Changes to the way we regulate and inspect community health, specialist mental health services and NHS acute hospitals

Interim regulatory impact assessment

This interim regulatory impact assessment has been published alongside our provider handbook consultations covering the:

1. Acute hospitals handbook
2. Community health services handbook
3. Specialist mental health services handbook.

Stakeholders may want to refer to this document before reading this impact assessment as these consultations provide information on our proposed methodology for inspecting those providers contained within the handbooks.

This document provides an analysis of the likely cost and benefit impacts of our proposals to the way we will regulate and inspect these providers. It builds on the analysis conducted in our initial RIA that accompanied our previous consultation A *New Start: changes to the way we monitor, inspect and regulate providers.*

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Introduction

1. The Francis Inquiry reported on failures in the mid-Staffordshire NHS Foundation Trust. Other external reviews, including the serious case review of Winterbourne View have reported on similar serious shortcomings. In response, and following extensive consultation on its new strategy, the Care Quality Commission (CQC) is planning to make a number of changes to the way it regulates, inspects and monitors providers of health and social care services. These changes are necessary to ensure that people who use services receive a level of care that meets fundamental standards of quality and safety, while also ensuring that providers continually strive to improve the quality of care they provide.

2. We published our summary of responses to 'A New Start' in October 2013. Building on this, we published a number of signposting statements including *A fresh start for the regulation and inspection of community health care* and *A fresh start for the regulation and inspection of mental health services*. These are documents that set out our priorities for improving how we monitor, inspect and regulate such services in future. We emphasised that we would develop our new approach with people who use services, their families, providers, commissioners and other organisations.

3. Having listened to external stakeholders, providers and users of services, we now plan to roll out these changes. Implementation of these changes will cover all NHS acute hospitals, community health, and all NHS and independent sector residential and community mental health services from autumn 2014.

4. This document provides an assessment of the likely impacts of the changes we are proposing, and builds on our initial regulatory impact assessment for our 'New Start' consultation. A final impact assessment will be published in autumn 2014, before we introduce our proposed changes.

Background to proposed changes

5. In the months leading up to the publication of our three-year strategy, intense external scrutiny and feedback from consultation with external stakeholders and organisations concluded that our current regulatory model needed to be fundamentally changed. This was further compounded by the learning from instances of very poor care such as at Mid-Staffordshire NHS Foundation Trust, University Hospitals of Morecambe Bay and abuse of residents at Winterbourne View care home in August 2012.

6. The elimination and deterrence of poor quality care by providers that fall under our regulatory remit is a fundamental part of our statutory duty. For CQC to

achieve this, we feel we need to make some major changes to the way we regulate, inspect and monitor providers of health and social care services. This will help to ensure that such events never happen again, and to provide strong incentives for providers to provide good quality care while also ensuring that there are appropriate sanctions in place for providers that fail to deliver acceptable levels of care that are expected of all providers.

7. In line with these broader changes we propose to make some specific changes to the way we will regulate, inspect and monitor community health, specialist mental health services and NHS acute hospitals from autumn 2014. This follows our earlier intentions to overhaul how we regulate these sectors and initial plans and proposals were communicated previously to stakeholders in our signposting statements.

8. Our Chief Inspector of Hospitals is responsible for overseeing the development of how we will regulate and inspect all providers of community health, specialist mental health services and NHS acute hospitals in future. Key to this is making sure that all providers are delivering care that is safe, effective, compassionate and of a high quality. The Chief Inspector will be responsible for oversight of the development and delivery of the tools and resources required to effectively regulate and inspect providers and will work closely with a range of stakeholders to deliver these changes.

9. We are keen to demonstrate to stakeholders that we will roll out and implement a regulatory model that aims to maximise the benefits to all stakeholders as a result of the proposed changes. As CQC now has a statutory duty to have regard to growth, we are keen to demonstrate to stakeholders a commitment to reducing the regulatory burden that providers may experience as a result of the proposed changes. As a starting point we propose to test our proposals on a group of pilot organisations that are affected by the upcoming changes to uncover their experiences of regulatory burden and how this can be minimised when the model becomes fully implemented.

10. The government is also planning to give us powers to award a rating to providers that fall under our regulatory remit (subject to the passing of the Care Bill 2014). This will allow commissioners and users of services to make a better informed choice as to the quality of care provided by any given provider.

11. CQC is undergoing an internal transformation programme to support these changes. The programme is designed to change the way CQC performs as an organisation and delivers on its statutory duties, and becomes high-performing, well-respected and fit for the purpose of regulating the adult social care providers that fall under its remit.

