Title:
Fit and Proper Persons Requirement for Directors
IA No: 6121

Lead department or agency:
Department of Health

Other departments or agencies:

Impact Assessment (IA)

Date: 29/04/2014

Stage: Final

Source of intervention: Domestic

Type of measure: Secondary legislation

Contact for enquiries: Sheila Evans

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
- £0.78m	NA	NA	No	NA

What is the problem under consideration? Why is government intervention necessary?

Directors of health and adult social care organisations play a crucial role in determining the safety and quality of care provided by the organisation through the decisions that they make and the culture that they set for the organisation as a whole. However, there are currently no requirements to ensure that directors of these organisations are, and continue to be, fit and able to carry out their role. It is at the discretion of the provider to ensure that the directors they appoint are of the right character and possess the necessary skills to carry out the role and to remove those who are not. In some cases this does not occur. Government intervention is required to close this gap in regulations.

What are the policy objectives and the intended effects?

The policy objective is to ensure providers take proper steps to ensure that their directors are fit and proper for their role. Requirements will be placed on providers to undertake the necessary checks to ensure that all directors exhibit the correct types of personal behaviour, technical competence and business practices required for their role. This is expected to have a positive impact on the quality of care by reducing the risk that unfit directors can negatively impact on the safety and quality of care. This will also strengthen the performance of directors by increasing the incentives on providers to scrutinise their performance and will enable CQC to take action against unfit directors including barring them from individual posts.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Do nothing: The existing regulations and requirements are insufficient to address the risks that poor governance might have on safety and care quality. Although the directors of health and adult social care providers can have significant influence over the level of safety and quality of care delivered, there are currently insufficient regulations governing the standards that a director must meet.
Option 2 (preferred option): A fit and proper persons requirement for directors: CQC requirements will be amended to place a clear duty on providers to ensure that all directors who are appointed to the boards of any health or care organisation regulated by CQC are of the right character and fit for their role, as is already the case for other staff members at the organisation, including senior managers. Subject to the parliamentary clearances, we will seek to implement this for NHS secondary care providers in October 2014 and for all other CQC registered providers from Apirl 2015.

Will the policy be reviewed? It will/will not be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: ..... Date: 2 July 2014

Summary: Analysis & Evidence

Policy Option 1

Description: Do nothing

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** 0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	**0**

Description and scale of key monetised costs by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

Other key non-monetised costs by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

Other key non-monetised benefits by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline. Under the do nothing option, there is a risk that health and adult social care regulation is not as effective as it could be, and that in the case of serious failings providers cannot be fully held to account for their actions.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	Yes	Zero net cost

Summary: Analysis & Evidence

Policy Option 2

Description: Review and recast the registration requirements so that they are clearer and easier to understand

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** -£0.78m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional	1	Optional	**Optional**
Best Estimate	£37,000		£86,300	**£0.78m**

Description and scale of key monetised costs by 'main affected groups'

Providers who do not currently carry out the necessary checks on their directors will face the costs of the additional actions they must take to do so. CQC will face the costs of undertaking the necessary monitoring and enforcement activity associated with the new requirement. Both providers and directors will be able to appeal against any enforcement action.

Other key non-monetised costs by 'main affected groups'

There may be a personal cost to a director if they are judged to be unfit and are removed for their duties. There could be other impacts on the labour market for directors that subsequently impact on providers

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional	1	Optional	**Optional**
Best Estimate	unquantified		unquantified	**unquantified**

Description and scale of key monetised benefits by 'main affected groups'

It has not been possible to monetise any benefits

Other key non-monetised benefits by 'main affected groups'

The main benefits are the reduction in the risks of poor quality care for health (and adult social care) service users associated with poor management or governance from an unfit director and the increase in accountability of directors for their actions arising from the increased incentives for providers to scrunitise the performance of their directors. Providers may also benefit where poor director choice would otherwise impact on business performance

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5

It remains unclear how many providers might currently be failing to undertake the necessary checks on whether their directors are fit and proper and thus what the true extent of the problem might be.
CQC are also making changes to their regulatory model which will have an impact on the levels of enforcement and compliance and the costs of regulation. It has not been possible to take into account these changes in the analysis as the policies are still under development.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: NA	**Benefits:** NA	**Net:** NA	No	NA

Evidence Base (for summary sheets)

Policy Background

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care providers in England and has a key responsibility in the overall assurance of safety and quality of health and adult social care services. Under the Health and Social Care Act 2008 all providers of regulated activities, including NHS and independent providers, have to register with CQC and meet a set of requirements of safety and quality.
2. CQC forms part of the wider quality framework, having responsibility for:
    - providing independent assurance and publishing information on the safety and quality of services;
    - registering providers of regulated activities (including NHS, adult social care and independent sector healthcare providers), ensuring the care they can provide is of a sufficient standard to allow them to enter the market safely;
    - inspecting and monitoring services against the registration requirements;
    - using enforcement powers (including prosecution) to ensure service providers meet requirements or, where appropriate, to suspend or cancel registrations;
    - undertaking special reviews and investigations of particular services, looking across providers and commissioners of health and adult social care;
    - monitoring the use of the Mental Health Act; and
    - operating a proportionate regulatory system that avoids imposing unnecessary burdens on providers and on the regulator itself, and helping to manage the impact of regulation more generally on health and adult social care service providers and commissioners.
3. CQC's purpose is to improve care by regulating and monitoring services. CQC provides assurance that only providers who have made a legal declaration that they meet the standards of quality and safety are allowed to provide care. Once services are registered, CQC continues to monitor and inspect them against these standards. It acts quickly in response to any concerns and takes swift enforcement action where services are failing people. This can include issuing a warning notice that requires improvement within a specified time, bringing a prosecution, or cancelling a provider's registration and removing its ability to provide regulated activities, or for the NHS, triggering the quality failure regime.
4. On 9th February 2013 Robert Francis QC published his report of the Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the Mid-Staffordshire NHS Foundation Trust from January 2005 to March 2009. This made a number of recommendations concerning the regulation of healthcare services, which were accepted by the Government in its initial response to the inquiry *"Patients First and Foremost"*[1], and confirmed in its final response *"Hard Truths"*[2]. The proposals outlined in this Impact Assessment form one part of the package of changes being brought in as a result of these recommendations. Other measures include:
    - Revising the existing CQC registration requirements to create a set of fundamental standards of care
    - Introducing a new statutory duty of candour to be enforced via CQC regulation
    - Allowing CQC to issue performance ratings to providers
    - Introduction of the three Chief Inspectors of Hospitals, General Practice and Social Care in place since Autumn 2013
5. In addition to these, CQC are also making changes to their regulatory model in order to improve the effectiveness of regulation. This will include changes in their internal practice on how they register, monitor and inspect providers, and will help to shift the burden of regulation away from high

[1] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

[2] Available at: https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

performing providers towards those performing at the lower end of the scale in order to drive up quality.

6. The initial policy driver for the fit and proper persons requirement came both from the Francis Inquiry into the mid Staffordshire Foundation Trust in relation to the NHS hospital sector and the Government response to the events at Winterbourne View Hospital in the adult social care sector.

7. However, subject to parliamentary clearances, implementation is expected to be in two stages: it will be introduced for NHS Trusts in October 2014 and all other sectors in April 2015. This Impact Assessment only considers the costs and benefits associated with implementing the policy for NHS secondary care providers only. A separate Impact Assessment, covering the implementation of the same policy for all other CQC registered providers from April 2015, will be published in due course.

8. For the purposes of this Impact Assessment, NHS secondary Care providers are NHS Trusts established under the National Health Service Act 2006, NHS Foundation Trusts, and Special Health Authorities. For brevity, we also refer to these organisations simply as 'NHS Trusts'.

The evidence base of this impact assessment is structured as follows:

Section A: Definition of the underlying problem and rationale for government intervention

Section B: Policy objectives and intended effects

Section C: Description of the options

Section D: Costs and benefits assessment of the options (including specific impacts)

Section E: Summary of specific impact tests

Section F: Summary and conclusion

Section A: Definition of the underlying problem and rationale for government intervention

9. The government is committed to ensuring that users of health and adult social care receive high quality and safe services. In order for a health and adult social care provider to provide a high quality and safe service, it is vital that the organisation has the right values and culture, and the people who work for it are of a sufficiently high standard and are fit to be entrusted with delivering these services. As demonstrated by the serious events at Winterbourne View Hospital, failure of an individual at any level of the organisation can have significant impacts on the health and safety of service users.

10. There are many policies, initiatives and levers in place to ensure that only those with the right character, qualifications and skills are involved in the delivery of care, such as through professional regulation and voluntary codes of conduct. However, there is a gap in the current regulatory system concerning fitness of directors of Boards or their equivalents (including members of the governing body of unincorporated associations or trustees of charitable bodies)[3].

11. As part of the system of regulation for health and adult social care providers, CQC requires those involved in managing or carrying out a regulated activity to remain fit to provide services and to be accountable for the actions that they take as set out below. Fitness is judged based on whether the individual is of good character and possesses the necessary skills and qualifications in order to carry out their role.

    - Providers: The service provider is registered with CQC and CQC itself makes a judgement about their fitness. Where the service provider is an individual or partnership this includes the fitness of the individuals involved. For other organisations, there is a fitness test for the nominated individual who is responsible for supervising the management of the regulated activity.

    - Registered managers: The registered manager is assessed and granted registration by CQC, which makes a judgement about their fitness. The role of the registered manager is designed to ensure that an individual is personally accountable for ensuring that the registration requirements are complied with in each location. (NHS Trusts are not required to have a registered manager).

[3] In this document, "director" is taken to include equivalent positions in other organisations, including members of the governing body of unincorporated associations or trustees of charitable bodies

- Staff: The service provider and registered manager are required to ensure that the staff they employ are fit to fulfil the function for which they are employed. This includes the fitness of senior managers, but only includes directors or other company officers if they are employed for the purposes of carrying out the regulated activity.

12. There is no registration requirement specifying that all directors or equivalents have to be fit and proper persons. As such directors or their equivalents are the only part of a registered provider's hierarchy where a fitness test does not apply. This is a gap in the current regulations.

13. Although the directors of the organisation are unlikely to be involved in carrying out regulated activities on a day-to-day basis, we would still expect that they will have significant influence over the safety and quality of care provided. The directors of a provider organisation have responsibility for leadership, providing oversight and making decisions and setting policies for the organisation as a whole. These decisions will influence how the organisation operates, and the culture, values and behaviours expected from all staff. Where directors fail to carry out their role properly, there can be significant and wide ranging risks to safety and care quality across the whole of the organisation.

14. This was demonstrated in the Serious Case Review for the events at Winterbourne View Hospital[4]. This report clearly outlined the failures of Castlebeck Care Ltd to assume responsibility for the ongoing concerns at the hospital, for example, through continuing poor oversight of patients and staff, failure to respond to concerns of a whistle-blower, and failure to ensure adequate management and safe staffing levels at the Hospital. Overall the report concluded that "Castlebeck Ltd's appreciation of events… was limited, not least because they took the financial rewards without any apparent accountability". *Transforming care: A national response to Winterbourne View Hospital"*[5] noted that although 11 former members of staff were sentenced in connection with the abuse of patients, the review identified weaknesses in the system of accountability where leaders of organisations were not fully held to account for poor quality care or for creating a culture where neglect and even abuse can happen. A similar situation was also identified by Robert Francis as part of the Public Inquiry into Mid Staffordshire Hospital. Francis criticised the trust's board for being 'disconnected' from what was happening on the ground at the hospital, relying on favourable external reports from the Healthcare Commission, but dismissing feedback from staff and patients and the findings of internal assessments.

15. As a result of this, in *"Transforming care""* the Government committed to working with CQC to explore options for introducing a fit and proper persons test for directors of boards, and ways in which accountability for board members can be strengthened where poor care has been delivered. This commitment was reaffirmed in both the Government's initial response to the Francis Inquiry *"Patients First and Foremost"*, and its final response *"Hard Truths"*. Following consultation on the policy proposals in July 2013 and on the draft regulations in March 2014, this Impact Assessment sets out the government's final proposals for a fit and proper person's test for directors of providers registered with CQC.

16. We will seek to bring in the new fitness requirement for directors NHS secondary care providers from October 2014, and, subject to further clearances and parliamentary scrutiny, for all other CQC registered providers from April 2015. This Impact Assessment accompanies the regulations that apply this requirement to NHS secondary care providers, and thus the costs and benefits are assessed for this group only.

The case for government intervention:

17. It is expected that the vast majority of health and adult social care providers are likely to take proper steps to ensure the directors that they appoint are suitable and fit for the job, since there is likely to be a strong link between the fitness of a director and the financial performance of the organisation. However, there is a potential tension between providing a high quality service which meets the needs of services users and in running a profitable organisation. It is important to ensure that the latter is not achieved at the expense of the former. An extreme example of this was the case of Winterbourne View Hospital where, despite the poor care provided, the hospital was financially the best performing of all those owned by the parent company Castlebeck Care Ltd. In other cases,

[4] South Gloucestershire Safeguarding Adults Board, *Winterbourne View Hospital: A Serious Case Review.* http://hosted.southglos.gov.uk/wv/report.pdf

[5] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

providers may fail to appoint fit directors for other reasons. For example, if recruitment decisions are based on other criteria such as family or personal ties. In very large organisations, it may be the case that the owner of the organisation is too far removed from the running of the organisation to make effective judgements about the fitness of the board.

