



Changes to the way we regulate and inspect services specialist substance misuse services

Regulatory Impact Assessment

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

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

Contents

1. Introduction	3
2. Background to policy changes	4
3. Summary of proposed changes from 1 April 2015	5
4. Scope of impact assessment	6
5. CQC assessment of impacts.....	7
6. Costs	12
7. Benefits	14
9. Next steps	19

1. Introduction

1. This document provides an assessment of the likely costs and benefits of the proposed changes that will affect providers of specialist substance misuse services, such as those that provide services in a community, community residential or inpatient setting.
2. We propose to roll out our regulatory model from April 2015. Initially, we will inspect and rate independent standalone substance misuse services. We will continue to test the feasibility and scope of inspecting and separately rating substance misuse services offered by other providers, such as NHS mental health and acute trusts and GP practices, with a view to rolling this out after the current inspection cycle for these providers ends.
3. Our new methodology was developed in collaboration with stakeholders, including providers, people who use services, national organisations, commissioners and government organisations.
4. The proposals follow on from commitments made in our previously published signposting document titled: ["A fresh start for inspecting and regulating substance misuse services"](#).
5. We will pilot, test and evaluate our proposed new approach to ensure we have a robust model that is fit for purpose. We also welcome your feedback as to what you believe the impacts will be on your individual organisations as a result of these proposed changes and have included some questions at the end of this document for stakeholders to consider.

2. Background to policy changes

6. The way we will regulate and inspect all providers of health and social care is changing. We want to ensure we have a regulatory model that is fit for purpose to regulate the many different providers across several sectors that provide a multitude of different and diverse health and social care services.
7. Publication of our three-year strategy and new start documents in 2013 set us on course to propose these fundamental changes. Our subsequent provider handbook consultations covering NHS acute hospitals, community healthcare, specialist mental health, adult social care and general practice services outlined further in-depth plans for how we would regulate these services in future. These proposals have now fully been implemented and are operational as of October 2014. We are also consulting on our plans for how we will regulate providers of [independent healthcare, ambulances and dental services providers](#) with a view to rolling out the proposed changes from April 2015.
8. To date, feedback from our stakeholders has largely indicated widespread support for our new model of regulation and inspection. In particular, stakeholders acknowledge the role that ratings can play in driving improvements in care quality and have welcomed the use of experts and specialists on our inspections of services under the new model.
9. We now want to build on these successes by applying a similar regulatory and inspection framework to substance misuse service providers. In doing so we will be creating a level playing field that ensures we are using an established model. However, where appropriate, we will make changes to make sure that we continue to employ the most appropriate regulatory methods to capture key differences inherent in other sectors.
10. We know that there will be a number of specific challenges to regulating the substance misuse provider community. Substance misuse treatment is a unique, diverse and multifaceted sector and people using these services often have complex and varied needs. Treatment may be short or long-term, and people's needs can be immediate or life-long. Outcomes for people who use substance misuse treatment services vary, and people often need help from a number of agencies. We want to make sure that we tailor our approach to focus on issues of key importance to stakeholders. This ensures we capture key differences across hospital inpatient, community settings and residential facilities accordingly, as well targeting our effort so as to add maximum impact. We will also need to ensure that we have a skilled operational workforce that understands the complexities of the sector.
11. Our consultation document published alongside this impact assessment brings together all of our current thinking on how best we can implement these changes. We want to ensure our model maximises benefits to stakeholders while helping to reduce unnecessary burden on those providing good care. We will continue to test, evaluate and refine the model to achieve these specific aims.

3. Summary of proposed changes from 1 April 2015

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

We propose that independent standalone substance misuse services will be inspected and rated under a new regulatory model to be rolled out from April 2015. This includes providers that provide care in community settings, inpatient facilities and those in residential centres.

We will continue to consider the scope and feasibility of inspecting and separately rating substance misuse services offered by other providers, such as NHS mental health and acute trusts, with a view to rolling this out after the current inspection cycle for these providers ends.

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 to define key indicators for monitoring the quality of services and identify the right information sources.

Inspection

The new CQC framework is based on five key questions. Inspectors will judge whether a service is safe, effective, caring, responsive and well-led. We will use key lines of enquiry to help guide our inspections. Inspection teams will generally include a CQC inspector with further training in substance misuse treatment services, and we will make appropriate use of Experts by Experience and specialist advisors.

