Care Quality Commission

Interim guidance on our approach to assessing integrated care systems

We will expand and update this interim guidance in collaboration with stakeholders as we develop our model and transition to ongoing assessment.

March 2023

Assessing integrated care systems is a core ambition in our current strategy. It will enable us to provide independent assurance to the public of the quality of care in their area.

Our aim is to understand how integrated care systems are working to tackle health inequalities and improve outcomes for people. This means looking at how services are working together within an integrated system, as well as how systems are performing overall.

The Health and Care Act 2022 gives us new regulatory powers that allow us to offer a meaningful and independent assessment of integrated care systems.

Our reviews will take into consideration the core purpose of integrated care systems, as referenced in NHS England's design framework and the requirements of the legislation. They will focus on 3 themes:

1. Quality and safety
2. Integration
3. Leadership

This guidance is interim and is awaiting approval by the Secretary of State for Health and Social Care as required by the Health and Care Act 2022. Its aim is to help integrated care systems understand more about our approach during the pilot phase.

We will expand and update this interim guidance in collaboration with stakeholders as we develop our model over the coming months and transition to ongoing assessment. It will form the basis for the more detailed end-to-end guidance later in the year.

Key points

Applying our single assessment framework to assessments of integrated care systems

- We will use our new regulatory model and single assessment framework across all our work. This includes all types of services in all health and care sectors and at all levels. It also includes our new role in providing meaningful and independent assessment of integrated care systems.

- The quality statements in the single assessment framework are based on people's experiences and the standards of care they expect. We will be using a subset of the quality statements in assessments of integrated care systems.
- These assessments will build on what we already know from regulating health and care providers and other existing sources of evidence, including our new assessments of local authorities under part 1 of the Care Act. We will use the information we receive from a range of sources to make assessments flexibly, without being tied to set dates. This ensures we have an up-to-date view of quality.
- Continued collaboration with our strategic partners nationally and at local level is an essential part of our approach.
- We are introducing 6 evidence categories to make our judgements structured and consistent.
- We will carry out initial assessments for all integrated care systems to achieve a baseline understanding of quality before starting our longer-term approach for ongoing assessment.
- We plan to test how we will award ratings using the approach set out in this guidance. If requested by HM Government, we can award ratings for all integrated care systems during the initial baselining period. Ratings will be produced on a similar basis to providers – based on building up scores from quality statements to a rating.
- Rather than rate all 5 key questions, we will structure the assessment and rating approach specifically around the context, aims and roles of an integrated care system.
- In time, our teams will be able to see all the data and insight they need on one digital platform, helping them to make better decisions about what they need to focus on, both in terms of risks and areas of improvement.

- Reports and outputs will have a shorter and simpler format making them easier to read. They will be clear about when we last assessed evidence and when ratings were updated.

People's experiences of health and care

Our new single assessment framework focuses on what matters to people who use local health and social care services and their families. We want to encourage people who use services, and organisations who represent them or act on their behalf, to share their experiences at any time.

We are using the term 'people's experiences' throughout our assessment framework and the associated guidance about our methods for this approach. We define people's experiences as "a person's needs, expectations, lived experience and satisfaction with their care, support and treatment, including equity of experience, access to and transfers between services". Our key principles for using people's experiences are:

- People using services, their families, friends and advocates are the best sources of evidence about lived experiences of care and their perspective of how good it is.
- People's experiences is a required evidence category for most quality statements.
- We value people's experiences as highly as other sources of evidence and weight them equally with other required evidence categories. We also consider the context, impact and equity of people's experiences in our analysis.
- If we receive feedback that people have poor experiences of care, this is always identified as a concern, even if other evidence sources have not indicated any issues. In these cases, we will need to review further and gather more evidence.
- We increase our scrutiny of, and support for, how integrated care systems encourage, enable and act on feedback, including from people who face communication barriers, and how they work with them to improve services.

We recognise that people's experiences are a diverse and complex source of evidence – ranging from a rating on a review website to a complex narrative. So, we are developing an effective approach to analysing these sources to inform our decision making. We will use a range of data characteristics such as data on demographics, inequalities and frequency of use for care services. We are committed to ensuring we consider the experiences of people most likely to have poor access, experiences or outcomes from care.

