Health Bill: patient safety measures - impact assessments

This document contains the following impact assessments:

1. Title: Abolishing Healthwatch England and local Healthwatch - IA number: DHSCIA9718

2. Title: Transfer of Health Services Safety Investigation Body (HSSIB) functions into the Care Quality Commission (CQC) - IA number: DHSCIA9717

3. Title: Care Quality Commission (CQC): extending the statute of limitations - DHSCIA9719

Final stage impact assessment

Title: Abolishing Healthwatch England and local Healthwatch

Type of measure: Primary legislation

Stage: Final

Source of intervention: Domestic

Department or agency: Department of Health and Social Care

Other departments or agencies: Healthwatch England and Local Healthwatch

IA number: DHSCIA9718

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

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

- The 'review of patient safety across the health and care landscape' (published in 2025) found that patient experience has not been given the attention it deserves
- The 10 Year Health Plan set out an ambition to make the NHS more transparent and to strengthen the impact of the patient and user experience on decision-making and commissioning.
- It is a complex landscape with many organisations carrying out reviews and, resulting in a large number of recommendations. The many routes for patient and user feedback are not always clear. There is a risk of duplication in the current system, and the patient voice lacks influence on commissioning and policy making.

What are the policy objectives of the action or intervention and the intended effects?

- To feature patient and user feedback more centrally in strategic and decision-making functions
- To simplify the patient safety landscape

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

- **Option 1 (business as usual):** Healthwatch England (HWE) and Local Healthwatch (LHW) continue to operate on a national and local level, respectively. HWE continues to provide leadership and guidance to LHWs, escalates concerns about services, and provides advice to the Secretary of State for Health and Social Care (Secretary of State), NHS England and local authorities. LHW continues to obtain the views of patients and service users, makes reports and recommendations, provides information to the public, makes recommendations to HWE and champions the views of patients and service users.

- **Option 2 (preferred option):** To abolish HWE and LHW. HWE's functions will be repealed, and a responsibility will instead be placed on the Secretary of State to oversee a more streamlined patient safety landscape. LHW functions related to social care will be conferred on local authorities and those related to healthcare will be repealed and integrated care boards (ICBs) existing duties surrounding patients' views will be expanded. Multiple reviews and inquiries have recommended action to address the lack of change in listening to patients and users resulting in a complex duplicative system. Without legislative action, the current system would persist.

Will the policy be reviewed? Itwill be reviewed. If applicable, set review date: TBC				
Is this measure likely to impact on international trade and investment?		NoNo		
Are any of these organisations in scope?	Micro No	Small No	Medium No	LargeNo
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: 8-9-2026

Summary: Analysis & Evidence

Policy Option 1

Description: Abolition of Healthwatch England and local Healthwatch

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

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

- ICBs, who do not currently collect patient feedback may incur opportunity costs between £33k and £451k per year and per ICB (subject to scenarios and upper and lower bounds) to carry out this duty. This cost will potentially also apply to local authorities should funding not continue after the financial year 2026 to 2027 (noting the intention is for funding to continue).

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

- Transition costs occurring when conferring functions to the Secretary of State and establishing oversight for changes
- Opportunity costs occurring for new reporting requirements for ICBs
- Productivity loss during the period of change is possible

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

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

- The potential opportunity costs to ICBs represent potential savings of the equivalent amount to local authorities between £33k and £451k (subject to scenarios and upper and lower bounds).

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

- Streamlining of the landscape and legislation, avoiding duplication of activity and effort Increased accountability for listening to the patient and user voice
- The patient and user voice shaping commissioning and delivery of services

Distributional impacts
• These changes aim to make it easier for patients to provide feedback and for provider of health and care services to action feedback in a simplified landscape. However, there is a risk that those with protected characteristics will experience differential impacts. • For example, current barriers to engaging directly with health and social care providers for disabled people or trans people may persist. Other groups, such as women affected by poor maternity care or people who have experienced discrimination for their sexual orientation may not want to or feel able to provide feedback directly to the providers where they have experienced poor treatment. • It is worth noting that patients and service users may have more confidence in providing feedback to ICBs and local authorities as the commissioners of services if they do not wish to communicate with providers directly. • DHSC will support ICBs and local authorities with guidance to support them manage risks and maximise the benefit of this new streamlined approach, including support to design inclusive feedback mechanisms, especially for hard-to-reach groups.

Key assumptions/sensitivities/risks	N/A
• Delivery risk associated with the conferring of functions, mitigated through guidance. • Risk of losing institutional knowledge through possible high attrition rates due to organisational changes, mitigated through knowledge management processes. • Risk of duplication of functions during the transition period as current contracts are coming to an end and the new operational model is being set up.	

Business assessment (Option 1)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

The role of Healthwatch

Healthwatch is the independent statutory national champion for people who use health and social care services. Its purpose is to understand the needs and experiences of health and social care users and speak out on their behalf.

Healthwatch consists of:

- **153 Local Healthwatch (LHW) organisations**: There is a LHW in each local authority area in England, whose role is to find out what people want from their local health and social care services and to share these views with those running services to help improve them. LHW also provide information and advice to the public.

- **Healthwatch England (HWE):** HWE provides leadership and support to LHW organisations. It also has a separate statutory function, which includes escalating concerns and providing advice about health and social care services.

Both LHW and HWE obtain feedback on services provided, escalating the concerns raised with relevant bodies if appropriate. This role is separate from the complaints process which are initially dealt with at provider or commissioner or local authority level (a complainant has the choice to complain to either a service provider or commissioner, but not both). If not resolved locally, complainants have the right to refer their complaint to the independent Parliamentary and Health Service Ombudsman or if related to adult social care complaints to the Local Government Ombudsman, whose roles are to make final decisions on complaints that have not been resolved by the NHS or local authority. NHS England also has a complaints team for dealing with complaints about NHS England commissioned services. HWE and LWE do not deal with complaints about the NHS but can help signpost individuals wishing to make a complaint.