Rating

At this stage we will begin to rate only independent standalone substance misuse services from April 2015. Ratings will be based on a four-point scale: outstanding, good, requires improvement, inadequate. The frequency of inspections will generally be directly linked to the overall rating awarded. We propose to rate independent standalone substance misuse services at key question and location level. We are further developing our approach as to how we rate independent substance misuse services that provide a multitude of services and will engage with providers as we develop our approach. We are also considering our approach to separately rating substance misuse services delivered by other providers, such as NHS mental health and acute trusts and GP practices, and will test this with a view to rolling out our approach after the current inspection cycle for these providers ends.

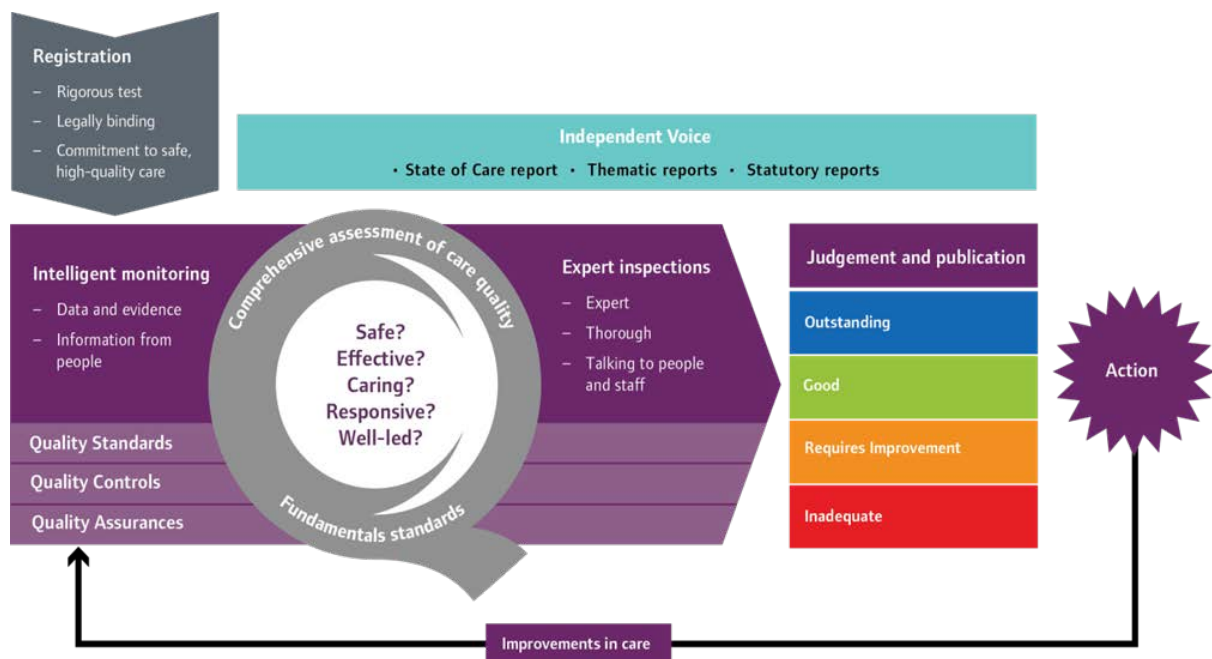
Enforcement

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

4. Scope of impact assessment

13. In this document, we describe our assessment of the likely costs and benefits arising from changes to the way we regulate and inspect substance misuse service providers, as set out in the consultation provider handbook. We discuss the costs and benefits arising from changes to inspections and ratings. These activities are represented in Figure 1 under the titles 'Intelligent Monitoring', 'Expert inspections' and 'Judgement and publication'. The activities 'Registration' and 'Action' are not covered in this impact assessment.
14. 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.
15. Our new registration process is not covered in this Impact Assessment because the policy is under development. Once the policy has been developed further we may assess its costs and benefits publicly if we deem its impact to be sufficiently significant.