We are also thinking innovatively about the relationship between our assessment activity at both the provider and system level (both local authority and integrated care system) and how we can use this to maximise improvement and reflect people's lived experience of care in a way that people can understand.

To achieve this, the assessment framework:

- sets out clearly what people should expect a good service to look like
- places people's experiences of care at the heart of our judgements
- ensures that gathering and responding to feedback is central to our expectations of providers, local authorities and integrated care systems.

The way we record and analyse people's feedback is changing so that we can make better use of the evidence. This includes quickly identifying changes in the quality of care and analysing qualitative information to better understand a picture over time, as well as responding to urgent individual incidents separately.

Our new single assessment framework

Our new single assessment framework is based on a set of quality statements. They are arranged under topic areas and describe what good care looks like.

To develop the quality statements, we reviewed our existing assessment frameworks as well as using aspects of the Making It Real framework. Making It Real was co-produced by Think Local Act Personal (TLAP) with a range of partners and people with lived experience of using health and care services. It is a framework for how to provide personalised care and support aimed at people working in health, care, housing, and people who use services. It contains a jargon-free set of personalised principles that focus on what matters to people.

Quality statements are written in the style of 'We' statements from a provider, local authority and integrated care system perspective, to help them understand what we expect of them. They are the commitments that providers, commissioners and system leaders should live up to in order to deliver truly person-centred care and support. They also help to provide a benchmark of what good care looks like by linking to the relevant best practice standards and guidance.

Our assessment framework will also help people understand what a good experience of care looks and feels like by linking it with 'I statements' from TLAP's Making It Real framework. We will use these statements to support us in gathering and assessing evidence under the People's experience evidence category.

Making people's voices prominent in our single assessment framework helps to focus the whole health and social care system on people as we increasingly work across the boundaries of health and care, at an integrated care system and national system level.

Safety through learning is a key theme in our strategy. We have reflected this in the quality statements to set our expectations for how services and providers need to work together, and within systems, to plan and deliver safe, person-centred care. We will assess the extent to which people can influence the planning and prioritisation of safe care and be truly involved as equal partners to transform safety and to ensure that human rights are upheld. We will also assess how leaders foster a culture of openness and learning to improve safety for people.

Driving improvement is also a key theme in our strategy. Our assessments of systems will transform how we bring together a view of quality across a local area, putting people at the centre and helping to drive improvement in health and care.

Adapting our approach to integrated care systems

The Secretary of State for Health and Social Care will set objectives and priorities for our assessments, which we will then publish.

These priorities are likely to change and evolve over time. They will be addressed as part of a wider assessment of the quality statements in the assessment framework.

As part of the assessments of the quality statements for integrated care systems, we will consider and report on the effectiveness of:

- arrangements for place-level working within the system
- variations in service quality
- people's experiences

- health inequalities and population health outcomes, and wider determinants of health across the system.

As required by the Health and Care Act, our assessments of integrated care systems will cover:

- the quality and integration of health care and adult social care within each integrated care system
- how partners in each integrated care system (the integrated care board, local authorities and registered service providers) are meeting their own responsibilities within the system
- the functioning of the integrated care system, especially how well system partners are working together to deliver good care and meet the needs of their populations, including through the work of Integrated Care Partnerships.

We will also cover the core purpose of integrated care systems:

- improve outcomes in population health and health care
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Assessment framework for integrated care systems

We will use a subset of the quality statements from the overall assessment framework.

This is because integrated care systems are being assessed against a different set of statutory duties to registered health and care providers. We will be assessing the requirements under the Health and Care Act and how integrated care systems are achieving their core purpose. We will do this using 17 quality statements across the 3 themes identified by the Health and Care Act 2022.

Themes and quality statements

Theme 1: Quality and safety

Quality statements:

- Supporting people to live healthier lives
- Learning culture
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes
- Safeguarding

Theme 2: Integration

Quality statements:

- Safe systems, pathways and transitions
- Care provision, integration and continuity
- How staff, teams and services work together

Theme 3: Leadership

Quality statements:

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Freedom to speak up
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable development
- Workforce equality, diversity and inclusion

Evidence we will look at

Six evidence categories signal the types of evidence we use to understand the quality of care being delivered against each quality statement. The evidence categories required to assess each quality statement vary according to what is being assessed.

