

Final report

Public attitudes towards health and social care ratings

Summary report prepared for Nuffield Trust by Ipsos MORI

11/03/13

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Social Research Institute

Introduction

Background and objectives

- Nuffield Trust has been asked by the Department for Health to undertake an independent review on the aggregate assessment of providers of health and social care.
- As part of this review, Nuffield Trust commissioned Ipsos MORI to conduct a small piece of qualitative research with the public to explore views around a ratings system for GPs, hospitals and care homes. In particular, this sought to address the following objectives:
    - understand public views on ratings systems for other services e.g. hotels, schools;
    - understand how users and potential users gather information on health and social care services and where a ratings system might fit within this;
    - explore how helpful it would be to have simple, summary ratings for GPs, hospitals and care homes (or whether service or departmental information might be better);
    - to understand how the ratings could be made most useful, what sort of information should be taken into account and how the ratings should be presented;
    - to understand how robust the ratings would likely be; and
    - to understand the similarities in this regard between GPs, hospitals and care homes.
- This report presents a summary of the findings from the qualitative research.

Methodology and interpretation of the findings

- Three focus groups were conducted with the general public between 4th and 6th March 2013. One discussion group was conducted in London, and two conducted in Sittingbourne, Kent. Each group consisted of eight participants.
- Participants for the groups were recruited based on a number of criteria
  - Social grade (two groups were social grades A, B and C1 – one in London and one in Sittingbourne – and one Sittingbourne group included social grades C2, D and E);
  - Having primary school aged children;
  - Having experience of choosing a care home in the last 12 months (e.g. for an elderly relative); and
  - Having experience of non-emergency hospital treatment in the last 12 months.

- As outlined previously, this report presents a summary of the findings from a small-scale qualitative research exercise conducted by Ipsos MORI. Analysis was carried out through detailed moderator analysis sessions, during which fieldwork notes were analysed and findings brainstormed. Sessions took place during and after the fieldwork period.
- Qualitative research is not designed to be representative of the views of the public in general, but to provide insight into the perceptions, feelings and behaviours of participants in the groups.

Making choices about services

Choosing consumer goods and services

- Generally, participants across the groups had experience of making use of the internet for seeking out information on consumer goods and services.
- Primarily, when it comes to consumer goods and services, it seems that people were interested in comparing goods based on price as well as perceived quality.
- Where reviews were sought out, greater weight seemed to be placed on ***customer reviews***, rather than ***expert reviews***.
- The use of reviews depended on the good or service being considered, for example, reviews were used for holidays, but less so for purchasing consumer goods.
- Whilst ratings systems, such as that available on Tripadvisor, were referenced, and some participants had used these, customer reviews were often considered to be more useful. Customer reviews provide more information for decision making, whereas customer expectations of what constitutes 3 or 4 star service varies.

Choosing public services

- For choosing public services in general – such as libraries, leisure centres – primary sources of information for informing a choice seemed to be word of mouth and personal experience – hearing about things from friends and relations, and looking around.
- For schools, whilst experience and knowledge of Ofsted ratings themselves varied there was a relatively high awareness of Ofsted and their role in regulating the education sector.
- It was generally agreed that Ofsted ratings were a useful tool, but that the ratings need to be used in conjunction with the more detailed report.
- In Sittingbourne, an area of lower choice relative to London and other larger cities, there was some discussion of the idea that ratings are undermined if you don't feel that you can make the choice. If you are not in the catchment area for any 'outstanding' schools then you can't make that choice.
- Most people who had recent experience of choosing a school had used Ofsted ratings and/or reports in some way. However, nobody seemed to have relied upon Ofsted ratings – some had used them, but not as sole basis for their decision.
- In contrast to the high awareness of Ofsted, CQC and other health and social care regulators were relatively unknown.

Rating health and social care

Is the concept of ratings transferable from education to health and social care?

The idea of a ratings system for health and social care is premised on the application of a ratings system such as the Ofsted system employed in the education sector. To understand public attitudes towards such a ratings system, it was crucial to understand how compatible health and social care services are with a ratings system. Based on the systems in place and public perceptions across the groups, the table below outlines some of the factors that make a ratings system a suitable fit in an education setting, and compares hospitals, care homes, and GP services. Many of the similarities and differences will be shown throughout this summary report to have driven perceptions across the groups.