Figure 1: CQC's overall operating model



5. CQC assessment of impacts

a. Overview of the previous substance misuse regulatory model

16. CQC regulates substance misuse services in hospital inpatient, community and residential settings. Specialist substance misuse services are not only delivered in different settings, but also by different types of providers (including independent providers, NHS mental health and acute trusts, and GPs) and providers of different sizes. Not all substance misuse service providers are required to register with CQC; further information is available in the consultation document and our [Scope of Registration](#) guidance.
17. To date, substance misuse services have been inspected under a generic compliance framework based on compliance. Quality of care was assessed against the 16 essential standards, and set the basis for any further action required should some areas be found to be non-compliant.
18. The nature of the actual inspection depended on a variety of factors that CQC took into consideration when planning an inspection of providers. The size of our inspection team, type of inspection and areas of the essential standards covered would all be dependent on the provider, the type of service provision, qualitative and quantitative information received (Intelligent Monitoring), previous compliance status and any other identified issues to be addressed.
19. To date, inspections of substance misuse services have not been treated differently to other sectors that fall under our regulatory remit. Our inspections have not focused on specific services or provider groups unless a risk was highlighted. Inspections occurred on an annual basis unless they had a compliance action against them. We inspected all substance misuse services that come under our regulation unless they were part of a trust, in which case they would be inspected following trust procedures (i.e. when we previously inspected trusts we would not inspect every single location or ward, but select a cross section - again based on information held by CQC).
20. At the time of publishing this document, CQC has recently started piloting its new approach to inspecting substance misuse services. The new approach will be tested in a total of 12 substance misuse services provided by NHS mental health trusts and independent providers between January and March 2015. We will roll out our new regulatory approach from April 2015, initially focusing on independent standalone providers of substance misuse services. We will continue to consider and test our approach for other providers of substance misuse services with a view to rolling this out following the completion of the current inspection cycle for these providers.

b. Policy objectives of proposed new approaches

21. A key driver for proposing changes is our recognition of the complexity of the substance misuse sector, and therefore, the need for a tailored approach. Inspections of independent substance misuse services will be undertaken by our hospitals (mental health) directorate. The principles of the approach will be the same as those for other sectors. However, the detail of how we do this will be specific to the sector and the services within it. This will include using inspectors

with further training in substance misuse treatment services and customisation of some of our methods, including the way we gather information, some of the questions we ask, and the type of data we use to assess risk. This will help to ensure that inspection teams have better expertise and information to inspect and appropriately assess services in this complex sector, and that inspectors are better able to focus on the issues that matter to this sector.

More generally, as with other sectors, a key reason for proposing changes to the way we regulate and inspect substance misuse services is to ensure that standards improve. We want to ensure that high performing organisations are commended and can act as role models for all providers to make continual improvements. Also, focusing on how safe, effective, caring, responsive and well-led services are will enable us to review the quality of services focusing on what matters to people.

22. We wish to provide greater assurance to the public around the quality of care provided by substance misuse services. To facilitate this we will rate independent standalone substance misuse services that we inspect after 31 March 2015. We are currently considering our approach to separately rating specialist substance misuse services provided by other providers such as NHS mental health and acute trusts and GP practices and will test this with a view to rolling out our approach after the current inspection cycle is completed.
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, while poorer performers will have more frequent contact with CQC to ensure they improve.
24. Our ultimate objective is to provide a robust and credible framework which helps drive continual improvements in the way care is delivered. Providers will have access to clear advice and information to help them deliver these improvements.

c. Monitoring, inspecting and rating substance misuse services from April 2015

i. Registration

25. As a starting point we propose to make registration a more robust process. This involves ensuring that all new providers are subject to more rigorous checks. Registration will assess whether all new providers, whether an organisation, individual or partnership have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to provide people with safe, effective, caring, responsive and high-quality care. The assessment framework will allow registration inspectors to gather and consider comprehensive information about proposed applicants and services, including where providers are varying their existing registration and make judgments about whether applicants are likely to meet these legal requirements. In making these changes, CQC propose to focus on the robustness and effectiveness of the registration system in a way that does not stifle innovation or discourage good providers of care services, but also ensures that those most likely to provide poor quality services are discouraged from doing so. This will help to protect the safety of users of services while also safeguarding the reputation of those organisations that provide services within hospitals and community health care settings.
26. Beyond registration we propose to collect and make better use of information that is key to CQC being able to effectively target and monitor regulatory and inspection effort to those providers most likely to be providing poorer quality care. We will continue working to identify key indicators that define the most important areas to monitor in relation to questions we will ask about services. We want providers to be open and to share their data with us so as to minimise any duplication or regulatory burden associated with generating new information requests in the first instance.

ii. Inspection framework

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

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

The underlying principles and overarching approach to the proposed inspection model will be consistent with the new approach to inspecting [specialist mental health services](#). We are proposing to adapt the details of the approach to ensure that inspection teams can properly consider issues of specific relevance to substance misuse services. This includes:

