

Primary care dental, ambulance, and independent acute healthcare services

Changes to the way we regulate and inspect services

Final Regulatory Impact Assessment

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

1. Primary Care Dental Services Handbook
2. Ambulance Services Handbook
3. Updated Acute Services Provider Handbook

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

This document provides an analysis of the potential cost and benefit impacts of changes to the way we will regulate and inspect Independent Acute Healthcare providers, ambulance services and dental services providers. It builds on the analysis conducted in our initial RIA that was published during November 2014.

Introduction

1. This document provides a final assessment of the likely costs and benefits of the changes from April 2015 that are due to affect independent acute healthcare providers, ambulance services and dental service providers.
2. From April 2015 those providers will be monitored, inspected and rated (where appropriate) 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. Between our launch of the consultations in November and publication of the final provider handbooks we piloted, tested and evaluated our proposed new approach across these sectors. The overarching aim of conducting these pilots was to ensure that we roll-out and implement a regulatory and inspection model that was robust, fit for purpose and was a significant improvement over our previous approach.
4. As we roll-out the new approach we will continue to monitor the cost and benefit impacts to ensure we continually minimise regulatory burden and maximise the overall benefits as a result of the changes. Over time we expect the benefits of these changes to greatly outweigh the costs of these changes to all different stakeholders.

Background to policy changes

5. In recent months we have made significant changes to the way we regulate providers of health and social care. The most recent changes included implementation of the new approach across providers of NHS acute hospitals, community healthcare, specialist mental health, adult social care and general practice services. We started inspecting these providers under the new approach from October 2014.
6. Our approach to implementing changes in the dental, ambulances and independent acute services sector follows directly from ensuring that all remaining providers would be phased into the new model from 1st April 2015. This will ensure we have a level-playing field approach across all sectors and that providers are given clear and consistent guidance on how we will regulate them in future.
7. As we have amassed a significant amount of learning and experience in applying the new model, we are confident that the changes made will provide significant benefits over and above our previous approach. Our piloting and evaluation of the new approach across the dental, ambulance and independent acute services sector has also broadly shown that stakeholders agree with the incoming changes and that the framework provides a solid understanding for both our inspectors and providers to understand what good care should look like.
8. We know that there will always be challenges in regulating different providers due to the size, complexity and diversity of the range of different services on offer. To this end we will ensure where possible we will apply our model in a differentiated way to ensure we are proportionate and do not impart undue regulatory burden on providers.
9. Over time we expect all providers to aim to be at least 'good' in how they plan for and deliver care to people who use services. Fulfilment of our statutory duty should be measured in the extent to which organisations do provide good quality care, which over time should also lead to assurance from stakeholders that CQC provides good value for money.

Summary of proposed changes from 1st April 2015

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

All ambulance services, dental provider services and certain types of acute independent service providers will be regulated under a new regulatory model from 1st April 2015.