12. The various handbooks for consultation that have been published alongside this document contain our proposals for how we will regulate and inspect community

health, specialist mental health services and NHS acute hospitals from autumn 2014. The proposals build on feedback gathered from external stakeholders who responded to previous consultation and others who attended our numerous stakeholder engagement events designed to gather views on how we can develop our approach going forward.

13. This impact assessment assesses the proposed changes to how we inspect and regulate providers affected by the changes in autumn 2014. We will provide a final assessment of these impacts once we publish our final regulatory impact assessment before implementation of the final model.

Summary of proposed changes from 1 October 2014

14. Our consultation documents provide detailed information to stakeholders of the proposed changes affecting community health services, specialist mental health services and NHS acute hospitals from 1 October 2014. These are summarised below.

All providers of NHS acute hospitals, NHS and independent residential and community-based mental health services, and community health services will be inspected and regulated under the new regulatory model from 1 October 2014.

Registration
We propose to make registration a more robust process both for new providers wishing to be registered and existing providers that already provide a service. We will undertake more checks to ensure potential providers can provide acceptable levels of care, ensure the fitness and suitability of applicants to ensure that they have the right values and motivations for providing care as well as having the right skills and experience.

Monitoring
We propose to make better use of information to be able to effectively monitor and target effort to areas where the risk of providing poorer quality care is greatest. We will continue to work with the stakeholders to define key indicators for monitoring, as well as information sets and quality standards that aid effective monitoring and regulating of providers.

Inspection
We propose to overhaul and refine the inspection framework into conducting inspections around five core questions. Inspectors will base quality of care judgements on whether or not a service is safe, effective, caring, responsive and well-led. We propose to continue to use a mixture of unannounced and announced inspections, and will make use of comprehensive, focused and themed inspections based on the service to be inspected. All our inspectors will be expert inspectors. The size of inspection teams will depend on the size and complexity of the service to be inspected, but we expect to make full use of Experts by Experience and other experts or professionals as required.

Rating
All providers will receive a quality of care rating by April 2016. The rating will be based on a four-point scale: outstanding, good, requires improvement and inadequate. Our ratings will be based on a combination of what we find at inspection, what people tell us, our intelligent monitoring data and local information from provider and other organisations. It will be subject to periodic reviews. Frequency of inspection will be directly linked to the outcome of a rating.

Enforcement and appeals
We propose to be tougher on providers who consistently provide poorer quality care and do not comply with conditions in their registration. We plan to consult separately on our approach to enforcement and appeals in Summer 2014.

CQC assessment of impacts

Overview of current regulatory model

15. CQC regulates a variety of NHS acute hospitals, NHS and independent residential and community mental health services, and community care providers that vary in size and specialism across England. Providers operate out of single or multi-site locations and can provide a mixture of different services that could straddle acute, mental health and community healthcare services.

16. The regulation and inspection of such providers generally includes many common themes and components irrespective of whether we are inspecting an NHS acute hospital, specialist mental health service of community health care service. For example, we would inspect all such organisations under a generic compliance framework based on compliance. Quality of care provided would be assessed against these 16 essential standards, and would set the basis for any further action required should some areas by found to be non-compliant.

17. The nature of the actual inspection would depend on a variety of factors that CQC would take into consideration when planning inspection of those providers listed above. For example, all providers can expect to receive a scheduled inspection to gauge compliance across any of the 16 essential standards as part of CQC's ongoing commitment to ensuring organisations provide an agreed level of care. If there are concerns about the level of care that is triggered by public complaints, external agencies or our own internal monitoring information then CQC may choose to use a responsive inspection. CQC also administers a themed inspection programme and may choose to inspect a provider on an agreed theme i.e. dignity, nutrition, etc. to be able to gauge performance in these areas.

18. These are some of the general regulation and inspection themes that would apply to all registered providers, including those listed above. The subsequent sections now contain information on key areas of regulation and inspection that are specific to the different types of provider to take into account the key differences between an organisation that provides care within an NHS acute hospital, mental health hospital or community health care setting.

NHS acute hospitals

19. At the time of publication of this document, CQC is currently trialling a new inspection methodology for NHS acute hospitals, and has discontinued the previous approach in this sector. This new methodology makes use of dedicated expert inspectors and more emphasis on including clinical specialists, Experts by Experience, and the general public on inspection visits. A total of 18 pilot NHS acute trusts were inspected under a new methodology aimed at uncovering how well services in NHS acute hospital locations were safe, effective, caring, responsive and well-led. A further group of NHS acute trusts are in the process of undergoing a second round of piloting of the new methodology which will help shape the final methodology once rolled out for all NHS acute hospitals from October 2014.

