Changes to the way we regulate and inspect NHS GP practices and GP out-of-hours services

Final regulatory impact assessment

This final regulatory impact assessment is published alongside our provider handbook covering the:

NHS GP practices and GP out-of-hours services handbook

Stakeholders may want to refer to this document before reading this impact assessment as it provides information on our final methodology for inspecting these providers.

This document provides an analysis of the likely cost and benefit impacts of the changes to the way we regulate and inspect NHS GP practices and GP Out-of-hours 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 providers* 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 published alongside the draft provider handbooks in April 2014.

2. From October 2014 NHS GP practices and GP out-of-hours services will be monitored, inspected and rated under a new methodology that was developed in collaboration with stakeholders across the health and social care sectors. These stakeholders included providers, people who use services, trade bodies, national organisations, commissioners and government organisations.

3. Our early proposals for how we planned to inspect and regulate these providers were contained in our draft provider handbook that we consulted on and published in April 2014. We committed to test our methodology and to refine it following formal evaluation. A key aim of developing, testing and refining our methodology before its implementation was to ensure that our chosen model of inspection and regulation maximises benefits to all stakeholders whilst keeping regulatory burden on providers and other key stakeholders to a minimum.

4. We have taken on board consultation responses as well as feedback from various stakeholder engagement events and integrated these views into development of the final model. We have also gathered a significant amount of further information that has allowed us to make a more informed assessment of the likely cost and benefit impacts of the changes that came into effect in October 2014. These impacts are discussed 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 external scrutiny and feedback from consultation with external stakeholders and organisations concluded that our regulatory model needed to be changed fundamentally. This was further compounded by the learning from instances of very poor care at Mid-Staffordshire NHS Foundation Trust, and the abuse of residents at Winterbourne View Hospital in August 2012.

6. The transformation programme outlined in our three-year strategy set us on course to make these changes. We appointed a Chief Inspector of General Practice to oversee the changes in inspecting and regulating NHS GP practices and GP Out-of-hours services. It was our specific intention that our new regulatory model would both incentivise direct improvements in quality of care, while also identifying providers most likely to provide sub-standard care.

7. The Care Act 2014 will be fundamental to the Care Quality Commission (CQC) in achieving such aims. This Act allows CQC to rate providers of care and health services. We think that ratings will have two main benefits. The first is to provide incentives to providers to improve their services to achieve the top ratings. The second is that ratings will enable people who use services to make an informed choice as to where they receive GP services.

8. If providers respond to the incentives of the new methodology, over time we would expect all providers to aim for at least a good rating. We want to recognise instances of outstanding care while also tackling poorly performing providers (i.e. using our special measures regimes for GP practices). The best practices themselves will benefit from being recognised for the good care they provide. Providers, people who use services and stakeholders should also all benefit from this if the new inspection model helps spread best practice through its recognition.

9. Our consultation documents, most notably the draft provider handbooks that we consulted on earlier this year, brought all of our emerging thinking together on how we could best develop and implement these changes. We also published an interim regulatory impact assessment that set out at a high-level the likely impact of the proposed changes and we committed to providing a fuller assessment of these impacts.

10. The final inspection methodology to be implemented is described in the *NHS GP practices and GP out-of-hours services provider handbook* that was published alongside this document. This regulatory impact assessment describes the likely cost and benefit impacts of the methodology described in the handbook.

3. Summary of changes from 1 October 2014

11. Our final provider handbook provides detailed information to stakeholders on our new regulatory approach. These are summarised below.

As of 1 October 2014, all NHS GP practices and GP out-of-hours providers are regulated under our new model.

Registration
CQC will make registration a more robust process both for new providers wishing to be registered and existing providers that wish to vary their registration. We will undertake assessments to ensure existing and potential providers 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's new inspection methodology makes better use of information so we can monitor and target effort to areas where the risk of providing poorer quality care is greatest. We will continue to work with the GP community to define key indicators as well as information sets and quality standards that aid effective monitoring and regulation of providers.

Inspection
CQC's new inspection framework seeks to answer five key questions. Inspectors are now judging whether or not a service is safe, effective, caring, responsive and well-led. We use predominantly announced inspections. Following the first rating a practice receives, subsequent inspections will either be to review the practice's existing rating or in response to concerns or risks. The size of inspection teams will depend on the size and complexity of the service to be inspected. We will make use of a range of specialist advisers, including GPs, practice nurses, practice managers and Experts by Experience as required. All inspections will include as a minimum a trained inspector and a GP specialist adviser.

Rating
We aim to rate all GP practices and GP out-of-hours services by April 2016. The rating will be based on a four-point scale: outstanding, good, requires improvement, inadequate. The rating will be based on a combination of inspection findings, feedback and data.

Enforcement and appeals
We shall be tougher on providers that consistently provide poor quality care and do not comply with conditions in their registration. Practices receiving poor ratings will be given time to improve and NHS England will work alongside these practices to assist their improvement. More information on this new policy is contained in a separate consultation on our approach to enforcement and appeals.

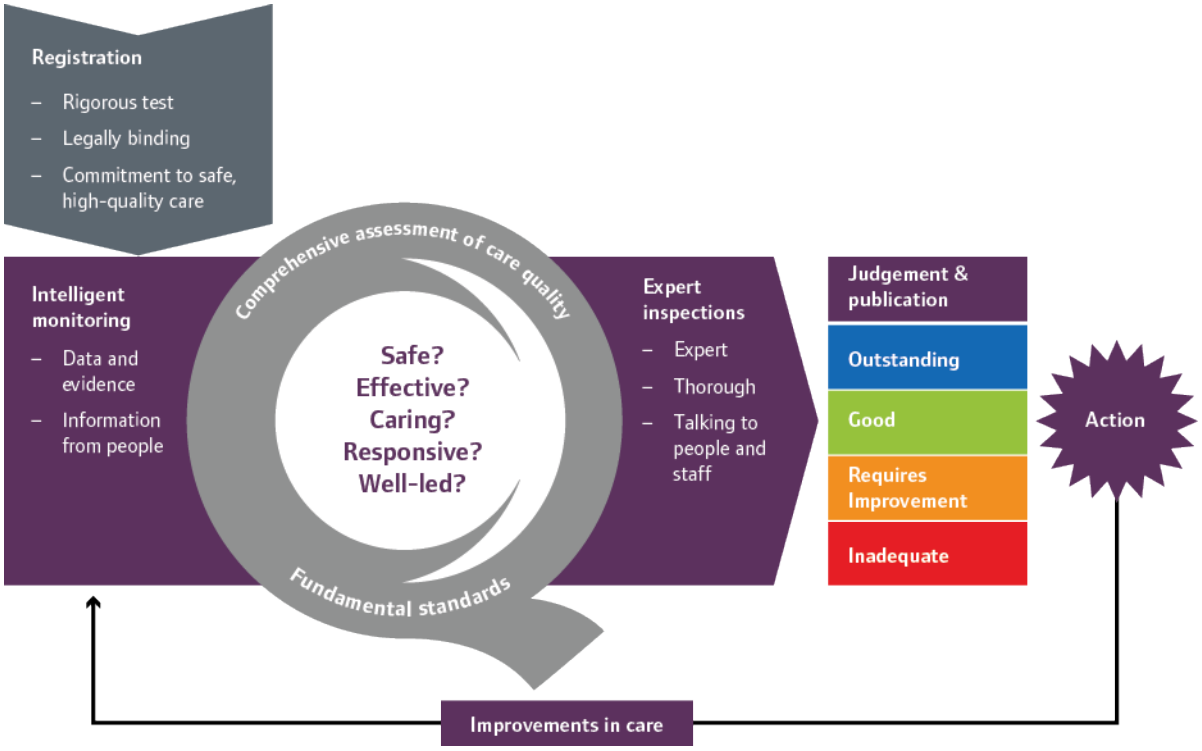
4. Scope of this final regulatory impact assessment