Schools	Hospitals	Care Homes	GPs
Local – *education as a local rather than national service.*	**National –** *health as a national service.*	**Local –** *a local market for care homes.*	**Local –** *GPs as a local rather than national service.*
Planned – *choosing a school has a long lead-in time.*	**Unexpected –** *choosing a hospital is often an unexpected decision.*	**Planned –** *choosing a care home often has a longer lead-in time.*	**Planned –** *choosing a GP can have a long lead-in time, but choice can also not be considered until needed.*
Long term commitment – *a school is a long-term choice as, once chosen, a child will be there for a number of years.*	**Short term commitment –** *in many cases a hospital is a short-term choice, in respect to one acute condition.*	**Long term commitment –** *a care home is a long-term choice.*	**Short term commitment –** *possible to change GP within and between practices.*
Perception and availability of choice - *people are used to the concept of making choices for schools.*	**Perception and availability of choice –** *perception that choice of hospital is limited or non-existent.*	**Perception and availability of choice –** *greater perceived choice for care homes.*	**Perception and availability of choice –** *perception that choice is limited by catchment areas.*
Wide engagement – *all pupils are affected by all aspects of a school.*	**Narrow engagement /complex service –** *patients engage with just one department of a hospital.*	**Wide engagement –** *residents are affected by all aspects of a care home's service provision.*	**Wide engagement –** *all patients are affected by many aspects of a GP service, though it is often though one GP.*
Stability – *service and quality is stable over time, change (positive or negative) is slower paced.*	**Less stability –** *service and quality is more variable over time and across different aspects.*	**Stability –** *service and quality is stable over time, change (positive or negative) is slower paced.*	**Stability –** *service and quality is stable over time, change (positive or negative) is slower paced.*

Reactions to ratings for health and social care services

- The initial reaction to the idea of ratings for health and social care services amongst the groups was mixed.
- Opening thoughts were often that the concept of ratings was useful – but this did vary across the groups, and also across services. Whilst there were still advantages to a rating system identified by the groups, as discussions progressed, several overall disadvantages were outlined as detailed below.

PROS

- Poor ratings could drive underperforming services to strive for improvement
- Useful as a point of reference, but not necessarily primary factor in a decision

CONS

- Not useful if you don't have a choice
- Difficult to implement – different departments in a hospital, different GPs in a practice.
- Not needed - level of service is, or should be, the same across all.
- Would the NHS just be rating itself?
- Detrimental effect of ratings – best services become oversubscribed and quality suffers.

Initial reactions to ratings for health and social care services – a matter of choice

- As outlined previously, the idea of choice was important to how comparable the idea of ratings for health and social care was to an education based rating, and subsequently how favourable participants were to the use of ratings. Therefore, predetermined beliefs and ideas about choice guided initial reactions to the idea of ratings.

Less positive about ratings

Many felt there was a lack of choice in healthcare.

•Experience of GP catchment areas restricted the idea of choice.

•Lots of people didn't think they had a choice of hospital - they assumed a catchment area system was in place (like GPs) or that there were very few to chose from where they lived.

More positive about ratings

Some people had more experience of making a choice in hospital care for their children and were generally more positive about ratings in this setting.

Where people felt they had a choice of private care they were generally more positive.

But people were not necessarily concerned about a lack of choice in healthcare, which tended to be driven by a belief that a national service should be relatively equal and unaffected by local demographics or characteristics.

Rating GPs, hospitals and care homes in detail

Reactions to ratings for health and social care services

Establishing more detail on the relative appetite for a rating system for GPs, hospitals and care homes amongst participants was not completely clear cut.

While, one of the groups in Sittingbourne were more in favour of a rating system for GPs and hospitals than other groups, even within this group views changed and differed.

However, it was clear that overall there was far less appetite for a rating system for GPs and hospitals than for care homes. Across all three groups there was value seen in a rating system for care homes.