18. Market mechanisms may not be able to address these issues because of information asymmetries whereby service users are not necessarily aware of the governance arrangements at a particular service provider, or the quality of care being delivered. Thus regulation is required to correct these issues and ensure providers recruit fit directors. Regulation of health and adult social care is a public good, and as such, the market does not always naturally provide it, and has not done so in this area, hence government intervention is required to close the gap in requirements identified above.

19. In addition, there is currently no mechanism (within the regulatory system or otherwise) to remove directors whose conduct or competence makes them unsuitable for their role. Government intervention is needed to ensure that there is a strong system to hold board members to account in cases where there have been serious failings in care. CQC, the national regulator of all health and adult social care services is best placed to do this via its enforcement powers.

Alternatives to regulation

20. This section considers the possible alternatives to regulation and discusses the options that were considered in the development of the policy. This discussion relates to the overall policy intention, which is to strengthen corporate accountability for **all** providers of health and adult social care. However, subject to parliamentary clearances, implementation is expected to be in two stages: for NHS Trusts in October 2014, and all other sectors in April 2015.

21. Overall, a number of different policies and initiatives are being pursued jointly in order to improve the quality of care and address poor leadership in response to the recommendations of the Francis Inquiry. Regulation is considered to be an important part of this package of measures and will act as the ultimate backstop by which providers can be held to account for failings.

    - Options to improve existing regulation, such as through the adoption of existing regulation, simplification or clarification of existing regulation or improving enforcement against the existing regulations were not considered to be appropriate for addressing the problem described above. As discussed in more detail in section C below, there is a gap in the current regulations whereby director level posts are the only part of a provider's management hierarchy that are not subject to fit and proper person requirements. Existing regulation concerning directors such as the Companies Act 2006 and the Director's Disqualification Act 1986 do not specifically address the fitness of a director to lead health and adult social care organisations. Furthermore, these requirements do to apply to unincorporated associations or voluntary sector organisations. Similarly, other existing requirements such as Monitor's licensing conditions for NHS foundation trusts or the Charities Act 2011 only cover parts of the health and adult social care sector, leaving dangerous gaps in the regulatory system where unfit directors could slip through.

    - Options to make legal remedies more accessible or cheaper were not considered to be appropriate as no such legal remedies exist by which a service user could hold a provider to account, save through the regulatory mechanisms described above. The existence of asymmetric information and often vulnerable position of some service users would continue to prevent the effective use of legal remedies in this area, thus necessitating the role of a regulator who is able to take action on behalf of service users.

    - Options to improve the provision of information or education for service users are being separately pursued through the introduction of aggregated performance ratings for providers issued by CQC. Although greater information provision is a pre-requisite for enabling greater choice amongst service users and improving service quality, the existing evidence on the effectiveness of this is mixed[6]. It is likely that even where an effective ratings system is in place, not all service users will be able to use this information effectively to challenge the governance of an organisation providing poor quality care. As a result, regulation will continue to play an important part in protecting service users from poor quality care. While the proposed rating for providers will consider whether the organisation is well-led, it is unlikely that this will be sufficient

[6] See Marshall M, (2002), The publication of performance data in the National Health Service, NHS research paper for more details

to prevent the problems of poor quality care resulting from poor management as described above and thus it has been judged necessary to also pursue other options to address this issue. A more targeted program of information provision specifically relating to the quality of the board of directors at a provider was judged to be too burdensome to compile and of potentially limited use, as service users may not fully appreciate the impact that poor quality management might have on the quality of care, or otherwise fail to take into account this information in their decision making process.

- In terms of options to improve corporate governance through self or co-regulation via codes of practice amongst service providers, *Hard Truths* sets out a framework of measures to ensure good leadership via such arrangements. For example, the NHS Leadership Academy will initiate a new leadership programme to fast-track NHS clinicians and individuals from outside the NHS to be the next generation of senior leaders. The National Skills Academy for Social Care has been commissioned to work in partnership with the Social Care Institute for Excellence (SCIE) to bring together and publish a Guide for Social Care Board Members. The Professional Standards Authority for Health and Social Care has updated its standards for members of NHS Boards and clinical commissioning group governing bodies that put respect, compassion and care for patients at the heart of leadership and good governance in the NHS. Monitor, the Trust Development Authority and NHS Employers are developing guidance for trust Boards on the appraisal, development, performance management and disciplinary arrangements of senior executives. While these policies are likely to help to improve the quality of leadership amongst health and adult social care providers, it is judged that regulation is still required to provide a common framework for all health and adult social care providers which ensures that directors exhibit the correct types of personal behaviour, competence and business practices required for their role. In addition, only regulation provides an effective mechanism for holding board members to account in cases where there have been serious failings in care, via CQC's enforcement powers.
- Options involving the use of taxes or subsidies to incentivise providers to improve corporate accountability were not considered further as they were judged not to be practical. The informational requirements needed to judge the quality of corporate governance at a provider and assign a financial reward linked to this is likely to impose a significant burden on both the government and providers. No simple indicator of the fitness of a board of directors could be identified for financial incentives to be attached to.
- Measures to improve competition within the NHS have been actively considered by the Government for a number of years. As discussed above, a system of ratings of providers is being separately explored in order to improve the information available to service users and address existing information asymmetries. However this is unlikely to eliminate the need for regulation altogether.

22. In addition to the options described above, another option that was considered was whether there should be a barring mechanism to ensure that NHS leaders and senior managers whose conduct or competence makes them unsuitable to work in the health and care system are prevented from working and moving to a similar job within the sector[7]. This option would allow a designated regulatory body to bar senior managers (executive and non-executive directors) from working at the same level in the health sectors and was judged to be an effective way to properly hold directors to account for their failings and ensure that service users are protected from these individuals in the future.

23. However, this option was ultimately rejected as it was judged to be a more burdensome approach. It would have involved introducing a new overview layer across the system of regulation of managers, requiring new legislation creating new offences and would have applied across a wide range of health and adult social care providers and commissioners. It would have been more expensive and bureaucratic and was therefore not deemed a proportionate response to the recommendation.

24. Overall the proposal is to take this forward through the new fit and proper person requirement for directors was judged to be a more proportionate and appropriate response to the risks to public protection posed by managers. It does not require the setting up of new infrastructure to support it, and (subject to parliamentary clearances) it would extend the scope of the system beyond NHS

[7] See *Patients First and Foremost*

bodies to all providers of health and adult social care registered with the Care Quality Commission – be they public, private or voluntary sector providers. However, in *Hard Truths*, the Government did commit to keeping the issue under review and to legislate in the future if the proposed mechanism for barring is not having its desired impact.

Section B: Policy objectives and intended effects

25. The policy objective is to strengthen corporate accountability in health and adult social care by ensuring that the board of directors are able and incentivised to provide high quality leadership, and strengthening the systems of accountability for boards in cases where there have been significant failings in care. This will be achieved by closing the current gap in the regulations. Providers will be required to take proper steps to ensure that all board members are fit and proper for their role. We will seek to bring in the new fitness requirement for directors of NHS secondary care providers from October 2014, and, subject to further clearances and parliamentary scrutiny, for all other CQC registered providers from April 2015.
26. The intended effect of this is to reduce the risks of poor quality care for service users associated with poor management or governance and to make directors more accountable for their actions. Providers will be expected to carry out the necessary checks to ensure that their directors are of the right character and are fit to carry out their roles. This will compel the minority of providers who currently do not carry out these checks to begin to do so. Newly registering providers will also be expected to carry out similar checks in order to make assurances to CQC about the fitness of their directors. Overall, the risk that a director who is not suitable or able to carry out the role is appointed will be reduced as a result, and this will in turn reduce the risk of quality failings relating to poor governance occurring. By creating a requirement in statute and determining a set of standards, providers will be able to exercise less discretion when deciding if directors are fit for the role. This is expected to reduce the potential variation in the quality of directors.
27. Providers will also be required to continue to monitor their directors to ensure that they continue to remain fit and able to carry out their role. Where it becomes apparent that a director is no longer fit for their role, providers will be expected to take appropriate action, including removing the director from their role. In addition to improving the quality of board leadership, this requirement is also expected to strengthen the accountability of directors by increasing the incentives on providers to scrutinise the performance and actions of their directors, and to ensure that there are appropriate consequences for a director where this is not satisfactory.
28. Where a board member is found to be unfit for their role, CQC will be able to require the removal of the director from their post. Where the director is appointed for a new role elsewhere in the sector, CQC will be able to make a judgement about the fitness of the director for this post by taking into account the director's past performance. This also has the direct effect of increasing the accountability of board members.

Section C: Description of the options

Option 1: do nothing

29. The existing regulations and requirements placed on providers are insufficient to address the risks that poor governance might have on safety and care quality. Although the directors of the provider organisation can have significant influence over the level of safety and quality at the provider, there are currently insufficient regulations governing the standards that a director must meet to be able carry out the role. It is currently at the discretion of the provider as to whether the directors that they appoint are, and continue to remain, fit for their role, and what action is to be taken where this is not the case. Providers may face incentives not to, or be otherwise unable to, carry out the appropriate and necessary checks to ensure directors are and remain fit for their role.
30. There is a gap in the current regulations. Providers of health and adult social care face requirements for all other individuals within their organisation hierarchy to be fit and proper for their role.
31. As discussed previously, although CQC requires providers, registered managers and staff to be fit and proper to carry out their role, there is no such requirement for directors. The existing requirements are unlikely to offer sufficient coverage for directors for the reasons below:

- Providers: Where the service provider is an individual or partnership CQC tests the fitness of the individuals involved. For other organisations, a fitness test applies for a nominated individual who is responsible for supervising the management of the regulated activity. The fitness of a director would therefore only be judged if they also carried out one of the roles listed above. Any other directors in the organisation would not be subject to the fitness test.
- Registered managers: The registered manager is the individual who is personally accountable for ensuring that the registration requirements are complied with in each location. A director is unlikely to undertake this role because the role of the director is to provide oversight and make policy and organisational decisions rather than day-to-day management.
- Staff: The service provider and registered manager are required to ensure that the staff they employ are fit to fulfil the function for which they are employed. This includes the fitness of senior managers, but only includes directors or other company officers if they are employed for the purposes of carrying out the regulated activity. This is unlikely to be the case as the role of the director rarely involves carrying out day-to-day activities. However it could capture executive directors overseeing the regulated activities.

32. Directors of NHS organisations may face requirements on their fitness from other sources, for example, Monitor includes a fit and proper person's test for directors as part of its licence conditions for providers of NHS services, which currently applies to all Foundation Trusts. The NHS Trust Development Authority (TDA) will also enforce appropriate requirements equivalent to licence conditions on NHS Trusts. However these requirements only concern whether the individual is bankrupt, has any criminal convictions or is subject to a disqualification order, whilst the Francis recommendations also considered the attributes necessary for good leadership such as the character and skills and experience of the individual.

33. While the Companies Act 2006 sets out the statutory duties falling on all directors and the Company Directors Disqualification Act 1986 allows for the removal and disqualification of directors if their conduct is found to be unfit, these provisions are not directly concerned with the fitness to provide health care services. Rather, the Companies Act 2006 sets out the general duties on a director, which are to work in the best interests of the company and to carry out the necessary formal processes required to run a company. There is no duty that a director is fit and proper for their role and there are no limits in law on who can be appointed as a director so long as they are over 16 years of age and have not been previously disqualified from being a director. Other types of organisations may face additional requirements on their directors e.g. the Charities Act 2011 sets out the conditions which disqualify people from acting as a trustee and undischarged bankrupts are prohibited from being company directors or charity trustees. However, none of these existing requirements will specifically concern the fitness of a director to lead a health care provider. To protect the safety and quality of services, we would expect directors of health care organisations to display specific skills and behaviours beyond those required generally in connection with running a company.

34. The Company Directors Disqualification Act 1986 allows the courts to disqualify directors for up to 15 years if their conduct is found to be unfit, however the definition of unfitness is focussed on compliance with companies legislation, conduct in relation to an insolvent company and compliance with competition law. This is unlikely to be a sufficient provision to enable CQC to remove unfit directors as it is unlikely that the appropriate test of fitness to provide health care services would only be concerned with compliance with existing laws. As is the case for CQC's fit and proper requirements on providers, registered managers and staff, the character, personal behaviours and technical skills (as demonstrated by their past performance and other relevant criteria set out in the proposed regulations) of the individual will also be relevant to the judgement of whether the individual is fit and proper for their role.

35. Although in some circumstances CQC will consider a director unfit to take up another post in the sector, the Company Directors Disqualification Act 1986 is unlikely to be the best tool for doing this. This is because many health (and adult social care) organisations are not limited companies and so this legislation does not apply to them. Moreover, the definition of fitness of a director for health (and adult social care) is likely to be such that a director could be unfit for one role, but remain fit for another. In these situations, it would not be appropriate to fully bar the director from all possible posts, including those outside of the health (and adult social care) sectors.

36. Thus the do nothing option would allow the current gap in the requirements to remain. This creates a risk to the safety and quality of care since directors play an important role within the provider organisation and will influence how care is provided through the decisions that they make and policies that they set for the organisation as a whole. Without requirements to ensure that these directors are of a suitable standard and fit for their role, providers may face incentives not to, or be otherwise unable to, carry out the appropriate and necessary checks to ensure directors are and remain fit for their role and CQC would be unable to take action where a provider has appointed an unfit director. Where unfit directors are appointed or remain in their role, this poses a risk to the quality of care provided. Governance failings at this level can lead to wide scale impacts on care quality for the whole organisation. We will seek to bring in the new fitness requirement for directors of NHS secondary care providers from October 2014, and, subject to further clearances and parliamentary scrutiny, for all other CQC registered providers from April 2015.

