Regulator Assessment: Qualifying Regulatory Provisions

Title of proposal	Provider Information Request for independent mental health services undergoing an announced inspection.
Lead Regulator	Care Quality Commission
Contact for enquiries	[redacted] BITA@cqc.org.uk

Date of assessment	14/07/2017
Commencement date	February 2016
Origin	Domestic
Does this include implementation of a Cutting Red Tape review?	No
Which areas of the UK will be affected?	England

Section 1: Brief outline of proposed new or amended regulatory activity

To help CQC inspectors plan their inspection of mental health providers, CQC requests provider locations to complete a Provider Information Return (PIR) prior to inspection. The PIR is used by inspectors to help decide the areas they wish to look at in more detail during their visit. CQC has revised the (PIR) for mental health services and the first batch of the revised PIRs was sent out in Feb 2016.

Previously CQC would send out one set of PIRs and ask providers to answer a number of questions and provide documentary evidence. The revised PIR is now sent out in two stages and now asks providers to self- assess their performance (further details are given below):

- Greater scope for self-reporting and a reduction in the additional documentary evidence sought. The revised PIR asks providers to self-report about the services provided. Providers are asked to self-declare their strengths and weaknesses, what has changed about the quality of care provided over the last year, what improvement plans they have and some examples of good practice.

- The revised PIR is now sent out in two stages. The first stage is a request to collect basic information on the range of health services delivered by these mental health services. This is used to inform a second request that is targeted to the specific core services provided. The format of the PIR has also changed from a word document to two excel documents.

In addition to the above revised changes, there have also been a number of minor incremental changes. We have not kept a record of all the changes made, but typically changes were made on a quarterly basis to incorporate provider feedback and to reflect improvements to CQC processes. We think it would be disproportionately costly to identify and assess the costs of every incremental change. For our analysis we have therefore decided to look at the changes to the PIR over the following periods: comparing the quarter four PIR in 2014/15 against the quarter four 2016/17 PIR. In discussion with Intelligence colleague from our Provider Analytics team responsible for managing the changes to the PIRs for Independent mental health, we think the above two periods best capture the changes that were made to the revised PIR.

Section 2: Which type of business will be affected? How many are estimated to be affected?

Mental health providers deliver a range of services to people with mental health needs. This includes care, treatment and support in hospital and the community.

Department of Health (DH) officials have told us that the information they hold strongly suggests that the vast majority of the services delivered by all the various independent providers are funded by NHS England either through Clinical Commissioning Groups or through NHS trusts contracts, i.e. although many of the different services are delivered by independent providers, they are in the main delivering publically funded services. DH thinks that only 6% of all the services delivered by independent providers can be classified as being delivered by businesses. We do not know how many mental health services provided by independent providers can be classified as being delivered by businesses, but using the above information, we have assumed 6% of services can be classified as being delivered by businesses.

In June 2017 our records show that there are a total of 273 independent mental health provider locations delivering community services and hospital services. Based on the information from DH we have assumed that 16 of these locations (6% of 272 locations) are delivering privately commissioned services and therefore can be classed as businesses.

The number of PIRs we ask businesses to complete depends on the number inspections we carry out. We are still planning our schedule of inspections for future years. We have therefore taken the same approach to the frequency of inspection as that of Independent acute specialist providers where our current thinking is that we plan to inspect provider locations within a 5 year time period (over time period 2015/16 to 2019/20). We think this is a reasonable assumption to make as both types of provider are in the Independent sector. Based on the 5 year inspection cycle, we have therefore assumed that 20% of mental health provider locations will be inspected every year. Furthermore we have assumed that the number of inspections will stay constant at the 2019/20 levels in 2020/21 and beyond.

Summary of costs and benefits						
Price base year	**Implementation date**	**Duration of policy (years)**	**Net Present Value**	**Business Net Present Value**	**Net cost to business (EANDCB)**	**BIT score**

2015	**2016**	**10**	**-0.01**	**-0.01**	**0**	**0**

Please set out the impact to business clearly with a breakdown of costs and benefits

Below we set out the cost and methodology used and our estimates of the impacts of this change. The assumptions used to calculate cost are based on:

I. Discussions with Intelligence colleague in CQC responsible for managing the changes to the PIRs.

II. Using information from the pilot evaluation of PIR changes for other independent providers- specialist and non-specialist sectors to determine costs. In discussion with the Intelligence colleague we think this is a reasonable approach.

