Research to understand CQC's regulatory impact in systems

IFF Research

on behalf of the Care Quality Commission

February 2025

Contents

Glossary of key terms

Key term	Definition
Assessment framework	Implemented in 2022, the new CQC assessment framework covers provider and system-level regulation, but system assessment activity centres around a subset of the quality statements to reflect the different statutory duties compared to providers. ICSs are assessed against a subset of 17 quality statements across 3 themes: quality and safety; integration and leadership. In LAs, a subset of 9 quality statements mapped across 4 overall themes is used. These themes are working with people, providing support, how the local authority ensures safety within the system and leadership. Further detail on this can be found in Appendix 1. Note the assessment framework has previously been called the single assessment framework.
Association of Directors of Adult Social Services (ADASS)	ADASS is a membership organisation for those working in adult social care. As a charity they work with professionals, other organisations and people with lived experience to influence decision makers, policy and legislation – from the local to regional and national level.
Initial formal assessment period	The initial formal assessment period covers CQC assessments undertaken beyond the pilot areas. For local authorities (LAs) this period started in December 2023. (The corresponding period for integrated care systems (ICSs) has yet to begin.)
Contribution analysis	Contribution analysis involves comparing the Theory of Change with the evidence collected by the research to draw conclusions about whether an intervention has contributed to the outcomes or changes observed. Contribution analysis is a rigorous and robust approach for evaluating complex systems. The goal of contribution analysis to create an evidence-based narrative that a reasonable person would accept as a plausible explanation of the contributing factors that led to the outcomes.
Experts by experience	People who have recent personal experience of using or caring for someone using the relevant services.
Information Return (IR)	A list of information CQC requests from a LA or ICS before notification of their site visit, covering the themes of the quality statements. This is used to inform the site visit and can be used as evidence in the assessment.

Integrated Care Board (ICB)	NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area (see below). They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the ICP's integrated care strategy.
Integrated Care Partnership (ICP)	The NHS organisations and local authorities in each ICS run a joint committee called an integrated care partnership (ICP). This is a broad alliance of partners who all have a role in improving local health, care and wellbeing. They may also include social care providers, the voluntary, community and social enterprise sector and others with a role in improving health and wellbeing for local people such as education, housing, employment or police and fire services. Each ICP must develop a long-term strategy to improve health and social care services and people's health and wellbeing in the area. They may also take on additional responsibilities, as agreed locally between the members.
Integrated Care System (ICS)	Joining up care leads to better outcomes for people. When local partners – the NHS, councils, voluntary sector and others – work together, they can create better services based on local need. Integrated care systems, (ICSs) have been set up to make this happen. Their aim is to improve health and care services – with a focus on prevention, better outcomes and reducing health inequalities. The 42 ICSs in England are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They are formed by NHS organisations and upper-tier local councils in that area and also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing. ICSs were legally established on 1 July 2022, covering all of England. These new arrangements build on partnerships that were already in place across the country.
Local Authority (LA)	LAs are made up of councillors who are elected by the public in local elections. Councillors work with local people and partners, such as local businesses and other organisations, to agree and deliver on local priorities. The decisions are implemented by permanent council staff, council officers, who deliver services on a daily basis.
Local Government Association (LGA)	LGA are the national voice of local government, working with councils to support, promote and improve local government.
NHS England (NHSE)	NHS England lead the delivery of NHS services in England.
Participatory Systems Mapping (PSM)	A collaborative approach used to visually represent and analyse complex systems. It highlights system dynamics and interdependencies. More detail can be found in Appendix 4.

Penny Dash review	In May 2024, Dr Penny Dash was asked to conduct a review into the operational effectiveness of the CQC. The purpose of the review was to examine the suitability of CQC's new assessment framework methodology for inspections and ratings of health and care providers. Interim findings were published in July 2024, with the final report published in October 2024.
Provider	An individual health and/or social care provider that is part of a broader system, for example, a hospital or care home.
Self-Assessment Return (SAR)	During pre-fieldwork, alongside an information return, local authorities can choose to assess their own performance in relation to the quality statements.
Systems	The word system is used to describe both ICSs and LAs. When discussing ICSs, 'system' refers to all organisations that make up the ICS, including the LA. When discussing LAs, 'system' refers to all organisations that contribute to social care delivery, such as care providers.
Theory of Change (ToC)	A visual representation that outlines the activities a programme will undertake, the ultimate impact it aims to have, and the outcomes that lead or contribute to the longer-term impacts.

1 Executive Summary

The Care Quality Commission (CQC) commissioned IFF Research in October 2023 to conduct research into its system assessment activity. The research aimed to explore the effectiveness of CQC's approach to system assessment, and the mechanisms through which it can have most impact. The Centre for Evaluation of Complexity Across the Nexus (CECAN) supported through delivery of Participatory Systems Mapping (PSM).

Introduction

The Health and Social Care Act 2022 gave CQC a new responsibility to provide meaningful and independent assessments of the provision of health and adult social care services within each Integrated Care System (ICS) and Local Authority (LA).

The aim of ICS assessments is to understand the extent to which they are meeting the needs of local populations. It is anticipated that this will help CQC understand how ICSs are working to tackle health inequalities and improve outcomes for people. This work also intends to provide independent and meaningful assurance to the public about the quality of care in their area.

For LA assurance, the aim is to understand how well LAs are meeting their duties under Part 1 of the Care Act (2014).[1] The Care Act 2014 sets out national eligibility criteria for both carers and the person being cared for. These criteria set a national minimum threshold to be met, and if a carer or the person being cared for meets this threshold, they will have eligible needs that the LA must then meet.

CQC's approach to ICS assessment and LA assurance is based around an assessment framework, implemented in 2022. The framework covers provider and system level regulation, but with system assessment activity centring around a sub-set of the quality statements to reflect the different statutory duties compared to providers. ICSs are assessed against a subset of 17 quality statements[2] across 3 themes: quality and safety, integration and leadership. In LAs, a subset of 9 quality statements mapped across 4 themes are used: working with people; providing support; how the LA ensures safety within the system, and; leadership.

In Summer 2022, CQC undertook test and learn exercises with 2 LAs and 2 ICSs to test the assessment approach. Using the learning from this, the approach was piloted in 5 LAs and 2 ICSs during Summer 2023. Findings from this supported the refinement of the process ahead of the initial formal assessment period. The first 3 LA initial formal assessment visits took place in February and March 2024, with reports published in May 2024. At the time of writing this report, 10 LA initial formal assessments had been completed, and 58 assessments were underway. Formal ICS assessments have not yet started due to delays

[1] Care Act 2014
[2] Quality statements are the commitments that ICSs and local authorities must commit to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

in obtaining ministerial approval of the assessment process and a formal pause in response to a recommendation in the Penny Dash Review.

Research approach

The research aimed to explore the following questions:

- How effective is CQC's regulatory approach to ICS assessment and LA assurance?
- What are the key mechanisms through which CQC has impact in a system setting?
- How can the impact CQC have be identified and measured (on an ongoing basis, taking account of the fact that some impacts may be yet to emerge)?
- What could be improved about CQC's approach to maximise its impact?

The research, conducted between October 2023 and October 2024, included qualitative case studies with 2 ICSs, 3 pilot LAs and 2 initial formal assessment LAs. It also included interviews with national stakeholders, CQC staff and secondary data analysis of surveys administered by CQC to initial formal assessment LAs. More detail on the methodology, including a breakdown of the roles and organisations included in the qualitative research can be found in Appendix 3. Figure 1.1 below summarises the research approach and timescales.

Figure 1.1 Research approach

Key findings

Foundations of system regulation

- ICSs and LAs felt that system assessment would enable a more comprehensive understanding and oversight of the quality of services provided. It was felt that assessments would be valuable in highlighting areas for ICS and LA development and identify good practice; ensure a joined-up approach to health and social care; and foster collaboration across systems.

- There was a strong understanding of CQC's new powers, but 2 aspects were commonly misunderstood. Firstly, that CQC's powers of enforcement were not the same as for provider regulation (most felt that CQC had direct powers of enforcement)[3]. Secondly, it was often assumed that CQC had already committed to ongoing system assessment and would be returning for future assessments. However, this is still in development and not yet confirmed.

- Although there was positivity about CQC's new system regulation role, 4 key concerns emerged across LA and ICS participants. First, there were worries about the implication of CQC highlighting areas of system activity that were not working well. Second, it was felt assessments, from preparation through to completion, could contribute to stress, anxiety, and increased workloads for LA staff and staff across organisations in the ICS. Third, aspects of the process, such as assessment scoring, were felt to need clearer explanation to mitigate concerns that they could lead to inaccuracies being shared publicly. Finally, there was concern among ICS staff that assessments were insufficiently tailored to systems and overlooked their complexity.

- Broadly, stakeholders[4] felt their engagement with the assessments had been working well. Though there were some who felt they could be given more opportunity to feed into aspects of the assessment (for example, case tracking and iteration of assessment reports). There were also requests for greater communication ahead of time about plans for ICS and LA assessments.

[3] In regulating providers, CQC have enforcement powers they can use when they identify poor care, or where registered providers and managers do not meet the standards required in their regulations.
[4] Interviews for this research were conducted with a range of Government staff, as well as those working in the third sector, public voice organisations, and organisations supporting health and social care staff. More information on the sampling can be found in Appendix 3.

Experience of local authority assessments

- Both pilot and formal assessment LAs found the process of completing the Information Return (IR) and self-assessment return (SAR) a valuable exercise as it highlighted potential areas for improvement and provided ideas for how they could collect useful data going forward. However, this phase of the assessment was felt to be time consuming due to the amount of information requested. CQC stakeholders and pilot and formal LA staff thought clarity around what was required within the IR could be improved to reduce LA time spent on providing unnecessary documents.

- The on-site stage of the assessment was viewed positively by LA staff. They thought CQC inspectors involved the right people in discussions, asked appropriate questions and seemed knowledgeable and experienced. It was felt that including session names that reflect the content of discussions could further help LA staff plan for the right people to attend each interview.

- Limited numbers of staff felt they had sufficient knowledge of the assessment framework to comment on its value and usefulness. Those who did, used it to prepare for assessments but CQC could consider whether further work is needed to ensure LAs have a comprehensive understanding of the criteria they will be assessed against and how this relates to the Care Act.

- Assessment reports were viewed as useful in that they highlighted areas of good performance and improvements needed within LAs. However, staff raised concerns over the factual accuracy of reports and how insight had been triangulated to arrive at judgements. Some staff also requested clearer guidance on what they needed to do to improve their assessment score.

Experience of ICS assessments

- A few ICS participants reported the IR helped them know what the CQC would focus on in the assessment. However, there was a general feeling that it required extensive work within too short a timescale. More guidance around completing the IR would also be welcomed; suggestions included greater clarity in documents required within the IR and an exploration of the language and terminology ICSs use ahead of time.

- Most ICS participants felt the fieldwork sessions were well run, allowed for the right information to be communicated and had an appropriate duration. There were some logistical challenges in organising interview slots, and a lack of clarity around who should be invited to each discussion. To improve this stage, it was suggested that CQC could profile ICSs before assessment to understand how they operate and who the key stakeholders are.

- There were mixed views around the assessment framework among those ICS participants that were aware of it. Most positive feedback noted it being a useful tool to underpin assessments and aid understanding of what good looks like. Negative feedback commonly included that it needed adapting for systems (e.g. focusing on the entirety of the system, rather than component parts) and that vital areas of focus were missing (e.g. a focus on working relationships)

- There were mixed views on the structure and usefulness of reports amongst those ICS participants that had seen them at the time of the interviews. Negative feedback focused on the existence of factual inaccuracies, difficulties understanding which part of the ICS were being referenced throughout the report, and delays around their publication. Suggestions for improvement include setting up a system that would allow CQC to cross-check data; receive feedback on the terminology used to ensure it is not too technical and appropriate for a general reader; and have timely publication.[5]

Capacity, capability and credibility

- Despite some concerns among ICSs, CQC inspectors were generally viewed as having the skills and experience needed to carry out system assessments. Inspector backgrounds in adult social care were seen as valuable among LA staff and staff across case studies valued senior inspectors with assessment experience.

- Perceptions of credibility were strongly correlated with perceptions of skills, knowledge and experience i.e., staff who had a high level of experience and knowledge were deemed to be credible. CQC should ensure their assessment teams continue to include experienced and knowledgeable team members.

- Some participants from ICSs and LAs thought CQC inspectors lacked thorough knowledge of systems thinking (e.g. how system components interact in a complex setting) and sufficient detail on how specific systems being assessed operated, which impacted credibility. Participants recommended that CQC profile the systems ahead of the on-site fieldwork to identify key roles and responsibilities within the system and key information.

- Participants were less likely to have strong views on CQC capacity. Some thought this seemed sufficient while others thought capacity might have affected specific areas of the assessment, for example the number of service users spoken to or the amount of analysis conducted on the IR.

[5] it is important to note that delays to publication were not related to internal processes at CQC, but discussions on the content and structure of the outputs between CQC and DHSC.

Wider CQC activity relevant to system assessments

- Delivery of CQC activity to collate intelligence across ICS and LA assessments and put insight into the public domain was limited to date.
- Some limited activity has taken place, including presenting findings at national conferences; including findings in the State of Care report; and using evidence in parliamentary round tables. Work was also ongoing to develop this activity.
- There was widespread positivity about the potential value of wider CQC activity. It was felt that activity could generate improvements in system and partnership working; improve public awareness of system regulation; and influence government policy.
- Key considerations for CQC around wider activity include ensuring generalisations are not made about complex systems, and ensuring insight is shared accessibly, without being too time consuming for staff.
- Many ICS and LA participants felt CQC could be involved in their ongoing improvement journey. Suggestions included CQC reviewing improvement action plans/strategies; providing ongoing independent scrutiny; and providing learning opportunities for senior system leaders. Further consideration should be given to exploring CQC's potential role in providing ongoing support for ICS and LA improvement.

Early evidence of outcomes

- The evaluation explored the extent to which CQC's system regulation activity contributed to anticipated immediate and short-term outcomes. These outcomes were outlined within the Theory of Change (ToC)6 that was developed at the beginning of the research (see Chapter 4). CQC's longer term outcomes were also included within the ToC, but participants were only asked for their reflection on the likelihood of them being achieved in the future. The extent to which CQC activity has contributed to the immediate and short-term outcomes is described below. More detail on these outcomes and how they were assessed is covered within Chapter 10.

[6] A visual representation that outlines the activities a programme will undertake, the ultimate impact it aims to have, and the outcomes that lead or contribute to the longer-term impacts.

- There was strong and consistent evidence that CQC activities have contributed to immediate outcome of 'creating a framework for ICSs and LAs to understand their performance and future priorities'. There was also some evidence that 'CQC have built a greater understanding of system regulation' through their assessment activities, though evidence was weaker for ICSs where delays in publishing assessment reports and starting formal assessments had limited achievement of this outcome. Both LAs and ICSs were positive about the potential for CQC activities to achieve the outcome of 'local and national insight into performance, what good looks like, and where system issues/gaps emerge', but this had not yet happened to date.

- There was strong and consistent evidence that CQC's regulatory activities have led to 'improvements at the ICS and LA system level'. For example, all LAs and 1 ICS described the development of action plans or strategies as a result of the CQC assessment, and there is evidence of LAs implementing improvements (e.g. around unpaid carers and Equality, Diversity and Inclusion) as a result of the assessment. There was some evidence of 'CQC contributing to a greater understanding of systems', largely through leading to increased self-reflection as a result of assessment activities. Most participants also said that improvements made across their ICS/LA were 'inclusive of adult social care', as collaboration and joined-up working was already a key element of their delivery. However, overall, there was limited evidence that CQC assessments themselves had led to greater inclusion of social care.

- Most participants felt it was too early to comment on the possibility of CQC achieving its longer-term outcomes. The limited number of assessments and short time period in which change could have occurred were cited as the main reasons for this.

- To date, CQC has had most impact by setting out their quality expectations within assessments and guiding ICSs and LAs to take necessary action by identifying areas for improvement. There is also the potential for CQC to have impact by sharing information on system regulation within the public domain.

Conclusions and future considerations

The research found many positives in CQC's regulatory approach for both ICS and LA assessment. Participants felt system regulation adds value and that CQC's approach has laid a solid foundation on which to conduct future formal assessments. However, CQC could make some considerations to improve their approach and potential impact (more information is included within Chapter 11). In future CQC could:

1) Further clarify pre-fieldwork requirements, minimising the burden this places on ICSs and LAs, and providing reassurance that all relevant information provided has been reviewed by CQC.

2) Continue to ensure assessment teams include members with relevant skills and experience and continue to share details on site visit assessment team roles with LAs, and in future ICS assessments.

3) Consider profiling LAs and ICSs before assessments to understand how they operate.

4) Consider how the assessment framework could be more comprehensive, including ways it could be further tailored to the ICS assessment approach.

5) Continue running LA surveys to gather perceptions on the assessments and begin this for the formal ICS process. Further consideration should be given to questions around impact that can help CQC understand their role, for example questions around actions systems took as a result of the assessments

6) To support any future theory-based evaluation, keep the ToC updated to reflect the reality of ICS and LA assessment delivery.

7) Ensure information about ICS and LA assessments continues to be codeveloped, outline future plans and provide regular updates to ICSs and LAs on any future changes.

8) Consider the level of specificity of information provided in the reports and ensure it is targeted and focused. A plain English summary could also be provided to complement the reports.

9) Continue developing activity to share wider information in the public domain through a variety of engaging formats.

10) Consider the potential of CQC providing ongoing support for ICS and LA improvement journeys.

2 Introduction

This is the final report from research into the effectiveness and mechanisms of impact of Care Quality Commission's (CQC) system assessment activity. The research, commissioned in October 2023, was undertaken by IFF Research. The Centre for Evaluation of Complexity Across the Nexus (CECAN) supported through delivery of Participatory Systems Mapping (PSM).

Policy and legislation background and context

The health and social care sector in England has faced a number of significant challenges in the last decade, including growing demand care, unfilled vacancies and an ageing workforce, high staff turnover, and deepening inequalities in access. Challenges in accessing care and receiving poor care are often influenced or caused by services not being joined up or working well together. When local services work together, people get better care.

In January 2019, the NHS long-term plan was published, setting out the key ambitions for health and care services over the next 10 years.[7] It included a range of commitments to improve care for patients, including making sure everyone gets the best start in life; delivering world-class care for major health problems; and supporting people to age well. The plan also confirmed a move towards integrated care and place-base systems as a defining feature of NHS policy.

Building on the ambitions set out in the long-term plan, the Health and Care Act (2022)[8] introduced significant reforms to the organisation and delivery of health and care services in England. The changes sought to embed and accelerate the collaboration between NHS and other partners

The Act also confirmed the creation of statutory Integrated Care Systems (ICSs). ICSs were legally established in July 2022, with 42 covering all of England.[9] ICSs are partnerships that bring health and care organisations together to develop shared plans and joined-up services. They are formed of NHS organisations and local councils in an area and also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing. ICSs have a responsibility to make sure services work together to meet people's health and care needs.

The NHS organisations and local authorities (LAs) in each ICS run a joint committee called an integrated care partnership (ICP). This is a broad alliance of partners who all have a role in improving local health, care and wellbeing. Each ICP must develop a long-term strategy to improve health and social care services and people's health and wellbeing in the area. There is also 1 integrated care board (ICB) in each ICS area. These are NHS

[7] NHS Long Term Plan
[8] Health and Care Act 2022
[9] NHS England » What are integrated care systems?

organisations responsible for planning health services for their local population. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree how the NHS will contribute to the ICP's integrated care strategy.

LAs[10] are also a central component of the health and care system – their work affects the way people experience health and care services by ensuring that people are able to live their best lives as independently as possible, while ensuring that their equality and human rights are respected and preserved. Publicly funded adult social care in England is largely the responsibility of local, not national, government[11], with more than £20 billion spent by LAs each year on care services. The Care Act 2014 set out national eligibility criteria for both carers and the person being cared for.[12] These criteria set a national minimum threshold to be met, and if a carer or the person being cared for meets this threshold, they will have eligible needs that the LA must then meet. LAs though set their own assessment procedures and have discretion to provide care to those with needs that do not meet the nationally set criteria.

CQC system assessment

The Health and Social Care Act 2022 gave CQC a new responsibility to provide meaningful and independent assessments of the provision of health and adult social care services within each ICS and LA. CQC is the independent regulator of health and social care services in England.[13] It is their purpose to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

The aim of ICS assessments is to understand the extent to which they are meeting the needs of local populations. It is anticipated that this will help CQC understand how ICSs are working to tackle health inequalities and improve outcomes for people. This work also intends to provide independent and meaningful assurance to the public about the quality of care in their area. For LAs assurance, the aim is to understand how well LAs are meeting their duties under Part 1 of the Care Act (2014).[14]

The Health and Social Care Act 2022 required the Secretary of State for the Department for Health and Social Care (DHSC) to set the priorities and objectives of CQC's new powers; with CQC determining the indicators of quality, methods, and frequency for the reviews with Secretary of State approval. Within the LA work, the Ministry of Housing, Communities and Local Government (MHCLG) plays a key role in ensuring LAs are meeting the 2014 Care

[10] LAs are made up of councillors who are elected by the public in local elections. Councillors work with local people and partners, such as local businesses and other organisations, to agree and deliver on local priorities. The decisions are implemented by permanent council staff, council officers, who deliver services on a daily basis.
[11] Note with the exception of NHS Continuing Healthcare.
[12] Care Act 2014
[13] About us - Care Quality Commission
[14] Care Act 2014

Act. DHSC work in partnership with MHCLG to share intelligence on common challenges and ensure a coordinated and collaborative approach across national government.

CQC's approach to ICS assessment and LA assurance is based around an assessment framework, implemented in 2022. The framework covers provider and system level regulation, but with system assessment activity centring around a sub-set of the quality statements to reflect the different statutory duties compared to providers. ICSs are assessed against a subset of 17 quality statements[15] across 3 themes: quality and safety; integration and leadership. In LAs, a subset of 9 quality statements mapped across 4 themes are used: working with people; providing support; how the LA ensures safety within the system; and leadership. See Appendix 1 for more detail.

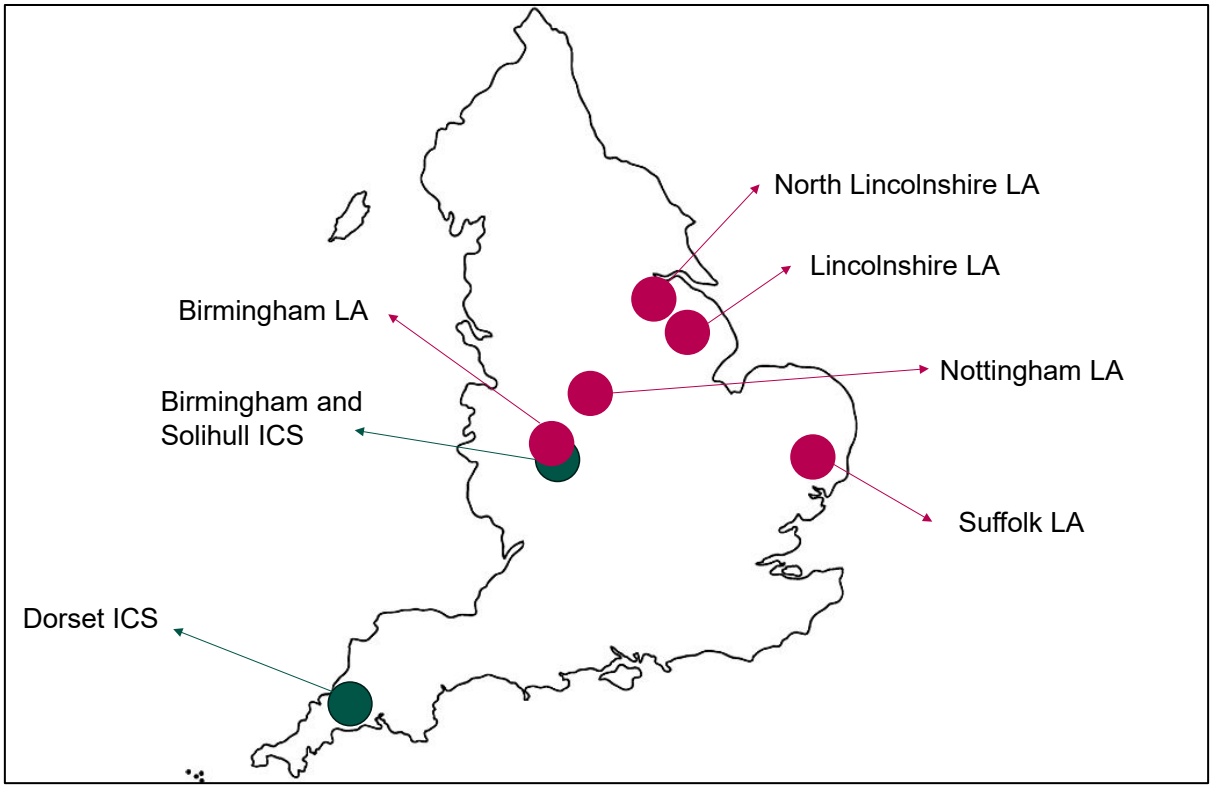
CQC commissioned a review of the assessment framework which was undertaken in late 2024. It highlighted that, while having some positive elements, it was too complex and, as currently constituted, did not allow for the substantial differences in the size, complexity and range of functions of the services that CQC regulates.[16] This is important for the reader to keep in mind when reflecting on the findings about the assessment framework in this report.

Pilot and roll-out of system assessments to date

In Summer 2022, CQC undertook test and learn exercises with 2 LAs and 2 ICSs to test their assessment approach.[17] Using the learning from this, the approach was piloted in 5 LAs and 2 ICSs during Summer 2023. The 7 pilot sites were selected from those who volunteered to take part and using criteria to ensure that the pilots covered a range of LA and ICSs by size and geography. The 7 pilot sites are shown on the map below (Figure 2.1).

[15] Quality statements are the commitments that ICSs and local authorities must commit to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.
[16] Review of CQC's single assessment framework and its implementation - Care Quality Commission
[17] To test the methodology for this, CQC led 2 test and learn projects in Hampshire and Manchester LA and Northeast London and South Yorkshire ICSs. This involved a team, including inspectors, data analysts and policy leads, testing the full assessment approach.