How Local Healthwatch operates

LHWs are social enterprises created by the Local Government & Public Involvement in Health Act 2007 (the 2007 Act) and amended by the Health & Social Care Act 2012. There are 153 LHW organisations across England. Their main statutory functions are to:

1. obtain the views of people about their needs and experience of local health and social care services
2. make reports and recommendations about how those services could or should be improved
3. promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services
4. provide information and advice to the public about accessing health and social care services and the options available to them
5. make the views and experiences of people known to HWE, helping it to carry out their role as national champion
6. make recommendations to HWE to advise the CQC to carry out special reviews or investigations into areas of concern.

They exercise their functions under arrangements made with local authorities, who must put in place contractual arrangements to ensure an effective Healthwatch is operating in their local area. Each LHW has separate legal personality as a body corporate, and they also have some powers under regulations made under the 2007 Act.

Funding for LHWs via local authorities is comprised of the Local Government Finance Settlement and the Local Reform and Community Voices grant.

LHW organisations employ 578 FTE staff nationally. Additionally, almost 4,000 volunteers support LHW organisations[1]. LHW organisations have an average of 3.8 FTE, but size and composition vary for each local organisation, depending on their needs and activities. LHW organisations also incur costs for their offices which also depend on local arrangements.

How Healthwatch England operates

Healthwatch England (HWE) is a statutory committee of the independent regulator the Care Quality Commission (CQC), funded by the Department of Health and Social Care (DHSC) and NHS England. Therefore, HWE is hosted within CQC as a Committee of the CQC and its chair is a Non-Executive Director of the CQC's Board, appointed by the Secretary of State.

HWE's functions are set out in the Health and Social Care Act 2008 (HSCA 2008). These functions are legally assigned to the CQC but carried out by HWE. HWE's main statutory functions are to:

- provide leadership, guidance, support and advice to Local Healthwatch organisations

[1] Healthwatch England (2025), Annual Report 2023-2024, p. 43 (viewed in August 2025)

- escalate concerns about health and social care services which have been raised by Local Healthwatch to CQC
- provide advice to the Secretary of State, NHS England and local authorities, especially where it is of the view that the quality of services provided are not adequate. Bodies to whom advice is given are required to respond in writing.

HWE has employed up to 36 FTE staff. It is structured as a committee: a chief executive (1) and deputy chief executive (1), a team of Network Developers (9), a Communications team (7), a Policy, Public Affairs and Research and Insights team (9), a Digital team (2), and an Operations team (5)[2]. HWE shares CQC premises.

The Dash review of patient safety across the health and care landscape (the Dash review)

Between October 2024 and February 2025, the Dash review focused on how patient safety could be best improved and as part of this focussed on six key patient safety organisations overseen by the Department of Health and Social Care (DHSC): Healthwatch England (and the local Healthwatch network), the Care Quality Commission, the National Guardian's Office, the Patient Safety Commissioner, the Health Services Safety Investigations Body and the patient-safety learning related functions of NHS Resolution.

Dr Dash made nine recommendations which the Government has accepted in full. Recommendation 5 of the Dash review[7] specifically references Healthwatch England and Local Healthwatch: "*Bring together the work of Local Healthwatch organisations, and the engagement functions of integrated care boards and providers, to ensure patient and wider community input into the planning and design of services.* As part of this recommendation the review outlined that *the strategic functions of Healthwatch England should be transferred to the new directorate for patient experience at DHSC."*

The 10 Year Health Plan for England

The 10 Year Health Plan sets out the Government's ambition to position the NHS as the most transparent healthcare system globally. Building on this foundation, it commits to a new era of transparency, a rigorous focus on high-quality care for all, and a renewed focus on patient and staff voice. As part of this, the Government is determined to put power back in the hands of people and professionals to make the best choices about their own lives, treatment and care.

Crucial to empowering patients in this way will be embedding a strong, influential patient voice at the very heart of the healthcare system. This aims to ensure that people's feedback and lived experiences not only inform service change, but drive meaningful, measurable improvements across the NHS. Abolishing HWE and LHW per the proposal aims to bring patient voice in-house, giving these views much greater profile in the reformed DHSC (the result of the NHS England and DHSC merger) and put greater accountability upon those providing and commissioning care to respond to the views of users and carers.

Challenges with the current Healthwatch approach

Complexity of the patient safety landscape

The current approach to HWE and LHW increases the complexity of the patient voice landscape. The Dash review concluded that there had been considerable resources deployed to improve patient safety (vs other areas of quality of care) over the last five to ten years, yielding relatively small improvements with limited strategic planning on improving quality of care. It found that there are many organisations carrying out reviews and investigations, leading to an overwhelming number of recommendations, or looking at user experience, and that this can cause confusion for patients and users who do not know where to turn to provide feedback or

[2] See Healthwatch England website 'Our staff | Healthwatch' (viewed in August 2025)

raise concerns. The Dash review found that there are more than 70 different channels or organisations that offer a place for patients or users to share feedback (including Local Healthwatch) and concluded that even though there are multiple organisations representing the voice of the user, patient experience has not been given the attention that it deserves.

There are also wider government ambitions to review Arm's Length Bodies (ALBs), as it is recognised that ALBs can come with additional costs and administrative burdens. While HWE is not an ALB and is a committee of CQC, it acts as a distinctive another organisation within the wider patient safety landscape which places additional administrative requirements on DHSC, such as a sponsor team.

Lack of influence of patient voice on policy making

There are challenges with the current system and the distance between policy-making and patient feedback, given it is currently gathered by organisations separate to where policy and key strategic decisions are made (DHSC and NHS England).