12. 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 GP practices and GP out-of-hours services, as set out in the provider handbooks. We estimate 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.

13. 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.

14. 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

15. CQC regulates more than 8,500 GP practices and GP out-of-hours services in England. Inspections of these services commenced in April 2013 and to date we have undertaken around 340 GP practice inspections under the new methodology. The CQC started registering providers of GP out-of-hours in April 2012.

16. There was one over-arching model that we used previously to regulate and inspect all providers of health and adult social care, including both NHS GP practices and GP out-of-hours services. Our inspectors assessed the services provided against our 16 essential standards of quality and safety, with compliance (or non-compliance) against these standards setting the basis for any further action if required. A typical inspection of a NHS GP practice or GP out-of-hours lasted for one day, after which an inspection report was written and submitted for internal quality assurance. The report was also sent to the inspected practice or out-of-hours service to check its factual accuracy prior to its publication on our website.

17. Our inspection teams were generally made up of a single inspector and often a specialist adviser. These specialist advisers were practice nurses, practice managers or GPs. We decided who should be included on an inspection on the basis of the service to be inspected. We typically used both planned and responsive inspections. The use of responsive inspections was triggered by new information which led to concerns about the quality of care being provided to people who use services. In these cases inspections tended to be unannounced.

b. Policy objectives of our new approach

18. NHS GP practices and GP out-of-hours services play a vital role in the health system. The impact of these organisations providing poor quality services can have serious consequences for the health and wellbeing of a large number of people. For example, the first thousand CQC inspections of GP practices have demonstrated that there is a minority of practices providing unacceptable care. A key reason for proposing changes to the way we regulate and inspect such providers is to ensure that standards improve. We want to ensure that good and outstanding GP practices are commended and can act as role models for all providers to make continual improvements. Also, focusing on how safe, effective,

caring, responsive and well-led services are will enable us to review the quality of GP services, focusing on what matters to people.

19. We want providers to improve continually and to provide high-quality care that directly benefits people who use services and their families. We aim to achieve this by working closely with NHS England Area Teams as commissioners of general practice and with clinical commissioning groups (CCGs), whose duty it is to support quality improvement in primary care.

20. All inspections will be carried out by our primary care inspection directorate. Inspectors will become dedicated experts in inspecting only GP practices and GP out-of-hours services. That is to say that an inspector will no longer inspect a GP practice one morning, then a care home in the afternoon, for example.

21. We wish to provide greater assurance to the public around the quality of care provided by NHS GP practices and GP out-of-hours services. To facilitate this we are providing all organisations with a rating so that the public can gauge the quality and performance of a provider.

22. We continue to work with our partners, including NHS England, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), to share information that will help focus our efforts and target poorly performing practices. We intend that those practices most at risk of delivering a poor service will receive tougher actions. Practices receiving poorer ratings will be given time to improve and NHS England will work alongside these practices to assist their improvement.

23. Underlining all of this is our aim to develop a model of inspection and regulation that maximises benefits to all stakeholders, while keeping regulatory burden on providers and other key stakeholders to a minimum. We want to be proportionate in how we carry out our activities, and aim to be more risk-based in the way we work. This means that those organisations that provide good quality care will likely experience decreases in the cost of inspection, whilst poorer performers have more frequent contact with CQC to ensure they improve.

24. Our ultimate objective is to provide a robust and credible framework that 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.

c. Monitoring, inspecting and rating GP practices and GP out-of-hours providers from October 2014

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 practices and 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 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 providers, 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 general practice 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 collect and make better use of information to target and monitor CQC's regulatory and inspection efforts. We are working in partnership with providers, commissioners and other stakeholders to design and develop the right information sources to be able to do just this. We want providers to be open and to share their data with us, while minimising any duplication or regulatory burden associated with information requests.

28. With regards to the way we now inspect NHS GP practices and GP out-of-hours services, we have changed the inspection framework so that we are able to gauge more effectively the quality of care provided by a GP practice or a GP out-of-hours provider. To do this our inspections are now based on the following five questions, which will inform our whole approach to regulation.

CQC's five key questions	
Is this service **safe**?	By safe, we mean that people are protected from abuse and avoidable harm. Providers need to demonstrate that their practices are clean and safe and that medicines are managed properly. We will check whether people who use services are supported by practice staff, particularly those who are in need of safeguarding, and whether practices learn from safety incidents such as prescribing errors or missed diagnoses.
Is this service **effective**?	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Providers need to demonstrate that they are providing people who use services with the right diagnoses and treatments and that care of people who use services with long term conditions is managed well. We also expect providers to ensure that people who use services are referred to the right specialist services, and that people who use services, and those who care for them, are involved in decisions about their care.
Is this service **caring**?	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect. Providers need to demonstrate that people who use services are treated with compassion, dignity and respect at all times.
Is this service **responsive**?	By responsive, we mean that services are organised so that they meet people's needs. We expect providers to assess and respond to the needs of the local population, which includes access to appointments. We check to see how the practice responds to feedback from people, for example through having an effective patient participation group. Provisions around how medical records are stored and shared with people who use services and other services are also key responsiveness measures.

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. We expect practices to support their staff, which should include training and supervision to make sure they are able to do a good job and have good quality governance. We also assess how well providers work with neighbouring health and social care services.

29. Our inspections, either comprehensive or focused, are led by an inspector, with clinical input led by a GP specialist adviser. All inspections will include as a minimum a trained Inspector and a GP specialist adviser. As the size of inspection teams will depend on the size and complexity of the service to be inspected. We will make use of a range of specialist advisers, including GPs, practice nurses, practice managers and Experts by Experience as required.

30. Since the Care Act 2014 passed into law, CQC has formal powers to grant ratings to providers reflecting our judgements about the quality and safety of care provided. We will rate all NHS GP practices and GP out-of-hours services on a four point rating scale: outstanding, good, requires improvement, inadequate. The *NHS GP practices and GP out-of-hours services appendices to the provider handbook* contains details about how practices will be rated according to our framework.