Figure 2.1 Seven pilot assessment locations



As part of the pilot work, CQC undertook an internal evaluation of both LA and ICS assessment processes. Findings supported the refinement of the process ahead of the initial formal assessment period for LAs and CQC plan to carry on developing and refining their LA assessment approach throughout the initial formal assessment period. In the initial 24 months of the assessment period it is expected that CQC will have undertaken the site visits for all 153 LAs in England. The first 3 LA initial formal assessment visits took place in February and March 2024, with reports published in May 2024. At the time of writing this report, 10 LA initial formal assessments had been completed, and 58 assessments were underway.[18]

Formal ICS assessments have not yet started due to delays in obtaining ministerial approval of the assessment process and a formal pause in response to a recommendation in the Penny Dash Review.[19] The review highlighted concerns over the rollout of the ICS assessments, with questions as to whether the 'right' approaches were being used to assess the 'right' outcomes. The review also noted that there was a lack of descriptors as to what 'good' looks like for ICSs, questions as to what data should be considered to make a

[18] Report for the LA evaluation can be found here: Local authority assessment reports - Care Quality Commission. Findings from the ICS evaluation have not been published.
[19] In May 2024, Dr Penny Dash was asked by the DHSC to conduct a review into the operational effectiveness of the CQC. The final report, published in October 2024, can be found here: Review into the operational effectiveness of the Care Quality Commission: full report - GOV.UK

meaningful assessment of leadership, integration and quality, and concerns around duplication of provider assessments.

For wider context, the Penny Dash Review (interim findings published in July 2024 and final in October 2024) also found significant failings in the CQC at provider-level. This included that CQC's ability to identify poor performance and support quality improvement in the health and social care sector has deteriorated. The review recommended that CQC should rapidly improve operational performance; improve the quality (e.g. structure, labelling, findings) and timeliness of reports; rebuild expertise and relationships; review the assessment framework (to define what different ratings look like for each evidence category and quality statement; give greater emphasis to outcome measures; and ensure inspectors know how to conduct assessments under the assessment framework); and make ratings more transparent.

3 Research approach

Aims and approach

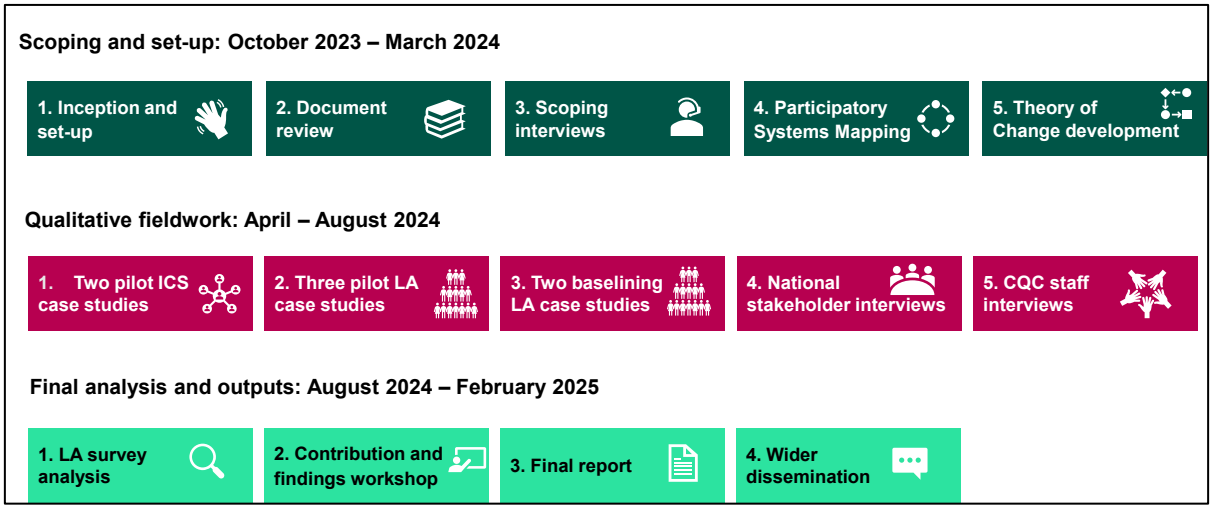
In October 2023, the CQC commissioned IFF Research to undertake research to assess the extent to which CQC's approach to LA and ICS assessment was effective, and to understand the mechanisms through which CQC can have impact as a regulator in a system setting.

The research aimed to explore the following questions:

- How effective is CQC's regulatory approach to ICS assessment and LA assurance?
- What are the key mechanisms through which CQC has impact in a system setting?
- How can the impact CQC have be identified and measured (on an ongoing basis, taking account of the fact that some impacts may be yet to emerge)?
- What could be improved about CQC's approach to maximise its impact?

The research used a contribution analysis method to achieve the research aims. This method involved comparing the Theory of Change (ToC) with evidence collected to determine if CQC's system assessment activity has contributed to the observed outcomes. Contribution analysis is a rigorous approach well-suited for evaluating interventions into complex systems. See Appendix 3 for more details on the approach. Figure 3.1 below summarises the research approach and timescales.

Figure 3.1 Research approach



Scoping and set-up

An initial scoping and set-up phase included a document review. This included reports from CQC's initial pilot research activity, assessment briefing documents, and information on key elements of the assessment process. A total of 37 documents were reviewed and analysed. Ten scoping interviews were also completed, with 4 CQC colleagues and 6 representatives from the pilot LAs and ICSs. These activities helped to govern research direction and inform research tool development. See additional detail in Appendix 3.

During this stage, CECAN undertook Participatory System Mapping (PSM).[20] The method engaged stakeholders from the Birmingham and Solihull ICS to explore the complexity of the system they work in. The process promoted a shared understanding of the context in which the research was operating in. It also highlighted the interlinkages between different parts of systems and aspects of system delivery that CQC could potentially influence as a regulator of systems. The mapping workshops involved 2 half-day sessions (with the first face-to-face and the second online) on 29th February and 4th March 2024. Key findings from the PSM can be found in Chapter 4 and the full PSM report drafted by CECAN can be found in Appendix 4.

A ToC was developed around CQC's assessment approach (see Chapter 4 below). Following this, a research and contribution framework was developed. The framework depicted the research objectives, associated research questions, and methods and sources for data. The full framework can be found in Appendix 5.

Qualitative fieldwork

Both pilot ICSs and 3 (of the 5) LA pilots took part in case studies between April and September 2024. Two LAs who had undergone initial formal assessments (referred to as formal LAs throughout this report) took part in case studies between August and September 2024. In total, 107 participants contributed to the research; this included 100 interviews and analysis of 7 transcripts from interviews CQC had undertaken (see 'Research Considerations' below). Twelve national stakeholders (e.g. government and sector body representatives and 10 CQC staff members also took part). See Table 3.1 for a summary of fieldwork, and Appendix 3 for details of how case studies were selected and for more detail on the organisations and roles of those who took part.

[20] Participatory systems mapping (PSM) is a facilitated stakeholder process used to develop a qualitative visual model of a system and capture narratives on how the system works. The system map generated shows the factors affecting the behaviour of the system and their causal relationships.

Table 3.1 Participation in qualitative fieldwork

	Number of participants
Dorset ICS (pilot)	17
Birmingham and Solihull ICS (pilot)	17
North Lincolnshire LA (pilot)	10
Lincolnshire LA (pilot)	12
Nottingham City LA (pilot)	10
Hertfordshire LA (formal)	9
Bracknell Forest LA (formal)	10
National stakeholders	12
CQC staff	10
Total	**107**

LA survey analysis

CQC designed and administered 3 surveys to be shared with LAs who had undergone an initial formal assessment to capture a range of perspectives on 1) the information return (IR); 2) on-site fieldwork; and 3) the assessment report. Surveys were first shared with LAs in September 2024 and the survey data included in this report is based on completes received up until November 13th 2024. At the time of analysis for this report, 92 responses had been received from 36 LAs. The number of responses and LAs represented varied between each survey. LAs received surveys depending on which stage of the assessment process they had reached, which meant that some LAs would only have been invited to survey 1, some to 1 and 2 and some to all 3 surveys. Surveys were completed at an individual level, with multiple responses allowed from each LA, although some LAs elected to coordinate a joint response. This data has been triangulated with the qualitative data described above and included where relevant in this report. See additional detail in Appendix 3.

Research considerations

CQC's system assessments and this research were undertaken within an ever-changing landscape. This included a change of Government in July 2024 and the publication of the Penny Dash Review in July (interim) and October (final) 2024. Readers should also keep in mind that there were delays in publishing the ICS assessment reports associated with the changing context. These factors affected the perspectives among ICS participants of the CQC assessment in general as well as affecting their ability to talk about the reporting aspect of the assessment. As described above, there were also delays in progressing ICS assessments beyond the pilots. This means that this report provides findings related to the pilot assessments only.

Additionally, data collection was undertaken at differing timeframes following completion of CQC assessments. For some pilots, the research took place close to a year after the assessment, whereas for the formal LAs, this was a matter of weeks. This resulted in some challenges engaging staff in the research or some participants saying they did not feel able to comment or provide observations given that either a substantial length of time had passed (so they struggled with recall) or that events had happened too recently to put them in perspective. CQC's previous evaluation of the pilot assessments also meant there was some reluctance to engage in further discussions. Data collection was adapted through analysing CQC's previous interviews instead of conducting new ones where participants requested this or were not available to take part in this research. Findings in this report represent progress at the point of data collection and provide illustrative examples that are not intended to be exhaustive.

It should be noted that findings from this research may not be generalisable beyond the particular case study areas explored in this research and the particular period of time the research covered. Qualitative case study evidence is not intended to imply prevalence but rather to illustrate the range of experiences of CQC's system assessment and provide depth of understanding.

4 CQC’s System Assessment Theory of Change

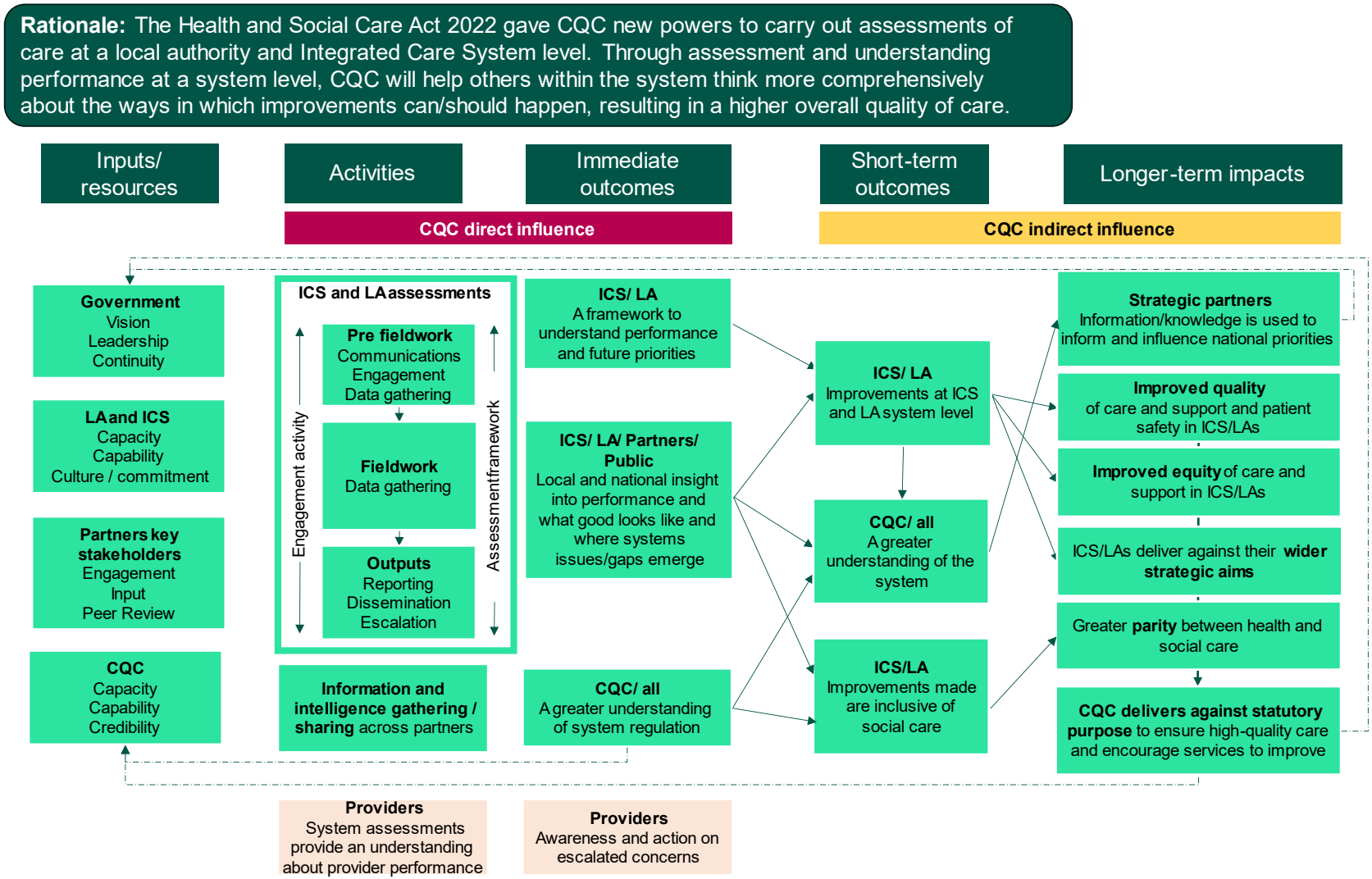
To sum up the purpose of CQC’s system assessment approach and how it is intended to deliver value, a ToC was developed. The ToC is a visual representation that outlines the activities that a programme is going to undertake, the ultimate impact it aims to have, and the outcomes that lead or contribute to the longer-term impacts. The ToC was developed through a dedicated workshop with CQC staff.

For the purposes of CQC’s system regulation activity, the ToC has 5 elements:

- The rationale for acting;
- The inputs and resources that are required to deliver the programme of work;
- The activities that are carried out with those resources;
- The outcomes (immediate and short-term resulting from the activities);
- The impact of the work and the ultimate effects of the combined outcomes.

Figure 4.1 below presents the full ToC. Suggested updates to the ToC following this research can be found in Appendix 2.

Figure 4.1 CQC system regulation ToC



Inputs and resources

Inputs are the resources – funding, policy and stakeholders - that are required to deliver the key activities of the CQC's system regulation activity, and which are necessary to bring about the desired outcomes and impacts. During the development of the ToC, CQC staff felt the key inputs were:

- Government vision: it is important that DHSC and MHCLG have a clear vision, approach and ask which is effectively communicated across stakeholders. There should also be a commitment to this over the long term.
- CQC leading regulatory activities: including communicating with partners/ICSs/LAs, gathering data, conduct assessments (score and report the data) and disseminate the findings, intelligence and insight to a wide range of stakeholders.
- LAs and ICSs engaging with the regulatory process: Local authorities and ICSs are required to engage with the regulatory processes so that data is effectively gathered against the assessment framework.
- Engagement of key partners and stakeholders: Partners and key stakeholders play multiple roles as part of the assessment process. They might be required to provide data/feedback or provide peer review on the outcome of the regulation process.

Activities

At the time of this research, CQC's ICS and LA assessments consisted of 3 key stages: 1) pre-fieldwork; 2) fieldwork; and 3) outputs. Engagement activity runs alongside the assessment. Full details of each of these stages are provided in the relevant chapters in this report, but in summary they involve:

- Pre-fieldwork: ICSs and LAs are required to share information with CQC ahead of the fieldwork stage. For LA assessments the pre-fieldwork stage also includes engaging with voluntary and community sector organisations, and some engagement with people who use services. The process differs between ICSs and LAs and has been amended over time.
- Fieldwork: this includes interviews and discussions with a range of staff and system partners on site at ICSs and LAs. It also includes gathering the experiences of local people.
- Outputs: the culmination of the assessment is a report that provides detail on the findings. It includes an assessment rating of outstanding, good, requires improvement, or inadequate.[1]

[1] More information on how CQC rate and score can be found here: How we reach a rating - Care Quality Commission

- Engagement (throughout the process): discussions with staff across ICS/LA (particularly before and after the assessment) to support their involvement in the process and answer any questions/queries.

In addition to these assessment activities, there is opportunity for CQC to undertake a range of engagement activities with key stakeholders outside of the assessment processes going forward. This includes making connections with partners to share insight and knowledge not specific to individual assessment outcomes – for example, key themes that have come out across ICSs and LAs. Potential activity includes both targeted engagement (e.g. speaking at conferences and attending networking events), as well as sharing through CQC's independent voice publications (e.g. the State of Care report[2]). This activity is currently still in its infancy and CQC will continue to develop this over the coming months, as and when there are useful insights to share.

Activity at a local level involves information and intelligence sharing across the system to support CQC provider-level activity. This is shown in the orange boxes at the bottom of the ToC. It was anticipated that system assessments would provide an understanding about provider performance and if it identified specific concerns at a provider-level, these could be escalated for CQC to undertake provider-level action. System-level assessments should also investigate what systems are doing about any concerns noticed at provider-level. These are important mechanisms (as the system regulation has no direct enforcement powers) and shows where the CQC provider and system level work can interact and support each other. It should be noted that for LAs, CQC has a duty to make Section 50 referral to DHSC for any inadequate rated LAs or where a quality statement (other than leadership) requires a score of 1.

Immediate outcomes

The ToC makes a distinction between direct and indirect outcomes. This is to distinguish the short-term outcomes that happen as a result of CQC activities, from the longer-term outcomes which depend upon a wider set of factors – and other stakeholder action - to materialise. Anticipated immediate outcomes, which CQC can directly influence, include:

- A framework for ICSs and LAs to understand their performance and future priorities: It is anticipated that the framework outlines a set of expectations and provides clarity to ICSs/LAs on what high-quality and effective care looks like. Assessment activity and the report will provide ICSs/LAs with an understanding of how they are performing in each area and clarity on areas of future focus.

[2] State of Care is CQC's annual assessment of health and social care in England. The report looks at the trends, highlights examples of good and outstanding care, and identifies factors that maintain high-quality care.

- Local and national insight into what good looks like and what is working well and less well: over time, as more regulatory assessments are completed, it is anticipated that the collective outputs will help to build up a local and national picture of system performance. The assessment activity will form a baseline that builds a clear local and national picture of what good looks like and what is working well and less well.

- A greater understanding of system regulation: through the process of conducting regulatory activities, it is intended that CQC builds a clearer understanding of the role of regulation in a system setting and how regulatory activities can be applied to add greatest value to ensure health and social care is high-quality and effectively delivered. It is anticipated that this process is time limited (primarily during initial delivery) as over time it would be expected that CQC has a stable and consistent approach to system regulation. After that it would be expected that CQC have a stable and consistent approach to system regulation and developing system assessment/assurance.

Short-term outcomes

Anticipated short-term outcomes include:

- Improvements within LAs and ICSs: one key assumption – and significant change mechanism – is that the LAs, ICSs and partners that take part in assessment activities and receive the assessment report reflect on and then *act upon* the findings. This assumption is especially critical because CQC has no direct powers to enforce change at system level, although they can escalate concerns for Government intervention (see point earlier about provider-level interactions).

- A greater understanding of the complexity of the health and social care system: it is anticipated that the immediate outcomes described above together help create a greater understanding of how systems operate as part of the wider health and social care landscape amongst CQC and other stakeholders. In addition to the assessment activity supporting an understanding of how well systems are performing and what are the common areas of strength and weakness, there will be a better collective understanding of how the overall health and social care system is operating.

- Improvements made are inclusive of social care: it is anticipated that stakeholders (including CQC, ICSs, and Government) will have a stronger understanding of the complexity of adult social care and through LA and ICS assessments and the sharing of insights may be encouraged to identify and act upon areas that require greater integration. The assumption being that these changes would be reinforced by a greater understanding of performance and system regulation to inform system-wide strategy and decision making and help systems to make changes that are more inclusive of social care.

Longer-term impacts

The longer-term outcomes of LAs and ICSs acting upon the system assessment findings are anticipated to be better quality and equity of care and support at a local level. There is also a longer-term outcome around improved quality and equity of care and support anticipated at a national level. It is also anticipated that social care will have greater parity with healthcare.

It is anticipated that improvements at ICS and LA drive improvements in quality and equity of care, support and safety across the wider system because a clearer picture of what good looks like and the process of regulation motivates other ICSs and LAs to implement self-directed improvement processes.

Taken together, it is anticipated that individual LA and ICS improvements alongside national strategic decision making, will lead to the overarching outcome that the CQC delivers against its wider statutory purpose to ensure high-quality care and encourage services to improve.

Wider context – participatory systems mapping

CECAN undertook PSM during the scoping phase of this research. This was designed to capture complexity of systems, rather than simplify it away. It also promoted a shared understanding of the context in which the research and systems are operating and, through making complexity explicit, make it easier to identify what is important for CQC system assessment and where efforts should be focused.

The PSM identified 5 key points of wider context important for CQC's system assessment:

- Systems are dynamic and there is ongoing transformation. ICSs and LAs are constantly evolving, and in the case of ICSs still becoming embedded. This creates challenges for leadership and stakeholders in delivering health and care.
- The map produced as an output from the mapping activity with Birmingham & Solihull ICS showed a clear division between health and social care systems, with the factors and mechanisms related to health care being more developed and established. Social care was consistently raised as an area that required further integration and inclusion within a system context. Social care and voluntary, community and social enterprises were also highlighted as being an important component of moves towards greater prevention of health and social issues. This finding is likely to be true for many ICSs.
- Pressures on the health system were highlighted, including growing waiting lists for care and lengthening Accident and Emergency waiting times. It was felt that these urgent pressures can make it challenging for systems (and wider stakeholders, e.g. Government) to focus attention on social care reforms, and develop plans for closer integration of health and social care.

- Budgetary and financial pressures were also noted and raised in relation to the interaction between NHS and LA systems and processes. The NHS and LA budgetary systems work alongside one another but have different processes, timescales, and priorities. It was felt that the aim was to achieve a balanced budget but pressures on services often result in an overspend.

  There were a number of factors outside health and care systems that were felt to be beyond the control of ICSs/LAs, but which can greatly impact them (and therefore should be kept in mind during system regulation). Inflation, cost of living, and population age profile and other demographic factors (e.g. ethnicity) were all cited as important.

PSM also helped identify where CQC could have an impact through its interactions with health and social care systems:

- CQC assessment activity needs to incorporate a systems perspective and demonstrate that it is understanding performance and outcomes through this lens. This means appreciating the importance of context to outcomes, considering the upstream factors that affect particular outcomes, which sometimes may be quite distant from the outcome of interest, and acknowledging that outcomes often result from the work of multiple organisations interacting.

- CQC should consider how and how well ICSs understand the complexity of their system and are building learning and improvement into their development. It will be important to consider a shift to making assessment of ICS 'an opportunity to support and incentivise improvement, rather than a 'box ticking' exercise or compliance approach' as the Hewitt Review notes.[3]

- The importance of the CQC making assessments based on 'distance travelled', direction of travel and value added, i.e. the progress a system is making considering its own operational constraints, rather than absolute performance measures was highlighted. This was particularly noted in relation to comparing ICSs operating in different contexts.

[3] See 'ICSs develop their own improvement capacity' section of the Hewitt Review, April 2023 (page 42) https://assets.publishing.service.gov.uk/media/642b07d87de82b00123134fa/the-hewitt-review.pdf#page=42

5 Foundations of system regulation

This chapter covers ICS, LA (pilot and initial formal assessment) and national stakeholder participants' initial views on CQC's system regulation role. It also covers national stakeholder engagement in system regulation, as well as enablers and barriers for effective stakeholder engagement.

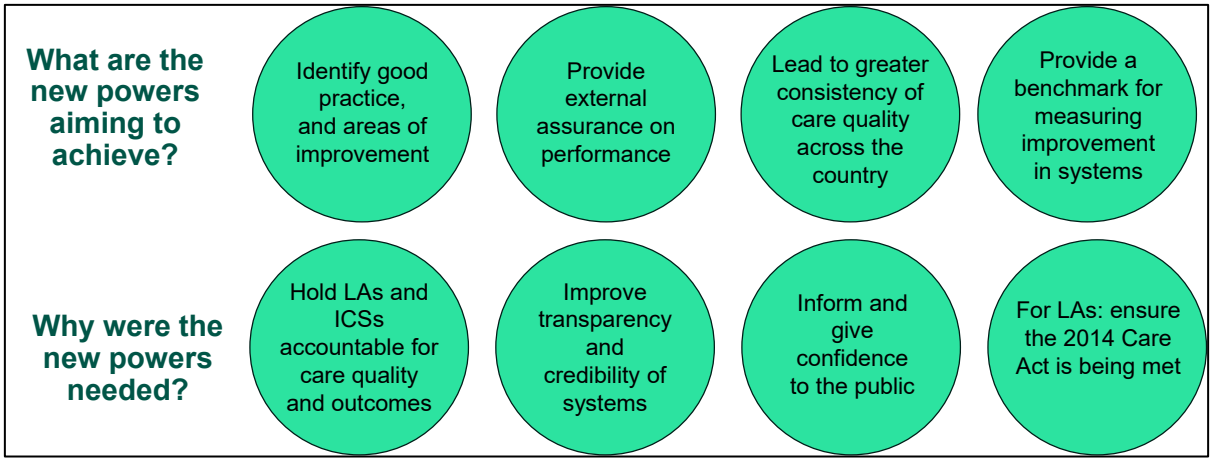
Key findings

- There was positivity around the added value that CQC's new system regulation role has had, and will continue to play, in health and adult social care. There was also generally strong understanding of CQC's new powers amongst ICS, LA and national stakeholder participants.
- Despite general positivity around CQC's new system regulation role, there were 4 potential risks or concerns frequently highlighted: the implications of CQC highlighting areas of system activity that were not working well; the potential for assessments to contribute to increased stress, anxiety and higher workloads for LA staff and those that work for organisations in the ICS; perceived fairness of the assessments and need for more clarity on how judgements were reached; and insufficient tailoring of assessments to the complexity of systems.

Understanding CQC's system regulation powers

There was generally strong understanding about the powers the 2022 Health and Care Act gave CQC, the rationale for the introduction of the new powers, and what this would mean in terms of system regulation for LAs and ICSs. Figure 5.1 shows the most common views from across LAs (both pilot and initial formal assessment), ICSs and national stakeholders.

