Changes to the way we regulate and inspect adult social care

Final regulatory impact assessment

This final regulatory impact assessment (RIA) is published alongside our provider handbooks covering:

1. Residential services
2. Community-based services
3. Hospices services (due to be published by 31 October 2014)

Stakeholders may want to refer to the handbooks before reading this impact assessment as they provide information on our final methodology for inspecting adult social care services.

This document provides an analysis of the likely cost and benefit impacts of the changes to the way we regulate, inspect and rate these services. It builds on the interim RIA published in April 2014 and the analysis conducted in the initial RIA that accompanied our previous consultation *A new start: changes to the way we monitor, inspect and regulate services* in June 2013.

Contents

1. Introduction

1. This document provides a final assessment of the likely costs and benefits of the planned changes from October 2014 and builds on our earlier interim regulatory impact assessment that was published alongside the draft handbooks in April 2014.

2. As of 1 October 2014 adult social care (ASC) services are being monitored, inspected, and rated under a new methodology. The Care Quality Commission (CQC) has revised its inspection and regulation methods in response to feedback from within CQC, from ASC services and from other stakeholders. To ensure that we developed an improved regulatory model we worked in collaboration with a diverse range of stakeholders across the health and social care sectors. These stakeholders included people who use services, providers of ASC providers, families and carers, national organisations, trade bodies and government organisations.

3. Our early proposals for how we planned to monitor, inspect, and rate these services were contained in our draft provider handbooks that we consulted on and published in April 2014. We committed to test our methodology with a diverse range of services across these sectors, and to refine our methodology following formal evaluation and learning gathered from two rounds of testing. Through these activities we sought to ensure that, within our chosen methodology, benefits to all stakeholders are maximised while regulatory burden on services and other key stakeholders are kept to a minimum.

4. The evaluation of our test inspections has also provided us with information to support our assessment of the likely cost and benefit impacts of the planned changes. These impacts are detailed in sections 7 and 8 of this document.

2. Background to policy changes

5. In the months leading up to the publication of our three-year strategy, intense internal and external scrutiny and feedback from consultation with external stakeholders concluded that our previous regulatory model needed to be changed fundamentally. This was compounded further by the learning from the very poor care at Mid-Staffordshire NHS Foundation Trust and the abuse of people at Winterbourne View Hospital in August 2012. We completed an internal investigation report into Orchid View, a care home that closed in October 2011. A coroner's report in October 2013 ruled that neglect had contributed to five residents' deaths with other residents suffering from being given 'sub-optimal care'. The shortcomings of our previous regulatory approach that were identified helped inform the design of our new approach.

6. Detecting and deterring poor quality care is a fundamental part of our statutory remit. For us to achieve this we needed to make some big changes to the way we regulate and inspect providers of health and social care services. The changes we are making should reduce the likelihood of the provision of poor care, and provide strong incentives for services to deliver good quality care. CQC will also ensure that there are proportionate sanctions in place for services that fail to deliver acceptable levels of care.

7. Our transformation programme outlined in our three-year strategy set us on course to make these changes. We appointed a Chief Inspector of Adult Social Care to oversee these changes. It was our specific intention that our new regulatory model would both incentivise direct improvements in the quality of care while also identifying services most likely to provide sub-standard care.

8. The Care Act 2014 will be fundamental to CQC in achieving such aims. We can now rate providers. We expect all services to aim for at least a good rating. We want to recognise outstanding care while also ensuring we have clear policies on how we tackle poorly performing services. The latter will be done through the use of our enforcement powers and where necessary our special measures regime that we are developing for adult social care.

9. Our consultation documents, most notably the draft provider handbooks, brought together all of our emerging thinking on how we could best develop and implement these changes to achieve a better model of regulation and inspection. In addition to the provider handbooks we published an interim regulatory impact assessment that set out at a high-level the likely impact of the changes we are now making on stakeholders, and we committed to providing a fuller assessment of these impacts. This fuller assessment is included in this document in sections 7 and 8.

3. Summary of changes from 1 October 2014

10. Our provider handbooks provide detailed information to stakeholders on our new regulatory approach. A summary of these changes is provided below.

All adult social care services will be regulated under the new regulatory model from 1 October 2014.

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 the ASC community to define key indicators for monitoring the quality of adult social care 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 a mixture of unannounced and short notice announced inspections. Through our inspections we provide ratings to providers, we review existing ratings or we follow up on concerns or risks. All our inspectors will be expert and dedicated ASC inspectors. The size of inspection teams will depend on the size and complexity of the service to be inspected, but we will make full use of Experts by Experience and specialists as required.

Rating
We aim to rate all adult social care services by April 2016. Ratings will be based on a four point scale: outstanding, good, requires improvement, inadequate. Ratings will be awarded for each of the five key questions and for the location as a whole, based on the characteristics for different levels of quality and rating principles. Frequency of comprehensive inspections will generally be directly linked to the overall rating awarded to a service.

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 and appeals.

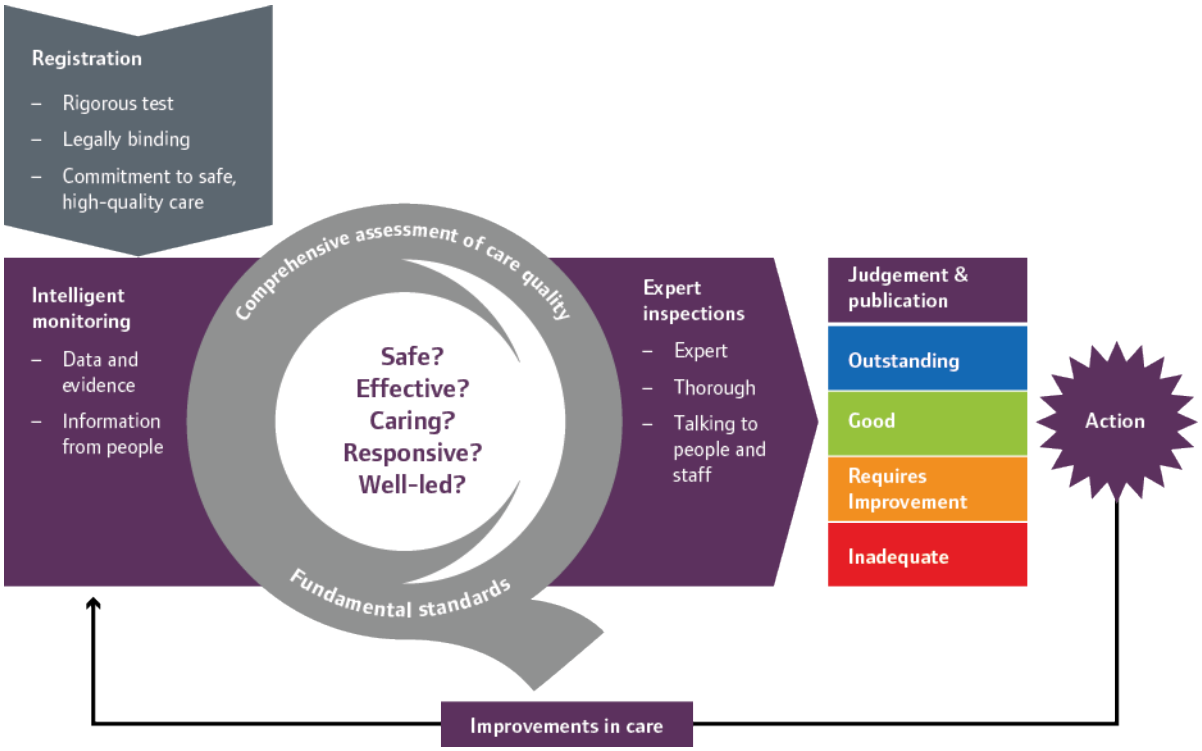
4. Scope of this final regulatory impact assessment

11. In this document we describe our final assessment of the likely costs and benefits arising from changes to the way we regulate, inspect and rate adult social care (ASC) services as set out in the 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.

