

<b>Title:</b> Impact Assessment of Provider Ratings Review <b>IA No:</b> DH 3120  <b>Lead department or agency:</b> Department of Health <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>		
	<b>Date:</b> 15/04/2013		
	<b>Stage:</b> Final		
	<b>Source of intervention:</b> Domestic		
	<b>Type of measure:</b> Primary legislation		
<b>Contact for enquiries:</b> Lucy Witter			

<b>Summary: Intervention and Options</b>	<b>RPC Opinion:</b> RPC Opinion Status
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Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
N/a	N/a	N/a	No
			NA

**What is the problem under consideration? Why is government intervention necessary?**

It is difficult to optimise patient and commissioner choice of health and social care providers without a systematic, clear and robust means of presenting information about quality and performance. Providers publish a range of information, but there is a gap in the provision of clearly presented, comprehensive and trusted information. A definitive assessment of the quality of providers could properly inform commissioners and service users about the quality of care and improve the accountability of providers to the public. Government intervention is necessary to solve this problem through the development and implementation of provider ratings, as the market will not automatically adjust to resolve the issue.

**What are the policy objectives and the intended effects?**

The policy objective is to improve patient choice and drive performance improvement of GP practices, acute trusts and care homes through the introduction of a single set of ratings.

The intended effects are to give a single version of provider performance, increase accountability, improve ability for patients to exercise choice, allow commissioners to make better evidence-based decisions and make the comparative quality of services clear to providers.

**What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)**

Option 1: Do nothing

Option 2: Consolidate various provisions to enable CQC to undertake ratings. This would require CQC to conduct a review, provide an assessment of the performance of the service providers and publish a report of its assessment. This is an enabling power and it will be for CQC to determine the exact methodology of the ratings and which indicators will be used. It is intended that the type of organisations to be rated will be set out in secondary legislation. In the first instance we expect this to include NHS-funded acute care, GP practices and care homes and domiciliary care agencies.

<b>Will the policy be reviewed?</b> It will be reviewed. <b>If applicable, set review date:</b> Month/Year					
Does implementation go beyond minimum EU requirements?				N/A	
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.		<b>Micro</b> Yes/No	<b>&lt; 20</b> Yes/No	<b>Small</b> Yes/No	<b>Medium</b> Yes/No
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)				<b>Traded:</b>	
				<b>Non-traded:</b>	

***I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.***

Signed by the responsible Minister: \_\_\_\_\_ Date: 28 December 2013

Norman Lamb MP

# Summary: Analysis & Evidence

# Policy Option 1

## Description:

### FULL ECONOMIC ASSESSMENT

Price Base Year N/a	PV Base Year N/a	Time Period Years N/a	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate: N/a

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	Unquantified		Unquantified

#### Description and scale of key monetised costs by 'main affected groups'

It is not possible to quantify the cost of this policy at this stage. However, it will ultimately be CQC's responsibility to undertake a thorough cost-benefit analysis after it has designed an appropriate ratings system, once its business planning processes are complete. It will need to ensure it has negotiated sufficient funds to undertake this duty.

#### Other key non-monetised costs by 'main affected groups'

From a qualitative perspective, we estimate that any additional costs over and above what CQC currently spends on inspections will consist largely of development costs of a rating system and any additional data analysis that will be required to implement one.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	Unquantified		Unquantified

#### Description and scale of key monetised benefits by 'main affected groups'

Due to the nature of the policy, it is not possible to quantify expected benefits at this stage. Therefore, no benefits have been monetised. It is important to note that the benefits realisation will depend upon CQC being adequately funded to carry out this function. To date, CQC has been granted an additional £20m to fund its transformation programme, some of which will be used to develop performance ratings.

#### Other key non-monetised benefits by 'main affected groups'

As above, it will be CQC's responsibility to undertake a comprehensive analysis of expected benefits. At this stage, however, key non-monetised benefits by the main affected groups - patients and service users, the organisation responsible for ratings, health and social care providers and local commissioners - are improved choice and quality improvement, increased transparency and accountability of providers.

Key assumptions/sensitivities/risks	Discount rate (%)
Key risks are detailed in the relevant section of the Impact Assessment. Given these potential risks the legal duty being introduced has a deliberately flexible scope, in terms of the institutions to be rated, the sets of ratings to be produced, the frequency of ratings, the information to be used, etc, to maximise the discretion of CQC to build the system gradually and as robustly as possible.	

### BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:	In scope of OIOO?	Measure qualifies as
Costs: Unquant	No	NA
Benefits: Unquant		
Net: Unquant		

## EVIDENCE BASE

### A. Characteristics of the underlying problem

Information is an essential component of the NHS and social care infrastructure. Better quality information and the sharing of information is critical to modernising the NHS and care services. Information can be used to improve the quality of care, improve our health and care outcomes, reduce inequalities and increase productivity and efficiency.

Despite previous government intervention (see Section B), a number of shortfalls remain

- Disjointed information
- Differences in levels of knowledge and information.

#### Disjointed information

Currently, there is no independent and comprehensive assessment of the quality of care across all providers and the spectrum of performance in England.

In both health and social care, current assessments by CQC are independent but not comprehensive. They focus on essential standards only. Current assessments by the commissioning system may be more comprehensive (e.g. using quality dashboards or Quality Accounts) but are not independent or nationally consistent as commissioners assess the providers from which they are purchasing services. Furthermore, the Commissioning Outcomes Framework reflects priorities set in the NHS Mandate by the Government of the day, which may be open to distortion away from what matters most to patients and service users and towards what matters most to politicians.

In social care, assessments focus on essential standards only. Current assessments by local authorities are variable in nature; they may not be a complete picture of the care offered by providers, do not cover all care homes (particularly those which have no local authority funded residents) and are generally not published. Analysis of outcome measures taken from the Adult Social Care Outcomes Framework are a start, but cover local authorities and not providers. Although a useful market already exists in supplying 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 rather than inspections to record their experiences. This may be of limited value as users can be reluctant to record dissatisfaction because of fear of reprisal. Furthermore, there is a plethora of these websites, which is confusing for the public to use.

Even where information is available, it is difficult for patients and service users, the public, providers and commissioners to find and use it. It is not available in one place, as is the case for schools provided by Ofsted. There are multiple providers of information about quality of health and social care service provision e.g. Information Centre, CQC, NHS Choices, myhealthLondon who may provide different verdicts on provider performance. If this is the case, the performance of a provider is not clear. This makes it more difficult for patients, service users and commissioners to make informed decisions, more difficult for providers to know which of their services are most in need of improvement, and more difficult for regulators to identify providers where there are serious issues with the quality of services provided.

At workshops conducted as part of the *Barriers to Choice Review*, patients and service users identified a serious lack of signposting right across social care, from the difficulties in finding out which personal assistants are available locally to the quality of local care homes. They identified that 'where this

information is available – it is sometimes only available informally.’ In addition, they found that it was ‘difficult to access genuinely helpful information they can use to choose between hospitals.’<sup>1</sup>

### Differences in levels of knowledge and information

For example, service users and GPs have different levels and types of knowledge; commissioners and providers will not know the same amount about commissioner priorities and provider performance; and different clinicians may have different knowledge about the individual. All of these can lead to care that may not be as good as it could be.