31. It is our specific intention that all NHS GP practices and GP out-of-hours services will be inspected and then given a rating by April 2016. Once we have rated all providers it is likely that we will inspect services that are judged to be providing poor quality care more frequently than those that we judge to be good or outstanding.

32. Finally, we will be tougher on providers that consistently fail to meet quality of care standards and requirements as set out in their registration with CQC. These changes will include working with NHS England Area Teams as commissioners of GP practices. These are part of our new special measures regime. Practices receiving poorer ratings will be given time to improve, and NHS England, as well as the Royal College of General Practitioners, will work alongside these practices to assist their improvement. More information on our proposed approach to enforcement and appeals is contained in a separate consultation.

Specific policy themes for NHS GP practices

33. As well as focusing on the five key questions in GP practice inspections we look at how services are provided to people in specific population groups. For every NHS GP practice we will look at the quality of care for the following six key population groups:

    - Older people
    - People with long-term conditions
    - Families, children and young people
    - Working age people (including those recently retired and students)
    - People whose circumstances may make them vulnerable
    - People experiencing poor mental health (including people with dementia)

34. By looking at services for these groups of people, we can make sure our inspections investigate the outcomes of care provided for all people. It also means we can present information to the public about local services relevant to them. For example, someone with a long-term condition can refer to our view of the quality of care provided by a practice for people with long term conditions.

Specific policy themes for GP out-of-hours services

35. GP out-of-hours services face particular challenges in providing safe, compassionate care. Cases are often more complex than those seen during in-hours general practice, with both a higher proportion of people with urgent care needs and a higher proportion of people whose circumstances might may make them vulnerable. Because of these factors we believe it is important that we improve how we regulate and inspect GP out-of-hours services quickly.

36. Our bespoke methodology for inspecting GP out-of-hours services was rolled out from 1 October 2014. We recognise that GP out-of-hours services are part of a wider system of care services, such as walk-in centres, minor injury units, NHS 111, and that there are different models for how GP out-of-hours services are organised. To that end, on inspections we consider the quality of communication between GP out-of-hours care and other local services, including GP practices, care homes and emergency services. We look at how people who use services with urgent needs are responded to and how GP out-of-hours providers make sure they appoint good staff. We also gather routine information from people who use services, those who care for them and local organisations such as Healthwatch to help us assess how responsive services are. We also ask local GPs for their views on how well the GP out-of-hours services are serving those registered at their practices.

37. In October 2014 we published a report summarising our findings from the first comprehensive inspections of NHS GP Out-of-hours services. It also describes improvements that have been made since the publication of the ministerial review into NHS out-of-hours care, *General practice out-of-hours services: project to consider and assess current arrangements*, in 2010.

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

a. Responses to the interim regulatory impact assessment

38. In April 2014 we published our interim regulatory impact assessment (RIA) setting out our initial assessments of the costs and benefits that might arise from our new inspection model. We received few responses to our interim RIA for GP practices and GP out-of-hours services.

39. A professional representative of the GP sector told us that they did not disagree with our assessment of costs and benefits described in the interim RIA. However, the body raised concerns over the size and cost of the new inspection system. They are concerned that CQC does not have a longer term intention to scale back inspections to ensure cost savings and efficiency.

40. The representative also voiced concerns over the complexity of the inspection process and the resource implications of being inspected, especially for smaller practices. They suggested the burdens faced by practices as a result of the new model may be disproportionate, especially given the other challenges currently facing the sector around workforce and workload pressures.

41. In response to this we wish to reassure stakeholders that costs to CQC of the new inspections are likely to be higher in the shorter term as a direct result of having to provide ratings to all providers. Cost savings and efficiency gains are likely to be made after we have provided the first ratings to all providers, as our model becomes more sustainable and when we become more targeted in how we plan for and administer inspections. It is our specific intention that the regulatory burden experienced by providers is kept to a minimum and that those providers that are providing inadequate care will experience greater regulatory costs. This will help to ensure our regulatory interventions are proportionate, fair and cost-effective.

42. In response to some feedback we received on our interim RIA, in this document we provide more information on what we think the costs and benefits from our new inspection model are. Specifically in this document we have:
    - Estimated the average cost to the CQC of new inspections in steady state.
    - Compared the cost of CQC staff on old and new inspections.
    - Estimated the cost of the being inspected to a handful of GP practices under the new model.

- Provided more information on the benefits to people who use services, providers, CQC and other stakeholders, where possible supported by findings from evaluation and consultation.

b. Wider consultation responses

43. 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
Population groups	• Online respondents largely understood the population groups and nearly all people responding through the public online community thought they should be rated and reported on. • Some online respondents expressed doubts about how relevant or useful population groups were as a basis for inspection, particularly in out-of-hours services. • Providers were concerned that some of the population groups may not be seen by some practices due to differences in the local population.
Gathering and using information from patients and the public	• Providers were concerned about unevenness of available data across the sector and wanted to see Intelligent Monitoring templates and information about the standard datasets that would be requested. • There was concern that information from other parts of the health and social care system could effectively distort how GP practices and GP out-of-hours services are assessed. • There was also concern about some of the sources of information used to assess GP practices. For example, some sources are more likely to be negative (for example NHS Choices) or based on inconclusive evidence (for example fitness to practise referrals). This view is supported by organisations representing the interests of GPs.

Key lines of enquiry (KLOEs)	• Some CQC staff were positive about the KLOEs and felt they represented an improvement over the current system. • Some providers felt that the KLOEs needed to describe best practice and be detailed enough to convincingly represent good standards for each key question and for services overall. • GP out-of-hours services said the KLOEs needed to be aligned specifically to them.
Characteristics of ratings	• The majority of those responding online either agreed or strongly agreed with the characteristics. • CQC staff and providers at events broadly supported our definition of what good looks like in NHS GP practices, although there were some suggestions about the language used.
Applying and reviewing ratings	• The majority of those who responded online agreed with the ratings principles. • Both CQC staff and providers felt that it should be tougher to be rated as outstanding, with many stating three out of five overall could be outstanding but others saying five out of five should be necessary. • Around two-thirds of those responding online thought that all five questions and the population groups were equally important when deciding an overall rating.
Compliance with the Mental Capacity Act	• There were mixed views from the online survey about the best way to encourage compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards. • From 42 online respondents, 19 thought we should give sufficient weighting in our characteristics of good, 11 thought we should apply limiters and 12 thought we should do this in other ways.
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 GP practices, and the issue of training for staff.

44. In response to the consultation feedback we have made some changes to our inspection models. Key changes are as follows.

Key lines of enquiry (KLOEs), prompts and ratings characteristics

- We have reviewed and amended some of the key lines of enquiry (KLOEs), prompts and rating characteristics based on the feedback we have received and the testing we did between January and September 2014.