Option 2: Fit and proper persons requirement

37. Under this option, the CQC registration requirements will be amended to place a clear duty on service providers to make sure that all directors and equivalents who are appointed to the Boards of any health or care organisation regulated by CQC are fit for their role, as is already the case for other staff members at the organisation, including senior managers. We will seek to bring in the new fitness requirement for directors of NHS secondary care providers from October 2014, and, subject to further clearances and parliamentary scrutiny, for all other CQC registered providers from April 2015.
38. The provider will be expected to undertake the necessary checks to assure themselves and CQC that their directors exhibit the correct types of personal behaviour, technical competence and business practices to undertake their role (as evidenced by the fit and proper requirements for directors set out in the proposed regulations).
39. These checks are expected to occur at the point of registration, in the recruitment of new directors, and as part of on-going monitoring of existing directors to ensure that they continue to remain fit and proper for their role. Where it becomes apparent that a director is no longer fit for their role, the provider would be expected to take appropriate action to remedy the situation, including removing the director from their role.
40. It is intended that this requirement will apply to all those individuals who sit on the board of directors of a provider organisation, or their equivalents. This will include both executive and non-executive directors and trustees (e.g. of charitable bodies and members of the governing body of non-corporate associations).
41. The regulations set out criteria for assessing both the fitness of directors or their equivalents and criteria for deeming a director or their equivalent to be deemed unfit. This means that a director must:
    - Be of good character;
    - Have the qualifications, skills and experience necessary for the relevant position;
    - Be capable of undertaking the relevant position, after any reasonable adjustment under the Equality Act 2010;
    - Not have been responsible for any serious misconduct or mismanagement in the course of any employment with a CQC registered provider;
42. A director would be deemed unfit if they:
    - Are an undischarged bankrupt;
    - Are subject of a bankruptcy order or an interim bankruptcy order;
    - Have a undischarged arrangement with creditors; or
    - Are included on any barring list preventing them from working with children and vulnerable adults.
    - Were prohibited from holding the relevant position under any other law e.g. under the Companies Act or the Charities Act, or under professional regulation.

43. The duty to ensure that directors are fit and proper would rest with the service provider. CQC would not separately carry out checks on directors as a matter of course. The expectation is that the chair or senior person in the organisation would sign off all director level appointments as fit. However if CQC were to have concerns about any particular director, they would be able to investigate further to reach a judgement about the director's fitness and take any relevant further action as necessary. The requirement will apply as follows in the three scenarios below:

    - **On** registration of a new provider: NHS secondary care providers seeking registration with CQC would need to provide an assurance to CQC that its directors, or equivalents were 'fit and proper', as defined in the regulations and guidance. CQC will collect information about directors and seek confirmation that the provider has undertaken the relevant checks on the fitness of its directors as part of the application process. CQC would need to review the provider's decision and could undertake its own independent assessment of the director to determine fitness and therefore compliance with the regulation. Where there is doubt about the suitability of a director, further investigation and assessment would be required. CQC may choose to interview the provider and the director to better assess the suitability of the individual for the role, as they currently have the power to do so in relation to the other registration requirements. CQC cannot grant registration if a provider cannot meet the registration requirements so a provider with a director judged to be unfit could not be registered. This provides an incentive for newly registering providers to carry out appropriate checks on their directors to ensure that the directors that they appoint are fit and proper for their role prior to registration.
    - At inspection: CQC will inspect providers for compliance against all registration requirements and, where there are concerns about governance and poor quality care, they will consider whether the relevant directors are fit for their role. If a director is found to be unfit for their role, CQC can take enforcement action to ensure that the director is removed from the role that they are unfit for. The inspection process therefore acts as an incentive for providers to assess directors on a continuing basis to ensure that they remain fit and proper for their role.
    - On appointment of a new director: NHS secondary care providers will be expected to carry out the necessary checks to ensure that the directors that they appoint are fit and proper for their role On notification of the Director's appointment, CQC would look at their records of inspections and conditions relating to Directors and would then consider in the light of all relevant evidence, whether this individual was fit to hold the Director post. If a director is found to be unfit for their role, CQC can take enforcement action to ensure that the director is removed from the role that they are unfit for. CQC may issue a warning notice or impose a condition of registration which would mean the director had to be removed. In serious cases where a director was considered to put service uses at risk of harm, urgent action to impose a condition meaning that the director had to be removed would be considered.

44. CQC would keep a record of decisions where an individual had been barred from a specific post, and records of other concerns e.g. where a director had resigned prior to CQC imposing a condition on the provider. CQC would look at their records of inspections and conditions relating to directors and would then consider in the light of all relevant evidence, whether the individual was fit to hold the director post. This will prevent directors who have previously been judged to be unfit for their role from taking up another similar role elsewhere in the health (and adult social care) system, where they are unfit to do so. Both CQC and providers will be expected to consider the past employment history and judgements about the fitness of the director in forming their judgement of whether the director is fit for their new role.

45. There will be a right of appeal by the provider against any condition imposed on its registration to the Health, Education and Social Care Chamber of the First-Tier Tribunal, as applies to other decisions taken by CQC to impose conditions on registration. The Government is introducing a new right of appeal to the first tier tribunal for individuals who are removed as a direct result of civil enforcement action to impose a condition by CQC. This is being put in place through the Care Bill.

46. CQC already have fit and proper requirements for providers, registered managers and staff. Adding in a fit and proper requirement for directors narrows the current regulatory gap for directors excluded from these requirements.

Section D: Costs and benefits assessment of the options (including specific impacts)

Costs:

Changes since the consultation stage Impact Assessment

47. We have used the consultation stage to gather further evidence on the potential costs and benefits of the proposals. A call for evidence was issued alongside the consultation document, which posed specific questions on the costs of provider's current recruitment practices and sought further evidence on the extent of checking of directors that might be occurring, as well as respondents' views on the consultation stage Impact Assessment. These questions were also posed to providers at a number of stakeholder workshops. We have also sought to update our estimates based on research and evidence from other comparable sectors.

48. In terms of our cost updates, the large majority of respondents at consultation agreed with our estimates and were supportive of the policy. 88% of those who responded to our call for evidence agreed that the cost estimates presented in the consultation stage Impact Assessment were a good representation of the potential costs of the policy. The main concerns raised by respondents were that the estimates of the average number of directors per provider felt too low, and we sought additional evidence on this issue in order to refine our estimates.

49. From discussions with providers, and as the regulations have been further developed, it has been possible to get a better sense of the different types of checks that providers might be required to carry out in the different scenarios that this proposal would apply to. This has allowed some refinement to particular cost areas, such as the types of retrospective checks that providers might choose to carry out on their directors.

Numbers of providers affected by the Fit and Proper Persons requirement

50. As discussed above, there will be different implementation costs falling to different groups of providers. Our estimates on the number of providers are summarised in table 2 below:

Table 2

Providers:	Number:	Source
Total number of NHS Trusts registered with CQC	247	CQC directory of registered providers
New Trusts registering each year	3	DH analysis of change in CQC directory over time
Number of applications for registration each year	3.33	Advice from CQC that approx. 10% applications per year are rejected or withdrawn
Existing (i.e. not new) NHS Trusts	244	No registered providers less number of new providers

51. Of the total number of providers considered below, we estimate that approximately 80% of providers already carry out adequate checks on their directors and 20% do not.

52. These calculations are discussed below:

Provider numbers:

53. There are approximately 250 NHS trusts registered with CQC who would be affected by the new fit and proper person's requirement. We further break this figure down into those providers who are likely to be newly registering trusts (i.e. registered with CQC in the past year) and those who might be considered existing trusts (i.e. those who have been registered with CQC for more than one year). This is necessary because new providers are assumed to incur costs associated with checking their directors during the initial registration process. They would therefore not be expected to also check the ongoing fitness of their directors again within the same year. The costs of ongoing monitoring of director fitness are therefore assumed to only apply for providers who have been registered with CQC for more than a year.

54. Analysis of the date of registration of the NHS Trusts registered with CQC indicated that approximately 1% (or 3 Trusts) could be classed as newly registered providers in any given year This leaves approximately 245 providers per year who would be classed as 'existing providers'.

55. However, the total number of applications will exceed the number of new registering providers, as CQC advise that approximately 10% of all applications are likely to be rejected or withdrawn[8]. Although this figure is perhaps less likely to be relevant for NHS Trusts (as they are large organisations who are likely to have experienced staff and work with other regulators to navigate the registration process), we nonetheless apply a 10% uplift to our estimate of the number of newly registering trusts to estimate the number of potential applicants.

Future growth in number of providers:

56. So far the analysis has not taken into account any change in the number of providers registered with CQC over time. Under this static assumption it would imply that the number of new providers registering in a given year is perfectly matched by an equivalent number of existing providers choosing to deregister in that year. However, an examination of the number of providers registered with CQC over time suggests that this is unlikely to be the case. This must be factored into our calculation of the costs and benefits to providers for future years of this Impact Assessment.

57. In terms of NHS Trusts, over the past 5 years there has been a trend in consolidation within the NHS, with an average reduction in the number of NHS trusts of approximately 8% on average over the past two years. However we judge that this is unlikely to continue for the whole duration of the 10 year period of this Impact Assessment (not least because this would result in more than half of NHS Trusts disbanding in this period). Based on internal advice from the DH provider policy team, it is not possible to accurately predict the likely number of NHS trusts over the next ten years. In the absence of further information, we therefore make the assumption that the number of NHS trusts is likely to remain more or less constant over the period of this Impact Assessment.

Proportion of providers already carrying out adequate checks of fitness

58. We expect that the large majority of providers will already be carrying out the appropriate checks to ensure that the directors that they appoint are, and remain, fit and proper persons for the role. Consequently we would not anticipate that there would be any additional cost burdens from this requirement for those providers, save for some additional transitional costs incurred by these providers in taking the time to inform themselves and understand the new requirement, and to assure themselves that they are already compliant.

59. There is currently little evidence to suggest what proportion of providers might already be carrying out adequate checks. The consultation stage IA used an assumption that 80% of providers would already be carrying out checks in compliance with the proposed fit and proper person test for directors. We tested this assumption with providers at consultation. A call for evidence was issued alongside the consultation document, which posed specific questions on providers' current recruitment and performance appraisal practices and asked providers for their views on the prevalence of poor checking in their sector. These questions were also posed to providers at a number of stakeholder workshops. 38% of respondents to our online call for evidence felt that others in their sector would not be carrying out similar checks on their directors, and the majority of providers who attended our stakeholder event also agreed that there would be a small minority of providers who did not carry out proper checks. , However, stakeholders were unable to further quantify this figure. One provider expressed the view that most charities would have a relatively informal process for appointing directors, but no further details were supplied.

60. Although evidence relating specifically to the health sector has been difficult to find, there is some limited indicative evidence from other sectors to suggest that our estimate of 20% of providers not carrying out adequate checks is approximately in the correct ballpark. For example, research by the New Zealand Education Review Office that looked into recruitment practices of New Zealand schools for Headmasters[9] found that most schools had appropriate policy and practices in place in place with 80 percent of primary schools and 74 percent of secondary schools had appropriate recruitment and appointment processes. Guidance produced by CIFAS and the CIPD[10] on taking staff fraud and dishonesty quotes a Mori poll which indicated that 34% of managers don't check the background of applicants (in relation to recruitment) because it is too time consuming, whilst

[8] If it becomes clear to a provider that their application is likely to be rejected, they may decide to withdraw it in advance of any formal decision.

[9] Please see: http://www.ero.govt.nz/National-Reports/Student-Safety-in-Schools-Recruiting-and-Managing-Staff-January-2014/Findings/Recruitment-and-appointments-that-emphasise-keeping-students-safe

[10] Please see: http://www.cipd.co.uk/publicpolicy/policy-reports/staff-fraud-dishonesty.aspx

research from the CIPD found that only 77% of organisations always take up candidate references. Finally, a 2010 poll of the Society of Human Resource Management shows that approximately 60 percent of employers use credit checks and approximately 92 percent use criminal histories in screening job applicants[11]

61. These figures, together with the general conclusions from consultation exercise, lend some support to our initial assumption of 20% of providers not carrying out checks. In the absence of other available evidence on this issue, we continue to use this assumption.

Number of directors affected

62. Many of the costs calculated in this section will depend on the number of directors. For example the total cost to a provider of conducing checks on their directors will depend on the total number of directors to be checked. Thus, we estimate the average size of the board for health care providers as well as the number of providers.

63. Research commissioned by the National Leadership Council[12] highlighted that membership of NHS trust boards may range from 8 to 11 members. We therefore apply a mid-point estimate of there being an average of 10 directors per board.

Provider Implementation Costs

64. As discussed above, it will be the duty of the provider to take action to ensure that their directors (or equivalent level appointments) are fit and proper for their role. Based on the discussion above, the main implementation costs to providers are therefore as follows:

- On the registration of new providers – newly registering providers would need to ensure that their directors are fit and proper for their role, and to make a declaration to CQC as such
- When new directors are appointed – providers already registered with CQC would need to carry out the appropriate fitness checks when appointing a new director
- Ongoing checks for existing directors – providers already registered with CQC would need to continue to monitor the performance and fitness of their directors on an ongoing basis

65. It is likely that the large majority of providers will already be carrying out these checks. Thus compared to the do nothing case, the bulk of the implementation costs will fall only on those providers who do not currently carry out proper checks.