## **B. Background and context**

The White Paper *‘Equity and Excellence: Liberating the NHS’*<sup>2</sup> set out a vision for the health and care system where organisations at all levels are more autonomous, having more control over decisions they make, and more accountable for those decisions. One of the underpinning principles is that decisions are taken by people or organisations who are in the most appropriate position to do so. For example, commissioning decisions have become the responsibility of GPs and other healthcare professionals as part of Clinical Commissioning Groups (CCGs), who generally have more day-to-day contact and hence greater insight into what will benefit patients than Primary Care Trusts (PCTs) have had in the past.

For this to work successfully, more transparency across the system is required. This allows organisations, services and potentially individuals to be held accountable. It also facilitates patient empowerment, another important tenet of the vision for the health and care system. If patients and service users are empowered to make decisions, and they can do so based on available information that is clear about relative performance of providers of health and care services, then this creates strong incentives for providers. Choice policy is an end in itself, as people place a value on choice, as well as a means to an end, as it encourages providers to improve their services and make themselves more attractive to people making decisions – otherwise, people will choose to go elsewhere.

There is a gap at present around a simple measure for provider performance. This is discussed in more detail below, and is the main justification for the proposed change. The Department of Health commissioned the Nuffield Trust to undertake a report about the purposes of a single rating for providers. This report forms the main basis for the information and analysis within this impact assessment.<sup>3</sup>

### The Nuffield Trust Review

For people in need of health or social care, the effectiveness, experience and safety of care available is crucial. While there is a significant amount of information available on organisations providing health and social care in England, there is currently no aggregated assessment or ‘rating’ to summarise and compare the performance of organisations or the services provided by them.

The Department commissioned the Nuffield Trust, an independent source of health policy analysis and advice, to conduct a review into ratings. This was to determine whether a single set of ratings of provider performance should be used in health and social care, and if so how best this might be done. This review was commissioned on 28th November 2012 and published on 22<sup>nd</sup> March 2013.

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<sup>1</sup> Boyle. D. 2013. *The Barriers to Choice Review – How are people using choice in public services?*

<sup>2</sup> <https://www.gov.uk/government/publications/liberating-the-nhs-white-paper>

<sup>3</sup> The full report *‘Rating Providers for Quality: A Policy Worth Pursuing?’* is available at <http://www.nuffieldtrust.org.uk/publications/rating-providers-quality>

This review considered current arrangements and accountabilities in the NHS and social care to improve quality and safety, and the possible place of ratings alongside these. The review sought to learn lessons from past experience of developing and using ratings in health and social care, from other areas of the public sector, and relevant experience from other countries. The emphasis was on engaging a wider group of local and national stakeholders in a dialogue to try, as far as possible, to gain consensus.

Due to time constraints, the Nuffield Trust Review focused on providers of acute care, GP practices, care homes and domiciliary care providers. They reported that there is no reason why the principles of ratings could not apply to other providers but further engagement and research would be needed to ensure support.

The key recommendations of the review are:

- There is a specific gap that a well-constructed rating could fill;
- Service specific ratings should be promoted where possible, particularly in hospitals;
- Ratings should include measures of safety, effectiveness, and user experience. There should not be undue reliance on any one indicator – a rating should be made up of a range;
- A ‘road map’ approach should be taken, developing information over time to support a rating, particularly if it were to cover areas of specific clinical care;
- Ratings should be updated regularly and made available in a timely way, rather than just refreshed annually for example;
- Ratings should be developed in consultation with a range of key stakeholders, including groups representing the public and users; in particular, ratings for hospitals should not be rushed, as any quick-fix would inevitably erode public support for ratings.
- While there is a legitimate role for national Government (and local in the case of social care) to influence priorities, the process should be largely sector-led including the public and users;
- Ratings 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);
- 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 NHS England and should involve a wide range of stakeholders;
- The ratings design should align with pre-existing outcome frameworks and NICE standards where applicable.

### Former government policies

A number of different ratings systems have been applied to the NHS and social care since 2000, and they have been published and operated by a number of different bodies. This is summarised in detail in Chapter 2 of the Nuffield Trust report, and a brief summary is provided below.

From 2000 to 2005, ratings of 0-3 stars were awarded to provider trusts annually based on performance against a range of national targets and delivery of financial objectives. The annual star ratings were first published by the Department of Health for 2000/01 before being taken on by the Commission for Health Improvement from 2002/03 and then the Healthcare Commission for 2004/05.

From 2005 to 2009, the star ratings were replaced for NHS providers by the Annual Health Check, which was published by the Healthcare commission for 2005/06 to 2007/08 and then taken over by the Care Quality Commission (CQC) from April 2009. The Annual Health Check was more transparent than the star ratings and included a consistent set of core standards alongside national priorities. Providers were separately rated on 'Quality of Service' and 'Use of Resources' as 'Excellent,' 'Good', 'Fair', or 'weak'. CQC published the last run of the Annual Health Check for 2008/09, and the system was intended to continue largely unchanged, renamed as 'Periodic Review'.

A star rating for care homes was introduced by the Commission for Social Care Inspection (CSCI) for 2007/08, and was continued by the CQC when this took over CSCI's functions from April 2009. This also fell under Periodic Review for 2009/10.

The Periodic Review function was discontinued so that CQC could be focused on the core function of registering providers against the registration requirements. The impact assessment accompanying the 2012 Act states that staff had been redeployed and there was no resource within the CQC to deliver this function.<sup>4</sup> Furthermore, as commissioning, through NHS England and CCGs aims to increase quality above the essential levels, it was thought not to be appropriate for the CQC to assess how providers were performing against service levels set for them in contracts agreed with NHS commissioners. Therefore, the role of the CQC became focused on essential standards.

In general, it is difficult to disentangle the effects of provider ratings from other policies across the system. As set out in the report of the Nuffield Trust, previous ratings systems were associated with an increase in quality – but, it is not possible to say that one caused the other, and given that this was a period of significantly increased resources to the NHS, it is likely that there were confounding factors at the time. Furthermore, it is likely that positive effects may have been reduced as the organisation(s) undertaking the ratings function changed over time.

General feedback on previous ratings systems in social care was positive. The evaluation of the former star ratings for social care providers, carried out by the Commission for Social Care Inspection, found that:

*“Almost all councils thought quality ratings were a very good or quite good idea, the main unprompted reasons being; because they give an indication of quality or allow comparisons between services; they are easy to understand; and inform people about the choice available.”<sup>5</sup>*

The evaluation of the former star ratings for social care providers (carried out by the Commission for Social Care Inspection) found that:

*“People in all sample groups found quality ratings easy to use. In particular, the ratings helped people to make decisions about which care services to use, especially if they then looked beyond the overall ratings to see the specific nature of the services provided and judged whether they met their individual needs.”*

### Related government policies

The introduction of ratings is in line with the government information strategy and drive for transparency.