Lack of influence of patient voice on commissioning decisions

Local authorities currently commission LHW to collect patient feedback, but this feedback expands beyond the remit of their commissioning role. Local authorities are responsible for commissioning social care, but local authorities currently commission LHW to collect feedback on both social care and healthcare (which ICBs commission).

Not involving ICBs in this process may hinder the ability of that feedback to influence ICB healthcare commissioning. LHWs are also not members of ICBs, so they have reported struggling to have impact on ICB commissioning decisions. The interim report of the Post Implementation Review of the Health and Care Act 2022[3] found that the roles of LHW in relation to place-based partnerships and ICSs are unclear, LHW often feel that they are not heard, and that the patient experience influence on commissioners and providers of care is lacking. This creates inequality when, as a result of this issue, LHW directs their activities to focus on areas that engage with them. The review also found that the small size of some providers such as those contracted to provide LHW functions, makes it hard to put in place governance structures to exert influence, so they can be limited in what they can achieve.

Risk of lack of alignment in the current system

ICBs already hold a responsibility to listen to and promote the needs of those access their services, this includes Patient Participation Groups and other patient experience initiatives. In the current system there is a risk that the work of LHW could overlap and not align with the patient experience duties of the ICBs.

Description of options considered

Option 1: Business as usual

Under this option, HWE and LHW continue to operate as they currently do and ICBs retain their existing duty to gather patient feedback.

Option 2 (preferred option): Abolish HWE and LHW and transfer responsibilities to Secretary of State, ICBs and local authorities

There are 2 changes proposed under the preferred option:

[3] Sanderson, M. (2025) and others. Post implementation review of the Health and Care Act 2022, Phase 1: Interim Report p.71-73 (viewed in August 2025)

- Abolition of HWE, with HWE functions being repealed and responsibility will instead be placed on the Secretary of State.
- Abolition of LHW, with LHW functions being repealed. Following the abolition of LHW, ICBs will continue their responsibility of collecting feedback on the services they commission with their existing duties strengthened. Local authorities will be responsible for collecting feedback on their social care and public health functions and the intention is for the existing funding will continue to cover the cost of this responsibility. In line with existing duties both ICB and local authorities will be required to have due regard to guidance and the Secretary of State will also be able to direct if they are found to not be fulfilling their duties. ICBs will be required to evidence the collection of feedback and what that has informed via their existing annual reporting mechanisms and upon request of Secretary of State. While local authorities will be required to evidence upon request from the Secretary of State.

Policy objective

The overarching objective is to simplify the patient safety landscape, including user feedback and improve quality of care, including safety. Abolishing HWE and LHW and conferring functions (or transferring their responsibilities) on other organisations will support this by reducing the number of organisations involved in the patient safety landscape.

Following the abolition of HWE, DHSC will have responsibility for patient and user voice at the national level, which enables patient voice to sit closer to policy making and have a stronger role in policy development. This approach may also reduce costs and enable funding to be re-directed to the frontline.

Abolishing LHW will enable ICBs to be squarely responsible for collecting feedback from patients, avoiding any potential duplication between the 2 organisations. It will also streamline the responsibilities of local authorities to focus on social care; an area they are responsible for commissioning. These changes also ensure that the organisations responsible for commissioning (ICBs and local authorities) are using feedback to inform their commissioning decisions.

These changes also support wider government ambitions (like reviewing ALBs) and enable wider 10 Year Health Plan ambitions to be achieved[4]. This includes embedding a strong, influential patient voice at the very heart of the healthcare system. The ambition is for patients and users to have a clearer path to providing feedback, which will directly input into the government policy makers, and to the commissioners and providers of health and social care. This will be achieved by streamlining the patient safety landscape and user feedback system.

If these ambitions are achieved, services would improve for patients and better meet the needs of the local population, given their views would have been taken on board. This may also show through via a reduction in reviews or inquiries highlighting a lack of listening to users and patients views and opinions.

Summary and preferred option with description of implementation plan

Abolition of Healthwatch England

The preferred option is to abolish HWE, repealing their statutory functions and placing responsibility instead on the Secretary of State to have oversight of the patient safety landscape. Following the abolition of HWE, DHSC will exercise functions to oversee and

[4] Department of Health and Social Care (2025): 10 Year Health Plan for England: fit for the future - GOV.UK, p. 89 (viewed December 2025)

implement a more streamlined patient safety landscape which aims to make the patient voice more effective and impactful. This will include responsibility for overseeing the collection of more informed feedback from both patients and carers and making it publicly available.

As the HWE statutory functions are repealed and responsibility placed on the Secretary of State, some small changes will be made. For example, the Secretary of State will not have requirements to report to themselves (as is the case for the existing HWE functions). The Secretary of State will also be able to use their existing powers to direct when failing or request information from ICBs and local authorities in relation to their role in patient and user involvement, which was not something HWE was able to do.

While the exact approach to implementation of these functions remains uncertain (as it depends on future policy decisions), the 10 Year Health Plan sets out some ambitions for patient voice. The 10 Year Health Plan announced a new centralised directorate will be included in the organisation design of the restructured DHSC[4]. This will be specifically dedicated to patient experience will allow patient voice to impact on decision making, like in other industries. This new patient experience directorate (PED) within DHSC will provide a central point for coordinating efforts for user voice to impact on DHSC policy making. The way PED will operate is the responsibility of the Transformation programme (please see the Impact Assessments Summary Document for more details in the abolition of NHS England impact assessment).