Figure 5.1 Understanding of CQC's new powers



A small group of those who took part in the research, and particularly some ICS staff and national stakeholders, were however not confident in their understanding of CQC's new powers. Their only awareness was that it involved an assessment process but were not able to provide further details about the rationale for implementation or the impact on ICSs and LAs. The main reasons for this included feeling that the new CQC's powers were poorly communicated to them or that paused ICS assessments raised questions around how the approach would work going forward. Participants also expressed that they would have welcomed more official communication directly from DHSC or MHCLG about CQC's new powers and what this would mean for their organisations.

"I'm not sure that I'm entirely clear, because from my point of view I think the messages have been a little inconsistent…I'm absolutely clear what CQC's powers are in relation to my provider organisations, but in relation to the shift to the system focus I think the messages have been a bit inconsistent...The inspections were happening across the system at system level, but those appear to have been paused...I'm not sure I can give you chapter and verse."

ICS manager

There were also 2 aspects of CQC's system regulation that were commonly unclear across ICS, LA and national stakeholders. Firstly, only a small number of participants in the research were aware that CQC's do not have powers of enforcement, though are able to escalate to the Government if action is needed.[4] Senior ICS staff were largely clear about this; though none felt it had been directly relevant for their assessment. Most ICS, LA and national stakeholders though thought that CQC held the same powers for system and provider regulation, i.e. that CQC had direct powers of enforcement.

The second aspect was future plans for CQC system assessments. Many believed that CQC would undertake a regular programme of ICS and LA assessments going forward, in the same way that provider assessments are undertaken. It was not widely understood that CQC are in the process of co-designing post baselining, so the ongoing programme is still being developed.

Views on CQC's system regulation role

Overall, views on CQC's new system regulation role were positive amongst LA (pilot and initial formal assessment) and ICS staff. They held similar views, and it was widely felt to be a value-added activity to support the health and social care sector, in 5 key ways:

- Providing a comprehensive and country-wide understanding and oversight of the quality of services provided to people in different areas;
- Highlighting areas for development opportunities and identifying good practice;

[4] It should be noted that for LAs, CQC has a duty to make Section 50 referral to DHSC for any inadequate rated LAs or where a quality statement (other than leadership) requires a score of 1.

- Introducing a level of rigour to ensure a joined-up approach to health and social care;
- Fostering collaboration across systems, particularly within ICSs to support them to work together to deliver co-ordinated and seamless care across health and social care services;
- Offering the government and public assurance that LAs are meeting their duties in the 2014 Care Act.

At an individual ICS and LA level, initial views about being involved in a system assessment mainly focussed on it being a good opportunity to understand and reflect on their current performance, showcase their good practice, and gain an external perspective on areas of strength and weakness. For pilot ICSs and LAs, taking part at an early stage was felt to be a good opportunity to lead and shape system regulation activity.

"We had a good story to tell, and we could do with some external validation of that, and also to say where it was that we needed to focus on."

"It would be really good to be a part of [i.e. take part in the pilot] shaping how the scheme [CQC regulation] is going to end up."

LA managers

Despite the general positivity, there were 4 common potential risks or concerns raised about system regulation.

Firstly, as with any assessment activity, concerns were raised about the implications of CQC highlighting areas of system activity that were not working well and/or being rated as inadequate. ICS and LA staff shared concerns about potential damage to their reputation and public criticism, loss of trust from local populations and other issues such as reduced employee morale and loss of funding opportunities. This concern was not highlighted as a reason for not progressing system assessment but was felt to be important for system leaders to keep in mind.

A second concern was that assessments could contribute to increased stress, anxiety and higher workloads for ICS and LA staff.

"I think anyone will say they don't really want to be assessed. It's nerve racking…doesn't mean it shouldn't be done, but just needs to be done in the right way."

ICS strategic lead

This was seen as a relevant concern given the already challenging financial and staffing constraints facing LAs and ICSs. Strategic leads described having to divert time and energy from other critical areas of work in order to ensure sufficient time was given to the assessment (for example to complete the IR).

"It is important [to regulate systems], but not at the expense of other activity. We need a balance."

LA strategic lead

Thirdly, that there were aspects of the system assessment process that could be better explained (for example, the assessment scoring) to help allay any concerns that the assessments were not 'fair' or would lead to an inaccurate picture of the ICS/LA being shared publicly.

More detail on LA and ICS experiences of specific aspects of the process, including reporting, can be found in Chapters 6 and 7.

A fourth concern was that insufficient thought had been given to how to tailor assessments to the complexity of systems. ICS and LA participants highlighted concerns around the challenges of the assessment framework in accurately accessing the variation and diversity in systems. More detail on the assessment framework in relation to LA and ICS assessments can be found in the 'assessment framework' section of Chapters 6 and 7 respectively.

National stakeholder engagement

National stakeholders, including MHCLG, DHSC, NHS England (NHSE), Local Government Association (LGA), and The Association of Directors of Adult Social Services (ADASS), played 3 key roles in CQC system assessments (Figure 5.2).

Figure 5.2 Roles played by national stakeholders

Collaborating with CQC in designing and developing the assessment methodology

Who?	LGA, ADASS, NHSE, HealthWatch, VCSE organisations (including AgeUK).
What?	This included providing advice and guidance around elements of the methodology. This was typically through regular meetings, or workshops to discuss and develop specific aspects of the methodology.
Why?	Providing a diverse perspective that brings valuable insights from different regions, sectors and levels of care and ensures the assessments reflect different lived experiences of service users; and building trust and confidence in the assessment process amongst the public and other organisations.

Overseeing and signing off assessment approach and methodology

Who?	DHSC and MHCLG.
What?	This included setting the priorities and objectives of CQC's new powers.
Why?	As outlined in the Health and Social Care Act 2022 (see Chapter 1 for more detail). Also ensuring the assessments' alignment with broader national health and social care priorities.

Providing support for ICSs and LAs in preparing for and undergoing a CQC assessment

Who?	LGA and ADASS.
What?	This included having weekly meetings with LAs, sharing good practices, supporting LA staff to develop their own narrative, encouraging LAs to support each other, as well as providing feedback to CQC on areas of improvement.
Why?	Ensure ICSs and LAs felt supported and able to have a member organisation to collate and share learning with CQC.

Broadly, stakeholders felt engagement with them had been working well. They appreciated CQC's collaborative approach, willingness to engage, and openness to feedback. Stakeholders felt value had been added to the assessment process through CQC incorporating their views.

"It did feel like we co-designed the system…The quality of those relationships is warm, honest and trusting…We've done joint engagement, so we've done webinars with them all across the country, so I think they've invested a lot of time in preparing local authorities and reassuring local authorities [about the process]."

National stakeholder

There were 3 suggestions for improvements to stakeholder engagement going forward:

- More opportunities for organisations to feed into the development of the system assessments. For example, organisations representing the patient and public voice felt they had valuable suggestions for improving the case tracking process, which they had not had the opportunity to share with CQC.
- More opportunities to feed into the iteration and development of the assessment reports. Some stakeholders felt they had ideas to contribute to ensure the reports were as useful as possible for systems and the wider sector.
- Greater communication ahead of time with stakeholders about plans for ICS and LA assessments. For example, the timetable and schedule for upcoming assessments, and when CQC were publishing reports that indicated that a system 'requires improvement'. Some stakeholders, e.g. LGA and ADASS, felt this would help them to be prepared to support systems in a timely manner.

6 Experience of local authority assessments

This chapter presents findings on how pilot and LAs who had undergone initial formal assessments (formal LAs) experienced the assessments, from pre-fieldwork activities to the reports. Across the pilot LAs of North Lincolnshire, Lincolnshire and Nottingham City, 32 participants took part in a qualitative interview. Across the formal LAs of Hertfordshire and Bracknell Forest, 19 participants took part in a qualitative interview. Formal LAs also had the opportunity to complete 3 surveys administered by CQC. At the time of analysis for this report, 92 responses had been received from 36 LAs.

Key findings

- LAs found the IR and self-assessment returns (SAR) to be valuable but time-consuming exercises. CQC staff and LA staff thought the clarity of the ask for the IR could be improved.
- The on-site stage of the assessment was viewed positively by LA staff who thought CQC inspectors involved the right people in discussions, asked appropriate questions and seemed knowledgeable and experienced.
- Across LAs, knowledge of the assessment framework was limited and there were mixed opinions on its usefulness and relevance.
- Assessment reports were viewed as useful overall, but staff raised concerns over accuracy. Some participants also said they were surprised and disappointed by instances where concerns raised by 1 individual were included in the final report without being corroborated with other sources.

Overview of the assessment process

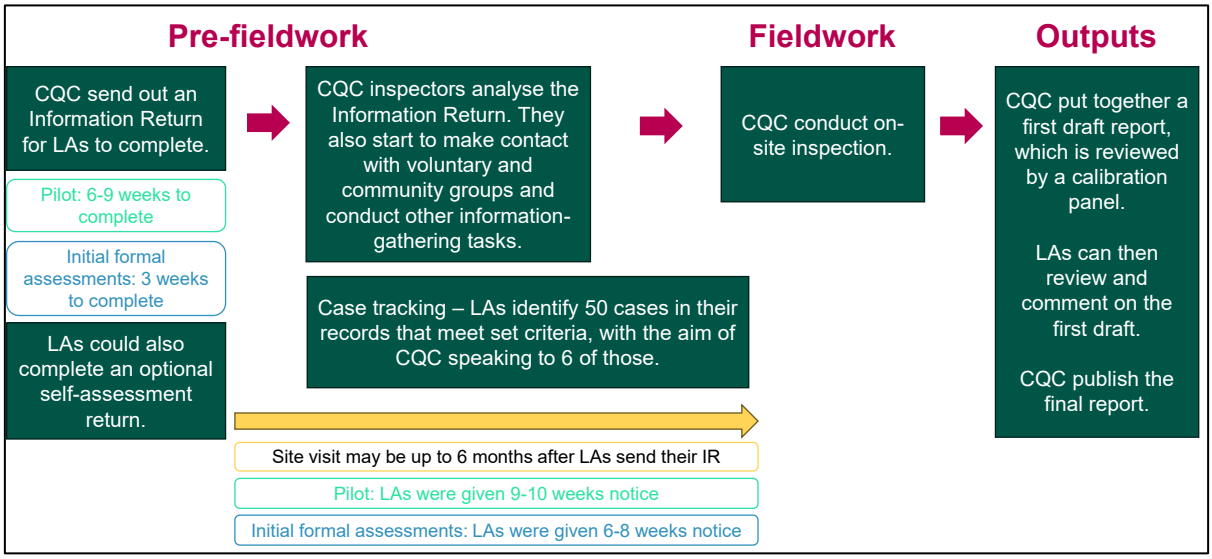
Both pilot and formal assessments included a pre-fieldwork information gathering stage, a case tracking exercise, on-site fieldwork and the delivery of an assessment report. As shown in Figure 6.1, LAs completed an IR ahead of the on-site visit. LAs received an IR request from CQC, which provided a list of the items, such as process, strategy and policy documents, that CQC wanted to review, the time period data requested should cover and guidelines on how LAs should approach the exercise. LAs were also given the opportunity to complete a SAR. CQC describes this exercise as an opportunity for LAs to assess their own performance against the quality statements. This SAR could be submitted in any format LAs chose.

After the IR was completed, CQC spoke with local voluntary and community groups and unpaid carers. They also sent a survey for registered providers to complete. The next main phase was on-site fieldwork, where a CQC assessment team carried out an on-site visit to conduct interviews with LA staff, partner agencies and other stakeholders. LAs received a notification of their site visit date up to 6 months after they send their IR.

A case tracking exercise also formed part of the assessment. This is where CQC follow the journey of interactions a small number of people have had contact with the LA i.e. from the initial assessment of their needs to their care planning, movement through services and outcomes. This process allows CQC to gather evidence on each stage of the service people receive across organisations (through both data and interviews). LAs were provided with themes that CQC were assessing and asked to put together an anonymised shortlist of 50 people who fit these themes. CQC then shortlisted 10 people from this list, with the view of speaking to 6.[5]

Finally, CQC evaluated the findings and put together a first draft report. This report was reviewed by a calibration panel (made up of internal and external figures), which ensures consistency in the assessment approach. LAs were given the chance to review and comment on this first draft report. Following any agreed amends, the final report is published.

Figure 6.1 Overview of the assessment process



Note pilot LAs were notified of the assessment and site visits at the same time, whilst initial formal assessments were notified after completion of the IR (with the site visit coming later).

There were some changes in process between the pilot and initial formal assessment phase, although CQC staff mentioned that they tried to keep the changes between the pilot and initial formal assessments to a minimum to ensure there was as much consistency as possible. Changes included:

- The time allotted for each stage differed slightly between the pilot and initial formal assessments (for example, the timescales for the completion of the IR and timing of the on-site visit – see Figure 6.1 above);

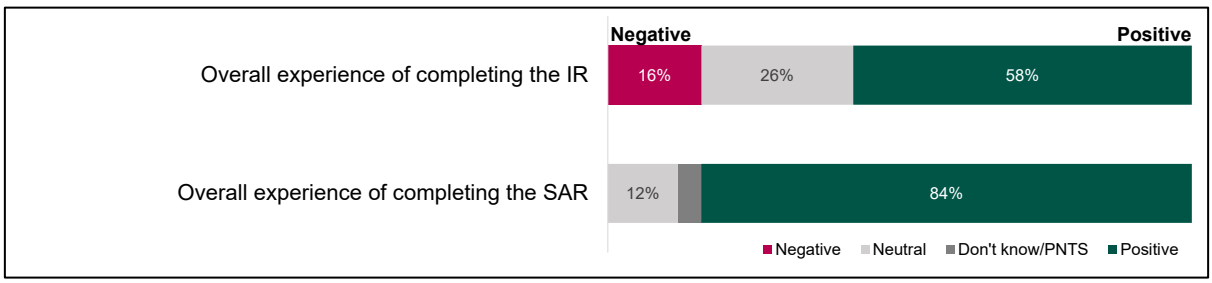
[5] More information can be found on this here: Case tracking - Care Quality Commission

- Moving interviews with senior members of the LA to the end of the on-site fieldwork so that they can discuss any issues or themes that have emerged;
- The case tracking was conducted by experts by experience[6] during the pilot stage but was led by CQC staff during the initial formal assessments, due to time pressures of having to brief the expert on what information they wanted to gather. Instead, experts by experience were more effectively used during the initial formal assessments to speak directly to unpaid carers;
- Outcomes was a standalone evidence category during the pilot, but these were incorporated into the 4 evidence categories[7] (people's experience, feedback from staff and leaders, feedback from partners, processes) during initial formal assessments (evidence categories outline the types of evidence CQC use to understand the LAs);
- Trying to reduce the burden on LA staff during the pre-fieldwork phase by providing better explanations and clearer guidance on what should be included in the IR. CQC did conduct work with the sector and pilot LAs to refine the IR before formal roll out. One CQC staff member said this was also something they would continue to work on and iterate throughout the initial formal assessment period based on LA feedback.

Pre-fieldwork

Overall, LAs had a positive experience of completing both the IR and the SAR, with particular positivity around the SAR. There were no substantial differences between pilot and formal LAs views on this phase. Over 4/5 (84%) of formal LAs that completed the survey said they had a positive experience of the SAR and 58% reported this for the IR (Figure 6.2).

Figure 6.2 Formal LA overall experience of the IR and SAR



Base: All Survey 1 participants n=50; All Survey 1 participants who submitted a self-assessment (n=49)

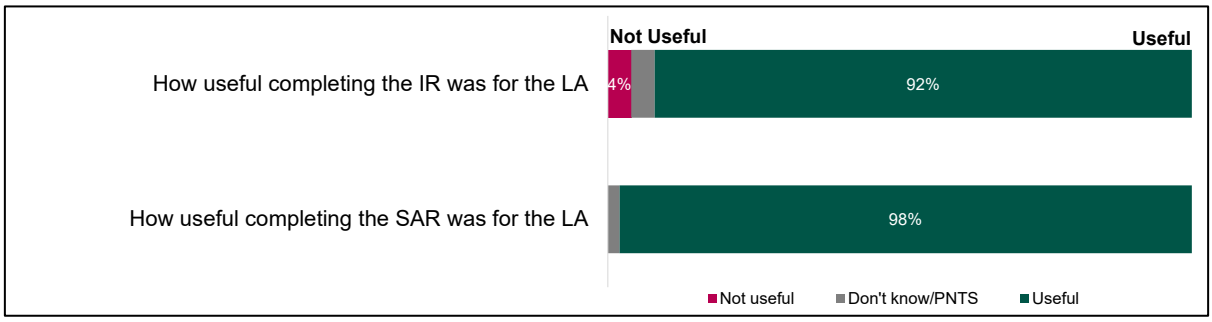
[6] Experts by Experience are people who have recent personal experience of using or caring for someone using the relevant services. More information here: Experts by Experience - Care Quality Commission

[7] Evidence categories describe the types of evidence CQC use to feed into their assessment of LAs.

The majority (92% for the IR and 98% for the SAR) of formal LA participants surveyed reported that completing the IR was useful for their LA, as shown in Figure 6.3. During interviews, LAs described valuing the thoroughness of the IR and SAR and that completing them painted a clear picture of their LA (e.g. in terms of where they are performing well and areas that needed additional attention). One participant from a formal LA said the SAR allowed them to "tell their story properly" since they could choose to present this in any way they wanted. Survey participants also referenced in open-ended comments that the IR contributed to improved understanding of how their own LA functions.

CQC staff also found this stage of the assessment to be useful as it provided them with an initial overview of the LA, which allowed them to highlight specific areas of interest to explore during on-site fieldwork.

Figure 6.3 Formal LA usefulness of IR and SAR



Base: All Survey 1 participants n=50; All Survey 1 participants who submitted a self-assessment (n=49)

There were several instances of LAs sharing how this stage of the assessment had already given them ideas for improvement, not only in terms of service delivery but also how they collect and organise data and information internally. Examples of this included: highlighting areas where they delivered a certain service but lacked a formal strategy related to it; improving how information is organised (e.g. storing documents in 1 place); inspiring them to collect more qualitative data and continuing to collect information in the same way as outlined in the IR (e.g. on waiting lists). One formal LA also highlighted that this phase of the assessment set them up well for the site visit, as it gave them the opportunity to think about how to articulate the work they do in the areas of focus for CQC.

"It's a good way of telling the story of what we do and what we still need to do."

Strategic lead

"It was also an amazing exercise because it also highlighted where we felt we could do more or make the system easier."

Manager

The main reason pilot and formal LAs were less positive about the IR (than the SAR) was how long it took to complete. Nine in 10 (92%) survey participants reported the IR was time-consuming (with just 8% suggesting it was not time-consuming).[8] LAs said that they had to collate a substantial volume of information from across their organisation. A strategic leader explained that the senior team capacity that had to go into this phase meant deprioritising developmental or transformational work. Participants from formal LAs also mentioned that some of the asks in the IR and SAR were repetitive, which they felt created unnecessary additional work. Nevertheless, LAs generally still felt like the time they had to complete the IR was appropriate.

"It would be easier next time…because it was the first point in the learning, it was more resource intensive … getting information into a format that was going to be accessible and not too lengthy for colleagues at the CQC took some time."

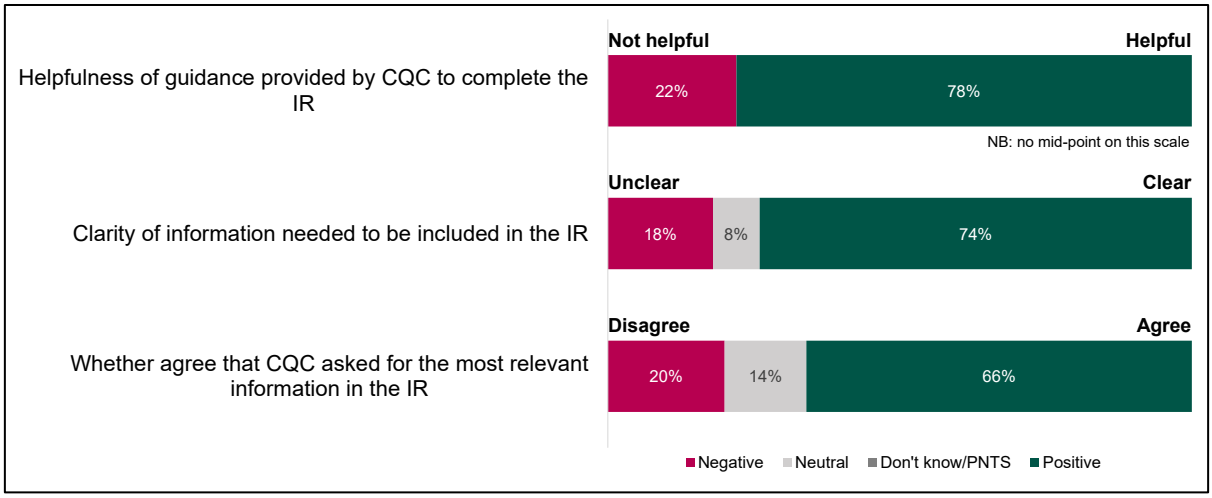
Strategic lead

Some LAs outlined specific factors that had supported them in completing the IR efficiently. For example, some said the information they needed to collate was already readily available because it was data that had previously been shared, for example through regular reporting to senior leadership. One formal LA described having recently undergone a peer assessment through the Local Government Association (LGA) following a request they made through ADASS (Association of Directors of Adult Social Services). They requested this on the basis of wanting to prepare for the CQC assessment. One participant from the LA said that a lot of the information they had pulled together for the peer assessment was relevant for the CQC assessment, streamlining the IR process.

Pilot and formal LAs felt like they had the necessary information to complete the IR but some staff across both assessment phases felt this was still an area CQC could improve in. As shown in Figure 6.4, the majority (74%) of surveyed participants were clear on the information they needed to include in the IR. Over 3/4 (78%) thought the guidance CQC provided to compete the IR was helpful and 2/3 (66%) agreed that CQC asked for the most relevant information in the IR.

[8] Base: All Survey 1 participants n=50

Figure 6.4 Formal LA views on information requested in the IR



Base: All participants n=50

However, some participants across pilot and formal LAs described having to spend significant time interpreting exactly what CQC wanted or trying to find a document that matched what CQC were asking for but which they labelled differently. For example, 1 pilot LA participant said the CQC requested a document in a specific format that the LA did not produce, so they agreed to share links to where the information was available on their website instead. Some survey participants referenced a lack of clear expectations and that they sometimes received mixed messages from different CQC staff as to what information was required. Another formal LA participant referenced that they supplied over 200 pieces of information just to ensure they had covered all possible interpretations of the exercise. This meant that CQC received a high volume of information from LAs keen to ensure they have covered all necessary bases.

"With the 34 information returns or however many there were, it was like an exam question, so it was up to us to determine what the answer was. So we ended up submitting over 240 pieces of evidence."

Manager

"I suppose the thing is all local authorities use different language. You'll have some stuff that of course you understand, but a lot of stuff is described differently, so you know we'd read line 31 of the information return…it says send us something like this policy and we'll go well, we haven't got that, but we've got this, which I think is that, but it's just called a different name. But they were very open in that we'd just gather a bit of that information and then just have a quick call with CQC and say, you know, we don't have this customer first charter but we've got this, would that fit?...They were saying don't make more work for yourself, but you did feel that if I don't submit anything, it's going to look like we've got a gap there, but we haven't, it's just that we don't gather it that way."

Strategic lead

CQC staff also suggested that they could be clearer in their requests for information so that they only receive the most relevant information from LAs. Staff mentioned that some LAs sent upwards of 500 documents and that it was impossible to review so much information. Going forward, ensuring the ask is clear would benefit not only LAs in terms of the time taken to complete the information together, but also CQC themselves in terms of time taken to find the necessary information within what is shared. One CQC staff member suggested this was something they were already consciously thinking about and that they now state more clearly what they want from the IR. The staff member suggested these improvements had been made based on feedback from LAs but did not provide specific examples of how the IR ask had been made clearer.

Case tracking

The case tracking activity was highlighted as an area of the assessment that needs further thought by both LA and CQC staff. LAs described it as a "massive" undertaking and both LA and CQC staff questioned how effective it was in representing the voice of the people. Identifying and gathering information for case studies that aligned with the CQC criteria was described as a large task in itself but some LAs put additional effort in to ensure that where possible the small number of cases they were selecting accurately reflected the work they do. One LA in particular questioned how useful it was to only speak to 6 people out of all the people supported by the LA, as they did not believe this would lead to a fair representation.

Another challenge raised by pilot LAs was the time that elapsed between the LA selecting the cases and CQC contacting the individuals. This led to situations where individuals were uncertain about when they would be contacted or where they were no longer available by the time CQC contacted them to discuss their case. One pilot LA also noted that individuals' circumstances had sometimes changed between the time their case was chosen and the time CQC contacted them. CQC staff also reported challenges contacting individuals. One assessment manager reported that during 1 of their assessments, they could only conduct the case tracking for 4 of the 6 cases due to individuals not getting back to them. LAs suggested that CQC could communicate timelines for when they would make contact so that individuals were not left feeling so uncertain about when they would be contacted.

"Where people were picked out for case file tracking, we'd ask for their consent to take part when we sent in the case files, and we thought that would happen prior to them coming on site. So what that meant was that we had carers and people with lived experience contacting us to say nobody's been in touch with me as of yet and I'm due to go on holiday, is that going to be a problem, do I need to cancel holidays?"

Strategic lead

CQC staff recognised that the case tracking activity was not completely effective in capturing the people's voice but that finding the best way to do this was challenging. The challenge was presented as ensuring that 1) they hear from enough people and 2) they hear from a range of experiences. The feedback on the case tracking activity suggests there could be further thinking done to decide on the best way to ensure the voice of the people is captured as accurately and usefully as possible.

CQC staff did engage the voice of the people in alternative ways to case tracking, for example, speaking to unpaid carers through experts by experience and looking at information relating to people's experience the LA themselves have gathered. However, even with these different methods, some national stakeholders raised concerns about the ability of the assessment to effectively capture the voice of the people. One VCSE organisation suggested that CQC's approach to collecting the people's voice was "pragmatic" but would not accurately show whether systems were performing as they should. Another VCSE organisation thought CQC tried too hard to fit people's experiences within pre-determined criteria when what they needed to do was ask broad open-ended questions to dig into real-life experiences.