Some related government policies are

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<sup>4</sup> Department of Health. 2011. *Impact Assessments for the Health and Social Care Bill*

<sup>5</sup> Commission for Social Care Inspection. 2009. *CSCI quality ratings market research report*

- *The Power of Information – Putting all of us in control of the health and care information we need*<sup>6</sup>
- *The Outcomes Frameworks*<sup>7</sup>
- *Quality Accounts*<sup>8</sup>
- *Quality Surveillance Groups*<sup>9</sup>
- *The National Quality Board*<sup>10</sup>
- *Caring for our Future White Paper*<sup>11</sup>

The introduction of ratings is also linked with future government policies of introducing the roles of a Chief Inspector of Hospitals and a Chief Inspector of Social Care, and there is also a link across to the integrated NHS failure regime and the changes to CQC's powers to issue improvement notices<sup>12</sup>. As such, provider ratings are associated with the Francis report and the Government's response, but also have wider implications beyond regulation and dealing with poorly performing providers only.

### **C. What are the policy objectives and intended effects?**

The ultimate objective is to improve the quality of services provided in acute providers, GP practices and care homes. This could extend to other organisations in the longer term. This aim is to be achieved through interim steps, set out in more detail below.

### **D. Progress to date**

In September 2013, CQC began its first inspections of 18 NHS acute trusts and intends to publish its inspection findings by the end of the year. The 18 trusts have been selected on the basis that they fall into three broad categories of performance based on existing assessments, good, average and poor. This is being done to test if CQC's new inspection model results consistent with existing assessments and why the results may differ.

Of these 18 trusts, three will be provided with a performance rating. Again these published ratings will be divided between Trusts in each of the three performance categories of good, average and poor.

### **Intended effects, and how the policy is expected to achieve this**

Chapter 5 of the Nuffield Trust report gives details about how a single assessment of provider performance may deliver benefits. This is split into five broad areas, around accountability; choice; performance; failure; and reassurance. The following section discusses broadly how this may occur.

<sup>6</sup> Department of Health. 2012. *The Power of Information – Putting all of us in control of the health and care information we need*

<sup>7</sup> Department of Health. 2012. *Improving Health and Care – the role of outcomes frameworks*

<sup>8</sup> Department of Health. 2010. *Impact Assessment of NHS (Quality Accounts) Regulations 2010*

<sup>9</sup> Quality Surveillance Groups are groups set up across health economies, bringing together all those with an interest in quality. More information is available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/156277/Establishing-Quality-Surveillance-Groups.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156277/Establishing-Quality-Surveillance-Groups.pdf)

<sup>10</sup> National Quality Board. 2012. *Quality in the new health system – maintaining quality from April 2013*

<sup>11</sup> Department of Health. 2013. *Caring for our future*

<sup>12</sup> More information about the integrated failure regime and CQC's improvement notices is available in the associated impact assessment, which is published alongside the Care Bill 2013.

Some of the mechanisms identified may fit into more than one of the categories. More information is available in the Nuffield Trust report.

The changes will produce a myriad of benefits. The changes will result in people being more aware of the levels of care they should expect and receiving better care as a result of the changes providers make in trying to achieve higher standards of care. Providers are likely to benefit from having clearer levels of quality that are required to be considered as a satisfactory provider of care. CQC will benefit from having to deal with fewer failing hospitals, whilst commissioners will gain greater understanding of the providers and the quality of care.

### **Accountability**

Ratings will allow the public to hold providers to account for the quality and care services. A comprehensive assessment of the quality of care across providers and the spectrum of performance in England will help the public to demand actions from providers where they believe that providers are falling short on quality. This can either be through campaigns or patient voice organisations or through more official channels such as Foundation Trust membership. The key value of a rating is in its simplicity and the fact that it could be communicated to a wide audience thus engaging more people in scrutiny. The Nuffield highlighted that this would be enhanced if there were an annual newsworthy 'verdict'.<sup>13</sup>

A rating will give a single version of provider performance. Assuming any rating is viewed as credible, there will be clarity about provider performance. This will mean that patients, service users, commissioners, providers and regulators can make more informed decisions, and providers can direct resources at improving services where they think this is most appropriate.

### **Choice**

Ratings would help patients, service users and their carers to make better-informed choices. A single set of ratings would provide the public with a full, accurate and transparent picture of the performance of providers. This helps patients, service users and their carers ability to exercise choice. A rating would provide more clarity and simplicity for the public, assuming it was viewed as both reliable and independent.

Ratings would also provide the public with an interpretation of information. Studies have shown that choice is not just dependent on making data available. As *The Barriers to Choice Review* reported even when people had the right information there was a demand for more face-to-face support for choosing.<sup>14</sup> There is not only a need for a complete picture of performance but that a 'judgement' is made on available data. A ratings system would go some way to providing patients and service users with that judgement.

Ratings would allow commissioners to make better decisions, based on evidence, about services and to agree priorities for improvement with providers. An single set of ratings would provide commissioners with a consistent picture of all providers, not just the providers in their health economy. This would allow them to identify areas of relative strength and weakness, for discussions with providers.

### **Performance**

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<sup>13</sup> The Nuffield Trust. 2013. *A policy worth pursuing – rating providers for quality*

<sup>14</sup> Boyle. D. 2013. *The Barriers to Choice Review – How are people using choice in public services?*



Ratings would ensure that providers place quality at the heart of their planning and delivery processes. The focus on ratings, particularly the emphasis on accessibility for the public would ensure that providers focus on quality. It would provoke regular self-assessment and direct performance improvement activity (institution or department, managerial or clinical).

Ratings will make it clear to the provider about the comparative quality of their services. Ratings would define and report examples of good practice, allowing providers to benchmark and compare their performance. This would be particularly useful for small, isolated providers.

### ***Failure***

Ratings may prompt action by organisations external to the providers. Ratings could encourage greater competition from other providers, enforcement action by regulators, more stringent contract specifications by commissioners, reward for performance through financial incentives, local benchmarking or peer review activity.

### ***Reassurance***

Ratings may make information available easier to understand. By summarising available information to the public, this may mean that the public has more confidence in the quality of services provided, thereby serving to reassure patients and service users, which may have an intrinsic benefit.

The Nuffield Trust is clear that a single assessment is more suited to some of these tasks than others. In particular, it will help with accountability, with choice (particularly in social care), and with performance improvement. The report is clear that any single rating can only be part of an overall package of measures to identify failure and cannot do so on its own. As the report makes clear, the regulator is the “third line of defence” – the first being frontline professionals and the second being senior leaders and boards in an organisation.<sup>15</sup>

## **E. Why is government intervention needed?**

There is currently no definitive, comprehensive assessment of quality across all providers from a credible source.

