

Specialist substance misuse services

Changes to the way we regulate and inspect services

Final Regulatory Impact Assessment

This final regulatory impact assessment (RIA) has been published alongside our final specialist substance misuse services provider handbook. Stakeholders may want to refer to this document before reading this impact assessment as it provides information on our new methodology for inspecting these services.

This document provides an analysis of the likely cost and benefit impacts of our new approach to the way we regulate and inspect these services. It builds on the analysis conducted in our interim RIA that accompanied our consultation *How we regulate specialist substance misuse services*.

Contents

1. Introduction	3
2. Background to policy changes	5
3. Summary of changes to our new approach to inspecting independent standalone substance misuse services.....	6
4. Changes to our inspection approach.....	8
5. Summary of consultation responses	13
6. CQC Assessment of impacts: costs	16
7. CQC Assessment of impacts: benefits	24
8. Next steps	32

1. Introduction

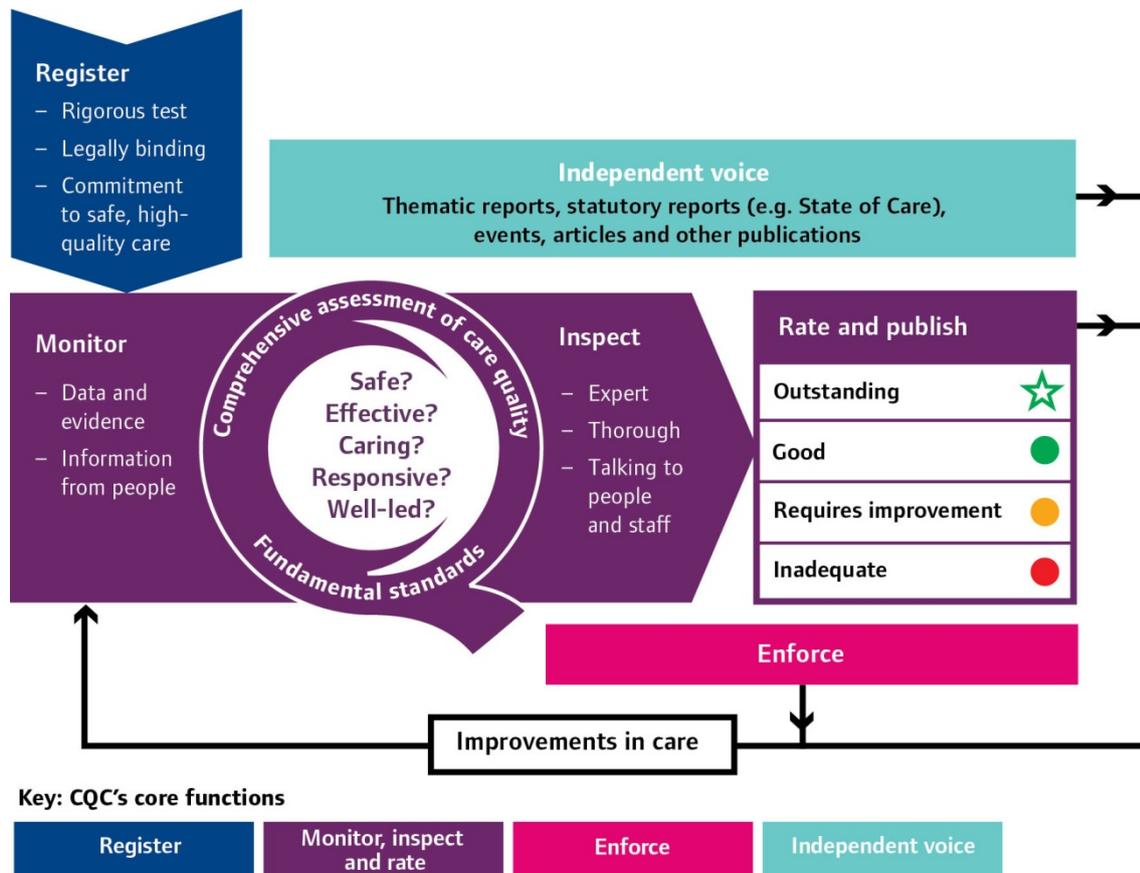
1. This document provides an assessment of the likely costs and benefits of the changes from July 2015 that affects all independent standalone substance misuse services. These are substance misuse services delivered by independent providers, which do not provide any other service types at location level.
2. From July 2015, we will monitor and inspect these services 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. This final approach follows on from commitments made in our previously published signposting document [A fresh start for inspecting and regulating substance misuse services](#), and our consultation from January to March 2015 on [How we regulate specialist substance misuse services](#).
4. We have piloted, tested and evaluated our new approach to ensure we have a robust model that is fit for purpose. During our consultation we asked for your feedback on the impacts of the changes we proposed. This feedback is reflected in [section 5](#). We are still keen to receive your feedback on the impact of new inspection model after its introduction. Our contact details can be found on the final page of this document.
5. We believe that the benefits to all stakeholders arising from our new inspection approach will be larger than its costs. While the costs of our new approach are likely to be higher in the short term, benefits should materialise over a longer period. Longer term benefits are likely to include an improvement in services and improvement in standards of care which should ultimately benefit the people who use such services.

