Independent acute healthcare, ambulance services and primary care dental services

Changes to the way we regulate and inspect services

Interim Regulatory Impact Assessment

This interim regulatory impact assessment (RIA) has been published alongside our consultations covering:

1. Independent acute healthcare consultation

2. Ambulance services handbook

3. Primary care dental services handbook

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

This document provides an analysis of the potential cost and benefit impacts of our proposals to the way we will regulate and inspect Independent Acute Healthcare providers, ambulance services and dental services 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".*

Introduction

1. This document provides an interim assessment of the likely costs and benefits of the proposed changes from April 2015 that are due to affect independent acute healthcare providers, ambulance services and dental service providers.

2. From April 2015 we are proposing that those providers will be monitored, inspected and rated under a new methodology that was developed in collaboration with stakeholders across the health and social care sectors. These stakeholders included providers, people who use services, trade bodies, national organisations, commissioners and government organisations.

3. These proposals follow on from commitments made in our previously published documents:

   i. A fresh start for inspecting and regulating independent healthcare
   ii. A fresh start for inspecting and regulating ambulance services
   iii. A fresh start for inspecting and regulating dental service providers

4. Prior to implementation we will pilot, test and evaluate our new approaches across these sectors to ensure we have a robust model that is fit for purpose. We also welcome your feedback as to what you believe the impacts will be on your individual organisations as a result of these proposed changes and have included some questions at the end of this document for stakeholders to consider.

5. A final impact assessment will be published prior to full implementation of the new methodology in Spring 2015. This will contain a more in-depth analysis of the costs and benefits to stakeholders that will be gathered as we test our new approach prior to implementation.

Background to policy changes

6. The way we will regulate and inspect all providers of health and social care is changing. We want to ensure we have a regulatory model that is fit for purpose to regulate the many different providers across several sectors that provide a multitude of different and diverse health and social care services.

7. Publication of our three year strategy and new start documents in 2013 set us on course to propose these fundamental changes. Our subsequent provider handbook consultations covering NHS acute hospitals, community healthcare, specialist mental health, adult social care and general practice services outlined further in-depth plans for how we would regulate these services in future. These proposals have now fully been implemented and are operational as of October 2014.

8. To date, feedback from our stakeholders has largely indicated widespread support for our new model of regulation and inspection. In particular stakeholders acknowledge the role that ratings can play in driving improvements in care quality and have welcomed the use of experts and specialists on our inspections of services under the new model.

9. We now want to build on these successes by applying a similar regulatory and inspection framework to those service providers outlined in this impact assessment. In doing so we will be creating a level-playing field that ensures we are using an established model. However, where appropriate, we will make changes to ensure we continue to employ the most appropriate regulatory methods to capture key differences inherent in other sectors.

10. We know that there will be key challenges in regulating independent acute healthcare given the diversity of the size and type of provider and the services they offer. These ranging from individuals providing single specialty services to large corporates providing multiple services across several locations. We want to be able to apply our regulatory model in a proportionate and appropriate manner to these services.

11. Similarly we are aware of the complexity of regulating ambulance services effectively given significant differences in size and degree of activity between NHS ambulance services, private and voluntary organisations. We will want to develop an approach that is consistent and comparable in how we regulate and inspect such services.

12. Finally our feedback from our dental stakeholders indicates that this sector poses fewer risks to patient safety than other sectors, in part because of the high quality level of services on offer. We want to recognise these facts by being flexible in how we apply our regulatory approach to ensure we do not impart undue burden on such providers.

13. Our consultation documents published alongside this impact assessment bring together all of our current thinking on how best we can implement these changes. We want to ensure our model maximises benefits to stakeholders while helping to reduce unnecessary burden on those providing good care. We will publish a fuller assessment of these potential cost and benefit impacts in a final impact assessment prior to implementation of the proposed model.

Summary of proposed changes from 1 April 2015

14. Our consultation documents provide detailed information to stakeholders on our proposed new regulatory approach. A summary of these proposals is provided below:

We propose that all ambulance services, dental provider services and certain types of acute independent service providers be regulated under a new regulatory model from 1 April 2015.

Registration

CQC will make registration a more robust process both for new services wishing to be registered and existing services that wish to vary their registration. We will undertake assessments to ensure existing and potential services have the capability, capacity, resources and leadership skills to meet the relevant statutory requirements, and are therefore likely to provide people with safe, effective, caring, responsive and high-quality care.

Monitoring

CQC will make better use of information to monitor and target resources to areas in which the risk of providing poorer quality care is greatest. We will continue to work with stakeholders within these sectors to define key indicators for monitoring the quality of services and identify the right information sources.