Fieldwork

Short timeframes between submitting the IR and CQC undertaking the site visit were viewed positively**.** One pilot LA described that the 6 weeks they had between submitting the IR and the site visit was a good amount of time. Several LAs commented that 6 months (as could be possible during the initial formal assessment period) would be too long to wait. Reasons given for this included: that a lot can change within a LA in 6 months, for example data and policies; and that the anticipation of a site visit can be stressful and impact staff ability to focus on their day-to-day jobs.

"I preferred that we could hand the information in and then literally 6 weeks later or something they were coming. I preferred that because it felt more in context, and I think especially in the world of social care everything changes so rapidly."

Strategic lead

Pilot and formal LAs reported positive experiences of the CQC on-site visit. LA staff thought CQC staff were knowledgeable and experienced, spoke to the right people and collected a good range of information.

Three quarters (75%) of survey respondents who had undergone an initial formal assessment said they were satisfied with the overall experience of the on-site assessment[9]. During interviews, LA staff across all levels emphasised that CQC inspectors were friendly and put people at ease. This was seen to benefit the assessment process as it created a relaxed atmosphere for staff to share their perspectives openly and honestly. One pilot LA participant referenced a staff survey that had been conducted post-assessment in which almost everyone reported a positive experience during their interviews. Drop-in sessions were also viewed particularly positively by formal LAs due to the flexibility they offered.

[9] Overall satisfaction with experience of the on-site assessment:75% satisfied, 7% neutral, 4% don't know, 14% dissatisfied – Base: All Survey 2 participants (n=28)

"More comfortable and straightforward than we perhaps expected … we took a stab in the dark about what it would look like the panel, who they would be, and the tone of the interview. Actually, it was more of a conversation we were part of so more of a dialogue than an interrogation or an interview. There were no wrong or right answers."

Frontline staff

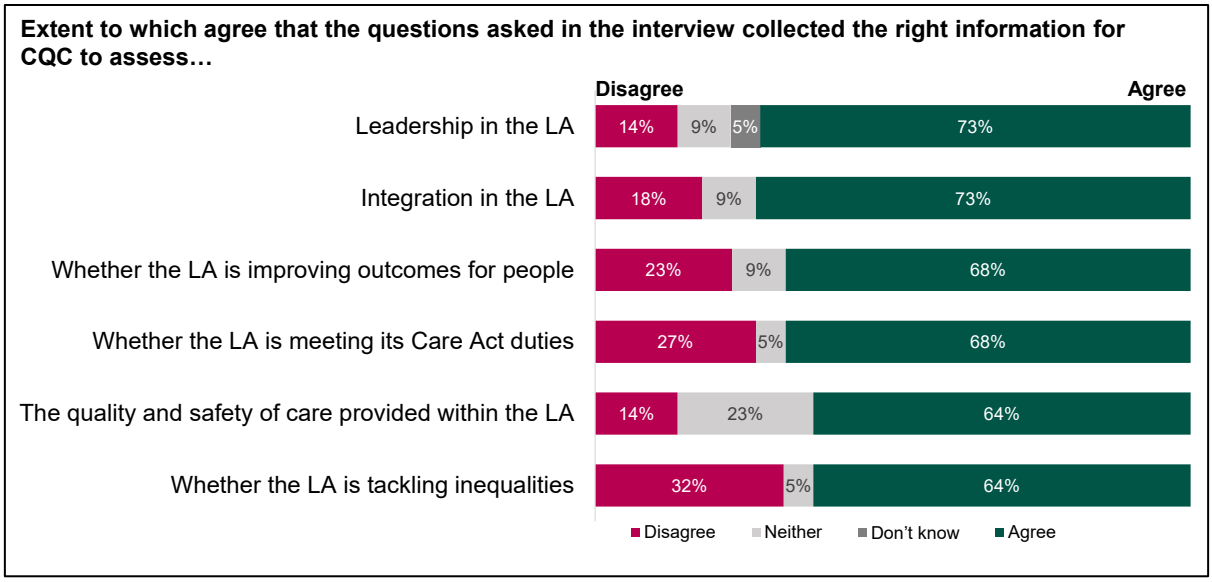
The majority (80%) of formal assessment survey respondents who were involved in the planning and organising of the on-site activity thought the assessment team spoke to the right people to understand the LA[10]. During interviews, LAs provided examples of where CQC had been open to the suggestion of including staff who initially had not been included in the original plan. For example, 1 pilot LA requested for heads of service to be spoken to, as they thought it was important to share information on the wider strategies of the LA with CQC.

Managers were not spoken to as standard during the pilot assessments. Following pilot feedback, manager drop-in sessions were introduced for the initial formal assessments. This change in approach received positive feedback from the initial formal LA case studies and in the open-text responses to the survey. It was felt that mangers had a valuable perspective to add.

Survey findings from formal LAs indicated that the questions asked during interviews collected the right information in CQC assessment areas. As shown in Figure 6.5, over 2/3 of formal survey respondents thought CQC asked appropriate questions during interviews to collect the right information for CQC to assess leadership (73%), integration (73%), improving outcomes for people (68%), and whether Care Act duties were being met (68%). Slightly fewer participants thought that questions were asked to collect the right information to assess quality and safety of care provided within the LA (64%) and whether the LA was tackling inequalities (64%). CQC should therefore consider whether interviews focus enough on quality and safety of care and tackling inequalities or whether the questions asked to investigate these areas were getting at the right information.

[10] The assessment team spoke to the right people to understand the local authority: 80% agreed, 20% disagreed – Base: All Survey 2 participants who were involved in the planning/organising of the on-site activity (n=15)

Figure 6.5 Views on interview questioning among formal LAs



Base: All Survey 2 participants who took part in an interview as part of the on-site activity (n=22)

Some LA staff suggested improvements to the planning of on-site fieldwork, which could lead to participants being better prepared. Some staff from pilot LAs and during the formal survey suggested that the proposed timetable could be shared further in advance (4 weeks was suggested by some) to ensure sufficient time for staff to organise their availability and prepare for sessions. Other staff from formal LAs explained that the titles given to certain group sessions were misleading, which risked not having the correct people attend the session. For example, 1 participant mentioned that 1 session had “strategy” in the title but actually ended up focussing more on operations. Some survey participants suggested that receiving more information than just the title would make it easier to identify the most appropriate staff to attend each session.

Some staff did not always think the on-site interviews were used to their full potential. For some, this was driven by the view that interviews were too short and did not allow enough time to discuss their service area in depth. Other staff felt like the questions asked were quite surface-level and did not probe for enough detail, which gave them the impression that CQC did not know enough about the work of the LA to ask in-depth questions. Adhering to high-level questions was a deliberate decision taken by CQC, but this was not always clear to LAs and had the unintended impact of leading LAs to question CQC expertise. Detail on views on CQC’s capacity, capability and credibility can be found in Chapter 8.

"It felt like a very short time frame to be trying to extract information … we didn't feel like any searching questions really had been asked, it felt they'd only really nudged the surface a little bit."

Manager

Assessment Framework

Awareness and understanding of the assessment framework was mixed. Some LA participants, including frontline staff, team managers and a minority of heads of services, were either not aware of the framework or did not feel like they had engaged with it sufficiently to comment on its usefulness. Among those who were aware, the majority held positive views on the framework but there were areas for improvement identified.

There were limited comments from LA staff on how the framework was used. Some participants made general statements about the framework being useful as a tool for ensuring consistent assessment across different LAs. Other participants suggested it was a useful way to make staff within their LA aware of what the assessment would focus on. One pilot LA staff member said that the assessment framework was a valuable tool to support them to get ready for the assessment process as it meant their LA could organise their approach and ensure they were focusing on the right areas. Another participant said they used the assessment framework on an ongoing basis to ensure they could always evidence their work against it. Given the limited comments on the framework overall, CQC could consider whether they need to do more to ensure LA staff comprehensively understand the criteria they will be assessed against.

"The assessment framework played a crucial role in our preparation for the pilot inspection. Having a clear framework allowed us to organise our approach and focus on the relevant aspects … I believe that having a well-defined framework is essential for effective preparation. It provides structure and ensures consistency in assessing different areas."

Strategic lead

General positive feedback on the framework focused on its relationship with existing materials and its perceived relevance. Some LA staff shared general comments that the framework was focused on the "right things". Staff in 1 pilot LA emphasised that the framework demonstrated the assessment was looking to find out if LAs were providing the highest possible standard of care for people in their area. Other LA staff were more specific and said they appreciated that the framework drew on existing materials, such as Think Local Act Personal's 'Making it Real' framework.[11] These were viewed as being important measures of performance for adult social care.

"Overall, I thought it was comprehensive and covered the majority of things you would expect it to."

Strategic lead

[11] Making it Real is a set of statements that describe what good care and support looks like: Making It Real - TLAP

National stakeholders held similar positive views about the framework in LA assessments. They described the framework as having good foundations, since it was based on “I” and “we” statements and was developed through a collaborative process. Some also commented that it contributed to ensuring there was a degree of consistency to LA assessments. CQC staff involved with LA assessments thought the framework worked well. Two staff members specifically said how well the framework mapped to the Care Act. One assessment manager referenced that this was even more so the case during initial formal assessments as the framework was updated slightly from the pilot phase.

Concerns raised about the framework by LA staff sometimes conflicted. One view shared was that the framework was not comprehensive enough. For example, some staff questioned whether the framework and quality statements could achieve an assessment of the whole LA. Other staff identified specific gaps in the framework, such as around prevention or working with partners. However, another view shared was that the framework tried to cover too much ground and that there were too many quality statements to respond to. Some participants suggested this diluted the assessment output because the LA could not go into so many areas in any depth.

Another area of concern raised by a minority of participants was that the framework was quite ‘abstract’. This led participants to question how robustly CQC could assess against the framework and opened up questions as to whether it was too subjective.

"It's all a bit woolly and a bit open to interpretation."

Manager

Assessment reports

LAs were generally satisfied that assessment reports reflected their LA and suggested key areas for improvement. Nevertheless, there was lack of clarity among some participants around the scoring process and how judgements were made. There was also concern about the weight given to individual opinions.

During interviews, pilot and formal LA staff tended to agree that the reports were representative of their LAs. Most participants described the reports as validating the views they already held of themselves. For most, this was reassurance of the areas they were performing well in, as well as reinforcing areas for improvement.

"It was a really strong report, and I know that staff who were involved in those focus groups and interviews would recognise themselves, so I knew that when they read the report, they would be happy with that and the workforce is really, really happy with it."

Strategic lead

Under a third (31%) of formal LA survey participants thought the report was sufficiently detailed.[12] Some staff commented that the reports lacked specific suggestions for improvements or recommendations for what steps to take to improve. For example, staff interviewed in 1 formal LA, though pleased with their score, which was a high “good”, did not feel like it was made clear to them how they could reach an “outstanding” grading. Staff from pilot LAs would also have welcomed some clear guidance on how to achieve a higher score.

Most interviewed LAs reported that they had to go back to CQC to correct factual inaccuracies in the report, not all of which they felt were effectively resolved in the final output. Only 8% of those who completed the formal survey said that the data presented in the report was accurate.[13] One LA staff member said that their service was originally mistakenly described as a charitable organisation when it was not. Another staff member said that they were aware that corrections needed to be done. There were also a couple of mentions from pilot and formal LAs that there were inaccuracies regarding the financial information reported. However, CQC have to act on guidance as to what financial information they include and where they obtain it from and it is not used to inform their assessment or judgement. The survey showed mixed levels of satisfaction with the process to check and correct the factual accuracy of the report – 46% of formal LAs were satisfied with this against 38% who were not[14]. This process therefore warrants further consideration.

Across LAs, some participants said they were surprised and disappointed by instances where concerns raised by 1 individual were included in the final report without being corroborated with other sources. In 1 pilot LA, a comment made by 1 provider about lack of referrals related to mental health made it into the final report without being checked against any other information or context. Another pilot LA staff member did not think a comment that said some people found it hard to find information on their website should have been included in the report. This was because when they asked CQC for the source of this finding, it emerged that it came from a comment from 1 council member in a focus group, which the staff member thought should have been disregarded as the comment was inaccurate. One participant from a formal LA also added that the CQC sometimes seemed to take 1 statement and present it as fact, for example the opinion of 1 carer. LAs thought this led to a misleading representation of some elements of their LA.

"This was a surprise to us, and it's never been raised before, but it had come up and made its way into the final report, but then the detail behind that as to why that would be an issue and what do we need to do about it was missing."

[12] The report is sufficiently detailed – 31% agreed, 15% neither agreed nor disagreed, 54% disagreed – Base: All Survey 3 participants who have seen the assessment report (n=13)
[13] The data presented in the report is accurate – 8% agreed 31% neither agreed nor disagreed, 62% disagreed – Base: All Survey 3 participants who have seen the assessment report (n=13)
[14] Satisfaction with the process to check and correct the factual accuracy of the report – 46% satisfied, 8% neutral, 8% don’t know, 38% dissatisfied – Base: All Survey 3 participants who have seen the assessment report (n=13)

"Unlike Children's inspections, they seemed to have a singular focus and take a comment as a statement for adult social care, for example if you get a carer that provides feedback, they may not be satisfied, that can be the carers' feedback statement that's in there. I think that's certainly one of the things that needs to be looked at: rather than making things singular, to take a slightly broader view."

Strategic leads

Some participants across LAs thought the scoring process used needed to be more transparent. One formal LA in particular did not think the narrative of their report aligned with the rating they received. They explained that the narrative seemed a more positive reflection of their LA than the score itself, which led to some confusion and even concern that the scoring was too subjective. Only around half (54%) of formal LA survey participants thought the scores/rating presented in the report were mostly or completely accurate (compared to 46% who thought they were only somewhat accurate). CQC could therefore consider if they could provide greater clarity on the scoring process and how judgements are made.

"Understanding the scoring...when you read it, it was very difficult to actually see why did we only get that mark."

Manager

CQC assessment managers might also benefit from clear guidance on how to score LAs. One CQC staff member said that they appreciated the internal quality assurance process reports go through as they found the scoring can be quite subjective. For example, they mentioned that they generally leave the on-site fieldwork feeling very positive, which they felt influenced them to be overly positive in their initial report drafts.

7 Experience of ICS assessments

This chapter presents findings based on data from the 2 pilot ICSs that had undergone assessments at the time of writing this report. It details their experiences from pre-fieldwork activities to reviewing their assessment reports. As there were delays in progressing ICS assessments beyond the pilots, this report provides findings related to the pilot assessments only. This means that the findings available are more limited than for the LA assessments. Readers should also keep in mind that there were delays in publishing the ICS assessment reports. These factors affected the perspectives among ICS participants of the CQC assessment in general as well as affecting their ability to talk about the reporting aspect of the assessment.

Key findings

- While some ICS participants recognised the value of the IR, the overarching feedback was that it required extensive work and could be tailored more effectively to ICSs.
- Most ICS participants felt the fieldwork sessions worked well and gathered the right information, but some felt key people were missing from certain conversations and expressed concerns about the level of inspector knowledge.
- There were questions around the effectiveness of the case tracking activity and whether the extensive efforts from ICSs yielded meaningful results.
- Positive feedback on the assessment framework suggested it was a useful tool to help aid ICS understanding of the assessments, while negative feedback suggested it was not appropriately adapted for a system.
- ICS participants suggested factual inaccuracies and difficulties understanding which parts of the ICS were being referenced influenced negative perceptions of the report.

Overview of the assessment process

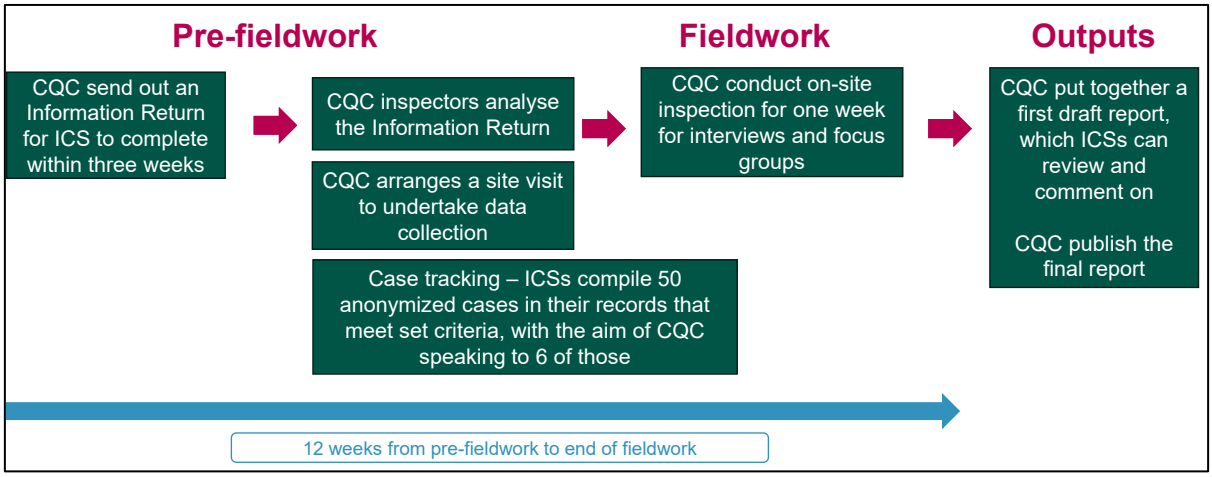
As shown in Figure 7.1, the assessment process began with a pre-fieldwork period where CQC asked ICSs to complete an IR, a structured template designed to capture data on key areas such as leadership, integration, quality and safety management, as well as efforts to address health inequalities. The IR request also included the time period the data should cover and guidelines on how ICSs should approach the exercise. ICSs were given 3 weeks to complete the IR.

This phase was followed by fieldwork, where CQC representatives carried out an on-site assessment for 1 week to conduct interviews with staff, service leaders and service users, observe processes (such as how staff interact with people and the care environment) and gather further evidence.

A case tracking activity also formed part of the assessment. This process focused on tracking individual cases to examine how well services are engaged and coordinated across the system and provide detailed understanding of how care is delivered. For this, ICSs were provided with themes that CQC were assessing and asked to put together an anonymised list of 50 people who fit these themes. CQC then shortlisted 10 in an attempt to case track 6 people.

Finally, CQC evaluated the findings and put together a first draft report, which ICSs had the chance to review and comment on. This was followed by the publication of final reports.

Figure 7.1 Overview of the assessment process



Pre-fieldwork

In general, staff at ICSs felt that this stage of the assessment required a lot of work, and that the time given to complete the IR (3 weeks) was too short. Some mentioned that the pre-fieldwork stage was a substantial undertaking that often led to staff capacity issues, as some staff had to spend all of their time on this over a couple of weeks. However, 1 ICS suggested that putting individual people in charge of different sections of the IR made it more manageable.

The timescales were felt to be too tight given the often-complex governance and consent issues that needed to be navigated. For example, 1 ICS reported struggling to obtain patient data in a timely way and with all approved consent, due to the absence of effective data-sharing processes across all organisations in the ICS. It was mentioned that ideally, they would need at least 3 times as long (i.e. 9 weeks) to complete the IR.

"Because we were gathering information across multiple partners [in] the 3-week turn around. that was really tight. I've done CQC inspections in my own organisation – 1 provider – you have control to say you need to give me that information and I need it by next Wednesday… when you're working with partners you're asking very nicely if they can provide information, if they can take part in a pilot, you're relying on other people to respond quickly in that time frame."

NHS Trust

Most ICS participants felt that the IR was a useful exercise for them to understand what CQC would be focussing on during the assessment and for them to reflect on their performance and progress since forming as ICSs in 2022. There were though 2 main suggestions for improving the IR.

Firstly, some participants felt that CQC could be more prescriptive in exactly what they want from the IR at the start of the process so that ICSs do not send more information than needed. It was noted that this had led to extensive communication exchanges between the ICS and CQC, which ICS participants found time-consuming and frustrating. It should be noted though that ICS participants did feel that CQC were communicative and responsive in the run-up to the assessment, by holding weekly meetings with them and maintaining open channels for addressing queries.

Secondly, ICS participants highlighted that some of the language used in the IR had not been updated to reflect their organisation and the wording of certain requests created challenges. For example one participant said that the terminology did not match what was used within their ICS, while another thought the language used was geared towards a provider organisation, not an ICS. Other participants focused on the asks of the IR more generally. For example, one participant suggested that the wording of the safeguarding questions was not clear while another thought that they should not be asked about the experience of specific patient groups, as that was something that should be covered in a provider assessment. It was suggested that CQC could consider exploring the language and terminology ICSs use ahead of time and using this in the pre-fieldwork phase, to ensure the IR reflects the differences between providers and systems.

One CQC staff member involved in the ICS pilot assessments said that the pre-fieldwork phase was useful to help the assessment team form initial hypotheses about the ICS and identify specific areas to focus on during fieldwork. Another staff member said that just because certain information is gathered at this stage it might still have to be covered during the on-site visit to ensure a first-hand look. This comment was made in relation to areas the staff member deemed to be critical assessment areas e.g. children and young people.

Case tracking

The case tracking was seen as a difficult and complex task by most ICS participants who commented on it, and many questioned how effective it was. Case tracking was seen as complex due to having to bring information together from multiple organisations within the system, and not always having the required data linkage or sharing processes in place. Many said more time was needed to complete this task than the 3 weeks allowed by CQC.

One ICS noted that when the 10 shortlisted individuals were contacted for consent, none responded, which led to the decision to not progress with the case tracking activity. Similarly, the other ICS reported they were not able to complete their case tracking activity, as timescales were too tight, and they had continuous issues with consent forms. For ICS participants, this raised questions around the effectiveness of the current approach to case tracking activity and whether it will yield any meaningful results.

"We never did finish it, but I think I think the time scales for it were a bit over ambitious."

ICB/ICP strategic lead

ICS participants suggested that CQC should consider reviewing the case tracking ask. One element for review suggested was the time allocated for the activity. Other participants suggested reviewing the whole process given the challenges they faced with collecting all the information they needed for case studies and collecting consent from individuals. More guidance on the role of the case tracking activity in the overall assessment, what information is needed and how to engage those identified as case study participants in the process might be useful.

Fieldwork

The overall experience of the CQC assessment site visits was a positive one for both pilot ICSs. Most staff across the ICSs praised that interview and focus groups sessions were generally well run, allowed for the right information to be communicated and had an appropriate duration.

"I think it's the right sort of approach, I wouldn't want it to be any longer and more intensive."

LA strategic lead

CQC inspectors were described as friendly and open, which aided their ability to carry out effective assessments. Participants across case studies described their interactions with CQC inspectors positively. Participants from 1 ICS described the positive relationship between the ICS and CQC that this attitude fostered, which meant ICS staff felt comfortable participating in the assessment.

"It didn't feel like inspections before – that militancy and not being frightened but being on the back foot which you can feel when regulators come in … very welcoming and wanted to hear what I had to say."

NHS Trust/ICB role

Despite the overall positive experience, ICS participants reported 3 main areas of difficulty. Firstly, that there were a lot of people to organise to speak with CQC. This resulted in logistical challenges due to the geographical spread of an ICS and its structure, as well as the time-consuming nature of co-ordinating availability across diverse teams, booking rooms, managing last-minute changes, and ensuring all relevant staff were prepared for interviews. One participant suggested that having more advanced notice of the date of the inspection, as well as who needs to be involved would be useful, but they admitted this might be an issue of the ICB not communicating with them far enough in advance, rather than CQC.

Secondly, despite the number of people spoken to, some ICS participants reported some lack of clarity on who should be invited to which discussion, which led to key people being missing from certain conversations. The impact of this was that some participants suggested CQC inspectors asked the right questions during interviews, just not necessarily to the right people. ICS participants suggested CQC could consider profiling the ICS before beginning assessment to understand how it operates and who the key figures they need to speak to on each topic are.

Thirdly, some ICS participants (and particularly those working as part of the ICS in the ICB/ICP) expressed concerns that the inspectors lacked sufficient knowledge about certain aspects of their organisation, including its structure, operations, and unique ways of working. This made it challenging for staff to explain the full scope of their work or the context behind certain decisions. Additionally, participants noted that inspectors appeared to have limited expertise in specific topics, such as safeguarding, which led to frustrations about the depth and relevance of the discussions. One participant suggested their reason for thinking expertise was limited was because CQC only asked broad, open questions. As previously mentioned, using this style of questioning was a conscious choice by CQC. More information on this can be found in Chapter 8.

Assessment framework

Awareness of the framework was mixed across ICS participants. Some participants were either not aware of the framework or did not feel like they had engaged with it sufficiently to comment on its usefulness. Those who were aware held generally positive views. Positive feedback included that it was a useful tool to underpin assessments. Some participants thought the framework provided a solid foundation for the assessment, enabling ICSs to effectively show their performance and impact. Participants working in adult social care were particularly positive about the ability of the framework to assess their delivery.

"From a social care perspective, it's good to use that same framework I think because it ultimately grounds the assessment in the services we're providing and the impact we have"

LA strategic lead

"The framework is like a safety net for the parameters of the inspections, and it is good that everyone is using the same language so we're all focussing on the same areas."

NHS Trust

Despite overall positive views, some participants felt that the framework needed further adaptation before it was useful for a system assessment specifically. One view shared by participants was that the framework focused too much on how policies are applied to individual parts of the system rather than across the entire system. For example, 1 participant said that an area like sustainability is relevant to multiple sections of the framework. Relatedly, another view shared was that the working relationships within an ICS are important to its success and this aspect of working together is not captured in the framework. There were also examples given of specific areas of focus that were deemed to be missing from the assessment. Examples given included finances, health inequalities and equality duty.

"You've got a system assessment framework but it didn't fit a system assessment, the model hasn't been adapted to fit that assessment so fundamentally you're using an assessment system that is designed for something else…some things are fundamentally the same, you might be assessing quality, so under that you might be assessing safeguarding… fundamentally the principles are the same but how you do that and your responsibilities at a different level are very different."

NHS Trust

Assessment reports

At the time of fieldwork for this research, only a small number of ICS participants in the 2 case studies could speak about the assessment reports in any detail due to delays in publishing them. Pilot assessments started around August-September 2023, with reports published in September 2024.[15]

Amongst those who had seen the reports, there were mixed views on their structure and the value of their content to understand performance and future priorities. Positive feedback around the report was generally related to the structure and usefulness of the findings. Most ICS participants mentioned that the reports overall had a good structure that broke findings into different themes and made sense in terms of how they work and their transformation priorities.