Community health services

20. Our model for community health care services uses a similar model to that currently used for NHS acute services. However, for large providers the range of services inspected has usually been very small, and has often focused on community inpatient and clinic-based services rather than care delivered in people's homes. The inspections also focus primarily on the individual services being looked at rather than the governance arrangements which sit above them or which are used to manage quality across the provider. Also, where an acute or mental health provider, usually an NHS trust, also provides community health services these have only rarely been considered during our inspections. This means the picture of quality that we have gathered for community health services has been extremely patchy.

21. A small section of community health care services are also in the middle of undergoing pilots that aim to trial a new inspection methodology around whether the service is safe, effective, caring, responsive and well-led. The first test inspections have focused on large complex organisations such as NHS trusts and social enterprises which provide a range of community health services to a local population. As with NHS acute trusts, the inspection pilots aim to place more emphasis on using expert inspectors, clinical specialists, Experts by Experience and the general public on inspection visits. We will aim to look at a much wider range of services, consider quality and governance at the provider level and also have a much more consistent focus on gathering views from and assessing care from people receiving care in their own homes, which we recognise is a predominant feature of community health services. We expect to have obtained an early indication of how the model has performed at the time of publication of this document as this will help to shape the final methodology once rolled out for all community health care services from October 2014.

Specialist mental health services

22. Our inspections of specialist mental health services have also followed a similar generic model that was outlined earlier in this document. In recent months we have initiated a mental health transformation programme which centres on developing an integrated approach to regulating specialist services for people with a mental health condition. In addition CQC also has statutory duties around people who are detained under the Mental Health Act 1983 and we are conducting work on how we propose to better integrate our various duties within mental health.

23. At the time of publication of this document, CQC is currently trialling a new inspection methodology for specialist mental health services. This new methodology makes use of dedicated expert inspectors and more emphasis on including clinical specialists, Experts by Experience, and the general public on inspection visits which will help shape the final methodology once rolled out for specialist mental health services from October 2014.

Policy objectives

24. The key drivers for changes to how we will regulate and inspect community health, specialist mental health services and NHS acute hospitals stem directly from a number of high profile care failings in recent times. These have included failures at Mid-Staffordshire NHS Foundation Trust, University Hospitals of Morecambe Bay and abuse of residents at Winterbourne View hospital in Autumn 2012.

25. It is our priority to ensure the public, users of services and all other interested stakeholders concerned, that care provided is of an acceptable nature and that organisations strive to make continual improvements to the way they provide care for those that require such services. Our extensive engagement with stakeholders to date has indicated that they are supportive of the changes we propose to make and that they welcome a CQC who is more risk and evidence-based, on the side of people, and strives to be expert, independent and transparent in the way we work for the benefit of all stakeholders.

26. As a starting point, we expect that all our inspectors become dedicated experts in their respective inspection areas. That is to say that an inspector would no longer be expected to inspect an acute hospital one day, then a care home a few days later – all inspectors would now be expected to specialise and become expert in their chosen area in future. They will work with practising professionals and lay inspection team members, who have experience in the type of service being inspected. In addition we wish to provide greater assurance to the public around the quality of care provided from different organisations within the

different segments of the acute, mental health and community health care sectors.

27. To facilitate this, we will move away from a model focused only on compliance with regulations; we plan to provide all organisations with provider ratings for the level of care provided. This will help to provide users of services and their families, commissioners, and local authorities with better information to be able to make an informed decision as to where they choose their care. Over time, this should facilitate improvements in care by providing organisations with objective measurements of how they are performing in relation to other similar providers, and measures they can take to improve their overall quality of care rating. Finally, we expect to make better use of information to help drive and target our efforts. This will help to ensure that those most at risk of providing a poor service will receive tougher action, and that those who already provide high levels of care are less affected by regulatory measures and any adverse burden associated with our inspection and monitoring of providers.

28. Measures such as those described above should help facilitate overall improvements in the way we currently regulate and inspect all providers. Underlining all of this is to ensure we roll out a model that helps to maximise the benefits to all stakeholders while helping to minimise any regulatory burden that providers may experience as a result of the proposed changes. We want to be proportionate in how we carry out our activities, and aim to be more risk-based in the way we work. This means that those organisations that provide good quality care will likely experience decreases in the cost of regulation, whilst those who are poorer performers have more frequent contact with CQC to help ensure they provide better quality care.