Inspection

The new CQC framework is based on five key questions. Inspectors will judge whether a service is safe, effective, caring, responsive and well-led. We will use “Key Lines of Enquiry” to help guide our inspections. All our inspectors will be expert and dedicated sector inspectors. The size of inspection teams will depend on the size and complexity of the service to be inspected, but we will make appropriate use of Experts by Experience and sector specialists as required.

Rating

With the exception of dental service providers, independent ambulances and certain independent healthcare ones, we will begin to rate independent acute hospital services and ambulance service providers from April 2015. Ratings will be based on a four point scale: outstanding, good, requires improvement, inadequate. Frequency of inspections will generally be directly linked to the overall rating awarded. We are developing our approach as to how and where we rate i.e. by service, location and provider level and will share details with stakeholders in due course.

Enforcement

We shall be tougher on services which consistently provide poor quality care and do not comply with conditions in their registration. More information on this policy was contained in a separate consultation on our approach to enforcement in August 2014.

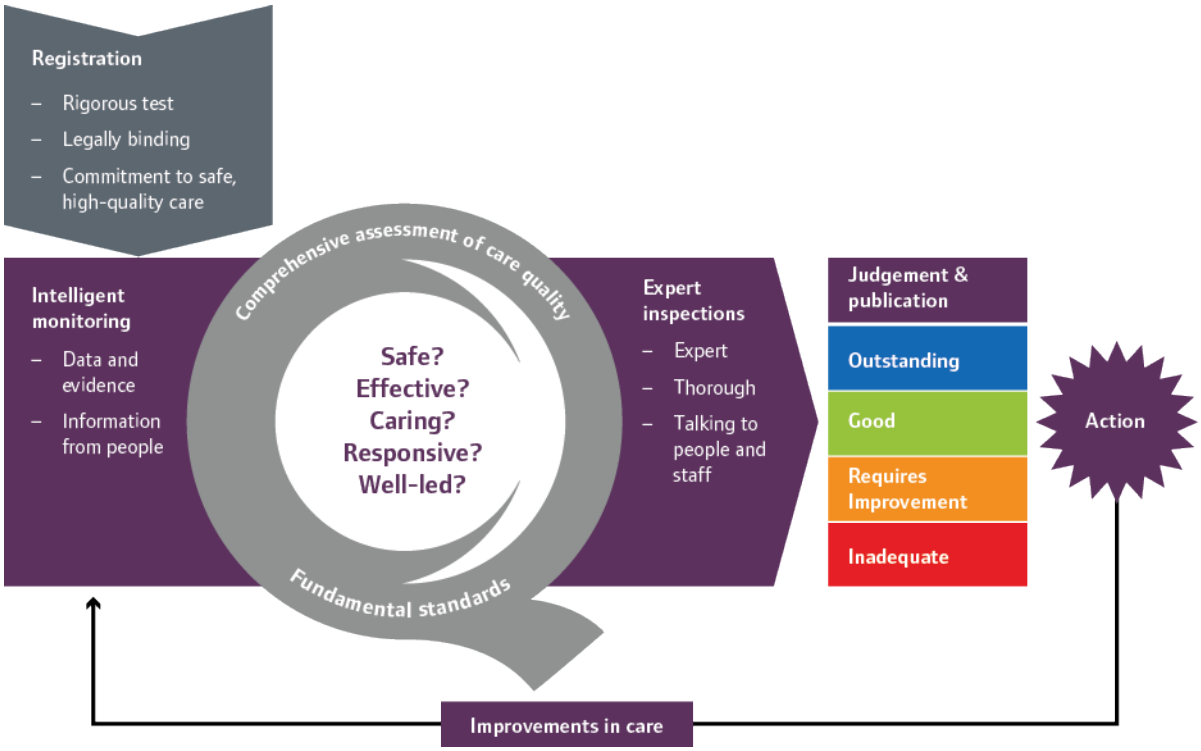
Scope of interim impact assessment

15. In this document we describe our interim assessment of the likely costs and benefits arising from changes to the way we regulate and inspect independent acute healthcare, ambulance services and dental service providers as set out in the consultation provider handbooks. We discuss the costs and benefits arising from changes to inspections and ratings. These activities are represented in figure 4.1 under the titles 'Intelligent Monitoring', 'Expert inspections' and 'Judgement and publication'. The activities 'Registration' and 'Action' are not covered in this impact assessment.