While the legislation abolishes HWE, it does not automatically lead to redundancies, as legislation is not required to make redundancies. Staff within HWE will go through a People Change process overseen by CQC; this supports staff through consultation and identifies transferable skills and expertise, providing the opportunity for staff to be considered for suitable alternative employment where vacancies exist. There may be opportunities for staff to move on TUPE or to find roles within the patient experience directorate within the restructured DHSC. However, as the structure of patient experience directorate are subject to future policy decisions, these opportunities are uncertain at this stage.

HWE has one Non-Executive Director (NED) currently sitting on the CQC board.

Abolition of Local Healthwatch

The preferred option also abolishes LHW. The approach to abolishing LHW will mean that

- ICBs collect feedback on the services they commission
- Local authorities collect feedback on social care and public health services

Currently, variation exists between ICBs in how they engage patients and users to obtain feedback in relation to their existing duty. However, with the abolition of LHWs, the ambition is for ICBs to strengthen and align their feedback functions.

Some existing LHW contracts may cover more than one local authority, as each area has their own contractual arrangements place. The length of these contracts varies ranging from 1 year to 10 years. With the abolition of LHW arrangements,the contracted organisations will be unable to use the ‘Healthwatch’ trademark. This is intended to provide clarity about the abolition of LHW and HWE, to continue to allow use of the name would confuse matters. Detail on transitional arrangements are to be determined; contracts will reflect the local decisions made by commissioners, and may come to a ‘natural end’, depending on the length of the contract or an end date may be stipulated during the development of policy and regulations.

As the policy develops, and while legislation is laid, Implementation Project Board(s) will be established. These Boards aim to provide robust governance, accountability and oversight of the abolition and transition of responsibilities.

Following the abolition of LHW, there will be a new statutory requirement on ICBs to report to DHSC on the collection of feedback and what that has informed. This is expected to be an annual return, included within the existing ICB annual reports. A similar requirement will be set on local authorities, but this will be at the Secretary of State's request rather than an annual return. The exact details of these reporting requirements will be set out in guidance as they depend on future policy decisions.

The overall costs of performing LHW functions are not expected to change under this proposal. However, there will be a distributional impact as instead of local authorities commissioning LHW to gather feedback on both social care and healthcare, they will only commission social care as ICBs will continue their responsibility to gather feedback on healthcare.

Monetised and non-monetised costs and benefits of each option (including administrative burden)

Summary of the analytical approach

This IA provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HMT Green Book guidance[5]. These proposals depend on future policy decisions regarding approach taken following abolition of HWE and LHW. Therefore, there is substantial uncertainty on the impacts because it will depend on the approach to implementing this legislation. For example, this includes the exact design of the new patient experience directorate in DHSC, and guidance provided to local authorities and ICBs to fulfil the functions previously associated with LHW organisations.

As those policy decisions have not yet been made, it is not possible to fully quantify costs and benefits at this stage. Where quantification has been possible, they are illustrative of potential impacts and based on assumptions that have been made clear. Some changes proposed also have non-quantifiable impacts which are challenging to measure and express in numerical terms. Instead, the expected impacts of these proposed changes are described in as much detail as possible.

In line with the Green Book guidance, monetised costs and benefits are presented in the prices of the implementation year, in this case Financial Year 2026 to 2027.

Option 1: Business as usual

This section presents the costs of business as usual in absolute terms to compare to the preferred option, as per Green Book guidance. These are:

- Costs for **Healthwatch England**
  - from DHSC and NHS England which was around £3.4 million in 2023 to 2024[6].
- Costs for **Local Healthwatch** organisations which amounted to a total spend of £25 million[7] in 2024 to 2025 and is comprised of:
  - the non-ringfenced contribution towards local authorities to meet their statutory duty to provide a LHW. This comes from the Local Reform and Community Voices grant[8], set at £14.15 million (2024 to 2025 prices), plus
  - the Local Government Finance Settlement

[5] HMT (2026): The Green Book - GOV.UK (viewed February 2026)

[6] Healthwatch England (2025), Annual Report 2023-2024, p. 43 (viewed in August 2025), please note this is the most up to date annual report from HWE.

[7] Healthwatch England, Local Healthwatch Funding 2023-2024, p.12 (viewed in August 2025)

[8] DHSC (2024), Local authorities social services grant determination 2024 to 2025: no 31/7496 - GOV.UK (viewed September 2025)

Option 2: Abolition of HWE and LHW

The costs and benefits of abolishing HWE and LHW have been separated below to clarify the impacts of each change.

Costs – Abolition of HWE

Productivity costs

The costs of short-term productivity loss are uncertain and carry associated risks which are addressed as a delivery risk in the risk section. While this proposal is not a merger, there are some similarities between mergers and the changes happening here. In 2019, the Institute for Government noted the potential for high costs in lost productivity resulting from mergers.[9] An example of a productivity cost could be the impact of uncertainty as the restructured DHSC sets up the new patient experience directorate, and officials spend time engaging with organisational design changes rather than addressing policy issues relating to this area.[10]

Transition costs

There are a range of one-off transitional costs associated with conferring responsibility for HWE functions on the Secretary of State. An independent panel is expected to be set up to oversee this process, which may come with a financial cost or an opportunity cost if it is resourced in-house. Any delays to the creation of the restructured DHSC could cause an increase in these transitional costs. Further, some staff may choose to leave during the transition period, which could impact on skills and experience which may then affect how the restructured DHSC exercises its new functions.

Potential redundancy costs

From an economic perspective, redundancy costs are treated as economic transfers, rather than costs in the HMT Green Book. However, there could be financial costs for redundancies if they are taken forward as a result of the abolition of HWE. Potential redundancy costs have not been quantified, as this is highly uncertain and dependent on future policy decisions.