Scope of the population groups

- We have clarified and refined the names and definitions for the six population groups to make it clear what is and what is not covered by each, and to describe our approach to inspecting them. For example:
  - The 'mothers, babies, children and young people' population group is now titled, 'families, children and young people'
  - The 'people in vulnerable circumstances who may have poor access to primary care' population group is now titled, 'people whose circumstances may make them vulnerable'.

Focused inspections

- We have developed our focused inspections to have a better understanding of what one means, and clarified the circumstances under which a focused inspection might take place. We have also provided more detail on the way a focused inspection might influence a change to a rating. We will undertake a focused inspection for two reasons: to focus on an area of concern or where certain changes in a provider occur. A focused inspection is not an opportunity to review a rating where there are no concerns.

Ratings principles

- We have clarified that:
  - For a service to be rated outstanding overall, there normally needs to be at least two outstanding ratings at key question level and the other three key questions need to be rated as good.
  - After we have rated all providers at least once, we may consider whether we should raise the bar for outstanding.
- In terms of aggregating individual ratings that may result in overall ratings of inadequate or requires improvement, we have clarified the proportions of each rating that we will apply to do this.

Inspection methodology

- We will now issue a pre-inspection information request that will provide us with a helpful insight into the practice before we carry out the site visit. It will also ensure that inspection teams are able to make the best use of their time when on the inspection.
- GP practices and GP out-of-hours services will be asked to spend half an hour at the start of the inspection telling us about its service and giving its own view of its performance, particularly in relation to the five key questions and six population groups (for GP practices). This should include anything they consider to be outstanding care and practice.

7. Costs

45. Changes to CQC regulation and inspection of NHS GP practices and GP out-of-hours services will have cost implications for CQC, providers and a variety of stakeholders. The cost impacts could be large as there are around 8,500 GP locations and CQC has to inspect all of these locations.

46. In this section we set out what the potential costs to CQC, to providers and to other stakeholders are likely to be once the new operating model is well established (i.e. the cost of the inspection model in the long term). The steady state indicates a period when the new inspection methodology is embedded in CQC and when providers are entirely familiar with the new style of inspections. We envisage that steady state could be reached once our initial provider ratings have been completed.

47. The annual cost to CQC of our new inspections requires an estimate of how frequently we will inspect providers in future. This will depend on the ratings providers received initially. Instead of choosing to present a highly assumption-based estimate of the annual costs of the total inspection model, we focus on the cost of a typical GP inspection.

48. Furthermore, we focus on the cost of a typical inspection in the steady state. This is for two reasons. First, work has started in CQC to estimate the costs of GP inspections we have conducted recently. This work is at an early stage and so we cannot yet present results from it. Second the costs of initial inspections under the new model are likely to be higher than the cost of future inspections. One-off developmental costs might be experienced following the introduction of the new model. Such developmental costs, likely to be experienced by the CQC and providers, are not a good indicator of the long-term future costs of regulating and inspecting the sector. For example, providers may need to provide more information in the shorter term as CQC requires this information, thereby increasing costs to them in the short term. However, in future should this information not be required there would not be a cost implication to those providers.

49. 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 regulatory approach. To date, this has been achieved through consultation and piloting our new inspections to improve our new 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.

50. In the following sections we first explore why providers are likely to experience higher costs of inspection under our new model. Second, we set out how much we think an average inspection costs CQC. Third, and finally, we discuss the costs of the new model to other stakeholders.

a. Common cost impacts on GP practices and GP out-of-hours services

51. Given that there are around 8,500 GP locations, the change in the inspection model affects a lot of practices. Even a small cost incurred by each practice would amount to a large cost to the entire sector. These practices will already have incurred costs having been inspected under our previous approach. However, the cost of the new inspections to providers is likely to exceed that associated with the old approach. Below, we explore why being inspected under the new approach is likely to be more costly to providers.

52. We expect costs to providers to be higher under the new inspection model because:
    - Inspections are more comprehensive with a GP specialist adviser on each inspection team.
    - The larger inspection teams mean there are more inspection staff to accommodate on the provider's site during inspection.
    - Inspection teams will request information from providers, particularly in advance of an inspection.
    - There are more interviews with provider staff.
    - There could be more actions for poorly performing providers following an inspection.

53. In table 7.11 we identify the main activities required by the new inspection model that are likely to lead to a higher burden for providers. The RAG rating indicates how much more of a burden these activities are following the introduction of the new inspection model. For example, providing CQC with information is red because now this is a formal activity required by the inspection process. We know from our engagement work with providers that the burden from inspection arises from activities like facilitating the inspection, gathering information for the inspection team and building new information and quality systems.

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

Activity	Changes in costs to providers [RAG rating]	
	GP practice	GP out-of-hours service
Providing CQC with information		
Preparing for the inspection		
CQC interviews with staff		
Closing the visit meeting		
Writing a high-level action plan		

b. Specific cost impacts on NHS GP practices

54. We are currently inspecting NHS GP practices for the first time under our new inspection model. We aim to inspect all practices under our new methodology by April 2016. We expect the cost to practices of their first inspections to be higher than the cost of future inspections. Once practices are used to our new style inspections the costs to them of being inspected should be lower.

55. As discussed in section 7a, our new inspections are likely to be more costly to practices than our old inspections. We would expect providers to comply and cooperate fully with our inspectors throughout the inspection so that an accurate account of the true nature and level of care is uncovered and subsequently published. This will inevitably raise costs for such providers and will depend, in part, on the size and complexity of the service to be inspected, as well as the time spent on site by our inspection team with regards to our inspection.

56. Following an inspection, costs to providers may increase or decrease according to the outcome of the inspection, including the rating and if any breaches of regulations were identified. For example, providers that are given a requires improvement or inadequate rating may need to be inspected more frequently in future, whereas those rated good or outstanding might only subsequently receive targeted inspections. This has a direct cost impact on providers. Those which are performing poorly will need to demonstrate how they are improving, and might need to spend more time with us to put in place plans to deliver better quality care. This will be the case for practices in special measures as they will be re-inspected every six months.

57. We are in the process of exploring ways in which CQC will take tougher action on providers that consistently do not meet their registration requirements. This could include the ultimate cost to the provider, which is cancelling their registration, if they repeatedly fail to provide acceptable levels of care. For more information on this we recently launched a consultation on our special measures regime for GP practices.

i. Estimating the costs to providers of our new inspections

58. Our new inspection model was piloted at around 350 GP practices from April 2014 to September 2014. We surveyed five GP practices following their inspections to find out what they had done and how long it had taken them to prepare for and accommodate our inspections. Using this information we estimated the cost to each provider 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.

59. Table 7.2 shows the range of costs incurred by these practices. To estimate the cost to providers we used the reported time spent by each member of staff multiplied by an appropriate wage rate. The assumptions for wage rates are detailed in table 7.3.