Registration

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

Monitoring

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

Inspection

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

Rating

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

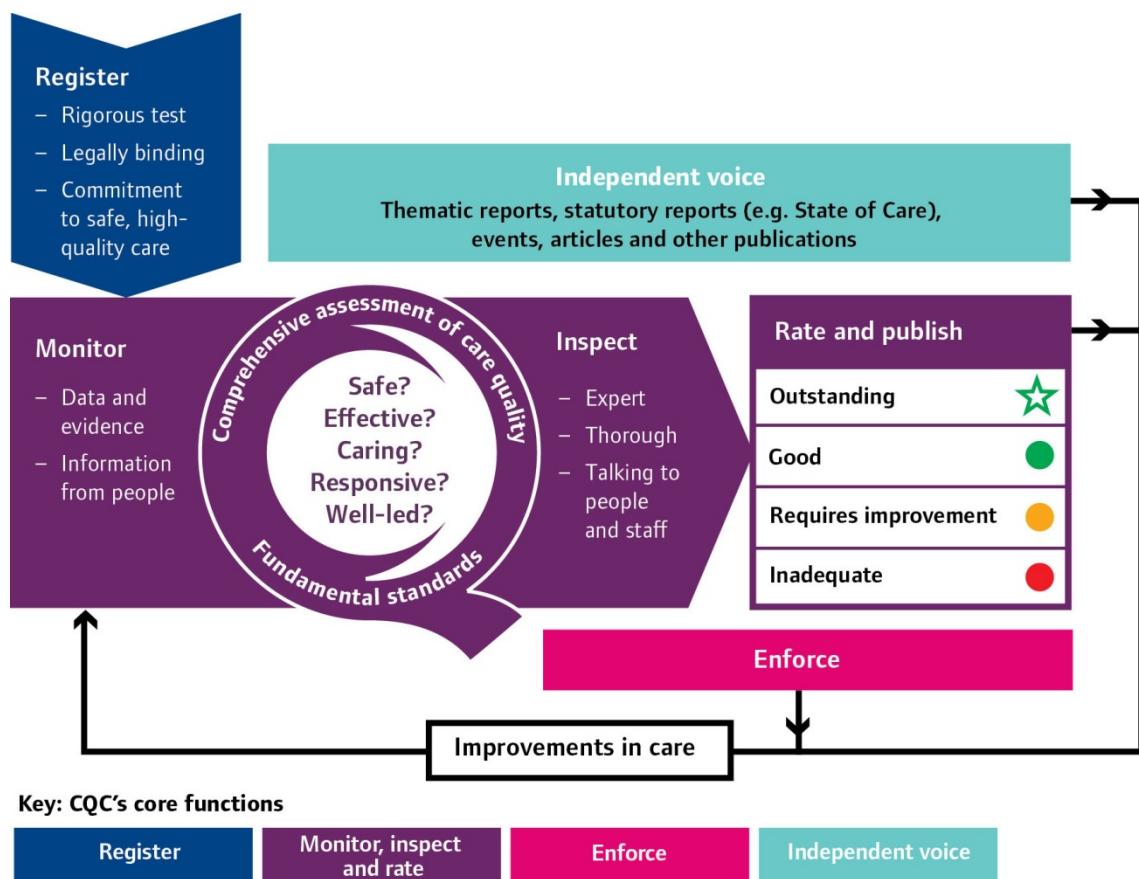
Enforcement

We shall be tougher on services which consistently provide poor quality care and do not comply with conditions in their registration. More information on [changes to our enforcement policy](#) was published in February 2015.

Scope of final impact assessment

11. In this document we provide our final assessment of the likely costs and benefits arising from changes to the way we regulate and inspect independent acute healthcare, ambulance services and dental service providers. We discuss the costs and benefits arising from changes to inspections and ratings. These activities are represented in figure 1 under the titles ‘Monitor’, ‘Inspect’ and ‘Rate and Publish’. The activities ‘Register’ and ‘Enforce’ are not covered in this impact assessment.
12. In the case of enforcement, a final regulatory impact assessment for this element of our new operating model was published earlier this month as part of our changes to our enforcement policy.
13. We are not assessing the impacts of changes to registration in this final RIA but may choose to do so in future if we deem its impact to be sufficiently significant.

Figure 1: CQC's overall operating model



CQC Assessment of Impacts

Overview of previous regulatory model

14. CQC regulates a variety of independent acute healthcare providers, ambulance services and dental service providers that vary in size and specialisms across England. Independent acute healthcare providers include a mixture of corporate providers who have a large number of hospitals operating from multiple sites and single service specialties operating one particular type of service clinics. Ambulance service providers are unique in that staff typically works across a range of other providers and professionals, such as, one shift can constitute interaction with GPs, community nursing staff, care home workers, midwives, police officers and fire service personnel. Similarly a significant number of dentists are sole practitioners operating out of single-site locations with a smaller number forming large corporates operating out of multiple sites.
15. The regulation and inspection of such providers generally includes many common themes and components irrespective of whether we are inspecting an independent acute hospital, ambulance provider or dental service provider. For example, we would inspect all such organisations under a generic compliance framework based on compliance. Quality of care provided would be assessed against these 16 essential standards, and would set the basis for any further action required should some areas be found to be non-compliant.
16. The nature of the actual inspection would depend on a variety of factors that CQC would take into consideration when planning inspection of those providers listed above. For example, all providers can expect to receive a scheduled inspection to gauge compliance across any of the 16 essential standards as part of CQC's on-going commitment to ensuring organisations provide an agreed level of care. If there are concerns about the level of care that are triggered by public complaints, external agencies or our own internal monitoring information then CQC may choose to use a responsive inspection. CQC also administers a themed inspection programme and may choose to inspect a provider on an agreed theme i.e. dignity, nutrition, etc. to be able to gauge performance in these areas.
17. These are some of the general regulation and inspection themes that would apply to all registered providers, including those listed above. The subsequent sections now contain information on key areas of regulation and inspection that are specific to the different types of provider. This takes into account the key differences between an organisation that provides care within an independent acute healthcare setting, ambulance or dental service provider.