12. 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.

13. 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



5. CQC assessment of impacts

a. Overview of our previous regulatory model

14. CQC regulates and inspects more than 27,000 locations that provide adult social care in England. These inspections cover residential care homes, community based adult social care services (including for example domiciliary care agencies and shared lives schemes), and hospice services that are registered with CQC.

15. CQC previously inspected all services under a generic compliance framework that tested whether services were complying with 'essential standards'. Regulatory action followed where an inspector judged that at least one regulation was not being complied with using the CQC's enforcement policy.

16. Different types of inspection were undertaken for different purposes. All services received regular, 'scheduled' inspections to assess compliance with the essential standards. If CQC received specific concerns about particular aspects of a service from sources such as complaints, partner agencies, or our own internal monitoring processes, then CQC undertook a 'responsive' inspection of compliance with the regulations that looked at that particular problem only. CQC also carried out 'themed' inspections of services in relation to particular topics, for example dignity and nutrition.

i. Residential care homes

17. All residential care homes received an inspection at least once a year – these were usually unannounced. The majority of inspections were scheduled. The inspection usually only looked at a small number of areas. The size of the inspection team depended on the size of the care home. Most care home inspections only had one inspector, but more inspectors were on inspections of larger or more complex care homes. Inspectors could also request an Expert by Experience and / or a specialist Professional adviser to be part of an inspection team. Inspectors could use the 'Short Observational Framework for Inspection 2' (SOFI2) when necessary. This observation tool is used when people who use services have significant cognitive and communication difficulties, such as dementia or profound learning disabilities and are unable to communicate their views of a service verbally.

18. Themed inspections normally made use of a number of different inspection methods, and could include a specialist professional adviser or Expert by Experience. For example, the inspection of dignity and nutrition in care homes

were conducted at any time during the day or night and sometimes took place at weekends.

ii. Community care services

19. Similarly all community care services expected to receive an inspection at least once a year. Most inspections took place at short notice (48 hours). The inspections included a visit to the provider's office location, though we also used questionnaires, visits or telephone conversations with people who used the service and sometimes observed care being provided in people's own homes. Community care inspections made use of questionnaires for both people using the service and their friends and family, to ensure we got a broad range of views on the service.

iii. Hospices

20. Inspection of hospice services normally followed the approach used for residential care or domiciliary care depending upon whether the care was provided in a hospice where people stay or in their own home. They included the mixture of scheduled, responsive and themed inspections described above, and the same frequency and duration of inspections. Our Inspectors planned the size and make-up of the inspection teams based on the characteristics of the service that was to be inspected.

b. Policy objectives across all adult social care services

21. While the regulation and inspection of some types of adult social care (ASC) services generally worked well, some areas needed significant improvement.

22. Our aim now is to have a regulatory model that benefits people who use services and their families the most. It is our priority to assure the public, people who use services and all other interested stakeholders that care provided in ASC services is of the right quality and that services strive to make continual improvements.

23. We want to maximise benefits to stakeholders while minimising any regulatory burden on services within our chosen regulatory model. 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 services providing good quality care will likely experience decreases in the cost of regulation relating to inspections, while services performing poorly will have more frequent contact with CQC to ensure

they provide better quality care. Services which are rated good and outstanding are likely to attract more business as people will want to use their services.

24. Our inspectors will specialise in the sectors they regulate. They will no longer be expected to inspect a GP practice one day and a care home the next. We aim to provide better information to the public about the quality of care provided by different adult social care services. We will award all services with ratings for the quality of care provided. This will help to provide people who use services, carers and their families, local authorities and other commissioners with better information to help them choose the right service. Over time this should give services incentives to improve based on measurements of how they are performing in relation to other similar services. Finally, we expect to make much better use of information about the quality and safety of services to inform our activity and to drive improvement in services.

c. Policy changes for regulating adult social care services

25. Under the new arrangements, registration will be a more robust process. All registration applicants (both new applicants and those varying their registration) will be subject to a more rigorous assessment. Registration will assess whether 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. This will apply whether the provider of the service is an individual, organisation or partnership. The assessment framework will allow registration inspectors to gather and consider comprehensive information about proposed applicants and services to make judgments about whether applicants are likely to meet these requirements. They will do this not only for initial registration applications but also for applications to vary a registration.

26. 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 potentially good care services, but also ensures that those most likely to provide poor quality services are discouraged from doing so. This will help to protect the safety of people who use services while also safeguarding the reputation of those organisations that provide adult social care services. As the registration policy is currently being developed we are unable to assess its costs and benefits in this impact assessment.

27. We will gather and make better use of key information about adult social care services, both continuously and in the period leading up to inspections. We have worked in partnership with people who use services, providers, commissioners and other stakeholders to identify the right information sources and the correct

indicators to support our regulatory judgements. We want services to be open and to share information with us. We will use this new approach, an 'Intelligent Monitoring' of services, to target and focus regulatory effort on those services most likely to be providing poor quality care.

28. We will involve Experts by Experience in as many inspections as possible. Experts by Experience will provide information to inform judgements about the quality of the service.

29. We will overhaul and refine the inspection framework to be able to gauge the quality and safety of services more accurately and more effectively. To do this we will ask the following five key questions, which will also inform our whole approach to regulation:

Table 5.1: CQC's framework for inspecting ASC services

CQC's five key questions	
Is this service **safe**?	By safe, we mean that people are protected from abuse and avoidable harm. Services will need to ensure that there is an appropriate balance struck between people's right to make choices and to take risks, and to guard their safety. A key aspect of safety would include safeguarding arrangements that a provider had implemented.
Is this service **effective**?	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible. Providers will need to demonstrate how they are delivering services in ways that help people live their lives independently and in ways they choose – a key aspect of this is personalisation. Personalised care will look different for a 28-year old disabled person and a 90-year old person with dementia.
Is this service **caring**?	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect. Such measures could include the importance of staff being kind, empowering people and treating people with dignity, respect and compassion, and how carers and family members are treated.

Is this service **responsive**?	By responsive, we mean that services are organised so that they meet people's needs. Services will need to demonstrate how they respond to people's preferences, aspirations and choices. We will want to know if the care is personalised and puts the person at the centre of decisions relating to their care, e.g. in identifying their needs, choices and supporting them in the way they want to live their life. The ability to respond to the needs of people living with more than one condition with complex care arrangements will be a key measure in our inspections.
Is this service **well-led**?	By well-led we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture. This will depend on the size and nature of the service, but overall we know leadership is important whatever the size of the service. We will also want to focus on the registered manager, as we know that the way they carry out their role has an important impact on setting the right culture, approach and leading good practice by example.

30. We will still conduct an inspection in response to a build-up of concerns, or looking into a theme across services. Similarly our inspections will continue to use a mixture of unannounced and short-timescale announced visits, and will be conducted at any time of the day or night, including weekends. The size and make-up of inspection teams will reflect the size and complexity of the service being inspected.

31. After the Care Act was passed into law in 2014, CQC received formal powers to grant a rating based on the level of care provided. We will rate all adult social care services on a four point scale as set out in table 5.2.

