NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

CQC Inspection of ICBs

4th of December 2023

Context

- For integrated care systems, CQC will start to form a national view of performance, initially focused on themes:

- Equity in access is the first theme

- This would show whether systems are working together to support people to access the care, support and treatment they need when they need it. It includes how we are responding to inequalities of access across our population. Their findings will inform CQCs annual 'State of Care' publication.
- Pilots are taking place in Dorset and Birmingham ICBs to test the approach before starting formal assessments.
- CQC are working closely with the Department of Health and Social Care on how they will deliver further assessments beyond this point.

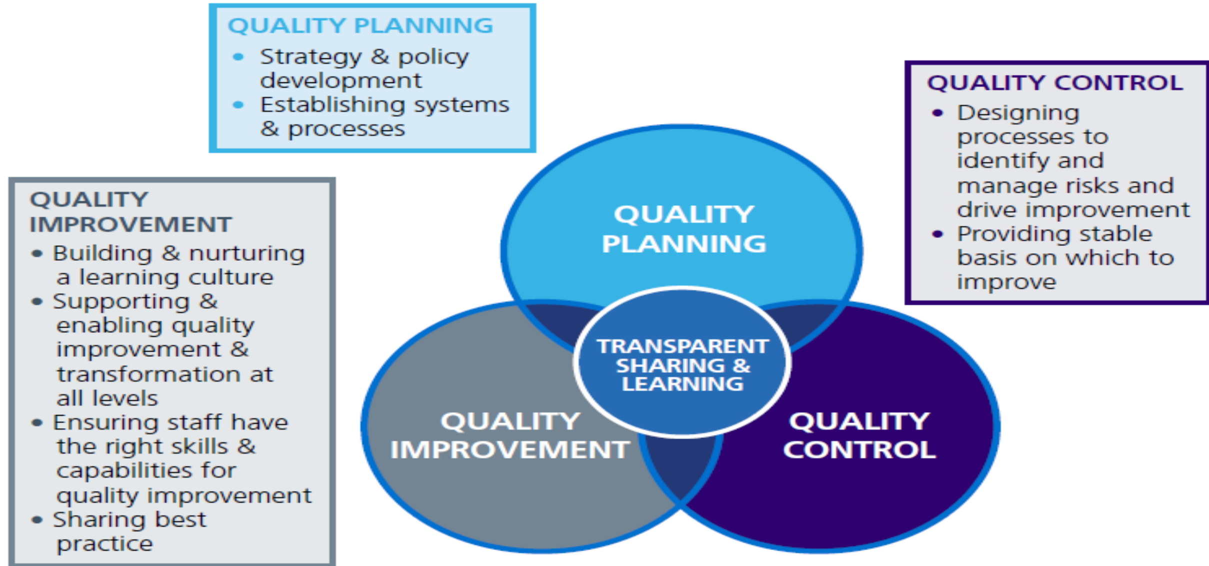
There are three main reasons for the change:

- To make things simpler so CQC can focus on what really matters to people.
- CQC to better reflect how care is actually delivered by different types of service as well as across a local area.
- To have one framework that connects their registration activity to their assessments of quality.

Judgements will be more structured and consistent, CQC have developed six categories for the evidence they collect:

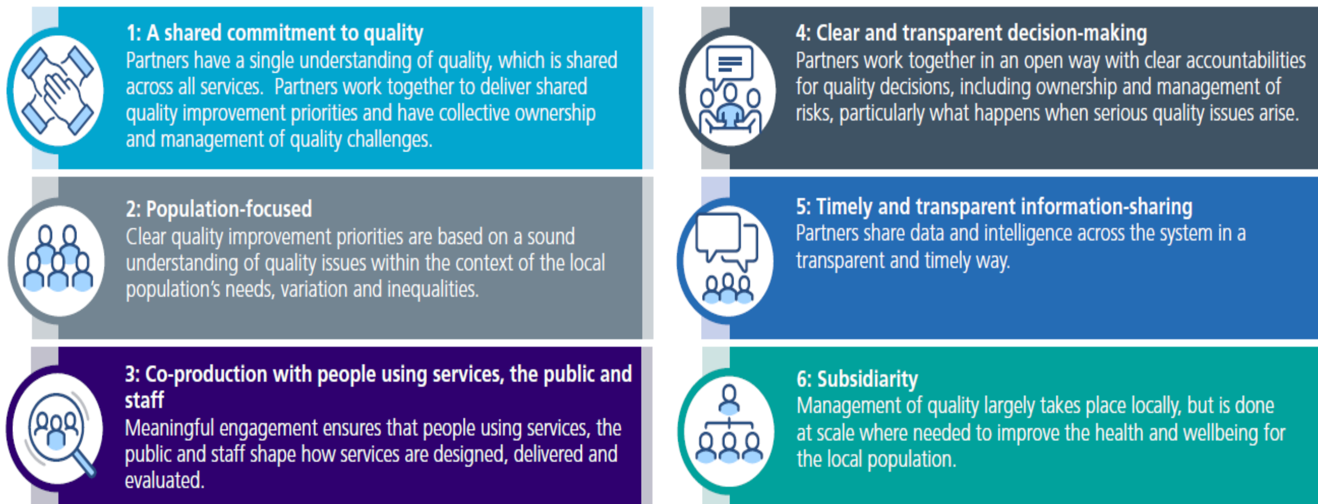
- people's experiences
- feedback from staff and leaders
- observations of care
- feedback from partners
- processes
- outcomes of care.