Scope of this impact assessment

6. In this document we describe our assessment of the likely costs and benefits arising from changes to the way we regulate and inspect independent standalone specialist substance misuse services as set out in the specialist substance misuse provider handbook. We discuss the costs and benefits arising from changes to monitoring, inspections and ratings which are represented in figure 1 under the titles *Monitor*, *Inspect* and *Rate and publish*. The activities *Register* and *Enforce* are not covered in this impact assessment.

7. In the case of *Enforce* a final regulatory impact assessment for this element of our operating model was published in March 2015 just before the launch of our new Enforcement approach.
8. As for *Register*, 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 1: CQC's overall operating model



2. Background to policy changes

9. The way CQC regulates and inspects providers of health and social care is changing. 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 as of October 2014. We have also consulted on our plans for how we will regulate providers in other sectors, for example, [How we regulate independent healthcare, ambulances and dental services providers](#).
10. 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.
11. We now want to build on these successes by using and adapting this regulatory framework to apply to independent standalone substance misuse services.
12. Our consultation documents published earlier this year brought together our emerging thinking on how best we can implement these changes. Having consulted on and tested our new model, we believe that it maximises benefits to stakeholders whilst helping to reduce unnecessary burden on those providing good care.

3. Summary of changes to our new approach to inspecting independent standalone substance misuse services.

13. All independent standalone substance misuse services will start being inspected and regulated under the new regulatory model from July 2015. Our provider handbook provides detailed information to stakeholders on our new regulatory approach. A summary of the main changes is provided below.

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. Indicators are likely to be related to treatment outcomes and safety events, information from the public (such as complaints) and information about staff (for example, staff turnover and sickness absence rates).

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 (KLOEs) 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 (specialist advisors) as required.

Rating

Initially, independent standalone substance misuse services will be inspected but not rated. However, our ambition is to rate substance misuse services in the future and we are working with the Department of Health to clarify our regulatory powers to do so.

Enforcement

We will be tougher on services that consistently provide poor quality care and do not comply with conditions in their registration. More information on this policy is contained in our published enforcement policy.

4. Changes to our inspection approach

Overview of our previous substance misuse regulatory model

14. CQC regulates substance misuse services in hospital inpatient, community and residential settings. Specialist substance misuse services are not only delivered in different settings, but also by different types of providers (including independent providers, NHS mental health and acute trusts, and GPs) and providers of different sizes.
15. Under our previous regulatory model substance misuse services were inspected using a generic compliance framework based on compliance. Quality of care was assessed against 16 essential standards which set the basis for any further action required should some areas be found to be non-compliant.
16. The nature of the actual inspection depended on a variety of factors that CQC took into consideration when planning an inspection. The size of our inspection team, type of inspection and areas of the essential standards covered were all dependent on the provider and issues to be addressed.
17. Inspections of substance misuse services were not treated differently to other sectors that fell under our regulatory remit. Our inspections did not focus on specific services or provider groups unless a risk was highlighted. Inspections occurred on an annual basis unless there was a compliance action against a service. We inspected all substance misuse services that came under our regulation unless they were part of a trust in which case they would be inspected following the trust inspection methodology. This meant that we would not inspect every single location or ward but we would select a sample – again based on information held by CQC.

Policy objectives of our new regulatory approach

18. Our priority is to reassure the public, people who use services and all other stakeholders affected that care provided is safe and that organisations strive to make continual improvements to the way they provide care. Our extensive engagement with stakeholders has indicated that they are supportive of the changes. They welcome a CQC that is more risk and evidence-based, on the side of people, and strives to be expert, independent and transparent in the way it works. We aim to implement an inspection model that benefits all stakeholders while minimising any additional regulatory burden on them.

19. Inspections of independent substance misuse services will be undertaken by our Hospitals (Mental Health) directorate. The principles of the approach will be the same as those for other sectors. However, we recognise the uniqueness of the substance misuse sector and therefore the detail of how we do this will be tailored to the sector and the services within it. This will include the use of inspectors and customisation of some of our methods, including the way we gather information, some of the questions we ask, and the type of data we use to assess risk. This will help to ensure that inspection teams have expertise and better information to inspect and appropriately assess services in this complex sector.
20. We wish to provide greater assurance to the public around the quality of care provided by substance misuse services. Because of this, it is our ambition to rate substance misuse services and highlight where care is outstanding, good, requires improvement or inadequate.
21. Our ultimate objective is to provide robust and credible regulation 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 substance misuse services from July 2015

Registration

22. We will ensure 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.
23. 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 whilst also safeguarding the reputation of those organisations that provide services within hospitals and community health care settings.

