Title: Single Failure Regime  
IA No: DH 6108

Lead department or agency: Department of Health  
Other departments or agencies: Impact Assessment (IA)

Date: 08/05/2013  
Stage: Final  
Source of intervention: Domestic  
Type of measure: Primary legislation  
Contact for enquiries:

### Summary: Intervention and Options

<table>
<thead>
<tr>
<th>Cost of Preferred (or more likely) Option</th>
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<tbody>
<tr>
<td>Total Net Present Value</td>
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<td>£0m</td>
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**What is the problem under consideration? Why is government intervention necessary?**

In the past, when poor care was detected, problems have not been addressed as quickly as possible, and effective action is not always taken to ensure that identified issues are resolved.

A critical finding from Robert Francis’s report into the failures of care at Mid-Staffs hospital was the significant failures of accountability and transparency in the role of system managers and regulators. Focus was directed at financial and organisational issues rather than the protection of patients and ensuring quality of care.

**What are the policy objectives and the intended effects?**

A new failure regime, with greater emphasis on quality, will ensure that, where the standard of care is below an acceptable level, firm action is taken until it is properly and promptly resolved. It will deliver a clear and coordinated regulatory approach to identifying and tackling failures.

The intention is to ensure provider Boards adopt as rigorous and comprehensive an approach to maintaining quality as they do to keeping in budget, as highlighted in the Francis report.

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

In response to the recommendations of the Francis report relating to regulatory reform, three options have been considered:

1) Do nothing: This would mean that quality failures would continue to be dealt with as they currently are;
2) A single failure regime: to deliver a simple, flexible process for tackling quality failures in NHS Trusts and NHS Foundation Trusts with a more clearly defined and timely end point for failed hospitals (preferred);
3) Transfer of functions from Monitor and the NTDA to CQC to create a single regulator of the health and care system.

The preference is for the option 2 as it would enable effective and proportionate intervention to address quality failure, without the restructuring costs observable in option 3.

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

<table>
<thead>
<tr>
<th>Does implementation go beyond minimum EU requirements?</th>
<th>No</th>
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<tr>
<td>Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.</td>
<td>Micro</td>
</tr>
<tr>
<td>What is the CO2 equivalent change in greenhouse gas emissions? (Million tonnes CO2 equivalent)</td>
<td>Traded: 0</td>
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I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister:  
Earl Howe  
Date: 8 May 2013
**Summary: Analysis & Evidence**

**Policy Option 1**

**Description:** Single failure regime

### FULL ECONOMIC ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th>Price Base Year</th>
<th>PV Base Year</th>
<th>Time Period Years</th>
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<tr>
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<td>High</td>
<td>Best Estimate</td>
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<td><strong>COSTS (£m)</strong></td>
<td>Total Transition</td>
<td>Average Annual</td>
<td>Total Cost</td>
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**Description and scale of key monetised costs by ‘main affected groups’**

The main costs will fall on the regulators, which operate the single failure regime. CQC is currently calculating these additional running costs as part of its business planning process to be published later this year. An enactment impact assessment will be produced, once the detailed estimates of costs and benefits are available. The obligation for providers to comply is not expected to be significantly costly, thanks to earlier intervention in case of failure.

**Other key non-monetised costs by ‘main affected groups’**

Key non-monetised costs include the potential alternative costs for regulators and providers of using resources to improve quality of NHS services; other regulatory or clinical activities; the cost of addressing poor care or quality failings providers; the impact on the local economy, and the cost of late intervention to resolve poor quality services.

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<th>Total Transition</th>
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<td>Best Estimate</td>
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**Description and scale of key monetised benefits by ‘main affected groups’**

It is not possible at this time to quantify, with satisfactory precision, the benefits for patients. It is also uncertain to what extent providers will improve the quality of their services and how this will change over time. Therefore, none of the described benefits have been monetised.

**Other key non-monetised benefits by ‘main affected groups’**

Key non-monetised benefits for patients, services users, providers and commissioners are improved quality, increased transparency, greater choice and definition of regulators roles and accountability of providers.

**Key assumptions/sensitivities/risks**

Powers to allow the CQC to instigate a new failure regime. This will mean that in cases where urgent changes are needed to address quality failings, this will detected quickly, and there will be a clear and time limited process for intervening and tackling problems. The uncertainty is around any potential cost to providers. If reaching quality standards increase their costs, this could lead to financial problems or even their financial unsustainability.