Costs – Abolition of LHW

Familiarisation costs to ICBs and local authorities

There would be familiarisation costs for ICBs and local authorities to understand and implement these legislative changes. Local authorities already commission LHW to gather patient feedback, so if they opt to continue commissioning this for social care functions, the disruption will be relatively minimal and mainly involve a narrowing responsibility for gathering feedback. Some local authorities could choose to collect social care and public health feedback in-house following the abolition of LHW, in which case the familiarisation and transition costs would be more substantial.

Also, for patients and service users who would ordinarily contact their LHW about their care, there will be a period of adjustment to familiarise themselves with the new system for patient voice.

Potential opportunity costs to ICBs and local authorities for collecting feedback

Where ICBs do not currently collect patient feedback in line with their existing duty, such as in cases where ICBs use the outputs of LHW, there would be an opportunity cost to those ICBs to meet this duty following the abolition of LHW.

[9] National Audit Office (2024), Progress with the merger of the FCO and DFID - NAO report, page 44, (viewed September 2025)

[10] Institute for Government (2019), Creating and dismantling government departments | Institute for Government, pages 11-14, (viewed September 2025)

LHW spending varies and is dependent on the activities of each individual LHW, not just the size or composition of the area they are serving. Therefore, to estimate possible opportunity costs for some ICBs, the annual expenditure (financial costs) of 2 illustrative LHW organisations have been used. These include pay, operational costs and office costs of both social care and health care functions, as it is not clear the proportion spent on each function.

2 example LHWs provide estimates for lower and upper bound of LHW costs. The 2024 to 2025 annual reports of these LHW organisations show an expenditure of (rounded to 3 significant figures):

- **Lower bound** (Redcar and Cleveland): £126,000[11], representing a smaller local authority in a more rural location
- **Upper bound** (Hackney): £576,000[12], representing a larger urban location.

Given ICBs will only be responsible for healthcare functions following the abolition of LHW, a range has been used to consider the proportion of LHW expenditure on just healthcare functions. Here, the low scenario assumes 25% of costs are spent on health and the high scenario assumes 75% of costs are spent on health. The costs have been converted to 2026 to 2027 prices and rounded to 3 significant figures unless stated otherwise.

The ranges for the low and high scenario are presented below, created from the lower and upper bound example LHWs mentioned above. These represent the estimated potential opportunity costs for ICBs, in cases where they do not currently collect feedback themselves:

- Low scenario (25% of spending relates to health): £32,900 to £150,000
- High scenario (25% of spending relates to health): £98,700 to £451,000

While some ICBs are responsible for only one local authority, other ICBs work across multiple local authorities[13]. Therefore, the costs provided here may underestimate the true opportunity cost to ICBs. On the other hand, ICBs may be able to operate more efficiently by centrally coordinating activities across their geography.

Some LHWs currently receive some funding from ICBs for particular activities, such as research engagement networks. These contributions vary from area to area and year on year. Following the abolition of LHW these contributions will no longer be paid but may be re-allocated by ICBs to meet responsibilities to collect feedback. Therefore, depending on the current arrangements of an ICB, the impact of the legislative changes will differ in each area.

The same opportunity costs may apply to local authorities if the funding they currently receive were to not continue past financial year 2026 to 2027, however the intention is for funding to continue.

Opportunity cost of reporting

There would also be an opportunity cost to ICBs and local authorities to meet new statutory reporting requirements, although this is expected to be relatively minimal. For ICBs this will be captured within existing annual reporting requirements to minimise resource requirements. For local authorities, this will be at the Secretary of State's request in cases when there are concerns about exercising functions.

Transition costs

There will be transition costs involved with overseeing the abolition of HWE and LHW. The exact approach to this oversight is dependent on future policy decisions, so the cost of this is

[11] Healthwatch Redcar and Cleveland (2025), Annual Report 2024-2025, p. 25 (viewed in August 2025)
[12] Healthwatch Hackney (2025), Annual Report 2024-2025, p.22 (viewed in March 2026)
[13] See: NHS England » Integrated care in your area for a map of ICB boundaries.

uncertain at this stage. However, the approach is expected to involve implementation boards being set up to oversee the transition.

Benefits – Abolition of HWE

Streamlined patient voice

Abolishing HWE helps enable the new patient safety landscape ambitions to be realised. This will involve the new patient experience directorate (PED) within DHSC, which aims to provide a central point for coordinating efforts to improve patient safety. This new centralised function will be able to oversee and implement a more streamlined patient safety landscape, which aims to utilise innovative solutions to make the patient voice more effective and impactful. Any potential duplication of roles between existing patient safety organisations should also be reduced under this approach. This could include user, patient, and community engagement and capturing the user or patient voice. This may cost more or less than the current cost of funding HWE (around £3 million for staffing and all activities), depending on future policy decisions. The abolition of HWE as a committee of CQC represents a small reduction in administrative effort. Therefore, there is potential for financial savings in the long-term.

Potential ongoing pay savings

While legislation is not required to enable redundancies, and future policy decisions about redundancies are yet to be made. If redundancies are made, this could generate ongoing pay savings. There may be opportunities for staff to move on TUPE or to find roles within the patient experience directorate in the restructured DHSC, but this is highly uncertain at this stage. Therefore, potential pay savings arising from any redundancies have not been estimated given the substantial uncertainty surrounding these future policy decisions.

Supporting wider government ambitions

A smaller patient safety landscape also supports wider government commitments to generate efficiencies. This is aimed at streamlining structures and operations, bringing them closer to the centre to reduce costs and administrative burdens. This is considered a more efficient approach to governance.

Benefits – Abolition of LHW

Patient feedback informing commissioning decisions

Placing responsibility for collecting feedback on the services they commission on the commissioners (local authorities and ICBs) aims to ensure patient voice more directly informs the commissioning of services which, in theory, should improve services for patients. ICB and local authority leaders will be better able to innovate and tailor service provision as inefficiencies are removed, and functions are brought in-house. This aims to lead to improved commissioning and co-design of health and social care services, driven by local communities.