Table 7.2: Estimated cost to NHS GP practices respondents of being inspected

GP practice	Estimated cost	Number of employees
1	£700	7
2	£240	32
3	£1,900	6
4	£890	28
5	£780	15

Source: CQC regulatory economics team analysis

60. What table 7.2 shows is that costs varied a lot across the five providers we surveyed. It appears that there is no relationship between the size of the GP practice (as proxied by number of employees) and the cost they experienced. The information provided to us indicated that the bulk of the costs experienced by providers was associated with preparing for the inspection. On average around 85% per cent of the time these GP practices spent on inspection was in planning

and preparation, which included collating information requests, staff briefings and preparatory meetings with CQC.

Table 7.3: Staff titles and their assumed hourly wage rates

Role in care home	Hourly wage
GP	£30.78
Practice manager	£14.74
Nurse	£16.11
Receptionist	£9.95
Dispensary manager	£20.28

Source: Regulatory economics team assumptions using ONS ASHE 2012 data

61. In addition to the costs incurred from being inspected, two of the practices surveyed reported ongoing costs as a result of CQC regulation. One practice reported monthly costs of £160 to maintain Health and Safety standards on an ongoing basis. Another practice reported an approximate annual cost of £1,000 for mandatory training of administration staff.

ii. Risks and limitations

62. We should treat the figures in table 7.2 with caution. The information from these practices used in this analysis was collected some time after their inspections had been completed. So the information provided could be quite imprecise hence our estimates might not accurately capture the true cost of inspection experienced by these practices.

63. Furthermore this is an initial analysis on the basis of the information we have received so far from five practices. The results presented in table 7.2 could change if we refine the analysis and receive additional responses from practices.

64. It is important to note that these cost estimates cannot be aggregated to estimate an annual cost to all GP practices of CQC inspections. This is for the following reasons, including the limitations mentioned in the two preceding paragraphs:
    - The five responses we received are not representative of the sector as a whole.
    - 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.

c. Specific cost impacts on NHS GP out-of-hours services

65. We envisage that the costs of inspection to NHS GP out-of-hours services are similar to those experienced by GP practices. At the time of publication we had not yet received information from GP out-of-hours services on the burden they faced due to CQC inspections. We are therefore not able to replicate the preceding analysis for these services.

d. Specific cost impacts on CQC

66. As a result of the new inspection model CQC is likely to experience higher costs over and above what it previously cost us to regulate, monitor and inspect NHS GP practices and GP out-of-hours services. This stems directly from using bigger inspection teams, which now routinely include GPs and sometimes additional specialist advisers and Experts by Experience. In the shorter term we expect costs to be even higher – this takes into account the development, testing, piloting, evaluation and roll-out of the regulatory model. Over time we expect that these costs will decrease as the CQC makes efficiency gains in the way it targets inspections based on the risks and demands placed on us by the sectors.

67. Another element of the inspection model leading to extra costs is the provision of ratings, which is a new process for CQC. Hence, we will experience additional costs in providing ratings and updating ratings for all providers throughout the end-to-end inspection process. It is uncertain what these costs are likely to be in the long term; however, these are likely to be higher in the shorter term as we assess ratings for all GP practices and GP out-of-hours services by April 2016. In the future, costs associated with ratings may decrease as all providers will have had a CQC comprehensive inspection and rating, and we move towards a ‘steady state’ model.

68. Table 7.4 summarises the activities for CQC required by the new inspection model. The RAG rating indicates how much more costly these activities are under the new model compared to our previous model. For example, CQC interviews with staff are highlighted as amber. Although the CQC inspectors interview staff as they did under the previous inspection model, we expect CQC will undertake more staff interviews as our inspections are now broader.

Table 7.4: Cost burden to the CQC of activities in the new inspection model

Activity	Changes in costs to the CQC [RAG rating]
Gathering and analysing information from the public and stakeholders	
Producing data pack	
CQC interviews with staff	
Rating process	
Report writing	
Closing the visit meeting	
Post-inspection meeting	

i. Our estimate of the cost of inspections over the longer term in the steady state

69. 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 inspections might be once the new inspection model is well established, i.e. in the steady state (for a description of steady state see paragraph 46).

70. These cost estimates were produced using assumptions around how much time different inspection team members spend on an inspection of a location and applying appropriate wage rates to these lengths of time. We did this at the level of type of staff on an inspection: CQC inspectors, Experts by Experience and specialist advisers. We multiplied the time assumptions by assumed daily wage rates for each group. We applied an uplift of ten per cent to staff costs to capture the cost of expenses. Table 7.5 shows the assumptions used in these calculations on average daily wage rates and expenses. These assumptions are based on preliminary work by the CQC cost of delivery team to estimate the daily cost of a CQC staff member on inspections. These daily rates are likely to be refined further in autumn 2014. In particular, we think that the daily rate for inspector managers is likely to be to lower than that presented in table 7.5. This will reduce the estimates presented in paragraph 71 by only a small amount given how little time inspector managers are assumed to spend on an individual inspection (see table 7.6).

71. We estimate that the cost of inspecting a GP practice and GP out-of-hours service will generally be in the **range of £2,300** for smaller practices with 5,000 or fewer registered people who use their services **to £5,600** for larger practices with more than 15,000 registered people who use their services. Hence, the cost to CQC of an inspection will depend on the size of the provider being inspected; generally the larger the provider the larger the inspection team required. Table 7.6 presents the assumptions on how long inspection team members are assumed to spend on inspections. The assumptions have been taken from CQC's resourcing model and have been informed by work by CQC on the cost of inspections.

Table 7.5: Daily wage rate assumptions

Role	Wage rate
CQC inspector	£333
Inspection manager	£620
Expert by Experience	£300
GP specialist adviser	£540*
Specialist adviser – all other types (e.g. practice manager, practice nurse)	£300

*Per inspection rate
Source: CQC cost of delivery group

Table 7.6: Assumptions on staff time on inspection in our direct cost estimates

Staff type	Number of days per staff type on an inspection*
Inspector	3 to 10 days per inspection.
Inspector manager	They spend more time on inspections of services judged to be riskier. We capture their total time across all inspections by assuming they spend 1/7 of the time of an inspector on an inspection.
Expert by Experience	Used flexibly[1]. For the purposes of planning and budgeting, Experts by Experience are assumed to be involved in approximately 17% of inspections for 1 day.
GP specialist adviser	One day per inspection.

[1] Experts by Experience will be involved on inspections depending on risk and size of the location to be inspected. For example we may choose to use 2 Experts at a large site and 1 across a few very small locations.

Specialist adviser (e.g. practice manager, practice nurse)	Assumed to be involved in approximately 30 per cent of inspections for 1 day [2].

*Assumptions vary according to the size of the trust
Source: CQC resourcing model

72. The assumptions presented in tables 7.5 and 7.6 are based on the typical size of inspection teams for GP practices and GP out-of-hours services. Typical team sizes are described in Box 7.1 below.