29. Our ultimate objective is to provide a robust and credible framework for organisations to continually improve the care they provide to all stakeholders concerned.

Proposed approach for community health, specialist mental health services and NHS acute hospitals

30. As a starting point, we propose to make registration a more robust process. This would involve ensuring that all new providers are subject to more rigorous checks. Registration will assess whether all new providers, whether an organisation, individual or partnership, have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to provide people with safe, effective, caring, responsive and high quality care. The assessment framework will allow registration inspectors to gather and consider comprehensive information about proposed applicants and services, including where providers are varying their existing registration and make judgements about whether applicants are likely to meet these legal

requirements. In making these changes, CQC proposes to focus on the robustness and effectiveness of the registration system in a way that does not stifle innovation or discourage good providers of care services, but also ensures that those most likely to provide poor quality services are discouraged from doing so. This will help to protect the safety of people who use services while also safeguarding the reputation of those organisations that provide services within hospitals and community health care settings.

31. Beyond registration we propose to collect and make better use of information that is key to CQC being able to effectively target and monitor regulatory and inspection effort to those providers most likely to be providing poorer quality care. We plan to work in partnership with providers, commissioners and other stakeholders to design and develop the right information sources to be able to do just this. We will continue to work with stakeholders to identify key indicators that define the most important areas to monitor in relation to questions we will ask about services. We want providers to be open and to share their data with us so as to minimise any duplication or regulatory burden associated with generating new information requests in the first instance.

32. With regards to the way we plan to inspect in future, we are proposing to overhaul and refine the inspection framework to be able to gauge more simply and effectively overall compliance, performance and level of care provided. To do this, the focus of our inspections will now be based on assessing performance against five key questions:

CQC's five key questions	
Is this service **Safe?**	By safe, we mean that people are protected from abuse and avoidable harm.
Is this service **Effective?**	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
Is this service **Caring?**	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Is this service **Responsive?**	By responsive, we mean that services are organised so that they meet people's needs.
Is this service **Well-led?**	By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

33. Subsequent sections of this document illustrate what this means in practice for the different providers that make up the various hospitals and community health care sectors. In practice we would expect our inspectors to use a combination of expert judgement, input from stakeholders i.e. specialists and Experts by Experience etc, data and local information to come to a robust conclusion around quality of care across these domains throughout the inspection process.

34. We still propose to use a mixture of inspections – the actual type and nature of inspection will depend on the service in question and whether we were responding to external complaints on concerns about the level of care provided by the organisation in question. Similarly our inspections will continue to use a mixture of unannounced and announced visits, which can be conducted at any time of the day or night, including weekends. We will have larger teams and propose to use expert inspectors that have dedicated specialisms in inspecting their chosen areas, and we would expect the size and make-up of the team to reflect the size and complexity of the service to be inspected.

35. Subject to the passing of the Care Bill 2014, the government is planning to give CQC formal powers to be able to grant a rating based on the level of care provided. We propose to rate all NHS acute hospitals, mental health hospitals and community health care providers on a four-point rating scale: outstanding; good; requires improvement or inadequate.

36. It is our specific intention that all hospitals and community health care providers will receive ratings by April 2016. This follows the outcome of a comprehensive inspection of a provider in question before granting a formal quality of care rating to that provider.

37. Finally we propose to deal more effectively than in the past with providers who consistently fail to meet quality of care standards and requirements as set out in their registration with CQC. We are currently in the process of developing our approach to enforcement and will plan to consult on this separately in summer 2014.

Specific proposed policy themes for NHS acute hospitals

38. All acute NHS hospitals that make up a trust will receive a comprehensive rating by December 2015. We will not inspect all of a trust's acute services. We have identified eight services that we will always inspect, irrespective of risk, at every NHS acute hospital where they are provided. These are known as core services and are comprised as follows:

    - Accident and emergency
    - Medical care (including older people's care)
    - Surgery

- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

39. To direct the focus of their inspection, our inspection teams will use specific key lines of enquiry (KLOEs) that directly relate to the five key questions – are they safe, effective, caring, responsive and well-led?. A full list of these KLOEs is included within the NHS acute handbook consultation document that is published alongside this document.

40. We are also introducing ratings as an important element of our new approach to inspection and regulation. We will do this in a phased way. We have published pilot ratings for three trusts inspected between September and December 2013.We intend to publish shadow ratings of all NHS acute trusts inspected from January 2014, during which time we will evaluate our approach.