No body has a statutory duty to conduct ratings. It is preferable to mandate that Periodic Review is conducted to ensure that:

- There is full participation of all providers in the ratings system;
- Ratings include all relevant data, including access soft intelligence and feedback resulting from inspection, currently done by CQC;
- A reasonable process is followed where all relevant bodies are consulted on the methodology and there is an appropriate procedure for providers to make representations against ratings;
- Ratings are aligned with other priorities in the system e.g. the Mandate and Outcomes Framework and complementary to other assessments made in the system; and
- The rating continues in the longer term, as the function is supported by legislation.

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<sup>15</sup> This is on page 79 of the Nuffield Report.

Sections 46-47 of the Health and Social Care Act 2008 enabled CQC to carry out 'periodic review' of NHS and adult social care services in England.<sup>16</sup> This was amended via a provision in the Health and Social Care Act 2012 from 1 April 2013 to remove the periodic review power in respect of NHS organisations.<sup>17</sup>

Without intervention, there is no longer be a power for an organisation to undertake this function. Therefore, any rating would be at the whim of an organisation undertaking it voluntarily, and it could be discontinued with little notice. It would also mean that without this being the responsibility of one particular organisation, there is a proliferation of information about provider performance, making it difficult to identify which providers are high quality and which are not.

### **Pressure from the system**

The Nuffield Trust, as part of the review of ratings systems (see Section B) conducted a large engagement exercise. In general it was found that social care was very positive about the idea of a single set of ratings for providers. The Nuffield received a number of comments on the difficulties that people face having to choose a 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.<sup>18</sup>

Healthcare had more of a mixed reaction, aware of the difficulty of providing one assessment of a hospital but the Nuffield view was that there would be support if done in the right way. Participants were more positive about the idea of a set of dials, allowing access to more granular information.

### **Market has not filled the gap**

A number of private companies have emerged onto the market to fill the gap in quality information with varying degrees of success and credibility e.g. myhealthLondon. The Nuffield Report cited the BBC who 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 4 or 5 star rating in the Sefton area were failing to meet one or more of the essential standards set out by the CQC.<sup>19</sup>

A ratings system could be viewed as a public good that improves patient choice. No one organisation is in a position to reap all the benefits of the production of the rating, so have few incentives to produce it voluntarily. Government intervention to compensate this market failure is therefore essential.

### **F. What policy options have been considered?**

This impact assessment covers a policy that is aimed at improving the quality of services provided, through accountability, choice and stimulating performance improvement. Given that this applies to virtually all Government policies regarding the NHS, it is necessary to constrain the scope of this impact assessment. Therefore, this is restricted to the introduction of an single set of ratings of provider performance only. Other policies aimed at improving the quality of information provided and its accessibility are covered elsewhere (See section B).

Two options are presented below.

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<sup>16</sup> Health and Social Care Act. 2008

<sup>17</sup> Health and Social Care Act. 2012

<sup>18</sup> Walden, 2013 cited in the Nuffield Trust Report

<sup>19</sup> Barnes. 2012 cited in the Nuffield Trust Report

## **Option 1: Do nothing**

Under this option, the Government will make no intervention to introduce a single set of ratings for health and social care providers. This means that the current power CQC has to conduct periodic reviews will be repealed, and it will no longer be the responsibility of any one organisation. This removes the possibility for CQC to undertake a reliable, independent overall summary rating of provider performance.

## **Option 2: Consolidate various provisions to enable CQC to conduct ratings**

This option will consolidate various provisions to enable CQC to conduct ratings. This would require CQC to conduct a review, provide an assessment of the performance of the service providers and publish a report of its assessment. This is an enabling power and it will be for CQC to determine the exact methodology of the ratings and which indicators will be used. In the first instance we expect this to include NHS-funded acute care, GP practices and care homes and domiciliary care agencies.

Sections 46-47 of the Health and Social Care Act 2008 enabled CQC to carry out the periodic review of NHS and adult social care services in England. This was amended as of 1st April 2013 via a provision in the Health and Social Care Act 2012 to remove the periodic review power in respect to NHS organisations. Option 2 therefore is to reintroduce this power to conduct periodic reviews.

Within this option a range of sub options have been considered about who could undertake any review, the sectors that could be covered and what the rating may look like for different sectors

### **Who could conduct ratings?**

CQC has been determined to be the logical choice to conduct ratings.

The Nuffield Trust, after consultation with the sector outlined the key features of an organisation charged with constructing ratings for health and social care providers.<sup>20</sup>

These are:

- 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 ratings 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

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<sup>20</sup> Figure 7.1, p102 of the Nuffield Trust report.

CQC is described as the ‘obvious choice’ by the Nuffield. It has the advantage that it also collects soft intelligence and feedback from inspections, which will be important to any rating to ensure validity. As CQC already conducts inspections, this would minimise any additional costs and duplication of functions. In addition CQC is one of the few organisations that crosses health and social care.

Other options were considered, namely the Information Centre (IC) and NHS England as well as independent or third sector bodies.

Of the alternatives, the IC provides independent data and analysis for healthcare. However, the IC would not have the expertise or soft intelligence to add inspection data into the rating. NHS England also lacks the inspection data, as well as having a conflict of interest given that it would be rating providers from which it commissions services, both directly and indirectly. Finally, an independent organisation like Dr Foster Intelligence would similarly not have access to the soft intelligence from inspections.

In addition, any rating will need to combine data with an element of judgement. A rating will give only an indication of provider quality so the use and interpretation of this rating and supporting data is crucial, as set out in the Nuffield report. CQC is best placed to use its existing information, as well as having the expertise to make this judgement. This will particularly be the case with the introduction of the Chief Inspector of Hospitals and the Chief Inspector of Social Care roles within CQC. Their responsibility will be to take the lead across the system on assessing the quality of care in hospitals. The Chief Inspector will provide oversight to CQC’s inspections, assessments and ratings of providers, identifying both good and poor performance. As a credible and trusted figure, they will communicate these findings to the public.

### Scope

It is intended that the type of organisations to be rated will be set out in secondary legislation. Initially, ratings will cover providers of NHS-funded acute care, GP practices and care homes and domiciliary care agencies, based on the focus of the Nuffield Trust report. As they point out, there is no reason why reviews could not cover other providers in the longer term, though the Nuffield Trust did not have enough time to undertake engagement with other sectors. As and when other providers can be included, further consultation and impact assessments will be done.

### Methodology

There was a strong recommendation from the Nuffield Trust that **performance** ratings should be sector led and removed from political interference. Therefore, in accordance with this recommendation, most of the detail of how a rating is constructed will be for the rating organisation to decide, in consultation with other bodies. This includes:

- The different methods for using indicators to determine what “good” looks like e.g. weighting, thresholds for achievement, tolerances etc.
- The different methods for aggregating indicators into one or more overall ratings, or ways of producing ratings without aggregating at all (e.g. using a small selection of sentinel indicators, automatically setting the overall rating using the lowest rated domain or most common score achieved, etc)
- The different indicators that make up a rating.