**BUSINESS ASSESSMENT (Option 1)**

<table>
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<th>Direct impact on business (Equivalent Annual) £m:</th>
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<th>Benefits: n/a</th>
<th>Net: n/a</th>
<th>In scope of OIOO?</th>
<th>Measure qualifies as</th>
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Evidence Base

A. The underlying problem

1. At present, quality problems within providers may not be addressed as quickly as possible to ensure that identified issues are resolved promptly and effectively. The Francis Report into the standards of care at Mid-Staffordshire NHS Foundation Trust (FT) identified some significant failures of accountability and transparency of managers and regulators in the period covered by the inquiry. The report highlighted focus by the national regulators was directed at financial and organisational issues with insufficient priority being given to quality of care.

2. It is clear that action taken to address issues with quality at Mid-Staffordshire FT was not sufficient. Robert Francis attributed the undue focus on financial and organisational issues to ‘poor communication, misaligned methods of assessment, and an over-reliance on assurances given by other organisations’.

3. At present, the powers that CQC currently has to address quality failures are relatively blunt – they can issue warnings on the basis of non-compliance with registration requirements and they can close down either individual services or whole providers, but there is nothing in between. For large providers deregistration, or even suspension of services, may not be a credible threat, and CQC has never previously deregistered an NHS Trust or FT. However, Monitor and the NTDA have interim steps for enforcement in the event of financial or governance failures which are not available to CQC for quality failures. Ensuring that providers can face equivalent interventions for both financial and quality failures will ensure that providing a high quality service is as important as staying in budget.

4. The intention of this policy is to revise the regulatory framework for providers who are failing on grounds of quality to create a more flexible, nuanced approach to tackling quality failures. To reduce duplication for NHS trusts and foundation trusts and to ensure clarity of roles for the regulatory bodies, CQC will focus on identifying and exposing quality problems. Enforcement and overseeing specific rectifying actions will be overseen by Monitor for Foundation trusts or the NTDA for NHS trusts.

B. Policy background and context

5. Over recent years, providers have been given more freedom over how they operate, with increasing transfer of power and control from organisations such as the Department of Health and Strategic Health Authorities (SHAs) to the providers of care. The intention behind this has been to encourage providers to become more innovative and responsive to patient needs and preferences.

6. The first major step was in 2004 with the establishment FTs, which have greater freedoms over the way in which they manage their organisations and resources. This increases their incentive to innovate, permitting them to thereby raise their income or reduce costs and then improve services by reinvesting any surpluses.
The Health and Social Care Act (2012) made legislative changes to the way the health and care system operates and provided a framework for moving all NHS providers to FT status. The Act moved commissioning decisions from PCTs to Clinical Commissioning Groups (CCGs) to ensure greater involvement of clinicians in the commissioning process. This has meant, firstly, that decisions about services are made closer to the individual and, secondly, that providers have more freedom to respond to patient needs and preferences. For this to work effectively, appropriate regulation is needed to ensure that sufficient focus and priority is given to quality improvement.

C. Role of the regulators involved

Monitor

8. Monitor is an independent economic regulator that authorises and regulates NHS foundation trusts and ensures that they are well-led and financially robust. Since April 2013, Monitor has also been the sector regulator for healthcare in England with a duty to protect the interests of service users by promoting health care services that are efficient and effective. As such, it sets out conditions that providers must meet to obtain a licence to provide NHS-funded care, and is responsible for ensuring adherence to these conditions, including meeting minimum quality standards.

9. The 2012 Act requires Monitor to ensure access to essential services within each geographical area in England. Monitor will investigate potential breaches of licence conditions and use a Risk Assessment Framework to highlight concerns, assess the risk to the continuity of commissioners requested services and to the governance of NHS Foundation Trusts.

