INFORMATION IS POWER – WHY RATINGS OF CARE SERVICES NEED TO RETURN

Summary

Published, independent, ratings of the quality of care services would be a great help to consumers, providers and commissioners in distinguishing between services in the adult social care marketplace – and in driving improvement.

It is more straightforward to (re)introduce ratings in social care than in health. Progress in adult social care does not need to wait for the development of an NHS system.

Most current or planned initiatives provide useful public information but operate on a voluntary - and therefore patchy - basis.

The most cost-effective, logical and consistent solution is for the Care Quality Commission to award ratings for social care quality.

CQC will need to attend to a number of operational and methodological issues in order for the sector - and the public - to have confidence in such ratings.

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Introduction

Imagine your mother of 88, living in Colchester, has advanced dementia which means she can no longer live at home. She does not need constant nursing so you look for a residential care home where she can be safe, comfortable and content. You look at a number of websites, including that of the regulator - the Care Quality Commission - for appropriate care homes for people with dementia. You limit the search to a 10 mile radius of Colchester, so that visiting will be easy. Within seconds a list of 19 care homes appears. But the information seems mainly about the facilities or whether the home complies with essential regulatory standards of safety and quality. You cannot tell which homes just meet those standards and which are outstanding. Nor can you research and visit 19 homes – how do you choose which ones to look at in depth?

This dilemma is all too common for those seeking to choose or arrange care for themselves or a loved one. It applies to home care services/providers as much as to care homes. There is a pressing need for better benchmarking information for consumers to exercise effective choices. That's why a recent announcement from Secretary of State for Health, Jeremy Hunt, deserves more attention in social care circles than it has yet received. Mr Hunt said:

"I know how well each school in my constituency is doing thanks to independent and thorough Ofsted inspections. But because the CQC only measures whether minimum standards have been reached, I do not know the same about hospitals and care homes.

"I am not advocating a return to the old 'star ratings' – but the principle that there should be an easy to understand, independent and expert assessment of how well somewhere is doing relative to its peers must be right."

He went on to announce that he had asked the Nuffield Trust, to review *"how this might be achieved in a way that does not increase bureaucracy."*

Mr Hunt's speech was focussed mainly on hospital care and on the need to empower consumers in the same way as Ofsted empowers parents – through simple and understandable ratings awarded by a body with a strong "brand" and level of public trust.

He included adult social care in his remarks but, as this paper argues, there is a more positive history of "star ratings" in social care and a more straightforward way of making progress there, to the enormous benefit of consumers and families. Of course there

are complexities but nothing to match those involved in boiling down everything done in a £500 million a year tertiary hospital, with rapid patient turnover, to a single descriptor. And social care is already a real market, with real consumer power - 90% of all services are already delivered by private or not-for-profit providers, not the public sector; and around 50% of all new care home places are purchased by individuals, not councils or Clinical Commissioning Groups. Comparisons with the NHS are therefore unhelpful and approaching health and care in the same way, whilst sensible in some circumstances, simply does not work for this issue.

A brief recent history

It is true to say that the "star ratings" awarded by health regulators in the 2000s were unpopular with managers, professionals and other staff who claimed they measured the wrong things and were too "politicised". By contrast, Quality Ratings in adult social care quickly received considerable support amongst providers, commissioners and other key bodies as well as the public. Introduced in 2008 by the then care regulator, the Commission for Social Care Inspection (CSCI), they were only in existence until late 2010 but, despite initial concerns from the care sector, rapidly became so accepted that their demise was much regretted across the sector.

In April 2009, the Care Quality Commission replaced CSCI and the Healthcare and Mental Health Act Commissions. The legislation setting up CQC explicitly required it to perform its functions so as to encourage:

- the improvement of health and social care services;
- the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and
- the efficient and effective use of resources in providing health and social care.