Specific proposed policy themes for community health

41. All community health services will receive a comprehensive inspection by April 2016. In large providers we will not be able to inspect all services, particularly where community teams are dispersed across a large geographical area. Therefore we have identified a set of core services which we will always inspect, irrespective of risk. We will also use a sampling approach for community based teams. For smaller providers we will also use these core services to organise our inspection and present our findings so that our information is meaningful to the public. The four core services are:

    - Community health services for adults
    - Community health services for children, young people and families
    - Community health inpatient services
    - End of life care.

42. To direct the focus of their inspection, our inspection teams will use a standard set of key lines of enquiry (KLOEs) that directly relate to the five key questions – are they safe, effective, caring, responsive and well-led? A full list of these KLOEs is included within the community healthcare handbook consultation document that is published alongside this document.

43. We will be more consistent in the methods we use to gather the views of people who use series, those close to them, the public, as well as staff. For example we are testing use of targeted focus groups with users of specific services, use of

surveys through local representative and user groups, and proactive calls for feedback. All large inspections will also include focus groups and interviews with key staff groups, managers and organisation leaders. In recognition of the level of care provided in people's homes, for community health services we are also testing approaches to accompanying staff on home visits to gather direct feedback and observation as well as using phone calls to seek feedback from a wider range of people receiving care from community services.

44. We will also introduce ratings for providers of community healthcare services and propose to do this in a phased manner. We intend to provide shadow ratings for a small number of community health service providers that volunteer to be rated during our Wave 2 inspections (from April 2014) during which time we will continue to evaluate our approach.

Specific proposed policy themes for specialist mental health services

45. The new approach to specialist mental health hospital and community services integrates CQC's responsibilities under the Health and Social Care Act and the Mental Health Act. For our first wave of inspections of specialist mental health services, we have identified a set of core services that, if they are provided, we will always include in an inspection. These core services are as follows:

    - Acute inpatient wards (all wards across all age groups)
    - Psychiatric intensive care units (all wards)
    - Health-based places of safety (all health-based places of safety)
    - Forensic inpatient/secure units (all wards)
    - Long stay/rehabilitation wards (all wards)
    - Child and adolescent mental health services (all inpatient wards and specialist community services)
    - Services for older people (all inpatient wards that are not acute admission wards and a sample of community services)
    - Inpatient wards for people with learning disabilities or autism (all wards) and community services for people with learning disabilities or autism provided by a mental health provider (sampling approach to be applied)
    - Community-based crisis services (all services)
    - Other adult community-based services (sampling approach to be applied)
    - Specialist eating disorder services (all inpatient wards and community services).

46. To direct the focus of inspections, our teams will use a standard set of key lines of enquiry (KLOEs) that directly relate to the five key questions we ask of all services – are they safe, effective, caring, responsive and well-led? A full list of

these KLOEs is included within the mental health handbook consultation document that is published alongside this document.

47. We will also introduce ratings for mental health hospitals and propose to do this in a phased manner. We intend to provide shadow ratings for a small number of mental health service providers that volunteer to be rated during our Wave 2 inspections (from April 2014) during which time we will continue to evaluate our approach.

48. We propose to have joint monitoring visits for scheduled and thematic inspections and produce information on the most difficult or pressurised areas of the system i.e. admission, assessment, community support, transfers and discharges. We also plan to focus more on whether an organisation is “well-led” and we aim to have separate human rights visits that always involve Experts by Experience to talk to people who are detained and to meet their families. We expect that our new integrated approach will strengthen our intelligent monitoring by using improved information on risks from patient and strategic partners.

Costs

49. Changes to CQC’s regulation and inspection of community health, specialist mental health services and NHS acute hospitals will have cost impacts and implications for a variety of stakeholders. In developing these changes we are keen to ensure that we develop a model that helps to minimise the impact of costs and overall regulatory burden on all stakeholders concerned. This will help to assure stakeholders that consideration of costs is central to the development of policy around how we will regulate and inspect providers once these changes have been formally implemented.

50. A key purpose of this regulatory impact assessment is clearly demonstrating to stakeholders what those cost impacts are likely to be. As we are in our initial stages of testing and making changes to our model of regulation and inspection, it is difficult to be precise as to what the cost implications will be on different stakeholders. Development of the emerging regulatory model for different providers across the sectors we regulate will invariably include an element of developmental costs – such costs may or may not be a good indicator of the long term future costs of regulating and inspecting the sector. For example, providers may need to provide more information in the shorter term as CQC requires this information (thereby increasing costs to providers in the short term) however in future should this information not be required there would not be a cost implication to those providers.