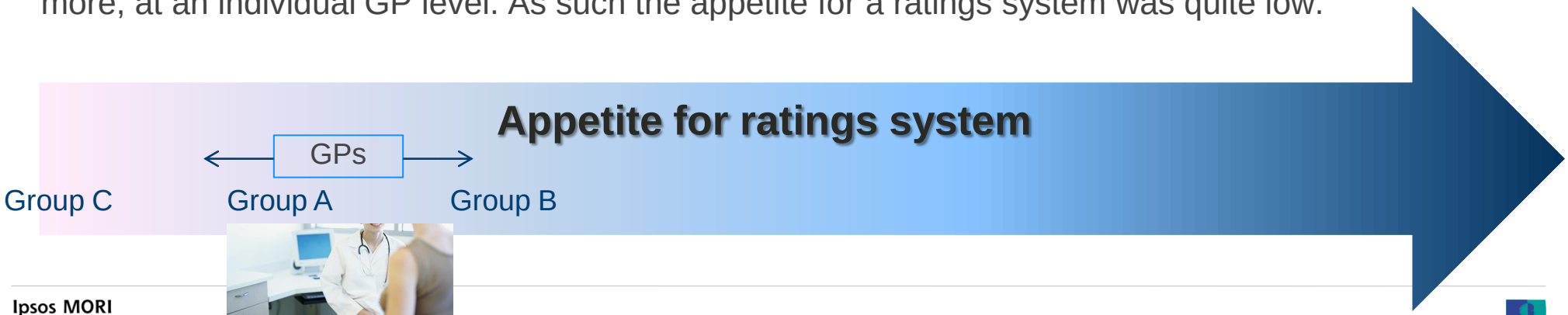
The following slides outline the views of participants on ratings for GPs, hospitals and care homes in more detail. The arrow at the end of each slide indicates the relative appetite for a rating system in that particular setting. To give a greater sense of weight the differences across groups are indicated:

- Group A is the London based group (social grade ABC1);
- Group B is one of the Sittingbourne based groups (social grade C2DE); and
- Group C is the other Sittingbourne based group (ABC1).

Reactions to ratings for health and social care services

Ratings for GPs

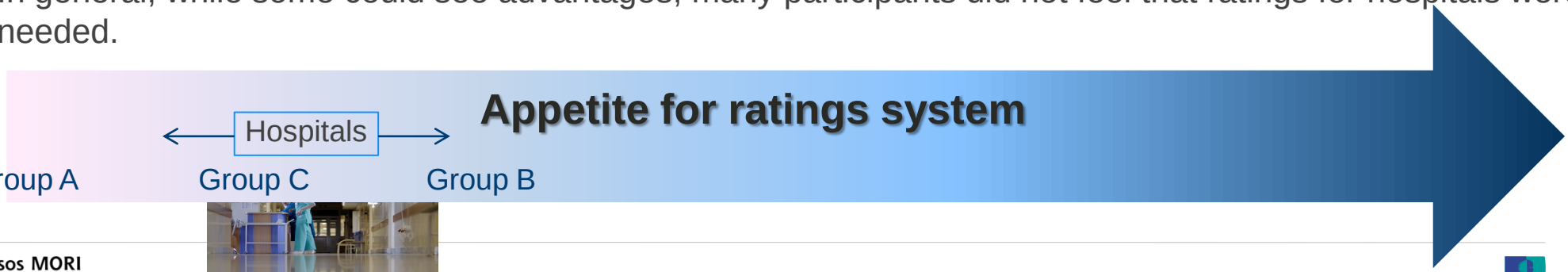
- There was a perceived lack of choice in terms of GPs: people felt restricted by catchment areas and, to some extent, the need to make a decision quickly if it had not been considered until a need arises.
- Experiences with GPs was considered to be a very personal issue – ratings could be seen as objective, but what one person likes about a doctor, others could easily dislike.
- It was felt that all GPs should all be good, but it was felt that beside manner may vary.
- Therefore, more personal reviews were seen to be important for GPs. Across groups, participants currently relied on word of mouth for this, rather than sites such as NHS Choices or other websites.
- General consensus across the three groups that an overall rating for GP practices would not be practical, and that if ratings for GPs were to be useful, they would have to be broken down more, at an individual GP level. As such the appetite for a ratings system was quite low.