Independent acute healthcare providers

18. CQC regulation of all independent acute healthcare providers under the Health and Social Care Act 2008 came into force in October 2011. Since then we have inspected all providers at least once and have generally found high levels of compliance across the spectrum of providers we regulate.
19. Our inspection teams have comprised a single inspector for the smaller providers to a larger team for more complex services.

Ambulance providers

20. From August 2014 we have phased in our inspection of NHS ambulance providers. To date we have inspected three NHS ambulance trusts as part of our Wave 1 and Wave 2 inspections; we intend to rate all NHS ambulances by the end of March 2016. We will continue to work with independent ambulance services to develop our approach for regulating and inspecting these services. We will begin pilot inspections to test our approach for inspecting and regulating independent ambulances from October 2015.
21. The composition and size of the inspection teams depend on the complexity of the services that are to be inspected. However, the teams will always consist of a CQC team leader and CQC inspectors (with varying levels of seniority). Clinical and other experts, with specific skills, will also make-up part of the team to reflect the services provided by the trust and the areas of focus for the inspection. We will also use Experts by Experience/patient and public representatives, to talk to people who use the services and tell us what they say and, where possible, observe care being delivered.
22. Regulating and inspecting ambulance providers have traditionally been challenging, with issues such as significant difference in size, intensity of activity, and operating out of multiple locations all contributing to difficulties in robustly assessing performance. Ambulance staff also work with a significantly larger number of professionals during any single shift and can therefore make it harder to assess overall care quality.

Primary care dental service providers

23. Primary care dental services were brought into CQC's regulatory model in April 2011. Most dental providers operate out of a single site location and they range in size from single-handed dental locations and partnerships to large corporate providers. Since our inspection of dentists commenced we have worked closely with the General Dental Council (GDC) and British Dental Association (BDA) to develop our approach.
24. We have now nearly inspected all dental locations registered in 2011 and have generally found high levels of compliance with the essential standards across the

dental provider community. We have also been selective in choosing which of the essential standards to inspect against, focusing on areas such as infection prevention and control and care and welfare. The overwhelming majority of our inspections have been announced inspections and have been carried out by a sole inspector.

Policy objectives of proposed new approaches

25. A key reason for making these changes to the way we regulate and inspect independent healthcare, ambulance and dental service providers is to ensure that standards improve. We want to ensure that high performing organisations are commended and can act as role models for all providers to make continual improvements. Also, focusing on how safe, effective, caring, responsive and well-led services are will enable us to review the quality of services focusing on what matters to people.
26. It has widely been acknowledged the key role that such services play within the health system. The impact of these organisations providing poor quality services can have serious consequences for the health and well-being of a large number of people.
27. We want providers to improve continually and to provide high quality care that directly benefits people who use services and their families. We aim to achieve this by working closely with our partner organisations such as the GDC, BDA, NHS England Area Teams with Clinical Commissioning Groups (CCGs) whose duty it is to support quality improvement in primary care.
28. Our inspections of independent acute healthcare services and ambulance services will be carried out by our Hospitals Directorate. Inspections of dental service providers will be carried out by our Primary Medical Services Directorate. Inspectors will become dedicated experts in inspecting only services in which they have built up a specialist expertise. That is to say that an inspector will no longer inspect a dental practice in the morning, then a care home in the afternoon.
29. We wish to provide greater assurance to the public around the quality of care provided by independent acute healthcare and NHS ambulance providers. To facilitate this we are providing most of these organisations with a rating so that the public can gauge the quality and performance of individual providers. For dental providers we will continue to work with the dental community and our partners to explore other methods of assurance, such as, accreditation schemes. We will also continue to work with our partners to share information which will help focus our efforts and target poorly performing providers.
30. Underlining all of this is our aim to develop a model of inspection and regulation that maximises benefits to all stakeholders whilst 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.

31. 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.

Registering, monitoring, inspecting and rating independent healthcare, ambulances and primary care dental services from April 2015

Registration

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

Inspection framework

34. 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.

