Department for
Business, Energy
& Industrial Strategy

BUSINESS IMPACT TARGET: SUMMARY TEMPLATE

Non-qualifying Regulatory Provisions (NQRP) summary reporting template

Regulator: Care Quality Commission

Business Impact Target Reporting Period Covered: 21 June 2018 to 20 June 2019

Summary of changes and activities in each category

Excluded Category*	Summary of measure(s), including any impact data where available
Casework	The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. In 2018/19 CQC undertook over 17,000 inspections of hospitals, mental health services, adult social care providers and primary care services. It received 41,755 applications for the registration of services, issued 2,206 enforcement actions and received 8,878 whistleblowing enquiries. Also, CQC carried out 1,203 Mental Health Act Review visits. (Source: CQC Management Information – more information will be available in July 2019 when the 2018/19 CQC Annual Report is due to be published).
Education, communications and promotion	CQC have been involved in education, communications and promotion activity related to sexual safety in both the mental health and adult social care services. More information can be provided on request.
Activity related to policy development	There were 18 policy development changes in the period. These changes included CQC continuing to fulfil its statutory responsibilities by publishing the State of Care and Mental Health Act Reports, as well as a number of thematic reports, including 'Opening the door to change' in December. The thematic report found that too many people are being injured or suffering unnecessary harm because NHS staff are not supported by sufficient training. It also found that, due to the complexity of the current patient safety system, it is difficult for staff to ensure that safety is an integral part of everything they do. Additional information on these changes, or any of the other not-listed changes can be provided on request.
Changes to management of regulator	There were several changes to the management of CQC in the period, including the recruitment of a new Chief Executive and Chief Operating Officer. CQC also introduced a new regulatory risk management framework to strengthen its approach to safeguarding and regulatory risk, following two independent reviews – into CQC's safeguarding alerts and Hillgreen Care Ltd. Additional information can be provided on request.

Individual changes and entries

Excluded Category*	Summary of measure(s), including any impact data where available
De minimis (measures with an EANDCB below +/- £5 million)	**Primary Care Providers at scale** From April 2019, CQC is changing how it engages with large-scale general practice and general practices that operate across more than one location. The definition of provider at scale is still to be agreed in co-production with providers, the highest estimate is that this will cover 300 businesses. CQC already engaged with providers at an organisational level; this change reduces the inconsistency in terms of frequency, content of engagement and who from the provider is engaged with. In some cases, this will lead to more frequent contact. CQC's highest estimate of the new annual cost to providers, based on discussions with Policy Leads, subject matter experts and providers, is c. £6,000 per annum. This gives a total gross impact to

Excluded Category*	Summary of measure(s), including any impact data where available
	business of £1.8m. Note that this engagement is not a new requirement for providers, therefore a large proportion of these costs will not be additional. These estimates are subject to CQC's full evaluation of the change, due in June 2019.
De minimis (measures with an EANDCB below +/- £5 million)	**Provider Information Collection and PMS (General Practice) changes** To meet its strategic aim of reducing regulatory demands on General Practices (GPs), CQC has made several changes to its regulatory model. These include: • Changes to the frequency of inspections. GPs rated "Good" or "Outstanding" in the previous round of inspections will subsequently be inspected less frequently - with an inspection interval of up to five years. • Moving away from comprehensive inspections to a more focused approach for those providers previously rated as Good' or 'Outstanding'. • GPs rated "Good" or "Outstanding" will be required to complete an annual Provider Information Collection (PIC). This new process includes a telephone conversation with an inspector. • Updating CQC's handbook for providers. Department of Health and Social Care (DHSC) and CQC convention is that GPs are treated as public bodies for the purposes of Business Impact Target, as such, these changes are treated as a Non-Qualifying Regulatory Provision.
De minimis (measures with an EANDCB below +/- £5 million	**Factual Accuracy** Following the inspection of a provider, CQC shares a draft copy of the inspection report with them before it is published. The provider can comment on the accuracy and completeness of the evidence used in the report and to do so they are asked to complete the factual accuracy comments form. CQC has updated the guidance document and form that support the factual accuracy process. The change will have no impact on the volume or type of challenges submitted by providers, but there will be a small time requirement for providers to familiarise themselves with the new guidance. CQC previously assessed the impact of implementing the whole factual accuracy process and the annual net cost was estimated to be £15,000 – the isolated impact of this change will be a fraction of this.
De minimis (measures with an EANDCB below +/- £5 million)	**Independent Health (IH) next phase Out of Hours, Urgent Care and NHS 111** In May 2018, CQC published its consultation on its next phase of regulation. As part of this document, CQC proposed several changes to its inspection methodology for Urgent care, Out of Hours and NHS 111 providers. Including: • Providers rated as "Good" or "Outstanding" being inspected less frequently. • Moving away from comprehensive inspections to a more focused approach for those providers previously rated as Good' or 'Outstanding'. • Implementing relationship management for a more consistent approach to working with providers and other stakeholders – to better understand the quality of care and to encourage improvement. • Introducing shorter inspection reports.

<table>
<tr><th>Excluded Category*</th><th>Summary of measure(s), including any impact data where available</th></tr>
<tr><td></td><td>CQC's management information shows that there are 77 Urgent Care providers, 20 NHS 111 providers and 88 Out of Hours providers. CQC and DHSC convention is that Out of Hours providers should be treated as publicly funded bodies and therefore not treated as businesses for the purposes of Business Impact Target.