51. We propose to continually test, refine and evaluate our proposed emerging regulatory and inspection model so that any unnecessary cost impacts to stakeholders are reduced, and that stakeholders are assured the final model is

efficient, economic and effective and provides overall value for money for all stakeholders. We plan to publish an in-depth final analysis of the cost implications to stakeholders within our final regulatory impact assessment concerning these proposed changes. This will be published before full implementation of the new model in the coming months.

Common cost impacts for NHS acute hospital, community health services and mental health services providers

52. We expect that in the three services the total costs of inspection is likely to increase from the current CQC approach as the inspection teams will involve more inspection days on site, as well as a broader assessment of risks prior to the inspection. These higher costs of carrying out initial comprehensive inspections are likely to reduce with a more focused set of follow-up inspections.

53. We know from our engagement work with providers that they face a number of costs including facilitating the inspection, gathering information for the inspection team and building new information and quality systems.

54. We are currently carrying out further work to further identify the main elements of costs to providers. Where possible we will quantify and put a valuation on these costs to providers as these start to emerge from feedback gathered from providers who are taking part in our various piloting of the new proposed methodology covering those providers as above.

Specific cost impacts for NHS acute hospitals

55. The initial comprehensive inspection of acute services involves an increase in the number of inspection days on site for a trust, compared to previous inspections. Having inspection teams on site will increase providers' costs through having to facilitate the inspection and provide information to support them.

Specific cost impacts for community health

56. We would expect the cost of inspections of providers to be higher than now as there will be more time involved in on-site inspections and therefore for trusts more effort involved in facilitating inspections and providing information. Also those providers who have a rating of requires improvement or inadequate will face higher costs because they will have more inspections.

Specific cost impacts for specialist mental health services

57. Costs will increase due to the use of bigger on-site inspection teams when carrying out the comprehensive inspections. After these have been completed, the costs may reduce from a more focused set of follow-up inspections. Also those providers who have a rating of requires improvement or inadequate will face higher costs because they will have more inspections. In these cases having inspection teams on site will increase their costs through having to facilitate the inspection and provide information to support them.

Specific cost impacts to CQC

58. Costs to CQC are also likely to increase over and above what it currently costs us to regulate, monitor and inspect NHS acute hospitals, mental health hospitals and community health care providers. This stems directly from using bigger inspection teams to facilitate comprehensive inspections, as well as integrating clinical specialists, Experts by Experience and all others that together make up an inspection team.

59. As the provision of ratings to providers is a new function for CQC, we will experience additional costs in providing ratings and updating ratings for all providers throughout the end-to-end inspection process. It is uncertain as to what these costs are likely to be at present. However these are likely to be higher in the shorter-term as we roll these out to all providers by April 2016. In future, costs may decrease as all providers have had a CQC comprehensive inspection and rating, and we move towards a “steady state” model.

Benefits

60. While changes to the way we regulate and inspect community health, specialist mental health services and NHS acute hospitals are likely to have cost implications for a number of stakeholders, it is important to note that many more benefits are likely to emerge as a direct result of these changes.

61. In making these changes we are keen to demonstrate to stakeholders that we roll out and implement an approach that maximises the overall benefits to all stakeholders concerned. This will help to ensure that we have a model that is efficient and effective, whilst also providing value for money for all stakeholders.

62. To be able to achieve these aims, we plan to roll out a regulatory model that has maximisation of benefits at the centre of its approach to developing the new model. A core focus will be ensuring that users of services benefit most from these changes, either through increases in the level of care experienced, or through more confidence in choosing a quality provider. We plan to continually evaluate and refine our regulatory model which has a core focus on ensuring the

benefits to stakeholders are maximised, and will do this primarily through the piloting and testing of our proposed regulatory approach between now and full implementation of the model in Autumn 2014.

63. It is important to note that not all stakeholders are likely to experience increases in benefits immediately – the changes we propose to implement are likely to lead to smaller incremental increases in benefits and are likely to be experienced and sustained over a longer period i.e. several years. For example, an immediate benefit for users of services could stem from having more information about the quality of care provided via publication of ratings, whereas a longer term benefit could centre on incentivising providers to make continual improvements in the way they provide care as a direct result of these ratings.

64. A key purpose of this regulatory impact assessment is to demonstrate to stakeholders what the likely benefit impacts will be to such stakeholders as a result of making changes to the way we will regulate and inspect community health, specialist mental health services and NHS acute hospitals in future. As we are in our initial stages of developing the model it is difficult to be overly precise as to what the size and magnitude of these benefits will be, as well as over what periods we would expect these benefits to materialise. A more in-depth analysis of these emerging benefits will be conducted and publication of this analysis will be contained within a final regulatory impact assessment that is due to be published before implementation of these changes in autumn 2014.