35. Subsequent sections of this document illustrate what this means in practice for the different providers that make up the various independent acute hospitals and other services, ambulance services and dental service providers. In practice we would expect our inspectors to use a combination of expert judgement, input from stakeholders, such as, sector specialists and Experts by Experience, data and local information to come to a robust conclusion around quality of care across these domains throughout the inspection process.
36. We will use a varied approach to inspecting providers – the actual type and nature of inspection will depend on the service in question and whether we were responding to external complaints or concerns about the level of care provided by the organisation in question. Similarly our inspections will continue to utilise a mixture of unannounced and announced visits, and can be conducted at any time of the day or night including weekends. Where appropriate we will use larger teams and propose to use expert inspectors who have dedicated specialisms in inspecting their chosen areas, and we would expect the size and make-up of the team to reflect the size and complexity of the service to be inspected.

Ratings

37. As the Care Act 2014 was given royal assent last year, we now have the formal powers to be able to grant a rating based on the quality of care provided. With the exception of primary care dental providers, independent ambulances and some independent healthcare providers, we propose to rate independent healthcare providers and NHS ambulance services on a four point rating scale:
- Outstanding
 - Good
 - Requires improvement
 - Inadequate.
38. We propose to begin rating independent healthcare hospital providers and NHS ambulance services from April 2015. This follows the outcome of a comprehensive inspection of an individual provider prior to granting a formal quality of care rating to that provider.

Enforcement

39. 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 changes to our [enforcement policy](#) was published in February 2015.

Specific proposed policy themes for independent acute healthcare providers

40. For purposes of regulating and inspecting independent acute healthcare providers we will be segmenting such providers into three groups (see updated handbook document for more details):

Hospital	Single Speciality	Others
<ul style="list-style-type: none">• Independent sector treatment centres• private patient units located within an NHS acute or specialty trust, where these are run and managed by an independent provider• independent providers of maternity services• Most cosmetic providers.	<ul style="list-style-type: none">• Termination of Pregnancy procedures• Haemodialysis or peritoneal dialysis• Hyperbaric therapy• Diagnostic imaging and endoscopy• Diagnostic laboratories• Refractive eye surgery• In-Vitro-Fertilisation• Specialist inpatient services for long-term conditions.	<ul style="list-style-type: none">• Mainly consulting room services and single-handed practitioners• Hair transplantation services.

41. Our updated handbook document provides detailed information on core services we would inspect and the key lines of enquiry (KLOEs) we would expect to utilise to gauge performance against our five key questions. In practice we will use a mixture of announced and unannounced inspections and will vary team size depending on the size and complexity of the provider to be inspected. However we anticipate that inspection teams will be smaller than those included in our pilots.
42. In light of feedback from the consultation we will work towards our Provider Information Request (PIR) becoming more automated and less detailed and prescriptive for providers with small volumes. This will be achieved through threshold questions i.e. providers proceed to the next level of detailed questions only if relevant to them.
43. We will begin to rate independent acute hospitals providers from April 2015. In light of feedback from the consultation we will rate all domains and core services with the exception of the effectiveness domain and end-of-life care. These ratings will occur at location level. We are continuing to engage with the sector in relation information gathered about the corporate function. We will work with the sector with the aim of rating effectiveness from October 2015.
44. To ensure a level playing field with NHS trusts and foundation trusts we will also implement special measures for independent healthcare providers. We are developing our approach as to how this would work in practice however this will not be the same as our approach taken for NHS trusts and Foundation Trusts, in part because there is not a similar body such as Monitor or the Trust Development Authority to provide support and assistance.

Specific proposed policy themes for ambulance service providers

45. We propose to always inspect and rate the following core services, if provided:
 - Emergency & Urgent Care Services
 - Patient Transport Services
 - Emergency Operations Centre.
46. Our inspections will normally be limited to these core services. However if we identify particular services, or the use of pathways of care which provide cause for concern, or where we believe the quality of care could be outstanding and they are not covered by these core areas, we will look at them in detail and report on them. We may also focus on additional areas where these represent a large proportion of a provider's activity or expenditure.
47. Due to the geographical split of ambulance services we will not always be able to visit every location from which a core service operates. Therefore we will take a sampling approach and visit a number of sites attributed to each core service.