- Ensuring that the key lines of enquiry (KLOEs) and ratings descriptors are generally consistent with those used for inspections of specialist mental health services, NHS acute trusts and GP practices, with small changes to make sure they reflect issues of significant importance to substance misuse services (these proposed KLOEs and ratings descriptors are published in the substance misuse service handbook consultation document that is published alongside this document).
- Inspection teams will utilise inspectors with further training in substance misuse treatment services, a relevant Expert by Experience (where possible) and a relevant specialist advisor (where necessary).
- Engagement activities will be tailored to capture the views of people who use these services, relevant staff and stakeholder organisations.
- Other inspection methods/information gathering will also be tailored, including by being more specific about the types of care records that will be looked at and, where applicable, looking at the use of restrictions on service users' movements and interactions. The information we request from providers is being tailored to substance misuse services – the specific information we will request from a provider will vary depending on the service, but is likely to include information about:
 - Staffing and governance
 - Safety and effectiveness, including serious incidents, adverse events and near misses; safeguarding referrals, and how the provider monitors and takes action in relation to safety and effectiveness
 - Complaints
 - Equality and diversity

- Medicine management
 - Current actions and planned improvements.
- Emphasis on transitions between services will be a key element of the inspection process.
28. We plan to roll out our regulatory model from April 2015. Initially, we will inspect and rate standalone independent substance misuse services.
29. We have already published provider handbooks that set out our approach to inspecting, rating and reporting on specialist mental health services, acute hospitals and GP practices. We are considering how best to incorporate elements of our proposed approach for inspecting specialist substance misuse services into our existing inspection frameworks for these providers, and will test this with a view to rolling out our approach after the current inspection cycle is completed. This approach will enable us an opportunity to ensure that relevant issues are appropriately considered, regulatory burden is minimised and that consistency of inspection and rating practices within the current inspection cycle is appropriately maintained.
30. We also expect some elements of the inspections process for independent substance misuse services to be informed by the approach to independent mental health providers, which is being further developed. This is intended to help to reduce any undue regulatory burden being placed on providers, particularly those that provide a multitude of services.

iii. Ratings

31. We propose to rate independent standalone substance misuse services at key question and location levels from April 2015. We are considering our approach to rating independent substance misuse services that provide a multitude of services. We will also continue to test the feasibility of separately rating substance misuse services that are delivered by other providers, for example NHS mental health and acute trusts and GP practices, with a view to rolling this out once the current inspection cycle for these providers ends.

iv. Enforcement

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

6. Costs

33. Changes to CQC's regulation and inspection of substance misuse service providers will have cost impacts and implications for a variety of stakeholders. In developing these changes we are keen to ensure that we develop a model that helps to minimise the impact of costs and overall regulatory burden on all stakeholders concerned. This will help to assure stakeholders that consideration of costs is central to the development of policy around how we will regulate and inspect these services in future.
34. A key purpose of this regulatory impact assessment is clearly demonstrating to stakeholders what those cost impacts are likely to be. As we are in our initial stages of testing our proposed new approach on such providers we cannot be precise on these cost implications to different stakeholders.
35. Development of the emerging regulatory model for substance misuse service providers will invariably include an element of developmental costs – such costs may or may not be a good indicator of the long term future costs of regulating and inspecting the sectors. For example, we may need larger team sizes initially in order to carry out comprehensive inspections of providers. If there are fewer concerns about care then costs should decrease as there would be less need to inspect as intensively. Similarly some providers may initially face higher costs themselves as a result of being regulated, as they are unaware how the new regulatory system could impact them. For example they might increase staff to facilitate inspection, or invest in systems to facilitate compliance.
36. We propose to continually test, refine and evaluate our proposed emerging regulatory and inspection model so that any unnecessary regulatory burden to stakeholders are reduced, and that stakeholders are assured the final model is efficient, economic and effective and provides overall value-for-money for all stakeholders.

a. Specific cost impacts for providers

37. Providers of substance misuse services will experience costs in relation to facilitating a CQC inspection. The marginal costs incurred by providers over and above our current inspection methods are likely to differ depending on how intensively we inspect. However, it is likely that costs will increase initially as we develop and test our proposed model, which may mean longer inspection days on site for different providers. Some providers may also experience additional costs associated with facilitating an inspection (for example, if a service assists us with service user engagement by helping to organise focus groups, allowing CQC inspectors to attend existing drop-in sessions or discussion groups or enabling us to use their peer supporters or service user representatives to help seek feedback from people who use the service).
38. Providers will also be required to submit key information to CQC as part of the inspection process. Costs incurred may initially be higher, however, where possible we will work with our strategic partners to ensure we do not duplicate information requests and impose undue regulatory burden. Costs may fall in future as information request templates become more standardised and providers implement systems to capture the required data on a routine basis.