66. Table 1 below summarises our cost estimates:

Table 1

At	Costs	Details	Who affected	Total Cost
Registration of new provider	Checking directors	Providers who do not currently carry out checks on directors will face additional costs of carrying out checks	Newly registering providers who don't already carry out checks	£2,100 p.a.
	Administration	All newly registering providers administration will increase slightly through additional information required on directors	All newly registering providers	£40 p.a.
	Interviews with CQC	Where CQC has questions around a director then there will be the cost of CQC interviewing the director	A small proportion of newly registering providers where CQC have concerns	£7 p.a.
Appointing new directors	Checking directors	Providers who do not currently carry out checks on directors will face additional costs of carrying out checks	Existing providers who do not carry out checks	£18,750 p.a.
	Interviews with CQC	Where CQC has questions around a director then there will be the cost of CQC interviewing the director	A small proportion of existing providers where CQC have concerns	£64 p.a.
Ongoing checks for directors	Appraisal of existing directors	Cost of ensuring that directors remain fit and proper for those providers that are not currently undertaking adequate checks	Existing providers who do not current carry out checks	£46,500 p.a.
Other Costs	Familiarisation costs	Cost of time for providers to review guidance and new requirements	All Providers	£5,900 one off

[11] Please see: http://www.lawyerscommittee.org/admin/employment_discrimination/documents/files/Employers-Best-Practices-Background-Checks-Guide.pdf

[12] National Leadership Council. , 2010. The Healthy NHS Board: A review of guidance and research evidence, available at http://www.foresight-partnership.co.uk/downloads

	One off compliance actions	Cost of any retrospective checking providers wish to carry out	Existing providers who do not already carry out checks	£27,300 one off

Figures rounded to 2 significant figures

Provider implementation costs: Registration of New Providers:

Registration - Cost of administration

67. The new fit and proper person's requirement will increase the paperwork for all applicants as they will need to provide more information to CQC via their application form about their directors along with a declaration that the directors are fit and proper to CQC. It is not clear how long this additional paperwork is likely to take to complete but, following discussions with CQC, we do not expect the additional time requirement to be significant as these additional informational requires are not expected to be overly large[13].

68. If this were to take 30 minutes of extra time for a manager to gather the evidence and complete the application the additional cost per applicant would be £12 (based on the median gross hourly wage for Corporate Managers and Directors of £24 (including 15.3% non-wage costs[14]) from the provisional 2013 Annual Survey of Hours and Earnings (ASHE) results[15]). This cost will fall on all new applicants for CQC registration, not just the successful ones. Thus across our estimate of 3.3 applications each year this will total around £40.

Registration – Cost of checks of directors

69. As discussed above, we expect that the large majority of providers will already be carrying out the appropriate checks to ensure that the directors that they appoint are fit and proper persons for the role, and we use the working assumption that only 20% of providers might be currently failing to carry out appropriate checks. If we were to apply this figure to the number of applications for registration discussed above, it would suggest that less than one of these applications would be failing to make appropriate checks on their directors.

70. However, we also know that up to 10% of these applications are currently being rejected by CQC for failing to demonstrate compliance with the existing registration requirements. Given that they are already unable to demonstrate how they will comply with existing registration requirements it may be unlikely that these providers would make the necessary changes to carry out proper checks on their directors. As a result, it is likely that only currently successful applicants might change their behaviour to carry out checks on the directors where they do not already do so. This group of successful applicants are the ones who would be at risk of moving from a successful to unsuccessful registration application due to the introduction of the fit and proper person's requirement, if they do not carry out appropriate checks on their directors. Consequently, they face the greatest incentive to change their behaviour and begin to carry out these checks if they do not already do so.

71. Based on the above analysis, we would therefore expect that up to 0.6 new providers might change their behaviour and undertake additional checks on their directors prior to applying to register with CQC (20% of the 3 newly registering i.e. successful providers[16]). Based on our analysis above on the average number of directors, this equates to there being approximately 6 directors requiring additional checks.

72. In terms of what these checks might look like and the associated the cost burdens this is likely to vary by different types of organisations and the role of the director. However, we consider two general categories of checks as follows:

    - Pre-employment type checks – where providers recruit new directors to the organisation, we would expect that a provider would determine the fitness of a director through the use of interviews, reference checks and other background checks. We estimate that the cost of these checks might be in the region of £200 to £500, based on a simple survey we conducted of the prices published on the websites of companies specialising in undertaking pre-employment

[13] They are more likely to contain details such as the name and address of the director rather than long statements of suitability or other evidence of fitness for each director

[14] See http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=Wages_and_labour_costs&stable=1

[15] This survey estimates average earnings for the period 2012/13

[16] Note that quoted figures may not necessarily sum due to rounding

vetting on behalf of other organisations[17]. This would roughly equate to between 7 and 19 hours of a HR manager's time[18].

- Continuing appraisal of director fitness – where there are existing directors at a provider organisation, it is less likely to be appropriate for the provider to conduct the full suite of pre-employment checks as the provider will already be familiar with the background of the director. Instead, providers might consider the fitness of a director by appraising the director's past performance. Based on a short survey of published appraisal policies for various organisations[19], we assume that such appraisals are likely to require up to 2 hours of a director's time to conduct a self-assessment and/or seek feedback on their performance from others, followed by approximately an hour's discussion with the Chair of board. This gives a total of 4 hours of staff time[20] and using a median gross hourly wage for corporate managers and directors from the provisional results of the 2013 ASHE survey of £24 (including 15.3% non-wage costs) this gives a cost per appraisal of £96 per director to be appraised. In addition to this, there may also be a separate discussion to assess the joint performance of the board as a whole, and providers may need to retrospectively carry out checks in relation to the specific criteria mentioned in the regulations if these were not previously carried out. A enhanced DBS check including a check of the DBS barred lists currently costs £44, whilst a provider would be able to search the individual insolvency register or register of disqualified directors online, with minimal stall time costs.

73. It is likely that where applicants are newly formed organisations seeking CQC registration, they would incur costs primarily associated with pre-employment type checks. On the other hand, other applicants will be existing organisations wishing to expand their activities into an area that requires them to register with CQC for the first time. In this scenario, we might expect providers to be more likely to utilities the second category of checks.

74. However, CQC do not hold information about the previous activity of organisations applying to register with CQC. As a prudent assumption, we therefore assume that all newly registering providers with CQC would elect to undertake a full pre-employment style set of checks in order to assure themselves of the fitness of the directors.

75. Taking the mid-point for the costs of carrying out checks of £350 and applying to the 6 directors that might be subject to additional checks gives an estimate of £2,100.

Registration costs – CQC interviews

76. Finally, as a part of the application process CQC may decide to interview the provider and director at the applicant organisation if there are any concerns about the director's possible fitness. It is difficult to predict how often this might occur, however based on an initial advice from CQC we use a starting estimate that up to 2.5% of applications could be interviewed. Again, we apply this figure against the base of 6 directors who might require additional checking rather than the full pool of approximately 33 directors we estimate to be associated with the 3.3 new applications, giving a total of less than 0.2 potential interviews a year (i.e. one every 5 years). This is based on the assumption that, for 80% of providers who we assume to be already carrying out adequate checks on their directors, CQC would be unlikely to begin interviewing these directors, given that they currently do not have any concerns. For the 10% of applications that are likely to be rejected in any given year,

[17] For example, please see http://www.knowyourcandidate.co.uk/pricing-for-employment-screening-checks.cfm and http://www.redsnappergroup.co.uk/vettingservices and http://www.advancedvetting.com/rates.php#p9

[18] Based on the median gross hourly wage for a human resources director or manager of £27 (including 15.3% non-wage costs) from the provisional results of the 2013 Annual Survey of Hours and Earnings (ASHE)

[19] For example, see http://www.ruh.nhs.uk/about/policies/documents/non_clinical_policies/black_hr/HR_110.pdf for the staff appraisal policy of Royal United Hospitals Bath, or http://www.southessexhomes.co.uk/resources/BoardAppraisalPolicyv3.pdf for the appraisal policy of South Essex Homes, an arm's length management organisation of Southend-on-Sea Borough Council. Policies for other organisations were also examined, alongside publically available guidance such as the Higgs review into the role and effectiveness of non-executive directors (http://www.iod.com/~/media/Documents/PDFs/IAS/Corporate%20Governance%20Reports/corp_gov_pub_higgs_review.pdf), guidance issued by the Institute of Directors on evaluation (http://www.iod.com/guidance/briefings/bis-board-and-director-appraisal), and advice issued by the charity Help the Hospices on board appraisal systems (http://www.helpthehospices.org.uk/EasysiteWeb/getresource.axd?AssetID=138318&type=full&servicetype=Attachment). All these documents made clear references to the need to evaluate individual board members in addition to the function of the board as a whole, and gave a clear expectation that, in the case of the former, the appraisal should involve both preliminary assessment or evidence gathering, followed by a conversation between the appraisee and appraiser

[20] This figure is also very close to what we heard from providers at consultation – providers suggested that the length of time required for them to appraise the fitness of a director ranged from 2 to 10 hours, with most estimated in the range of 3 to 5 hours.

regardless of the fit and proper requirement on directors, CQC will continue to scrutinise the applicant's ability to comply with the existing registration requirements as before. Whilst the fitness of the applicant's director is likely to form a part of this scrutiny, the focus is likely to be reduced and so the additional cost burden on both the applicant and CQC would be minimal.

77. Based on discussions with CQC, we assume that an interview to assess the fitness of a director could last up to an hour on average and be attended by a panel of one registration manager and two registration assessors at CQC, and a provider representative and the director in question on the provider side. In addition to incurring costs for providers, CQC will also face additional costs associated with this. CQC costs of implementation are discussed further down below.

78. Based on the median wage for a corporate manager or director (from ASHE, including 15.3% non-wage costs) of £24, this gives a total cost of unfit director interviews of only £7 on average per year.

Provider implementation costs: Appointment of new directors

79. When a new director is appointed there will need to be checks that the director is fit and proper. We previously estimated that the cost of pre-employment style checks of a director's fitness is between £200 and £500 (mid-point estimate of £350).

80. In terms of the number of new director appointments expected, as previously discussed, we begin with estimate of approximately 2,440 directors employed at the 244 existing NHS Trusts registered with CQC and apply our assumption that roughly 20% of these are not carrying out proper checks. This gives an estimate of approximately 490 directors not currently being appropriately checked.

81. In terms of the number of new director appointments expected, a 2013 survey of recruitment and retention carried out by the Chartered Institute of Personnel and Development[21] suggested that the median labour turnover rate in the economy was 12%. As this figure applies to the whole economy and will include very junior as well as very senior staff, it is not clear if it is applicable for directors. An American analysis of S&P 1500 company boards[22] found that 54% of boards had some level of turnover during the last fiscal year with a mean average turnover rate for those firms that experienced turnover of 17.8%. This suggests an overall average turnover of 9.6% across all S&P 1500 companies. It is not clear however how applicable this study will be as it concerns to large American companies. For FTSE 100 companies, turnover of directors was estimated to be 12.5% in 2010[23], but this again applies to very large organisations. However, using the above figures as a guide suggests an estimate of board turnover of 10-12%. If we use the mid-point estimate of 11% a year, this suggests that there may be around 54 new directors who do not already face checks on their fitness on appointment.

82. Costing the checking of these directors as we have done previously at £350, the total cost of checking these 54 or so directors would be just under £18,750 per year.

83. Finally, as in the case of registration, upon notification of a new director CQC may decide to interview these newly appointed directors if there are concerns about the director's possible fitness. It is difficult to predict how often this might occur, and we make a similar initial estimate that 2.5% of these director appointments may require an interview. Similarly, we assume that an interview at this stage would have the same time requirements as for an interview for to check the fitness of a director on registration. Thus the cost of each interview is estimated to be in the region of £50 for a provider. If this is undertaken for 2.5% of the above 54 new director appointments the total cost will be around £64 on average per year for providers.

Provider Implementation costs: On-going costs for existing providers

84. Existing providers will be required to ensure that their directors continue to be fit and proper. It is likely that many existing providers are already reviewing their directors but again assuming that 20% of providers are not currently undertaking proper reviews of the fitness of their directors, we estimate that approximately 490 directors across will need additional checks under the new requirements.

85. It will be at the discretion of the provider how they choose to monitor the continuing fitness of their directors and this may take a number of different forms. For the purposes of illustration, we assume

[21] Available at: http://www.cipd.co.uk/

[22] Please see http://www.equilar.com/corporate-governance/2013-reports/diving-in-to-board-turnover

[23] Lord Davies, 2011. Women on Boards, available at http://www.bis.gov.uk/assets/biscore/business-law/docs/w/11-745-women-on-boards.pdf

that this process might take place within the formal performance appraisal of director as discussed above, at a cost of £95 per director to be appraised. This suggests an additional annual cost of just under £46,500 to providers.