48. We will rate NHS ambulances at four levels:
- Level 1:** rate every core service for every key question
- Level 2:** an aggregated rating for each core service
- Level 3:** an aggregated rating for each key question
- Level 4:** an aggregated rating for the trust as a whole.
49. We have also made a number of changes in response to the feedback from the consultation. We will now ensure that our unannounced inspection window will be between 10-15 days and that all quality summits will involve a cast list that includes a representative for a stakeholder groups rather than involving a representative for each area of the stakeholder group the ambulance is involved with (for example, one Healthwatch rep for all the different Healthwatch areas covered by the ambulance).
50. The PIR will be in two stages and we will collect information at the point of scheduling (12 weeks before the inspection) on what services are provided and then information about quality (8 weeks before the inspection). In assessing well-led the focus will be on location level. We will be testing options further on whether and how to comment on corporate level.
51. For independent ambulances we will rate at location level; we will not rate at corporate level but will include this level in relationship management, comprehensive surveillance and generally involve them more in the inspections of locations than in the past (for example, inspections notified to location via head office). We will rate core services where they occur. This may be one core service for many independents (such as, PTS). Where it is too small a core service to collect enough evidence to rate, or apply the aggregation rules, we will prepare further guidance.

Specific proposed policy themes for primary care dental providers

52. Our main priority is to carry out an assessment of the quality of primary care dental services leading to a judgement about whether they provide people with care that is safe, effective, caring, responsive and well-led, based on whether the regulations are being met.
53. Prior to inspection we may write to practices and ask them for some information which will help facilitate the inspection process. Practices will have five working days to respond to our request. We will make clear what information to send, where to send it and who to contact with any queries or questions. We would expect the info request to include an up-to-date statement of purpose as well as current information about any complaints or compliments associated with the practice, information about staff such as registration with the General Dental Council and information about any good practice/accreditation schemes they are part of.

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

Comprehensive Inspection	Focused Inspection
<ul style="list-style-type: none"> • Will be carried out at 10% of registered practices in 2015/16. • Addresses all five key questions CQC asks of services (safe, effective, caring, responsive, well-led). • Usually takes one day at the practice. • Likely to include a specialist adviser. • Usually announced two weeks before the inspection. 	<ul style="list-style-type: none"> • Follow-up to a previous inspection, or to respond to a particular issue or concern. • Does not look at all the fundamental standards. • Will not address all five key questions CQC asks of services (safe, effective, caring, responsive, well-led). • Team composition and size will depend on the concern(s). • May be conducted in partnership with one of our partners, for example, NHS England. • May be unannounced.

55. As the approach further develops, we will collaborate closely with the General Dental Council (GDC), NHS England, and NHS Business Services Authority and CQC to review the approach to dental regulation and inspection across England, assess current arrangements and ensure our model for regulation is continually fit for purpose now and in future.
56. In addition we have made further changes to our model as a direct response to the feedback from the consultation. We will assess, but not rate, if a practice meets the five key questions CQC asks of our services. We will look for notable practice to promote learning and encourage improvement, as well as make sure that dental practices meet the requirements set out in the regulations (including the new fundamental standards of care coming into force in April 2015).
57. Our handbook document now includes more information about our approach to how we identify the 10% of practices to be inspected (circa 1,000 per annum), particularly the practices we view as being of greater risk of not meeting the regulations, including the fundamental standards of care. We also anticipate conducting a further 200 focused inspections per annum as a follow-up to the 10% inspection model. We will ensure we make intelligent use of data, evidence and information to monitor services whilst we develop our approach to intelligent monitoring of the dental service throughout 2015.

Costs

58. The changes we will make to CQC's regulation and inspection of independent acute healthcare services, ambulance and dental service providers will have cost impacts and implications for a variety of stakeholders.
59. We have piloted, tested and evaluated our new approach across a representative sample of providers that we regulate to ensure 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.
60. A key purpose of this regulatory impact assessment is clearly demonstrating to stakeholders what those cost impacts are likely to be. The analysis contained in the document builds on the initial RIA that was published in November. Although we cannot be precise on these cost impacts and implications, we will continually test, refine and evaluate our approach to ensure we are proportionate and these impacts are kept at a minimum. In time this should help to assure stakeholders that the model is efficient, economic and effective and provides overall value-for-money to all stakeholders.