16. In the case of Enforcement ('Action') a regulatory impact assessment for this element of our new operating model was published in August 2014 as part of our consultation on our proposed enforcement policy.

17. Our new registration process is not covered in this Impact Assessment because the policy is under development. Once the policy has been developed further we may assess its costs and benefits publicly if we deem its impact to be sufficiently significant.

Figure 4.1: CQC's overall operating model



CQC assessment of impacts

Overview of previous regulatory model

18. CQC regulates a variety of independent acute healthcare providers, ambulance services and dental service providers that vary in size and specialisms across England. Independent acute healthcare providers include a mixture of large corporate hospitals operating from multiple sites and single service specialties operating out of single-site clinics. Ambulance service providers are unique in that staff typically works across a range of other providers and professionals i.e. one shift can constitute interaction with GPs, community nursing staff, care home workers, midwives, police officers and fire service personnel. Similarly a significant number of dentists are sole practitioners operating out of single-site locations with a smaller number forming large corporates operating out of multiple sites.

19. The regulation and inspection of such providers generally includes many common themes and components irrespective of whether we are inspecting an independent acute hospital, ambulance provider or dental service provider. 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 be found to be non-compliant.

20. 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 are 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.

21. 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 organisations that provide care within an independent acute healthcare setting, ambulance or dental service provider.

Independent acute healthcare providers

22. CQC regulation of all independent acute healthcare providers under the Health and Social Care Act 2008 came into force in October 2011. Since then we have inspected all

providers at least once and have generally found high levels of compliance across the spectrum of providers we regulate.

23. Our inspection teams have comprised a single inspector for the smaller providers to a larger team for more complex services.

Ambulance providers

24. From August 2014 we have phased in our inspection of both NHS and independent ambulance providers. To date we have inspected two NHS ambulance trusts as part of our Wave 1 inspections (August to September 2014) and have the intention of rating all NHS ambulances by the end of March 2016. We are continuing to work with independent ambulance services to develop our approach for regulating and inspecting these services. We will begin piloting our approach for inspecting and regulating independent ambulances from April 2015, with the aim of rolling out our final approach by October 2015.

25. The composition and size of the inspection teams depend on the complexity of the services that are to be inspected. However, the teams will always consist of a CQC team leader and CQC inspectors (with varying levels of seniority). Clinical and other experts, with specific skills, will also make-up part of the team to reflect the services provided by the trust and the areas of focus for the inspection. We will also use Experts by Experience/patient and public representatives, to talk to people who use the services and tell us what they say and, where possible, observe care being delivered.

26. Regulating and inspecting ambulance providers have traditionally been challenging, with issues such as significant difference in size, intensity of activity, and operating out of multiple locations all contributing to difficulties in robustly assessing performance. Ambulance staff also work with a significantly larger number of professionals during any single shift and can therefore make it harder to assess overall care quality.

Primary care dental service providers

27. Primary dental services were brought into CQC's regulatory model in April 2011. Most dental providers operate out of a single site location and they range in size from single-handed dental locations and partnerships to large corporate providers. Since our inspection of dentists commenced we have worked closely with the General Dental Council (GDC) and British Dental Association (BDA) to develop our approach.

28. We have now inspected all dental locations registered in 2011 and have generally found high levels of compliance with the essential standards across the dental provider community. We have also been selective in choosing which of the essential standards to inspect against, focusing on areas such as infection prevention and control and care and welfare. The overwhelming majority of our inspections have been announced inspections and have been carried out by a sole inspector.

Policy objectives of proposed new approaches

29. A key reason for proposing changes to the way we regulate and inspect independent healthcare, ambulance and dental service providers is to ensure that standards improve. We want to ensure that high performing organisations are commended and can act as role models for all providers to make continual improvements. Also, focusing on how safe, effective, caring, responsive and well-led services are will enable us to review the quality of services focusing on what matters to people.

30. It has widely been acknowledged the key role that such services play within the health system. The impact of these organisations providing poor quality services can have serious consequences for the health and well-being of a large number of people.

31. We want providers to improve continually and to provide high quality care that directly benefits people who use services and their families. We aim to achieve this by working closely with our partner organisations such as the GDC, BDA, NHS England Area Teams with Clinical Commissioning Groups (CCGs) whose duty it is to support quality improvement in primary care.

32. Our inspections of independent acute healthcare services and ambulance services will be carried out by our Hospitals Directorate. Inspections of dental service providers will be carried out by our Primary Medical Services Directorate. Inspectors will become dedicated experts in inspecting only services in which they have built up a specialist expertise. That is to say that an inspector will no longer inspect a dental practice in the morning, then a care home in the afternoon.