39. The costs incurred to substance misuse services are likely to vary significantly in magnitude due to the size and variety of different organisations within the sector.
40. Our comprehensive inspections are also likely to initially increase costs to relevant providers as we seek to rate across all five key questions. Providers that receive a requires improvement or inadequate rating are likely to be inspected on a more frequent basis and would incur higher costs, whereas those that are found to be performing well are likely to see a reduction in inspection costs.
41. Initially these costs are most likely to affect independent standalone substance misuse services. We will continue to consider how best to incorporate elements of our proposed approach for inspecting specialist substance misuse services into our existing inspection frameworks for organisations such as NHS acute and mental health trusts and GP practices that provide substance misuse services, and will test this with a view to rolling out our approach after the current inspection cycle is completed. As part of this, we will seek to avoid imposing any undue regulatory burden on these providers.

b. Specific cost impacts to CQC

42. Costs to CQC are also likely to increase over and above what it currently costs us to regulate, monitor and inspect substance misuse services. This stems directly from implementing a tailored approach to inspecting substance misuse services, including training inspectors as well as integrating clinical specialists and Experts by Experience that may participate in inspection teams, and developing relationships with stakeholders relevant to substance misuse services and local service user groups to facilitate access to relevant information.
43. As the provision of ratings to providers is a new function for CQC, we will experience additional costs in providing ratings and updating ratings for providers throughout the end-to-end inspection process. It is uncertain as to what these costs are likely to be at present, but these are likely to be higher in the short term as we roll those out to independent providers of substance misuse services and consider the feasibility of separately rating substance misuse services provided by other organisations.

c. Specific cost impacts to other stakeholders

44. Other stakeholders may also experience some costs arising from our new inspections approach, particularly where CQC requests information from them as part of the inspection process.

7. Benefits

45. While changes to the way we regulate and inspect substance misuse service providers are likely to have cost implications for a number of stakeholders, it is important to note that there will also be more benefits that are likely to emerge as a direct result of these proposed changes.
46. In making these proposed changes we are keen to demonstrate to stakeholders that we roll out and implement an approach that puts maximisation of benefits at the centre of its approach to developing the new model. This will help to ensure that we have a model that is efficient and effective, while also providing value-for-money for all stakeholders.
47. We plan to continually evaluate and refine our regulatory model which has a core focus on ensuring the benefits to stakeholders are maximised, and will do this primarily through the piloting and testing of our proposed regulatory approach.
48. It is important to note that not all stakeholders are likely to experience increases in benefits immediately – the changes we propose to implement are likely to lead to smaller incremental increases in benefits and are likely to be experienced and sustained over a longer time period, i.e. several years. For example, an immediate benefit for users of services could stem from having more information about the quality of care provided via publication of ratings for relevant services, whereas a longer term benefit could centre on incentivising providers to make continual improvements in the way they provide care as a direct result of these ratings.
49. A key purpose of this regulatory impact assessment is demonstrating to stakeholders what the likely benefit impacts will be to such stakeholders as a result of making changes to the way we will regulate and inspect such providers in future. As we are in our initial stages of developing the model it is difficult to be overly precise as to what the size and magnitude of these benefits will be, as well as over what time periods we would expect these benefits to materialise. A more in-depth analysis of these emerging benefits will be conducted and publication of this analysis will be contained within a final regulatory impact assessment.
50. In the interim we include below what we believe are the main benefits to stakeholders as a result of changes we propose to make to the regulation and inspection of substance misuse service providers.

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

51. Those who use substance misuse services should benefit the most from our proposed new inspection model. We set out in more detail below what we believe will be the main benefits to service users as a result of changes to the regulatory model. Stakeholders should note that we will be testing these assumptions as we pilot and refine our approach across sectors and will ensure we make any necessary changes to the model.

i. Confidence for people who use services

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

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

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

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

For substance misuse providers a clear departure from the previous inspection model is the introduction of ratings, which will initially be rolled out to independent standalone substance misuse services from April 2015. Eventually the new inspection model should raise awareness among the public that the quality of care can vary.