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

61. All providers will experience costs in relation to facilitating a CQC inspection. The marginal costs incurred by providers over and above our current inspection methods are likely to differ depending on how intensively we inspect. However it is likely that costs will be higher initially as the sector transitions to the new model. For example this may mean longer inspection visit days on site for different providers.
62. Similarly all providers will be required to submit key information to CQC as part of the inspection process. Costs incurred may initially be higher however where possible we will work with our strategic partners to ensure we do not duplicate information requests and impose undue regulatory burden. Costs may fall in future as information request templates become more standardised and providers implement systems to capture required data on a routine basis.
63. We are currently carrying out further work to identify the main elements of costs to providers. Where possible we will quantify and put a valuation on these costs as these start to emerge from feedback gathered from providers which have taken part in our pilots of the new model.

Specific cost impacts for independent acute healthcare providers

64. For independent acute hospitals we would expect costs in relation to facilitating an inspection to reflect how many core services we inspect as well as how many locations we inspect at. For single speciality services costs are likely to only be marginally higher than they are currently as we would expect staff numbers facilitating to stay relatively constant. However we would expect costs to increase proportionately more for those providers rated as requires improvement or inadequate.
65. At the time of publication we have yet to robustly measure the costs accrued to both independent acute hospitals and single speciality providers. However work is ongoing to ensure this is captured in a model we are developing to help track provider costs.

Specific cost impacts for ambulance services

66. The costs incurred to ambulance services are likely to vary significantly due to the size and variety of different organisations within the sector. Larger NHS ambulance trusts operate out of several locations and have greater volumes of activity compared to small independent ambulance providers operating just two or three vehicles. Therefore we would expect costs incurred to directly reflect the size and number of locations we would need to inspect to gather the information required.
67. Our comprehensive inspections are also likely to initially increase costs to providers as we seek to rate across all five questions and core services. Those which receive a Requires Improvement or Inadequate rating are likely to be inspected on a more frequent basis and would incur higher costs as a result whereas those who are found to be performing well are likely to see a reduction in inspection costs.

Specific cost impacts for dental service providers

68. Our approach is that only 10% of providers will be inspected annually and will be based on the potential risks posed to service users. Therefore the majority of registered dental services providers are not likely to face additional costs as a result of CQC's regulatory oversight.
69. There are likely to be smaller cost impacts for providers where we ask for information prior to inspection. Providers who provide unacceptable levels of care are likely to face additional costs in the form of enforcement action and potential re-inspection. Costs for providers will increase depending on the numbers of staff used to facilitate inspection, as will any upfront investment in systems to help support and maintain care quality provision.

Specific cost impacts to CQC

70. CQC has undertaken work to estimate what resources it might need in the future to carry out its programme of inspections across all the sectors we regulate. We can use assumptions underpinning this work to estimate what the cost of a typical inspection might be once the new inspection model is well established (such as, in the steady state). Table 1 provides information about these assumptions:

Table 1: Inspection planning and resource assumptions

Independent acute healthcare providers (hospitals and single specialities)

A typical inspection will last between 5 and 10 days (to account for the size and complexity of the provider to be inspected) which will include preparation on-site inspection and report writing. We will typically have 3 to 6 inspectors onsite as well as an inspection manager, between 5 – 10 specialists and up to 2 experts by experience. For focused inspections the inspection team size and length of inspection would be no more than half that of a comprehensive inspection.

Ambulance provider services (NHS)

A typical inspection will last for around 30 days including preparation and report writing (although for significantly larger trusts this could be as many as 60 days). For a comprehensive inspection a typical team could include 10 inspectors, 1 inspection manager, 20 specialist advisors and two experts by experience. For focused inspections the inspection team size and length of inspection would be halved.

Ambulances provider services (independent)

A typical inspection will last for around six days including preparation and report writing. For a comprehensive inspection a typical team could include two inspectors and an inspection manager, six specialist advisors and one expert by experience. For focused inspections the inspection team size and length of inspection would be halved.

Dental service providers

A typical inspection will last for around three days, including preparation and report writing. For a comprehensive inspection our typical team will normally include a single inspector and a specialist dental advisor. We are planning to undertake comprehensive inspections of circa 1,000 dental practices with a further 200 focused inspections per year.