[15] ICS pilot assessment reports can be found here: https://www.cqc.org.uk/care-services/integrated-care-system-assessment-reports

"It's got a good structure to it, it breaks down into leadership, quality and integration I think, and that makes a good sense for how we work and our transformation priorities."

NHS Trust

Some participants also felt that the reports provided clear findings, particularly around high-level themes such as leadership, integration and quality and safety. This meant that it was seen as a useful tool for development, enabling them to assess their progress to date and allowing them to generate a narrative on the direction they were heading as an ICS.

"I thought it was a helpful report that held up a mirror to the system and gave helpful commentary in terms of where we are and the progress we've made to date."

NHS Trust

It was common, however, for ICS participants to raise issues with the assessments reports. These included:

- A high volume of factual inaccuracies in early drafts of reports. For example, within 1 ICS, 2 LAs were confused and 1 was said to be performing poorly on safeguarding when in fact, it was the other one. There were also examples of the terms ICB and ICS being confused. These factual inaccuracies were usually attributed to a lack of understanding or knowledge on CQC's behalf or due to CQC considering statements from interviews and focus groups as facts.

- Difficulties understanding which elements of the ICS were being referenced. For example, 1 ICS report had referenced the county name, and it was unclear whether this referred to the ICS or the LA. As with factual inaccuracies, CQC could consider the implementation of a triangulation system to cross-check information and receive feedback around the terminology used.

- Use of technical language. One view shared was that language used within social care and health can sometimes differ, which could confuse readers. Another view shared was that if an aim of the report is to communicate findings to the public, then the language used needs to be simplified as it was not appropriate for a general reader.

- Lack of transparency of assessment criteria. Some participants suggested the scoring was unclear. For example one participant said they did not understand how a service could be 'good' overall when one section of it is 'inadequate'. Another participant did not think it was clear how judgements were made based on the evidence presented. A third participant made the more general comment that it was unclear what the specific purpose of the report was, which made it hard to reflect on it's usefulness. To address this, CQC could provide transparent criteria for assessment and an overview on how judgements are made in the report.

- Reports lacking detail, especially considering the amount of evidence that was gathered during the assessment. When asked what details were missing from reports, guidance and suggested improvements for ICSs were most commonly mentioned. They felt that this would help ensure the assessment process resulted in improvement to care.

- Delays in publishing the reports. ICS participants highlighted this created a sense of uncertainty around the usefulness of the assessment given the year-long wait for the report to be published. For example, one ICS mentioned that some of the improvements alluded to in the report had already been actioned. Additionally, the long wait for the published report created frustration and disengagement within ICSs, which in turn hindered their ability to plan effectively, and address any highlighted issues.

"There was that delay and confusion around what was going to happen...we would have had a very different response to a report that was formally published and that we had a follow up plan for."

ICB/ICP strategic lead

“The bit that probably needs some attention paid to it is the kind of ‘so what?’ coming out of the report...So what do you do in response to it? Are the findings clear enough to allow you to effectively come up with some directive action that's then going to make a difference to the functioning of the system, that makes a positive difference to population health.”

NHS Trust

CQC staff involved in the pilot ICS assessments also reported challenges with the ICS reports. One staff member suggested that they did not have the balance right yet for how much weight was placed on different parts of the system within the report, particularly if one part of the system is particularly effective or ineffective. Relatedly, another staff member said that it was difficult to balance the aim of a condensed, short and clear report with ensuring the report reflected the whole system. They added that the long and iterative reporting process, which was necessary as part of the pilot in order to test the reports, was a contributing factor to there being a delay in their publication , which they thought ran the risk of the ICS having already made changes (which limited the impact the report could have). The main reason for the delays in reports being published was linked to wider contextual issues and the requirement for review and sign-off of the overall approach to reporting before it could be published. This kind of delay is not expected to occur in future assessments.

8 Capacity, capability and credibility

This chapter presents findings on how ICSs, pilot and LAs who had undergone an initial formal assessment (formal LAs) perceived the capacity, capability and credibility of CQC in relation to the assessments undertaken. These three areas of focus were discussed in detail as part of the research due to the important role they play in supporting CQC's ability to have an impact as a regulator of systems. This chapter includes findings from the LA, ICS, CQC staff and national stakeholder interviews, as well as the LA formal survey.

Key findings

- CQC inspectors were generally viewed as having the skills and experience needed to carry out system assessments.
- Perceptions of credibility were strongly correlated with perceptions of skills, knowledge and experience i.e., staff who had a high level of experience and knowledge were deemed to be credible.
- Some participants from both ICSs and LAs thought CQC inspectors lacked thorough knowledge of how their systems worked, which impacted credibility for some.
- Participants were less likely to have strong views on CQC capacity. Some thought this seemed sufficient while others thought capacity might have affected specific areas of the assessment.

CQC capability

LAs and ICSs generally thought CQC inspectors had the appropriate skills and experience to undertake effective assessment. The three areas participants focused on when describing CQC capability (or perceived lack of this) were: knowledge and capability relating to carrying out assessments in general, subject matter knowledge and contextual knowledge.

General assessment knowledge and capability

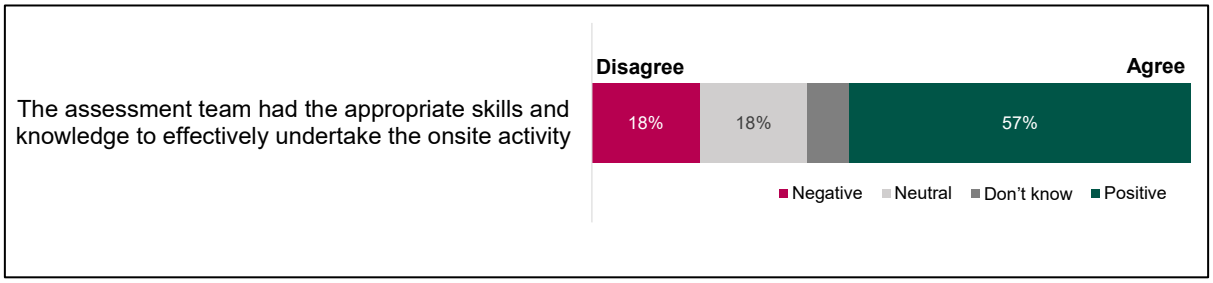
Participants across case studies thought general assessment knowledge and capability was an area of strength for CQC inspectors. Having at least some senior members of an assessment team was viewed as an important contributor to this (discussed further in the next section).

"The people that were there were knowledgeable and were fairly senior…They were able to ask the right questions and have an informed debate really."

ICS General Practice

As shown in Figure 8.1, just over half (57%) of formal LA survey respondents thought the assessment team had the appropriate skills and knowledge to effectively undertake the on-site activity.

Figure 8.1 Views on inspector skills and knowledge of formal LAs



Base: All Survey 2 participants (n=28)

Subject matter expertise

Opinions differed on whether CQC had sufficient subject matter knowledge, particularly between ICSs and LAs. Some ICS participants that inspectors had good knowledge of the service areas they were discussing during interviews, but this view was more commonly shared by LA participants, who gave inspector backgrounds in social care as evidence of capability. A participant from 1 formal LA said that this knowledge was visible in specific group interviews they were part of, where the work was quite specialist, and they could tell the inspectors understood it.

Participants in both pilot ICSs felt that CQC inspectors had gaps in their knowledge when it came to the specific service areas they were assessing. One ICS felt that inspectors asked quite basic questions during interviews and did not seem to be able to follow-up on comments in any detail. Another participant was left with the impression that CQC inspectors had been given a list of questions to read out, but that they did not have the experience or knowledge to truly understand the responses or probe for further detail. Specific areas highlighted for lack of knowledge were safeguarding and workforce. One further participant described a situation where an inspector confused the areas of equality duties and health inequalities.

"My personal experience with the workforce one felt like, if I'm truly honest, I was presenting to someone that didn't know enough detail to ask me any questions…I mean, obviously they had the skills to be able to do the general interview and to ask the questions. I'm not sure if we'd given them an overly positive view, for example, they'd have been able to dig deeper."

ICB/ICP strategic lead

Contextual knowledge

ICSs and LAs were in agreement that CQC contextual knowledge could be improved. Both ICS case studies thought CQC inspectors needed to develop a more comprehensive understanding of how ICSs work. Participants provided a range of examples for this including: CQC inspectors conflating the ICB and the ICS; lack of understanding of the roles of individuals within the system and who was responsible for what, which led to the wrong questions being asked of the wrong people during interviews; and incorrect terminology or language used to describe the system. One ICS participant said that even when it came to the final interview with their Chief Executive, the CQC inspectors were still not using the correct language and had not fully grasped how the ICS worked. Both ICS case studies also suggested that CQC lacked understanding of how to assess a system specifically (covered previously in Chapter 7). Participants suggested that CQC should take time to understand and map how ICSs operate before assessments to improve their understanding.

Some LA participants also thought CQC could improve their knowledge of how LAs work and the different systems and processes within them. Just under 2/3 (64%) of formal assessment survey respondents thought that the CQC assessment team were sufficiently informed about the local context of the LA, while 1 in 5 (21%) disagreed[16]. Some participants in pilot and formal LA interviews suggested the CQC inspectors lacked knowledge of the organisational structure of LAs. One specific example given by a formal LA was that they could have better knowledge of the specific responsibilities of LAs as opposed to the responsibilities of providers commissioned by LAs. Another participant from this LA gave an example that lack of knowledge of their operating model led to inappropriate questioning, i.e. they were asked about waiting lists at the “front door”[17], when it is not their practice to carry out assessments at this stage. One pilot participant thought that while CQC inspectors had a good grounding in adult social care, they did not have specific understanding of adult social care within an LA setting as opposed to at provider level. CQC staff noted that in the initial formal assessments they have a meeting with LA senior leadership ahead of the site visit to understand more about their context and structure. This was not mentioned by the initial formal assessment case studies.

A few LAs also said that CQC requested quite basic information about how the LA worked to be explained during interviews that they already had access to from the IR stage. While CQC does deliberately ask for this information during interviews in order to hear it from LA staff themselves, they could also consider building their understanding of the responsibilities of different teams across the LA before assessment begins (and make it clearer to LAs that they have done so but would like the information confirmed during interviews).

[16] The assessment team was sufficiently informed about the local context of the local authority: 64% agree, 14% neutral and 21% disagree – Base: All Survey 2 participants (n=28).
[17] This refers to the initial point of contact or arrangements LAs have in place to respond to inquiries or concerns related to those who may require support social care services.

CQC credibility

Views on CQC credibility were strongly associated with perceptions of inspector skills and capability. Overall, CQC were viewed as credible in their ability to assess complex systems. Participants frequently cited either inspector seniority or sector experience as influencing this perception. However, some participants, particular ICSs, expressed concerns over credibility related to the idea that CQC lacked thorough knowledge of how ICSs work.

Participants tended to judge CQC credibility based on their experience of assessments themselves**.** Most participants drew on their own experience of CQC assessing their system to determine their credibility. Nevertheless, some participants remarked on CQC's wider reputation as a driver of credibility or said the fact they were the appointed body was enough evidence for them of credibility. A minority of participants referenced the Penny Dash interim report, but no participants suggested this had negatively impacted their view of CQC credibility. However, 1 participant from a formal LA thought that the report might impact the public's perception of their credibility.

Participants from across ICS and LA case studies described CQC inspectors as credible due to their knowledge and experience. Among LA participants specifically, inspector backgrounds in adult social care were key to enhancing perceptions of credibility. This was because these inspectors were seen to have appropriate knowledge but also understanding of the challenges that are faced in the sector. Health stakeholders within ICSs were more likely to reference inspector experience in terms of experience of carrying out assessments. Two ICS participants stressed that the perceived seniority of the CQC assessment team aided credibility as they felt they would be less likely to respect the judgements of junior inspectors (i.e. those who had not carried out as many assessments) as they would have had limited "on the ground" experience. Other ICS participants said they thought CQC were credible because they were focusing on the right areas during the assessment and asking the right questions, for example probing on the focus of the ICS on children and young people.

"I think because it seemed a fairly senior team or people that I thought were good, that brings credibility and the independence. I think when you end up with junior teams or junior people that's what kind of undermines it really…Even if we don't agree with everything they've said, they were credible people that came in and they've done a lot of these reviews."

ICS General Practice

Perceived CQC transparency was also a driver of credibility among some participants. One example of transparency that aided perceptions of credibility was CQC sharing inspector profiles with LAs before the fieldwork. These were not individual profiles but rather communications about the experience of the whole LA inspection team. This was viewed positively as it meant case study sites could see how qualified inspectors were and it built confidence in their suitability to carry out the assessment. Another example given by 1 participant from an ICS was that CQC were transparent about the aims of the assessment and what they were hoping to achieve. This supported credibility for this participant as it meant CQC could clearly demonstrate why they were doing the assessment and its value.

"You could see the intention of what they wanted to do and that's what builds credibility from my perspective, that clear vision and what they're hoping to achieve."

NHS Trust

Some LA and ICS participants thought CQC lacked credibility due to a lack of understanding of how the systems work and expertise within the areas assessed (covered in more detail in the previous section). One ICS participant thought the CQC did not understand the 'bigger picture' of ICSs and spent too much time focused on health in isolation and not how this interacts with other areas within the ICS. Other ICS and LA participants worried that CQC inspectors did not have enough experience in all the different service areas they were assessing. These opinions were often formed based on experiences during interviews, with participants rarely considering the relevant expertise might sit elsewhere within the wider CQC inspection team.

CQC capacity

Participants across ICSs and LAs were generally less likely to have a strong view on CQC capacity, compared to capability and credibility. Among those who did comment, participants tended to think CQC had enough capacity for the assessments but there were still some concerns raised about this.

Some participants mentioned that they did not see any issues with CQC capacity during their assessment and that it felt broadly sufficient. Examples of evidence given for this view were that CQC responded to queries in good time and the on-site visit ran to plan.

"They were well staffed, there was lots of meetings and no delays. A few clashes but this did not impact the assessment."

LA frontline staff

However, there were a small number of suggestions that CQC might have stretched capacity. There were examples of staff who:

- Questioned whether CQC had the resource to fully read, digest and analyse the information in the IR (and the SAR for LAs) that was sent to them as they did not feel the assessment report included much extra analysis (and simply summarised some of the information sent). This also came up in the LA survey.
- Questioned CQC capacity more broadly, for example a minority wondered whether CQC had the capacity to complete all the initial formal assessments in the allotted time and 1 participant referenced the Dash Review that suggested they were lacking capacity for assessments they had been doing for years, however they did not see any capacity issues within their own assessment.
- Suggested on-site assessments would ideally have bigger teams or last longer. LA staff in particular felt that because so much goes on within their LA, that CQC would benefit from speaking to more people or spending more time focusing on each service area to ensure a thorough understanding of the authority.

CQC staff aligned with both pilot and formal assessments thought they had sufficient capacity. However, assessment managers from initial formal assessments mentioned that there are challenges with ongoing staffing due to a lot of assessment staff contracts being fixed term or temporary.

9 Wider CQC activity relevant to system assessments

This chapter presents findings on the delivery to date of wider CQC activity, beyond the LA and ICS assessments, including views from across the ICS and LA case studies, and national stakeholders about the potential value of this activity going forward.

It was intended that CQC would undertake a range of activities outside of the ICS and LA assessment processes to collate intelligence and put this into the public domain. The aim of this was to contribute to the wider development of systems, provide regular insights to contribute to the evidence base around what works in system activity, and share good practice to support systems to develop.

It was anticipated that this CQC activity could include making connections with key stakeholders to share insight and knowledge not specific to individual ICS or LA assessment outcomes. For example, sharing key themes from across ICS and LA assessments. It was anticipated that activity would include both targeted engagement, for example speaking at conferences and attending networking events, as well as sharing insight through CQC's website, bulletins and publications (e.g. State of Care).

Although this activity is currently still in its infancy and CQC will continue to develop this over the coming months, the evaluation sought to understand the potential future value of this activity.

Key findings

- Delivery of CQC activity to collate intelligence across ICS and LA assessments and put insight into the public domain was limited to date. Some limited activity has taken place, including presenting findings at national conferences.
- There was widespread positivity about the potential value of wider CQC activity. It was felt that activity could generate improvements in system and partnership working; improve public awareness of system regulation; and influence government policy.
- Many ICS and LA participants requested ongoing contact and support from CQC in their improvement journey.

Wider activity to date

Delivery of wider CQC activity to date was still in its infancy at the time of writing this report. The main reason for this being slower than anticipated progress in undertaking ICS and LA assessments, which had limited CQC's ability to progress wider activity to support system working. Internal CQC restructure also meant wider activity had not been prioritised. Work was ongoing to develop this activity, with CQC staff describing upcoming plans to share insight through webinars and thematic reports.

"It is just too early I think. We need to have done more assessments before we start sharing findings…I don't think we are at the right point to do that [share wider findings] at the moment."

CQC staff

Activity that had taken place to date included presenting system assessment learning at sector conferences in both 2023 and 2024. This included presenting findings around improving transitions for carers from children's to adult services at the National Children and Adult Services Conference in November 2024. A session was also held to share learning and advice on the practicalities of the assessment process and understanding the wider national context.

Findings were also included in the 2023/2024 CQC State of Care report[18], published in October 2024. Detailed findings and themes from across ICS and LA assessments were covered in a dedicated chapter ('local system response'). Minor references were also made to system assessment in the previous years (2022/2023) report[19]. CQC has also shared themes and trends from the system assessment as evidence to be used in parliamentary round tables. Bulletins and podcasts have also recently started to move away from focussing on the logistics of system assessment to sharing insight.

Generally though there was limited awareness amongst ICS, LA and national stakeholders about activity to date; with only a small number of participants in the research reporting having engaged with it.

Potential value of future activity

There was widespread positivity about the potential value of wider CQC activity in future. ICS and LA staff highlighted 3 areas of potential value:

- Generating improvements in system and partnership working. ICS and LA staff felt that CQC collating insight, identifying common themes across systems and sharing good practice had the potential to drive improvements in system operation. It was felt that this could build on the existing examples of LA staff reviewing other LA assessment reports to highlight good practice that could be useful within their own area.

- Improving public awareness around systems and system regulation. It was felt that there was potential value in CQC sharing information with the public to support their understanding of systems, including how systems work and what it means for them. This would be an important first step in building their understanding of system regulation to improve confidence and trust that action is being taken on key issues identified across systems.

[18] The state of health care and adult social care in England 2023/24 - Care Quality Commission
[19] State of Care 2022/23 - Care Quality Commission

- Influencing government policy. Some participants, and particularly those in LAs, felt that CQC sharing insight from system assessments could support calls to government for changes in health and social care policy (e.g. adult social care funding). CQC was seen as having power to influence policy through collating and sharing system assessment insights.

"I think it would be interesting to see what challenges other local authorities have experienced, whether they echo the challenges that we experience, and anything that other local authorities have done to counter those and some examples of good practice or where they've made progress."

"It would be good for CQC to share where things are working well…and use the intelligence they have to support the government in terms of their decisions and policy around health and social care."

LA managers

Despite the general positivity about the potential value of this activity, a minority (and particularly national stakeholders) highlighted the need for CQC to consider the timing of *when* they start to undertake this activity on a larger scale. It was felt that CQC need to undertake more system assessments before they are able to collate valuable and meaningful insight. More assessments were needed to build a greater evidence base on what good looks like and determine what constitutes good practice, before it could usefully be shared with systems.

"They [CQC] need to have undertaken enough assessments to know what good is. They haven't got a good enough sense of the sector at the moment."

National stakeholder

CQC should also be cautious of making generalisations about systems. A small number of LA participants noted that LAs are all different and complex systems so sharing good practice that is relevant to all might be difficult. They also shared a risk that sharing aggregated findings might lead to generalisations across complex systems.

"I think to have that regulatory body trying to really define what good looks like within adult social care is incredibly difficult because we differ so much and it might just make the insights meaningless..."

LA manager

Maximising value of future activity

ICS, LA and national stakeholders were asked how CQC could best support systems through their wider activity. Most responses focussed on how CQC could effectively share good practice with systems, and key considerations for doing this. ICSs and LAs would welcome sharing of good practice in relation to tackling specific issues, for example addressing health inequalities or supporting those with learning disabilities. They would also value thematic reports around key findings, for example around leadership and partnership working.

"I would like to see reports on key issues and things that everyone is struggling with, e.g. mental health or health inequalities. I'm a big believer that there is always something you can learn from others and I do think CQC have a role to play in that."

ICB/ICP strategic lead

ICSs and LAs would like to see good practice examples from system assessment being publicised on the CQC website, social media and other channels (e.g. CQC's podcast or via bulletins). CQC staff noted that the maternity assessment programme had recently trialled an approach to sharing good practice on their website by collating examples against prioritised themes of interest (e.g. triage). This is something that CQC system assessment teams could usefully consider. ICS, LA and national stakeholders would also value good practice tailored and shared at national, regional and local levels. The latter 2 would be helpful to identify geographical trends.

A key message from ICS and LA staff was the importance of making insight sharing accessible and easy to engage with, without being too time consuming for staff.

"The last thing we want is lots of time consuming stuff to read…make it easy to read, clear and practical. That is what will help us the most."

ICB/ICP strategic lead

A similar point was made in relation to sharing insights with the public. As system language (e.g. ICB, ICP etc.) is not accessible to the general public, it was felt to be important to reframe concepts to help people understand how individuals fit within a system and the anticipated benefits (e.g. greater joined-up working). CQC staff described using this approach when speaking with local people as part of ICS assessments. It was felt to have worked well to explain how populations might interact with systems, to avoid use of jargon or complexity.

"My dad isn't going to know what a system is or an ICS or ICB, but he doesn't need to. That's not the point. He wants integration and co-ordination and that can be explained to people using non-technical language."

National stakeholder

Contribution to improvement journey

Only strategic leads in Birmingham and Solihull ICS described having regular contact with CQC following their pilot assessment. This included CQC attending their regular quality review meetings. Strategic leads valued this activity for enabling open and ongoing conversations about improvements.

Other case study areas described no interaction with CQC after their assessment. For some participants, this was the right approach. They felt that the assessment report should be the final stage in CQC's process, and that any closer involvement would risk CQC's independence. The majority of participants though requested ongoing contact and support from CQC. This was especially the case amongst LAs; largely because they had received their reports and were more advanced in their improvement journey (see Chapter 10 below for more detail on this).

"I think CQC should do more than assess. Otherwise they just knock on our door [i.e. complete assessment] and run away. I could see them playing a role as a partner, rather than just a [inspector]."

LA strategic lead

Suggestions for ongoing support included:

- Reviewing improvement action plans/strategies to support systems to understand and have reassurance that their plans align with CQC's expectations based on assessment findings.
- Providing ongoing independent scrutiny to support monitoring of progress and building relationships with systems. This was typically requested in the form of light-touch follow-ups after 6-12 months to check-in on progress, and a regular schedule of assessments going forward.
- Providing learning opportunities for senior system leaders. This could potentially include mentoring/coaching and acting as a 'critical friend' on key strategic decisions.

CQC staff also felt that further activity could be valuable, and described already beginning to explore what this could look like and the practicalities. It will also be important to consult with national stakeholders, including LGA, NHSE and ADASS, to prevent any duplication or overlap in support provided to systems.

"Our current plan for assessments [establishing a baseline for each LA/ICS over a period of c. 2 years] will provide insight about 1 snapshot in time which quickly becomes irrelevant. I think there's more benefit in an ongoing dialogue with each system to build a relationship and understand their competing priorities…we need to work hand in glove with systems rather than just running assessments."

CQC staff

To note, CQC will be working closely with stakeholders and partners including DHSC to co-produce what LA assurance will look like after the initial formal assessment phase. For ICS, CQC are currently engaging with systems and partners to inform further refinements to the ICS assessment proposal. CQC staff noted that this may mean that any wider activity beyond the assessment that would take place currently would need to be undertaken on a case-by-case basis with individual LAs and ICSs.

10 Early evidence of outcomes

As discussed in Chapter 2, this research aimed to explore the effectiveness of CQC's approach to system assessment, and the mechanisms through which it can have most impact. To sum up CQC's approach to system regulation and how it is intended to deliver value, we developed a ToC. This chapter explores the extent to which the anticipated outcomes of CQC's system regulation, as outlined in the ToC (see Figure 4.1), have been achieved. Within the qualitative research, only the immediate and short-term outcomes were covered in depth, with participants asked for their general reflections on CQC's longer-term outcomes.

As previously discussed, CQC do not hold directive powers in relation to ICSs and LAs and can only influence change. As a result, a contribution analysis approach was chosen to explore the anticipated outcomes. This approach compares a programme's ToC (in this case, for CQC's system assessments) with the evidence to draw conclusions about whether the intervention has contributed to the outcomes or changes observed. It ensures that CQC's role as a singular influencing power within complex systems is considered, measuring the extent of their contribution to these outcomes, and does not assume that CQC has the power to achieve these outcomes alone. The extent to which these outcomes were achieved as a result of CQC activity is then scored using the approach outlined in Table 10.1. More information on the contribution analysis approach can be found in Appendix 3.

Table 10.1 Contribution analysis scoring approach

Outcome score	Scoring criteria
Achieved	Consistent views are evidenced across 3 or more case study ICS/LAs/national stakeholders/CQC that CQC activities have contributed to achievement of outcomes
Partially achieved	There is data from only 1 or 2 ICS/LAs/national stakeholders/CQC that CQC activities have contributed to achievement of outcomes
Not achieved	No evidence or evidence provides a different explanation for achievement (or not) of the outcomes
Inconclusive	Evidence from multiple audiences and sources is contradictory

Key findings

- There was strong and consistent evidence that CQC activities have contributed to immediate outcome of 'creating a framework for ICSs and LAs to understand their performance and future priorities'. There was also some evidence that 'CQC have built a greater understanding of system regulation', though evidence was weaker for ICSs. Both LAs and ICSs were positive about the potential for CQC activities to achieve the outcome of 'local and national insight into performance, what good looks like, and where system issues/gaps emerge', but this had not yet happened.
- There was strong and consistent evidence that CQC's regulatory activities have led to 'improvements at the ICS and LA system level'. There was some evidence of 'CQC contributing to a greater understanding of systems'. Most participants also said that improvements made across their ICS/LA were 'inclusive of adult social care', though there was limited evidence that CQC assessments themselves had led to greater inclusion of social care.
- To date, CQC has had most impact by setting out their quality expectations within assessments and guiding ICSs and LAs to take necessary action by identifying areas for improvement. There is also the potential for CQC to have impact by sharing information on system regulation within the public domain.