33. We wish to provide greater assurance to the public around the quality of care provided by independent acute healthcare and NHS ambulance providers. To facilitate this we are providing these organisations with a rating so that the public can gauge the quality and performance of individual providers. For dental providers we will continue to work with the dental community and our partners to explore other methods of assurance i.e. accreditation schemes. We will also continue to work with our partners to share information which will help focus our efforts and target poorly performing providers.

34. Underlining all of this is our aim to develop a model of inspection and regulation that maximises benefits to all stakeholders while keeping regulatory burden on providers and other key stakeholders to a minimum. 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 inspection, while poorer performers have more frequent contact with CQC to ensure they improve.

35. Our ultimate objective is to provide a robust and credible framework which helps drive continual improvements in the way care is delivered. Providers will have access to clear advice and information to help them deliver these improvements.

Monitoring, inspecting and rating independent healthcare, ambulances & primary care dental services from April 2015

Registration

36. 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 judgments about whether applicants are likely to meet these legal requirements. In making these changes, CQC propose 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 users of services while also safeguarding the reputation of those organisations that provide services within hospitals and community health care settings.

37. 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.

Inspection framework

38. 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 quality of care provided. To do this the focus of our inspections will now be based on assessing performance against five key questions:

Safe	By safe, we mean that people are protected from abuse and avoidable harm.
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.
Caring	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By responsive, we mean that services are organised so that they meet people's needs.

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.

39. Subsequent sections of this document illustrate what this means in practice for the different providers that make up the various independent acute hospitals & other services, ambulance services and dental service providers. In practice we would expect our inspectors to use a combination of expert judgement, input from stakeholders i.e. sector specialists & Experts-by-Experience, data and local information to come to a robust conclusion around quality of care across these domains throughout the inspection process.

40. 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 or concerns about the level of care provided by the organisation in question. Similarly our inspections will continue to utilise a mixture of unannounced and announced visits, and can be conducted at any time of the day or night including weekends. Where appropriate we will use larger teams and propose to use expert inspectors who 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,

Ratings

41. As the Care Act 2014 was given royal assent earlier this year, we now have the formal powers to be able to grant a rating based on the quality of care provided. With the exception of primary care dental providers, independent ambulances and some independent healthcare providers, we propose to rate independent healthcare providers and NHS ambulance services on a four point rating scale: *Outstanding / Good / Requires Improvement / Inadequate.*

42. We propose to begin rating independent healthcare hospital providers and NHS ambulance services from April 2015. This follows the outcome of a comprehensive inspection of an individual provider prior to granting a formal quality of care rating to that provider.

Enforcement

43. Finally we propose to deal more effectively than we did in the past with providers who consistently fail to meet quality of care standards and requirements as set out in their registration with CQC. Information on what providers can expect under our future enforcement policy was contained in our previous consultation document published in August 2014. We will be publishing an update on our approach to enforcement in early 2015. Alongside this document we will be publishing a Final Regulatory Impact Assessment on the costs and benefits of the policy.

Specific proposed policy themes for independent acute healthcare providers

44. For purposes of regulating and inspection independent acute healthcare providers we propose to segment such providers into three groups (see consultation document for more details):

Hospital	Single speciality	Non-hospital acute
- Independent sector treatment centres - Private patient units located within an NHS acute or specialty trust, where these are run and managed by an independent provider - Independent providers of maternity services	- Termination of pregnancy procedures - Haemodialysis or peritoneal dialysis - Hyperbaric therapy - Diagnostic imaging and endoscopy - Diagnostic laboratories - Refractive eye surgery - Fertility services - Hair transplantation services - Specialist inpatient services for long-term conditions	- Mainly consulting room services and single-handed practitioners

45. Our consultation document provides detailed information on core services we would inspect and the key lines of enquiry (KLOEs) we would expect to utilise to gauge performance against our five key questions. In practice we will use a mixture of announced and unannounced inspections and will vary team size depending on the size and complexity of the provider to be inspected.

46. We will begin to rate independent acute hospitals providers from April 2015. We will provide a rating for every core service and for each of the five key questions at each location. For large providers operating out of multiple locations we will look in future as to how we might provide an overall rating for the provider as a whole.

47. To ensure a level playing field with NHS trusts and foundation trusts we will also be considering how we implement special measures for independent healthcare providers. We are developing our approach as to how this would work in practice however this will not be the same as our approach taken for NHS trusts and foundation trusts, in part because there is not a similar body such as Monitor or the Trust Development Authority.

