses occur in providers scored as 'good' or 'excellent'. It will just be a question of time.

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Additionally, 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 detect, investigate and remedy significant lapses in quality. And if there were 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 with an effective underpinning system of surveillance to try to spot failure has been noted. While the public would not expect a 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 Government's 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. The main report (Chapter 6) discusses how best a rating might be designed, balancing the need for simplicity (for example, for accountability) and the need for complexity (to have more detailed information on clinical care to aid choice and engage clinicians).

In summary, we conclude that the overall approach to ratings should allow complex organisations to be assessed at different levels and to 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, which we believe are crucial elements. These three components have the advantage that they are common currency in the NHS, and can apply equally well to social care and health sectors. There should not be undue reliance upon any one indicator – a rating should be composed of a range.

Alongside these three domains of quality developed by Lord Darzi (safety, effectiveness and user experience), 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. 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.

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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 public and patients – to help in the development of the rating system 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 their use by the public, 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 of social care) to

influence priorities, the process should largely be sector-led, including the public and users, with an agreed process for development that should focus not only on the short but also 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 – in other words, 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 National Institute for Health and Clinical Excellence 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 them.

Which organisation should oversee any new system?

The main report (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 and developing surveillance to help spot failure – would add to those management challenges. The CQC would need political support, support from the main national stakeholders, resources, time to develop, and stability over a period of time, if a rating system were to be effective.

We also considered how a rating system might effectively coexist with the wider system in health and social care for 'improvement' – that is, 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, especially 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 in the main report. We conclude that although the rating should be continually refreshed throughout the year as new information comes 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 the 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, with 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 Commissioning Board. The Department of Health has a role here to help coordinate strategies appropriately. We note the regrettable lack of evaluation on 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 that 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 the Review, for example, the overall likely costs of introducing a rating system next to other priorities in both sectors. These overall costs could be reduced if a rating could be an adjunct to other similar activity (as described in Chapters 3 and 4 of the main report) or if it could 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 the Review.

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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, 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 occurs 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 the Review does some justice to their generous contributions.

We await the Government's response to the Review, which is expected in due course.

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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 of the report, and which are available to view at **www.nuffieldtrust.org.uk/ratings-review**. The conclusions in the report, however, are solely those of the Nuffield Trust.

As part of the 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. 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. We hope that this review does some justice to their contributions.

Update – June 2013

Since the report's submission, many of its key conclusions have been accepted as part of the Government's policy on care quality. It has been cited as an important basis for provisions of the 2013 Care Bill, which was laid before the House of Lords on 10 May and provides the legislative framework for an independent system of ratings. The Care Quality Commission has been asked by the Government to take this forward. On 17 June, the CQC launched a consultation on the future of inspection and regulation, which includes proposals for how hospitals and other care providers are performance-rated. The consultation closes on 12 August 2013.

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