Immediate outcomes

The immediate outcomes were expected to be achieved as a direct result of CQC regulatory action. Table 10.2 below shows the intended immediate outcomes, along with whether they have been achieved, partially achieved or not (yet) achieved.

Table 10.2 Achievement of immediate outcomes

Immediate outcomes	Achievement
ICS/ LA: A framework to understand performance and future priorities	**Achieved**
ICS/ LA/ Partners/ Public: Local and national insight into performance and what good looks like and where systems issues/gaps emerge	**Not achieved**
CQC/ all: A greater understanding of system regulation	**Partially achieved**

CQC activities generate a framework to understand performance and future priorities

This outcome anticipates that system assessment will provide ICSs and LAs with a framework to set expectations and provide clarity to ICSs/LAs on what high quality and effective care looks like. This should enable ICSs and LAs to see where their current performance has strengths and weaknesses, and where they need to prioritise improvement in the future.

This outcome was assessed as achieved. For the ICSs and LAs that had taken part in an assessment to date, there was broadly agreement that the findings from the assessment had supported systems to understand their performance and identify areas for development and improvement. The key drivers of this were the assessment framework and assessment reports.

Within the pilot LAs, it was noted that these areas for improvement had been incorporated into action plans that were used to drive improvements. Examples were also given of the assessment report and findings being used in strategic decision making and also being shared with LA staff at all levels, so they could understand areas of their delivery that were working well and where there could be improvements. Within the CQC survey of formal assessment LAs, some participants reported that the CQC assessment had reaffirmed their existing action plans and intended areas of focus. This had helped to confirm that they were taking the correct steps to improving their performance, and the future priorities they had identified were correct. Some pilot LAs also mentioned that following the assessment, monthly case audits were implemented to support their ongoing understanding of performance.

"We used the learning as part of our decision making; we had a meeting with all staff to share key points and are going to use it to make changes. It [the CQC assessment findings] will have a big difference."

LA strategic lead

"I absolutely think so and I think we've embedded that right through because the audits have it exactly as you would be looking at a case audit for CQC."

LA manager

Pilot LAs also reported implementing these changes to ensure they were 'assessment ready' for when CQC return. This outcome brings both benefits and risks. As the assessment and assessment framework is built on a set of key themes and standards, implementing changes to ensure these are met should bring positive outcomes for ICSs and LAs. For example, ensuring caseloads are regularly audited should improve case management processes and mean issues are flagged early.

However, it is important for CQC to consider how they want to have impact as a regulator of systems. The risk is that over time, these actions focus primarily on ensuring LAs and ICSs are CQC compliant rather than bringing substantial, long-lasting change. CQC should consider ways in which they can encourage outcomes that are more embedded, for example those that are focused on more complex challenges such as health inequalities and local population health outcomes. An exploration of whether longer term outcomes such as these could be incorporated into the assessment framework could be beneficial.

Some ICS participants felt this outcome had not yet been achieved. This was predominately related to concerns about duplication with other performance frameworks (e.g. NHSE's oversight framework). Some participants were positive about the assessment framework's alignment with the Care Act but felt it was not appropriate for an ICS system assessment. Whilst the frameworks for providers and systems are based on the same fundamental principles, like quality assessment, the latter needs refining to acknowledge the differences in the ways they should be assessed. Some ICSs were also apprehensive about the usefulness of the assessment reports to support this understanding, as discussed within Chapter 7.

"We need to be careful that we don't have loads of performance frameworks coming out of our ears that we do nothing with … I have not seen future priorities from this assessment but I might have missed it"

NHS Trust

"Because that is fundamentally what the regulator is there to do, which is to identify risk, it's not a performance management tool ... that's NHS England's job. I think that's a missed focus and I don't think it would help the system."

ICB/ICP strategic lead

Some participants, and particularly national stakeholders, also noted the importance of undertaking more assessments before a broader sense of performance and future priorities across systems could be assessed.

Local and national insight into performance, what good looks like and where systems issues/gaps emerge

Over time, as more regulatory assessments are completed, the ToC anticipates that the collective outputs will help to build up a local and national picture of system performance. The assessment activity will form a baseline that builds a clear local and national picture of what good looks like and what is working well and less well. This outcome was assessed as not achieved.

Both LAs and ICSs were positive about the potential for this outcome to be achieved. The fixed set of standards within the assessment framework was felt to be a positive base on which to build, ensuring consistency in identifying good practice and system gaps moving forward. However, the limited number of assessments that had been completed to date and subsequently the limited wider CQC activity to date (see Chapter 9) meant this outcome had not been achieved.

"I think it should and I think it will, but until we start to see more reports, I'm not clear at the moment."

ICB/ICP strategic lead

For this reason, we suggest this outcome should become a short-term outcome on the ToC rather than an immediate one (see Appendix 2 for the updated ToC). This reflected participants' views that this would only be achieved once a greater volume of assessments had been completed. This outcome is also now being supported by the immediate outcome 'ICS/ LA: A framework to understand performance and future priorities'; participants suggested this would be important to enable CQC to share insight into performance and what good looks like.

A greater understanding of system regulation

Through the process of conducting regulatory activities, the aim is that CQC builds a clearer understanding of system regulation, considering how it can add greatest value. It is anticipated that this process is time limited (only during initial delivery) as over time it would be expected that CQC has a stable and consistent approach to system regulation. This outcome was partially achieved.

Following the pilot LA assessments, CQC refined their assessment approach. The changes were relatively minor (as discussed in Chapter 6) to ensure consistency but indicate that CQC had built a greater understanding of system regulation in relation to LAs. The delays in the publication of ICS reports and starting formal assessments has meant CQC remain unsure on how to best regulate ICSs. This evidence gap is another key reason this outcome is only partially achieved. Detail on improvements that could be made to the assessment approach from the perspective of ICSs is discussed in Chapter 7.

There was some evidence among pilot and formal LAs of the assessment leading to systems having a greater understanding of system regulation, but this was isolated. Some LA pilots commented that engaging with the assessment activities and reading the published reports gave them greater clarity on the CQCs expectations as a system regulator. Some also felt that the assessment framework itself meant they reflected on their areas of improvement focus within the system and it added an additional way of understanding what areas of practice should be a focus. It also increased their understanding of CQC's approach to system regulation, as it set out a set of themes and standards that underpin system regulation. As discussed above, ICS/LAs also felt having a greater understanding of system regulation would ensure they were 'assessment ready' for when CQC return.

"I think the framework's great, I do, it's just too big. It covers the breadth of social care, I think the themes are spot on, I think the individual questions are spot on, I like the way the framework's laid out."

LA manager

Short-term outcomes

The next 3 outcomes were intended to be achieved within the short-term and as an indirect result of CQC's influence. They broadly relate to the stage in which CQC disseminates the assessment findings to relevant partners who use them to implement change. Table 10.3 below shows the intended short-term outcomes along with whether they have been achieved, partially achieved or not (yet) achieved.

Table 10.3 Achievement of short-term outcomes

Short-term outcomes	Achievement
ICS/ LA: Improvements at ICS and LA system level	**Achieved**
CQC/ all: A greater understanding of the system	**Partially achieved**
ICS/LA: Improvements made are inclusive of social care	**Partially achieved**

Improvements are made at ICS and LA system level

One key assumption – and significant change mechanism – is that the LAs, ICSs and partners that take part in assessment activities and receive the regulation report reflect upon and then *act upon* the findings. This outcome was assessed as being achieved. Across LAs, there was strong evidence that the CQC assessment encouraged reflection on areas for improvement and translated these into plans for change. There was less evidence of this within ICSs, with most participants feeling it was too early to comment. Overall, 5 main themes were identified from the qualitative evidence (each is discussed in turn below). It is important to note that these themes do not represent sequential stages, with some ICSs/LAs reporting evidence for more than 1 theme.

Figure 10.1 Views on the outcome: improvements are made at ICS and LA system level

Firstly, many within the ICS pilots could not provide feedback on whether improvements had been made within their systems. Participants mostly attributed this to not having seen the reports at the time of fieldwork, due to the delays in its publication. Participants hoped that once the report became available, they would be able to use the findings to implement changes where necessary. This was supported by CQC staff who acknowledged it may be too early to assess if any outcomes have been achieved, with the reports being a key facilitator.

Secondly, some participants across LAs and ICSs felt the assessments created the potential for change. As discussed previously, assessment activities encouraged self-reflection and an internal examination of strengths and weaknesses. It was felt by pilot and formal LAs that this facilitated self-awareness within their systems and helped to identify potential improvements. In addition, both ICS case studies felt this self-reflection brought individuals together and created an opportunity for collaborative change involving all areas of their system. Within 1 ICS, the focus on their children and young people's services within the assessment made them think strategically about how they can apply best practice learnings generated from this to other areas.

"It forces you into that focal point of let's all just stop and consider where we are right now and how we want to be moving forward."

ICB/ICP strategic lead

One ICS also felt that the assessment activities would, in time, improve partnerships and create a more collaborative approach to working across the ICS. The pilot was reported as a good opportunity to discuss the ambitions of the system with colleagues and how they are going to be achieved. This helped to forge new relationships and has encouraged individuals to reflect on how the system should work together, for example around financial sustainability.

"The pilot certainly formed relationships across the ICS – it is a good opportunity for system partners to come together to support each other in the delivery of the inspection."

ICB/ICP strategic lead

Improved relationships were seen within ICSs/LAs and between these organisations and the CQC, through the collaborative approach to learning that the assessment encouraged. This was felt to be an important first step to achieving other outcomes within the ToC, such as improvements at the ICS/LA system level, and has therefore been added to the updated ToC in Appendix 2.

Another way in which CQC activity created the potential for change was through areas identified for improvement in the assessment report. One ICS mentioned that this will help them to drive improvements in health inequalities, but that tangible change would take time.

Thirdly, all LAs and ICSs felt that whilst the assessment may not have highlighted anything new, it helped to reinforce changes or improvements that were already underway. For example, 1 pilot LA reported that CQC had highlighted that their participatory work and engagement with their local population needed improvement. While the LA had already identified this and begun work in this area, the findings were useful in confirming they were already taking the right action.

“It contributed to an improvement journey, rather than being the sole cause of it.”

ICB/ICP strategic lead

"The improvements that were identified we already knew about. I suppose it gives us that focus and that we now need to be doing something."

LA manager

In a similar vein, it was mentioned by some pilot LAs that the findings helped justify a focus on areas for improvement that had already been identified. For example, 1 pilot LA felt they could use the evidence to support their argument that more work and funding should be put towards lowering the waiting lists within adult social care.

"[Before the assessment] there was no weight to put behind our arguments around waiting lists in adults."

LA manager

Fourth, all LAs and 1 ICS described the development of action plans or strategies as a result of the CQC assessment. Within 1 LA, monthly case audits had been introduced. These aimed to identify areas for improvement and ensure they were communicated to staff regularly, therefore supporting the LA to understand their performance and future priorities.

Action plans were also developed that focus on each area of improvement highlighted in the report. These plans included steps the system will take to ensure the improvements are made. One ICS mentioned they already had some action plans in place, but the assessment helped to refine them.

Fifth, there is evidence of LAs implementing improvements as a result of the assessment. For example, 1 pilot and 1 formal LA reported the development of an Equality, Diversity and Inclusion (EDI) strategy after this was identified as an area for improvement in their reports. After the experience of carers was noted as an area for improvement for 1 formal LA, they have begun to develop a new carers strategy and made changes to carers assessments to ensure they are more streamlined. The hope is that once implemented, more carers will receive the support they need and the process will be more accessible.

"We've devised our CQC action plan, and we've divided it up between different service areas. Now we're very focused on co-production and citizen feedback, so that was sort of one of the outcomes and actions that came from the report…We regularly review the action plan...we've tied it in with our own self-assessment as well so there's 1 overarching plan, and we regularly meet to see how we're getting on with those actions."

LA manager

A greater understanding of the system

There are a range of activities already described within CQC's direct influence which together wrap up to create a greater understanding of the system more generally. This is underpinned by assumptions that wider stakeholders:

- Are assured of CQC approach being valid and reliable;
- Are assured of the standard of care being provided by systems nationally; and therefore
- Engage with intelligence and insight relating to local and national performance including what good looks like and where system gaps emerge.

This outcome was partially achieved. CQC assessment has led to a greater understanding among LAs and 1 ICS of how their own systems work but most felt that more assessments were needed for commonalities and differences to be identified across systems.

Within individual systems, greater understanding was largely attributed to increased self-reflection as a result of assessment activities. For example, within 1 pilot LA strand leaders were assigned for each theme within the information request. These individuals were required to reach out to different parts of their system to gather examples of good practice and bring it together, facilitating a greater understanding of how their own system operates. Another pilot LA also felt the assessment had encouraged better partnership working as a result of its activities promoting interaction. For example, 1 respondent reported that as a result of the assessment, they became involved in monthly meetings with area managers from different departments within the LA.

Participants from 1 ICS suggested that they had a greater understanding of their own system but provided limited evidence to support this. However, both were positive about this being achieved in the future, particularly as a result of anticipated improvements to partnership working as a result of CQC activities. As discussed in Chapter 9, CQC's role in wider information sharing, particularly around best practice and common themes from assessments, was felt to be important in improving these partnerships and promoting a greater understanding of the system.

Improvements made are inclusive of social care

This outcome assumes that stakeholders (including CQC, ICSs, and Government) will have a stronger understanding of the complexity of adult social care more generally. The assumption being that a greater understanding of performance and system regulation will inform system-wide strategy and decision making and help systems to make changes that are more inclusive of social care.

Most participants said that improvements made across their ICS or LA were inclusive of adult social care, as collaboration and joined-up working was already a key element of their delivery. For example, participants at 1 ICS cited their Children and Young People partnership board which focuses on both health and social care and also mentioned that all place-based work is led by the LAs so there is always a focus on social care as well as health.

A small number of ICS, LA and national stakeholders did provide examples of how the assessments had led to systems making changes that were more inclusive of social care. For example, following a CQC finding that the ICB and LA were not always acting in unison, 1 participant from a pilot LA felt they had seen this partnership improve. They reported this could have a positive impact on ensuring solutions for service users are agreed upon in a timelier manner.

However, overall, there was limited evidence that CQC assessments themselves had led to greater inclusion of social care, which is why this outcome was partially achieved.

"I would say we are always striving to be inclusive of social care – that is a key part of the ICS. But more inclusive since the [CQC] assessment, I don't think I could stretch to saying that."

ICB/ICP strategic lead

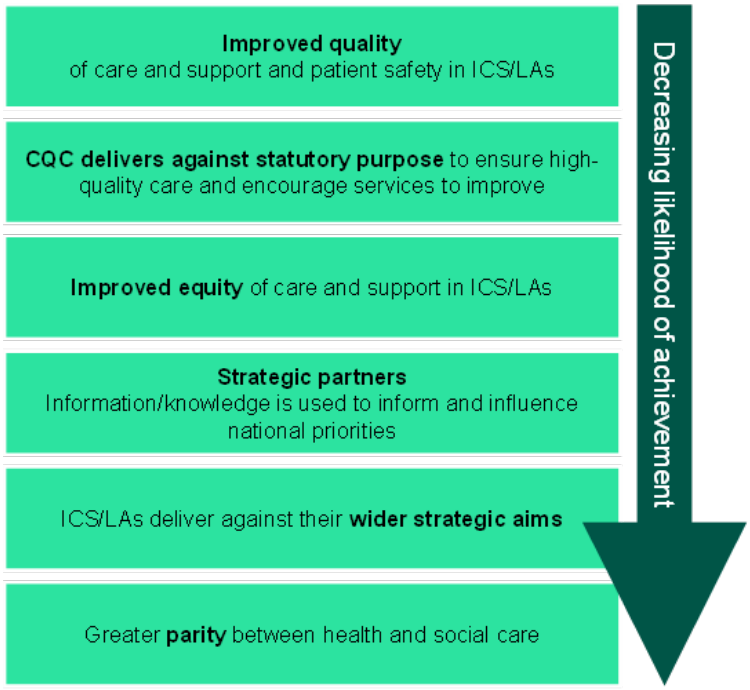
The challenge of greater inclusion between health and social care was identified within the PSM, which demonstrated how ingrained the current divide is. The map established a clear desire for greater unity between health and social care but also identified barriers that make this challenging. For example, growing demand for services and financial pressures were all noted as obstacles to achieving greater inclusion of social care. It was suggested that alignment among strategic leaders, such as national policymakers, and a strategic vision focused on delivery, quality and safety, and financial concerns were the key to achieving greater parity between health and social care – any role that CQC can play in making this happen is likely to be welcomed by LAs and ICSs. The full PSM report can be found in Appendix 4.

Long-term outcomes

The ToC identified 7 longer-term impacts (outlined in Figure 10.2 below in order of likelihood of being achieved). As it would not be reasonable to expect the long-term outcomes to be achieved at this stage, no scoring approach was used. Instead, participants were asked for their thoughts on the likelihood of these outcomes being achieved in the future. Whilst CQC assessment activities can directly contribute to these outcomes, they also require engagement from national stakeholders, such as DHSC and NHS England.

Overall, participants felt it was too early to know whether these outcomes could be realised. The limited number of assessments and short time period in which change could have occurred were cited as the main reasons for this. Participants had varying views on the degree to which these outcomes could be achieved, and the diagram below depicts this from most likely, through to least likely. More detail on each of these is covered below.

Figure 10.2 Perception on ability to achieve long-term outcomes



Participants found the outcome, improved quality of care and support and patient safety in ICSs and LAs, to be the most achievable. It was felt the assessment should naturally drive this outcome and should be CQC's primary focus. For example, having an external regulator hold LAs and ICSs to account should provide a sense of urgency and ensure areas needing improvement are prioritised.

"Someone famous said some time ago basically that if somebody's looking at it and checking it, then you're more likely to do it then if they're not. So I think that helps to hold people to account."

LA manager

Participants felt CQC delivering against its statutory purpose and improving the equity of care and support in ICSs and LAs were the next most achievable. This is due to CQC's assessments identifying improvements that LAs and ICSs should then implement, driving positive change. Within equity of care, a common improvement identified within pilot LAs was their approach to EDI. As discussed within the first short term outcome, changes are underway within these LAs which aim to improve this area. In terms of CQC delivering against its statutory purpose, participants felt this would be achieved from CQC improving the quality of care and support and patient safety for all.

"I think from the fact that they identified EDI for us, and we need to better understand our communities, that should bring some equity and from those seldom heard groups. I would agree with some of that to an extent"

LA manager

Participants felt strategic partners information/knowledge being used to inform and influence national priorities was also likely to be achieved. Similarly to other outcomes, it was felt more assessments are needed before national trends can emerge, and once this evidence base is built, it can be utilised by policy makers. More detail is provided on this in Chapter 9.

Participants provided limited insight on ICSs and LAs delivering against their wider strategic aims, and most felt achieving parity between health and social care was unlikely. For the former, participants were unsure about how this could be achieved and measured, and some felt it was not within CQC's remit of influence. Some participants from pilot LAs and ICSs felt that moving towards parity between health and social care was too big a challenge for CQC to realistically address, given that inequality between the 2 parts of the system is so entrenched (as discussed above). It was suggested this is an issue with legislation and the distribution of finance and resources between health and social care, and as such something CQC may struggle to influence directly.

Impact mechanisms

One of the research objectives was to identify the key mechanisms through which CQC has impact in a system setting. These mechanisms depict the ways CQC assessments may influence systems to improve and aims to support CQC to understand how they can have most impact as a regulator of systems. In talking about impact, we are referring to ways that CQCs regulatory activities may influence ICS/LA behaviour and performance. This builds on CQC-commissioned research which identified 8 provider-level impact mechanisms.[20]

[20] Impact of Care Quality Commission on provider performance: room for improvement

The framework of 8 provider level impact mechanisms was developed as CQC acknowledged that assessments can influence change in a range of ways that go beyond a simple direct response to an enforcement action. The framework is beneficial in describing and evaluating impact across the assessment process, and simultaneously broadening CQC's understanding of impact. Whilst CQC cannot take enforcement action within systems, their activities will influence change through similar pathways, making this approach relevant within system assessments.

This section explores the mechanisms through which CQC has had most impact, where mechanisms may need to be adapted from the provider level work to ensure they are relevant, and how CQC can bolster its impact through these pathways. Only 7 of these mechanisms are discussed as the final mechanism, systemic, was not felt to be relevant within the context of system regulation. This is due to its focus on the identification of systemic or inter-organisational issues; which is the central aim of CQC system regulation.

Figure 10.3 Impact mechanisms

Directive
Changed 'directive' to 'guided' given CQC doesn't have 'directive' authority to force ICSs or LAs to take action

Mechanism	Meaning	Evidence	Example reported by interviewees
Anticipatory	The regulator sets quality expectations, and ICSs and LAs understand those expectations and seek to make improvements in any areas identified.	Pre-assessment activities and the quality expectations set by the assessment framework support ICSs and LAs to make changes	Some pilot LA's implemented monthly case audits following the assessment to support an ongoing understanding of performance
Guided	ICSs and LAs take actions that they have been guided to take by the regulator.	Areas for improvement identified from assessment and outlined in the reports guide ICSs and LAs to make changes	**An LA manager lists the areas of improvement from the report to review their progress regularly in managers forums**
Organisational	Regulatory interaction leads to internal organisational developments, reflection and analysis by ICSs and LAs that are not related to specific CQC guidance. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.	Some examples of changes to culture were seen within ICSs and LAs as a result of the assessments	Some pilot and formal LA's felt that the focus of the assessment on positive aspects of their work improved their team culture
Relational	Results from the nature of relationships between regulatory staff (i.e., CQC assessment team members) and ICSs and LAs. Informal, soft, influencing actions have an impact on ICSs and LAs.	Some evidence of impact, but CQC staff were found to be approachable and friendly	Whilst on-site CQC staff were open and transparent about the aims of the assessment and what they were hoping to achieve
Informational	The regulator collates intelligence and puts information about ICS and LA performance into the public domain or shares it with other actors who then use it for decision-making (e.g., commissioning, patient choice).	Limited activity but big potential to generate improvements via the sharing of wider information	Sharing best-practice in the public domain*
Stakeholder	Regulatory actions encourage or influence other stakeholders to take action or to interact with ICS members or LAs.	Very limited evidence, but CQC can encourage stakeholder buy in and support with necessary actions	Inviting stakeholders to a webinar where assessment learnings are shared and co-produced*
Lateral	Regulatory interactions stimulate inter-organisational interactions, such as ICSs and LAs working with their peers to share learning and undertake improvement work.	Impact requires greater influence to first be achieved via the sharing of wider information and building partnerships	An ICS holds a webinar to share ideas on best practice*

*Where we do not have an example from an interview a hypothetical example has been used

At this stage of system assessment delivery, CQC is having the most impact as a regulator through the anticipatory and guided mechanisms. It is a positive sign that LA/ICSs see the positive role of pre-assessment activities, the assessment framework, and the assessment reports in helping them to make improvements and ensure they are held to account. Going forward, CQC should seek to learn from the findings elsewhere in this report to strengthen understanding and confidence in the assessment framework and assessment reports to strengthen their impact as a regulator.

There was some evidence of CQC having an impact through the organisational and relational mechanisms, but these were weaker (than anticipatory and guided) because they are not as strongly tied to elements of the assessment process. Evidence suggests that CQC activity is on the right track to utilise these outcomes (e.g. creating a relaxed environment during fieldwork) but could build on this through a more long-term contribution to LA/ICS improvement journeys.

For the informational, stakeholder and lateral mechanisms, more work must be conducted by CQC outside of its direct assessment activities before impact will be seen. There is real potential for these mechanisms to have impact and early CQC plans (e.g. around wider information sharing) are building strong foundations, but it is too early in the assessment lifecycle for these mechanisms to have had influence. Ongoing reflection by CQC on the value and use of these mechanisms would be valuable.

The findings against the mechanisms, how they may need to be adapted to ensure they are relevant within system assessments, and how CQC can bolster its impact through these pathways, is discussed below.

Anticipatory and guided mechanisms

To date, CQC has had most impact as a regulator of systems through the anticipatory and guided mechanisms. With anticipatory, LAs referenced the pre-assessment activities such as the IR and SAR as supporting change in advance of the assessment. Both ICSs and LAs also felt the assessment framework played a key role within this mechanism, setting out CQC's quality expectations ahead of assessment. As previously mentioned within the outcome 'CQC activities generate a framework to understand performance and future priorities', some ICSs and LAs introduced action plans or case audits that were closely aligned with the themes and standards set out by CQC in the assessment framework. In some cases, these plans and audits were designed to ensure that ICSs and LAs were 'assessment ready' for when CQC return, demonstrating how CQC has achieved impact by establishing quality expectations.

The guided mechanism has been developed from the 'directive' mechanism that was identified as operating in the provider level assessments. The previous mechanism was based on CQC being able to enforce change, while the new guided mechanism focuses on CQCs ability to influence ICSs and LAs to implement change based on their assessment findings. For example, both ICSs and LAs felt the reports were an important facilitator in guiding them to make improvements and ensuring they are held to account. With only a few

ICS participants having seen their reports, this was seen as a key reason LAs had made more progress towards making changes and improvements.

"We've listed out all the areas of improvement that's broken down into different sections, so I would oversee the workforce development side of it, so I would then look at our ASYE [Assessed and Supported Year in Employment] programme, comms engagement, co-production, citizen feedback. We have to regularly give updates on to how we're meeting those outcomes and actions, the progress we're making. It's regularly shared out our Manager's Forums and other places, it's available for everybody to see as well...it's very visible it's very live"

LA manager

For CQC to strengthen their influence through the anticipatory mechanism and guided mechanisms, it will be important for them to make efforts to boost system awareness and understanding around the assessment framework. This will ensure systems feel confident on the quality expectations ahead of assessment and have greater clarity on the changes that are needed to ensure they are met. it is also important that CQC develop their own understanding of good practice and share this in the public domain. Whilst the assessment framework is based on clear standards, this will ensure that quality expectations are tailored to systems and are defined. This will also help to guide the action that ICSs and LAs take to improve in the areas identified.