In May 2017 we asked mental health providers, through their trade association, a number of questions relating to the time taken to complete a PIR along with details about the staff involved. Unfortunately, we only received one response from a NHS mental health provider. Given the lack of response, we have opted to use information from the existing pilot evaluation of PIR changes for other independent providers, covering the specialist and non-specialist sectors. The pilot evaluation of other independent provider asked a number of open and closed questions to ascertain providers' experience of completing the PIR (in total 14 other independent providers responded to the pilot evaluation).

Given that this costing rounds down to zero, we have not sought further input from providers as it would not be proportionate to invest resources in establishing this given the scale of the expected impact.

On-going staff costs of completing the new PIR template

We estimate that the net annual cost increase of completing the PIR is £800.

We assume all providers will incur on-going staff costs from completing the PIR. We use the standard cost model to monetise the costs of reading this new guidance. We have used the same assumptions as the independent acute sector to calculate cost:

- We assume that around seven members of staff are involved in completing the PIR. We have assumed the grades of staff are as follows: Registered Manager (Director of nursing), one Nurse (grade 7), four mangers and heads of services (x4 staff at grade 8a) and one administrative staff (grade 4).
- We do not have information on staff pay for mental health providers and have used NHS pay grades as a proxy for hourly staff wage rates. The hourly rate of pay is sourced from NHS agenda for change 2016.
- Based on the evaluation of the pilot PIRs, we think the median amount of time taken to complete the revised PIR is 60 hours, involving multiple members of staff. We assume it took 53 hours to complete the old PIR. Our Intelligence colleague thinks that the increase in staff time is a reasonable assumption to make given that the new PIR is more reliant on self-reporting.
- The evaluation of the pilot PIR does not provide detailed information about the amount of time spent by individual staff completing the PIR, in discussion with our Intelligence

colleague we have assumed the following staff time allocation:

- For the revised PIR, we have assumed the Registered Manager and a lead nurse spend the bulk of the time completing the PIR (40 hours), four managers and heads of services are assumed to spend 10 hours and one administrative member of staff is assumed to spend 10 hours collecting information.

- We have assumed that the balance of time for all members of staff spent completing the old PIR is exactly the same as the balance of time that they spend on the new PIR. We think this is a reasonable assumption to make as the old PIR would not require anything different in terms of staff input. We have therefore assumed the Registered Manager and lead nurse spent 34 hours, four managers and heads of services spent 9 hours and one administrative member of staff is spent 9 hours collecting information.

- We have assumed provider locations will typically have to complete the PIR once every 5 years.

- The net annual cost increase of completing the PIR is £800 (£831 = £6,703 (cost of completing the new PIR) - £5,872 (cost of completing the old PIR))

  - Cost of completing the revised PIR is £6,703 (40 hours x (£52.56 Registered Manager's wage per hour + £16.26 Nurse's wage per hour)) +(10 hours x (£22.50 manager wage per hour x 4 members of staff at grade 8a)) + (10 hours x £10.80 admin staff wage per hour) x 55 businesses x 1.2 for 20% overheads x 0.2 frequency per location= £6,703)

  - Cost of completing the old PIR is £5,872 (34 hours x (£52.56 Registered Manager's wage per hour + £16.26 Nurse's wage per hour)) +(9 hours x (£22.50 manager wage per hour x 4 members of staff at grade 8a)) + (9 hours x £10.80 admin staff wage per hour) x 55 businesses x 1.2 for 20% overheads x 0.2 frequency per location= £5,872)

Other costs and benefits not covered in this assessment

On the basis of discussions with our colleagues in Intelligence we do not think any indirect costs or indirect benefits arise from this change.

One benefit not covered in this assessment is the following:

- A benefit of self-assessment is that providers are better able to evaluate and identify their own strengths and weaknesses in delivering services. A consequence of this might be that provider locations are now better able to identify those services that need to improve. We do not have sufficient evidence to monetise these benefits.