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

iv. Encouraging services to improve

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

b. Specific benefits to providers

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

i. More comprehensive and credible CQC assessment of provider performance

57. Under the new inspection model the sources of information to support inspections and the depth of this information will be more thorough and tailored to substance misuse services. Along with the use of inspectors with further training in substance misuse treatment services, this will ensure that judgements about provider performance are more credible. As a result we expect that providers are more likely to think our judgements are credible and fair and are hence more likely to agree with our ratings.

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

ii. Giving healthcare staff a voice

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

iii. Acknowledgement of and sharing good practices

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

iv. Identifying improvements providers can make

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

62. A longer term benefit from the new inspection model might be that it encourages providers to give a higher priority to the development of information that assesses the performance of their services. Providers might improve quality systems and processes to ensure that quality is consistent across their organisation.
63. Where the CQC finds poor practices, and where improvements are not made, such providers may be subject to the failure regime that might ultimately end up with them being closed or the services in question no longer being provided on that site. The costs and benefits associated with the CQC's enforcement regime will be discussed in the final enforcement regulatory impact assessment to be published in early 2015.

v. Shifting focus to quality of care

64. The new inspection model is designed to focus attention on the quality of services provided in providers. Through the introduction of ratings for relevant substance misuse services we hope that providers will strive to achieve a rating of 'Outstanding'. There may be two reasons for providers to do so. The first is that better rated providers may be more appealing to people who use services who are free to choose where they are treated. Second, providers that are rated good or outstanding are likely to be inspected less frequently or will receive less intensive inspections in the period following this rating.
65. Other channels through which we hope the focus will shift to quality of care are as follows:
- Boards, directors, leaders and (where applicable) registered managers of providers become focused on quality of care and recognise their personal role in achieving high-quality care in their organisation.
 - The new model should promote a dialogue between providers and commissioners that focuses on outcomes for people who use services rather than activity and cost.
 - Staff working for providers believe in, and participate in, building high quality care and professional practice.
 - Staff act on and speak out about poor quality care.
 - Services not providing good quality care are held to account by third parties using our information.
 - Experts by Experience on inspection promote the service user's view of services and identify areas where improvements that could be made to the benefit of the experience of the service user.

vi. Potential commercial benefits for independent providers

66. As independent substance misuse providers operate in a commercial environment, introduction of ratings should create direct incentives for providers to improve relative to other similar providers. The rating can be used as a vehicle by which providers can market and promote good or outstanding services to potential service users therefore potentially leading to increased revenue and identified future growth streams for their commercial enterprises. Within the NHS

commissioning context, it could also lead to an increase in contracts for such organisations.

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

c. Specific benefits to the CQC

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

- CQC will benefit from a more robust and specialised framework for gauging and making judgements about the quality and safety of services in a provider. We believe our guidance on KLOEs and ratings will help guide inspection team decisions, and to help providers prepare for their inspections.
- Inspectors will gain more support from expert professionals and Experts by Experience in making better informed, more robust judgements about the quality of care being provided by the service to be inspected.
- In addition to opinions from experts, they will also have access to more information from external sources to direct their investigations and to support their judgements.
- We intend that our new inspection model will now also be more joined up with our partner organisations. This will ensure that we are drawing on expertise and advice from organisations that work closely with these providers and service users and will help to facilitate a better access to information and understanding of risk.
- As the benefits from the new regulatory model are felt by people who use services and the wider sector, the CQC will be able to demonstrate that it provides good value for money to our stakeholders.

9. Next steps

69. CQC will continue to engage with providers, the public and other stakeholders on our proposed inspection model for substance misuse providers. This is part of an effort to ensure the benefits to the sector are maximised and the costs minimised from our inspection model. We welcome feedback on the information presented in this document.
70. We would strongly welcome your feedback on the costs and benefits presented in this impact assessment. In particular we would like to ask stakeholders four key questions:

Consultation questions

- i) What costs have you experienced in terms of time and one-off expenditures relating to individual CQC inspections in the past?
- ii) How do you envisage the costs of inspection to change for your provider as a result of our new inspection model?
- iii) What benefits to your organisation do you feel will be experienced as a result a result of these proposed changes?
- iv) Have we missed out any other costs and benefits that you feel should be included in the analysis?

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

72. Alternative you can post a response using the following address:

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

73. We will also 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 providers and post-registration survey of providers. We will also be piloting a survey of inspection team members; and
- We have commissioned an external economic consultancy to establish a methodology for the CQC to assess its costs and benefits on an ongoing basis. This work should provide a more comprehensive and detailed view of the impact of the CQC on the sectors it regulates.