71. In addition we use data on what it costs us per day per inspection team member:

INSPECTION TEAM MEMBER	COST PER DAY
Inspector	£333
Inspection Manager	£400
Specialist Advisor	£324
Expert by Experience	£300

72. Combining these assumptions we can come up with a broad estimate of what the cost of a typical inspection could be once we are in steady state. This is included in Table 2:

Table 2: Estimated costs per inspection in steady state

Provider type	Estimated cost per inspection (direct costs only)
Independent Acute Providers <i>(Comprehensive Inspection)</i> <i>(Focused Inspection)</i>	£18,000 - £36,000 £9,000 - £18,000
Ambulance Services (NHS) <i>(Comprehensive Inspection)</i> <i>(Focused Inspection)</i>	£97,000 - £194,000 £48,500 - £97,000
Ambulance Services (Independent) <i>(Comprehensive Inspection)</i> <i>(Focused Inspection)</i>	circa £10,600 circa £5,300
Dental Service Providers <i>(Comprehensive Inspection)</i> <i>(Focused Inspection)</i>	circa £1,600 circa £1,600

73. The key differences in potential costs described in table 2 above stems directly from the size and complexity of the provider to be inspected. Those that are sizable and with complex operations are likely to need more time and more resource dedicated to it, which is reflected in the potential increase in cost per inspection.

Risks and limitations

74. The costs presented are purely estimates and are based on our current planning assumptions for how an inspection is likely to be conducted once the model has been implemented in April. In practice there is likely to be some significant deviation in costs, which is likely due to the following factors:

Provision of ratings: although cost per inspection may stay the same, there is likely to be some deviations depending on how intensively we may need to inspect/re-inspect providers. For those who are rated as inadequate we may need to dedicate more inspection resource on re-inspection than those in our current planning assumptions.

Future efficiencies: as the model settles down and we become more targeted and efficient in how we inspect, we may need less inspection resource per inspection in future. This will likely push the cost of inspection down.

Developmental costs: we have not included one-off costs in our analysis at this stage. These costs are linked to the overall development and refinement of the model and include cost of making changes, training, piloting and development of the overall inspection framework.

75. Stakeholders also need to be aware that the costs presented in the analysis are only “direct costs of inspection”. There are other costs associated with development of policy, planning, analytical input, call-centre, and other overheads which together make up a significant bulk of inspection costs. As we are still in the early stages of quantifying what these costs could be we cannot robustly include these costs estimates in the analysis at this stage.

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.

Benefits

76. While changes to the way we regulate and inspect independent acute healthcare providers, ambulances and dental service providers are likely to have cost implications for a number of stakeholders, it is important to note that there will also be more benefits that are likely to emerge as a direct result of these proposed changes.
77. In making these proposed changes we are keen to demonstrate to stakeholders that we roll out and implement an approach that puts maximisation of benefits at the centre of its approach to developing the new model. This will help to ensure that we have a model that is efficient and effective, whilst also providing value-for-money for all stakeholders.
78. It is important to note that not all stakeholders are likely to experience increases in benefits immediately – the changes we propose to implement are likely to lead to smaller incremental increases in benefits and are likely to be experienced and sustained over a longer time period i.e. several years. For example, an immediate benefit for users of services could stem from having more information about the quality of care provided via publication of ratings, whereas a longer term benefit could

centre on incentivising providers to make continual improvements in the way they provide care as a direct result of these ratings.

79. 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. The benefits included in this analysis are of a qualitative form, due mainly to the difficulty in being able to robustly measure benefits at this stage. However we have commissioned an external consultancy to help us develop a model to track our benefits to stakeholders over time.
80. We include below what we believe are the main benefits to stakeholders as a result of changes we propose to make to the regulation and inspection of independent acute healthcare, ambulance and dental service providers. These have been formulated directly from feedback and engagement from our partners, users of services, provider groups, and all other stakeholders and will be used as a basis for which we will test the emergence of benefits (both over the immediate and longer term) that will be fed directly into development of the model.

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

81. Those who use health and care services should benefit the most from the CQC's new inspection model. We set out in more detail below what we believe will be the main benefits to service users as a result of changes to the regulatory model.

1. Confidence for people who use services

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

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

83. The new inspection model provides formal and informal opportunities for the public and people who use services to provide feedback to 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.

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

84. For most independent acute healthcare providers and all ambulance services, a clear departure from the previous inspection model is the introduction of ratings. Eventually the new inspection model should raise awareness among the public that the quality of care can vary across providers.
85. By providing ratings at various levels within a provider and across our five key questions that are also supported by qualitative information, people who use services will be able to get a clearer view of the quality of services provided. A comprehensive and tailored assessment will more clearly define poor and good practice and what people who use services can expect from them. In the event that people who use services have choice over which service provider to attend, they can use the more reliable and comprehensive information to make better informed choices.