**The Care Bill 2013 presently passing through Parliament makes clear that in the future, Government Ministers will not have a power of veto of the CQC, when it comes to the development of the**

performance ratings methodology. CQC will, however, be under a duty to consult on its proposals for the performance ratings system.

There should be different systems of ratings used for different types of providers. A rating of GP practices and nursing homes is considered to be comparatively straightforward whereas the rating of a hospital will need to be disaggregated into clinical teams or service lines. This is because of the likelihood that performance in one service line will not be reflected in all service lines across the hospital. In contrast, it is more likely that a single rating will be reflective of the performance of a clinical team or service line.

The rating will be made up of a mixture of input, process and outcomes measures and will include inspection information. As set out in the Nuffield Trust report, including both process and outcome measures will be important.<sup>21</sup> The rating organisation will need information from CQC, Monitor, NHS Trust Development Authority and NHS England to include intelligence on finance and governance in the rating. This is to ensure that ratings are a complete picture of provider quality.

The rating organisation will need to work with other parties to ensure that any ratings system is a shared approach, and that it fits in with existing policies and initiatives across the system. As CQC is the preferred option for this role they will hold a public consultation and specifically seek agreement from Monitor, TDA, NHS England and all other such persons they consider appropriate. Ratings will be aligned with the Mandate to NHS England, NHS Outcomes Framework, the Adult Social Care Outcomes Framework and Public Health Outcomes Framework.

While the Department will not interfere in precisely how the rating organisation sets up the rating – something that was an important conclusion of the Nuffield report, to ensure there is not inappropriate distortion reflecting political priorities – the Department will issue high-level guidance. This will be based on the recommendations of the Nuffield Report, and will include (for example) the condition that a rating for an acute provider should include a set of dials covering the different domains of quality – safety, effectiveness and experience.

## **G. What are the benefits and costs of Option 2?**

The expected costs of the policy presented in this IA are for the most part qualitative. We provide cost estimates of previous ratings systems, but we cannot count on these as representative of a future system, given the uncertainty around the organisation ultimately chosen to undertake the ratings, the design of the system, the degree of reliance on inspections over and above current levels, any additional data burdens, and the number and types of provider within its scope.

The discussion below around the sub-options is therefore focused on which are the most likely to achieve the desired effects. These are based on the assumption that CQC is the preferred option. Given that the content and shape of the ratings review (methodology, frequency, data sources and resources) will be decided by CQC independently, and will develop over time, estimates of costs, benefits and risks are based predominantly on the Nuffield Trust's report and the Department's assumptions about such a system.

While there is evidence supporting the aims of the policy, little of this is quantified. Therefore, the benefits and costs below are presented as qualitative and non-monetised. Both direct and indirect effects of the ratings are considered.

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<sup>21</sup> Chapter 6 of the report gives more information. Regarding patient experience, it is likely that process measures are more amenable, as well as being more timely. In contrast, outcome measures may only be observable a long time after the event.

The impacts of a future rating have been broken down according to the groups affected. There are four distinct groups:

- a) Patients and service users
- b) Organisation in charge of a single set of ratings
- c) Health and social care providers
- d) Commissioners and local authorities

These groups are central to the ratings review process and to achieving the desired effects, and are therefore those most affected by its development.

### **Patients and service users**

The main aim of introducing the rating is to improve outcomes to patients and service users. Section C above sets the mechanisms through which this is anticipated to be achieved.

One aim of ratings is to enable people to compare providers. This should help patients, service users, their carers and families make better choices about their care. It will supplement the information currently available through NHS choices, the Care Quality Commission and other sources. In turn, this should therefore help improve outcomes from treatment across the health and care system. An independent study published in Archives of Internal Medicine in February 2012 found that hospitals recommended by patients on the NHS Choices website tend to have lower death rates and lower readmission rates, on the assumption that the website guided patient choice of providers to some degree.<sup>22</sup>

More indirectly, once providers are rated, they could be incentivised to take steps to improve the services they provide. This is through a greater awareness of their own performance, peer effects and actions of external organisations. This could result in improved effectiveness of treatments and improving patient experience in particular. This is explored in more detail below.

Although it is assumed that a single set of ratings will benefit patients and service users, some costs could result. For example, there is potential for patient and service user frustration in those cases where they might be unable to exercise real choice of providers (for example, due to distance, time constraints, or financial considerations; or because of limited provider capacity), despite increased awareness and knowledge of the relative quality of different providers. Patients and service users may also be nervous about using services provided by relatively poorly performing providers. This was highlighted as one of the key areas of concern by patients and service users during the Nuffield Trust's public engagement exercise. In addition, where patients and service users are able to exercise choice, they may face increased travel time and cost to reach a more highly rated provider, which are marginal opportunity costs.

### **Organisation responsible for the ratings**

The benefits expected to accrue to the organisation responsible for the ratings will be limited. If the rating system has support from the sector and from patients and service users, there may be a reputational benefit to the organisation. In addition, a rating may focus data collection on what is really

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<sup>22</sup> Imperial College London News Release. 2012. Patients' ratings of hospitals tally with objective measures of the hospital's performance.

important to patients and service users, which could reduce the burden of collection. This links to work that the NHS Confederation is undertaking, looking at reducing the costs associated with bureaucracy.<sup>23</sup>

The development and implementation of a single set of ratings, on the other hand, may impose additional costs on the organisation undertaking the work. It is not possible to quantify these costs at this stage, as this IA focuses exclusively on enabling legislation for CQC to undertake its duty to conduct ratings.

From a qualitative perspective, we estimate that any additional costs imposed on CQC will consist largely of development costs and any additional data analysis that will be required to implement one. It is important to note that CQC currently undertakes inspections, so only additional inspections over and above current ones will have to be considered as part of future cost estimates. It should also be noted that it will ultimately be CQC's responsibility to undertake a thorough cost-benefit analysis after it has designed an appropriate ratings system, once its business planning processes are complete, and while ensuring it has negotiated sufficient funds to undertake this duty.

It is clear that this and other policies related to the Francis report such as the integrated failure regime, are likely to impose an additional burden on CQC. The overall effect upon CQC and its funding will be set out in the full Francis response, which will be published this autumn.

### Cost Impact to CQC of Implementing Ratings

At this stage, the closest examples we have of a single set of ratings are the Annual Health Check (rating NHS providers) and the star rating system (rating social care providers), both of which were undertaken by CQC or one of its predecessors.

Although the Annual Health Check only covered NHS, rather than social care providers, and was not compiled using any inspection information, estimates of development and ongoing costs of that ratings system are the best available information we currently have.

Review	Development costs	Ongoing costs
Annual Health Check (NHS providers)	£4m <sup>24</sup>	£0.5m

CQC has undertaken further work to determine the cost of implementing its new programme of performance assessments which will lead to ratings for providers. This work is being conducted as part of CQC's organisation wide transformation programme, which involves significant changes to CQC's operational processes. The first year costs for the programme are broken down as follows.