Monitoring

24. We will collect and make better use of information that is key to CQC being able to target and monitor regulatory and inspection efforts effectively. We will continue to work with stakeholders to identify key indicators that define the most important areas to monitor in relation to the questions we ask about services. We want providers to be open and to share their data with us to minimise any duplication or regulatory burden associated with generating new information requests.

Inspection framework

25. Our new regulatory approach will allow us to gauge more simply and effectively the 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.

26. Our new approach to inspecting specialist substance misuse services is consistent with the underlying principles and overarching approach of our new overall regulatory model. Key features of our new approach are:

- Use of comprehensive and focused inspections.
- Use of key lines of enquiry (KLOEs) to direct the focus of an inspection.
- Making greater use of information from people who use services.

27. However, we have adapted the details of the broad approach to ensure that inspection teams can properly consider issues of specific relevance to substance misuse services. This includes the following.
28. Existing mental health KLOEs and ratings descriptors for mental health will be used, with minimal changes to reflect issues significant to substance misuse services (these KLOEs and ratings descriptors are published in the substance misuse service provider handbook that is published alongside this document).
29. Inspection teams will utilise inspectors, a relevant Expert by Experience (where possible) and a relevant specialist advisor (where necessary).
30. A specific set of Intelligent Monitoring indicators is being developed, that is customised to substance misuse services.
31. Engagement activities will be tailored to capture the views of people who use these services, of relevant staff and of stakeholder organisations.
32. Other inspection methods for information gathering will also be tailored, in particular when it comes to the types of care records that will be looked reviewed.
33. Emphasis on transitions between services will be a key element of the inspection process.
34. The information we request from providers has been tailored to substance misuse services. The specific information we will request from a provider will vary depending on the type of provider and services offered, but is likely to include information about:

- Staffing and governance
- Safety and effectiveness, including serious incidents, Deprivation of Liberty Safeguards applications and medicines management
- Complaints
- Equality and diversity
- Current actions and planned improvements

Key stakeholders and any shared contracting relationships that may exist with other providers.

Ratings

35. Initially, independent standalone substance misuse services will be inspected but not rated. However, our ambition is to rate substance misuse services in the future and we are working with the Department of Health to clarify our regulatory powers to do so. If we rate independent standalone substance misuse services in the future, we propose that ratings would be based on a four point scale:

outstanding, good, requires improvement and inadequate. This rating would be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and information from the provider and other organisations.

Enforcement

36. Finally, in April 2015 we introduced a new [enforcement](#) approach the aim of which is to deal more effectively than we did in the past with providers which consistently fail to meet quality of care standards and requirements as set out in their registration with CQC. We set out our new approach in a suite of documents published in April 2015. Alongside this document we published a final regulatory impact assessment on the expected costs and benefits impacts of the policy.

5. Summary of consultation responses

37. In this section we summarise feedback on our interim regulatory impact assessment and on our consultation Provider handbook.

Responses to our interim regulatory impact assessment

38. We published our interim regulatory impact assessment in January 2015 setting out our initial view of the costs and benefits that could arise from our new approach to inspecting and rating. We received no responses to this document. However, we discussed the questions posed in the document with members of an external advisory group. We summarise their views below.

39. Members of the group noted that the new inspection model would mean staff at services would spend more time on activities related to CQC inspections and monitoring. This is because they would subsequently spend more time on:

- Preparing for an inspection – driven by the recognition that CQC inspections will now be more rigorous.
- Filling in the Provider Information Return (PIR) prior to an inspection – some attendees noted, however, that the short term costs of completing these would be higher, but that the cost of completing them subsequently in the longer term should fall.
- Being prepared to provide more information to the CQC – for example, the expectation to identify their services' stakeholders.
- Accommodating inspections with its subsequent impacts on service delivery – larger CQC inspection teams mean more inspectors on visits which has implications for staff time.

40. Higher non-staff time costs discussed included the following:

- Services might incur costs from establishing new auditing methods.
- There may be reputational costs to services awarded lower ratings, which could be amplified by the length of time it takes CQC to re-inspect the service.
- The potential for hidden costs was identified.

41. Benefits of our new inspections approach identified by the group were the following:

- The inspection model offers the opportunity for learning between and across organisations. For example, good practice can be identified and shared in relation to key questions. The visibility of reports will facilitate this learning across organisations.
- Ratings should provide services with incentives to improve.
- Specialist advisors on inspection teams.
- Although PIRs impose costs, they may highlight things that are going wrong in services. As a result, services can try to fix these things and make improvements prior to the CQC visit.

Wider consultation responses

42. Alongside this document we have published a summary of the responses we received to our consultation on the provider handbook. Our consultation response document sets out in detail what this feedback was and what changes we have made to our approach as a result of this feedback. The table below summarises what we asked, the feedback received and what we have done in response to this feedback.