However, CQC – and the Department of Health – appeared to take the view that their core remit was to monitor and enforce compliance with essential standards of quality and safety - as a pass/fail or MoT system rather than a more graded, Ofsted-type approach. Arguably it was therefore logical for it to go on to say that it could no longer differentiate between excellent services and those which were barely compliant and as a result could no longer award quality ratings.

Interestingly, Health Ministers, clearly aware of the limitations of the pass/fail approach, later requested CQC to devise an alternative scheme which could award the label of "excellent" to a small percentage of top performing services, estimated at some 10-20%.

Following substantial opposition across the sector to the system which CQC proposed, it was obliged in late 2011 to abandon plans for the excellence award because of several concerns which remain relevant:

- **Voluntary nature of the scheme.** It was widely felt that a voluntary scheme would be confusing for the public and would not facilitate choice between providers who had applied for the award and those who had not.
- **Preference for a graded system.** Many respondents felt that a scheme which recognises the stages in between essential and excellent would better enable choice and motivate providers to improve.
- **Clarity and detail.** Many respondents felt that a lack of clarity and detail in the proposals (particularly as to the level of charges) made it difficult to respond.
- **Proposed timeline.** There was concern that the proposed timeline was unachievable.
- **Use of assessor bodies.** There was widespread concern about the potential for inconsistency of assessments made by multiple awarding bodies.
- **Costs to providers.** It was widely felt that the potential costs would discourage applications for the award and disadvantage smaller providers. Concerns were raised specifically within the context of rising fees for registration.

Whatever the merits of these arguments, the outcome has been counter-intuitive. Whilst Ministers rightly proclaim the importance of information, competition and choice as drivers of better and more efficient services, there is less independent information today to help people make care choices than there was 2-3 years ago.

So why do consumers need ratings?

Despite the current position, few would argue against the proposition that people need more and better information with which to choose care and support services. This is particularly true of regulated services such as residential and home care which increasingly cater for those with complex or multiple needs and

whose quality can have a major impact on a person's whole quality of life. Choice of care home is difficult to change later and, of course, these services are in a genuine consumer market, where many residents pay out of their own pockets. In parts of the Home Counties, it is said that over 80% of new care home places are by such "self funders" and the national average across care services is approaching 50%.

So it is hardly surprising that little-noticed market research commissioned by CSCI and published in March 2009, less than a year after quality ratings were introduced, suggested that consumers liked them as a source of trusted information, though they used other sources too, especially visits and recommendations from family and friends. The research's overall conclusion in relation to people using care was that:

"Amongst people who use services and their families, quality ratings are seen as a good idea and a helpful factor in decision-making when choosing a care service. Whilst awareness and usage of the ratings varies between service type and by whether the person is the individual using the service, a relative or carer, this represents a good start to a new, accessible source of information about care services."

CSCI Quality Ratings – Market Research Report by Continental Research.

Why do providers value ratings?

Providers were initially hostile to the notion of quality ratings, fearing a simple one-word description could harm reputations and businesses. However, within a few months they had completely turned around. As the Chief Executive of Four Seasons Healthcare, Britain's largest care provider, said recently:

"I thought [star ratings] were a most powerful way to encourage providers to take a good look at their services against an external, objective benchmark. They were a fantastic internal tool."

As well as an internal management lever, providers used their quality rating in promotional material, often citing the independent nature of the judgement. The current compliance regime simply does not give consumers or managers enough differentiated information; in the most recent CQC state of care report, 73% of all health and care services were described as "compliant with all standards" at the end of March 2012 and in social care most standards were met by at least 80% of providers. This gives insufficient granularity for informed choice, without a lot of further

research by individuals. Even then some internal processes are very difficult for individuals to judge.

Did commissioners find Quality Ratings useful?

The CSCI research showed that local authority commissioners had the greatest awareness of Quality Ratings. The report said:

"In councils, there was an almost universal awareness of the quality rating scheme. 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".