	Annual Budget
(All figures in £millions)	2013/'14
<b>New Exec Team</b>	1
<b>National Hospital Inspections</b>	4
<b>Central PMO</b>	3

<sup>23</sup> More information is available at <http://www.nhsconfed.org/priorities/latestnews/Pages/NHS-Confed-to-lead-review-of-bureaucracy-in-NHS-announces-health-secretary.aspx>

<sup>24</sup> This figure includes methods design and development, informatics and analytics. An additional £1m (approx) was spent on publishing (making a product that was understandable to the public, testing it with users, building and refining it.

<b>New Approach</b>	7.6
<b>CQC's Structure</b>	1
<b>Management</b>	0.4
<b>Building CQC's Skills &amp; Talent</b>	0.7
<b>Sustainable Change</b>	0.7
<b>Involving &amp; Engaging Others</b>	1.6
<b>Total Revenue Costs</b>	20

At present, the costs for the development of performance ratings are not disaggregated from the overall costs of the additional £20 million provided to CQC for its transformation programme. All of the changes listed in the table above are intended to enable CQC to become a more robust regulator and obtain credible findings on the performance of providers through surveillance and inspection, from which performance ratings will be derived. The changes are necessary to restore confidence in CQC and give credibility to the Commissions inspection processes, because without these, the public will not have confidence in ratings published.

CQC has not yet published ratings for providers and therefore has not calculated what the costs of publishing and developing performance ratings will be. Clearly the cost for developing ratings will not be £20m per annum and instead this figure reflects the wholesale costs to CQC of ensuring that once ratings are published, they will be viewed as credible.

The new ratings system is likely to be broken down in different ways (by department, by speciality, etc.) and may therefore cost more than previous ratings systems. In particular, it will be costly to include primary care providers (given the heterogeneity of data systems and the difficulty of achieving statistical significance when identifying outliers). As a result, the estimates presented here are only indicative, are likely to underestimate future burdens on CQC and provide the best available estimates we have from past experience, although we cannot take these to reliably represent the likely costs of any future system, which is yet to be designed.

The specific development costs will depend in large part on the shape and nature of the rating system, which is discussed in more detail below. Broadly, the Nuffield Trust has recommended that ratings should be based in part on data collection and in part on inspections, as set out in Chapter 6 of the report. Inspections will be particularly important in rating social care providers, where data-driven aggregation will not be sufficient to make a coherent judgment about quality. Inspections are likely to be announced and unannounced, and both targeted and random. However, CQC currently undertakes inspections as part of its quality regulator role, and should not be double counted in the future, unless a ratings system will require additional inspections.

It is likely, however, that increased staff time, both analytical and managerial, will be necessary to develop and consult on a suitable and credible rating system. **However, much of this staff time will be in parallel with the improvements being made to CQC's surveillance model and new inspections model.** For example, the Annual Health Check, which covered all NHS providers registered by CQC, the staff burden was equal to 16 full-time analysts working to develop the check each year. It is likely that there will be an additional need for analytical resources to compile existing information into a future rating, but this additional burden will have to be determined by CQC once its ratings system is designed.

## Health and social care providers



The relevant literature suggests that the publication of data stimulates quality improvement in providers due to concerns about public image and reputation.<sup>25</sup> One of the key benefits of a rating system could therefore be better and more responsive services. This finding is backed up by research from other countries, where more transparency of information results in improvements in the quality of services provided. For example, studies have examined the effect of ‘consumer reports’ or ‘report cards’ used in the United States for over a decade to provide information on the performance of hospitals and doctors. Marshall et al report that there was evidence that providers respond to the publication of performance data by attempting to improve performance (so-called ‘peer effect’).<sup>26</sup> A low rating therefore may stimulate providers to innovate, economise and enact reforms that could provide more responsive and higher quality services. More recent systematic reviews found similar results.<sup>27,28</sup> Hibbard et al conclude that provider responses to the publication of performance information – regardless of whether patients act on the information – arise because of concerns about public image and reputation.<sup>29</sup>

While these responses will improve the quality of services provided, and are therefore likely to improve patient outcomes as well, there may be costs involved. It is possible that quality improvements reduce costs, either in the short term (for example, through more efficient and effective services) or in the longer term (through improved services resulting in lower readmission rates). It is also possible that quality improvements increase costs, as a result of the investments necessary to enhance services. This is the case for most markets, and is likely to prove particularly difficult for providers in the health care market, where prices are fixed (reimbursement occurs through tariffs or ‘payment by results’ and cannot easily be transferred to ‘consumers’ of health care). In social care, providers may be able to improve quality and offload costs onto self-funders or commissioners

The Table below gives current CQC estimates<sup>30</sup> of the number of health and social care providers across the sectors that are expected to be covered by the ratings review, based on the recommendations from the Nuffield Trust.

	<b>GP providers</b>	<b>NHS/FT Acute</b>	<b>Care homes</b>	<b>Domiciliary care</b>
	8,000	164	8,443	4,927
<b>Total</b>	21,534			

It is likely that the introduction of a single set of ratings will result in both benefits and costs for providers, though indirectly. It is likely that a rating will be based on existing data and inspection information, which implies that there could be no additional burden on providers, and therefore no direct costs associated with ratings. Furthermore, the review conducted by the NHS Confederation (referenced above) may serve to reduce burdens on providers. If ratings were to result in additional data burdens, it could also mean increased staff time within providers to collect, clean and return the data requested, which would be both a direct cost and a potential distortion away from other activities the provider is undertaking. Nevertheless, this is not a direct result of the ratings review – and indeed is already covered by existing

<sup>25</sup> The Kings Fund. 2012. Patient Choice – How patients choose and how providers respond.

<sup>26</sup> Marshall MN, Shekelle PG, Leatherman S and Brook RH. 2000. ‘The public release of performance data: what do we expect to gain? A review of the evidence’. *Journal of the American Medical Association*, vol 283, pp 1866–74.

<sup>27</sup> Fung C. 2008. The public reporting of performance data: an intervention in need of more evaluation National Quality Measures Clearinghouse.

<sup>28</sup> Shekelle, P. et al. 2008. Does public release of performance results improve quality of care? A systematic review. Rand Corporation.

<sup>29</sup> Hibbard JH, Stockard H and Tusler M. 2003. ‘Does publicizing hospital performance stimulate quality improvement efforts?’. *Health Affairs (Millwood)*, vol 22 (2), pp 84–94.

<sup>30</sup> Care Quality Commission (CQC) database. 18 March 2013. *Data Requests Team/Intelligence Directorate*.

work around ensuring that the right information is collected centrally. This is set out in more detail in the review of data returns.<sup>31</sup>

The only direct effect will be that a public ratings will make clear the quality of services provided by different organisations, which may enhance or diminish their reputation. NHS providers spent between £48,000 and £95,000 on the Annual Health Check, depending on the size of the trust.<sup>32</sup> It is difficult to know whether the new rating system would impose an additional burden on providers over and above these estimates, or indeed whether these figures would represent an actual cost – i.e. providers would need to employ additional staff – or an opportunity cost – i.e. providers would need to divert existing staff from elsewhere.