The following are the 6 evidence categories and some illustrative examples:

1. **People's experience** as set out in our experience principles and framework. This category covers all types of evidence where the source is from people who have experience relating to a specific health or care service, or a pathway across services. It also includes evidence from families, carers and advocates for people who use services. Examples include interviews with people, Give Feedback on care forms, survey results and feedback from representative groups.
2. **Feedback from staff and leaders** for example, from direct interviews, compliments and concerns raised with us, surveys and evidence from self-assessments.

3. **Feedback from partners** for example, from commissioners, providers, professional regulators, accreditation bodies, royal colleges, multi-agency bodies. This will include partners involved in the wider determinants of health and wellbeing such as housing, licensing, or environment services.
4. **Observation** including case tracking, and observation of meetings and forums that co-ordinate health and care in the system such as integrated board and partnership meetings, place-led meetings and health and wellbeing boards.
5. **Processes** are the series of steps, or activities that are carried out to deliver care and support that is safe and meets people's needs. We will focus on the effectiveness of the processes rather than simply the fact they exist. This category includes metrics such as waiting times, audits, policies and strategies.
6. **Outcomes** are focused on the impact of processes on individual people and communities, and cover how care has affected people's physical, functional or psychological status. Evidence includes information on the quality of providers in an integrated care system, clinically relevant measures, quality of life assessments and population data.

The quality statements and evidence categories remain relatively static, but the specific evidence sources we will look at to assess quality will change more frequently, in line with the most up-to-date best practice standards, guidance and information.

As part of our assessments, we will consider evidence of the quality of health and care services provided across the area of each integrated care system alongside other evidence of the outcomes of system working. Ratings of individual providers will not directly determine the outcome of an integrated care system assessment, but will form part of the evidence we use for assessments.

Our assessment and inspection teams will share information about quality and partnership working within each integrated care system. Assessments will not directly inform ratings of individual providers, but in some cases, the evidence we gather during an integrated care system assessment may form part of the evidence we will use for assessing providers. For example, this evidence could be around partnership working or it could inform decisions about further assessment activity required at provider level.

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.

Working with national and local partners

We will work with key national and local partners to share data and to gather evidence.

Examples of partners include:

- health and care providers
- professional regulators (for example, the General Medical Council, General Pharmaceutical Council)
- national and local Healthwatch
- community groups, especially those involving people more likely to have poorer access, experiences or outcomes from care

- the Parliamentary and Health Service Ombudsman
- the Local Government and Social Care Ombudsman.

In our assessments of integrated care systems, we will work closely with NHS England. NHS England provides leadership, oversight and support for NHS services in England, and carries out an annual performance assessment of integrated care boards.

We will use the results of NHS England's oversight and assessments of integrated care boards in our assessments of the integrated care system. Findings from these assessments will inform NHS England's oversight and support for integrated care boards.

When working together, CQC and NHS England follow these principles:

- We work together to carry out our respective functions effectively, while recognising that each organisation is legally and operationally independent.
- We make sure our definitions, measurement and operations are based on a single shared view of quality.
- We work to remove duplication between our organisations.
- We focus on quality and how it is maintained and improved alongside financial sustainability.

We work together across all aspects of our regulatory and oversight model by:

- sharing data and aiming to use a single, shared standard of measurement, both to review performance and to decide where to target support or oversight
- co-ordinating how we gather evidence to plan assessment activity, using information from NHS England as evidence to inform our judgements
- sharing information on the results of our assessments
- co-ordinating how we engage with individual providers as well as with wider healthcare systems.

How we will determine ratings

A scoring framework to support consistent judgements

To support the transparency and consistency of our judgements, we intend to introduce scoring into our assessment process for integrated care systems. This approach will be consistent with our assessments of registered providers.

For each quality statement in the assessment framework, we will assess the 'required evidence' in the evidence categories and assign a score to the quality statement.

The scoring framework to support decisions is:

1 = Evidence shows significant shortfalls

2 = Evidence shows some shortfalls

3 = Evidence shows a good standard

4 = Evidence shows an exceptional standard

Developing scores and ratings

When we assess evidence, we assign a score to the relevant quality statement. The scores for the quality statements aggregate to ultimately produce the ratings, and an overall score. All evidence categories and quality statements are weighted equally.

This approach makes clear the type of evidence that we have used to reach decisions.