Potential financial benefit for local authorities

The intention is for the existing funding to local authorities to continue to cover the cost of this responsibility. The funding to do this has been confirmed via the Local Reform and Community Voices grant to local authorities[14] for the financial year 2026 to 2027. If this funding continues in the long-term at a similar level then the costs to ICBs described above would correspond to a financial benefit (saving) for local authorities. This is because local authorities would be receiving the same level of funding for performing social care functions, as they do now for performing health and social care functions.

[14] Any changes to this arrangement will be part of wider funding conversations ahead of the Financial Year 2026 to 2027.

As this funding is not ring-fenced, the impact of potential savings depends on decisions by local authorities. Any potential savings on LHW functions could be re-allocated to fund other services for local authority residents or support the local authority's overall financial position, therefore reducing the amount of tax the local authority needs to collect from its residents.

Streamlining legislative functions

There is a risk of overlap in legislative functions between LHW and ICBs as both organisations are currently responsible for collecting feedback on healthcare. Abolishing LHWs removes this legislative duplication (even if not duplicating work in practice), to streamline the legislation and clarify responsibilities.

Strengthening accountability for patient voice

The new reporting requirement placed on ICBs and local authorities will provide the Secretary of State with more information on the collection of patient feedback and how that is informing commissioning decisions. This aims to strengthen the accountability of local leaders, to ensure they are collecting and implementing feedback from patients and carers. This legislative change also enables 10 Year Health Plan ambitions, like collating it at the national level to make publicly available.

Direct costs and benefits to business calculations and impact on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and assumptions

Risks – Abolition of HWE

Delivery risk

Following the abolition of HWE, as functions move to difference parts of the system, there is a risk of disruption to the business-as-usual service, as the restructured DHSC takes on new responsibilities previously undertaken by NHS England. Absorbing these functions could result in increased pressures that could lead to bottlenecks in the decision-making process depending on decisions about the level and type of Ministerial approvals.

For ICBs and local authorities, this risk would be mitigated through guidance provided by DHSC to support their delivery of these functions. For the Secretary of State, this risk would be considered as part of the organisational design decisions being made about the restructured DHSC following the abolition of NHS England. Please see the Impact Assessments Summary Document for details on the wider changes happening as part of the abolition of NHS England.

Risk of losing institutional knowledge

While HWE staff may be redeployed within CQC, the process of transferring staff may lead to higher attrition rates than business-as-usual operations, which could lead to a loss of institutional knowledge. For HWE, CQC's knowledge management protocols and engagement with staff and unions would reduce this risk. Engagement with HWE to ensure best practice and expertise is captured would form part of the wider work of the implementation panel that would oversee the transition.

Risks – Abolition of LHW

Less independent voice

There is a risk that the independence from healthcare providers and commissioners that LHW currently offers will be lost, depending on how providers fulfil the duty to collect feedback and how providers implement the feedback they receive. The policy intention is for greater transparency within the healthcare system, and a renewed focus on patient and user voice, which helps to mitigate this risk. As outlined, this will be achieved by the Secretary of State directing ICBs and local authorities to capture patient and user feedback.

DHSC will issue guidance to ICBs and local authorities, who will be legally required to have due regard to that guidance and direction. They will be required to evidence that they have done so (either annually in relation to ICBs or upon the Secretary of State's request for local authorities) and how this feedback has been used in commissioning. The Secretary of State can use existing powers to direct ICBs and local authorities in when the. This aims to ensure patients and user views, which can be lost and not heard loud enough within the current system, are effectively captured and acted upon.

Potential delivery risk for ICBs

ICBs already have a legal duty to promote patient involvement in their planning and receive funding to perform this and all their current functions. However, where ICBs currently utilise the outputs of LHW to perform this duty, there may be a delivery risk on those ICBs as they will have to gather this feedback (either commissioning it or in-house) following the abolition of LHW. This, alongside the wider changes happening to ICBs (see *Abolition of NHS England impact assessment* for more information), could create a delivery risk for gathering healthcare feedback. DHSC guidance on the expectations for ICBs aims to mitigate this risk.

Risk of duplicating LHW functions during transition

Each of the 153 LHW organisations are commissioned by a local authority and operates on individual contracts over varying lengths of time. If existing contracts are left to come to a 'natural end', some costs may occur during the transition phase as functions may initially be duplicated between a LHW organisation, an ICB and a local authority.

If those individual contracts come to an end at different times, the proposed legislative changes and the transfer of functions may come into effect at different times in different areas. If this was the case, there is a risk that during this transition phase LHW functions could be duplicated between ICBs (particularly where ICB boundaries are changing). This risk may be minimised by utilising the exit clauses within each contract, to ensure ICBs and local authorities take on the functions at the same time.

Risk of misalignment across the health and social care system

Currently, LHW organisations fulfilled functions relating to both social care and healthcare. The changes proposed in this bill mean ICBs will be responsible for collating feedback on the services they commission and local authorities will be responsible for collating feedback on their social care and public health functions. This could risk creating differences in how data collections, patient and user engagement, and research are conducted and used. Therefore, a holistic view across the whole person experience of health and social care (as LHW do for their areas at the moment) could be lost This could be mitigated through clear guidance issued to local authorities and ICBs, with the aim of establishing expectations regarding key national insights. Health and Wellbeing Boards (HWBs) are formal committees of the local authority charged with promoting greater integration, which ICBs sit on. Therefore, HWBs could also have a role in ensuring the feedback is brought together to inform commissioning to mitigate this risk.

Equalities impacts

Any risks relating to those with protected characteristics as a result of these policy proposals are considered in more detail in the equalities impact assessment (EQIA). Please see the Health Bill equality impact assessment.