4. Encouraging services to improve

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

B. Specific benefits to providers

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

1. More comprehensive and credible CQC assessment of provider performance

88. Under the new inspection model the sources of information to support inspections and the depth of this information will be more thorough. This will ensure that judgements about provider performance are more credible. As a result we expect that providers are more likely to think our judgements are credible and fair and are hence more likely to agree with our ratings.
89. The new ratings system should help providers gauge their performance and benchmark themselves against other providers. In that sense the model will always provide the opportunity for providers to self-improve continually.

2. Giving healthcare staff a voice

90. 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.

3. Acknowledgement of and sharing good practices

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

4. Identifying improvements providers can make

92. 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.
93. 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.
94. Where the CQC finds poor practices and where improvements are not made such providers may be subject to the failure regime which might ultimately end up with them being closed or the services in question no longer being provided on that site.

5. Shifting focus to quality of care

95. The new inspection model is designed to focus attention on the quality of services provided in providers. Through the introduction of ratings we hope that providers will strive to achieve a rating of 'outstanding'. There may be two reasons for providers to do so. The first is that better rated providers may be more appealing to people who use services who are free to choose where they are treated. Second, providers that are rated good or outstanding are likely to be inspected less frequently or will receive less intensive inspections in the period following this rating.
96. Other channels through which we hope the focus will shift to quality of care are as follows:
- Boards, directors and leaders of providers become focused on quality of care and recognise their personal role in achieving high quality care in their organisation.
 - The new model should promote a dialogue between providers and commissioners that focuses on outcomes for people who use services rather than activity and cost.

- Staff working for providers believe in, and participate in, building high quality care and professional practice
- Staff act on and speak out about poor quality care.
- Services not providing good quality care are held to account by third parties using our information.
- Experts by Experience on inspection promote the service user's view of services and identify areas where improvements that could be made to the benefit of the experience of the service user.

6. Independent acute healthcare providers

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

7. Ambulance Service Providers

99. We would expect the introduction of ratings to be a key improvement driver for ambulance services. This would be especially important where an ambulance service has a regional monopoly or operates in a geographical location that contains only a few providers. We would expect the rating to gauge how well ambulance staff work together in an integrated manner to meet demands placed on them by emergency situations.
100. For independent ambulance services operating in a commercial environment, the inspection and rating of providers should add further credibility of their value and may lead to more business opportunities and areas for growth with partner organisations. This maybe the case where independent ambulance services are generally rated better than NHS ambulance services which could lead to an increase in contracts for such organisations.

8. Primary Care Dental Providers

101. We will become more risk-based in how we inspect dentists and therefore only plan to inspect a sample of 10% dental providers in any given year. This should lead to a sharp drop in costs for providers that are not re-inspected brought on by dental staff not needing to facilitate our inspections.
102. Although we will not be rating providers from April 2015 we may explore this in future if the dental community believe there will be added benefit from doing so. Our

experience of the sector has indicated that there is already an overall high level of care provided by the dental community. Our changes to registration will also help to safeguard the reputation of the dental community by keeping out organisations which may provoke adverse reputation damage through poor provision of services.

C. Specific benefits to the CQC

103. There are a number of ways in which the CQC will benefit from the new inspection model. These benefits include the following:
104. The CQC will benefit from a more robust framework for gauging and making judgements about the quality and safety of services in a provider. We believe our guidance on KLOEs and ratings will help guide Inspection team decisions, and to help providers prepare for their inspections.
105. 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.
106. 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.
107. Our new inspection model will now also be more joined up with our partner organisations such as the General Dental Council (GDC). This will ensure that we are drawing on expertise and advice from organisations that work closely with these providers and will help to facilitate a better understanding of risk and the need to inspect which may reduce regulatory burden in future.
108. 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.

Next steps

109. The inspection models as described in this regulatory impact assessment and in the provider handbooks will be rolled out from 1 April 2015. From this date all inspections conducted by CQC will be using the method described in the provider handbooks.
110. 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 provide this by post to the following address:

111. To provide us with your feedback please email: economics@cqc.org
112. 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
113. 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.
 - 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.