CQC's highest estimate of the annual net cost of these changes on providers is c. £100,000 per annum. This is based on survey data that assessed the provider staff time requirement for the above activities before and after the change and CQC management information on the likely frequency of upcoming inspections. Some data used for the estimates are caveated in terms of their timeliness and sample size, however CQC believes it would be disproportionate to collect further data and is confident that the net impact to business will not reach the threshold for a Qualifying Regulatory Provision.</td></tr>
<tr><td>De minimis (measures with an EANDCB below +/- £5 million)</td><td>Next phase for Independent Health Providers
In 2018 CQC closed its consultation around the next phase of its inspection methodology for Independent Healthcare (IH) providers. The main change proposed in the consultation was in response to the extension of CQC's powers to award a rating to certain types of IH services from 2018/19 onwards; the consultation focused on how CQC proposed to introduce the ratings (see (a) below). The other proposed changes (see (b) and (c) below) represented an evolution of CQC's existing processes – rather than the introduction of new methods.

A list of the changes, and the different types of providers that are affected is shown below. Note that CQC has not changed its assessment framework for these providers.

<table>
<tr><th>Change</th><th>Type of providers affected</th></tr>
<tr><td>(a) Introduction of ratings for IH providers CQC has inspected previously</td><td>IH acute (cosmetic surgery only), single speciality services, IH community, IH residential substance misuse and community substance misuse, IH ambulance, Non-hospital acute independent doctors and IH Doctors providers primary medical services.</td></tr>
<tr><td>b) Change to the frequency of inspection based on the inspection rating of the provider</td><td>Independent acute hospital (excluding cosmetic surgery), IH mental health hospitals, Hospices and single specialty: long- term conditions</td></tr>
<tr><td>c) Increased relationship management for multi-site and corporate providers</td><td>Such as large IH providers covering community, ambulance, acute, mental health and corporate providers</td></tr>
</table>

For (a), CQC has always inspected and published reports on these providers but it had not previously rated them. Newly introduced ratings could be used by service users to help them choose which provider they should go to</td></tr>
</table>

Excluded Category*	Summary of measure(s), including any impact data where available

	for treatment. This therefore could impact on provider income, with better rated providers taking activity from poorer rated providers, or rating being incorporated into provider contracts. However, findings from The King's Fund and Manchester Business School report (September 2018) identified the lack of available national data as a key limitation in understanding the impact of CQC rating on service user choice. Given that the lack of available national data is more even more prominent for IH providers and that CQC has only recently started to rate IH providers - quantitative analysis of the impact of this change would not be possible without significant data collection. CQC deems this as being disproportionately costly to collect. This is further compounded by the challenge CQC would face in isolating the impact of publishing ratings from the previous approach of publishing general findings and recommendations.
	
	For (b), CQC carried out a survey of providers to understand which staff are involved in inspections and how much of their time an inspection takes up. Using the standard cost model, CQC calculated the average cost of inspection for different types of providers. Using inspection data, CQC identified the current and future frequency of inspections for these providers and calculated the net cost of the future schedule (taking the current inspection schedule into account).
	
	For (c), CQC spoke with policy leads to estimate the likely additional time requirement providers would face under the new relationship management process (including calls, face-to-face meetings and preparation times).
	
	CQC's highest estimate of the annual net cost to providers of these changes is c. £500,000 per annum. Some data used for costing are caveated in terms of their timeliness and sample size, however CQC believes it would be disproportionate to collect further data and is confident that the net impact to business will not reach the threshold for a Qualifying Regulatory Provision.

De minimis (measures with an EANDCB below +/- £5 million)	**Regulatory history** Previously, once a location providing health and social care services moves to a new/different provider (legal entity) their old rating disappears, and the 'new' location shows as unrated. The purpose of the change is for the regulatory history of a service (i.e. rating and inspection reports) to continue after it transfers (is bought, sold, merged) to a new provider. The primary aim of this change is to ensure transparency for the people using services. Whilst the change could be perceived as creating a disincentive for providers to buy inadequate services, CQC already identifies and creates links between locations that have undergone a change of ownership or address. The public has been able to view the previous history of a location by clicking a link back to the previous provider's record. This work is therefore not making any new information available but will display the previous rating and report in a more transparent way. It is assumed that this will have no impact on providers.

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	An additional intention/benefit of this change is to enable CQC to apply a more proportionate approach to scheduling the first inspection post-registration. Currently all newly registered services must be inspected within 12 months of registration. Services previously rated Inadequate or Requires Improvement would need inspecting within this time frame anyway, but for services previously rated Good or Outstanding the continuation of regulatory history will enable CQC to take a more risk-based approach to scheduling the first inspection under new owners. The impact of this reduces the burden on both CQC and providers caused by having to reinspect sooner than is necessary. The total impact on business, of not being re-inspected within one year, is estimated to be a c. £180,000 saving.
L2. Education/publicity campaigns, factsheets, helplines	**Adult Social Care and Health Care Providers Registration Assessment Framework** CQC published new guidance in late 2018 for Adult Social Care and Health Care providers. The guidance aligns CQC's registration framework with its inspection framework. This aims to make the registration process clearer for providers and means that providers will be registered against the same standards that they are inspected against. The guidance does not require providers to take any action nor are providers required to read this guidance. CQC sought advice from DHSC Better Regulation Unit and were advised to treat the change as a Non-Qualifying Regulatory Provision under education and promotion.

*This column will be updated with the other exemption categories once the Business Impact Target has been announced. Complete the summary box as 'Following consideration of the exclusion category there are no measures for the reporting period that qualify for the exclusion.' where this is appropriate.