At the NHS Confederation's roundtable with the CQC on 23 October, the regulator acknowledged it remains very much in the early stages of the development process for provider ratings and will continue to learn lessons as it proceeds. The key points made at the meeting are summarised below and grouped together where most appropriate.

The new inspections process

- The Keogh reviews have been seen as the pilot for the new inspections.
- Teams of 25-30 people will be involved in each inspection, a CQC expert part of each sub-team.
- Announced inspections are expected to last around two days, with the total inspection process lasting up to three days with unannounced elements (including out-of-hours provision) included.
- The King's Fund are undertaking an independent evaluation of the first two waves of the new inspections for the CQC.
- Further pre-inspection work is planned for future waves, to enable the 'deep-dives' to be targeted more specifically.
- There will be a cultural shift away from just an 'inspection judgement' towards a more nuanced assessment of the quality of care provision.
- The community trust representative felt that there was nothing outlined by the CQC that couldn't be applied to community trusts with only a little tweaking.

Development of ratings

- CQC acknowledged that ratings in the past have suffered from being too mechanistic and failing to provide a true perspective on service quality.
- The regulator has a clear responsibility to promptly publish revisions to ratings in circumstances where trusts move up from 'requires improvement' to 'good.'
- CQC agreed with the NHS Confederation's position that service-level ratings are more meaningful to the public.
- If there is an additional level of information from external accreditation, it should be utilised for all organisations.
- A semantic point was raised – all or even a majority cannot by definition be 'outstanding'. Therefore are the ratings relative rather than absolute and could there be a reluctance on that basis to rate trusts inspected early in the process as 'outstanding'? In response the CQC highlighted that 'outstanding' trusts will be rated against benchmarked criteria.
- CQC noted that they have yet to hold discussions on how ratings will be published. However they recognise the importance of timeframes and the constantly changing picture of the information utilised in the ratings. It will be a different process to the annual health check.
- 'Outstanding' trusts would still have data monitored, whistle-blowing reports noted etc between inspections. The principle of less frequent inspections still applies, albeit with tighter timescales than originally envisaged.
- The CQC did acknowledge concerns around the timeliness for some data sources that may be used.
Important aspects of acute care are management of frail elderly and those with mental health problems. It was felt that these issues were not currently reflected in this approach and they should be incorporated into the ratings assessment.

Public engagement
- The public-facing meetings for the Keogh reviews were perceived as 'Marmite events', with people either attending because they love their local trust or alternatively because they hold serious concerns about the services.
- There has been little interest shown in a trust-level rating, including among the public who were very keen on service-level ratings.
- The model was tested with the public through the use of mock web-pages, with people tracked as to how they proceeded through the site.
- The data pack will be published to ensure the public is provided with all of the information.

Distinctions between providers
- The distinction between specialist and non-specialist trusts was discussed. The former handle discrete conditions and patient groups, therefore it is at least theoretically 'easier to excel' in such circumstances.
- Some hospitals may be providing largely 'non-core' services. In such circumstances, it was argued the CQC shouldn't be assuring the public that a hospital is safe when the services fall outside the inspections process.
- It was asserted that every service will have a named manager and clinician. However concerns were raised that there is not a level-playing field in terms of registered managers.

The domains under review
- There is currently no guarantee that all 48 ratings proposed will be published, this option needs further testing.
- Scepticism was raised about the ability to have a reliable rating for each domain. However the CQC responded that the public regard granularity as important and therefore provider-level ratings were not felt to be sufficient. It was argued that it would not always be possible to distinguish between the domains (e.g. when a service's safety is inadequate, it will automatically also be so for effectiveness and well-led). However the delegate accepted that it would be helpful internally to have discrete ratings by domain.
- Each domain is weighted equally. The CQC will be proportionate in its response if it is felt that a trust has a good chance of delivering prompt improvements.
- Each trust would have a rating for each domain. Hospital-level domain ratings also being considered.
- In response to a question about whether domain criteria will be published, the CQC stated that it wishes to avoid a focus on targets such as staffing levels. However a delegate asserted it wasn't appropriate to not advise trusts striving for an 'outstanding' rating of the criteria involved. The handbook will include principles and provide a framework across the various domains.

What are the key indicators?
- Safety indicators such as infection rates, complication rates, unexplained mortality rates, were felt to be integral. It was noted that many safety measures are already part of the clinical dashboards, e.g. serious incidents, never events, falls.
• The suggested information sources are taken from NHS providers and therefore the independent sector will have to develop those systems. A query was raised for the CQC to consider how comparable data will be assessed in the meantime.
• One delegate had undertaken reviews of failing services and the handling of incident reports are crucial. They can help to provide assurances that systems are in place. This also applies to complaints handling, with commissioners examining this as part of service reviews. Wave 2 inspections from January will include a piloted approach to examining the experiences of complainants.
• Another delegate highlighted clinical audits, which don’t appear to be on the current lists of indicators. The CQC offered assurances that they are in ongoing discussions around gaining access to the audit data, which is currently only available to the individual trusts. A delegate argued that utilising such information as part of the ratings system would help to raise the profile of the audits.
• It was noted that inadequacy in one indicator is likely to be associated with inadequate practice elsewhere.
• It was suggested by one delegate that 'unexplainable' mortality should be a trigger indicator. Some services will inherently have higher mortality rates than others, but such cases should only be explainable. In response, the CQC expressed caution about using mortality rates. It confirmed that 'risk list' data will be included in the data packs, alongside further contextual and qualitative data.

Timetable for inspections
• A similar set of steps will be adopted for each sector as the new approach is rolled out across the service.
• All acute trusts will be rated by the end of 2015. Social care organisations will be rated between October 2014 and October 2016.
• Wave 1 for community and mental health trusts is scheduled for January 2014.
• In relation to adult social care services, they will be inspected on the five domains from April 2014, with reports being published from October. There will be an opportunity to contribute towards the methodology development for this process.

Next steps
• The CQC has now published a document examining the responses received to their A new start consultation.
• A draft handbook will be published in December, detailing the acute trust assessment process including information sources and methodology. A final version will be subsequently released in April 2014, following engagement with providers and stakeholders.
• From April 2014, the CQC will be able to determine 'what does good look like?' across all eight core services, which will always be inspected. However it was noted that how the eight services are defined may change over time.
• Consultation on provider guidance the enforcement policy for all sectors will also be published in December.

Key issues arising from recent events with CQC
There were some common themes that arose out of both this roundtable and our recent jointly held event with CQC and the Foundation Trust Network (FTN) earlier in October, which will require continued focus as the inspection process develops further:

• Trusts should have plenty of opportunities to corroborate inspection findings and sufficient involvement in the final report. This is of particular importance in respect of the following: correction of any inaccuracies; additional details that can put inspection
findings into appropriate context (e.g. systemic risks of services under review); and the trust being able to share information on high-performing services or sites not included within the eight core services under review.

- The need for a clear strategy regarding the information to be shared with the public. This should cover the balance to be struck between the information that would only be of value to internal organisational operations and that which would be of most importance to patients. It should also provide clear timelines for inspected trusts and sites to clarify when ratings and associated information will be publicly reported.

- The processes for different types of providers need to be aligned with clear communication for commissioners to ensure they are fully aware of their involvement in the process. Commissioners have been concerned in the past regarding a lack of clarity about their roles and responsibilities in respect of regulation.

- Clarity regarding performance management and alignment of the regulatory system after the inspection process has concluded.