32. We aim to rate all adult social care services at least once under the new inspection method by April 2016. Our new approach is risk based and inspections will occur at least every two years subject to available resources. We have decided to inspect with this frequency because of the vulnerability of some people's circumstances, the lack of any other oversight in some instances (for example, people who are self-funding their care) and the lack of robust data

about the sector. Our decision when to inspect will be risk based but frequencies will normally be determined by a provider's last rating (see table 5.2).

Table 5.2: CQC's summary of ratings definitions for ASC services

CQC's rating scale	
Outstanding	Innovative, creative, constantly striving to improve, distinctive, exceptional. Outstanding rated services can expect to be inspected within 2 years of the last comprehensive inspection (subject to resources).
Good	Consistent level of service that people have a right to receive, robust arrangements when things go wrong, open and transparent. Good rated services can expect to be inspected within 18 months of the last comprehensive inspection (subject to resources).
Requires Improvement	May have elements of good practice but inconsistent, potential or actual risk, inconsistent response when things go wrong. Requires improvement rated services can expect to be inspected within 12 months on the last inspections (subject to resources).
Inadequate	Significant harm has or is likely to occur, shortfalls in practice, ineffective or no action taken to put things right or improve. Inadequate rated services can expect to be inspected within 6 months of the last inspection (subject to resources).

33. We have introduced the Provider Information Return (PIR) for all adult social care services to enable us to collect information on a continuous basis.

34. We will be tougher on services which consistently fail to meet the fundamental standards set out in the regulations and any other relevant requirements of the law, such as conditions on their registration with CQC. This could include fining services which are without a registered manager for long periods of time. We are

currently consulting on our approach to Enforcement and will publish a new policy in 2015.

i. Specific policy changes for residential care services

35. Feedback from the residential care sector indicated that the new methodology works reasonably well. We have worked with residential care sector to refine our definitions and criteria in relation to the five key questions and ratings. We have also worked with the sector to agree the information we need to collect both continuously and before inspections so we can monitor and target our regulatory efforts on services most likely to provide poor quality care.

ii. Specific policy changes for community care services

36. The regulation and inspection of community social care services is the area we believe needs the biggest changes and improvements. In addition to the main proposals affecting all adult social care services detailed above, we plan to assess the quality of community-based services more effectively by significantly increasing our use of home visits, interviews, telephone calls and questionnaires. We will send questionnaires to people using services, their families, carers and friends, to staff who work for providers and to health and social care professionals. We want to know what those closest to the services think of them.

37. We have worked with the community based social care sector to agree the information that CQC will require continuously and the information that will be required before inspections. We have also worked with them to refine our key lines of enquiry that sit under the five key questions and the characteristics of ratings and how they apply to community services. We have also made further changes to the way we regulate and inspect community based social care services based on feedback from the community, in particular in relation to ‘supported living’ schemes, shared lives and extra care housing.

iii. Specific policy themes for hospice services

38. The new regulation and inspection methods that will be applied across all adult social care services will apply equally to hospice services. For hospices our inspections will also make use of questionnaire responses from those who receive hospice care in their own homes. Our inspection teams will include relevant health expertise and other professional advisers as required, such as pharmacy inspectors or end of life care specialists. We also use Experts by Experience in our teams.

6. Consultation responses to the interim regulatory impact assessment and wider consultation responses

a. Responses to our interim regulatory impact assessment

39. In April 2014 we published our interim regulatory impact assessment (RIA) setting out our initial assessments of the costs and benefits that could arise from our new inspection model. We received a small number of responses to this document from adult social care providers and other stakeholders.

40. In response to our interim RIA a large provider said that they hope that:

> *…CQC's approach to the regulation, rating and inspection of domiciliary care services follows through on the core themes set out in the 'Changes to the way we regulate and inspect Adult Social Care: Interim regulatory impact assessment' document*.

41. A provider welcomed the additional resources being made available for more thorough inspections, noting it as a 'very positive development' for CQC. In particular they praised the increased use of questionnaires and interviews, which should support ratings.

42. In terms of the burden imposed by the new inspection model, a commissioner suggested that the new fundamental standards that will come into force from April 2015 seem to be no more onerous than the essential standards that they are replacing.

43. That we had not tried to quantify the costs and benefits of the new inspection model given the absence of reliable evidence in the interim RIA was considered a strength by one provider respondent. However, in this RIA we have sought to quantify some costs of the new inspection model as we have received more data and information from pilot inspections to provide an evidence base for these estimates.

44. Specifically in this document we have:

- Quantified the average cost to CQC of inspections in the steady state.
- Quantified the cost of CQC staff on an average inspection under our previous inspection model.
- Estimated the cost to some ASC services of being inspected under our new model.

- Provided more information of the benefits arising from our new model to people who use services, adult social care services, CQC and other stakeholders, where possible supported by evidence.

b. Wider consultation responses

45. Alongside this regulatory impact assessment we published a document that summarises the responses we received to the consultation on our provider handbooks. This document also sets out in detail what changes we have made to our approach as a result of this feedback. Below we summarise pertinent findings from this document.

What we asked you about	Your feedback
Gathering and using information from people who use services and the public	• There were mixed views about whether Intelligent Monitoring will help to identify both good and poor practice in adult social care services. • The vast majority of those responding online were confident that the local relationships and ways of gathering information set out in the handbooks will be effective in supporting CQC's approach. • Many providers wanted CQC to work in a more collaborative way with them and to develop 'two way' communication.
Key lines of enquiry (KLOEs)	• Most people at our events and respondents to our online form, including people who use services, were confident that the KLOEs and prompts would help inspectors to judge services. However, there was slightly less confidence in the hospice sector. • Providers and our staff supported the focus on the views of people who use services and carers in the KLOEs. • However, some of our staff and providers would like the KLOEs and prompts to be less vague.
Characteristics of ratings	• There was strong support for CQC descriptions of outstanding, good, requires improvement and inadequate care in adult social care services.

Applying and reviewing ratings	• Most of those responding online and in written responses, including local and national bodies, strongly agreed with the ratings principles, limiters and guiding indicators. • Most responding online, including people who use services, also agreed that the test of severe harm should limit a rating.
Compliance with the Mental Capacity Act	• Respondents said that the Mental Capacity Act and Deprivation of Liberty Safeguards were not well understood by providers and CQC staff alike, and further guidance and training is required. • Some suggested that Mental Capacity Act should link with some of the prompts for the key lines of enquiry for 'Effective', and that human rights legislation and Deprivation of Liberty Safeguards need to be more strongly expressed in the KLOEs generally.
Covert surveillance and mystery shoppers	• There were hugely mixed views from those responding online about whether CQC should carry out surveillance activity. Generally, however, people agreed this was an area of concern that required further thought. At the round table people also expressed a wide range of opinions. It was clear there was no consensus on this issue. • A number of organisations did not believe that covert surveillance is a job for CQC but for the police and safeguarding committees.
Our Human Rights approach	• The majority of online respondents (92 per cent), as well as responses from written submissions and the broader consultation, agreed that our strategy is the right approach on human rights. However, there were still concerns that it was being viewed as an 'optional extra' and that it should also include factors such as socioeconomic deprivation.
Equality and human rights impact analysis (hospitals, community, GPs and adult social care)	• In general, respondents were supportive of our approach to equality and human rights impact analysis. Where concerns were raised, these were around: making sure the approach was strong enough to deal with denial by providers; the amount of work for some providers; and the issue of training for staff.