Reactions to ratings for health and social care services

Ratings for hospitals

- Some feeling (across ABC1 participants in particular) that for hospitals ratings shouldn't be necessary - as every hospital should be giving the same level of care.
- Related to this there was also some opposition to the idea of the competition a ratings system might bring or indicate as already in place.
- The cost of introducing a ratings system in this setting was also questioned by some.
- Amongst those who were more in favour of, or who could see the benefits of, having some form of rating system for hospitals, there were a couple of points of general agreement:
    - Ratings should be department of ward based as there would be variation across the hospital e.g. bad experiences of hospital overall, but one specialist unit very positive.
    - They would need to take into account patient feedback, but there was also seen to be a role for independent regulator here.
    - Patient reviews, not just a star rating/score, should be available.
- In general, while some could see advantages, many participants did not feel that ratings for hospitals were needed.



Reactions to ratings for health and social care services

Ratings for care homes

- The concept of a ratings system for care homes was received more favourably across all groups.
- Reasons why ratings considered to be more useful here included:
    - Choosing a care home for a relative is a process that takes a longer period and means there is (usually) more time to consider options;
    - A care home is more of a long term commitment – and often it's for a close family member;
    - Often you're making a financial contribution;

- As with hospitals, it was felt that ratings would need to be made up from a number of components, but these would be different to those for a hospital. Instead they would be based on elements of the experience (such as quality of food, time spend with residents etc.).
- BUT – whilst participants thought ratings would be useful they generally felt they would not be the key factor in choosing a care home: they would be helpful in informing choice, but there was a perception that reality could differ from the rating and as such they felt they would need to go in and visit care homes personally. This made them similar to schools however.

Appetite for ratings system

All groups

Care homes

Summarising the use and impact of ratings

How useful did the public think ratings would be?

- **If choice possible** – i.e. if range of services exists, and if choice is allowed.
- **If care long-term** – placing somebody in a care home, choosing a hospital you will be visiting for the same treatment regularly
- **For a simple/homogenous service** – that ratings/reviews can easily evaluate
- **For private health and social care** – more lies power with patient/user to make choice

Would ratings be useful and important?

- **If no choice exists –** ratings system undermined if lack of ability to use this to make a choice.
- **For complex/diverse services –** a meaningful ratings system would be difficult to implement.
- **For short-term care –** ratings less useful, decisions may need to be taken quickly.
- **If there is a trusted mediator -** to assist choice (e.g. GP) then ratings would have lesser role.

What would the impact of having a ratings system?

- **Performance improvement –** poor ratings could drive poor services to shut down/improve service.
- **Enable exercising of choice** – provide information on which to base a choice.

Would would be the impact of a ratings system?

- **Cost** – expensive to put into place.
- **Prevention of choice** – unable to gain access to “outstanding” services – long waiting lists
- **Performance decline –** “outstanding” services oversubscribed – if take on all patients who want to go there – standards could slip
- **Wouldn’t be a guarantee** - mistakes would still happen in “outstanding” hospitals
- **Reduce satisfaction in current service** - might be happy with it, but if it is rated badly, would question that decision
- **If national –** if all services in an area ‘inadequate and unable to travel, would have to settle for substandard care.

Choosing strategies

The journey to using ratings

•Across both the commercial and public service settings, there was a clear choice strategy journey outlined to access and ultimately use a rating system.

-Firstly, people needed to believe that they had a choice. This was evident in the choice of care home in particular, where it resonated most with the feeling of choice of school and when purchasing a product.

-Secondly people needed to feel that the choice mattered. Indeed, even where people believed they had a choice in GP or hospital, they tended not to be as concerned about making a choice in these services. This was most prominently seen with hospitals, where there was a strong view amongst many participants that the service should be equal across the country and so choice should not be needed and was not as desirable.

-Once people believed they have a choice and they wanted to make a choice, they needed to have trusted sources of data available to them. This could include peer reviews, but people recognised the bias that can appear in peer reviews so data from another trusted source, such as a regulator, was seen to be of value.