Specific proposed policy themes for ambulance service providers

48. We propose to always inspect the following core services:

- Emergency & Urgent Care Services
- Patient Transport Services
- Emergency Operations Centre
- Resilience Planning

49. Our inspections will normally be limited to these core services. However if we identify particular services, or the use of pathways of care which provide cause for concern, or where we believe the quality of care could be outstanding and they are not covered by these core areas, we will look at them in detail and report on them. We may also focus on additional areas where these represent a large proportion of a provider's activity or expenditure.

50. Due to the geographical split of ambulance services we will not always be able to visit every location from which a core service operates from. Therefore we will take a sampling approach and will visit a number of sites attributed to each core service.

51. We will choose some providers on a random basis and for others we will consider various factors about risk, quality and the context of the services to help us select and prioritise areas we visit. These may include:

- Where previous inspections, our intelligence or information gathered by Monitor, TDA, NHS England or a local CCG, has flagged a risk or concern;
- About which we have received a complaint, there has been a safeguarding alert or we have heard from a whistleblower;
- We have not inspected for a long period or have not previously inspected at all;
- Where the quality of care may be Outstanding

52. We will rate NHS ambulances at four levels:

    Level 1: rate every core service for every key question
    Level 2: an aggregated rating for each core service
    Level 3: an aggregated rating for each key question
    Level 4: an aggregated rating for the trust as a whole

Specific proposed policy themes for primary care dental providers

53. Our inspections will primarily focus on whether or not the provider is meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. From April 2015, these regulations will be replaced by the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which include the fundamental standards.

54. Prior to inspection we may write to practices and ask them for some information which will help facilitate the inspection process. Practices will have five working days to respond to our request. We will make clear what information to send, where to send it and who to contact with any queries or questions. We would expect the info request to include an up-to-date statement of purpose as well as current information about any complaints or compliments associated with the practice.

55. We plan to use a mixture of comprehensive and focused inspections. The key characteristics of each of these include:

Comprehensive Inspection	Focused Inspection
- Looks at all regulations applicable to primary care dentistry; - Usually takes 1 day at practice and is usually a single inspector (but we may have larger inspection teams depending on the provider); - May not always include a specialist advisor; and - Inspections is usually announced two weeks before inspection;	- Follow up to a previous inspection, or to respond to a particular issue or concern - Does not look at all the regulations - Team composition and size will depend on the concerns - May be conducted in partnership with one of our partners i.e. NHS England; and - Inspection may be unannounced

56. However at this stage we are not planning to rate dental providers from April 2015 but will continue development work to assess whether we may need to rate such providers in future.

57. ***Regulation of Dental Services Programme Board***
There are a number of organisations involved in monitoring the quality and safety of dental services and dental care professionals. We all have a mutual interest in ensuring that patients receive high-quality, safe dental services from professionals and organisations that are competent and meet national standards. We are extremely pleased that these organisations, including the General Dental Council (GDC), NHS England, NHS Business Services Authority and CQC have agreed to work closer together to review the approach to dental regulation and inspection across England, assess current arrangements and determine an effective model for regulation for the future.

Costs

58. Changes to CQC's regulation and inspection of independent acute healthcare services, ambulance and dental service providers 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 these services in future.

59. 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 our proposed new approach on such providers we cannot be precise on these cost implications to different stakeholders.

60. Development of the emerging regulatory model for independent acute healthcare services, ambulances and dental service providers 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 sectors. For example, we may need larger team sizes initially in order to carry out comprehensive inspections of providers. If there are fewer concerns about care then costs should decrease as there would be less need to inspect as intensively. Similarly some providers may initially face higher costs themselves as a result of being regulated, as they are unaware how the new regulatory system could impact them. For example they might increase staff to facilitate inspection, or invest in systems to facilitate compliance.

61. We propose to continually test, refine and evaluate our proposed emerging regulatory and inspection model so that any unnecessary regulatory burden 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 have commissioned an external organisation to develop a model which captures the costs of the CQC and which will encompass the ongoing costs of CQC regulation on stakeholders. This will inform ongoing development of our regulatory model as a means of implementing efficiencies in how we regulate and inspect providers.

62. 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 prior to full implementation of the new model for regulating and inspecting independent acute healthcare, ambulance services and dental service providers in April 2015.

Common cost impacts for independent acute healthcare providers, ambulance services and dental service providers

63. All providers will experience costs in relation to facilitating a CQC inspection. The marginal costs incurred by providers over and above our current inspection methods are likely to differ depending on how intensively we inspect. However it is likely that costs will

increase initially as we develop and test our proposed model, which may mean longer inspection visit days on site for different providers.