Box 7.1: The profile of typical inspection team sizes under our new approach

GP practice & GP out-of-hours service

A typical inspection is one day on site and takes up to nine days from preparation for the inspection to report writing (for larger locations). An inspector manager will have oversight and may be involved on the basis of risk or sample locations. An inspector will coordinate the inspection and be involved in the end-to-end process. The size of inspection teams will depend on the size and complexity of the service to be inspected. We will make use of a range of specialist advisers, including GPs, practice nurses, practice managers and Experts by Experience as required. All inspections will include as a minimum a trained inspector and a GP specialist adviser.

ii. Risks and limitations

73. 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. We cannot say that they represent an accurate picture of what the costs of inspections are in future. However, they provide a useful indication of what costs could be reflecting gains from learning and improvements as the inspection process matures.

74. We should highlight further limitations of these cost estimates. The first is that they are based on predictions around the use of staff time on inspections. We do not actually know if these will materialise in future. The second is that the estimated costs in paragraph 71 do not capture the costs to CQC of all activities related to an inspection. CQC is currently considering ways to estimate, what we call, these 'indirect' costs of an inspection. This work is at the stage of

[2] In reality specialist advisers will be used flexibly depending on individual circumstances at locations and risk.

establishing the principles to ensure an accurate attribution of these costs across the sectors we regulate. The third is that, as mentioned in paragraph 70, CQC will continue to refine our estimates of how much it costs to involve CQC inspector staff on inspections. This could change our estimate of the cost of inspection in steady state, and reduce the estimates presented in paragraph 71.

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

75. Impact assessments typically include an estimate of how much the change in policy being considered costs relative to the status quo. For 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.

76. 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.

77. We have used time recording data to estimate the average cost of an inspection under the previous inspection 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 in each sector over the same period to estimate the average cost of an inspection. As a result of this methodology, these estimates tell us only what we spent on CQC staff on an average inspection. We did not previously record details on where we employed external staff.

78. To ensure that these figures are comparable with our estimated costs of new inspections, we have isolated CQC staff costs on these new inspections too (i.e. we have removed the cost of expenses and non-CQC staff inspectors from the cost estimates presented in paragraph 71).

Table 7.7: Comparing costs of inspection in the old and new models

Average cost of an inspection	
Old model	**New model**
£1,700	£1,300 – £4,200

(NB. excludes cost of external inspectors and expenses)

79. As noted above we will not use the figures presented in table 7.7 to produce marginal cost estimates of our new inspections. This is for the following reasons. First, the average cost of an inspection under the old and new models has been calculated using different methods. Second, we have not included non-CQC staff costs and the cost of expenses in this analysis so the estimates do not provide us with enough information to estimate the true marginal cost of new inspections.

80. The figures presented in table 7.7 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.

e. Specific cost impacts on other organisations

81. Some organisations are likely to incur additional costs from the new inspection model as CQC intends to collect more information from them to inform provider inspections. Organisations from which CQC is likely to request information include the following:
    - CCGs and NHS England Area Teams.
    - Local education and training boards (post-graduate deaneries).
    - Local authorities.
    - Other local health and social care services, including local authorities, hospitals, care homes, public health departments.
    - Local GPs and other practice staff about the quality of GP out-of-hours services.
    - General Medical Council.
    - Nursing and Midwifery Council.
    - Health and wellbeing boards.
    - Nationally collated feedback from people who use services and carers (for example patient survey data, evidence of complaints from the Parliamentary and Health Service Health Ombudsman, NHS choices, family and friends test).
    - Healthwatch.
    - Third sector and organisations.

82. Other organisations will face additional costs because some organisations should have clear roles to play in encouraging NHS GP practices and GP out-of-hours services to improve. These activities did not formally occur under the previous inspection model.

83. It is uncertain as to what the cost impacts to commissioners are likely to be as a result of the changes. The organisations formally involved in the inspections at the beginning and at the end are clinical commissioning groups (CCGs) and NHS England Area Teams. The new inspection model will add to the burden on these organisations. Where providers are given a requires improvement or an inadequate rating, this could require commissioners to help these providers improve.

84. There may be further direct actions for CCGs as a result of our inspections. As we will inspect practices on a CCG basis we might find that they need to improve commissioning for certain population groups. If this is the result of a series of inspections within a CCG then this will lead to further costs for the CCG.

85. However, for commissioners, the burden from the new inspection model could decrease if commissioners conclude that they do not need to inspect practices themselves, particularly following a good or outstanding rating by CQC.

f. Summary

86. While it is clear that additional costs will arise to a range of parties, most notably CQC, as a result of the new inspection model, 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 our new inspection model.

8. Benefits

87. In this section we explore the main intended benefits of our new approach, and where it exists we provide evidence to support these benefits. This evidence has been gathered from consultation, surveys and interviews. Through these channels we have engaged with the public, providers, people who use services and our own staff.

88. If the intended benefits emerge from our chosen regulatory approach in GP practices and GP out-of-hours services then its impact will be widespread, given that there are 8,500 GP practices. General practice is an integral part of the health sector; GP practices are usually the first point of contact for a patient seeking treatment or advice about their health. Around 90 per cent of contacts with the NHS are with these services. There are approximately 300 million consultations a year and only five per cent of patients are referred on to secondary care.[3] It is difficult to specify how the benefits arising from our new inspection model will materialise; however, we anticipate that patients should receive better quality care. As a result of our new model, poorly performing GP practices will either have to improve or they will no longer be able to provide services.

89. The benefits we discuss in this section are likely to arise once the new inspection model has been established for a while – we wish to explore the steady state benefits of the model. We explore the steady state benefits because not all stakeholders are likely to experience increases in benefits immediately – the changes we are implementing 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 to people who use services could stem from having more reliable information about the quality of care provided via publication of our ratings and reports. A longer term benefit could arise from incentivising providers to make continual improvements in the way they provide care as a direct result of these ratings.

90. CQC aims for people who use services to benefit the most from the changes we are making. We want to ensure that NHS GP practices and GP out-of-hours services provide people with safe, effective, compassionate, high-quality care and we want 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 approach prior to its implementation in October 2014. When designing our inspection models we listened to feedback from our partners, people who use services, provider groups, and other

[3] RCGP – The 2022 GP – Compendium of Evidence

stakeholders. This helped to ensure that we have a model that is efficient and effective, which also provided value-for-money for stakeholders.

91. In this section, first, we consider the benefits to the public and people who use services. Second, we discuss the intended benefits to providers. Third, we explore the benefits intended for CQC and other stakeholders arising from the new inspection model.

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

92. People who use health and care services should be the prime beneficiaries from CQC's new inspection model. We set out in more detail below, supported by evidence, the benefits that we think will be experienced by people who use services from the new inspection model.

i. Confidence for people who use services

93. CQC will be able to make better informed judgements about the quality of care provided in NHS GP practices and GP out-of-hours services. This is to be achieved through more comprehensive inspections and expert inspection teams. This will benefit those who use services as more information will be made available to them on the quality of care that NHS GP practices and GP out-of-hours services provide.