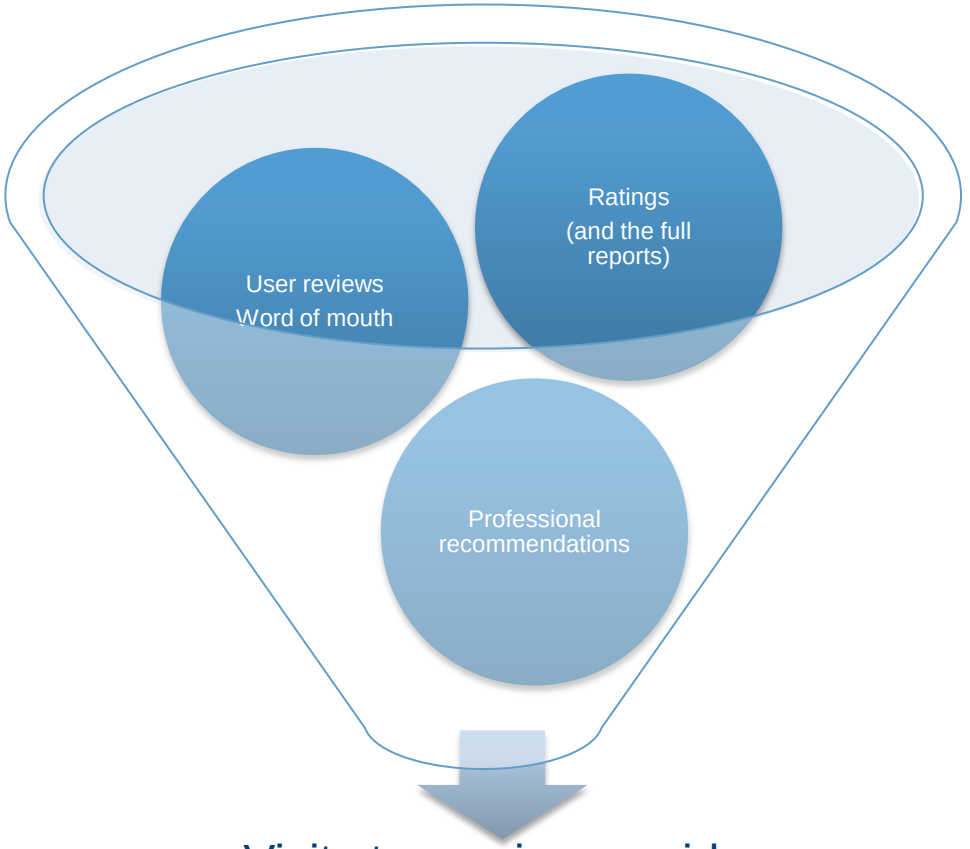
-Finally, the data needed to be easily accessible or they could use it to build a picture of services.

Choosing strategies

Finalising the choice

Once accessed, the ratings were seen to be just one of several decision making factors combined with other sources of information to create a list of choices.

As in the commercial setting, ratings formed part of a choice strategy in which people wanted to visit the provider before making the final decision. When people spoke about doing this with schools they sometimes mentioned going against the rating - i.e. choosing a school that was not necessarily rated the best.



Designing the ratings

How should ratings for health and social care services be used?

From the groups conducted, it became apparent that participants' thoughts on the design of the ratings varied depending on what the objective behind the ratings system would be.

For performance management

- If used for regulation and performance management, then bottom two ratings , as they are in the Ofsted ratings, should not be publicly available – any health or social care service "requiring improvement" or "inadequate" should not be allowed new patients and should be made to improve.

To enable choice

- If designing the system to enable choice expectations varied by service: whilst participants talked about only looking at "outstanding" schools – for health and social care – "good" or "average" was seen as the expected norm, and would be satisfactory.

Who should create the ratings?

PROS

- Objective
- Consistent – enables comparison – people's standards change over time
- Better for care homes.

Trust

Regulators

CONS

- Assessment at one time-point – even if regularly re-assessed – a lot can change in 6 months.
- Perception of bias – role of independent regulator needs to be clarified
- Expensive to collect sufficient data

PROS

- Continuous feedback
- Word of mouth always very important – patient/user feedback can be seen as an extension of this
- Less expensive – no need for sending out inspectors

Patient and user feedback

CONS

- Subjective – perceptions of what is good and bad differ
- If based on reviews – a lot of reviews to read through
- 'Customer' generated star rating could be brought down by

What if bad things happen in supposedly high performing services?