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.

Specific monitoring and evaluation considerations for this proposal

As the policy develops, and while legislation is laid, Implementation Project Board(s) will be established. These Boards aim to provide robust governance, accountability and oversight of the abolition and transition of responsibilities.

For this proposal, monitoring and evaluation will likely draw upon reporting and financial data from local authorities, ICBs and CQC, interviews with employees at local authorities, ICBs and CQC and interviews with patients using the service.

The exact questions that the post-implementation review will cover are to be determined but may aim to investigate questions such as:

- Has the abolition of HWE and LHW organisations helped to consolidate and simplify patient safety functions?
- Has the abolition of LHW organisations enabled more informed and efficient care planning because engagement is managed by ICBs and local authorities?
- Have the benefits of the abolition of HWE and LHW as set out above outweighed any additional administrative or financial burdens?
- How well have ICBs and local authorities taken on their new responsibilities?
- Have any unintended consequences been observed, such as the patient voice not demonstrably featuring in service design?
- Do patients and service users feel able to provide meaningful feedback to providers directly?

Final stage impact assessment

Title: Transfer of Health Services Safety Investigation Body (HSSIB) functions into the Care Quality Commission (CQC)

Type of measure: Primary Legislation

Stage: Final

Source of intervention: Domestic

Department or agency: DHSC

Other departments or agencies: wider engagement with CQC

IA number: DHSCIA9717

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026)

Total net present social value (in £m):

Business net present value (in £m):

Net cost to business per year (in £m):

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

- the Dash review of patient safety across the health and care landscape established (the Dash review) the need to simplify the patient safety landscape and reduce the number of organisations operating in this area
- the 10 Year Health Plan set out the intention to cut the number of organisations, bodies and entities that increase complexity in the health care system
- legislative action is needed to abolish HSSIB and transfer its functions into CQC

What are the policy objectives of the action or intervention and the intended effects?

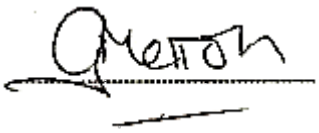
- to simplify the patient safety landscape and reduce the number of organisations operating in this area
- to focus HSSIB's investigations more effectively, with the aim of reducing the number of unimplemented recommendations from reviews, inquiries, and reports to the system

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

- **option 1 (business as usual):** HSSIB continues to operate as a separate body, carrying out patient safety investigations and making national level recommendations, funded through a grant-in-aid
- **option 2 (preferred option):** To transfer HSSIB's functions into CQC, where investigations will continue as a discrete function within CQC

Will the policy be reviewed? It will be reviewed. If applicable, set review date: TBC				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		Traded:	Non-traded:	

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: 8-9-2026

Summary: Analysis & Evidence

Policy Option 2

Description: Transfer of Health Services Safety Investigation Body (HSSIB) functions into the Care Quality Commission (CQC)

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

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

- transition costs for digital, data and technology between £175k and £221k (excluding VAT) are estimated to incur

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

- headcount reductions are possible but uncertain at this point
- there may be short term productivity costs as part of the transition
- CQC may appoint a non-executive director (NED) which would entail a financial cost for recruitment

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				

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

- non-staff members of HSSIB will not transfer to CQC, their fixed term contracts will end, resulting in an estimated saving of £281k per year

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

- providers will receiver more streamlined recommendations, reducing the burden on them to respond and implement recommendations
- streamlining recommendations on organisations aims to improve patient safety

Distributional impacts N/A		
Key assumptions/sensitivities/risks	Discount rate	N/A
• the transition could negatively impact employee productivity, and if staff decided to leave the organisation, knowledge and experience would be lost, which will be mitigated through staff engagement and knowledge management processes • CQC itself is undergoing reform, so HSSIB merging into CQC may risk impacting on the day-to-day operations in CQC, which will be mitigated by close monitoring by DHSC • HSSIB's may risk being perceived to be less independent when it is transferred into CQC, despite it being set up as a discrete arm within CQC, which will be mitigated through organisational design to ensure HSSIB retains independence		

Business assessment (Option 2)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

Background to HSSIB and the CQC

The Health Services Safety Investigations Body (HSSIB) was established in 2023 under part 4 of the Health and Care Act 2022[1] to conduct independent investigations into patient safety incidents within the NHS and independent health care sector in England.

HSSIB currently perform independent systems-based investigations into patient safety issues across the NHS and the independent healthcare services. For example, a recent HSSIB report[1] showed how the 'Patient Safety Incident Response Framework' helps to reduce blame and foster learning for improvement in patent safety investigations, another report[2] highlighted the patient safety risks of 'corridor care' and received widespread attention by the Health and Social Care Committee. As part of their investigations, HSSIB take a systems-based perspective that generates insight that can be used to reduce the likelihood of similar patient safety incidents happening in the future. HSSIB share insight that can support patient safety improvement, and which may be relevant across the whole healthcare system in England. Anyone can make a referral to HSSIB. This includes patients, healthcare providers, commissioners, staff and family members. HSSIB also scan the system for patient safety concerns utilising patient safety data, patient safety incident records, healthcare publications and coroners' reports (Prevention of Future Deaths reports).

HSSIB reviews all referrals against their agreed criteria for investigations. This helps them to understand experiences of people who directly interact with healthcare to ensure that the issues

[1] HSSIB (2025), Investigating under the Patient Safety Incident Response Framework (PSIRF): sharing HSSIB learning for future development — HSSIB (viewed in April 2026)
[2] HSSIB (2026), Patient care in temporary care environments (viewed in April 2026)

they prioritise for investigation have a meaningful impact on patient outcomes. HSSIB publishes reports on around 20 of these investigations a year (19 each in 2023 to 2024 and 2024 to 2025). HSSIB makes recommendations to national organisations. However for those recommendations to have an effect, providers or regulatory bodies ultimately need to take action and respond to them to deliver the safety improvement.