10. When Monitor identifies that an NHS Foundation Trust has breached, or is likely to breach, its licence conditions, it will take progressive and appropriate actions to recover the quality and safety of healthcare services, without disrupting the continuity of the services requested by commissioners. Monitor will use a range of powers to intervene at different levels of failure:

- If Monitor suspects an NHS Foundation Trust is in breach of a licence condition or has not complied with a request for information, it can undertake enforcement action (section 106 of the 2012 Act) to comply with its requirements, restore the situation or pay a penalty.
- If the Foundation Trust fails to meet the terms of the undertaking, and so breaches the condition of its licence, Monitor will oblige it to take discretionary actions (section 105 of the 2012 Act) to restore the situation.
- If the Foundation Trust is at risk of breaching a licence condition, Monitor may act according to the section 111 of the 2012 Act and impose additional conditions relating to its governance. If those conditions are breached by the Foundation Trust, then, Monitor may remove, suspend, or disqualify one or more directors or members of the Board.
- Eventually, in the event of extreme failure, Monitor may revoke the licence of the Foundation Trust, preventing it from operating. In the event of serious failure, Monitor
will put in place a contingency planning team to identify services that will need to be protected and determine how to maintain their delivery.

**NHS Trust Development Authority (NHS TDA)**

11. The NHS Trust Development Authority is the body with responsibility for overseeing the management of NHS Trusts and their progress towards Foundation Trust status. It sets directions about the exercise of any of NHS Trusts’ functions and also supervises, develops and supports them, in order that they reach conditions to obtain a licence from Monitor. Its four main functions are:

- performance management of NHS Trusts;
- management of the Foundation Trust pipeline;
- assurance of clinical quality, governance and risk in NHS Trusts; and
- appointments to NHS Trusts of chairs, non-executive members and trustees for NHS Charities where the Secretary of State has a power to appoint.

12. Where the NHS TDA considers improvements in clinical quality, governance or management of risk could be made, or where English NHS trusts are not meeting relevant standards, the NHS TDA will assist Trusts to make improvements and meet requirements, by providing advice, support, help or guidance.

13. The NHS TDA will seek and consider advice from Monitor, including advice on what steps an English NHS trust is to take to comply with section 35(2) of the Act as to which Monitor must be satisfied prior to giving an authorisation as an NHS Foundation Trust.

**Care Quality Commission (CQC)**

14. The Care Quality Commission is the statutory regulator for the quality of health and social care, including in hospitals, dental practices, ambulances, care homes, people’s own homes and elsewhere. CQC assesses whether providers registered with CQC meet national standards of quality and safety and are protecting the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

15. Providers of ‘regulated activities’ must be registered with CQC and comply with registration requirements in order to be able to provide regulated activities. CQC regulates provider compliance with the registration requirements (the sixteen essential standards of quality and safety). To make assessments of compliance, CQC can:

- make unannounced inspections of services both on a regular basis and in response to concerns
- carry out investigations into why care fails to improve
- continually monitor information (national and local, and from the public, local groups, care workers and whistle-blowers)

16. If a provider is deemed to be non-compliant with its registration requirements, CQC can make use of its statutory enforcement powers. These include warning notices that require improvement within a specified period, penalties, suspension or restriction of a provider's activities, or in extreme cases, cancellation of a provider's registration.
17. The CQC takes a proportionate approach to regulation. From time to time a provider may dip temporarily below the bar breaching one or more of the ‘essential standards of quality and safety’. Where there are significant, repeated, multiple and/or sustained breaches of registration requirements, it is likely that the provider is experiencing a serious failure, and that there are systemic problems within the organisation.

18. In order to regulate successfully, the CQC works in conjunction with other organisations such as commissioners, other national bodies, and regulators including Monitor and the NHS TDA.

D. **What are the policy objectives and the intended effects?**

19. The objective of a single failure regime is to deliver a simple, flexible process for tackling quality failures in NHS Trusts and NHS Foundation Trusts with a better defined and timely end point for failed hospitals. The intention is to more clearly define the roles of regulatory bodies, reduce bureaucracy for providers, and take firmer action on failure wherever possible.

20. When the quality of care at an NHS Trust or FT requires significant improvement, the Chief Inspector will issue a warning notice requiring the hospital board to improve within a fixed time period. Monitor (for foundation trusts) or the NHS Trust Development Authority (for NHS trusts) will be able to step in to take appropriate action, including removing or suspending hospital boards if necessary. Where breaches remain after a warning notice has expired, CQC must review what further action is required, including whether to trigger special administration, to ensure problems don’t become long-standing.

21. The principle that initial responsibility for dealing with the problem lies with the provider will not change; however, if problems persist, Monitor or the NHS TDA will be able to step in to ensure sufficient action is taken.