Provider Implementation costs: Other

86. All providers registered with CQC will need to take time to review and understand the change in legislation. While we estimate that most providers will already be undertaking sufficient checks there will still be a cost of provider's time in reviewing the change in legislation. Providers will incur some transitional costs associated with providers taking time to understand the new requirements and determine whether they need to take any additional action to comply with the requirements. As these changes will be made as part of a package of measures to revise the CQC regulations, it is difficult to disentangle the familiarisation costs associated with each separate measure. If these actions were to require one hour of a senior manager's time to carry out, then based on the median gross wage of £24 for a corporate manager or director from the ASHE survey (plus 15.3% non-wage costs), this would imply a total transitional cost of £5,900 across all 250 or so NHS Trusts.

87. Existing providers who have not already carried out appropriate checks of their directors may wish to undertake one off retrospective checks to reassure themselves that their directors are fit and proper and meet the new requirement. As discussed above, it is likely that existing providers would be able to assess the fitness of their directors using existing evidence on the performance of the director, rather than needing to carry out pre-employment type checks. The costs of these appraisal type checks have already been factored into the analysis above and so are not separately considered here. However, other criteria of the proposed fit and proper persons test may require providers to undertake retrospective checks. These are to ensure that the director is not on any barred lists, are not subject to any bankruptcy proceedings and have not been previously been disqualified from carrying out a similar post. As previously mentioned an enhanced DBS check including a check of the DBS barred lists currently costs £44, whilst a provider would be able to search the individual insolvency register or register of disqualified directors online, with minimal staff time costs.

88. Based on the assumption that half an hour of manager time is required to search the bankruptcy and director disqualification databases, at a cost of £12 for a corporate manager or director, this suggests that the cost of carrying out these retrospective checks would be £56 per director in total. Applying this figure to the 490 directors who may not have undergone proper checks suggests a total cost of £27,300.

CQC implementation costs

89. The implementation costs for CQC are as follows:

At	Cost	Description	Total cost
Registration	Admin costs	Although CQC will not carry out any independent checks on directors, they will wish to check their records to determine if there are any existing concerns about a director	£58 p.a.
	Interviews	Where CQC have concerns about the fitness of a director, they may choose to interview the director	£18 p.a.
Appointment of new director	Admin costs	Although CQC will not carry out any independent checks on directors, they will wish to check their records to determine if there are any existing concerns about a director	£4,700 p.a.
	Interview	Where CQC have concerns about the fitness of a director, they may choose to interview the director	£165 p.a.
Existing providers	Inspection	CQC will inspect and make judgements on the overall quality of governance of a provider as part its routine inspection process	£4,000 p.a.
Other	Issuing guidance	CQC will issue guidance for providers on the new registration requirement	£4,000 one off

90. These are discussed in more detail below:

CQC implementation costs: admin costs

91. Where new providers apply to register with CQC, they will provide CQC with information about their directors and a declaration of their fitness. CQC will not carry out independent checks of director fitness, but will examine their own records to check if they have any existing concerns about directors. It is difficult to estimate the additional cost of this process as CQC will also be making other changes to its registration process to improve the robustness of registration as discussed

above. However, as an illustrative figure, we assume that it would take approximately thirty additional minutes of a CQC staff member's time to carry out these basic checks per application. Based on an hourly cost of a registration assessor of £35 (inclusive of on costs) from CQC's standard costing model, this suggests that over the 3.3 or so applications received by CQC per year, the total cost for CQC would be almost £58.

92. On the appointment of a new director, providers are currently required by the CQC regulations to notify CQC. This will not be affected by the fit and proper requirement. However on receipt of a notification CQC will now check the new director against their records to determine whether there are any existing concerns about the director. As above, we assume that this would take approximately thirty additional minutes of a CQC staff member's time to do. Over the approximately 2,440 directors and based on a labour turnover rate of 11% we estimate that there would be approximately 270 notifications for CQC to process. Based on the hourly cost of a registration assessor of £35 (inclusive of on costs), this give a total cost estimate of just over £4,700 per year to CQC.

CQC implementation costs: interviewing directors

93. On registration and on appointment of a new director, where CQC have concerns about the fitness of a director they may choose to interview the director. Based on information from CQC, we have assumed that an interview to assess the fitness of a director could last up to an hour on average and be attended by a panel of one registration manager and two registration assessors at CQC, and a provider representative and the director in question on the provider side.

94. Based on CQC hourly wage costs (including on costs) of £35 for a registration assessor and £52 for a registration manager, the total cost to CQC per interview would be £122. We previously estimated that there might be fewer than 0.2 interviews required per year for newly registering providers and just over 1 for new director appointments. The total annual cost to CQC of these interviews might therefore be in the region of £180.

95. It is likely that in addition to these interview costs, CQC will incur some additional investigative costs prior to deciding whether or not to interview the director. For example, where the initial search of CQC's records indicates that they hold additional information of concern about a particular director, the registration assessor will undertake further action to investigate these concerns, and if necessary call the director in for an interview. It is not possible to quantify these additional costs. The types of investigative activities and thus staff time requirements are likely to vary significantly depending on the facts of the case. In some cases, the assessor may ask for additional information from the provider, whilst in other cases it may be felt that any issues are best director addressed through an interview. A small proportion of additional cases might result in investigation by CQC but are not taken forward to interview. However, CQC advise that in the majority of these incidents, they would wish to interview the director in order to judge fitness.

CQC implementation costs: inspection costs

96. Under CQC's proposed new regulatory model and the introduction of ratings for providers, CQC will hold comprehensive inspections of all providers in the future for the purposes of providing a rating. The fitness of directors is likely to be scrutinised as a part of this comprehensive inspection, as one of the five domains used to produce ratings will be whether the organisation is well led. CQC may also focus on the fitness of directors as part of any follow-up inspections that they carry out under their new model, for example if there are existing concerns about the leadership of an organisation. The final type of inspection that CQC will carry out will be themed inspections which will concentrate on different themes, and are less likely to be focus on the fitness of directors.

97. As a result of these changes to CQC's inspection model, it is difficult to separate out the changes to CQC's inspection costs due to the new fit and proper person's requirement, and those arising from provider ratings. Additionally, it is difficult to determine what the marginal impact of an additional registration requirement is on the total time required for an inspection. There is unlikely to be a one to one relationship between the number of registration requirements and the amount of time required for an inspection, as this will depend on the complexity of the requirement, and whether CQC choose to focus on the issue during a particular inspection, which will be in part be driven by their findings and vary between providers. Additionally, the assessment of compliance across a number of different requirements may be based on the same sources of evidence and so require minimal additional inspection time.

98. If the additional time required came to an average of half an hour per inspection, then based on the average hourly rate of a compliance inspector of £36 supplied by CQC (inclusive of on costs), this implies an additional cost to CQC of approximately £18 per inspection. Compared to the approximately 30,500 providers registered with CQC, NHS trusts represent approximately 0.8% of all those registered with CQC. We therefore assume that of the 28,000 inspections CQC carried out in 2012, 0.8% or approximately 230 were in relation to NHS trusts. This implies an additional annual cost to CQC of approximately £4,000 for inspection and monitoring of these organisations.

99. Although this estimate is an average across all CQC inspection activity, there is a risk that costs could be substantially higher if CQC receive a large number of concerns around director fitness from other sources (for example, complaints by members of the public). It is not possible to quantify this risk.

CQC implementation costs: other

100. CQC will produce new guidance to inform providers of their requirements under the FPPT. CQC estimate that the cost of producing additional guidance is approximately £4,000 based on an assumption that on average guidance requires 3 days to prepare, 2 days to review, 2 days for quality assurance, 2 days for sign-off and 5 days to publish, with a daily staff rate of £277, which includes on-costs and absorbed overheads. This estimate is an average across all types of guidance CQC produce, and does not take into account the differing time requirements that there might be for producing guidance of different lengths or complexity. In addition, as CQC will also be seeking to revise their guidance in response to the other changes to the CQC regulations, and changes to CQC's regulatory model, it is difficult to disentangle the costs of producing guidance for each of the separate parts of the changes. We have estimated an average cost of £4,000 for producing guidance on each of the separate changes to the regulations, but this is likely to overstate the total cost due to the inter-linkages between the policies.

101. There may also be other transitional costs associated with implementing the policy. For example, CQC advise that they may need to make some adjustments in their IT system in order to record information about directors. It has not been possible to quantify these costs.

Costs associated with removing an unfit director

102. The costs associated with removing an unfit director are as follows:

Cost	Description	Who	Total Cost
Removing director	The cost associated with the administrative process of removing an individual from employment	Providers	Unquantified
	The recruitment costs associated with replacing the director	Providers	£4,500 p.a.
	Personal costs to the directors affected	Directors	Unquantified
	Employment tribunal risks	Providers	£395 p.a.
		Directors	£250 p.a.
		HMCTS	£300 p.a.
Enforcement costs	The cost associated with any CQC action to remove an unfit director	CQC	£210 p.a.
Appeal costs	The costs associated with directors or providers exercising their right to appeal against CQC decision to require removal of a director	CQC	£1,250 p.a.
		Appellant (provider or director)	£1,250 p.a.
		HMCTS	£1,750 p.a.

Costs of removing a director – director removals

103. The proposed policy requires providers to ensure that their directors are fit and proper. Thus, where a provider has an unfit director, they would be expected to remove this director from their role. This has associated costs for the provider, the individual director concerned and potentially other bodies.

Potential number of unfit directors

104. In terms of the numbers of directors that might potentially be removed, figures from the Companies House register of directors disqualified under The Company Directors Disqualification Act 1986 suggest that approximately 1,000 to 1,500 directors are disqualified per year. Comparing this figure to the estimate of the total number of directors in the UK by the Institute of Directors of approximately 2,235,000, this suggests that, as a general rule, approximately 0.07% of directors might be considered to be unfit. However, as we have discussed previously, when considering the

fitness of directors for health (and adult social care) organisations, it is likely that there will be additional relevant criteria beyond those considered by the Company Directors Disqualification Act that should be taken into account. We adjust for this by doubling our estimate of the potential proportion of unfit directors to 0.15%.

105. Based on our estimate of there being approximately 2,440 directors within the scope of the fit and proper person's requirement, and assuming that 20% are not currently being adequately checked for fitness, then applying our estimate of a rate of unfitness of directors of 0.15% suggests that we may expect just fewer than 1 director per year to be removed from CQC registered providers. We make no assumptions about the distribution of these potentially unfit directors over the number of newly registering and existing providers, or whether the directors are newly appointed or existing directors. Instead we make the assumption that based on the discussion of the likely costs of removing a director above, these costs are unlikely to change based on when in the process a director is removed[24].

106. However, the above analysis does not take into account the risk that other directors who are fit and proper for their role may potentially be judged to be unfit by providers (or even CQC) and removed from their role. If this were to occur then there could be more directors removed from their role per year. It is currently difficult to determine how likely this risk is to occur, as it will depend in part how the regulations are interpreted by providers and the quality of the guidance available on what constitutes a fit and proper director, how risk averse providers are to potentially being in breach of the regulations, and how stringently CQC choose to apply the regulations. Although we previously quantified the number of additional directors that could be removed in the consultation stage Impact Assessment, it has not been possible to verify this figure. The consultation responses suggested that it would not be possible to know this without further information about exactly how CQC intend to enforce the requirement. Ultimately, the policy intention is that the fit and proper requirement incentivises providers to undertake better scrutiny of their directors and ultimately make better recruitment decisions about their board. Intuition would suggest that providers would tend to be reluctant to remove their directors without good reason to do so, and so the risk of high quality directors being removed due to the fit and proper requirements is likely to be low. We therefore do not attempt to further quantify the potential number of additional director removals that might occur.

Removing the director

107. There is little evidence available on the administrative and time costs associated with removing an unfit director as this is highly dependent on the process by which providers use to remove a director[25]. As such, these costs remain unquantified.

108. In addition the removal (or prevention of appointment) of an unfit director also has the effect of constraining the choice providers have over their directors. In some cases, providers might feel that their first choice of (unfit) director remains the best choice for the organisation, and being prevented from having this director would have adverse effects on the provider's performance. However, in the majority of cases, it is difficult to see how a director judged to be unfit might positively impact the performance of an organisation. Evidence from the NAO report on the Companies Director's Disqualification Scheme found that 15% of directors who were involved in a company failure were likely to be involved in one or more subsequent failures. Where a company failure was sufficiently serious to have involved the barring of a director under this scheme, the average debt left behind by these organisations was £150,000. As a result, it is likely that the decision by a provider to appoint an unfit director is usually due to lack of information or improper checking of the director or failure to understand the potential consequences of appointing an unfit director. In the case of Winterbourne View, although financially the Hospital was the best performing of all those in Castlebeck Care Ltd's portfolio, this was at the expense of good quality care being provided. In the long run, such a position is unlikely to be sustainable, especially given

[24] We only count directors of registered CQC providers. Where a provider unsuccessfully applies to register with CQC and subsequently takes action to ensure that it meets the registration requirements, we assume that the costs of any action taken in relation to the fit and proper requirement would be captured within subsequent years of the analysis, when the provider is successful in its application and thus becomes a newly registered provider

[25] Where there is gross misconduct of a director, it may be justifiable to dismiss the director on the spot, however it is more likely that if a director is suspected of being unfit, there would have to be a more lengthy period of investigation in order for the provider to determine this. The director may be suspended pending the outcome of this investigation. Additionally other contractual and statutory procedures would need to be taken into account.

all of the changes being made to CQC regulations and other measures in order to address poor quality care. Following the discovery and publication of the problems at Winterbourne View, Castlebeck Care subsequently went into administration. Therefore on balance, we consider that it is far more likely that the removal of an unfit director would positively impact the provider's performance, rather than harm it. This is discussed more in the benefits section below.