Although these figures provide rough costings of previous ratings systems, they cannot be taken as precise and reliable estimates of the likely costs of any future system. Costs will depend on the organisation ultimately chosen to undertake the ratings, the design of the system, on its reliance on inspections over and above current levels, on any additional data burdens, and on the number and types of provider within its scope.

### **Commissioners and local authorities**

It is assumed that a clear and transparent rating review will make it easier for commissioners (clinical commissioning groups and NHS England) and local authorities to make better decisions about contracting. A public rating will make it easier for commissioners to access data and increase the likelihood that this may lead to more efficient and evidence-based decisions about care. In 2009, a review on the first year of operation of star ratings for social care providers suggested that some councils used the ratings to help level improvement in a competitive market, achieving better value for money. It also found that since the introduction of ratings, there had been a significant reduction in the overall numbers of poor services.<sup>33, 34</sup> However, a rating system may increase pressure on commissioners and local authorities to change the way they commission health and social care services. This could either lead to a decrease in costs due to better contracting and a more efficient use of resources, or lead to an increase in administrative costs as a result of such changes. **The Government has made clear during debates in the Lords on the Care Bill 2013, that where CQC's inspections of providers reveal concerns that poor commissioning practise is leading to unsafe care, the CQC will (with Ministerial approval) be able to undertake special reviews or investigations of commissioning.**

### **H. What are the risks of Option 2?**

There are a number of considerations that must be made with respect to Option 2. Below is a list of challenges, and a discussion of how they could be mitigated:

#### Performance

There is a risk that ratings may over-simplify a complex picture of provider performance and quality. This is particularly relevant for acute trusts, given the heterogeneity of hospitals, their functions and clinical specialisations. It is possible that ratings may be misunderstood or misused by the public, providers, or third parties trying to capitalise on them. It will therefore be important for the responsible organisation to ensure that the necessary caveats are placed around any ratings.

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<sup>31</sup> Department of Health. 2011. Impact Assessment of Fundamental Review of Data Returns

<sup>32</sup> Department of Health. 2008. Impact Assessment of Health and Social Care Bill provisions for future regulation of health and adult social care.

<sup>33</sup> Commission for Social Care Inspection. 2009. *CSCI quality ratings market research report*. London.

<sup>34</sup> Commission for Social Care Inspection. 2009. *Annual Report and Accounts 2008-09*, London: Stationary Office.

The value of a rating lies in it being a single trusted independent source of aggregate information. Therefore, the key risk to patients and service users relates to the possible confusion over the existence of several quality measures and vehicles. Presenting the ratings on a single trusted 'official' site, like Ofsted does for education sector ratings, might be a helpful way of presenting a clear and coherent picture to the public. In addition, ensuring that patients and service users are appropriately consulted in the development phase of any rating system should help prevent confusion that might otherwise arise.

If the rating were perceived as an oversimplification of the truth, this could translate into a lack of trust in the work of the regulator and in the rating itself. In addition, should a rating fail to signal a serious failure of quality (such as in the case of the Mid-Staffordshire Trust), it would undermine its aims. To mitigate this risk, any future rating system will have to be closely aligned with the integrated failure regime that is being developed and the rating system may need to have a 'health warning' to clarify to the public what ratings can and cannot say about the quality of care.

While there are many mechanisms through which a rating can improve provider performance, as set out in Section C above, there are also risks of it resulting in worse performance. Figure 5.3 of the Nuffield Trust report on page 76 sets this out in more detail. It is difficult to say at this stage the extent of these risks.

If there is significant variation in provider performance that results in significantly different patient flows, either in the short term or the long term, this may result in waiting lists at 'good' providers. This serves to reduce the patient experience aspect of their service. That said, this should create the incentive for other providers to respond, thereby bringing their quality closer to that of the 'good' provider.

If a provider's performance is weak, this could become self-fulfilling. This is because a poor rating may result in patients and service users choosing to go elsewhere, thereby leaving providers with diminished revenue sources and likely making it more difficult to attract staff. This could particularly be the case if the rating is poor because of circumstances largely beyond the control of the provider, such as in the case of hospitals with inadequate neighbouring local primary care and social care services. Taken to its extreme conclusion, if a rating system were to be very effective in guiding patient, user and commissioner decision-making, it could imply that poorly performing providers may enter a spiral of decline, which may result in Monitor, CQC or the NHS Trust Development Authority needing to intervene.

Finally, the rating may pick up false positives – i.e. identify providers' performance as being sub-standard when it is not – or false negatives – i.e. not identifying genuine poor performance. This is not least because the nature of statistics is that some outliers are expected. This emphasises the need for a single assessment to be one part of an overall, rather than the sole indicator of provider quality, and that a poor rating may warrant further investigation rather than sanctions, and that a good rating should not preclude further investigation.

## Data

There is potential for an extra burden being placed on providers, both in terms of staff time, costs and data collection. This fear is particularly relevant for social care providers, which may not currently be collecting the type of data that will feed into the rating. There is also a risk that new data available to providers may not be sufficiently robust to feed into a rating that providers feel able to sign off as true and fair.

The Department of Health, NHS England, CQC and other interested parties will work together to ensure that new metrics are available and that data quality is improved. The risk of poor data quality is therefore

one that should decrease over time. The review conducted by the NHS Confederation will also help to ensure that any burden on providers is reduced.

There is also likely to be some delay between the intervention and the outcome of it becoming apparent. For example, Patient-Reported Outcome Measures (PROMs) can have a 6-month lag between intervention and follow-up, with a further delay while data is recorded and collated. Therefore, any assessment will by definition be based on past performance, and so indications of poor performance (or good performance) may be out-dated by the time they become available. This can be mitigated through data being made available and feeding into ratings as soon as it is available rather than only at year end (for example), as well as the rating being used as an indicator only that merits further investigation, rather than a robust, all-encompassing measure on its own.

### Reputation and choice

There is a reputational risk for the organisation responsible for ratings if the system it develops is not perceived as credible, whether due to a lack of legal authority, lack of robust data or a lack of credible standards and indicators. If the CQC were chosen as the responsible agency, it may also face a transitional risk as it shifts from ensuring compliance with essential standards towards a new system.

This risk could be mitigated through:

- ensuring CQC is granted sufficient legal powers to authoritatively carry out its functions;
- ensuring CQC is given adequate funds to carry out any additional functions;
- strengthening the inspection role of the CQC;
- consulting widely with sector stakeholders and test the system adequately before rolling it out nationally to all providers;
- ensuring that whatever ratings are devised are not subject to political interference and changes or reflect political targets; and
- ensuring that an adequate quality assurance process is in place.