22. Where CQC has determined that a provider is clinically unsustainable in its current form, Monitor will be able to place the provider into trust special administration and ensure that the local population can access a comprehensive range of safe, sustainable health services.

E. **The rationale for Government intervention**

23. The current framework for identifying and addressing quality failure is not as effective as it could be at tackling and rectifying poor quality of care by providers. Government intervention is required to make the necessary changes to legislation to ensure that the regulatory system is able to respond effectively when problems are identified to secure high quality care for those people accessing services.

F. **Options under consideration**

24. Three options have been considered for how to respond:

1) **Do nothing:** This would mean continuing with the current situation, so that quality failures would be dealt with as they currently are by CQC. Under this option, CQC’s powers would continue to be limited to warning notices and the closure of services or of whole providers,
without the ability to take timely action when significant improvement in the quality of care is required.

2) **Introduce a single integrated failure regime:** Under this option, there would be a greater range of tools to use in response to quality failures, which are not currently available to CQC, including a power to put a trust into special administration on quality grounds. With the knowledge that regulators can employ a broader range of tools with respect to quality failings, the correct incentives will be built into the system to ensure that, for providers, delivering a quality service is as important as staying in budget.

Rather than merging CQC and Monitor, as Francis suggests, we intend to have greater clarity over the respective roles of CQC and Monitor/NTDA. It is important that assessing quality and highlighting failures of care are not conflated with the responsibility for overseeing the turnaround of failing NHS providers. To reduce duplication, there will be a clear delineation between CQC’s role as the assessor of quality and Monitor’s role in intervening to resolve the problems.

If there is a serious quality failure, it is currently not often feasible for CQC to close the provider. If, for example, the provider is the sole hospital in a relatively remote area, then patients would have nowhere else they can go for treatment. Even if there are alternative providers around, there may be insufficient capacity for the provider (or even an individual service line) to be closed down, and the failure would have to be tolerated in the short term. This in turn serves to reduce the incentive on a provider to improve the quality of its care as there is no realistic threat of intervention. In contrast, when there is a failure on the grounds of finance or governance, Monitor and the NTDA have various powers they can employ, which are not available to CQC as the quality regulator.

While there does tend to be a link between quality and finance – for example, poor quality may require a significant amount of money to be invested to rectify the problem – this is not perfectly correlated. There can be examples of a provider only being poor on one thing or the other, or there being a long lag time before poor quality leads to a failure of finance. Enabling the regulators to place a failing trust into special administration on the basis of quality failures will ensure that problems are not allowed to persist.

3) **Merge Monitor and NTDA into CQC:** This would mean that, as recommended in the Francis report, both Monitor and the NTDA would be abolished as organisations in their own right, and their functions would be transferred to the CQC. This option would reduce the problems created by poor communication and avoid duplications in the respective responsibilities of the regulators involved.

**Benefits and costs of each option, and justification for the preferred option**

**Option 1: Do nothing**

25. By definition, the benefits and costs of this option are zero. This is the baseline against which the other options will be assessed.

**Option 2: Single failure regime**

a. **Benefits of introducing the single failure regime**
26. The primary benefit of this option is to build the correct incentives into the regulatory system and to improve communication and alignment between the regulators. This will result in a greater emphasis being awarded to the quality of care. The proposed legislative changes required to deliver a single failure regime are outlined in Annex A.

- **Decisions being made on the basis of all available information**

27. The single failure regime is part of an overall set of measures aiming to reduce the likelihood of quality failure in the health and care system, and to deal with them effectively if they do occur. In terms of surveillance, CQC will look at quality in the round, make assessments of providers and develop ratings. This will end the potential confusion about the ‘true’ performance of providers and should help to ensure that the most appropriate decisions are made when intervention is required.

28. This in turn should help to both save money and improve the quality of services across the health and care system because, compared to the ‘do nothing’ scenario, there is likely to be more appropriate and timely intervention.

- **Quicker resolution of quality issues**

29. The proposals under option 2 would enable failures in quality to be dealt with through a clear method for detection and resolution. The delineation between the roles of CQC and Monitor/NTDA to deal with quality failure will mean that there is no doubt as to the respective responsibilities of the regulators and how quality failures will be identified and resolved.

30. Under this option, Monitor will be able to make use of its intervention powers where CQC has identified issues with the quality of care. CQC would also receive a new power to direct Monitor to place a Foundation Trust into special administration on quality grounds if local efforts had failed and the provider is clinically unsustainable.

