The assessment process

Initial baseline assessments of integrated care systems

Assessing integrated care systems is a new legislative role for CQC.

Before we can move to our new assessment model of ongoing assessment, we need to establish a 'baseline' of completed initial assessments for each one.

The baselining period will take a phased approach to these initial assessments. In the first phase, our work will focus on:

- further developing and embedding our assessment approach
- gathering evidence
- developing our understanding of relative performance across systems
- building relationships within each of the areas.

We will explore opportunities for themed reporting at national level during this first 6 months.

The second phase involves formal assessment. We will gather all required evidence for each integrated care system, report on our findings and award ratings. The aim of the second phase is to complete all the initial assessments and award a rating for each one. We aim to award ratings in this phase within 2 years.

For the initial assessment, we will start by assessing evidence that we **have**, followed by evidence we need to **request** and finally evidence that we need to actively **collect**.

Examples of evidence that we have include:

- Outcomes evidence for all integrated care systems. We will begin to benchmark and assess this against each quality statement for each ICS. In some cases, we will also have partial evidence from some of our other evidence categories. For example, we will have insight from our regulation of providers (Feedback from partners category) and data on the effectiveness of some processes (Processes category).

Examples of evidence that we will **request** include:

- specific policies and strategies (Processes category)
- any survey information that integrated care systems hold (People's experience, and Feedback from staff and leaders categories)
- the views of integrated care systems on their current performance (Feedback from staff and leaders category).

Evidence that we actively **collect** includes:

- people's experiences (for example, through case tracking and focus groups), more focused engagement with partners and conversations with staff and leaders.

In this way, we will be gathering evidence across all integrated care systems throughout the baseline period. This will enable us to provide or publish national insights on progress and share information that supports improvement. This approach will also help us develop our longer-term regulatory intention of ongoing assessment.

Our aim is to sequence the assessment activity to ensure that assessments of integrated care systems are informed by completed assessments of all the local authorities within the area of the system. We will work to ensure we only request required evidence once for both types of assessments, and to hold interviews or focus groups to cover both assessments wherever possible.

Our insight will also take into account our regulation of health and care providers.

We will continue to learn and evolve our approach during initial baselining assessments and once we move to the third phase of our ongoing assessment model.

Collecting evidence on site and off site

During the baselining period, we will use the best options to collect evidence, which may be either on site or off site. This will depend on the type of required evidence for a quality statement.

We can collect some evidence entirely off site. For example, we can collect data on population health and service performance without a site visit. Some evidence can only be collected on site, for example observing meetings and understanding the culture and how staff interact with each other across the system.

Other types of evidence can be collected either on site or off site or a combination of the two, for example people's experiences or feedback from staff and leaders. There are circumstances where face-to-face contact is the most effective and appropriate way to communicate and understand experiences, for example:

- where people have communication needs that would make telephone or video conversations challenging (or not suitable at all)
- where the nature of inquiry is sensitive, such as following a death or serious incident
- in establishing a rapport with a new lead contact
- where there are concerns around confidentiality (for example, if other people are in the same room, or potentially trying to influence the person we're talking to)
- when we want to corroborate what we see and what we hear in real time.

We will use Specialist Advisors to inform our assessment activity. This ensures our reviews are informed by up-to-date and credible clinical and professional knowledge and experience.