Replacing a director

109. The 2013 survey of recruitment and retention carried out by the Chartered Institute of Personnel and Development suggested that the median cost of recruitment (advertising, agency or search fees) for senior managers or directors was £6,000.

110. Based on the above estimate of there being potentially just under 1 director removed a year on average, this suggests a total cost of £4,500 p.a.

Employment tribunal implications

111. Additionally, where a provider removes a director from their post, this could potentially lead to the director initiating an unfair dismissal claim. Previous estimates from the Department of Business Innovation and Skills suggest that an employment tribunal case would post the following costs on the provider, claimant, and the exchequer:

Table 1.3: Summary of costs incurred throughout employment tribunal process, by outcome

	Employment Tribunal Hearing	Individual Conciliation	Average across ET claim outcome
Employer	£4,200	£3,300	£3,700
Claimant	£1,500	£1,100	£1,300
Exchequer	£4,450	£640	

Source: BIS estimates from Acas, HMCTS, SETA and ASHE data in 2011 prices. Figures are rounded.

112. The costs to the provider include the time costs of managers and directors spent on the case, as well as legal costs, whilst the cost to the claimant includes loss of earnings, legal costs and communication and travel costs. The cost to the exchequer consists of the costs to HMCTS in the court time required for an employment tribunal hearing[26].

113. Since July 2013 a new charging system introduced in 2013 requires that for unfair dismissal and discrimination claims be subject to a £250 issue fee with a further £950 hearing fee. This has the effect of shifting some of the cost of an employment tribunal from the exchequer to the director bringing about the appeal, and the costs are adjusted accordingly.

114. Overall, we therefore estimate the costs of an employment tribunal in 2012 prices to be £4,260 for providers, £2,720 for directors and £3,315 for HMCTS.

115. If a tribunal finds in favour of the director, the provider would have to pay the director a compensatory award for unfair dismissal. As this is a transfer payment for from the provider to the director, there is no overall economic impact.

116. In terms of the potential number of employment tribunals, analysis by BIS suggests that there are approximately 400,000 dismissals a year, relative to a steady state of roughly 50,000 unfair dismissal cases per year on average[27]. Based on this overall rate of unfair dismissal claims is approximately 12.5%, this would imply that approximately 0.1 directors might make an unfair dismissal case per year (i.e. 1 cases every 10 years). Based on the costs discussed above, this gives total associated costs of approximately £395 for providers (after uprating the figures in the table to 2012 prices using the GDP deflator), £250 for directors and £300 for HMCTS.

[26] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32182/11-1381-resolving-workplace-disputes-final-impact-assessment.pdf

[27] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32137/12-626-dismissal-for-micro-businesses-call.pdf

Costs to directors of removal

117. Those directors who are removed from their post will suffer a personal cost as they will no longer be able to act as a director for the provider organisation and will have to seek alternative employment. One way to value the cost of this might be in terms of the earnings forgone by the individual due to the enforcement action. However, it is difficult to quantify this as it will depend on what alternative employment the director might be able to find and how long this would take. It may be the case that the director is unable to find a role as a director again, or it may be that the director may be judged still to be suitable for other director roles, depending on the circumstances of the breach.

118. Although it is not possible to quantify these costs as it is not possible to predict the likely impacts of the proposed policy on director's subsequent earnings, and other policy proposals may also impact on these costs in the future, it is possible to gain a sense of the size of these impacts based on information on the average earnings of directors from the 2013 Annual Survey of Hours and Earnings (ASHE). This survey found that the median gross annual pay for the Standard Occupation Class (SOC2010) Corporate Managers and Directors was £40,200, whilst for Chief Executives and Senior Officials it was £78,000 and for Health and Social Services Managers and Directors it was £40,600, compared to the median gross pay across all employees of £21,900.

Costs of removing a director: Costs of Enforcement by CQC

119. We previously speculated that 0.15% of directors might be unfit to lead a health (and adult social care) organisation, as these directors are picked up at registration, inspection, and notification giving a total estimate of just under 1 unfit director a year. As discussed above, if the introduction with the fit and proper requirement for directors led to 100% compliance, we would expect that providers would take the necessary steps to replace these unfit directors and carry out the necessary checks to ensure that their directors remained fit going forward.

120. However, in reality we would not expect there to be 100% compliance with the requirement and CQC may be required to take enforcement action against a provider where it becomes apparent that a director is unfit for their role and the provider has failed to meet its duty to ensure that their directors are fit and proper. CQC will be able to take enforcement action against the provider to remove the director by placing conditions on the provider's registration. Other further enforcement action may also be taken for more serious breaches, or if the provider fails to comply with the requirement to remove the director from their duties.

121. Based on information on the number of inspections and enforcement action taken by CQC in 2012, approximately 4% of inspections led to further enforcement action being needed, or in other words, a 96% compliance rate. If this compliance rate can be applied to the figures above, this would imply that CQC would need to take almost no enforcement action against an unfit director. However, it is not clear if this 96% figure is applicable in this case. The 96% figure is an average across all different types of providers inspected by CQC, and is likely to include some providers who would meet the registration requirements even in the absence of regulation. On the other hand, the providers we would be applying this figure to have specially been identified as those who are least likely to already be in compliance with the requirements and so we would expect that the rate of compliance is likely to be lower. Further, it is possible to argue that non-compliance will be further focused on those providers whose directors are actually unfit, as these providers might be those who have taken the least effort to ensure that their directors are fit, or have purposely made the decision to appoint someone unfit, and thus are least likely to change their behaviour.

122. It was not possible to find further evidence to suggest what the most appropriate rate of compliance might be. Thus we consider the worst case scenario, where CQC would need to take enforcement action against all unfit directors, compared to the best case, where almost no enforcement action is required. In the absence of evidence to the contrary, we take the mid-point of these estimates of 0.4 cases a year on average (i.e. 1 case ever 2 and a half years) as our best estimate for the potential number of enforcement cases for CQC.

123. It is difficult to cost CQC enforcement activity as enforcement activity cuts across many CQC functions and requires input from various different departments and staff. As a result, the costs of enforcement activity by CQC are difficult to disentangle. CQC advise that the budget for legal fees is £800,000 per annum and that approximately 75% of this might be related to enforcement activity (CQC will also use legal services for other activities such as debt collection). Based on this fairly

basic measure of total enforcement costs, and using the fact that there were approximately 1100 cases involving some enforcement activity by CQC in 2012, we estimate that the average cost of an additional case of enforcement activity could be in the region of £550. Thus the total additional cost of additional enforcement action could be as high as £405, with a best estimate of approximately £210.

Costs of removing a director: Costs of appeals

124. There would be a right of appeal by the provider against any condition imposed on its registration to the Health, Education and Social Care Chamber of the First-Tier Tribunal, as applies to other decisions taken by CQC to impose conditions on registration. Directors will also have a right to appeal against any conditions imposed on the provider that directly name them. This will have a cost implication for CQC, the appellants, and the justice system.

125. In terms of the costs to the justice system of a tribunal, the HMCTS advise that the average cost per case is in the region of £6,000 with start-up costs of almost £1,700

126. As discussed above, it is difficult to estimate accurate unit costs for different types of enforcement action due to the integrated approach that CQC take towards enforcement activity. Based on details from a recent case that ended in a tribunal, CQC estimate that the costs of responding to an appeal could be as high as £45,000, although it is not clear how representative this particular case might be of a 'typical' case. This particular case was heard twice in court and CQC had to instruct a barrister rather than a solicitor so the day rates are likely to have been higher. Consequently, these costs should be treated as an estimate of the worst case scenario tribunal costs rather than a representation of the average costs. CQC are carrying out further work to better understand their costs; however the timing of this work has meant that it has not been possible to estimate a more accurate estimate of the costs to CQC to inform this Impact Assessment.

127. In terms of evidence on the average legal costs that a director or provider might face, evidence is also limited. The small numbers of providers who have chosen to appeal mean that this group have not been subject to much study or research previously. As a proxy, we therefore assume that the costs to appellants are likely to be similar to those incurred for employment tribunal cases as discussed above. Although the direct read across to the care standards tribunal would be for provider (and/or director) appeal costs to map to the claimant costs above, we will instead take the higher employer costs associated with employment tribunal hearings as an estimate of the provider costs of CQC appeals. This is because the use of legal advice may differ significantly between organisations and individuals, and the loss of earnings category of costs for claimants is unlikely to be applicable if it is a provider appealing CQC's decision to require removal of a director. Uprated to 2012/13 prices, we therefore estimate that the cost of appeal to be £4,260 for providers (and/or directors). In the absence of better information on CQC appeal costs, we also make the assumption that they are in line with the employment tribunal costs of £4,260 per case.

128. It is difficult to determine how many appeals we might expect to have. The analysis above indicates that there could potentially be less than 1 organisation facing additional enforcement action, with a best estimate of 0.4. Based on a comparison of the total number of cases in 2012 where CQC took enforcement action beyond issuing a warning notice (110) against the total number of receipts and disposals in the Health, Education and Social Care Chamber of the First-Tier Tribunal (but we note that this will also cover cases other than appeals against CQC enforcement) this suggests a potential appeal rate of up to 75%. This figure is an overestimate of the potential appeal rate as the data on the number of receipts and disposals to the Tribunal will include non-CQC related appeals as well. CQC advise that since April 2009, only 116 appeals to the Tribunal have be brought against the organisation. This suggests a much lower appeal rate of 20%[28]. As it is likely that providers are likely to be reluctant to remove their directors, and directors themselves would certainly wish to challenge their removal, the rate of appeals against the new proposal may in fact be higher than the estimated 20%. For the sake of prudency, we continue to use the 75% appeal rate figure estimated in the consultation stage Impact Assessment as an upper bound on the potential number of appeals. This suggests an average of 0.3 appeals per year (or just under one every three years).

[28] 116 cases in 5 years suggests an average of 23.2 cases per year, compared to approximately 110 enforcement cases per year

129. The total additional annual cost for HMCTS might therefore be in the region of £1,750. For CQC and appellants the total additional annual costs could be as high as £1,250.

130. This analysis is likely to be further complicated when we consider the potentially different combinations of appeals that might arise. The above analysis makes the assumption that each appeal case would consist of a provider and a director jointly appealing against CQC's decision to place a condition on the provider's registration to remove the director. Even if the director and the provider were to put in separate appeals, as the facts of the case are the same it is likely that CQC and the courts would treat the case as a single case so that the above costs are still applicable. In terms of the legal costs incurred by the provider and the director, we also assume that these costs would be jointly shared between the provider and the director. However, other potential situations might also be possible. For example, if multiple directors at a provider organisation were considered to be unfit, this could result in fewer, more complex cases for CQC and the courts.

Risks and other potential impacts

131. The fit and proper requirement on directors may also have other secondary impacts on the labour market for directors of health (and adult social care) organisations, which will impact on providers. For example, it could be the case that making requirements on the provider to ensure that their directors are fit and proper for the role effectively shrinks the pool of potential directors that are available. This may drive up the costs of recruitment for providers due to the increased search costs required to locate a suitable director. Additionally, as the supply of suitable directors is reduced, this could increase the price of a director via the increased wages that would need to be paid to attract a director of the required standard. It has not been possible to find any evidence on what the likely size of these effects might be and the size of any impact is likely to depend on the size of the existing labour market for directors and the proportion of potentially unfit directors within this.

132. However, it is not clear whether these changes in the labour market would be likely to occur. As we expect that the majority of providers to already be carrying out the necessary checks to ensure that their directors are fit and proper, we would expect demand for high quality directors to already be high, so any additional change in demand due to the proposed policy is likely to be limited. The pool of potential health (and adult social care) directors is likely to be very large due to the ability of directors from other related sectors to move into the role.

133. When we consulted on the fit and proper requirement for directors, some providers expressed some concern that for charitable organisations, a significant proportion of the board would be made up of volunteers, who might be put off volunteering in future by the fit and proper requirement. If providers are no longer able to find volunteers to act as trustees for their boards, they would need to appoint additional employed directors, at considerable additional cost. It has not been possible to quantify this at this stage. However, in developing the fit and proper person requirement for directors we have ensured that as far as possible this is consistent with Charity Law. All charitable trustees already have to meet similar fit and proper requirements set by the Charity Commission[29]. We therefore anticipate that the proposed fit and proper requirement is likely to have minimal additional impact in this area.

134. As is the case with all new regulations, there is a risk that already compliant providers will take additional action and go above and beyond to ensure that they meet the regulations. This risk will be mitigated through clear communication and guidance from CQC to ensure that the new requirement is well understood and providers have a good understanding of how CQC will judge compliance against the new requirements.