94. 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. We aim for our assessments 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 CQC regulation of providers and in the information we provide so that they can be confident in the assurance we provide about local services.

95. Confirmation that people who use services should have more confidence in CQC judgements of service quality comes from the largely positive responses to our proposed characteristics of good care detailed in our GP and GP out-of-hours consultation provider handbook. At consultation events, providers and staff broadly agreed with the description of what good care looks like in NHS GP practices and GP out-of-hours services, although they felt some of the language needed to be amended slightly. People responding through the public online community all agreed or strongly agreed with the description of our proposed rating of good. There was less support for the description of inadequate, however.

The majority of those responding online agreed with the way all the ratings (good, outstanding, requires improvement, inadequate) were described.

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

96. 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 these services.

97. This feedback will be used to plan and direct inspections. Furthermore, CQC should be able to provide reassurance that poorly performing services will be more easily identified and action taken to improve them. During inspection we will listen to people's views of the provider being inspected.

98. Confirmation that it will be beneficial to gather opinions on services comes from those responding to our consultation. Many said that they thought it was important to collect opinions from people who use services.

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

99. A clear departure from the previous inspection model is the introduction of ratings. Under the previous inspection model, NHS GP practices and GP out-of-hours services were either compliant or non-compliant with the regulations being inspected. In the long term we expect the new inspection model to raise awareness that the quality of care can vary across NHS GP practices and GP out-of-hours services.

100. We will focus on how GP services are provided to key population groups. These ratings will enable those choosing services to find out how the services they are considering using treat those who are similar to them.

101. By providing ratings, people who use services will be able to get a clearer view of the quality of services provided by NHS GP practices and GP out-of-hours services. A comprehensive and tailored assessment will more clearly define poor and good practice and what people who use services can expect from services. In the event that people who use services have choice over which NHS GP practice to attend, they can use the more reliable and comprehensive information we provide to make better informed choices.

102. Thirty eight members of the public online community responded to an online survey asking for their views about two published GP out-of-hours service inspection reports. The majority of respondents felt the reports were clear or very

clear, although some respondents thought the reports were too wordy and would benefit from the inclusion of pictures, graphs or tables. The majority of respondents agreed that the report did help them to understand the quality of the service being provided.

103. Feedback from members of the public who read inspection reports was positive. The new-style reports for GP out-of-hours services were considered to be easy to read, well laid out, concise and contained relevant information. Those reading the documents expressed a preference for ratings as they provided the key information on the provider at a glance.

104. Our published inspection reports can be found on the CQC website and are available as links through the NHS Choices website.

iv. Encouraging services to improve

105. Ratings should encourage services to improve. We expect providers to seek to achieve either outstanding or good ratings. In order to achieve these providers will raise their standards in line with our expectations for these ratings. Ultimately this benefits patients through the reduction in poor care in some providers and the provision of a better standard of care across all providers.

106. We know that the majority of people receive good quality care from their GP. However, our first 1,000 inspections of GP practices have also highlighted some clear examples of poor quality care. Although they happened in a minority of practices, they had a significant impact on a large number of patients and on health and social care services in the local area. For example, we found a practice at which staff were directing patients to A&E during working hours when no doctor was available. In others we discovered out-of-date medicines, some of which were there to be used in emergencies. There were also examples of vaccines being stored incorrectly, which could have potentially put hundreds of lives at risk. We will use the full range of our enforcement powers in response to services that provide poor care to make sure that they improve. This will include, where necessary, stopping a practice from providing services or prosecuting it. We are currently consulting on our enforcement powers.

107. As people can choose which GP practice to register with, if many people choose not to register with a particular practice because of its poor rating this should put pressure on the practice in question to improve its services. However, we do recognise that this could increase pressure on nearby practices with better ratings, which might gain registered members.

108. There is some evidence to support that, competition among providers drives improvements in the quality of care.[4,5] In a system which accommodates patient choice and in which information about the quality of services provided is available, we might expect there to be pressure for providers to improve relative to their neighbours to attract people who use services. We would welcome this as an outcome if our new inspection model facilitates this process.

109. People who use services should also benefit from better outcomes if the new inspection model leads to more informed commissioning of services which meets the needs of local people.

b. Specific benefits to providers

110. Providers should benefit directly from the changes to how we regulate and inspect NHS GP practices and GP out-of-hours services. The advantage of the key questions being consistent across all sectors is that it creates a 'level playing field' approach that treats all providers in an even-handed and fair way. We also envisage that there will be reputational benefits to providers of being in a sector which is transparently and robustly regulated.

111. In the remainder of this section we draw on evidence from consultation responses and the CQC post-inspection provider survey, which is ongoing. Although we have not received many responses to this survey so far, a relatively high proportion of the responses received were from GP out-of-hours providers, therefore we present some findings from the survey below. Given that the number of responses is small, and contains respondents from other sectors 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.

i. Improved transparency for providers on how we will regulate, inspect and rate them

112. CQC's new inspection model is underpinned by clear principles and guidance. The ratings that providers receive are based on clear standards and are supported by evidence in inspection reports. The inspections are undertaken by experts in general practice. This expertise and transparency that we bring to inspections and their outputs will show practices and services that we seek to

[4] Response to the consultation, *Liberating the NHS: no decision about me, without me,* September 2012, pp 4 - 5

[5] Santos et al (2013), *Does quality affect patients' choice of doctor? Evidence from the UK*, Centre for Health Economics, University of York, July 2013

support them. This transparency should also benefit the sector as they will know what changes to make to their services to achieve the top ratings.

113. The new inspection model and ratings should also help providers gauge their performance and benchmark themselves against other NHS providers. In that sense the model will always provide the opportunity for providers to improve as a result of their own actions.

114. We are now collecting more information and data from a wider range of sources under the new inspection model. This will ensure that judgements about provider performance are more credible as they are supported by more detailed information. Hence, we anticipate that more providers are likely to agree with and sign up to our assessments of their performance.

115. Of the GPs surveyed as part of our consultation process:

- **Twelve out of twelve** said that they have confidence in the changes the CQC is making to the way it regulates, inspects and rates health and social care services.
- **Eleven out of eleven** said they feel the CQC has improved in the last two years.

116. Of community (1), social care (2) and GP out-of-hours providers (5) responding to the post-inspection survey of providers**,** respondents were generally positive about the thoroughness of the inspection against the five domains: safe, effective, caring, responsive and well-led. As positives of the new inspections they recognised good communication, probing interviews, a wide range of evidence and knowledgeable CQC Inspectors. One respondent from primary medical services commented, "*The inspection team were very thorough and were keen to assess knowledge of our entire team."* Another commented: *"Although the inspection was only for a number of hours the interviews and evidence requests were searching and provided a good flavour of our service delivery and management*."

ii. Giving NHS GP practices and GP Out-of-hours services staff a voice

117. The new inspection model includes opportunities for staff to provide feedback to CQC inspectors on the NHS GP practices and GP out-of-hours services for which they work. CQC intends to protect those who provide us with feedback.