What we asked you about	Your feedback	What we have done in response
Key lines of enquiry (KLOEs)	<p>The majority of respondents were confident that the KLOEs will help inspectors to assess a specialist substance misuse service.</p> <p>We received suggestions for alterations and additions to the KLOEs and prompts.</p>	We have made a change to one of the prompts to refer more explicitly to drug and alcohol-related deaths.
Data and intelligence monitoring	<p>Most respondents were confident that the sources of information we are planning to look at will identify poor quality care and good practice.</p> <p>Most respondents said that there were other sources of information that we should be looking at and some suggested specific indicators that we should consider.</p>	We are continuing to work with Public Health England to develop our Intelligent Monitoring for specialist substance misuse services.
Evidence gathering	<p>Most respondents supported our approach to evidence gathering. Many offered suggestions for further information that we should ask providers for.</p>	We will ensure that feedback is considered as we provide detailed guidance to inspection teams.
Gathering the views of people who use services and stakeholders	<p>Most respondents agreed with our proposed methods for gathering the views of people who use substance misuse services.</p> <p>Some respondents suggested additional ways of gathering views.</p>	<p>We have added telephone interviews in our engagement methods.</p> <p>We will continue to explore the use of social media.</p>
Applying and reviewing ratings	<p>Respondents were generally supportive of our proposals for rating substance misuse</p>	We are working with the Department of Health to clarify our regulatory powers

	services.	to rate standalone substance misuse services.
Our human rights approach	Overall, respondents were positive about our equality and human rights duties impact analysis.	As planned, we will integrate our human rights approach into our inspection methodology.

6. CQC Assessment of impacts: costs

43. Changes to CQC's regulation and inspection of independent standalone substance misuse services will have cost impacts on CQC, services and some stakeholders. A key purpose of this regulatory impact assessment is to demonstrate clearly to stakeholders what the cost impacts of these regulatory changes are likely to be.
44. In introducing these changes we have sought to develop a model that minimises the impact of costs and overall regulatory burden on those affected by the changes. We expect the costs of our new regulatory model to be higher in the short term than the long term.
45. We have used the evidence gathered in the specialist substance misuse inspection pilots, as well as the views of inspectors and stakeholders to support our assessment below of the likely costs of our new approach.
46. Following the introduction of the model we will continue to test, refine and evaluate our model so that unnecessary regulatory burden to stakeholders is reduced, and that stakeholders are assured the final model is efficient, economic and effective and provides overall value-for-money for all stakeholders.
47. Initially, independent sector providers of standalone substance misuse services will be inspected but not rated. However, our ambition is to rate substance misuse services in the future and we are working with the Department of Health to clarify our regulatory powers to do so. Hence in the sections below we discuss the costs of rating services.

Specific cost impacts for services

48. It is likely that all independent standalone substance misuse services will experience higher costs as a result of our new inspection model. We expect these costs to be higher in the short run as services spend time becoming more familiar with the new regulatory model. For example, they might invest in systems for record keeping necessary to produce evidence to demonstrate compliance.
49. Costs can manifest themselves in staff time, or non-staff costs like one-off purchases or reputational impacts. It is not only the monitoring and inspection processes themselves that could result in higher costs for services, a more rigorous model might identify more necessary improvements which could imply further costs impacts to services.

50. We have not established the cost to the independent standalone substance misuse sector of the new inspection methodology. This is because we do not yet have enough evidence on which to base such estimates. To address this gap CQC is undertaking further work to improve its understanding of the provider landscape in this sector; this would encompass identifying the number of substance misuse services of different types. Furthermore CQC will also undertake annual work to establish the typical cost to services and providers of regulation.
51. Our new comprehensive inspections are likely to increase costs to services initially as we seek to assess care across all five key questions. This is because our inspections will be more comprehensive at first but subsequently might become less intensive depending on our initial assessment of the quality delivered by a service. For services which are judged to be providing poor care, we are likely to inspect them on a more frequent basis at greater depth and hence they would incur higher costs of inspection. In contrast those services that are found to be performing well are likely to see a reduction in inspection costs in the longer term.
52. All providers will be required to submit key information to CQC as part of the inspection process. Costs of this 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 on services. Costs to services of submitting information to us may fall in the future as services implement systems to capture the required data on a routine basis.
53. We have not collected detailed information on such services on the costs to them of being inspected by CQC. However, we received feedback from representatives of two substance misuse providers which were subject to new approach pilot inspections of their experience of our new approach.
54. The biggest costs the two providers identified as a result of our new approach were from spending time gathering and collating data for CQC prior to the inspection. One provider employed a project lead for six months whose salary was equivalent to £40,000 per year; this person spent half of their time preparing the provider for a CQC inspection. It is worth noting that we would not expect all services to experience similar costs for this activity. Where services are managing their own quality information well we would expect far less staff time would need to be spent preparing for an inspection. Additional costs incurred by services could be affected by a number of things including the size of the service and the existing systems services might have for gathering and reporting information.

55. We provide an indication of the components of our inspection model which are new compared to our previous model, and we use a RAG rating to show which of these activities we would expect to be more costly now to substance misuse services (table 6.1).