The overall rating will use our 4-point rating scale. The score will indicate a more detailed position within the rating scale. For example, if an integrated care system was rated as good, the score will tell us if this is in the upper threshold of good, nearing outstanding. Similarly, if an integrated care system was rated as requires improvement, the score would tell us if it was at the lower or higher threshold, so nearer to inadequate or good. We will work with the integrated care systems, the Department of Health and Social Care and other stakeholders on the best way to publish our findings.

For integrated care systems, we will combine the evidence category scores to give a score for each quality statement, which then collectively give a score for each theme and an overall score and rating.

Reporting and sharing information

What our reporting will look like

When we have gathered enough required evidence across the quality statements, we will start to publish assessment reports for integrated care systems. There will be a short period between assessment and publication to provide an opportunity for the organisations within an integrated care system to carry out a factual accuracy check. For an integrated care system, we would share the draft assessment report with the Integrated Care Board and Integrated Care Partnership.

We will publish our reports on our website. They will include a short summary of the key features of the integrated care system and will focus on people's experiences of care. We will publish our most up-to-date findings against the themes and for each quality statement. Reports will include:

- information on what people have said about their experience and how we used it in our assessments.
- narrative on areas that require improvement and areas of strength
- commentary on the progress of the integrated care system.

We will engage with people to clearly understand what different audiences need from our reports and this will influence their design.

Publishing ratings under the assessment process

We will begin publishing scores and ratings for integrated care systems once we have sufficient evidence. We will be gathering evidence and building relationships over time rather than on a single inspection.

When we publish ratings, we will publish:

- the overall rating
- the score for each theme of the assessment
- the score for each quality statement.

The scores will indicate where an integrated care system sits within a rating, showing whether it is nearer the upper or lower threshold.

We use a sampling approach to quality assure our processes and reports to check that our view of quality is reliable. If we identify anomalies, we will update our approach accordingly.

We may not update a rating on our website every time we review and update a score at quality statement level, but we will indicate that a review has taken place and make clear when this has happened. We will always update our website when a rating moves from one level to another (for example, from requires improvement to good at either quality statement, theme or overall rating level).

Intervention and escalation

Our assessment reports will clearly set out required improvement and best practice.

Following the report, system partners (integrated care boards, local authorities, and providers) are expected to come together through a local system improvement summit to review assessment findings and publish action plans, which we will monitor.

Improvement summits are intended to be a forum to discuss the findings from the assessments. They also enable integrated care system leaders to:

- share learning, good practice and innovation
- drive improvement
- develop action plans
- work with national bodies where appropriate to secure an improvement offer of support to enable leaders to implement changes across the system.

Where necessary, we will share any concerns with national partners across health and social care (for example, NHS England, Local Government Association, the Association of Directors of Adult Social Services, Department of Health and Social Care or the Department for Levelling Up), recognising that lines of accountability are different for NHS organisations and local authorities. The relevant organisation will oversee support or make an intervention. Where appropriate, we will help to identify improvement support.

We will continue to work with the Department of Health and Social Care as it develops its intervention policy for local authorities.

Up-to-date, transparent assessments of quality

When we have completed initial assessments of integrated care systems, we will move to our ongoing assessment approach.

Under that approach, we will gather and assess evidence at different points in time. The associated quality statement scores, theme level scores, overall score and rating may also change.

We will also have flexibility to look at elements of the assessment framework on an ongoing basis and update scores and ratings when needed.

We will report on the history of our assessments, showing how integrated care systems have performed over time in terms of scores and ratings.

Frequency of assessments

Our ongoing assessment model will be informed by risk. We use this risk-informed approach to decide where we focus our activity, how often we carry out assessment activity and what type of activity we use to gather evidence. This allows for both planned and responsive activity.

National priorities may also affect the evidence collection timeline and approach. The need to collect evidence may also be modified by the risk profile of an integrated care system.

If immediate risks are flagged (for example, information of concern) this will trigger the necessary action to collect evidence. We will prioritise which integrated care system to assess according to the significance of the change in quality.

Where our teams are prompted to review and potentially update what we know about an integrated care system, we will decide what evidence to gather to enable this. This will be guided by the minimum evidence requirements set out for integrated care systems.

Sometimes there will be a trigger to review multiple quality statements and evidence requirements. When this happens, we will take a planned and co-ordinated approach to this activity, including more intensive activity on site if needed.

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