118. Of inspection team members surveyed, 87 per cent (79/91) responded that they completely or mostly felt they achieved a good understanding of the views and experience of front line staff (for example, GPs, nurses and receptionists).

119. Of community (1), social care (2) and GP out-of-hours providers (5) responding to a post inspection survey, all eight 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. One commented, "*The team were around for a long time and spoke to most of the staff on duty during that time about the service.*"

iii. Acknowledgement of and sharing good practice

120. The advantage of the new inspection model is that the CQC will recognise and publicly acknowledge NHS GP practices and GP out-of-hours services that provide good quality services. It is CQC's intention that through this mechanism good practice can be recognised and will spread throughout the sector.

121. A key way that this will happen via our new inspection model is through specialist advisers. Specialist advisers on inspections will be employed by other NHS GP practices and GP out-of-hours services. If they identify good practice in the NHS GP practices and GP out-of-hours services they inspect they can take these ideas and apply them where they work.

122. We surveyed inspectors following their experiences on inspections under our new methodology. We asked the question: *Are you currently employed by a health or social care provider? If yes, as a result of your experience of the inspection(s) is there anything that you plan or have shared with your organisation?*

123. In response to this question there were many comments from people who were employed by a health or social care provider that indicated they had indeed shared experiences of inspection with their organisation. Several GPs said that they had shared instances of good practice they had observed at other practices during inspections.

124. Examples of learnings from inspections are as follows. One respondent said that, "The visits helped me to learn and I have shared the good practice in my own practice". A practice manager who was given information about an off-site service for patient records told us that he is now considering using it in his practice. The manager then proceeded to explain that inspections present a good opportunity to learn what good and bad looks like in GP services; he said that he could take this knowledge back to his employer to identify bad practices and to highlight good ones. A more specific example of how innovation can spread is that one GP said that on an inspection he had seen the value of patient

participation groups in practice development. So he said he was considering setting up a group at the practice where he works.

125. When specialist advisers were asked the same question about the GP out-of-hours inspections they had been on, the following examples were given. One adviser responded that he had shared good practice from his inspection experience, and spotting bad practice on inspection has helped him to improve his service. Another specialist adviser reported sharing what he had learned on inspections with his local practice manager group.

126. On the basis of our initial GP out-of-hours service inspections we published a report in October 2014 summarising our findings from these inspections, and we highlight the good practices that we found.

iv. Identifying where GP practices and GP out-of-hours services can make improvements

127. Not only will inspections identify what good practices are, the inspections are designed to identify where services, practices and processes need to be improved. A credible CQC assessment will provide NHS GP practices and GP out-of-hours services with a clearer view of the quality of their services, their strengths and weaknesses and how they can improve.

128. A longer term benefit from the new inspection model might be that NHS GP practices and GP out-of-hours 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.

129. Of community (1), social care (2) and GP out-of-hours (5) providers responding to a post inspection survey**,** all eight either agreed or strongly agreed that, **'**The inspection visit helped us to reflect on how we could improve our service**'.** A range of specific improvements were noted; including:

> *The inspection made us review all our practices and I believe the biggest improvement was around communication and engaging with staff*.
>
> *We now have better policies and procedures and better compliance which improves patient safety*.

v. Shifting focus to quality of care

130. The new inspection model is designed such that there is a renewed emphasis on the quality of care provided in NHS GP practices and GP out-of-hours services. Through the introduction of ratings we hope that providers will strive to achieve a rating of outstanding. There may be two reasons for practices and services to do so. The first is that better rated providers may be more appealing to people who can choose their GP practice. Second, for those providers that are rated good or outstanding it is likely that they will face a decrease in costs associated with facilitating CQC inspections as they would not need to be inspected as frequently as those which are rated as requires improvement or inadequate.

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

- GP practice partners and leaders become focused on quality of care and recognise their personal role in achieving high quality care in their organisation.
- The new model should promote a dialogue between providers and commissioners that focuses on outcomes for people who use services rather than activity and cost.
- Staff working for providers believe in, and participate in, building high-quality care and professional practice.
- Staff act on and speak out about poor quality care.
- Providers not providing good quality care are held to account by third parties using our information.

c. Specific benefits to CQC

132. CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of practices and 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 provided by practices and services. In addition to opinions from specialists and experts, inspectors will also have access to more information from external sources to direct their investigations and to support their judgements.

d. Specific benefits to other stakeholders

133. 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.

134. In particular we plan to collaborate closely and develop good working relationships with CCGs and the Area Teams in NHS England to avoid duplication of activity.

135. As part of the new inspection model we also plan to receive and to share information with a wide variety of bodies in the sector, like the General Medical Council. The additional information we share with them will provide useful in the work they deliver.

i. Commissioners

136. The key benefit of CQC's new inspection model to commissioners is that our assessments will provide them with a clearer view of the quality of provider services. This will inform their commissioning decisions and should enable them to make better decisions on behalf of people who use services. This evidence base should facilitate and promote a dialogue with providers that focuses on outcomes for people who use services rather than just activity and cost.

137. Commissioners of services should also benefit as they are more likely to receive better information about the quality of services. A possible benefit from our findings, especially given that we inspect GP services on a CCG basis, is drawing out broader findings for how well services are currently commissioned and how effectively practices and services (on a CCG basis) serve the needs of the local population.

138. There may also be reduced duplication with regards to inspection effort by commissioners as they should have more confidence in CQC's rating system, especially given our commitment to increased transparency. This should free commissioners' time to concentrate on core commissioning activities, with stronger links being built between GPs, CCGs and other stakeholders concerned.

ii. Organisations with which we share information

139. As part of the new inspection model we plan to receive and share information with a wide variety of bodies in the sector, like the General Medical Council. We envisage that both CQC and the organisations with which we share information (see list on page 24) will benefit as a result. Indeed the General Medical Council has told us that they are:

…Seeking to work closely with the CQC, in particular, around information sharing. We have already developed a Joint Working Framework with the CQC and are developing a joint approach to the evaluation of the Operational Protocol, with an interim evaluation scheduled for September 2014 and a full evaluation in September 2015.

9. Next Steps

140. The final inspection model as described in this regulatory impact assessment and in the final provider handbook was rolled out on 1 October 2014.

141. CQC will continue to engage with providers, 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 model. 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

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

- We will continue to monitor our new inspection model through activities including our post-inspection survey of providers and post-registration survey of providers. We will also be piloting a survey of inspection team members; and
- We have commissioned an external economic consultancy to establish a methodology for the CQC to assess its costs and benefits on an ongoing basis. This work should provide a more comprehensive and detailed view of the impact the CQC has on all stakeholders.