Table 6.1: Comparing inspection activities for services under the new and previous inspection models

Activity	New part of regulatory model?	Changes in costs to services [RAG rating]
Completing PIR	Yes	Amber
Preparing for the inspection	No	Amber
CQC interviews with staff members	No	Amber
CQC focus groups with staff members	Yes	Red
Closing the visit meeting	Yes	Amber
Writing a high level action plan	Yes	Amber

Cost impacts on CQC

56. After the introduction of this new model it will cost us more to regulate, monitor and inspect substance misuse services. We expect our costs to be higher in the short run. This is because in the short run there will be the costs of further developing and embedding the new regulatory model. The CQC might also need larger inspection team sizes initially in order to carry out comprehensive inspections of services. In the future if there are fewer concerns about care then costs could decrease as there would be less need to inspect as intensively with more focused inspections taking place.

57. Even in the longer run costs will still be higher to CQC of our new approach. This is because of the broader and deeper scope of our new inspection model:

- Our new approach requires more inspectors.
- Our new approach requires us to recruit and train inspectors, as well as integrating clinical specialists and Experts by Experience into inspection teams.
- Under our new approach we need to spend more time with stakeholders, collecting and using their information to inform our judgements.

58. We have sought to estimate the cost to CQC of inspections of independent standalone substance misuse services based on pilot inspections of a number of services in the wider substance misuse sector.

Our estimate of the cost of inspections

59. CQC has piloted our new approach to inspecting specialist substance misuse services to begin to estimate how much they could cost the CQC in terms of staff time and expenses. It is worth bearing in mind that these are the costs of inspection at the moment; the cost of inspections in the longer term might fall as staff become more used to our new inspection model. Furthermore these are the costs of comprehensive inspection. In future if we undertake more focused inspections that might be shorter inspections or require smaller inspection teams, then the costs will be different to those of comprehensive inspections.

60. Our [provider handbook for specialist substance misuse services](#) states that comprehensive inspections for such services might last between one and three days on site. The length of inspection and the size and composition of our inspection teams will vary according to the service being inspected. Generally the inspection teams will include:

- A CQC inspector with further training on specialist substance misuse services.
- A relevant Expert by Experience (people with experience of using specialist substance misuse services) where possible.
- A specialist advisor with expertise in specialist substance misuse services where necessary.

61. We have recently conducted 11 pilot inspections of specialist substance misuse services, some of which were of independent and standalone. We estimated the likely costs of these inspections and present cost ranges below (table 6.2). The independent standalone services that we inspected all received inspections that lasted one day on site. The costs in table 6.2 demonstrate the potential costs of an independent standalone substance misuse service if the inspection takes as long and involves as many staff as are detailed in the table.

Table 6.2: Approximate direct cost of pilot inspections

Length of inspection (days on site)	Size of inspection team	Approximate range of costs
1 days	3 – 5 people	£2,500 – £4,000
2 days	4 – 5 people	£6,000 – £6,500
3 – 4 days	3 – 5 people	£7,000 – £13,000

62. The cost to CQC of an inspection will depend on the size or complexity of the service being inspected; generally the larger or more complex the service the larger the inspection team required which subsequently increases our costs.

63. It is worth noting that the estimates presented in table 6.2 are not typical costs of inspecting independent standalone substance misuse services. This is for two reasons: the first is that these were pilot inspections and might not reflect the costs of inspections under our final approach; and the second reason is that we do not know the typical size of an independent standalone substance misuse service. We will be carrying out more work on the provider landscape to improve our knowledge of the type, number and size of services across the sector.

64. The cost estimates in table 6.2 were produced using data on the time spent by different members of staff on inspections. Beyond time spent on site, inspectors will spend time preparing for the inspection, attending meetings and writing a report and completing records prior to and after the site visit. We collected information on the time spent on inspections from our time recording system, complemented by information from inspection colleagues.

65. To convert these time estimate into staff costs we used CQC wage rates (table 6.3). We did this at the level of type of staff on an inspection: CQC staff, Experts by Experience and specialist advisors. We multiplied the time assumptions by assumed daily wage rates for each group and we also included the cost of expenses which include expenditure on printing, train travel and accommodation (assumed to be £179 per person per day).

Table 6.3: Daily rate assumptions

Role	Daily wage rate
CQC Head of Inspection	£333 – £400
CQC Inspector	£333
Expert by experience	£359
Specialist advisor	£324

Source: CQC Finance Team

Risks and limitations

66. The cost estimates presented in table 6.2 use a mixture of actual results and assumptions as we did not have perfect information on the time that inspection members spent on inspections.

67. We cannot say that this range of costs represents an accurate picture of the actual costs of inspections of independent standalone substance misuse services. The inspection methodology used in these pilots was not final; changes in the methodology might require a different amount of staff time which will have cost implications for CQC. Nevertheless these estimates provide a useful indication of what costs could be if most inspections have similarly sized inspection teams.