46. The following are the key changes we are making to our original proposals, in response to what we heard during the consultation and what we learned during the testing of our new approach.

i. Provider Information Return (PIR)

47. In the future when we have on line services we plan to have a provider return that is continuously open. In the meantime we will contact providers in batches to ask them to complete the PIR.

ii. Focused inspections

48. Along with our colleagues in other sectors we have clarified the circumstances under which a focused inspection may take place. We have also provided more detail about the circumstances in which a focused inspection might influence a change to ratings.

iii. Assessment framework key lines of enquiry, characteristics of ratings, ratings)

49. We have reduced the number of key lines of enquiry (KLOEs) from 23 to 21, and increased the number of mandatory KLOES from 13 to 16, ensuring a wider coverage and more consistent base for comprehensive inspections and ratings judgements.

50. We have made our descriptions of each rating level clearer so that they better reflect the differences between the four levels.

51. Along with our colleagues in other sectors we have:
    - Rationalised some of the KLOEs and prompts to reduce areas of duplication that were in the framework we consulted on. Our test inspections also helped us to identify where some of elements of the assessment framework needed to be set out more clearly. For example, we have made the distinction between what is covered in our assessment of ‘effective’ and ‘responsive’ much clearer.
    - We have introduced new KLOEs to reflect specific areas that were lacking in the right level of focus:
        - For example, the Mental Capacity Act, Deprivation of Liberty Safeguarding (DoLS) and best interests decision making were previously referred to under the

key questions of ‘safe’ and ‘effective’. We have now introduced a KLOE on consent, under effective, which brings together all these issues.

- We have reviewed the language of the KLOEs and prompts to make sure that we are using terms that reflect current practice and that we do not use jargon.
- We have reviewed the format of the prompts and changed them from being short bullet points to questions. This is so that they provide more detail and clarity about what topics are covered under each KLOE.
- We have made sure that the characteristics of outstanding truly demonstrate outstanding care so that our approach to ratings provides the necessary challenge and stretch.
- We will publish guidance for the public and providers on the use of covert and overt surveillance and the issues to take account of in considering its use.

iv. Training our staff

52. CQC is committed to the learning and development of our staff. We are developing programmes of learning that will ensure that, as an employer, we have competent and confident staff working for us. Learning activities are developed at three levels: awareness, core skills and specialist. In this way we ensure our staff have the right training at the right level at the right time. Our flexible and blended approach to learning also encourages staff to learn at the right time for them.

53. In response to the consultation and the evaluation of our pilots we have developed a training programme that all inspectors will attend before they begin inspections. The programme focuses on the assessment framework and provides opportunities for practice in a safe learning environment so that inspectors will begin their inspections with understanding and confidence. This should ensure a consistent approach.

v. Ratings principles

54. The majority of people responding to our consultation thought that for a service to be outstanding there should be at least three ratings of outstanding at key question level. However, we have decided not to do this. This is because our pilot inspections showed that if we set the overall rating at this level there would be fewer than 1% of outstanding services, whereas we want to create a level that providers can truly strive to achieve.

7. Costs

55. Changes to CQC's regulation and inspection of adult social care (ASC) services will have cost impacts on the Care Quality Commission (CQC), ASC services and other stakeholders. In this section we discuss what these costs might be. We seek to predict the costs to these parties once the inspection model is well established, i.e. the costs in steady state. In this report we do not predict the annual total cost of the new inspection model. Instead we present the average of costs of an individual inspection since we are more confident in our estimates of these.

56. We are predominantly interested in the cost of inspection in the steady state. The steady state describes a point in the future when the new inspection policy is well established. At this point all costs associated with it are recurring (i.e. are predictable) and the full benefits from the policy have been realised. The costs of initial inspections under the new model are likely to be higher as one-off (e.g. developmental) costs might be experienced following the introduction of the new model. Such costs, likely to be experienced by CQC and services, are not a good indicator of the long term future costs of regulating and inspecting the sector. For example, the first time services complete a Provider Information Return (PIR) it will take them a long time to gather relevant information and fill in the form. This is a one-off cost. However, each subsequent time CQC asks providers to submit their PIR services will only have to update the information in the form that they submitted previously.

57. While we recognise the costs of the new model to CQC, providers and stakeholders are now higher we have sought to keep them to a minimum on providers and stakeholders within the chosen approach. To date this has been achieved through consultation and testing our new inspections to improve our model. We shall continue to test, refine and evaluate our regulatory and inspection model so that any unnecessary cost impacts to stakeholders are reduced. We want to ensure that the final inspection model is efficient, economic and effective and provides overall value-for-money for all stakeholders.

58. In this section, first we use data from ASC services to estimate the cost of an average inspection to them. Second we set out how much we think an average ASC service inspection costs CQC. Finally we discuss the costs of the new model to other stakeholders.

a. Common cost impacts for adult social care services

59. We expect the burden of the new inspection model to be higher now for adult social care services than under the previous model. Our new, more comprehensive inspections will feature the following which impose higher costs on services:
    - Larger inspection teams will be sent to many services (often one inspector and an Expert by Experience and larger teams in bigger services). More of their staff members will be interviewed and the services will need to accommodate the larger inspection teams on site.
    - CQC will request more data from services, particularly in advance of an inspection.
    - If the new inspection model works as intended there are also likely to be more actions for some services following the conclusion of inspections.

60. Ultimately the implication of a more comprehensive inspection model is that services will spend more staff time on activities relating to inspection. We know from our engagement work that the perceived burden from inspection arises from activities including facilitating the inspection and gathering information for the inspection team.

61. In table 7.1 we identify the activities required by the new inspection model, which will likely increase the burden on services. The RAG rating indicates how much more of a burden these activities will be following the introduction of the new inspection model.

Table 7.1: Comparing inspection activities for services in the new and previous inspection models

Activity	**Changes in costs to providers [RAG rating]**
Provider Information Return	
Facilitating the inspection	
CQC interviews with staff	
Closing the visit meeting	
Actions following inspection	

i. The burden might be higher on community services

62. All adult social care services are likely to see increased costs in relation to our plans to gather more information through the Provider Information Return (PIR), which we might ask to be updated prior to an inspection. These costs are likely to be higher for community services, where access to information from people using the service and others is both a) harder to gather and b) most needed to improve the efficiency and effectiveness of regulation. This includes an increase in use of questionnaires and telephone calls, which will add to costs for these services as they will need to supply CQC with contact information. These additional costs for these services are likely to be recurring.

63. Community care services may also see bigger cost increases than residential care services because we are making more substantial improvements to community services regulation which will feed into higher costs for these services.

ii. Extra costs for services given requires improvement or inadequate ratings

64. Costs will be higher for those services which will be inspected more frequently. Care services which receive requires improvement or inadequate ratings will likely see inspection costs increase compared to those who have been rated good or outstanding. This is because the former are likely to be inspected more frequently.

65. Services which are rated as requires improvement or inadequate may also experience cost increases as a result of loss of business from people who use services and from the potential unwillingness of Local Authorities and Clinical Commissioning Groups to commission services from them.

66. Finally we are exploring ways in which CQC will take tougher action against providers which consistently do not meet their conditions of registration and other legal requirements. Services without a registered manager for long periods of time without good reason are likely to see increases in costs resulting from fines or other sanctions. We are currently consulting on a new Enforcement policy.

iii. Additional costs to corporate providers

67. Certain providers deemed sufficiently large will be recognised as ‘corporate providers’ and CQC will keep in touch with these organisations on a regular basis. The extra time that these organisations will spend being in touch with CQC could add to the burden experienced by these services under the new CQC inspection model.

b. Our estimates of the cost to adult social care services of the new inspections

68. We surveyed thirteen adult social care services following their inspections to find out what they had to do for it and how long it took them. Figure 7.1 shows how much time these respondents spent preparing for an inspection, being inspected, and on follow up actions. It shows that the time spent on inspections varied a lot across services.