64. Similarly all providers will be required to submit key information to CQC as part of the inspection process. Costs incurred may initially be higher however where possible we will work with our strategic partners to ensure we do not duplicate information requests and impose undue regulatory burden. Costs may fall in future as information request templates become more standardised and providers implement systems to capture required data on a routine basis.

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

Specific cost impacts for independent acute healthcare providers

66. For independent acute hospitals we would expect costs in relation to facilitating an inspection to reflect how many core services we inspect as well as how many locations we inspect at. For single speciality services costs are likely to only be marginally higher than they are currently as we would expect staff numbers facilitating to stay relatively constant. However we would expect costs to increase proportionately more for those providers rated as requires improvement or inadequate.

67. During piloting of our new inspections we will be formally evaluating independent acute healthcare organisations' experience of costs incurred as we test our new approach. We have commissioned an external research agency (Research Works) to interview a sample of providers so we can understand the costs incurred as a result of piloting our regulatory model. An analysis of this will be included in the final impact assessment due to be published in April 2015.

Specific cost impacts for ambulance services

68. The costs incurred to ambulance services are likely to vary significantly in magnitude primarily due to the size and variety of different organisations within the sector. Larger NHS ambulance trusts operate out of several locations and have greater volumes of activity compared to small voluntary ambulance providers which may operate just two or three vehicles. Therefore we would expect costs incurred to directly reflect the size and number of locations at which we would inspect such providers.

69. Our comprehensive inspections are also likely to initially increase costs to providers as we seek to rate across all five questions and core service. Those which receive a Requires Improvement or Inadequate rating are likely to be inspected on a more frequent basis and would incur higher costs as a result whereas those who are found to be performing well are likely to see a reduction in inspection costs.

Specific cost impacts for dental service providers

70. Our proposals indicate that only 10% of providers will be inspected annually and will be based on the potential risks posed to service users. Therefore the majority of registered dental services providers are not likely to face additional costs as a result of CQC's regulatory oversight.

71. There are likely to be smaller cost impacts for providers where we ask for information prior to inspection. Providers who provide unacceptable levels of care are likely to face additional costs in the form of enforcement action and potential re-inspection. Costs for providers will increase depending on the numbers used to facilitate inspection, as will any upfront investment in systems to help support and maintain care quality provision.

72. As we have committed to evaluating and refining the regulatory model prior to implementation, we will be interviewing a sample of dental providers to find out about the costs they incurred as a result of our new inspections as we pilot and test our proposed approach across the dental sector. An analysis of this will be included in the final impact assessment due to be published in April 2015.

Specific cost impacts to CQC

73. Costs to CQC are also likely to increase over and above what it currently costs us to regulate, monitor and inspect independent acute healthcare providers and ambulance services. 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.

74. 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 those included in this impact assessment from next year (not including certain independent healthcare providers and dental providers). In future costs may decrease as all providers will have had a CQC comprehensive inspection and rating, and as we move towards a "steady state" model.

75. As we pilot and test our proposed methodology we will collect data on costs of inspecting providers and will include an analysis of this in the final impact assessment that will be published prior to implementation next year.

Benefits

76. While changes to the way we regulate and inspect independent acute healthcare providers, ambulances and dental service providers are likely to have cost implications for a number of stakeholders, it is important to note that there will also be more benefits that are likely to emerge as a direct result of these proposed changes.

77. In making these proposed changes we are keen to demonstrate to stakeholders that we roll out and implement an approach that puts maximisation of benefits at the centre of its approach to developing the new model. This will help to ensure that we have a model that is efficient and effective, while also providing value-for-money for all stakeholders.

78. 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 April 2015. We have also commissioned an external organisation to develop a model to assess our ongoing benefits to stakeholders as a result of our new regulatory model. This will be instrumental in helping to demonstrate our overall impact as the model develops over time.

79. 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 time 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.

80. A key purpose of this regulatory impact assessment is demonstrating 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 such providers 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 time 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 prior to implementation of these changes in Spring 2015.