Costs - summary:

135. The costs above are summarised in the table below:

[29] The Charities Act 2011 sets out the conditions which disqualify people from acting as a trustee. This includes where a person: has an unspent conviction for an offence involving dishonesty or deception; are currently declared bankrupt, subject to bankruptcy restrictions or and interim order; has an individual voluntary arrangement to pay off debts with creditors; is disqualified from being a company director or has previously been removed as a trustee by either the Charity Commission or the High Court due to misconduct or mismanagement

Summary of costs

			Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	
Costs	**At**	**Description**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
Provider Implementation costs	Registration of new provider	Checking directors	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	21,000
		Administration	40	40	40	40	40	40	40	40	40	40	397
		Interviews with CQC	7	7	7	7	7	7	7	7	7	7	71
		Total	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**21,500**
	Appointing new directors	Checking directors	18,800	18,800	18,800	18,800	18,800	18,800	18,800	18,800	18,800	18,800	188,000
		Interviews with CQC	64	64	64	64	64	64	64	64	64	64	639
		Total	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**189,000**
	Ongoing checks for directors	Appraisal of existing directors	46,500	46,500	46,500	46,500	46,500	46,500	46,500	46,500	46,500	46,500	465,000
		Total	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**465,000**
	Other Costs	Familiarisation costs	5,880										5,880
		One off compliance actions	27,300										27,300
		Total	**33,200**										**33,200**
Total			**101,000**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**708,000**
CQC Implementation costs	Registration	Admin costs	58	58	58	58	58	58	58	58	58	58	583
		Interviews	18	18	18	18	18	18	18	18	18	18	183
		Total	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**766**
	Appointment of new director	Admin costs	4,700	4,700	4,700	4,700	4,700	4,700	4,700	4,700	4,700	4,700	47,000
		Interview	164	164	164	164	164	164	164	164	164	164	1,640
		Total	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**48,600**
	Existing providers	Inspection	4,080	4,080	4,080	4,080	4,080	4,080	4,080	4,080	4,080	4,080	40,800
		Total	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**40,800**
	Other	Issuing guidance	4,000										4,000
		Total	**4,000**										**4,000**
Total			**13,000**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**94,100**
Costs of Removing director	Removing director	Providers - admin costs of removal	Unquantified										
		Providers - cost of replacement	4,450	4,450	4,450	4,450	4,450	4,450	4,450	4,450	4,450	4,450	44,500
		Directors - personal cost of removal	Unquantified										
		Providers - employment tribunal	395	395	395	395	395	395	395	395	395	395	3,950
		Directors - employment tribunal	252	252	252	252	252	252	252	252	252	252	2,520
		HMCTS - employment tribunal	307	307	307	307	307	307	307	307	307	307	3,070
		Total	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**54,000**
	Enforcement costs	CQC	210	210	210	210	210	210	210	210	210	210	2,100
		Total	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**2,100**
	Appeal costs	CQC	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	12,300
		Appellant (provider or director)	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	12,300
		HMCTS	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	17,600
		Total	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**42,200**
Total			**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**98,300**
Total cost (undiscounted)			**123,000**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**900,000**
Discount adjustment			1	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	
Total Present Cost (discounted)			**123,000**	**83,400**	**80,600**	**77,900**	**75,200**	**72,700**	**70,200**	**67,900**	**65,600**	**63,300**	**780,000**

(£)

NB: figures may not sum due to rounding

Benefits:

136. The policy objective is to strengthen corporate accountability by ensuring that the board of directors are able to provide high quality leadership, and strengthening the systems of accountability for boards in cases where there have been significant failings in care. This will be achieved by closing the current gap in the regulations. Providers will be required to take proper steps to ensure that their all board members are fit and proper for their role.

137. The intended effect of this is to reduce the risks of poor quality care for service users associated with poor management or governance and to make directors more accountable for their actions. The proposed policy is therefore expected to have benefits as follows: better outcomes for service users associated with the reduction in the risk of poor quality care, societal benefits associated with increased accountability for directors and improvements in performance for providers associated with improved governance. In addition, improvements in the quality of care may also benefit providers via reputational benefits or otherwise.

138. Although it has not been possible to quantify any specific benefits, we provide some illustrative examples and break even analysis in order to contextualise the potential size of the benefits we discuss.

Health benefits through improved quality of care

139. It is expected that the proposed policy will reduce the risk of poor governance resulting in poor quality care. Both on registration and appointment of a new director, providers will be expected to undertake the proper checks on the board to ensure that they are fit and proper for their role. CQC may also undertake additional scrutiny of directors at these stages. Providers will also be expected to monitor the ongoing performance of their directors to ensure that they remain fit and proper, and CQC may offer further scrutiny of this through their inspection process. Overall this is expected to improve the quality of directors of health care providers.

140. In terms of the evidence on how better governance might affect the quality of care of a health (and adult social care) providers, there is a growing body of research that suggests that good leadership is linked to better outcomes in healthcare. A 2002 study by Vance and Larson[1] reviewed the existing literature in this area and found that the introduction of physician leadership led to a dramatic increase in hospital discharge rates, whilst Wong and Cummings (2007)[2] similarly found evidence of a link between positive leadership behaviours and improved patient satisfaction and a reduction in adverse events. The NHS Leadership Academy[3] in their review of the evidence between leadership and health outcomes quote Prosser (2009), who says that "the evidence, while not voluminous, is sufficient to assert that effective leadership (and leadership development) does make a positive difference to the patient experience."

141. In addition, there is also a strong link between poor leadership and poor quality care. As far back as the 1995 Bristol Inquiry, a strong connection was made between leadership and performance. As discussed in Section A of this Impact Assessment, it is very evident from the recent high profile care failings at Winterbourne View Hospital and Mid Staffordshire NHS Foundation Trust that poor governance from the board absolutely contributes to, or exacerbates, incidences of poor quality care. As an illustrative example, a lower bound estimate of the potential number of unexpected deaths at Mid Staffordshire based on the Healthcare Commission Report in 2009 was 400. If these unexpected deaths resulted in an average of 6 months of loss of life per person[4], the potential social cost that could have been avoided associated with these unexpected deaths would have been in the region of £12m, based on an a societal willingness to pay of £60,000 per Quality Adjusted Life Year (QALY)[5]. However it is not possible to estimate what impact better governance might have had on this scenario, nor how likely such a scenario might be to occur again.

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[1] Vance, C. and Larson, E. (2002), Leadership Research in Business and Health Care. Journal of Nursing Scholarship, 34: 165–171

[2] WONG, C. A. and CUMMINGS, G. G. (2007), The relationship between nursing leadership and patient outcomes: a systematic review. Journal of Nursing Management, 15: 508–521

[3] See http://www.leadershipacademy.nhs.uk/about/

[4] Hogan H, Healey F, Neale G et al,(2012) "Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study", BMJ Qual Saf, estimates that for the majority of preventable deaths, death is only averted for an average of 6 months.

[5] The QALY approach weights life years (saved or lost) by the quality of life experienced in those years. Years of good health are more desirable than years of poor health. A value of 1 is equivalent to one additional year of perfect health. Please see Appendix 4 of the

142. We also calculate the societal value associated with more modest health gains using the EQ-5D framework[6]. This framework asks individuals to rate their health from 1 to 5 in five different domains, including the experience of pain, mobility and anxiety. These ratings can then be converted into QALY values using standard mapping tools based on surveys of the general population on their preference over different health states. Based on this methodology, any reduction in quality of life away from perfect health for one year equates to a QALY loss of at least 0.094 points. Thus if one service user is able to avoid one month's worth of less than perfect health due to poor quality care, there would be at least a 0.008 QALY gain. Based on a societal willingness to pay of £60,000 per QALY, this would equate to a societal benefit of at least £470.

143. Tackling the problem the other way, compared to the average annual undiscounted cost of £86,000, a societal willingness to pay per QALY of £60,000 would suggest that an annual QALY gain of 1.5 would be sufficient for the annual societal benefits of the policy to exceed the estimated annual costs above. Across the 250 NHS trusts, this is equivalent to an average QALY gain of 0.0057, or a gain of between 15 days and one month of improved health (as described in the preceding paragraph) for at least 1 patient per provider.

Improved accountability

144. Providers will also be expected to continue to monitor and appraise the performance of their directors to ensure that they continue to remain fit and able to carry out their role. Where it becomes apparent that a director is no longer fit for their role, providers will be expected to take appropriate action, including removing the director from their role. This is expected to strengthen the accountability of directors by increasing the incentives on providers to scrutinise the performance and actions of their directors, and to ensure that there are appropriate consequences for the director where this is not satisfactory. The fitness of directors will also face additional scrutiny from CQC as part of their assessment of the provider's compliance with the registration requirement. The increased accountability of directors is a benefit to society. Where directors make mistakes and are found to be unfit for their role, they should and must be properly held account for their actions. It is not possible to quantify this benefit.

145. For those affected by poor care, the on-going effects of the damage caused and sense of injustice can be substantial and will often lead individuals to expend considerable time and effort in seeking justice. For example, in the case of Mid-Staffordshire NHS Foundation Trust, campaigning by families for justice has been on-going since 2007. In the case of the Hillsborough disaster, campaigning has lasted over 20 years since the incident. While it is not possible to quantify the exact value affected individuals place on achieving justice, these examples give an indication of the magnitude of feeling that might be involved in where a case of ill-treatment or wilful neglect has caused serious harm or death.

146. For the general public and those not directly affected by the failings, there may still be a feeling of injustice associated with the perception that those guilty of inflicting harm on patients or service users are not appropriately punished. While it would be difficult to derive a total value for this benefit and it would be likely to represent a relatively modest amount per individual, the cumulative effect across society as a whole could potentially be very large. As there are approximately 44m adults in England and Wales, this suggests that for the societal benefits of improved accountability to outweigh potential costs of the proposal, the average willingness to pay for increased accountability would only need to be less than £0.01p to generate a total annual gain to society that would outweigh the estimated average annual cost of the proposal.

Improvements in governance and provider performance:

147. The proposed fit and proper person's requirement will compel providers to carry out proper checks on their directors. It is expected that this will encourage providers to better recruitment choices for their board members and to increase the scrutiny of their board's performance. These actions are expected to improve the overall leadership quality of health care organisations and thus the financial performance of these organisations. This effect may be most prevalent where providers

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supplementary Green Book guidance for more information.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191503/policy_appraisal_and_health.pdf

[6] As developed by the EuroQol Group. Please see Appendix 4 of the supplementary Green Book guidance for more information.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191503/policy_appraisal_and_health.pdf

previously did not carry out adequate checks on their directors, but there may also be impacts for already compliant providers for example, if the increased accountability of directors (via CQC) incentivise all directors to improve their performance to avoid being judged as unfit.

148. It is hard to quantify a direct link between improvements in governance and an organisations performance however there is evidence that better governance and leadership does lead to improves performance of organisations. Although the literature on the effects of good governance on performance is not clear, the fact that investors are willing to pay a premium for believed good governance support our assumption that reducing unfit directors will be of beneficial value to providers[7]. A survey by McKinsey found that two thirds of investors would pay more for a company that was well governed, with one respondent stating "Companies with good board governance practices have a shareholder-value focus.", following on from this view we can assert that by ensuring good governance in the health and care sector, providers should have a patient and care user focus. One of the reasons in the McKinsey survey that investors gave for valuing good governance was a reduction in risk through reducing the likelihood of bad things happening to the company, the benefits of this reduced risk in the health (and adult social care) sector could lead to better outcomes for patients and care users[8]. There is a greater premium on good governance from investors in emerging markets[9], an area where markets are less researched and investors have less information thus the goodness of governance is more important to investors, we can find a parallel to this in the health (and adult social care) market which is also characterised by problems in information, as such using the same logic then we can argue that governance in health (and adult social care) is more important than relative to other sectors. Another US study of corporate culture and firm performance found that when employees perceive top managers as trustworthy and ethical, firm's performance is stronger[10].

149. Further the NHS Leadership Academy[11] cite the following studies:

- A study in the Harvard Business Review (Bassi and McMurrer 2007) provides a strong link between leadership skills and the bottom line
- The Institute for Strategic Change reports that the stock price of companies perceived to be well-led grew 900 per cent over 10 years versus 74 per cent for companies perceived to lack good leadership (2008)
- The Corporate Leadership Council estimates that employees working for good leaders put in 57 per cent more effort and are 87 per cent less likely to leave than those with poor leaders
- The Hay Group study of 2012 demonstrated that the top 20 companies for leadership had a 36 times better shareholder return over a 5 year period than the companies with the poorest leadership.
- Murray Dalziel, Director of Liverpool Business School summarises: "There is incontrovertible evidence from the academic literature that leadership makes a difference. Across a wide range of industries about 15 per cent of the variance in performance can be directly attributed to CEO performance. This figure has been constant for over 25 years."

150. Finally, it is possible that poor leadership will negatively influence the performance of an organisation. As discussed above, evidence from the NAO report on the Companies Director's Disqualification Scheme found that 15% of directors who were involved in a company failure were likely to be involved in one or more subsequent failures. Where a company failure was sufficiently serious to have involved the barring of a director under this scheme, the average debt left behind by these organisations was £150,000. In the case where care quality suffers, organisations might be at risk of remedial or legal action[12] which would adversely impact on the organisation, and there

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[7] Nicholson, Gavin J. and Kiel, Geoffrey C. (2007) Can directors impact performance? http://eprints.qut.edu.au/13261/

[8] Excerpts from THE McKINSEY QUARTERLY - 1996 Number 4 - Page 170 - http://www.lens-library.com/mckinsey.html

[9] Paul Coombes and Mark Watson, "Three surveys on corporate governance," The McKinsey Quarterly, 2000 Number 4 special edition: Asia revalued, pp. 74–7

[10] Luigi Guiso et al ,The Value of Corporate Culture, September 2013 http://faculty.chicagobooth.edu/luigi.zingales/papers/research/The_Value_of_Corporate_Culture.pdf

[11] See http://www.leadershipacademy.nhs.uk/about/

[12] Such as from CQC, local authorities, commissioners or Monitor or the NHS Trust Development Authority, depending on the type of provider

may also be reputational risks. The large scale changes that are currently being made to the regulatory architecture of the health and adult social care sector as a result of the Francis Inquiry is likely to ensure that poor quality care is more easily detected in the future, and consequently, providers of poor quality care are more likely to face consequences for their action. As discussed above, although it is unlikely that a poor director will ever be solely responsible for care failings, they play a potentially important role in influencing care quality through the decisions that they make.