- This was a concern – but participants felt that if incidents are reacted to quickly, and dealt with, they should affect the ratings system.
- Participants were generally accepting that there is no such thing as a perfect service – incidents will, and do, happen.
- The impact would be the need for investigation by regulators – establish cause and rectify – make sure it doesn't happen again.
- Therefore, it did not appear that this would undermine the ratings system.

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1 Share

University Hospital of North Staffordshire death rates researched

A hospital in Staffordshire has had higher than expected mortality rates in three categories, research firm Dr Foster said.

The figures relate to University Hospital of North Staffordshire NHS Trust from April 2010 to March 2011.

In one category, deaths after surgery, the figure was 46% higher than would be expected.

A spokesman for the hospital said it took the warning from the figures "very seriously".

The figures relate to the trust from April 2010 to March 2011

'Sort it out'

The Dr Foster review looked at performance overall in England, warning death rates appeared to be higher than they should be in more than a quarter of trusts.

It said relating to the measure of deaths in hospital, 16% more patients were dying than would be expected at University Hospital of North Staffordshire NHS Trust.

In terms of deaths linked to low-risk conditions, there were 1.39 deaths per 1,000 patients at the trust.

Medical director at University Hospital of North Staffordshire Robert Courteney-Harris said if there was an issue, it would "sort it out".

'Better than average'

He added that in terms of deaths in hospital, the Hospital Standardised Mortality Ratio, it did not "have a history of high HSMRs" and this year it was nearly back to average.

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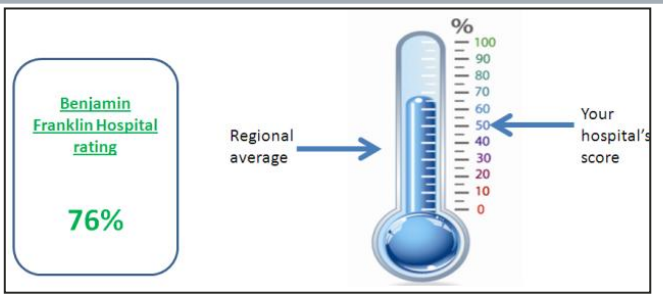
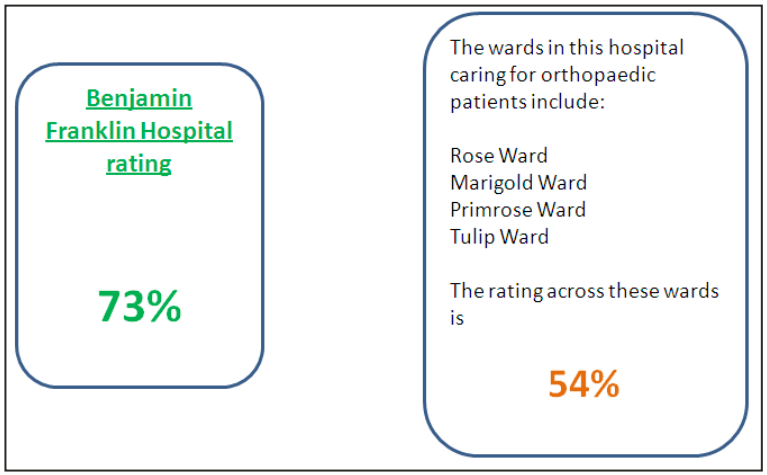
Presentation of ratings

- Given the general misgiving expressed towards the feasibility and practicality surrounding the application of ratings for health and social care services, the concept of how any ratings should be presented visually was only discussed with one group.
- Early indications were that that a thermometer graphic presentation gained more favour than some of the other options presented.
- Presenting ratings in the form of stars was seen to be too simple, and drew unwanted comparisons to ratings in the style of those use by services such as Tripadvisor.
- The third option presented on this page brought in some aspects that participants saw as desirable – in particular the ability to break down ratings by different specialties within a hospital.
- However, it should be noted that participants views and preferences for presentation of any ratings varied depending on whether they were seen as a tool for assisting regulation of services, or enabling patient and user choice.