65. In the interim we include below what we believe are the main benefits to stakeholders as a result of changes we propose to make to the regulation and inspection of community health, specialist mental health services and NHS acute hospitals. These have been formulated directly from feedback and engagement from our partners, users of services, provider groups, and all other stakeholders and will be used as a basis for which we will test the emergence of benefits (both over the immediate and longer term) that will be fed directly into development of the model.

Specific benefits from new approach to NHS acute hospitals services

Benefits to people who use services

66. The main beneficiaries of a change in health regulatory policy will accrue to patients as the users of services. This has been reinforced through the engagement we have had with the public and providers and the feedback we got from our RIA that was published alongside the New Start consultation in June 2013. In this context we believe the main benefits to the people who use services include:

- Providing stronger assurance to the public that acute care services deliver care that is safe, effective, caring, responsive and well-led;
- Encouraging services to improve through the publication of ratings;
- Demonstrating that our judgements are completely independent of the health and social care system and Government;
- Demonstrating that CQC is on the side of people who use services.

67. We know from our engagement with the public and other stakeholders that these potential benefits include having credible information to empower them to make choices to better judge good and bad care, increased reassurance that CQC will identify good practice, where improvement is necessary result in timely actions and the use of ratings as an incentive for hospitals to improve.

Benefits to providers

68. Providers will also directly benefit from the proposed changes to how we will regulate and inspect NHS acute hospitals in future. We know from previous engagement with providers that the core benefits are likely to include:

- More credible inspection and reports and closer working with CQC to define areas for improvement;
- Ratings which will help gauge performance and benchmark such providers against other NHS acute hospitals;
- Better sharing of good practice between our experts and those within the inspected premises;
- For those that are rated good or outstanding it is likely that they will face a decrease in costs associated with facilitating inspections and providing information to CQC as they would not need to be inspected as frequently as those who are rated as requires improvement or inadequate.

Benefits to commissioners and other stakeholders

69. For commissioners of NHS acute hospitals the new CQC approach means:

- Credible CQC independent assessments that provides them with a clearer view of the quality of different provider services to inform their commissioning decisions;
- Promoting a dialogue with providers that focuses on outcomes for patients rather than activity and cost;
- A ‘level playing field’ approach that treats all providers in an even-handed and fair way to provide a single framework for commissioners to understand the performance of providers of all types and ownership.

Benefits to CQC

70. CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of services. Inspectors will gain more support from expert professionals and Experts by Experience in making better informed, more robust judgements about the quality of care being provided by the service to be inspected.

71. CQC wants to be an effective, well respected regulator that is fit for purpose in relation to the regulation of health and social care. These changes will ensure we target our resources in the right way.

Specific benefits from new approach to community health services

Benefits to people who use services

72. There are a number of potential benefits to patients and their families receiving community health services including:

- Having a clearer view of the quality of services. A comprehensive and tailored assessment will more clearly define poor and good practice and what patients can expect from services;
- The assessments will be more authoritative, credible and can be trusted;
- More reliable and comprehensive information will be provided for patients to make informed choices between services or to enable them to demand improvements in local services;
- Better outcomes for patients will be enabled through more informed commissioning of services by local commissioners looking to meet the needs of local people;
- Reassurance that poor performing services will be more easily identified and action taken to improve them.

Benefits to providers

73. For providers of services there are a number of potential benefits:

- credible CQC assessment that provides them with a clearer view of the quality of their services, their strengths and weaknesses and what services they need to improve;
- Public acknowledgement of their good practices and access to the good practices of others providing similar services;
- A higher priority being given to the development of information that assesses the performance of their services;

- A ‘level playing field’ approach that treats all providers in an even-handed and fair way;
- Promoting a dialogue with commissioners that focuses on outcomes for patients rather than activity and cost;
- Clarity on how the provider is performing;
- Lower burden on those that are performing well.

Benefits to commissioners

74. For commissioners of community health services the new CQC approach means:

    - Credible CQC independent assessments that provides them with a clearer view of the quality of different provider services to inform their commissioning decisions;
    - Promoting a dialogue with providers that focuses on outcomes for patients rather than activity and cost;
    - A ‘level playing field’ approach that treats all providers in an even-handed and fair way to provide a single framework for commissioners to understand the performance of providers of all types and ownership

Benefits to CQC

75. CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of services. We will have better and more improved understanding of quality across the sector and will be able to identify trends and influence our own internal policy and improvement processes. Inspectors will gain more support from expert professionals and Experts by Experience in making better informed, more robust judgements about the quality of care being provided by the service to be inspected.