"Where they can have an impact is being really clear on what good and outstanding looks like, and when they're undertaking the assurance inspection process, I still think the gap is in what are the key areas for attention for improvement"

ICB/ICP strategic lead

Organisational and relational mechanisms

There was some evidence of CQC having an impact through the organisational and relational mechanisms. For organisational, this was mostly in relation to encouraging wider self-reflection on LA/ICS activities, as discussed throughout this chapter, rather than direct organisational developments. For example, 1 pilot LA implemented case audits as an indirect result of CQC assessment. However, there was more limited evidence of this leading to change. There were some examples of changes to culture being made following the assessments. For example, it was mentioned by some pilot and formal LAs that the assessment influenced the culture within their team. The assessments' focus on the positive aspects of their work and how they were making a difference, encouraged them to adopt this approach in their day-to-day.

To maximise impact through this mechanism, CQC should focus on the elements of their assessment which can encourage positive self-reflection. This could involve a focus on known areas of expertise within an LA or ICS, ensuring the correct individuals are invited to fieldwork sessions, and continuing to foster a friendly and relaxed atmosphere when on-site.

“We report back to the team when things haven't gone well and what we don't do as well is tell you what we did really well and how fantastic we do every single day. So, the actual inspection has changed how we talk to our staff and changed what we're looking at. It doesn't mean we negate the stuff that isn't going well, but it means we are more positive about the practice we are doing.”

LA manager

"You know, our service has been under a lot of pressure over the last few years and morale has dipped in that time. But we definitely saw - it picked back up again since CQC have come."

LA frontline staff

There was some evidence of impact being achieved through the relational mechanism. As discussed within Chapter 6, LA participants found CQC staff to be approachable and they created a positive on-site atmosphere, but there is no evidence of this leading to tangible outcomes to date. CQC should, however, continue to focus on creating a relaxed environment during fieldwork and building relationships outside of the assessment. As discussed within Chapter 8, it is also important for CQC to continue ensuring that their assessment teams are capable and credible, with the correct experience and expertise. This will help foster positive relationships between regulatory staff and ICSs and LAs that can have benefits for all involved.

As discussed in Chapter 9, LA/ICS staff would also value the opportunity to develop longer-term relationships with CQC staff, that could add value to their improvement journey. For example, mentoring support for senior leaders could support the development of opportunities to build and sustain relationships, and for CQC to have an impact informally and through soft influencing.

Informational, stakeholder and lateral mechanisms

For these 3 mechanisms, more work must be conducted by CQC outside of its direct assessment activities before impact will be seen.

Whilst there has been limited activity for CQC to benefit from the informational mechanism, as discussed within Chapter 9 LAs and ICSs were positive about its potential impact. Participants felt CQC sharing wider information within the public domain, particularly around good practice, could bring consistency in service delivery and generate improvements. It is clear that this mechanism provides CQC with the potential to have real impact as a regulator. When asked about how CQC can have the most impact as a regulator, the triangulation and circulation of wider information was often mentioned by pilot LA and ICS respondents.

To date, there is limited evidence of the stakeholder and lateral mechanisms enabling CQC to have impact as a regulator of systems. Overall, it is too early in the assessment lifecycle for these mechanisms to have had influence. However, some changes could be made to ensure these they are system specific and maximise CQC's influence going forward.

The stakeholder mechanism focuses on regulatory actions encouraging, mandating or influencing stakeholders to take action, and as such should be tailored to suit system regulation. Impact via this mechanism hinges on CQCs ongoing engagement with relevant regional and national stakeholders and ensuring they are consulted on future developments in the right ways, and at the right time. Utilising this mechanism for system assessments could involve a focus on ways CQC could encourage stakeholder buy-in and to support any action that is identified. This could come in the form of inviting stakeholders to webinars or conferences where assessment learnings or wider information is shared. National stakeholders that were invited to a webinar held by CQC, for example to explain how assessments would work in practice, found them to be helpful and engaging. They felt they had a positive impact on the relationship and made the assessments feel more collaborative.

Consideration should also be given to joining up the work of CQC provider level assessments and any actions taken by stakeholders as a result. It was intended that system assessments would provide an understanding about provider performance and if it identified specific concerns at a provider-level, these could be escalated for CQC to undertake provider-level action, but this has not yet been relevant. System-level assessments should also investigate what systems are doing about any concerns noticed at provider-level. In future, it would be valuable to consider how provider and system level assessments could work together to share insight and contribute to building a clearer picture of system performance.

The lateral mechanism relies on ICSs and LAs sharing information with their peers that can encourage improvement. Given the positive impact that CQC sharing wider information is expected to have on relationships / partnerships (as discussed in Chapter 9), it is possible that these strengthened relationships could also lead to more best practice identification and then sharing this between LAs and ICSs. CQC should first focus their efforts on sharing themes and insights, particularly around partnership working, in the public domain (i.e. the informational mechanism) to encourage improvements in the ways systems operate.

11 Conclusions and future considerations

In October 2023, the CQC commissioned IFF Research to undertake research to assess the extent to which CQC's approach to ICS and LA assessment was effective and understand the mechanisms through which CQC can have impact as a regulator in a system setting. Conclusions and future considerations are structured around each of the key research questions below.

How effective is CQC's regulatory approach to ICS and LA assessment?

Overall the research found many positives in CQC's regulatory approach for both ICS and LA assessment. There is a clear view amongst ICS, LA and national stakeholders that system regulation adds value and that CQC have implemented a broadly effective approach. This provides a solid platform on which to proceed with the remaining initial LA formal assessments, and upcoming ICS formal assessment if progressed.

ICSs and LAs were generally positive about the pre-fieldwork stage in helping them to strengthen their understanding of what good looks like and to build a greater understanding of their system. It was though generally described as time consuming, especially where it was felt that CQC's requirements for the IR were unclear. This resulted in further frustrations where LA and ICS staff felt that CQC had not analysed and used all of the information shared.

Reflecting on the fieldwork stage of the assessment, both ICS and LA staff thought CQC had the skills, capability and capacity to add value in the assessment of complex systems and viewed them as credible and independent. Views around credibility were largely based on the experience of the assessments (rather than external factors or wider views on CQC), with the perceived knowledge and experience of the CQC assessment team an important factor. To allay the concerns of a small number of those who contributed to the research, it will be important to strengthen evidence provided about the depth of CQC's knowledge about how LAs and ICSs operate and their knowledge of certain service areas (e.g. mental health).

Views were generally positive about the assessment framework and the role of this as a tool to underpin the assessments and contribute to an understanding of performance and future priorities. Some negative feedback was expressed around the assessment framework, in relation to the terminology being unfamiliar and that it was too rigid to be able to understand performance within complex and differing system structures. For ICSs, this extended to concerns that the approach to assessments had not been sufficiently adapted for system assessments, and that it was missing vital areas of focus (e.g. finances and health inequalities). This feedback will be important for CQC to reflect on within the broader ongoing discussions about the assessment framework (following the external review of the assessment framework in late 2024).

Future considerations

- CQC should continue to work with ICSs and LAs to ensure they have clarity about the information they are required to share with CQC during the pre-fieldwork stage. It should be ensured that information covers exactly what is required and provides some guidance on the volume of information that CQC are expecting to receive. It should be ensured that ICSs and LAs are only being asked for the most pertinent information in order to reduce the burden. Consideration should also be given to providing reassurance during fieldwork and in the assessment reports that all relevant information provided has been reviewed by CQC. This could include setting clearer expectations for the topics to be covered during interviews, to allay concerns that CQC has not digested information provided.

- During the remaining initial formal assessments, CQC should ensure assessment teams continue to include members with relevant skills and experience to contribute to overall team knowledge (e.g. having senior and experienced staff as part of teams and having detailed knowledge of at least 1 service area being assessed), as well as increase perceptions of credibility. Information on the assessment team that was shared with LAs before fieldwork were working well to provide a high-level summary of who is in the team and what their role is. This should continue in LA assessments and be used in future ICS assessments.

- CQC could consider building a greater understanding (e.g. organisation structure) of individual LAs and ICSs before beginning assessments to understand how they operate, including the language and terminology they use. The senior leadership meetings that have been introduced as part of the LA formal assessments are an example of good practice for CQC to build their knowledge of LAs and their operating context ahead of assessments. This practice should continue and be incorporated into the ICS initial formal assessment period.

- Within the context of broader discussions, consideration should be given to how the assessment framework could be more comprehensive. This should include considering if any further tailoring can be made to the ICS assessment approach and to communicate differences in assessment between systems and providers to ICSs.

- The findings of the PSM also suggest that CQC assessment activity needs to incorporate a systems perspective and demonstrate that it is understanding performance and outcomes through this lens. In practice, this means ensuring CQC continue to build an approach that recognises (and reflect in assessment scoring and reports) the importance of context to outcomes, considering the upstream factors that affect particular outcomes, which sometimes may be quite distant from the outcome of interest, and acknowledging that outcomes often result from the work of multiple organisations interacting. CQC should also ensure the wider context around LA/ICS operating constraints is considered and reflected in the assessment process. This could include reflection on the distance travelled.

What are the key mechanisms through which CQC can have an impact in a system setting?

Across both pilot and formal LAs, there was positivity about the role of CQC assessments in leading LAs to reflect on areas for improvement, and in many cases, translating these into plans for change. CQC assessments were seen by many in LAs as an opportunity for staff to come together and reflect on what was working and areas for improvement. Since the assessments, action plans or strategies in all 5 LA case studies have been put in place for areas for improvement noted by CQC, and in some LAs this has led to them seeing the results of implementing improvements.

The key mechanisms for LAs to make improvements were anticipatory[1] and guided[2] (detail on the mechanisms can be found in Appendix 7). LAs mentioned that the need to complete the IR and collate data had supported the change process in advance of the assessment (the anticipatory mechanism). LA staff highlighted the importance of the self-assessment because it identified their strengths and identified areas of concern or areas for development. A key focus of the guided mechanism was the assessment reports. LA staff felt that seeing CQC's findings was a useful steer on their future activity, and making these available publicly was important to hold LAs to account. For the organisational mechanism, there were some examples of changes to culture following the assessments (for example, boosting staff morale).

There was some evidence for the organisational[3] and relational[4], but these were weaker (than anticipatory and guided) because they are not as strongly tied to elements of the assessment process. Evidence suggests that CQC activity is on the right track to utilise these outcomes (e.g. creating a relaxed environment during fieldwork) but could build on this through a more long-term contribution to LA/ICS improvement journeys.

[1] The regulator sets quality expectations, and ICSs and LAs understand those expectations and seek to make improvements in any areas identified.
[2] ICSs and LAs take actions that they have been guided to take by the regulator through the assessment reports.
[3] Regulatory interaction leads to internal organisational developments, reflection and analysis by ICSs and LAs that are not related to specific CQC guidance. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.
[4] Results from the nature of relationships between regulatory staff (i.e., CQC assessment team members) and ICSs and LAs. Informal, soft, influencing actions have an impact on ICSs and LAs.

For the informational[5], stakeholder[6] and lateral[7] mechanisms, more work must be conducted by CQC outside of its direct assessment activities before impact will be seen. There is real potential for these mechanisms to have impact and early CQC plans (e.g. around wider information sharing) are building strong foundations, but it is too early in the assessment lifecycle for these mechanisms to have had influence. Ongoing reflection by CQC on the value and use of these mechanisms would be valuable.

There is also the potential for CQC assessments to lead to ICS implementing improvements, but there is limited evidence of this happening to date. This is likely due to delays in publishing the pilot reports limiting the effectiveness of the guided mechanism. There was no evidence to suggest that once the initial formal ICS assessments start that the positive findings from the LA case studies should not be replicated, but it will be important for CQC to continue to monitor this.

Future considerations

- Given the slower progress with ICS assessment, it is suggested that additional case study research is undertaken around a couple of initial formal assessments once they are started. This could mirror the approach taken in this research with the two formal LA case studies. Important learning was gathered from our case studies in the 2 formal LAs to establish how well/not the process is working and identify any learning to feed into ongoing delivery.

How can the impact CQC have be identified and measured (on an ongoing basis, taking account of the fact that some impacts may be yet to emerge)?

Identifying and measuring the impact of CQC's system regulation activity will always be a challenging task, owing to the complexity of the wider context in which the assessments are taking place and the volume of additional activity contributing to improvements in the health and social care sector. This creates substantial challenges for collection and analysis of quantitative data and attributing changes to CQC.

This research has successfully used contribution analysis (a method involving comparing the ToC with the evidence collected to determine if CQC's system assessment contributed to the observed outcomes) to show the early impact of CQC's system regulation activities. The research team would suggest that a similar process is used at future points within the initial formal assessment period to provide up-to-date evidence from a greater sample of LAs and ICSs about the impact of CQC assessments. It would also be valuable to undertake

[5] The regulator collates intelligence and puts information about ICS and LA performance into the public domain or shares it with other actors who then use it for decision-making (e.g., commissioning, patient choice).
[6] Regulatory actions encourage or influence other stakeholders to take action or to interact with ICS members or LAs.
[7] Regulatory interactions stimulate inter-organisational interactions, such as ICSs and LAs working with their peers to share learning and undertake improvement work.

some longitudinal follow-up with a sample of ICSs and LAs to gather perspectives on whether and how CQC has made an impact over a longer timeframe.

Within this research, LAs and ICSs provided evidence about how they were planning to monitor and evidence progress. This included monitoring progress against key performance indicators in action plans, analysing longitudinal data, and collecting feedback from staff, partners and local populations. There was uncertainty however about when, if and how ICSs and LAs would be required to demonstrate to CQC their progress and how this would be best achieved. This suggests an opportunity for CQC to engage with LAs and ICSs around the best approaches to gathering evidence to understand progress and performance. It is also an opportunity to ensure ICSs and LAs understand that the purpose of system regulation is around improving outcomes for local people, rather than improving their future CQC assessment rating. This research found evidence that this was clear in most people's minds, but reiterating this would provide further reassurance to ICS and LA staff. It would also be valuable to ensure the assessment framework also closely reflects and contributes to a shared understanding of what improved outcomes for local people should look like and the actions needed to deliver those.

Future considerations

- CQC are advised to continue running the LA surveys that are working well to gather insight into perceptions of the assessments. Similar surveys should also be used as part of the ICS initial formal assessment period. Given the findings from the PSM that systems are dynamic and there is ongoing transformation, it would be valuable for CQC to continue to gather regular feedback on both ICS and LA processes to ensure they remain fit-for-purpose. Considerations could also be given to including questions around impact to help CQC understand their role. This could include questions around actions systems took as a result of the assessments.

- To support any future theory-based evaluation, it is advisable that CQC keep the ToC updated to reflect the reality of ICS and LA assessment delivery. The research team have provided an up-to-date version reflecting the findings in this report in Appendix 1.

- It would be valuable to ensure that information about future plans for ICS and LA assessments are shared widely and promptly to support system and system partner understanding and planning. CQC should also continue codeveloped of the approach with LAs/ICSs and provide regular bulletins and podcasts for them to keep updated on any future changes to plans and timescales, as well as sharing insight from assessments.

What could be improved about the CQC's approach to maximise its impact?

This research highlighted 2 key activities that could support CQC to maximise its impact as a regulator of systems. The first relates to the assessment reports and the second to wider sharing of insight and intelligence.

As discussed above, assessment reports are a key mechanism for CQC to impact systems, meaning it is important that they are as useful as possible. Although CQC has undertaken substantial amounts of work to iterate the reports to date, it is clear that improvements could be made to increase their value. A few suggestions relate to the practicalities of drafting and agreeing the reports; for example, reducing the number of factual inaccuracies and reducing jargon and grammatical errors. In relation to the ICS pilot reports, it was clear how important it was to ensure timely publication of reports to ensure the insight is not considered out-of-date. A harder point to resolve is the level of detail included in the report; it is undoubtedly a tricky balance to include a useful level of detail, without reports becoming overly long and complex. ICSs and LAs placed emphasis on the importance of reports providing clear, actionable guidance to support improvement journeys.

The second area that CQC could use to maximise its impact is the sharing of findings from across assessments and sharing this with stakeholders and the public. It is encouraging that this research has found widespread system interest in CQC taking a leading role in sharing good practice to drive improvements. Although delivery of this activity has been limited to date and has progressed slower than planned, work is ongoing to develop activity to share insight at conferences, webinars and through thematic reports. Many participants also requested ongoing contact and support from CQC in their improvement journey, and it seems that, if possible, this would be another valued-added activity for CQC. Suggestions included reviewing improvement action plans/strategies; providing ongoing independent scrutiny; and providing learning opportunities for senior system leaders.

Future considerations

- To address the point around level of detail versus length of report, it is advised that CQC consider the level of specificity of information provided and ensure it is targeted and focussed. Appreciating that it is not CQC's direct remit to provide recommendations, it is clear that ICSs and LAs would welcome guidance and suggestions around areas for improvement and what good would look like. This research has also found that the guided mechanism and the assessment reports are a keyway for CQC to have impact as a regulator.
- It is suggested that a plain English summary is added to assessment reports. Although the 'overall summary' section provides a helpful overview, a plain English summary could provide a version that is shorter, and easier to read and digest by the general public.

- CQC should continue developing activity to collate intelligence and put it in the public domain. This should use engaging formats that work for ICSs and LAs. For example, via podcasts, conferences, thematic reports and webinars. Topics to cover should include good practice around challenging issues (e.g. addressing health inequalities and supporting those with learning disabilities). It is acknowledged that completion of assessments is still in the early stages, meaning CQC do not necessarily have an authoritative view on what constitutes good practice. Nonetheless, ICSs and LAs would welcome any early indication of what good looks like, even with appropriate caveats.

- Further consideration should be given to exploring CQC's potential role in providing ongoing support for ICS and LA improvement journeys. This should include exploring how this could be feasible and practical within the legislation and staffing capacity. Work has already started with ADASS to explore what relationships with ICSs could look like outside of assessment activity. These discussions should continue and also include relevant LA organisations (e.g. LGA).

Appendices

Appendix 1: Quality statements and themes

ICS assessment framework

Theme 1: Quality and safety

1. Supporting people to live healthier lives
2. Learning culture
3. Safe and effective staffing
4. Equity in access
5. Equity in experience and outcomes
6. Safeguarding

Theme 2: Integration

7. Safe systems, pathways and transitions
8. Care provision, integration and continuity
9. How staff, teams and services work together

Theme 3: Leadership

10. Shared direction and culture
11. Capable, compassionate and inclusive leaders
12. Freedom to speak up
13. Governance, management and sustainability
14. Partnerships and communities
15. Learning, improvement and innovation
16. Environmental sustainability – sustainable development
17. Workforce equality, diversity and inclusion

LA Assessment frameworks

Theme 1: Working with people

1. We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

2. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce future needs for care and support.

3. We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Theme 2: Providing support

4. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

5. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Theme 3: How the local authority ensures safety within the system

6. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

7. We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Theme 4: Leadership

8. We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

9. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Appendix 2: Suggested updates to the Theory of Change

Reflecting on the research findings, the ToC developed at the outset broadly remains fit for purpose. However, there are some refinements recommended to better reflect how the CQC's system assessments operate in practice. An updated ToC is presented below (Figure A2.1). Any future changes to the CQC's system assessments should be reflected in a revised ToC.

Amendments included are:

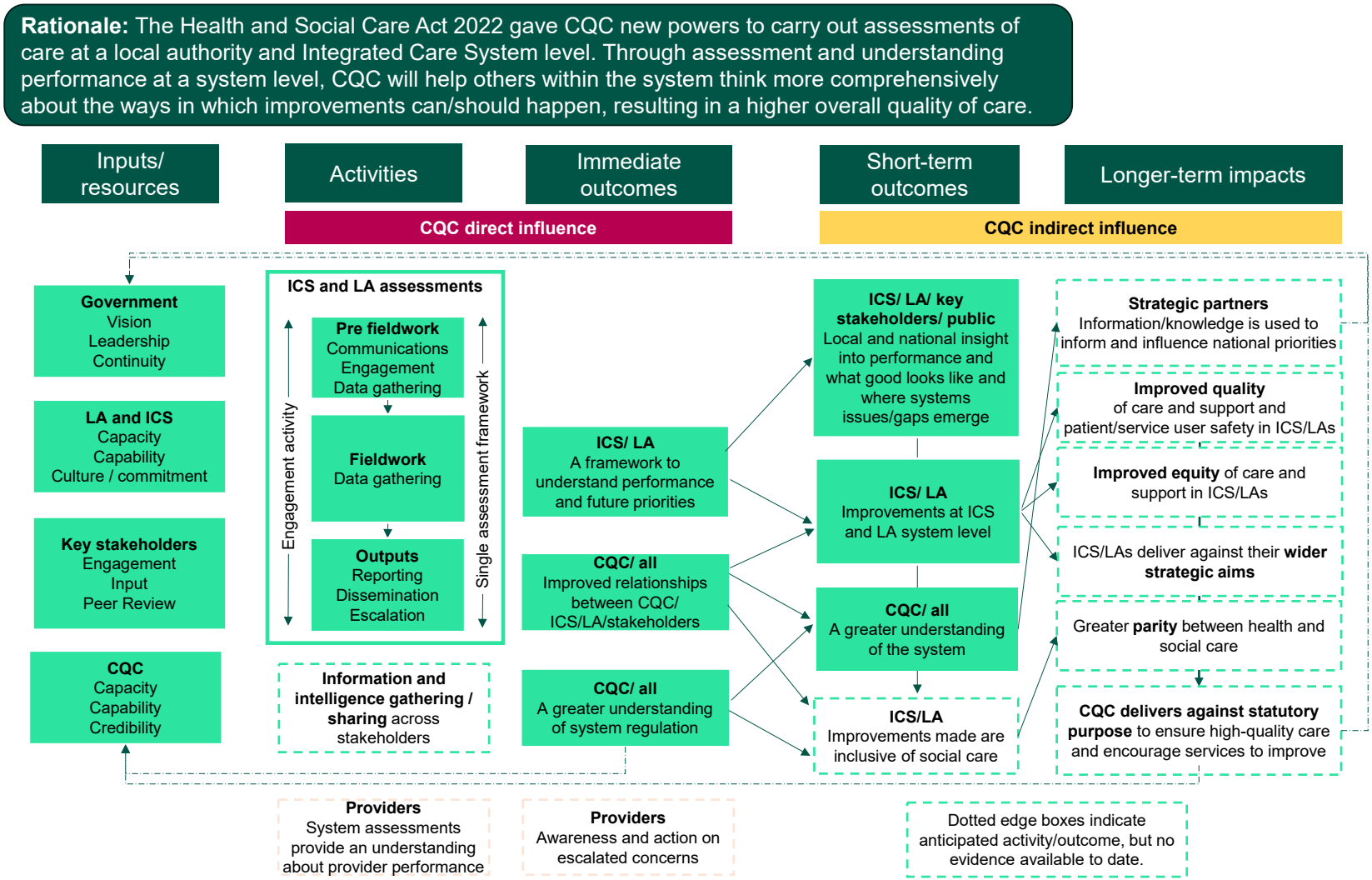
- Minor changes in language, for example changing 'partner' to 'key stakeholder' to reflect language used by research participants. Also amending 'patient' to 'patient/service user' to ensure inclusion of those receiving support from adult social care.

- Adding additional formatting to show progress to date. For example, adding dotted edged boxes to show where there is currently no evidence, but this activity or outcome is *anticipated* to happen in the future (meaning it should not be removed from the ToC).

- Adding an additional immediate-term outcome: 'CQC/ all: Improved relationships between CQC/ ICS/LA/stakeholders'. This included both internally within their organisation (e.g. between different teams) and between organisations (e.g. ICS and LAs). Participants felt this was an important first step to achieving other outcomes included in the ToC, for example improvements at ICS/LA system level; a greater understanding of the system; and improvements made being inclusive of social care.

- Moving 'ICS/ LA/ key stakeholders/ public: Local and national insight into performance and what good looks like and where systems issues/gaps emerge' from an immediate to short-term outcome. This reflected participants' views that this would only be achieved once a greater volume of assessments had been completed. This outcome is also now being supported by the immediate outcome 'ICS/ LA: A framework to understand performance and future priorities'; participants suggested this would be important to enable CQC to share insight into performance and what good looks like.

Figure A2.1: Updated ToC (following research evidence)



Appendix 3: Research approach additional detail

Contribution analysis

The research used a theory-based approach called contribution analysis. Contribution analysis compares a programme's theory of change (in this case, for CQC's system assessments) with the evidence to draw conclusions about whether the intervention has contributed to the outcomes or changes observed. The goal of contribution analysis is to create an evidence-based narrative that a reasonable person would accept as a plausible explanation of the contributing factors that led to the outcomes. The approach is iterative, systematic and transparent.

The analysis drew on multiple methodologies and sources of evidence to build a strong narrative as to whether, how, and why CQC's system assessments contributed to change on the intended outcomes, plus the role played by the different measures and any external factors that affected the outcome. Crucially, using the principles of contribution analysis enabled us to achieve reflexive rigour: delivering a research approach that was realistic, practical and sensitive to contextual factors while providing robust and informative findings that stand up to public scrutiny.

There are 6 key steps to contribution analysis that were undertaken as part of this research.

- Step 1: Scoping. Development of narrative and hypothesis. This involved the inception meeting, document review, scoping interviews, and development of the ToC. A ToC workshop was held with key CQC stakeholders in February 2024.
- Step 2: research and contribution analysis framework. This involved the development of a framework to function as the research plan for the rest of the project (see Appendix 4). This included 4 contribution claims (see more detail below).
- Step 3: data collection. This involved primary data collection from the case study areas and triangulating this with data from CQC and national stakeholders.
- Step 4: assessing the evidence and challenges to it. Part-way through data collection, a contribution workshop took place (August 2024), involving CQC colleagues and the research team. During this workshop, the strengths and weaknesses of the contribution claims were reviewed, considering the available evidence gathered to date and the relevance of other influencing factors.
- Step 5: testing and revising. This involved undertaking remaining data collection to further unpack assumptions around how CQC's system regulation activity influences outcomes, the main drivers of change and associated risks to enable the testing of key contribution claims or areas in the ToC that were weakest or had uncertainties. Moreover, remaining interviews aimed to fill any gaps in the evidence.

- Step 6: synthesis and reporting. Key findings from across the data collection were brought together to analyse and address each research question and to underpin the analysis and 'testing' of the ToC. All sources of evidence were used to explore each element of the ToC, enabling the triangulation of findings, making sense of potentially contradicting evidence, and providing a claim score for each contribution claim. Evidence was weak if there was no evidence for it or if evidence from multiple audiences and sources was contradictory. The scoring approach is outlined in Table A3.1 below.