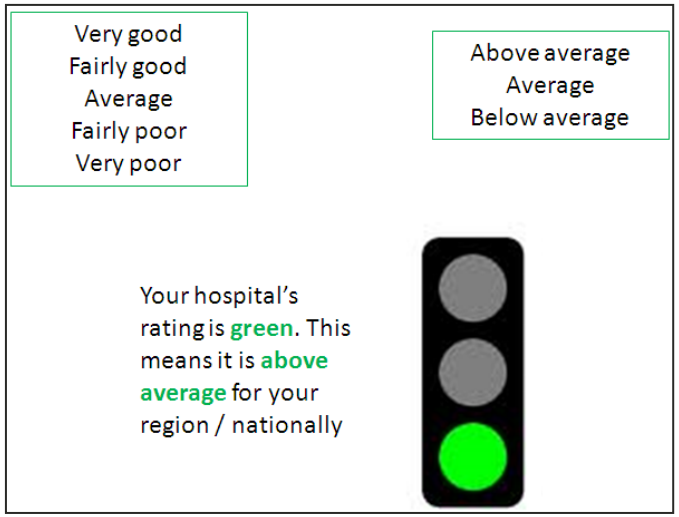


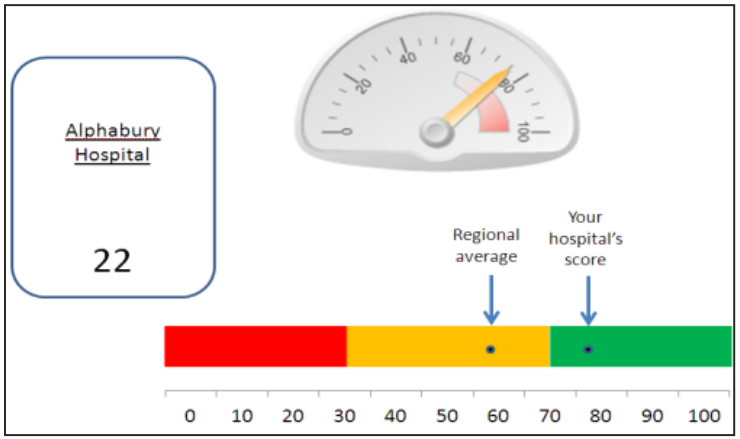


Other options for presentation of ratings

• Other options generally did not gain support from the group. For example, a traffic light approach reminded one or two people of food labelling, whilst for one or two others a speedometre was not seen to be suitable for health and social care.

•A red cross made some participants feel that those services should not be allowed to continue. As such, early indications are that incorporating the public perceptions of whether and rating system is needed and what its purpose should be will be important in how they are graphically presented.





Conclusions and recommendations

Conclusions and recommendations (i)

- Overall, based on the findings from the three discussion groups conducted, there did not appear to be a strong desire or appetite amongst the public for a ratings system for health services. There was, however, more of an appetite for a ratings system in care homes. This can be seen to correspond the choice strategy people employ when making decisions about these services.

Conclusions and recommendations (ii)

- However, it is important to consider that this exercise was about establishing an idea of people's reaction to the idea of health and social care ratings in principle, rather than an exploration of the detailed design of the ratings.
- Should the introduction of a ratings system across these services be pursued, then, before progressing down this route, there will be a number of important things to be considered. In particular, there is work to be done to provide clarity, for the public, on who would be responsible for drawing up the ratings, how this would be done, and how they would be different from what already exists in the sector.
- Furthermore, in this event, there would be a need for communications to be undertaken to achieve two things:

  i. Communicate to the public that they have a choice, especially when it comes to choosing hospitals

  ii. Increase public awareness of what information is already available, so that they can identify any information gaps that a ratings system might help to fill.

Conclusions and recommendations (iii)

- In addition, it would be necessary to conduct further research, once any decision is made, in order to further explore how a ratings system should be implemented and presented to the public.
- Whilst initial ideas on this were explored in this research, reactions to the idea of a ratings system differed depending on how this would be created, and what the intended purpose of this ratings system would be. Views also differed depending on whether the ratings system was seen to be a tool for enabling choice amongst patients and users, or as a tool for facilitating regulation of health and social care services.

Thank you

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