76. CQC wants to be an effective, well respected regulator that is fit for purpose in relation to the regulation of health and social care. These changes will ensure we target our resources in the right way.

Specific benefits from new approach to specialist mental health services:

Benefits to patients

77. There are a number of potential benefits to patients and their families receiving specialist mental health services including:

- Having a clearer view of the quality of services. A comprehensive and tailored assessment will more clearly define poor and good practice and what patients can expect from services;
- The integrated assessments of the Mental Health Act and CQC's new regulations based around the five questions (are services safe, effective, caring, responsive and well-led) will produce a single set of consistent findings;
- Where there is an overlap between the Mental Health Act and regulatory powers, such as when assessing 'well-led' and the governance of a mental health service, this would mean that recommendations made by CQC could be enforced through the use of the appropriate regulation;
- Strengthening the voice of people using services through more inspection teams including Experts by Experience and having as part of the assessment more events to engage with the voice of people using the service;
- More of a focus on community-based services, alongside hospital-based assessments. This will provide more opportunities to test care pathways that people experience between providers and between different departments in the same service provider, for instance those that occur when there are crisis interventions involving A&E departments, the police and mental health services;
- Viewing services 'in the round' because assessments will cover whole providers rather than only an individual services. This will enable an assessment of how well services work together to benefit all patients as well as individuals detained under the Mental Health Act;
- More reliable and comprehensive information will be provided for patients in the form of a rating to better enable them to make informed choices between services or to enable them to demand improvements in local services;
- Better outcomes for patients will be enabled through more informed commissioning of services by local commissioners looking to meet the needs of local people;
- Reassurance that poor performing services will be more easily identified and action taken to improve them.

Benefits to providers

78. For providers of services there are a number of potential benefits:

- Broader CQC assessment that provides them with a clearer view of the quality of their services, their strengths and weaknesses and what services they need to improve;
- Single set of consistent findings in one report (that saves provider the effort of having to reconcile the findings from different reports produced by CQC);

- Public acknowledgement of their good practices and access to the good practices of others providing similar services;
- A higher priority being given to the development of information that assesses the performance of their services;
- A 'level playing field' approach that treats all providers in an even-handed and fair way;
- Promoting a dialogue with commissioners that focuses on outcomes for patients rather than activity and cost;
- Clarity on how the provider is performing;
- Lower burden on those that are performing well, as inspections are focused on poor performance.

Benefits to commissioners

79. For commissioners of community health services the new CQC approach means:

- Credible CQC independent assessments that provides them with a clearer view of the quality of different provider services to inform their commissioning decisions;
- Promoting a dialogue with providers that focuses on outcomes for patients rather than activity and cost;
- A 'level playing field' approach that treats all providers in an even-handed and fair way to provide a single framework for commissioners to understand the performance of providers of all types and ownership;
- A rating will send a strong signal in a commercial and competitive market about making choices and making long standing decisions about from whom to commission services.

Benefits to CQC

80. CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of services. Inspectors will gain more support from expert professionals and Experts by Experience in making better informed, more robust judgements about the quality of care being provided by the service to be inspected.

81. CQC wants to be an effective, well respected regulator that is fit for purpose in relation to the regulation of health and social care. These changes will ensure we target our resources in the right way.

Next steps

82. This is the first stage in integrating an approach which ensures that the maximisation of benefits and minimisation of regulatory burden are central to how we develop changes to the way we will regulate and inspect NHS acute hospitals, mental health and community health service providers in future.

83. In the coming months, we will undertake a fuller analysis of the costs and benefits to stakeholders as we pilot our new approach. This includes gathering feedback and key pieces of information on costs experienced by providers and other stakeholders as a result of the proposed changes for those undergoing the pilot. We will also be gathering feedback on benefits experienced by users of services and other stakeholders (both actual and perceived benefits) as we continue to trial and test our new regulatory and inspection methodology across these providers.

84. This analysis will help to ensure that the final model, once implemented in October 2014, is economic, efficient and effective and provides good value for money in the way we roll out and implement the proposed changes that affect stakeholders in future. Figure 1 below illustrates the key steps in being able to achieve these aims, as well as the anticipated timeline for delivery:

Figure 1: RIA next steps and timeline for delivery