Table A3.1 Scoring approach

Outcome score	Scoring criteria
Achieved	Consistent views are evidenced across 3 or more case study ICS/LAs/national stakeholders/CQC that CQC activities have contributed to achievement of outcomes
Partially achieved	There is data from only 1 or 2 ICS/LAs/national stakeholders/CQC that CQC activities have contributed to achievement of outcomes
Not achieved	No evidence or evidence provides a different explanation for achievement (or not) of the outcomes
Inconclusive	Evidence from multiple audiences and sources is contradictory

Contribution claims

Contribution claims are statements about what has most likely contributed to the observed change as a result of CQC activity. They articulate how CQC activity leads to change, while recognising the importance of other influencing factors. Claims are an explanation of behaviour, a hypothesis of what are believed will bring about CQC's intended outcomes.

Our 4 contribution claims were:

- CQC staff have the skills, capability and capacity to add value in the assessment of complex systems and are seen as credible and independent
- Assessment/assurance collectively build a greater understanding of systems
- Regulatory interaction leads to ICSs/LAs implementing improvements
- CQC collates intelligence and puts it in the public domain or shares it with other stakeholders who use it to inform the best approaches to system working

These claims were used to structure the analysis and contribution story to help isolate the intervention's relevant inputs, activities and outputs and the anticipated relationship to specific outcomes.

Scoping interviews

Four interviews with CQC staff helped us to build our understanding of the nuances of the ICS assessment and LA assurance approach and CQC's perspective on how the delivery of the pilots. We also spoke with a key stakeholder at 6 of the 7 pilot sites to understand more about set-ups, local population needs, why they decided to take part in the pilot and perceived benefits and risks. Note no representative from Suffolk LA was available to take part.

Case study selection

Both ICS pilots were engaged in the research. Of the 5 LA pilots, 3 were selected and asked to take part. Reasons for the initial selection included:

- Nottingham City: given they were the only LA with a 'requires improvement' rating in the CQC pilot, it was felt that they could add valuable insight to the research.
- Birmingham LA: to represent a large metropolitan district, with high levels of deprivation. Received a LA rating of 'good' in the CQC pilot.
- Lincolnshire: also received an LA rating of 'good' but is a rural LA, with an ageing population so offered a useful contrast to Birmingham LA.

Due to financial difficulties faced by Nottingham City LA, they declined to take part in the case studies and were replaced by North Lincolnshire LA. The final 3 LAs (Birmingham, North Lincolnshire and Lincolnshire) provided a good mix of characteristics in terms of size, region, local population needs (e.g. deprivation profile), CQC ratings of local providers, and maturity of partnership working within their ICS.

For the initial formal LAs, Hertfordshire and Bracknell Forest LAs were selected based on the recency of their assessment and because they varied in size and location.

Interviewed population by case study

The tables below show the range of roles and organisations included in the interviews across the case studies, and national and CQC interviews.

Table A3.2 Case study LAs

	Manager	Strategic Lead	Frontline staff	**Total**
Hertfordshire Country Council (formal)	3	4	2	**9**
Bracknell Forest Council (formal)	3	3	4	**10**
Lincolnshire Council (pilot)	1	8	3	**12**
North Lincolnshire Council (pilot)	4	3	3	**10**
Nottingham County Council (pilot)	4	3	3	**10**
Total	**15**	**21**	**15**	**51**

Table A3.3 Case study ICSs

	Ambulance Trust	General Practice	ICB/ ICP	Local Authority	NHS Trust	VCSE	Other	**Total**
Dorset (pilot)	0	1	4	4	5	2	1	**17**
Birmingham and Solihull (pilot)	1	0	5	2	6	3	0	**17**
Total	**1**	**1**	**9**	**6**	**11**	**5**	**1**	**34**

Table A3.4 National stakeholders

	Total
CQC staff	10
Department for Levelling Up, Housing and Communities (DLUHC)	2
NHS England	2
ADASS	1
Age UK	1
Arc England	1
Department of Health and Social Care (DHSC)	1
Healthwatch	1
Homecare Association	1
Local Government Association	1
National Voices	1
Total	**22**

Qualitative data management and analysis

All discussions were recorded with consent, stored on IFF's secure drive in a folder to which only designated team members had access, and written up thematically by the researcher using a bespoke analysis framework.

IFF's qualitative analytical approach is informed by grounded theory and structured by the research questions but builds upwards from the views of participants. It is continuous (during and after fieldwork periods, and between phases) and iterative, moving between the data, research objectives and emerging themes.

The analysis framework was structured by key research questions and data entered into relevant cells including direct quotes and examples. It included columns for the researchers' own interpretation and key conclusions. Data was then coded, looking for patterns by theme within and across interviews.

The analysis process consisted of 2 key elements. Firstly, recordings of discussions were coded and systematically summarised into an analytical framework organised by issue and theme. Secondly, an interpretative element focussed on identifying patterns within the data and undertaking sub-group analysis. Researcher analysis sessions, led by the director, during which the team came together to discuss and test emerging themes and insights, were conducted after each phase and used to support interpretation of the data.

All evidence sources were analysed in their own right; the analysis process then went on to compare and contrast the findings across evidence sources. During this, the quality of evidence was weighed up. Any inconsistencies between different data sources were explored and explained. Where there were competing findings by evidence source, stronger evidence was considered over evidence with gaps.

LA survey

Summary of the areas each survey covered:

- Survey 1: overall experience of completing the IR and views on clarity, use and time commitment; overall experience and use of the self-assessment;
- Survey 2: the extent to which questions asked in the interview collected the right information; whether the assessment team spoke to the right people; skills and knowledge of assessment team; overall satisfaction with on-site assessment activities.
- Survey 3: clarity and accessibility of the report; accuracy of report and general satisfaction; how effective CQC's assessment approach is.

Table A3.2 Survey respondents

Survey	Survey 1: The information return	Survey 2: On-site fieldwork	Survey 3: Assessment report
Total Responses	**50**	**28**	**14**
Director	11	5	3
Head of Service or Senior Manager	18	5	4
Senior Officer, Advisor or Team Leader	10	5	4
Technical Specialists, Manager or People Manager	5	3	0
Frontline worker	0	6	1
Other	6	4	2
Number of local authorities represented	**34**	**13**	**7**

Appendix 4: Participatory Systems Mapping

The full PSM report drafted by CECAN can be found here.

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Appendix 5: Research framework

Key research question	Key information (e.g. from the ToC or contribution analysis)	Measures	Source
1. How effective is CQC's regulatory approach to ICS and LA assessment and assurance?	**Input 1:** Relevant Government departments have a clear vision, approach and ask which is effectively communicated across stakeholders and committed to in the longer term	Awareness and view of Government's vision around system regulation and CQCs role within it. This will include extent to which Government has: * a clear vision for this work * shared this vision across key stakeholders * articulated the role of CQC * articulate the 'ask' for key stakeholders to engage with the process * adequately funded/resourced system regulation (if relevant)	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
		Perceptions around whether and how Government-led activity varies for different parts of the system e.g., DHSC, DLUHC and why	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
		Views on the impact of Government change (noting the election year) and potential change in vision on CQC regulatory approach	National stakeholders (could also ask LAs / ICS but may be more valuable areas to cover with these groups given pressure on guide length)
	Input 2: LAs and ICSs have the skills, resources and motivation to engage with assessment activities regardless of their structure/complexity of delivery	Initial views and expectations of the new CQC assessment, including motivation to take part in the pilot	LA case studies - pilot and formal ICS case studies LA survey (for views on processes, whether guidance used to help with information return etc.)
		How they engaged with CQC pilot assessment (including in terms of set-up) and reasons for any variation from the planned approach	
		Views on CQC's system assessment processes	
		Extent to which LAs/ICSs felt that they had the skills to engage competently and efficiently with the CQC assessment	

		Extent to which LAs/ICSs felt that they had sufficient resource/capacity (and the right type of resource/capacity) to engage in the CQC assessment	
		Variation in engagement with CQC assessment depending on: *Maturity of partnerships/relationships *Leadership and organisational culture / priorities *Regional complexity/provision (both in terms of urban/rural but also map across other jurisdiction/boundaries) *Systems, data collection and sharing	
	Input 3: Key stakeholders engage with all aspects of regulation	Range of stakeholders and their role in the CQC assessments	LA case studies - pilot and formal ICS case studies National stakeholders
		Perceptions of the barriers and enablers to engaging stakeholders in CQC assessments, e.g., in relation to the motivation, skills and resources to engage, any other barriers/enablers and what might increase engagement in future	
		Perceptions of the variation/nuance in stakeholder engagement within LA and ICS and between LA and ICS (and reasons for this)	
		Views on the effectiveness of stakeholder engagement - what is working well, what are the barriers	National stakeholders
		How are stakeholders involved beyond the system assessments themselves, including other opportunities for their involvement to support system regulation	National stakeholders
	Input 4: CQC have the capacity, capability and credibility to deliver assessment activities	Views on the skills/capability required by CQC staff to add value in the assessment of complex systems - and the extent to which this is currently in place	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
			LA survey
		Views on the capacity required by CQC staff to add value in the assessment of complex systems - and the extent to which this is currently in place	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
			LA survey

		Views on the credibility and independence of CQC to undertake system assessments and reasons for this - include potential ways to improve this	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
		Perceptions whether there is any variation/nuance of CQC capacity, capability and credibility between LA and ICS (and the reasons for this)	LA case studies - pilot and formal
			National stakeholders
			ICS case studies
		Views on the ability of the Assessment Framework to be flexible and meaningfully used as part of system assessments - including key enablers and challenges/barriers	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
	Activities: Assessment activities across 3 stages - pre-fieldwork, fieldwork, outputs	What activities have taken place - including what worked well and why; the barriers and enablers to impact e.g., communication around assessment activities, scale of 'ask,' capacity for LA and stakeholders to engage, other barriers and enablers etc.	LA case studies - pilot and formal
			ICS case studies
			LA survey
		Suggested improvements/developments to the assessment process - from pilot to formal, and from formal onwards	LA case studies - pilot and formal
			ICS case studies
			LA survey
		Views on support available from CQC to engage with the assessment process - including potential improvements and other support that would be helpful	LA case studies - pilot and formal
			ICS case studies
			LA survey
		View on the value and use of the assessment outputs - including reasons and evidence for this	LA case studies - pilot and formal
			ICS case studies
			LA survey
		Suggestions on other ways CQC could support LAs/ICSs following assessments	LA case studies - pilot and formal
			ICS case studies

		Variation in views across all measures in this section between LAs and ICSs - including what are the key differences between LA and ICS processes; views on the relative efficiency and impacts of the different processes	LA case studies - pilot and formal ICS case studies National stakeholders
	Activities: Information and intelligence gathering and sharing (non assessment activity)	How are CQC delivering wider information and intelligence gathering and sharing (i.e. non-assessment activity. This could include: sharing information and intelligence in the public domain and targeted at specific stakeholders.	National stakeholders
		Awareness, view and perceived impact of CQC non-assessment activity. This could include: sharing information and intelligence in the public domain and targeted at specific stakeholders.	LA case studies - pilot and formal ICS case studies
	Activities: Other activities not currently identified in theory of change that develop over time	Other activity being delivered not currently on the ToC and why they have been introduced/developed (the gap or opportunity they seek to address) - including how activities are delivered and what is working well and less well (and could be improved)	National stakeholders LA case studies - pilot and formal ICS case studies
		Suggestions for other activities CQC could undertake to support better system regulation	LA case studies - pilot and formal ICS case studies National stakeholders
This section contains the 8 provider-level mechanisms which will be tested through the research. We will be exploring whether or not these mechanisms also enable CQC to have an impact at system-level.			
2. What are the key mechanisms that have enabled CQC to impact systems?	**1. Anticipatory:** the regulator sets quality expectations and providers understand those expectations and seek compliance in advance of any regulatory interaction	Perception that LAs/ICSs understand CQC's system quality expectations - including extent to which there is a shared understanding of 'what good looks like' for systems and clarity of information on this from CQC	LA case studies - pilot and formal ICS case studies National stakeholders LA surveys
		Perception that CQC are able to impact systems through setting quality expectations	
		ICS/LA activity in advance of the pilot/formal assessments (and anything they might do differently next time)	
		Perception that LAs/ICSs have or plan to seek compliance with CQC's system quality expectations -	

		including impacts of the pilot/formal work on planned future activity and engagement with CQC	
	2. Directive: providers take actions that they have been directed or guided to take by the regulator.	Extent to which ICSs/LAs have made changes as a direct result of the CQC assessment outcome - including what changes have looked like; what specifically drove these changes; and what has been the impact of the changes on the system	LA case studies - pilot and formal ICS case studies
		Views on the key enablers and key challenges/barriers to making changes based on the CQC assessment outcome/report	
		Views on the role of escalation of concerns to other bodies who might have the powers to force/direct changes - including around CQC's escalation powers to initiate any enforcement	
	3. Organisational: regulation interaction leads to internal organisational developments, reflection and analysis by providers that are not related to specific CQC directions. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing	Extent to which CQC system regulation has led to internal organisational development - including what organisational developments have taken place e.g., leadership development, partnerships or relationship building, organisational development, new data capture and/or IT systems, data sharing, resource and capacity building etc - including what changes have looked like; what specifically drove these changes; and what has been the impact of the changes on the system	LA case studies - pilot and formal ICS case studies
		Views on the key enablers and key challenges/barriers to making organisational changes	LA case studies - pilot and formal ICS case studies
	4. Relational: results from the nature of relationships between regulatory staff (i.e., inspectors) and regulatory providers. Informal, soft, influencing actions have an impact on providers	Views on the nature of the relationship between CQC staff and LA/ICS staff - how and in what ways did they engage with each other, and how did this change according to the specific LA/ICS staff role e.g., management, frontline etc	LA case studies - pilot and formal ICS case studies
		Extent to which relationship generated wider learning and insight beyond 'formal' assessment activities and outputs	

		Perceptions around the extent/in what ways did this relationship/interaction affect or inform change in delivery and what was the impact of these changes	
		What could be improved around engaging with regulatory staff and how things could be improved in future	
	5. Informational: the regulator collates intelligence and puts information about provider performance into the public domain or shares it with other actors who then use it for decision-making (e.g., commissioning, patient choice)	Perception that CQC sharing information (see activities above) informs system-level and provider-level decision making - reasons why/why not; what decision-making processes look like; and what evidence is available for this	LA case studies - pilot and formal ICS case studies National stakeholders
	6. Stakeholder: regulatory actions encourage, mandate or influence other stakeholders to take action or to interact with the regulated provider	Extent to which stakeholders interact with LAs/ICSs on the basis on system regulatory actions - what does this look like; which types/groups of stakeholders are more/less engaged; what role do stakeholders play; reasons for more/less engagement	LA case studies - pilot and formal ICS case studies National stakeholders
	7. Lateral: regulatory actions stimulate inter-organisational interactions, such as providers working with their peers to share learning and undertake improvement work	Extent to which CQC system regulation has led to both greater system collaboration (e.g. a system working better together) and also how systems sharing learning between each other - what activity took place; how did this come about; who was involved (e.g. which organisations); what was the goal/intention behind this (e.g. what was it looking to achieve); how linked to CQC regulation	LA case studies - pilot and formal ICS case studies National stakeholders
		Views on the role of the CQC provider assessment within the context of system collaboration - including any potential for a competitive culture and any challenges that provider level assessments can have at system level	LA case studies - pilot and formal ICS case studies

		Views on how the process of CQC escalation of concerns to provider-level enforcement action has worked in practice - what are examples of where this has been needed, what has worked well/less well	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
		Views on how the process of CQC exploring system-level issues because there has been a problem raised at provider-level or with a group of providers in an area	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
	8. Systemic: aggregated findings/information from regulation are used to identify systemic or inter-organisational issues, and to influence stakeholders and wider systems other than the regulated providers themselves	Views on how effective CQC's national reporting and sharing of themes from across assessment activity has been t a national level - including what is working well and what could be improved	LA case studies - pilot and formal ICS case studies National stakeholders
		Suggestions for how CQC's national reporting and sharing of themes from across assessment activity could be improved and strengthened to further achieve intended outcomes (see below and ToC)	
	Other system-level mechanisms	Analysis of all evidence	N/A

3. How can the impact CQC have be identified and measured (on an ongoing basis, taking account of the fact that some impacts may be yet to emerge)?	**Immediate outcome:** CQC activity generates a framework to understand performance and future priorities	Views on the CQC assessment reports and whether (or not) they capture the right level of specificity and detail to enable systems to interpret and make changes	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		Extent to which CQC information/intelligence resulting from assessments is shared with stakeholders and contributes to decision-making within ICSs/LAs	
		What evidence is available for these outcomes (and how is this collected, monitored etc.)	
	Immediate outcome: Local and national insight into performance, what good looks like and system gaps	Views on the impact of CQC delivering wider information and intelligence gathering and sharing (i.e. non-assessment activity.) This could include: sharing information and intelligence in the public domain and targeted at specific stakeholders.	LA case studies - pilot and formal ICS case studies National stakeholders
		Extent to which CQC activities have generated a clearer view of what good looks like and where there are system issues/gaps	
		What evidence is available for these outcomes (and how is this collected, monitored etc.)	
	Immediate outcome: CQC activity leads to greater understanding of system regulation	Views that CQC activities has increased understanding of how systems should be regulated and the best processes/methods for doing this	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		What evidence is available for these outcomes (and how is this collected, monitored etc.)	
	Short-term outcome: Improvements at ICS and LA system level	Extent to which ICSs/LAs have made changes as a direct result of the CQC assessment outcome - including what changes have looked like; what specifically drove these changes; and what has been the impact of the changes on the system	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		What evidence is available for these outcomes (and how is this collected, monitored etc.)	
	Short-term outcome: A greater understanding of the system	Views that CQC activities has increased understanding of systems	LA case studies - pilot and formal ICS case studies

		What evidence is available for these outcomes (and how is this collected, monitored etc.)	National stakeholders LA survey
	Short-term outcome: Improvements made are inclusive of social care	Views that system improvements incorporate both health and social care to benefit both aspects of the system	LA case studies - pilot and formal ICS case studies National stakeholders
		View that social care has greater parity in the system, alongside health and social care	
		What evidence is available for these outcomes (and how is this collected, monitored etc.)	
	N/A	Differences in outcomes between ICSs and LAs, as well as between different ICSs and LAs. Also differences between LAs in the pilot and those in the formal assessments	Triangulation of all evidence
	Long-term outcomes ***Long-term outcomes will not be explored within the research, due to the long timescales for achieving these. However, we will explore the measures relating to long-term outcomes in column C.***	Perceptions on the likelihood of achieving long-term outcomes - including reasons for this, suggested risks/mitigations and likely timescales	LA case studies - pilot and formal ICS case studies National stakeholders
		Views on potential approaches to measuring this future impact - including ways to collect required evidence and potential challenges/barriers to this	
	N/A	Perceptions of any unintended outcomes	LA case studies - pilot and formal
			ICS case studies
			National stakeholders
	Contribution claim 1: CQC staff have the skills, capability and capacity to add value in the assessment of complex systems and are seen as credible and independent	What evidence (and how is this collected, monitored etc.) that CQC staff have the skills, capability and capacity to add value to the assessment of complex systems	LA case studies - pilot and formal ICS case studies National stakeholders LA survey

		Perception of the contribution of this claim to immediate and short-term outcomes - including reasons for this and why (not) this is important	
	Contribution claim 2: Assessment/assurance collectively build a greater understanding of systems	How are findings from assessment/assurance communicated and shared to build an understanding of systems	National stakeholders
		Awareness and access of CQC information to build an understanding of systems - including changes made as a result and reasons for this	LA case studies - pilot and formal
			ICS case studies
			LA survey
		Perceptions that CQC information on systems influences stakeholders in the wider system	National stakeholders
		Views on gaps in current information or what additional information would support a better understanding of systems	National stakeholders
			LA case studies - pilot and formal
			ICS case studies
			LA survey
		What evidence (and how is this collected, monitored etc.) is there for this claim	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		Perception of the contribution of this claim to immediate and short-term outcomes - including reasons for this and why (not) this is important	
	Contribution claim 3: Regulatory interaction leads to ICS/LAs implementing improvements	What evidence (and how is this collected, monitored etc.) is there for this claim	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		Perception of the contribution of this claim to immediate and short-term outcomes - including reasons for this and why (not) this is important	

	Contribution claim 4: CQC collates intelligence and puts it in the public domain or shares it with other stakeholders who use it to inform the best approaches to system working	What evidence (and how is this collected, monitored etc.) is there for this claim	LA case studies - pilot and formal ICS case studies National stakeholders
		Perception of the contribution of this claim to immedi+C3ate and short-term outcomes - including reasons for this and why (not) this is important	
4. What could be improved about the CQC's approach to maximise its impact?	**What is working well in achieving intended outcomes?**	Examples of good practice around how the CQC can have impact in systems	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		Perceptions of the variation/nuance within LA and ICS and between LA and ICS	
	What is working less well in achieving intended outcomes?	Perceptions of requirements for improving CQC's impact as a system regulator	LA case studies - pilot and formal ICS case studies National stakeholders LA survey
		Perceptions of the variation/nuance within LA and ICS and between LA and ICS	
	Overarching learning and recommendations to consider	Based on the analysis above	N/A

Appendix 6: LA process maps

Figure A6.1 LA initial formal assessment process map

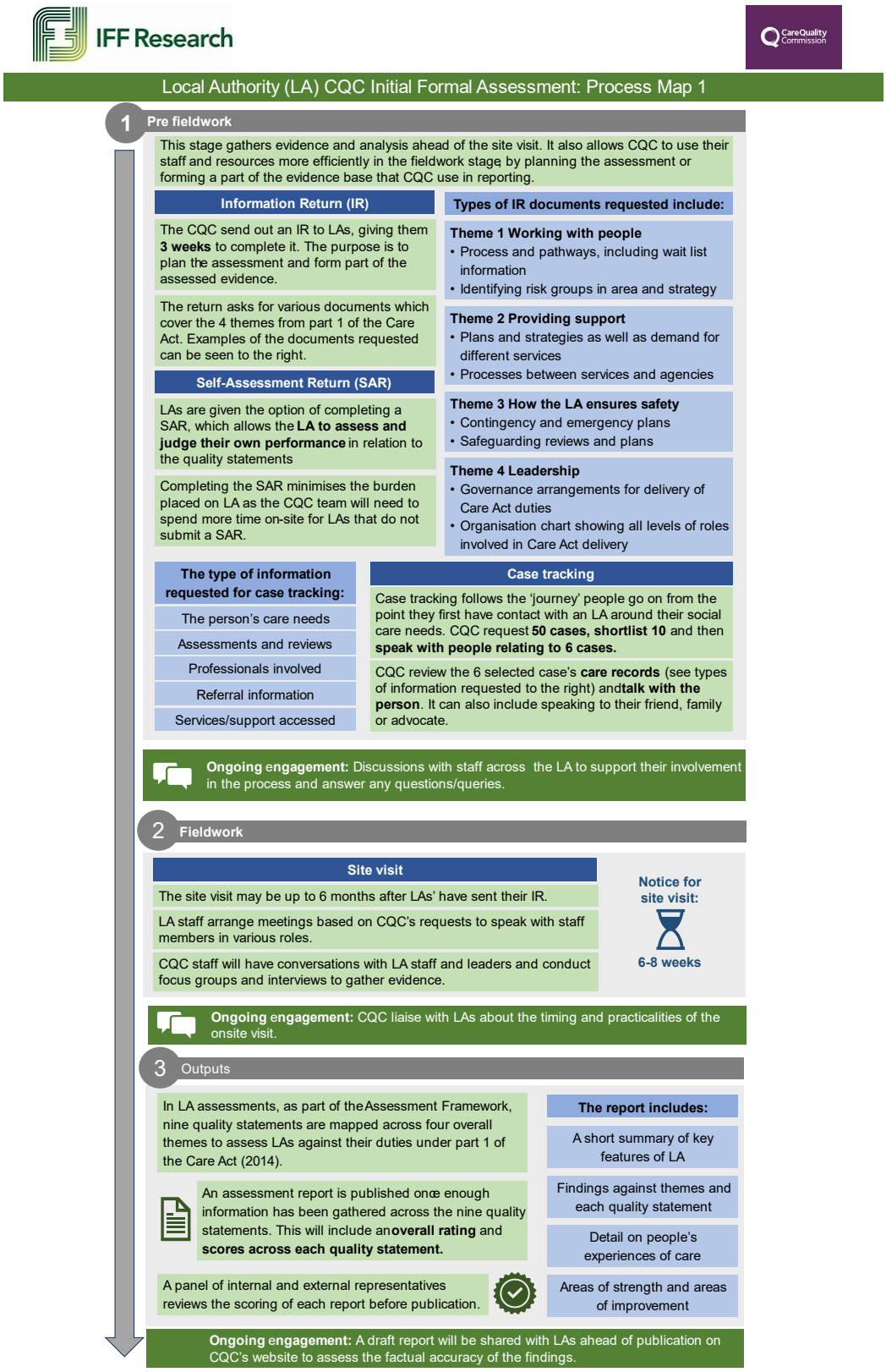

Figure A6.2 LA initial formal assessment process map, with enablers and barriers to delivery

Appendix 7: Regulatory impact mechanisms[1]

Impact mechanism	Description of logic/causal chain/process
Anticipatory	The regulator sets quality expectations, and ICSs and LAs understand those expectations and seek to make improvements in any areas identified.
Guided	ICSs and LAs take actions that they have been guided to take by the regulator through the assessment reports.
Organisational	Regulatory interaction leads to internal organisational developments, reflection and analysis by ICSs and LAs that are not related to specific CQC guidance. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.
Relational	Results from the nature of relationships between regulatory staff (i.e., CQC assessment team members) and ICSs and LAs. Informal, soft, influencing actions have an impact on ICSs and LAs.
Informational	The regulator collates intelligence and puts information about ICS and LA performance into the public domain or shares it with other actors who then use it for decision-making (e.g., commissioning, patient choice).
Stakeholder	Regulatory actions encourage or influence other stakeholders to take action or to interact with ICS members or LAs.
Lateral	Regulatory interactions stimulate inter-organisational interactions, such as ICSs and LAs working with their peers to share learning and undertake improvement work.

[1] The 8th provider mechanism, systemic, is not relevant for impact within systems, so has been removed.

“

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