31. Providers will therefore be encouraged to deal with quality issues early before any intervention is required, which will send a strong message that delivering a high quality service is as important as staying in budget.

- **The role of new warning notices**

32. At present CQC issues warnings when providers are in breach of registration requirements. However, the intention is for CQC to only issue warning notices when there is need for significant improvement in the quality of the services provided. This will provide a legislative basis for CQC to highlight systemic failings and require improvement.

33. Providers would need to respond to the warning notices within a fixed time period. If an NHS Trust or FT fails to make the necessary improvements within the specified period, CQC will be required to review what further action is required, including considering if special administration is appropriate.

- **Improved incentives across the system**
34. At present, if there are quality issues at a trust, the provider may not respond as quickly as they could. Enabling Monitor and the NTDA to intervene on the basis of quality issues will increase the incentive on providers to resolve problems, as there will be a more credible threat that action will be taken by the regulators.

35. When a warning notice is issued, providers will be aware of the clear and time-limited process that will be followed to secure an improvement. This will increase the likelihood, firstly, that the provider will respond quickly and effectively and, secondly, that the provider increases its focus on the quality of their services before a breach occurs.

b. Costs of introducing the single failure regime

36. The main costs associated with the introduction of the single failure regime will fall on the regulators, who will be operating it. There may also be costs incurred by providers. These are set out below.

- Costs to the regulators

37. For CQC, Monitor and the NTDA to operate the single failure regime, some additional resource may be required. The additional costs related to the single failure regime, on top of the additional costs incurred by legislating for many of the other recommendations in the Francis report, are not currently available and would be better estimated later this year once CQC has concluded its business planning process to be published in the autumn.

- Costs to providers

38. It is likely that the proposed primary legislation will result in more action being taken by some providers to ensure that the services they deliver are of higher quality. However, improving the availability of intermediate intervention tools and presenting special administration as a credible threat, should ensure that breaches are resolved quickly and effectively, which will limit the number of cases of large, costly failures from arising.

c. Net benefit of Option 2

39. Given the stage of policy development it has not been yet possible to produce a precise estimate of any of the effects, benefits or costs. It is difficult to disentangle the costs of the single failure regime from the other costs incurred by the regulators, and especially CQC, as part of the Francis response. An enactment impact assessment with fully developed costs and benefits will therefore be produced to accompany the autumn response to the Francis report in light of the results of CQC’s business planning. Therefore, currently, this impact assessment focuses on the benefits and costs on a qualitative basis only.

40. The direct costs of Option 2 would be incurred by the regulators only and, they would be funded out of existing non-frontline resource. These costs are also likely to be limited, as they would be based only on staff costs within CQC, related to the additional time and efforts to follow up on warning notices. However, it is difficult to be specific on the precise implications, as it is not yet clear how much resource would be required.
41. The benefits also cannot be quantified at this stage. This is because it is uncertain how much of an incentive effect there would be for providers to improve. It is unclear to what extent providers would respond and improve the quality of their services.

42. On balance, it is considered this option would be net cost beneficial if resources are allocated appropriately. Funding allocated to the regulators to deliver this revised regulatory framework needs to be sufficient to achieve the benefits but not so great that the system becomes bloated and inefficient.

43. The biggest area of uncertainty is around any potential cost to providers. As set out above, this could in fact be cost-reducing overall, but there is the possibility that it increases costs to an individual provider. If this is the case, it could then lead to financial problems locally, as the provider cannot provide services to the required level of quality without becoming financially unsustainable. That said, if this is the case and the provider cannot offer adequate services within the cost, then this should be dealt with. In such cases, the single failure regime will improve transparency across the health and care system, highlighting where there are issues which should be resolved.

**Option 3: Transfer of functions from Monitor and TDA into CQC**

44. Under this option, CQC would take over key regulation functions from Monitor and NTDA. Therefore, CQC, as the only regulator, would assess and enforce the compliance of providers with quality requirements and fundamental standards for clinical and governance, as well as finance control.

**a. Benefits, costs and net benefit of Option 3**

45. The benefits of Option 3 are the same as set out for Option 2, in the sense that more appropriate tools for intervention would be available to resolve any kind of failure. Moreover, the duplication of roles and actions is prevented through the mergers of regulators into one organisation. Similarly, the incentive effect would encourage providers to respond and improve the quality of their services, which is uncertain at this stage.