81. 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 independent acute healthcare, ambulance and dental service providers. 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.

a. Specific benefits to the public and people who use services

82. Those who use health and care services should benefit the most from the CQC's new inspection model. We set out in more detail below what we believe will be the main benefits to service users as a result of changes to the regulatory model. Stakeholders should note that we will be testing these assumptions as we pilot and refine our approach across sectors and will include further evidence of these in our final impact assessment prior to implementation in Spring 2015.

i. Confidence for people who use services

83. As a result of the new more comprehensive inspections the CQC will be able to make better informed judgements about the quality of care delivered by a provider. The CQC should be able to give stronger assurance to the public that services deliver care that is safe, effective, caring, responsive and well-led. More and better information should be made available to the public on the quality of services provided. Our assessments will be more authoritative, credible and can be trusted and we can demonstrate that our judgements are completely independent of the health and social care system and Government. We intend for the public to have confidence in CQC regulation of providers and in the information we provide. People who use services are confident in the assurance we provide about local services.

ii. Giving a voice to people who use services and the public

84. The new inspection model provides formal and informal opportunities for the public and people who use services to provide feedback to the CQC on their experience of the services being inspected. This feedback will be used to plan and direct inspections. Furthermore, the CQC should be able to provide reassurance that poorly performing services will be more easily identified and action taken to improve them.

iii. Clearer information for people who use services to make choices

85. For most independent acute healthcare providers and all ambulance services, a clear departure from the previous inspection model is the introduction of ratings. Eventually the new inspection model should raise awareness among the public that the quality of care can vary across providers.

86. By providing ratings at various levels within a provider and across our five key questions that are also supported by qualitative information, people who use services will be able to get a clearer view of the quality of services provided. A comprehensive and tailored assessment will more clearly define poor and good practice and what people who use services can expect from them. In the event that people who use services have choice over which service provider to attend, they can use the more reliable and comprehensive information to make better informed choices.

iv. Encouraging services to improve

87. When people who use services have a choice over where they receive treatment and many of them choose not to go to a particular provider because of its poor rating this should put pressure on the service provider in question to improve. People who use services should also benefit from better outcomes if the new inspection model leads to more informed purchasing of services by local commissioners seeking to meet the needs of local people. This is an outcome which we think will emerge over the longer term.

b. Specific benefits to providers

88. Providers should benefit directly from the changes to how we regulate, inspect and rate providers. The advantage of the key questions being consistent across all sectors is that it creates a 'level playing field' approach that treats all providers in an even-handed and fair way. We also envisage that there will be reputational benefits to providers of being in a sector which is transparently and robustly regulated. We set out in more detail below what we believe will be the main benefits to providers as a result of changes to the regulatory model.

i. More comprehensive and credible CQC assessment of provider performance

89. Under the new inspection model the sources of information to support inspections and the depth of this information will be more thorough. This will ensure that judgements about provider performance are more credible. As a result we expect that providers are more likely to think our judgements are credible and fair and are hence more likely to agree with our ratings.

90. The new ratings system should help providers gauge their performance and benchmark themselves against other providers. In that sense the model will always provide the opportunity for providers to self-improve continually.

ii. Giving healthcare staff a voice

91. The new inspection model includes opportunities for provider staff to give us feedback on the providers they work for. The CQC intends to protect those who provide feedback to us.

iii. Acknowledgement of and sharing good practices

92. The advantage of the new inspection model is that the CQC will recognise and publicly acknowledge providers that provide good quality services. It is the CQC's intention that through these mechanisms good practice can be recognised and could spread throughout the sector. A key way that this will happen via our new inspection model is through specialist advisors in question. Specialist advisors on inspections are likely to be employed to work with other providers. If they identify good practices in the organisation they are inspecting they can take these ideas and apply them in the providers they work for.

iv. Identifying improvements providers can make

93. Not only will inspections identify what good practices are, they are designed to identify where services, practices and processes need to be improved. These CQC judgements could provide impetus to staff to address such problems.

94. A longer term benefit from the new inspection model might be that it encourages providers to give a higher priority to the development of information that assesses the performance of their services. Providers might improve quality systems and processes to ensure that quality is consistent across their organisation.

95. Where the CQC finds poor practices and where improvements are not made such providers may be subject to the failure regime which might ultimately end up with them being closed or the services in question no longer being provided on that site. The costs and benefits associated with the CQC's Enforcement regime will be discussed in the Final Enforcement Regulatory Impact Assessment to be published in early 2015.

v. Shifting focus to quality of care

96. The new inspection model is designed to focus attention on the quality of services provided in providers. Through the introduction of ratings we hope that providers will strive to achieve a rating of 'Outstanding'. There may be two reasons for providers to do so. The first is that better rated providers may be more appealing to people who use services who are free to choose where they are treated. Second, providers that are rated Good or Outstanding are likely to be inspected less frequently or will receive less intensive inspections in the period following this rating.