151. It is not possible to quantify these benefits. However, as an illustration, annual expenditure for NHS Trusts was estimated to be £65.5bn in 2011/12 by the Nuffield Trust[13]. This suggests that if the proposed policy led to an improvement in leadership amongst providers led to even a small improvement in financial management or performance in the NHS, the benefits could be substantial.

Value for money:

152. The tables below show the profile of expected costs and benefits over the next ten years:

[13] See: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending.pdf

Overall Net Present Value:

			Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	
Costs	**At**	**Description**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
Provider Implementation costs	Registration of new provider	Checking directors	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	21,000
		Administration	40	40	40	40	40	40	40	40	40	40	397
		Interviews with CQC	7	7	7	7	7	7	7	7	7	7	71
		Total	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**2,150**	**21,500**
	Appointing new directors	Checking directors	18,800	18,800	18,800	18,800	18,800	18,800	18,800	18,800	18,800	18,800	188,000
		Interviews with CQC	64	64	64	64	64	64	64	64	64	64	639
		Total	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**18,900**	**189,000**
	Ongoing checks for directors	Appraisal of existing directors	46,500	46,500	46,500	46,500	46,500	46,500	46,500	46,500	46,500	46,500	465,000
		Total	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**46,500**	**465,000**
	Other Costs	Familiarisation costs	5,880										5,880
		One off compliance actions	27,300										27,300
		Total	**33,200**										**33,200**
Total			**101,000**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**67,500**	**708,000**
CQC Implementation costs	Registration	Admin costs	58	58	58	58	58	58	58	58	58	58	583
		Interviews	18	18	18	18	18	18	18	18	18	18	183
		Total	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**77**	**766**
	Appointment of new director	Admin costs	4,700	4,700	4,700	4,700	4,700	4,700	4,700	4,700	4,700	4,700	47,000
		Interview	164	164	164	164	164	164	164	164	164	164	1,640
		Total	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**4,860**	**48,600**
	Existing providers	Inspection	4,080	4,080	4,080	4,080	4,080	4,080	4,080	4,080	4,080	4,080	40,800
		Total	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**4,080**	**40,800**
	Other	Issuing guidance	4,000										4,000
		Total	**4,000**										**4,000**
Total			**13,000**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**9,010**	**94,100**
Costs of Removing director	Removing director	Providers - admin costs of removal	Unquantified										
		Providers - cost of replacement	4,450	4,450	4,450	4,450	4,450	4,450	4,450	4,450	4,450	4,450	44,500
		Directors - personal cost of removal	Unquantified										
		Providers - employment tribunal	395	395	395	395	395	395	395	395	395	395	3,950
		Directors - employment tribunal	252	252	252	252	252	252	252	252	252	252	2,520
		HMCTS - employment tribunal	307	307	307	307	307	307	307	307	307	307	3,070
		Total	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**5,400**	**54,000**
	Enforcement costs	CQC	210	210	210	210	210	210	210	210	210	210	2,100
		Total	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**210**	**2,100**
	Appeal costs	CQC	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	12,300
		Appellant (provider or director)	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	1,230	12,300
		HMCTS	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	17,600
		Total	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**4,220**	**42,200**
Total			**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**9,830**	**98,300**
Total cost (undiscounted)			**123,000**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**86,300**	**900,000**
Discount adjustment			1	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	
Total Present Cost (discounted)			**123,000**	**83,400**	**80,600**	**77,900**	**75,200**	**72,700**	**70,200**	**67,900**	**65,600**	**63,300**	**780,000**
Benefits													
Health benefits for patients			**Unquantified**										
Improved accountability			**Unquantified**										
Improved performance for providers			**Unquantified**										
Other benefits for providers			**Unquantified**										
NPV			**- 123,000**	**- 83,400**	**- 80,600**	**- 77,900**	**- 75,200**	**- 72,700**	**- 70,200**	**- 67,900**	**- 65,600**	**- 63,300**	**- 780,000**

NB: figures may not sum due to rounding

153. The costs are based on information from a number of different sources and assumptions about what the likely impacts of the policy might be. The true implementation costs of the policy are not known as this depends on the number of providers who might not already be carrying out the appropriate checks. Although we have estimated that this figure could be as high as 2,500 providers, this is based on an assumption that there could be up to 20% of providers who do not carry out the appropriate checks on their directors. It is not possible to confirm whether this assumption is likely to be accurate or not, although the evidence from other sectors suggests that this may be a good approximation. As such the quantified costs are estimates only. Given this they are sensitivity tested below under different scenarios:

- If only 10% of providers do not already carry out the necessary checks, the overall net present cost would fall to £433,000.
- If 30% of providers do not already carry out the necessary checks, the overall net present cost would increase to £1.13m.
- If the costs of undertaking pre-employment style checks on a director were 20% higher at an average of £420 the overall net present cost would increase to £816,000.
- If the costs of undertaking pre-employment style checks on a director were 20% lower, at an average of £280, the overall net present cost would be £744,000.
- If the costs of appraising a director were 20% higher, at an average of £114, the overall net present cost would be £859,000.
- If the costs of appraising a director were 20% lower, at an average of £76, the overall net present cost would be £699,000.

154. Overall the higher the number of providers who do not carry out the appropriate checks, the greater the burden of the proposed policy will be, but the higher the potential for the policy to induce behaviour change and so the higher the benefits of the policy.

155. It has not been possible to quantify the benefits of the policy. However, we have carried out some break even analysis which suggests that under, relatively modest assumptions, the benefits of the policy would outweigh the costs to society. For example, if 185 patients were able to enjoy an additional month with no anxiety or pain (EQ-5D score of 1), the total annual benefit to society would be approximately £87,000 compared to an average (undiscounted) annual cost to society of £86,000.

156. During the consultation, the majority of stakeholders also agreed with this assessment of the balance of costs and benefits of the policy. In our call for evidence 88% of respondents agreed that the potential benefits of the proposal would outweigh the costs.

Section E: Summary of specific impact tests

Equality Impact Assessment

157. This policy proposal impacts all NHS Trusts. The costs will not impact service users. Directors of NHS Trusts are likely to be impacted as they will face additional scrutiny over their suitability to be or remain as directors of these organisations. Those directors who are found to be unfit for the role will face costs associated with being removed from their role. The benefits of improved quality of care through better assurances on the quality and performance of directors will be realised by users of health services equally. This policy will not disproportionately affect any one demographic or social group. In general, the users of healthcare services tend to be people from older age groups, lower income distribution and those with disabilities or long term conditions.

158. Responses to the consultation on strengthening corporate accountability in health and social care raised concerns about the proposed requirement for directors to be physically and mentally fit to take on the role – and in particular that this might impact on the appointment of service users to Board level appointments who have disabilities or mental health conditions. The draft regulation provides that the person must be capable by reason of their health after such reasonable adjustments as may be required under the Equality Act 2010 of properly performing the tasks for which they are appointed or employed. The regulations apply in relation to the relevant position

which will enable to provider to qualify the conditions for service user positions to avoid any adverse impact.

159. The consultation on the draft regulations asked whether respondents had any concerns about the impact of the proposed regulations on people sharing protected characteristics as listed in the Equality Act 2010. Nearly 97% of respondents who answered this question said they did not have any concerns.

Competition

160. In any affected market, would the proposal:

- Directly limit the number or range of suppliers?

161. No. The proposals do not involve the award of exclusive rights to supply services, procurement will not be from a single supplier or restricted group of suppliers.

- Indirectly limit the number or range of suppliers?

162. CQC ensures that only providers who have made a legal declaration that they meet the standards of quality and safety are allowed to provide care. The proposed policy will increase the standards that providers must meet before they are able to enter the market.

- Limit the ability of suppliers to compete?

163. This requirement is not expected to have any impact on suppliers. The introduction of the fit and proper person's requirement for NHS providers will strengthen the existing conditions placed by Monitor and the Trust Development Authority. Subject to parliamentary clearances, the requirement will eventually apply to all CQC registered providers of health and adult social care equally.

164. This requirement does not limit the scope for innovation for the introduction of new products or supply existing products in new ways. It does not limit the sales channels a supplier can use, or the geographic area in which a supplier can operate. It does not limit the suppliers' freedoms to organise their own production processes or their choice of organisational form. It does not substantially restrict the ability of suppliers to advertise their products.

- Reduce suppliers' incentives to compete vigorously?

165. The proposal does not exempt the suppliers from general competition law. They do not require or encourage the exchange between suppliers, or publication, of information on prices, costs, sales or outputs.

Small and Micro Business Assessment

- How does the proposal affect small businesses, their customers or competitors?

166. This Impact Assessment only considers the impact of NHS secondary care providers. NHS trusts are all large organisations with over 250 employees. Thus no small businesses are affected.

Legal Aid/Justice Impact

167. The following have been considered in the main impact assessment above and in the Ministry of Justice impact test provided alongside this document:

- Will the proposals create new civil sanctions, fixed penalties or civil orders with criminal sanctions or creating or amending criminal offences? **No**
- Any impact on HM Courts services or on Tribunals services through the creation of or an increase in application cases? **Yes**
- Create a new right of appeal or route to judicial review? **Yes**
- Enforcement mechanisms for civil debts, civil sanctions or criminal penalties? **No**
- Amendment of Court and/or tribunal rules? **No**
- Amendment of sentencing or penalty guidelines? **No**
- Any impact (increase or reduction on costs) on Legal Aid fund? (criminal, civil and family, asylum) **No**

- Any increase in the number of offenders being committed to custody (including on remand) or probation? **No**
- Any increase in the length of custodial sentences? Will proposals create a new custodial sentence? **No**
- Any impact of the proposals on probation services? **No**

Sustainable Development

168. The proposals are not expected to have a wider impact on sustainable development. There will be no impact on climate change, waste management, air quality, landscape appearance, habitat, wildlife, levels of noise exposure or water pollution, abstraction or exposure to flood.

Health Impact

- Do the proposals have a significant effect on human health by virtue of their effects on certain determinants of health, or a significant demand on health service? (primary care, community services, hospital care, need for medicines, accident or emergency services, social services, health protection and preparedness response)

169. The potential impacts on health have been considered above in the cost benefit analysis of this impact assessment, see Section D above

170. There are no expected health risks in association with, diet, lifestyle, tobacco and alcohol consumption, psycho-social environment, housing conditions, accidents and safety, pollution, exposure to chemicals, infection, geophysical and economic factors, as a result of the proposals

Rural Proofing

- Rural proofing is a commitment by Government to ensure domestic policies take account of rural circumstances and needs. It is a mandatory part of the policy process, which means as policies are developed, policy makers should: consider whether their policy is likely to have a different impact in rural areas because of particular circumstances or needs, make proper assessment of those impacts, if they're likely to be significant, adjust the policy where appropriate, with solutions to meet rural needs and circumstances.

171. The proposals will not lead to potentially different impacts for rural areas or people.

Wider impacts

172. The main purpose of the proposed policy is to reduce the risks of poor quality care for health and adult social care service users associated with poor management or governance and to make directors more accountable for their actions. This will be achieved by making requirements on providers to ensure that their directors are of the right character and are fit to carry out their roles.

Economic impacts

173. The costs and benefits of the proposals on businesses have been considered in the main cost benefit analysis of this impact assessments, see Section D above.

Environmental impacts and sustainable development

174. The proposals have not identified any wider effects on environmental issues including on carbon and greenhouse gas emissions.

Section F: Summary and Conclusions

175. Based on the above impact assessment, the preferred option is Option 2 (preferred option): A fit and proper persons requirement for directors: CQC requirements will be amended to place a clear duty on service providers to make sure that all directors who are appointed to the boards of any health or care organisation regulated by CQC are fit for their role, as is already the case for other staff members at the organisation, including senior managers. CQC would be given the power to take enforcement action against providers where it becomes apparent that they have not taken the proper steps to ensure that their directors are and remain fit and proper for the role, including placing conditions on a provider's registration to remove the unfit director. We will seek to bring in the new fitness requirement for directors of NHS secondary care providers from October 2014,

and, subject to further clearances and parliamentary scrutiny, for all other CQC registered providers from April 2015.

176. The costs of such a policy to providers are expected to be low, as it is expected that the majority of providers will already be taking the necessary steps to ensure that their directors are fit and proper. CQC will face some additional costs of enforcing the policy and there will also be costs to CQC, HMCTS and the provider and/or directors associated with both the provider and director having the right to appeal any enforcement action.

177. Overall, although the policy is not expected to impact on a large number of providers, the identified benefits of improved accountability and patient safety are still expected to outweigh the costs, due to the potentially significant impact that poor leadership can have on the quality of care of an organisation. We also anticipate that there may be additional benefits to the NHS, as better leadership may also improve financial performance for NHS Trusts. Break even analysis suggests that under relatively modest assumptions, these benefits will outweigh the costs of the policy.