69. Using this information we have been able to estimate the cost to each service of their inspection. Costs here are characterised as the time spent by staff members on inspection and associated activities; this is time that could have been spent on other activities by service staff.

70. Figure 7.2 shows the range of costs experienced by these services and the number of people each employs. In line with figure 7.1, it shows that there was quite a range in the costs experienced. It shows no relationship between the size of the service inspected and the inspection costs they experienced.

71. We should note that Figure 7.2 is missing two services for which we have data. The first is a care home service with just over 100 employees which reported time spent on inspections that we calculated to be in the region of £7,000. This service's cost does not fit into the scale on our chart. This care home experienced such a high cost associated with inspection because they chose to re-train and test their 100+ staff in response to an inspection. The second is a care home that did not tell us how many staff they employed. We calculated that the cost they incurred from inspection was around £180.

Figure 7.1: Number of hours spent by services on inspection

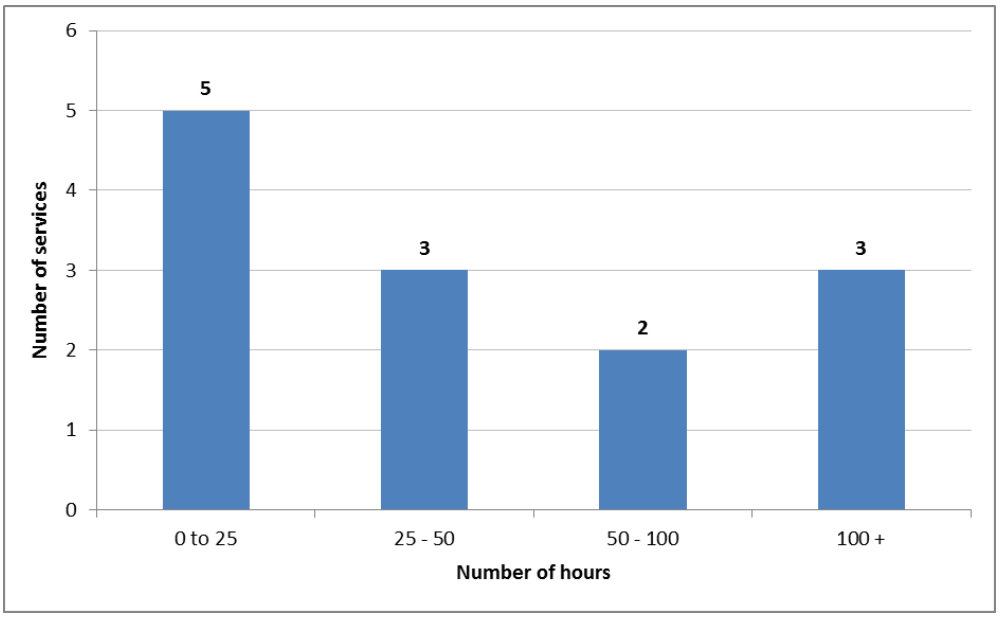
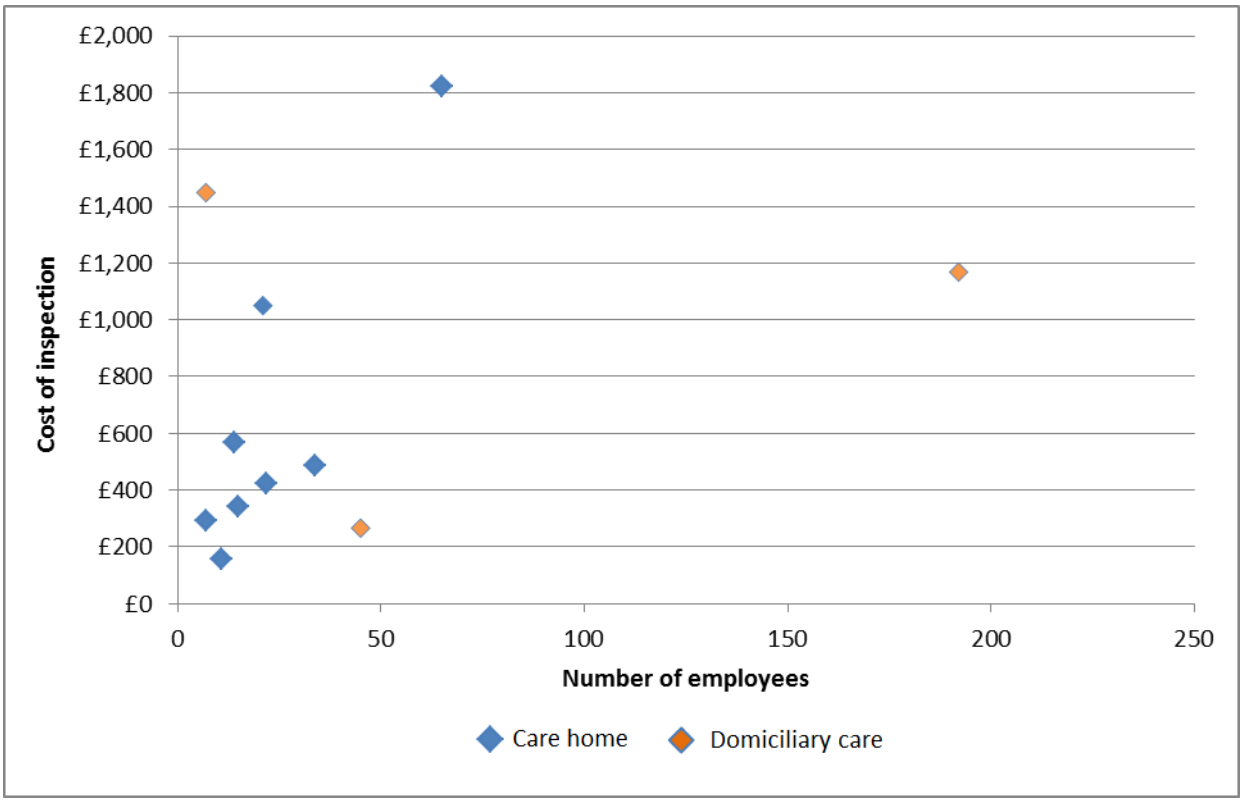


Figure 7.2: Cost to adult social care services of being inspected under the new model



72. To estimate these costs we used the time spent by each member of staff multiplied by an assumed appropriate wage rate. The assumptions for wage rates are detailed in table 7.2.

73. The most common activities related to our inspections were: collating information requests, facilitating the site visit and factual accuracy checks. During inspection these activities were also the most costly, accounting on average for 55 per cent of the costs providers experienced.

74. These findings tally with a survey of providers on the Provider Information Return (PIR). For these providers filling in the PIR, analogous to collating information requests, was a time-consuming activity with providers spending on average 15 hours on this activity (worth noting is that this average covers a wide variety in the time spent by providers on this activity).

Table 7.2: staff and assumed wage rates

Job title	Hourly wage
Director	£22.16
Regional manager	£17.97
Site manager	£14.57
Misc. manager roles	£14.57
Care manager	£14.57
Senior carer	£8.05
Carer	£7.90
Coordinator	£9.95

Source: Regulatory Economics Team assumptions using ONS ASHE 2012 data

Risks and limitations

75. This is an initial analysis on the basis of the information we have received so far from services. The results above could change if we refine the analysis and receive additional responses from services.