68. Finally, these inspection cost estimates are not exhaustive in the sense that they do not capture the costs of all activities related to an inspection. For example, they do not include the time spent by staff members who are not inspectors on activities relating to particular inspections; these are what we call indirect costs. For example, our cost estimates do not include administration staff time of arranging inspections and papers for inspection teams, or Deputy Chief Inspectors' time reviewing judgements and decisions following an inspection. CQC will soon be finalising methods by which we can estimate these indirect costs for each inspection.

CQC costs and provider fees

It is important to note that these direct cost estimates (table 6.2) are based on provisional data, and hence are an indication of what costs might be in a few years' time. Providers reading this document should not use this information as an indication of what we might charge in provider fees in future. There is a significant indirect cost element not fully captured here and we are currently conducting work internally to agree how we can apportion these costs to determine what the true cost to CQC is likely to be as a result of inspecting providers. We will instead consult separately on our future fees policy in due course.

Our estimate of the marginal cost of inspections using the new inspection methodology

69. Impact assessments typically include an estimate of how much the new policy costs relative to the current policy – the true cost of changing policy. For this work such an analysis would involve comparing the cost of an inspection under the new model to the cost of an inspection under the old model. The difference between these estimates would then tell us how much more the new inspection model costs us.

70. Pressure on staff time and data limitations means that we have not produced such marginal cost estimates. Instead we demonstrate in table 6.4 what aspects of the new inspection model will add to CQC's costs relative to our previous inspection model.

71. Essentially our new inspections will cost more because they require more members on inspection teams. This is because our inspections are now more comprehensive and include more elements. To use one of these as an example, if we rate substance misuse services in the future, as we intend to, the provision of ratings to services in this sector would be an additional activity for CQC compared to our previous inspection approach. Undertaking this activity will come at the cost of more staff time.

Table 6.4 Comparing inspection activities for CQC in the new and previous inspection models

Activity	Changes in costs [RAG rating]
Gathering and analysing information from the public & stakeholders	Yellow
Gathering and analysing information from the provider	Yellow
Producing data pack	Red
CQC preparation time prior to inspection, e.g. training Experts by Experience and Specialist Advisors	Red
Gathering views of staff – individually or in focus groups	Red
Closing the visit meeting	Red
Rating process	Red
Report writing	Yellow

Specific cost impacts on other stakeholders

72. Other stakeholders may also experience additional costs as a result of our new approach. This is particularly likely to be the case for the organisations from which CQC will request information as part of the inspection process.

73. Organisations that we will seek to work more closely with, for example in sharing information, following the introduction of our new inspection approach are likely to include the following:

- Local Healthwatch
- Local authorities
- Clinical Commissioning Groups
- The NHS Complaints Advocacy services and other advocacy groups
- Drug and alcohol action teams
- Other local organisations and groups that may interact with substance misuse service providers and people who use these services, such as criminal justice organisations, community mental health teams, social services, crisis services and homelessness services.

74. A key aspect of our new regulatory model across all of the sectors that we regulate is that we collect information relating to the experiences from people who use services to help inform our inspection judgements. Given the nature of independent standalone substance misuse services it is challenging to collect

information from people who use these services. As a result we expect to engage a lot with other organisations active in the sector and patient representative groups to gather information on people's experiences of services. This may increase time costs on these groups.

75. We expect these groups to include:

- Voluntary and community groups, e.g. for substance misuse, mental health, or equality groups
- NHS England
- The Parliamentary and Health Service Ombudsman and Local Government Ombudsman and Local Government Ombudsman
- Professional regulators, such as the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council
- The Royal Colleges
- Public Health England.

7. CQC Assessment of impacts: benefits

76. While changes to the way we regulate and inspect independent standalone substance misuse services are likely to have cost implications for a number of stakeholders, we believe that benefits are likely to emerge as a direct result of these changes.
77. Maximising benefits to stakeholders has been a central principle in developing our new approach to inspecting these services. CQC is keen to introduce a regulatory model that is efficient and effective that provides value-for-money. We plan to continue to evaluate and refine our regulatory model to ensure that the model continues to maximise benefits to stakeholders.
78. While the costs of our new approach are likely to be higher in the short term, benefits should materialise over a longer period. Longer term benefits should include improvements in services and the standards of care that they deliver. This should ultimately benefit people who use these services. Providers we spoke to about our new approach recognised that the short term higher costs of the new inspection model should be followed by improved services in the long term.
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 incremental increases in benefits that are only likely to be experienced fully over a longer time period, which we anticipate, could be several years. For example, an immediate benefit to people who use services could stem from having more information about the quality of care provided via publication of ratings for relevant services. A longer term benefit would be our new approach incentivising services to make continual improvements in the way they provide care as a direct result of these ratings. This would then benefit people who use services in terms of better care.
80. Below we confirm what we believe are the main benefits of the changes we are making to the regulation and inspection of independent standalone substance misuse services. 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.
81. Initially, independent standalone substance misuse services will be inspected but not rated. However, our ambition is to rate independent standalone substance misuse services in the future and we are working with the Department of Health to clarify our regulatory powers to do so. Hence in the sections below we discuss the benefits of rating services in the sector.