Delivering quality care in systems: the Juran trilogy

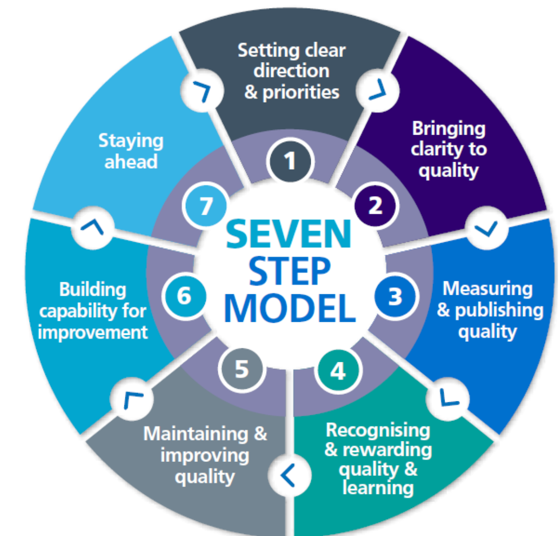


A shared single view of Quality

Delivering quality care in systems: key principles



Delivering quality care in systems: The 7 steps



Quality Insight

Internal	External
Quantitative	**Quantitative**
• Serious Incidents data and National Patient Safety Alert data • Infection prevention and control data including HCAIs • Hospital mortality data • Freedom to Speak Up (FTSU) data • Integration Index (forthcoming 2022/23) • Staff Survey results data • Workforce data - absence rates and turnover rates • Quality Accounts data • Maternity reporting tool data on quality • Quality data in Model Health System and the Quality Toolkit • Adult and child safeguarding • Local Authority data (eg ASCOF) • Charity/voluntary organisation data • Quality data in the Commissioning for Quality and Innovation (CQUIN) Framework • Workforce Race Equality Standard (WRES) data	• CQC inspection ratings data • Quality data in the System Oversight Framework (SOF) • Quality data in the GP Quality and Outcomes Framework (QOF) • External Audit data • External benchmarking data • Clinical Audits data • NHS Digital data/intelligence on quality • UK Health Security Agency (UKHSA) data/intelligence • External horizon scanning data • Homicides/unlawful killings – historic and ongoing including action plans • National surveys data - CQC patient surveys, HEE training surveys, GMC National Training Survey, GP patient survey (GPPS) • Public Health Outcomes Framework • Friends and Family Test
Qualitative	**Qualitative**
• Complaints, PALS and concerns data • Quality Accounts information • Speaking up reports from staff • Serious Incident investigations and action plans • Internal Audit reports and action plans • Internal reviews (lessons learned, peer reviews, thematic), recommendations and action plans • System Quality Groups/Quality Committees • Staff feedback/survey information • Mandatory and statutory training records • Staff professional development plans (PDPs) • Maintaining High Professional Standards (MHPS) • Risk and issues registers • Contractual and legal action • Quality impact assessments • Healthwatch reports library	• CQC Inspection reports, warning notices, related notifications • HSCRF emerging concerns protocol • HEE intensive support framework and Deanery reports • Professional regulators intelligence • Oversight and Scrutiny Committees, Health and Wellbeing Boards • Central Alerting System (CAS) safety alerts • Patient/service user websites, groups and forums • Traditional media and social media • Getting It Right First Time (GIRFT) and RightCare reports • Regulation 28 Prevention of Future Death reports • Judicial review reports • Safeguarding serious case reviews • Charity Commission case reviews/reports • Use of NICE Quality Standards • Independent Reviews

‘Insight’ work aims to improve understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information.