76. It is important to note that these cost estimates cannot be aggregated to come up with an annual cost to providers of CQC inspections. This is for a number of reasons:
    - The thirteen responses we received are not representative of the sector as a whole.
    - This information was collected some time after inspections had been completed and hence may not accurately capture the cost of inspection to these services.
    - These responses capture the costs to providers of being inspected for the first time under the new inspection model. We expect that costs to providers might fall once they are more familiar with our new inspections, i.e. when in steady state.

77. On the final point above, the cost of completing the Provider Information Return (PIR) in these initial inspections was likely to be much higher than it will be in future. This is because the PIR software that we shared initially with ASC providers did not work properly. Providers will have spent much longer trying to complete the PIR than they will do now that the software has been improved.

c. Specific cost impacts to CQC

78. The new inspection methodology will be more expensive for CQC to operate. In the shorter term we expect costs to be even higher – this takes into account the development, testing, piloting, evaluation and implementation of the regulatory model. Over time we expect that the cost of the new model will decrease as CQC makes efficiency gains in the way it targets inspections based on the risks and demands placed on us by the sectors.

79. Table 7.3 summarises the activities for CQC required by the new inspection model. The RAG rating indicates how much more of a burden these activities will be following the introduction of the new inspection model.

Table 7.3: Costs of activities to CQC under the new inspection model

Activity	**Changes in costs [RAG rating]**
Gathering and analysing information from the public & stakeholders	
Producing inspecting information pack	
CQC interviews with staff	
Rating process	
Report writing	
Closing the visit meeting	

80. An important part of the new inspection model leading to extra costs is the provision of ratings which is a new process for CQC. The extra costs associated with providing ratings are likely to be higher in the short term as we provide the first ratings for all adult social care services by April 2016. In the future costs associated with ratings may decrease as all providers will have had a CQC comprehensive inspection and will have been rated, and we move towards a 'steady state' model. In the steady state we intend to inspect good and outstanding providers less frequently than services rated inadequate or requires improvement.

81. Not captured by the above are demands placed on CQC inspection teams as a result of the new and more comprehensive inspection model. Team members can work very long days while on inspections. We hope that these demands will lesson in the future as inspection teams become more experienced with the new inspection model and its associated processes.

82. In the remainder of this section we provide a more in-depth analysis of cost impacts that build on the interim Regulatory Impact Assessment (RIA) published

in April 2014. Firstly we consider what the cost of inspection will be to CQC in the longer term. Secondly we compare the cost of inspection under the new and old models.

i. Our estimates of the cost to CQC of the new inspections in steady state

83. CQC has undertaken work to estimate what resources it might need in the future to carry out its programme of inspections across all the sectors we regulate. We can use assumptions underpinning this work to estimate what the cost of a typical inspection might be once the new inspection model is well established, i.e. in the steady state, which we describe in paragraph 57.

84. We have estimated the cost of an average inspection of an ASC provider location. This encompasses time spent by those employed on inspections and their expenses – we call these the direct costs of inspection. We believe that the average cost to CQC of an inspection of an ASC provider location could **range from £2,400 for the smallest services[1] to £8,000 for the largest services[2]**. These were calculated by estimating the expected total cost of the staff (inspector managers, inspectors, Experts by Experience, and specialist advisers) and their expenses on inspections of services of different sizes.

85. Inspections across the ASC services are similar in terms of the number of people involved (based on size) and the time to undertake inspections. We have therefore chosen not to differentiate but instead to give a simpler high level view of costs across the adult social care sector in residential care services, community care services and hospice services. For simplicity we estimate the resources used for a typical inspection of a location; these resources can then be used flexibly across our ASC inspections. For instance, we know that it might cost us more to inspect community servicers than residential care services. This is because the former are larger and more dispersed.

86. Table 7.4 details the assumptions used in these calculations. These have been taken from CQC's Resourcing Model and have been informed by work by CQC on the resources required for inspections. It sets out the assumed cost per staff member and the total days per type of staff member on an inspection. These assumptions are based on what we predict a typical inspection team will be in each sector in steady state. We assume a ten per cent uplift on staff costs to capture the cost of expenses.

87. An inspector manager will have oversight of the inspection and may be involved on the basis of risk or sample locations. An Inspector will coordinate the

[1] For residential care homes we assume the smallest services have 5 or fewer beds.
[2] For residential care homes we assume the largest services have 50 beds or more.

inspection and be involved in all parts of the inspection. A typical team will also involve an Expert by Experience and we assume that on one in every ten ASC inspections there will be a specialist adviser.

Table 7.4: Assumptions used to estimate the direct cost of inspecting a service location

Staff type	Daily cost to CQC	Assumed resources required for an inspection in steady state	
		Smallest providers	**Largest providers**
Inspectors	£333	One Inspector for 4.5 days	Two Inspectors for 8.5 days each
Inspector Managers	£620	They spend more time on inspections of services judged to be riskier. We capture their total time across all inspections by assuming they spend 1/8th of the time that inspectors spend on each inspection.	
Experts by Experience[3]	£300	1 day per inspection. An Expert by Experience is assumed to be on every inspection.[4]	
specialist advisers	£300	1 day per inspection. A specialist adviser is assumed to be on 1 in every 10 ASC inspections.[5]	

Source: CQC cost of delivery group and CQC resourcing model

Risks and limitations

88. The cost estimates presented in paragraph 84 are the predicted direct costs of inspection - they take account of the staff working immediately on a given inspection. A number of costs that might arise from the new inspection model are not captured in these estimates, which we might call indirect costs. These indirect costs could include the time spent by staff in CQC checking and assuring the quality of each inspection report prior to its issue to providers and subsequent publication. This being a thorough process does not represent an insignificant cost in terms of staff time to CQC. Analysis is beginning in CQC to establish the indirect costs of recent inspections. This work is at a preliminary stage and hence it is too early to report estimates of how large these indirect costs are how they might be attributed to different sectors.

89. Work has also begun in CQC to estimate how much it has cost us to undertake our first inspections of ASC services. This work is also at a preliminary stage and hence it is too soon to include its findings in this impact assessment.

[3] Excludes CQC internal specialist resource, for example Pharmacist Inspectors.
[4] In reality the CQC is likely to be more flexible around how Experts by Experience are used. For example we may choose to use 2 Experts at a large site and 1 across a few very small locations.
[5] In reality specialist advisers will be used flexibly depending on individual circumstances at locations and risk.

90. It should be noted that these steady state cost estimates use a mixture of actual results and assumptions as we are in the early stages of rolling out our methodology. They are heavily assumption based in the sense that we have made judgements about the number of staff required on a future inspection. We cannot say that these represent an accurate picture of what the costs of inspections will be in future. However, they provide a useful indication of what costs could be reflecting gains from learning and improvements as the inspection process matures.

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

91. Impact assessments typically include an estimate of how much the change in policy being considered costs relative to the status quo. In in this RIA this 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 cost estimates could tell us how much more the new inspection model costs us.

92. We can produce some indicative estimates of cost of inspections under the old and new inspection models for comparison, but data limitations mean we cannot produce true marginal cost estimates.

93. We have used time recording data from before our inspection model changed to estimate the average cost of an inspection under the old model. We estimated how much time had been spent by CQC staff on inspections across each sector. We then applied this time split to wage data for the same period to estimate the total cost of inspection in each sector. For each sector we divided this total cost by the number of inspections over the same period to estimate the average cost of an inspection. Given our chosen methodology these estimates tell us the cost of only CQC staff on an inspection. We did not previously record details on where we employed external staff. The results are shown in table 7.5.