Specific benefits to the public and people who use services

82. People who use independent standalone substance misuse services should benefit the most from our new inspection model. We set out in more detail below what we believe the main benefits to them will be.

Giving a voice to people who use services and the public

83. The new inspection model provides formal and informal opportunities for the public and people who use services to provide feedback to CQC. Given the nature of substance misuse services it is challenging to collect information from people who use services. As a result we expect to engage with other organisations active in the sector and patient representative groups to gather information on people's experiences of services. This feedback will be used to plan inspections and will feed into final judgements about quality of care.

Confidence for people who use services

84. Our more comprehensive inspections mean that CQC will be able to make better informed judgements about the quality of care delivered by a service. 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 quality information should be made available to the public on the quality of services provided.

85. 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 services and in the information we provide.

86. Furthermore, CQC should be able to provide reassurance that poorly performing services will be more easily identified and action will be taken to improve them or to close them where they are causing harm.

Clearer information for people who use services to make choices

87. A long term benefit of our new inspection model will be to raise awareness of what good independent standalone substance misuse services look like. People will be more familiar with the standards of care they should expect, and services will need to improve to meet these expectations.

88. If we do provide ratings at various levels within a service 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 care provided. A

comprehensive and tailored assessment will more clearly define poor practice and good practice. In the event that people who use services have choice over which service to use, they can use the more reliable and comprehensive information to make better informed choices.

Encouraging services to improve

89. If improvements are made as a result of our new inspection model, which our interviews with providers following pilot inspections indicate they should be, then this benefit will be felt by people who use such services.

90. We believe that our new model has two key ways in which it will encourage improvement. First services will seek to meet the standards that are required of them – that is they will aim to meet our regulations. Second, where ratings apply, we believe that services will seek to improve to achieve the top ratings, thereby delivering top quality care for people who use services.

Specific benefits to independent substance misuse services

91. Services should benefit directly from the changes to how we regulate, inspect and rate independent standalone substance misuse services. The key questions for inspection will now be consistent across all sectors which should create a “level playing field” approach that treats all services in an even-handed and fair way.

92. We also envisage that there will be reputational benefits to services of being in a sector which is transparently and robustly regulated. Below we set out what we think are the benefits to services of our new approach.

More comprehensive and credible CQC assessment of service performance

93. Under the new inspection model we are using more information and more in-depth information to support our judgements. This will ensure that our judgements about service performance are evidence based and more credible.

94. Inspections will also be supported by experts in substance misuse services; they are the specialist advisors on inspection teams. Having specialist inspection teams means that our judgements should be more informed and more sound. Representatives from providers we spoke to agreed that including experts on inspection teams is definitely a benefit of our new inspection model.

95. Providers also said that using Experts by Experience to interview people who use services is a strong aspect of the new inspection approach. Views from people with experience of substance misuse services should give CQC a better overall

picture of the service and how it is delivering to meet the needs of the people it serves.

Giving healthcare staff a voice

96. The new inspection model includes opportunities for service staff to give us feedback on the services they work for. We want staff to act on and speak out about poor quality care. CQC intends to protect those who provide feedback to us.

Acknowledgement of and sharing good practices

97. The advantage of the new inspection model is that CQC will recognise and publicly acknowledge services that deliver good care. It is CQC's intention that through these mechanisms good practice can be recognised and could spread throughout the sector.

98. The inspection model facilitates the opportunity for learning between and across organisations. This was recognised by the services we spoke to. They thought that our new model would identify good practice and then it could be shared in relation to the key questions. The visibility of reports will enable this learning across organisations.

99. This could also happen through Specialist Advisors on inspection teams. They could take good practices identified on inspection back to the service or provider at which they work and apply them there.

Identifying improvements services can make

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

101. The new inspection model might encourage services to give a higher priority to the development of information that assesses their performance. Providers might improve systems and processes to check that quality is consistent across their services. We spoke to representatives of providers who recognised that although PIRs impose costs, they may highlight where things are going wrong. This will help services identify what improvements should be made – and this would even happen without CQC inspecting.

102. Where CQC finds poor practices and where improvements are not made by services, they may become subject to the success regime which might ultimately end up with them being closed. The costs and benefits associated

with CQC's new Enforcement regime were discussed in the Final Enforcement Regulatory Impact Assessment which was published in March 2015.