46. As for Option 2, there are thought to be direct costs to the regulators of undertaking more work, and potentially indirect costs resulting from the actions that providers take to improve the quality of their services.

47. There is also an additional direct cost associated with merging CQC and Monitor. An NAO report\(^1\) estimated the cost of each reorganisation of an organisation at £15m, so the additional cost here could be of the order of £30m.

48. By merging the organisations, there is no delineation between the assessment of quality and the intervention to resolve it. This separation of roles (achieved in option 2) would mean that CQC could make independent assessments without the dual responsibility of needing to intervene to solve them.

**b. Comparison of Options**

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49. Based on the arguments set out above, it is thought that both Option 2 and Option 3 will be preferable to the 'do nothing' baseline scenario.

50. Given that it is assumed that benefits of Options 2 and 3 are broadly equivalent, the structural change proposed in the Option 3 will add an extra cost that is not thought to be justified by additional benefits. Therefore, Option 2 is preferred since it is estimated to have a higher net benefit compared to Option 3 on the basis of the evidence available.

6. Equality Analysis

51. Section 149 (1) of the Equality Act 2010 and the Equality Duty aims to:
   - Eliminate unlawful discrimination, harassment and victimisation;
   - Advance equality of opportunity between people who share a protected characteristic and people who do not;
   - Promote good relations between people who share a protected characteristic and those who do not.

52. It is not expected that the single failure regime will impact negatively upon groups according to the protected characteristics outlined in the Equality Act 2010, nor is the policy expected to widen inequalities. The aim of this policy is to deliver a clear and coordinated regulatory approach to identify and tackle failures of quality at NHS Trusts and Foundation Trusts across England for the benefit of all patients. Where quality of care is below an acceptable standard, firm action will be taken until it is properly and promptly resolved.

53. Currently, if there is a problem with quality at an acute trust, it would be very difficult for CQC to close the provider or a service line. Notably, in rural areas or for specialist services, closing a provider would cause patients to have nowhere else to go for treatment. Even if there are alternative providers around, there may not be sufficient capacity in the area to meet the created demand. The intention of the failure regime is to ensure that there is a clear and credible plan for intervening and resolving quality problems wherever they exist.

54. We know that some groups of people are more likely to use hospitals and we envisage that the policy will therefore be most relevant to them. The ONS Census data (2011) has shown that for all acute hospital inpatient episodes 38.1% were people over the age of 65, despite this group accounting for only 16% of the UK population. We also know that 70% of all inpatient bed days are taken up by the 15.4 million people in the UK with one or more long term condition.

55. People who receive care in an NHS hospital should have greater confidence that quality failures will be resolved with greater efficacy. The implementation of this policy will make it clearer for patients, their families and carers, and professionals to understand the distinct roles of CQC and Monitor.

56. The actions taken to resolve identified issues of quality will be at the discretion of hospitals and regulators and commissioners, as necessary and appropriate. Bodies performing public functions, including hospitals, the Care Quality Commission and Monitor, are also subject to the Public Sector Equality Duty and must pay due regard to it in everything they do.
Regulations require listed public authorities to publish relevant information which demonstrates compliance with the equality duty annually and to set objectives to improve their performance every four years.
Annex A: Proposed Legislative changes

A small number of clauses in the Third Session Bill are included to amend the existing legal framework for identifying and dealing with provider failure:

- Where quality is poor, CQC will be able to issue and publish a new warning notice that will require the board of the provider to make significant improvements, within a stated fixed time period. Where improvements are not observed within the time period stated on the notice, CQC will be required to review what further action is required, including considering if special administration is appropriate.

- Monitor's transitional intervention powers over Foundation Trusts will be amended to clarify that timely enforcement action can be taken where CQC issues a warning notice requiring significant improvement.

- The existing special administration regime for Foundation Trusts will be broadened from an insolvency regime to one which is suitable for dealing with Foundation trusts that are clinically and/or financially unsustainable.

- Monitor will be able to put an FT into special administration on the basis of financial or quality failures, and the CQC will also have a new power to trigger special administration in respect of FTs which have failed on quality.

- No additional legislative changes are required for the NTDA to be able to take action to resolve quality failures for NHS Trusts.