94. To ensure that these figures are comparable with our estimated costs of new inspections we have isolated CQC staff costs on these new inspections (i.e. we have removed the cost of expenses and non-CQC staff inspectors from those cost estimates presented in paragraph 85).

Table 7.5: Comparing costs of inspection in the old and new models

Sector	Average cost of an inspection (Excludes cost of external inspectors and expenses)	
	Old model	**New model (steady state)**
Residential care	£3,600	£1,800 - £7,000
Community based social care services	£1,900	

95. As noted above we do not use the figures presented in table 7.5 to estimate the marginal costs of our new inspections. This is for three reasons. Firstly the average costs of an inspection under the old and new models have been calculated using different methods. Secondly we have not estimated the resources required to inspect different types of ASC provider. Thirdly as we have not included non-CQC staff costs and the cost of expenses in this analysis the estimates do not provide us with enough information to estimate the true marginal cost of new inspections.

96. The figures presented in table 7.5 simply provide an indication of how much more our new inspections could cost relative to the previous inspections when it comes to CQC staff.

CQC costs and provider fees

It is important to note that these direct cost estimates 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.

d. Specific cost impacts on other organisations

97. Other organisations we work with, including commissioners, are likely to incur additional costs from the new inspection model as CQC intends to collect more information from them. These additional costs will arise from more time being spent on activities related to CQC inspections – activities they would not have

done before and the time spent on these could have been spent on other activities.

98. For commissioners, the burden from the new inspection model could decrease if commissioners conclude that they do not need to inspect ASC services themselves, particularly following a good or outstanding rating by CQC.

99. A key part of the new inspection model is to collect additional information from organisations to inform provider inspections. As part of the new inspection model we also expect to maintain ongoing relationships with these organisations. These organisations are likely to experience cost increases as a result of our new inspection model. These organisations include the following:
    - Local authorities and their Health and Wellbeing Boards
    - Clinical Commissioning Groups
    - Local community groups and voluntary organisations
    - Local Healthwatch organisations
    - Care professionals
    - Learning disability partnership boards
    - Local learning disability groups
    - Older people and carers groups for people with dementia
    - Community Service Volunteers
    - Carers UK
    - Age UK
    - Regional Voices

100. We have found through evaluation of the new CQC inspections in adult social care that inspectors piloting the new approach have raised concerns about the potential burdens on organisations like local Healthwatch and Local Authorities if many inspectors seek to contact them in relation to services. This may suggest the need for a coordinated approach to requesting information from such bodies to ensure burden on them is kept to a minimum.

Summary

101. While it is clear that our new inspection model will increase costs for a range of parties, we believe that the benefits arising from the new model justify the increase in costs. In the following section we detail what we believe to be the chief benefits of the new inspection model across adult social care services in England.

8. Benefits

103. In this section we explore the main intended benefits to stakeholders from our new inspection model and where it exists we provide evidence to support these benefits. This evidence has been gathered from consultation and surveys of adult social care (ASC) services, the public, people who use services and our own staff.

104. We explore the steady state benefits because not all stakeholders are likely to experience increases in benefits immediately – the changes we are making to our model are likely to lead to small incremental increases in benefits and are likely to be experienced and sustained over a longer time period i.e. they are likely to emerge after several years. For example, an immediate benefit for people who use services could stem from having more information about the quality of care provided via publication of reports and ratings. A longer term benefit could arise from incentivising services to make continual improvements in the way they provide care as a direct result of these ratings.

105. CQC aims for people who use services to benefit the most from the changes we are making. We want to ensure that adult social care services provide people with safe, effective, compassionate, high-quality care and we wish to encourage services to improve. When designing our final inspection model we focused on ensuring the benefits to stakeholders would be maximised by piloting and testing our new regulatory model prior to its implementation in October 2014.

106. Our inspection models have been formulated directly from feedback from and engagement with our partners, people who use services, provider groups, and all other stakeholders and will be used as a basis by which we will test the emergence of benefits that will feed directly into development of the 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.

107. In this section firstly we consider the benefits to the public and people who use services. Secondly, we discuss the intended benefits to providers. Thirdly, we explore the benefits intended for CQC and other stakeholders from the new inspection model.

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

108. People who use adult social care services should benefit the most from CQC's new inspection model. We set out in more detail below what these intended benefits are, supporting them with relevant evidence where possible.

i. Confidence for people who use services

109. CQC will be able to make better informed judgements about the quality of care provided in ASC services. This is to be achieved through more comprehensive inspections and the expert inspection teams which will include trained inspectors and may include specialist advisers and Experts by Experience. This will benefit those who use services as more information will be made available to them on the quality of services provided.

110. As a result CQC should be able to give stronger assurance to the public that providers deliver care that is safe, effective, caring, responsive and well-led. Our assessments will aim to be more authoritative and credible, demonstrating that our judgements are completely independent of the health and social care system and Government. We intend for the public to have confidence in the CQC regulation of providers and in the information we provide so that they can be confident in the assurance we provide about local services.

111. There was strong support in adult social care consultation responses for the CQC's planned changes in regulating, inspecting and rating services from those submitting written responses on-line. Online respondents also expressed strong support for the proposed characteristics of our ratings in adult social care services.

112. Many of those returning self-completion consultation forms were also confident that they key lines of enquiry and prompts would help inspectors to judge services.

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

113. We are making better and more systematic use of people's views and experiences, including suggestions and complaints. Our new inspection model provides formal and informal opportunities for the public and people who use services to provide feedback to CQC on their experience of the services.

114. This feedback will be used to plan and direct inspections. During inspection we will also seek people's views of the provider being inspected.

115. The evaluation findings from pilot inspections of adult social care services suggest that Experts by Experience have the potential to be effective on inspections in speaking to people who use services. The Experts by Experience have the time to focus on gathering people's views and people who use services

may be willing to have a more honest conversation with the Experts by Experiences than inspectors as the Experts by Experience and people who use services due to their shared experience.

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

116. A clear departure from the previous inspection model is the introduction of ratings. Under the previous inspection model, adult social care services were either compliant or non-compliant with the regulations beings inspected. Eventually the new inspection model should raise awareness among the public that the quality of care can vary across adult social care services.

117. By providing ratings, people will be able to get a clearer view of the quality of services provided by adult social care services. A comprehensive and tailored assessment will more clearly define poor and good practice and what people can expect from services. People who use services can use this more comprehensive information to make better informed choices. People who use services should also benefit from better outcomes if the new inspection model leads to more informed commissioning of services by local commissioners.

118. Those consulted about what good adult social care looks like suggested that inspection reports could be used as a ‘starter’ when choosing a care home.

119. We have tested with readers the online content of our website relating to the ratings of care homes and domiciliary care services. Readers reported that the facility to search and see ratings as a glance was useful in filtering out services which they would not be interested in. Overall the clarity, quality and quantity of information provided were felt to be good and appropriate. Everyone said the content was clear and that the information contained in the report met their expectations. Everyone said the five key question ratings made sense and were relevant to the things they wanted to find out about when looking for services.

iv. Encouraging services to improve

120. Ratings should encourage services to improve. The first mechanism through which we expect this to happen is that providers will seek to achieve a rating of either outstanding or good. In order to achieve these ratings some providers will need to raise their standards in line with our expectations for these ratings. Ultimately this benefits people who use services through the reduction in poor care in some providers and the provision of a better standard of care across all providers.

121. The second mechanism is through people exercising choice. People who use ASC services can choose which service they use. If people choose not to use a particular service because of its poor rating this should put pressure on the service to improve.