Shifting focus to quality of care

103. The new inspection model is designed to focus attention on the quality of services. If we introduce ratings we hope that services will strive to achieve a rating of outstanding. There may be two reasons for services to do so. The first is that better rated services may be more appealing to people who use services who are free to choose where they are treated. Second, services 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.
104. If we issue ratings following inspections these should help services gauge their performance and benchmark themselves against others. In that sense the model will always provide the opportunity for services to self-improve continually.
105. Providers that we interviewed believed that the new inspection model would galvanise services to make changes to improve. The inspections were reported to be useful to improve service delivery, staff skills and staff morale. Our new inspection method was acknowledged as useful in facilitating an in-depth review of services, standardisation of procedures and identifying improvements that needed to be made.
106. Other channels through which we hope the focus will shift to quality of care are as follows:
- Leaders of these organisations should become more focused on the quality of care and recognise their personal role in achieving high quality care.
 - The new model should promote a dialogue between services and commissioners that focuses on outcomes for people who use services rather than activity and cost only.
 - Staff working for services believe and participate in building high quality care and professional practice
 - Services not providing good quality care are held to account by third parties using our information.
 - Experts by Experience on inspection promote people who use services' view of services and identify areas where improvements that could be made to the benefit of the experience of people who use services.

Potential commercial benefits

107. As independent standalone substance misuse services operate in a commercial environment, ratings could create direct incentives for services to improve relative to other similar services. Ratings could be used as a vehicle by which services can market and promote good or outstanding services to those looking to choose a service.
108. We might also expect that services rated Good or Outstanding would experience lower costs as a result of needing to be re-inspected less frequently.

Greater certainty for staff

109. The tendering process by commissioners for independent standalone substance misuse services means that their staff do not know whether they will still deliver services after the process. This uncertainty could be lessened for some staff if commissioners use CQC ratings to guide commissioning decisions. Staff working for services with Good or Outstanding ratings should face reduced uncertainty as they should be more confident that the services they work for would retain contracts with commissioners.
110. The transparent inspection framework we use to inspect such services should also provide staff with a better knowledge of what is expected of them. That should help them improve their skills, and motivate them to make changes since they are more accountable in our new model. Over the long term this should lead to an improvement in the quality of the staff working in independent services.

Specific benefits to CQC

111. There are a number of ways in which we anticipate CQC will benefit from the new inspection model. These benefits are outlined below.
112. We will have a more robust and specialised 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.
113. Our new inspection model will now also be more joined up with our partner organisations such as Public Health England. This will ensure that we are drawing on expertise and advice from organisations that work closely with these services and people using them. Inspectors will have access to more information from external sources to direct their investigations and to support

their judgements. This information will also help us understand the risks in the service better.

114. As the benefits from the new regulatory model are experienced by people who use services and the wider sector, CQC will demonstrate its value for money to stakeholders.

Specific benefits to other stakeholders

115. The intended impact to the wider health and care system is that health and care professionals will be confident in the assurance we provide about local services. Strategic partners will be able to rely on our findings and will be confident in our judgements.

116. As part of the new inspection model we plan to receive and to share information with a wide variety of bodies in the sector. The additional information we share with these bodies will provide useful in the work they deliver.

117. Further intended benefits to specific stakeholders are detailed below.

Commissioners

118. The key benefit to commissioners of CQC's new inspection model should be that more credible CQC independent assessments will provide commissioners with a clearer view of the quality of services. This should inform their commissioning practices and should enable them to make better decisions on behalf of people who use services. The evidence we present should facilitate and promote a dialogue between commissioners and services that focuses on outcomes for people who using services rather than only activity and cost.
119. If we provide ratings to independent services in the sector as we intend to, we expect that commissioners should commission from services rated as Good or Outstanding. Services which demonstrably deliver poorer care and have ratings reflecting that should be at a significant disadvantage in the tendering process.
120. Commissioners of services should benefit directly from better information about the quality of services, potentially a reduction in service monitoring, and sharing of information about services with us. Organisational benefits from increased clarity around roles and responsibilities should also lead to reductions in duplicated effort and associated costs.
121. Finally the new inspection methodology provides a single framework for commissioners to understand the performance of substance misuse service and

ownership. It should promote a “level playing field” approach that treats services in an even-handed and fair way.

8. Next steps

122. CQC will continue to assess the performance of its new regulatory model for independent standalone specialist substance misuse services. This is part of an effort to ensure the benefits to the sector are maximised and the costs minimised from our new approach.

123. CQC welcomes feedback on the information presented in this impact assessment. To provide the CQC Economics Team with your feedback please email:

economics@cqc.org

124. Alternatively you can post your feedback to the team at the following address:

CQC Regulatory Economics Team
14th floor
Finsbury Tower
103 – 105 Bunhill Row
London
EC1Y 8TG

125. We are committed to ensuring that CQC has the impact it intends. In order to monitor and assess our on-going impact we have the following work streams planned:

- We will continue to monitor our new inspection model through activities like our post-inspection survey of providers, post-registration survey of providers and our inspection team survey.
- We commissioned an external economic consultancy to establish a methodology for CQC to assess its costs and benefits on an ongoing basis. This work has provided a framework by which we can understand the impact of CQC on the sectors it regulates. This work is being taken forward and will contribute to an annual report by CQC on its impact and value for money.