Provider Quality Schedule

Learning through observation

Assurance- good practice (Good Governance Institute)

The right amount of assurance

- more is not necessarily better.
- Ensuring balance between assurance and reassurance.
- Assurance is more than metrics- metrics are just one of the forms of assurance a board can receive. Action plans, strategy updates, service users' feedback and deep dive presentations are all forms of assurance and help determine whether controls for strategic risk is working.
- Assurance should be additive, not duplicative, with providers monitoring and improving performance, Place providing assurance on point of intersection and system assurance focused on system-level outcomes and improvements.

Triple A Approach

Alert

- To escalate any issues that require board discussion or action. There is no requirement to put anything in the alert section unless the committee absolutely needs to escalate a risk or issue. Please state 'none' rather than leaving the section blank.

Advise

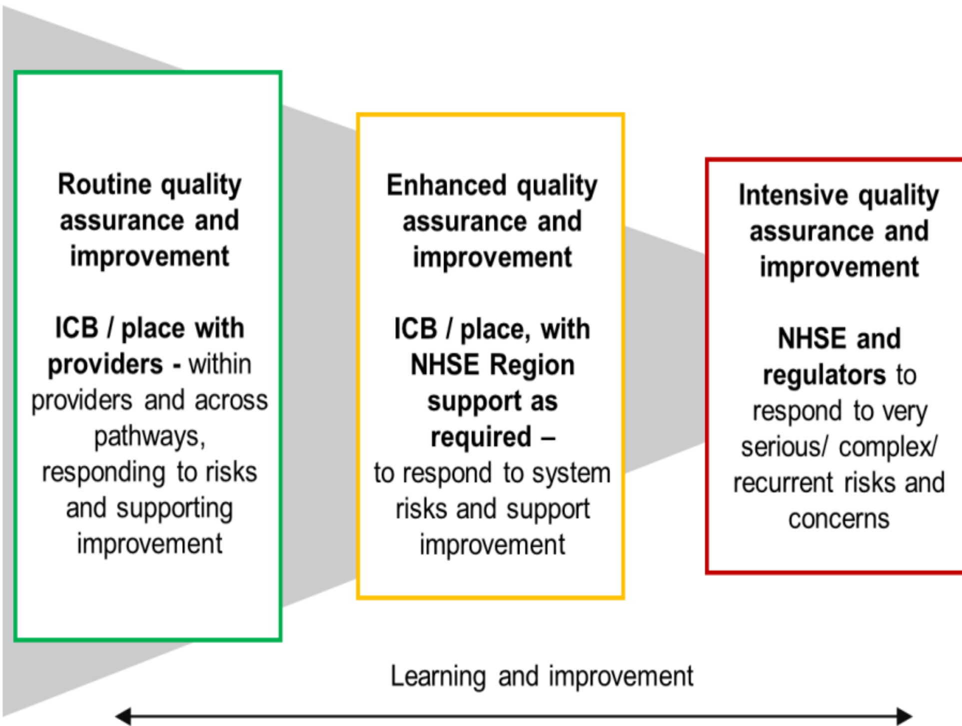
- To highlight an issue that may require further monitoring by the committee over a period.

Assure

- To provide positive news on performance, best practice or to celebrate successes/ awards.

Risk response and escalation (National Quality Board)

Risk response and escalation and the three levels of quality assurance and support.



- The move into enhanced assurance for health commissioned providers will be authorised by the ICB
- The move into intensive assurance by NHSE.
- Decision must reflect the risk profile and regulatory and accountability arrangements.
- Role of System Quality Groups will be integral to decision making as they provide joined up quality intelligence and engagement, enable improvement and support to system risks.
- Where there is an emerging risk that is deemed to be a significant or immediate risk to quality, including safety, which is not being addressed in wider discussions and the need to rapidly share intelligence, diagnose, profile risks, and develop action/improvement plans, the ICB or other key partners such as NHSE, regulators or Local Authorities will instigate Rapid Quality Review meetings
  - including the development of an Improvement plan and if required
    - additional Quality Improvement Groups to ensure the required actions are taken forward and improvements realised.