97. Other channels through which we hope the focus will shift to quality of care are as follows:
    - Boards, directors and leaders of providers become focused on quality of care and recognise their personal role in achieving high quality care in their organisation.
    - The new model should promote a dialogue between providers and commissioners that focuses on outcomes for people who use services rather than activity and cost.
    - Staff working for providers believe in, and participate in, building high quality care and professional practice
    - Staff act on and speak out about poor quality care.
    - Services not providing good quality care are held to account by third parties using our information.
    - Experts by Experience on inspection promote the service user's view of services and identify areas where improvements that could be made to the benefit of the experience of the service user.

vi. Independent acute healthcare providers

98. As independent acute healthcare providers operate in a commercial environment, introduction of ratings should create direct incentives for providers to improve relative to other similar providers. The rating can be used as a vehicle by which providers can market and promote good or outstanding services to potential service users therefore

potentially leading to increased revenue and identified future growth streams for their commercial enterprises.

99. We also expect such providers that have been rated as good or outstanding to experience lower costs as a result of needing to be re-inspected less frequently. This would allow providers to redistribute this resource to other areas of the business which could lead to further improvements in service provision.

vii. Ambulance service providers

100. We would expect the introducing of ratings to be a key improvement driver for ambulance services. This would be especially important where an ambulance service has a regional monopoly or operates in a geographical location that contains only a few providers. We would expect the rating to gauge how well ambulance staff work well together in an integrated manner to meet demands placed on them by emergency situations.

101. For independent ambulance services operating in a commercial environment, the inspection and rating of providers should add further credibility of their value and may lead to more business opportunities and areas for growth with partner organisations. This maybe the case where independent ambulance services are generally rated better than NHS ambulance services which could lead to an increase in contracts for such organisations.

viii. Primary care dental providers

102. We will become more risk-based in how we inspect dentists and therefore only plan to inspect a sample of 10% dental providers in any given year. This should lead to a sharp drop in costs for providers that are not re-inspected brought on by dental staff not needing to facilitate our inspections.

103. Although we will not be rating providers from April 2015 we may explore this in future if the dental community believe there will be added benefit from doing so. Our experience of the sector has indicated that there is already an overall high level of care provided by the dental community. Our changes to registration will also help to safeguard the reputation of the dental community by keeping out organisations which may provoke adverse reputation damage through poor provision of services.

c. Specific benefits to the CQC

104. There are a number of ways in which the CQC will benefit from the new inspection model. These benefits include the following:

105. The CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of services in a provider. We believe our guidance on KLOEs and ratings will help guide Inspection team decisions, and to help providers prepare for their inspections.

106. 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.

107. In addition to opinions from experts, they will also have access to more information from external sources to direct their investigations and to support their judgements.

108. Our new inspection model will now also be more joined up with our partner organisations such as the General Dental Council. This will ensure that we are drawing on expertise and advice from organisations that work closely with these providers and will help to facilitate a better understanding of risk and the need to inspect which may reduce regulatory burden in future.

109. As the benefits from the new regulatory model are felt by people who use services and the wider sector, the CQC will be able to demonstrate that it providers good value for money to our stakeholders.

Next steps

110. The CQC will continue to engage with providers, the public and other stakeholders on our proposed inspection model for regulating independent healthcare providers, ambulance and dental service providers. This is part of an effort to ensure the benefits to the sector are maximised and the costs minimised from our inspection model. We welcome feedback on the information presented in this document.

111. We would strongly welcome your feedback on the costs and benefits presented in this impact assessment. In particular we would like to ask stakeholders three key questions:

Questions for stakeholders

i) What costs have you experienced in terms of time and one-off expenditures relating to individual CQC inspections in the past?

ii) How do you envisage the costs of inspection to change for your provider as a result of our new inspection model?

iii) What benefits to your organisation do you feel will be experienced as a result a result of these proposed changes?

iv) Have we missed out any other costs and benefits that you feel should be included in the analysis?

112. To provide us with your feedback please email:
economics@cqc.org

113. Alternative you can post a response using the following address:
CQC Regulatory Economics Team
14th floor
Finsbury Tower
103 – 105 Bunhill Row
London
EC1Y 8TG

114. We will also continue to evaluate how our new inspection model is working in practice. The CQC has the following work streams planned:
- We will continue to monitor our new inspection model through activities including our post-inspection survey of providers and post-registration survey of providers. We will also be piloting a survey of inspection team members; and
- We have commissioned an external economic consultancy to establish a methodology for the CQC to assess its costs and benefits on an ongoing basis. This

work should provide a more comprehensive and detailed view of the impact of the CQC on the sectors it regulates