Ratings also helped commissioners focus on driving improvement, not just deal with failure. Some councils used them to incentivise commissioning, paying premia for higher quality. It is also possible that an independently-verified rating could reduce the need for duplicate inspections by councils as well as CQC – which is a growing and costly problem, partly driven by the lack of an external rating system. In addition, some councils have their own grading system – one has 8 elements, others only 4. It is doubtful that the public, faced with different schemes using different methodologies, would easily be able to make sense of this information.

Why not simply rely on consumers using websites and published data?

Some argue that, as social care is a market, consumers should just be provided with clear, accessible information and left to make their own choices. That argument has merit and some recent initiatives seek to support that approach:

- New websites, such as the Good Care Guide, Find Me Good Care and NHS Choices, are springing up all the time, providing useful information about care options and how to pay for them as well as on the quality of particular services.

- Similarly, approaches like the Transparency and Quality Compact run by some provider trade associations will provide a raft of useful data on such areas as:

  - staff turnover (both home care and care homes)
  - ratios of trained to untrained staff (both home care and care homes)

- % residents developing new pressure ulcers (care homes)
- number of medication errors (care homes)
- appointments carried out at the agreed time (home care)

These schemes all enhance the information available to care consumers and their families. However, they suffer from being voluntary, act as portals rather than assessors and may require the provider to pay to join. They cannot solve problems which the public rightly raise:

- Are any reviews or judgements completely independent of providers?
- Even if they are, are they consistent across different providers?
- Do they cover the less good providers or just the better ones who are naturally keen to showcase themselves?
- Given the proliferation of websites, which ones should the public trust?

Who could award an adult care rating - and how would it work?

So – having multiple awarding bodies is likely to be costly and unpopular; and voluntary approaches are bound to have patchy take-up. Nor can consumers rely on an adequate supply of useful, regular and consistent data across the 12,500 or so separate providers operating in over 25,000 locations.

Add to this the Secretary of State's injunction that any new ratings system needs to both command public confidence and minimise bureaucracy – and everything points to the Care Quality Commission as the body best placed to take this on. This is a logical conclusion because CQC:

- is the only organisation in contact with all regulated services in respect of care quality and so able to make considered and regular quality assessments, against agreed benchmarks.
- already charges fees to regulated providers, wants to use those fees to incentivise provider compliance with standards and has a strategy which encompasses frequent and robust inspections. Any alternative awarding body risks putting up costs to providers, and duplicating CQC activities, whereas CQC might absorb these costs or charge only a modest addition for awarding ratings.
- has said in its recent strategy consultation that it plans to "move

towards regulating different sectors in different ways."

- could build on the short but powerful track record of Quality Ratings.
- has the legal power to award ratings under its "periodic review" function.

Would giving this responsibility to CQC overload an organisation with a very wide remit and widespread concerns about its past performance? Any inadequate performance obviously needs to be tackled but cannot in itself justify avoiding placing responsibilities in the most cost-effective place, especially as the new CQC Chief Executive has made clear his determination to emphasise its statutory improvement function.

BUT if the job of awarding ratings were given (back) to CQC, it would need – as the Health Select Committee recently emphasised – to:

- Work hard to gain the public's and the sector's trust and to build a reputation for competence;
- tackle head-on the issue of consistency between inspectors;
- develop an appropriate methodology whereby the ratings award flowed from the inspection evidence and judgement. There is also a strong argument for developing grade descriptors as Ofsted has done, so everyone is clear in advance how to achieve different levels of award and what they mean;
- be able to differentiate quality at several levels. The categories could be: under enforcement action; requires improvement (because non-compliant with essential standards); satisfactory (ie compliant); good (ie compliant for several years consecutively) and excellent/outstanding.

Guidance on the dimensions of good and excellent care is already available from the "Think Local, Act Personal" Partnership, including work by the Social Care Institute for Excellence in defining excellence. This could be developed into advice for CQC inspectors.

What about non-regulated care services?