122. A provider responding to our adult social care handbook consultation supported linking the frequency of inspections to ratings as they thought it would be an effective incentive to ensure that quality standards are raised throughout the domiciliary care sector.

b. Specific benefits to services

123. Services should benefit directly from the changes to how we regulate and inspect adult social care services. The advantage of the key questions being consistent across all sectors is that it creates a 'level playing field' approach that treats all services in an even-handed and fair way. We also envisage that there will be reputational benefits to services of being in a sector which is transparently and robustly regulated. More specific benefits arising from the new inspection model and supporting evidence are detailed below.

i. More comprehensive and credible information for adult social care services to act on

124. The information collected on inspections will be more extensive under the new inspection model and our inspection teams will specialise in this sector. This will ensure that judgements about provider performance are more credible as they are supported by more informed judgements. As a result we expect that adult social care services are more likely to think our judgements and the ratings they receive are credible and fair and this was evidenced in the testing.

125. The vast majority of those responding on-line to our handbook consultation were confident that the local relationships and ways of gathering information set out in the handbooks will be effective in supporting the CQC's approach. This was also generally supported in written submissions (Trade Association, National Charities). Further to this community services at engagement events were supportive that inspectors could use now use a range of data to support their judgements.

126. Thirty ASC services were interviewed following their inspection. Many of them thought that it is very important to be inspected by those with sector experience, as is the case under our new inspection model. Providers liked that inspectors could communicate effectively with the people who use services to get a good

understanding of their experience of the services. Providers were also pleased that the inspectors sought to understand how the provider operated in practice and did not only rely on paperwork to judge the effectiveness of services.

127. The majority of providers interviewed were satisfied with the rating they were given following their inspection. Only a small number of providers did not think their rating entirely 'fair'. CQC feedback and reports were well received with the latter having been perceived as thorough, clear and accurate.

ii. Giving staff at adult social care services a voice

128. The new inspection model includes opportunities for staff to provide feedback to CQC inspectors on the adult social care services they work for. CQC intends to protect those who voice concerns to us.

129. ASC services interviewed following their inspection reported that the CQC inspection team had ensured that the service staff were given an opportunity to share their views and experiences. Respondents considered it important for the staff to have the opportunity to talk to CQC for a number of reasons including that it gives staff an opportunity to raise issues that they are not comfortable to do so with the registered manager.

130. Of community (1) and social care (2) services responding to a post inspection survey, all three either agreed or strongly agreed that, 'Staff were given an opportunity to share their views and experiences with the inspection team'. Respondents were very positive about how staff had been kept informed before and during the process.

131. In the paragraph above we have drawn on findings from the ongoing CQC post-inspection provider survey. We have not received many responses to this survey so far, Given that the number of responses is small, and contains respondents from other sector other than ASC we should not over-emphasise the value of these results. We will continue to analyse the new findings to this survey so that we can use this feedback in the continued development of our inspection models.

iii. Recognising services which deliver good care

132. The advantage of the new inspection model is that CQC will recognise and publicly acknowledge adult social care services that provide good quality services.

133. Market dynamics should see adult social care services rated as good or outstanding benefiting from increases in business from self-funders and contracts with local authorities and other commissioners. Many stakeholders have said that these ratings will form the basis of positive marketing material that helps them stand out from other services. Since the frequency of future inspections is also linked to service ratings, services which are rated good or outstanding should see reductions in inspection visits which should decrease costs in relation inspection-related resource demands.

134. Better performing services may also find reduced levels of scrutiny from commissioners. In addition it is likely that services will benefit additionally from not having to facilitate multiple inspections by different organisations or to provide the same information twice as local authorities should have more confidence in the way CQC regulates and rates care.

135. In response to our consultations members of Healthwatch said that ratings were important because they motivated staff, and gave people information about caring and quality standards in particular locations.

iv. Identifying improvements adult social care services can make

136. Not only will inspections identify good practices, they will also identify where services need to be improved. Reports and results from the new inspection model will enable services to gauge their performance against other similar services and encourage them to improve. A credible CQC assessment will provide adult social care services with a clearer picture of the quality of their services, their strengths and weaknesses and how they can improve.

137. A longer term benefit from the new inspection model might be that adult social care services 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 the organisation.

138. Although it has been recognised to involve a “huge amount of paperwork”, many of the services we talked to told us that the new Provider Information Return (PIR) benefits them too. The PIR helped these services align their focus with CQC’s ways of working and has helped them prepare for inspection. In some cases it has also enabled them to see their services from another perspective and has helped them identify areas for improvements.

v. Shifting focus to the quality of care

139. The new inspection model is designed such that there is a renewed emphasis on the quality provided in adult social care services. Through the introduction of ratings we hope that services will strive to achieve outstanding. There may be two reasons for services to do so. The first is that better rated services may be more attractive to people who use services who can choose where they receive care and support. Second, for those services that are rated good or outstanding it is likely that they will face a decrease in costs associated with inspections.

140. Other channels through which we hope the focus will shift to quality of care are as follows:

- Boards, directors and leaders of organisations 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 services and commissioners that focuses on outcomes for people rather than simply activity and cost.
- Staff working for services 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.

c. Specific benefits to CQC

141. CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of services. Inspectors will gain more support from specialist advisers and Experts by Experience in making better informed, more robust judgements about the quality of care being provided by the service to be inspected. In addition to opinions from specialist advisers and Experts by Experience, they will also have access to more external information to direct their investigations and to support their judgements.

142. From the adult social care test inspections we gathered inspection team members' views about how effectively Experts by Experience and specialist advisers had contributed to inspections. It was found that they brought a different perspective and were able to identify issues that inspectors would not have identified themselves. Furthermore specialist advisers could potentially identify best practice and bring that knowledge to bear on inspections.

143. CQC staff members attending the adult social care consultation events were generally confident that the key lines of enquiry (KLOEs), as described in the handbook, would enable them to make judgements about services. Both community and residential services were generally confident that the KLOEs were sufficient, appropriate and a positive development; those responding on-line were also generally supportive of the KLOEs. Furthermore most of those returning self-completion consultation forms were also confident that KLOEs and prompts would help inspectors to judge services.

d. Specific benefits to other stakeholders

144. The intended impact to the wider health and care system is that 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.

i. Local authority commissioners

145. The key benefits to commissioners of CQC's new inspection model is that more credible CQC independent assessments will provide commissioners with a clearer view of the quality of different services. This will then inform their commissioning decisions and should enable to help them make better decisions on behalf of people who use services. The evidence we provide should facilitate and promote a dialogue with services that focuses on outcomes for people rather than cost alone.

146. If our new inspections are as effective as we intend then commissioners may not need to duplicate our inspection efforts. They can simply use our judgements to inform their activity and decisions. Benefits from increased clarity around roles and responsibilities should also lead to reductions in duplicated effort and associated costs. That means Local Authority commissioners will have more resources to dedicate to other activities.

9. Next steps

147. The final inspection models as described in this Regulatory Impact Assessment and in the final provider handbooks were rolled out from 1 October 2014.

148. CQC will continue to engage with services, the public and other stakeholders on our new inspection model. This is part of an effort to ensure the benefits to the sector are maximised and the costs minimised from our inspection methodology. We welcome feedback on the information presented in this document. To provide us with your feedback please send it by post to the following address:

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

149. We will continue to evaluate how our new inspection model is working in practice. CQC has the following work streams planned:

- We will continue to monitor our new inspection model through activities including our post-inspection survey of services and post-registration survey of services. We will also be piloting a survey of inspection team members; and
- We have commissioned an external economic consultancy to establish a methodology for 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 CQC on all stakeholders.