There is also the potential that in areas with no choice, the public would be worse off if faced with the prospect of attending hospitals that were rated as requiring improvement or inadequate, without having the choice of going elsewhere. The potential impact of this risk on exacerbating inequality is addressed in the Equality Assessment section of this IA (Section H). It is also possible that high performing commissioners and local authorities will use the information provided by ratings in useful and constructive ways, whereas poorly performing commissioners and local authorities will fail to do so, ultimately impacting on some patients and service users rather than others.

### Provider behaviour

A rating system may create perverse incentives. For example, providers may modify their practices, divert resources to achieve a better rating, change the coding or classification of their clinical activities, game the assessment by generating misleading data, or in extreme circumstances, avoiding certain types of treatments or patient groups if they are likely to adversely affect the rating. It is also possible that providers will focus a disproportionate amount of resources on risks that are measured through a rating system, rather than unmeasured or accounted for elsewhere, which could harm patients in the long run.

Another risk may arise if the performance of a high quality provider weakens when a weaker neighbouring provider leads to excess demand in the first provider. Similarly, the rating and quality provided by a provider may decrease following its merger with a weak performer. In addition, there is a risk that if a rating is not respected and there is no follow up (by the regulator, commissioner or provider) or if the follow up actions of these bodies are misaligned, providers may be happy to accept middling performance on a rating. This could be due to the acceptance of mediocrity or because a rating is not seen to assess the most important aspects of quality. In order to alleviate these risks, it will be important to devise and implement a rating that measures aspects of quality amenable to improvement, within provider control and subject to appropriate follow-up by relevant parties.

A single assessment may result in more legal challenges about assessment of particular providers. When the Annual Health Check was in place, an 'extenuating circumstances' process, which allowed providers to seek exemptions for a variety of reasons, was put in place and used a large amount of staff time and resource. The set up of a formal appeals process may help the regulator and providers prepare, although not prevent this risk from manifesting itself. This is a cost to be borne that is associated with the introduction of the rating, but the cost itself cannot be estimated at this stage. The more effective and accurate the rating is, the lower the associated cost will be as there will be fewer appeals.

## **I. Equality Assessment**

Section 149 (1) of the Equality Act 2010 and the Equality Duty aims to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share a protected characteristic and people who do not;
- Promote good relations between people who share a protected characteristic and those who do not.

It is not expected that a single set of ratings will systematically impact upon groups according to their background, nor is the policy expected to widen inequalities. On the contrary, information that is easier to digest and access should allow all patients to make better health care choices, which would decrease the divergence between people of different backgrounds, in light of the social determinants of health. However, the proposal may have an impact on vulnerable groups, which are considered below. In the future, the Department will commission an independent evaluation of the ratings system (set out below), which will further explore any positive or negative impacts on vulnerable populations and their direct or indirect effect on inequality.

The evidence is generally positive about the effect of publishing information, and demonstrates that patients are keen to have more information about health providers.<sup>35, 36, 37</sup> While the evidence is less clear about the use that patients have made of this data in exercising choice, the existence of a clear and simple rating could provide a valuable platform for patients to be more consciously involved in the choice of providers. However, the literature does warn about the impact of such reporting on 'vulnerable'

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<sup>35</sup> Fung C. 2008. The public reporting of performance data: an intervention in need of more evaluation National Quality Measures Clearinghouse.

<sup>36</sup> Schneider E.C. and Lieberman T. 2001. Public disclosed information about the quality of health care: response of the US public Qual. Health Care, Vol.10, pp96-103.

<sup>37</sup> Robertson. R and Burge. P. 2011. The impact of patient choice of provider on equity: analysis of a patient survey Journal of Health Services Research & Policy, Vol 16 Suppl 1, 2011: 22-28.

population groups – such as people on low incomes, the less educated, chronically sick or people from ethnic minorities.

Evidence shows that certain groups are better able to make use of published information on quality than others.<sup>38</sup> The *'Barriers to Choice Review'*<sup>39</sup> found that people without access to computers or cars are at a disadvantage when it comes to exercising choice. Therefore, while exclusion rates may remain constant, the gap of relative quality between groups may widen, thus increasing inequalities.

In addition, in wealthier areas, patients may look at the ratings and vote with their feet – the assumption is that they have a choice of providers; and regulators can decide to shut providers on the basis of quality considerations without posing major risks to access and continuity of services, due to the abundance of services available. In poorer areas, patients may not have that choice because they cannot afford to travel. Regardless of how bad services are, bad services may be perceived as better than no services, both for patients and regulators.

There are ways, however, to mitigate against some of the more negative impacts:

- Documenting and evaluating any differential effects of publicly reporting healthcare quality information
- Making specific efforts to address the information needs of 'vulnerable' groups – for instance providing information that recognises social and cultural information needs and not just information on diseases and clinical procedures
- Over-sampling minority groups and stratifying data
- Using appropriate risk-adjusted methodologies when reporting information

While mitigating action can and will be taken to minimise potential adverse impacts on different population groups, more critically, the effects need to be properly evaluated.

The Nuffield Trust has suggested that standards for the rating will be sector-led with public input and feedback, to ensure a rating that contains accurate information and provides a balanced view of healthcare services. This should help provide some assurance that ratings are representative of the local population's needs and views. Ratings therefore have the potential to enable local individuals and groups in the equality groups to play a greater role in holding local providers to account for the services they receive. Local flexibility in partly deciding on the content of a rating will, we hope, also give providers, with additional encouragement from local commissioners, an incentive to improve equality for under-served and discriminated groups in local populations and to report on their initiatives.

Ratings will be accessed by a variety of people, from members of the public to Medical Directors, prospective employees to commissioners. The organisation responsible for implementing the ratings will also have to ensure that ratings are accessible to all, in order to meaningfully support patient choice. Any guidance the Department or the responsible organisation will issue may have to ask that providers consider the communication needs of their local community and whether it is appropriate to communicate all, or part, of a rating in different languages or formats (e.g. Braille). It should also

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<sup>38</sup> Comptroller and Auditor General. 2000. Good practice in performance reporting in executive agencies and non-departmental public bodies.

<sup>39</sup> Boyle. D. 2013. *The Barriers to Choice Review – How are people using choice in public services?*

consider distribution methods for those members of the community who may not have access to the internet, having regard to their duties under equality legislation when preparing their rating.

Below is a summary table of the specific impact tests that we have considered as applicable to this policy:

<b>Test</b>	<b>Applicable?</b>
Competition	No
Small firms impact	No
Legal aid	No
Sustainable development	No
Carbon assessment	No
Other environment	No
Health impact assessment	No
Equalities assessment	Yes
Rural Proofing	No

## **J. Post-Implementation Review**

While the evidence suggests that a rating can be helpful, it is contingent on how it is constructed. This means that the implementation of a rating will be vitally important to the extent of its success. There are also risks identified above, the majority of which can be mitigated but some of which are not.

Therefore, an evaluation about the operation and the effects of the rating is likely to be both helpful and necessary. This should cover both its effects and the process by which it has been developed and implemented. A commitment to undertaking an evaluation to inform future development of the ratings was also set out in the initial Francis response. The precise timing and content of an evaluation will be decided in due course.

## References

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