Personalisation in care, and the growth of Personal Budgets, have increased the number of micro, unregulated services, operating at small scale. It could be unpopular and difficult to bring them

within the scope of any award scheme, whether or not run by CQC, and could be costly. In practice they are likely to need to rely on local schemes and awards, such as the Quality Mark developed by Community Catalysts and run by some councils.

Would the NHS need to operate the same system?

Some may argue that an integrated health and care regulator could not award ratings in care without doing the same in health. As well as risking real overload for CQC, the same approach does not have to apply universally, even with one regulator and one set of overarching standards, as the regulator itself increasingly acknowledges.

So, whilst in time CQC might award ratings in health as well as care, it seems sensible to begin with a sector which would strongly welcome their return, subject to the caveats outlined above. In the short term, a different approach, perhaps based on published data and metrics, might be more appropriate for the NHS.

Conclusion

The Secretary of State is absolutely correct to say that the public, as well as providers and commissioners, require better, more graded, information from an expert source about the quality of health and care services. This paper argues that it would be wrong to wait for the complexities of doing this in health to delay an obvious, logical and cost-effective "quick win" in adult social care – namely, that the regulator should again award ratings for regulated care services.

David Walden, Public Policy Consultant

for the Voluntary Organisations Disability Group and the National Care Forum

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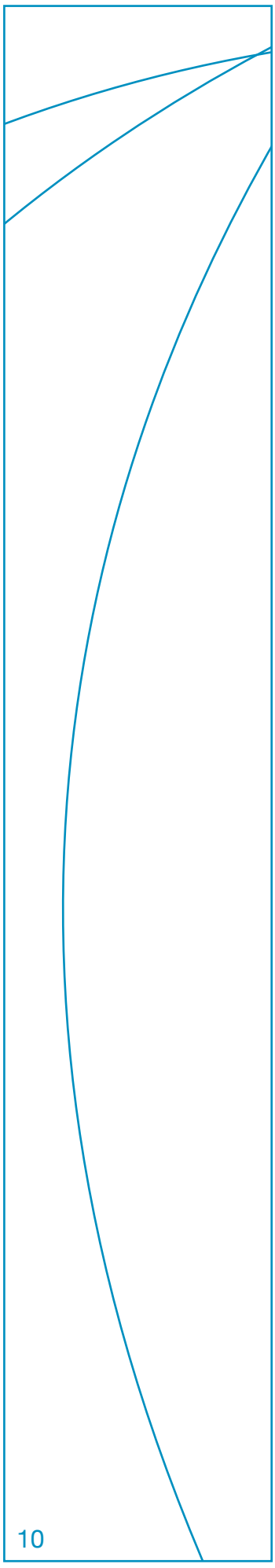
David Walden has worked for the Department of Health, CSCI (where he was Director of Strategy from 2004 to 2009) and SCIE. He has also had spells at Anchor Trust and Poole Hospital.



The National Care Forum (NCF) is a membership organisation with a clear purpose to promote quality care outcomes for people who receive care and support services through the not-for-profit sector. The membership reflects the wide diversity of the care sector and includes home care, housing with care, day care, intermediate care, outreach services, residential and nursing care and specialist provision for all adults and older people. Our combined resources include considerable business, operational and managerial skills and, by working together, we seek to make a positive impact on outcomes.

The Voluntary Organisations Disability Group (VODG) is a national grouping of voluntary sector social care providers. We bring together the separate skills, experiences and knowledge of individual member organisations to share learning, challenge barriers, influence social care policy and promote best practice. Our members support people of working age with a wide range of physical, sensory and cognitive impairments.

VODG and NCF members, in partnership with local and national government and the NHS, provide social care services to around a million disabled people, employ more than 150,000 staff and deliver in excess of £3.5bn of publicly funded services, the majority of which are registered with the Care Quality Commission.

Together we are therefore uniquely placed to comment on the current health and social care ratings review commissioned by the Secretary of State for Health to determine whether aggregate ratings of provider performance should be used and how best this might be done.

www.nationalcareforum.org.uk

www.vodg.org.uk