HSSIB reports must not include any assessment of liability or blame, and their reports are not admissible in any proceedings (including regulatory proceedings). There are strict requirements to prevent the unauthorised disclosure of information relating to their investigations, with the aim of encouraging openness and maximising learning without fear of retribution – a 'safe space' for disclosure. HSSIB also provides education and training in safety investigations to the NHS and shares investigation tools and techniques.

The Care Quality Commission (CQC) was established under the Health and Social Care Act 2008 as an independent regulator of health and adult social care providers in England. CQC register, monitor, inspect and regulate provision of health and adult social care services to ensure they meet fundamental standards of quality and safety. When a provider is failing to meet the required standards, CQC may take enforcement action, which in some cases can include prosecution.

Separately, integrated care boards (ICBs) also conduct or commission between 100 and 200 local patient safety incident investigations on an annual basis. Issues are escalated to NHS England by providers and ICBs when they are unable to conduct an effective investigation. NHS England then commissions an investigation which is either carried out by NHS England's regional teams or nationally and is independent of the providers and ICBs. This is separate to HSSIB investigations. ICBs will continue to carry out investigations after NHS England has been abolished.

Problem under consideration

It has long been reported that the health system's safety and regulatory infrastructure is overly complex, unnecessarily cluttered and in need of careful reform[3] [4].

The Dash review reported that over the last 10 years, there has been an increasing focus on the safety of care with a number of high-profile failures. The reaction to these has typically been to set up a public inquiry or review into what went wrong, with subsequent recommendations for changes that often establish new organisations and bodies external to the mainstream work of the commissioners and providers of care. While this is understandable, it has led to a growth in the number of organisations considering safety and the wider quality of care, with the resulting impact of a cluttered landscape.

The Dash review states that a number of bodies, including HSSIB, are working to review, investigate and improve patient safety (finding 3). HSSIB was established to build skills and capabilities in order to carry out investigations into cases of severe harm and, for example, CQC also has the power to conduct reviews or investigations. Therefore, HSSIB and CQC currently overlap in their functions including measurement and investigation (as primary functions) and engagement (as secondary functions).

Finding 3 within the Dash review also found that (inquiries and reviews) recommendations vary in quality; some are contradictory or overlap. The level of complexity and volume of recommendations is a challenge for health and care providers. Which may result in a slower or lack of implementation and ultimately prevent effective patient safety improvement.

[3] Vincent C., and others (2020), Redesigning safety regulation in the NHS | The BMJ (see abstract) (viewed in August 2025)
[4] Oikonomou E., and others (2019), Patient safety regulation in the NHS: mapping the regulatory landscape of healthcare | BMJ Open (p.7) (viewed in August 2025)

Finally, the Dash review found that the number of recommendations is overwhelming for the NHS and the system ('finding 3' that there is a need to effectively investigate patient safety concerns without over burdening the system with recommendations).

Rationale for intervention

Without intervention the overlapping functions set out above will remain; there are too many organisations carrying out reviews and investigations, or looking at user experience. Along with other measures set out in the Dash Review (for example in relation to the National Quality Board discussed further below) this intervention is intended to support a reduction in the number of unimplemented recommendations from inquiries and investigations. This can also cause confusion for patients and users who do not know where to turn to provide feedback or raise concerns.

HSSIB was established through legislation, therefore, to implement the recommendation of the review and to meet the commitments made in the 10 Year Health Plan for England, government action is required to make required changes to legislation. Government oversight is required to ensure the functions HSSIB are transferred effectively into CQC and that CQC operate an investigation function that operates discretely from its regulatory functions.

Description of options considered

Option 1: business as usual

This option retains current arrangements, with HSSIB operating as a separate body.

Option 2 (preferred option): transfer the functions of HSSIB to the CQC

HSSIB functions will be transferred to CQC as part of a wider effort to simplify the regulatory landscape. Where this impact assessment refers to the transfer of functions, the functions will, in legislation, be repealed and conferred on CQC. These functions within CQC will operate as a discrete unit preserving the independence of investigations.

Policy objective

The overall objective is to improve outcomes for patients. This bill aims to simplify the patient safety landscape and reduce the number of organisations operating in this area (focused on commissioners, providers and regulators). The aim is to enable investigations to be more focussed, which could help reduce the number of unimplemented recommendations from reviews, inquiries and reports to the system.

The overall outcome for this intervention is that there will be fewer organisations in the patient safety landscape.

Summary and preferred option with description of implementation plan

To initiate the changes required to simplify the patient safety landscape the government must make changes to legislation. This bill proposes to transfer the functions of HSSIB to CQC, expanding the role of CQC to cover investigations in addition to their regulatory role. The CQC will then establish a discrete unit to perform these functions. HSSIB will therefore be abolished as a separate body, with its' staff, property and liabilities to be transferred to CQC.

The new investigation function in CQC will obtain the same 'safe space' powers that currently exist in HSSIB. It will also be independent from the other regulatory functions of CQC and will

continue to make recommendations to CQC's regulatory arm as it currently does. There will be mechanisms in place to ensure that information is not passed between the new investigation function of CQC and the wider existing regulatory functions of CQC, which are much broader and cover not just the NHS but social care, GPs and dentists. These mechanisms to protect the disclosure of information between the investigation and regulatory function are an important part of maintaining trust in the investigation function that has been built up by HSSIB.

There will no longer be a Chief Investigator in legislation, however CQC will be required to appoint a 'person responsible for disclosure'. As this person will be responsible for ensuring disclosures of material fall within the relevant exceptions and CQC will have the flexibility to appoint a NED with experience in patient safety and governance, (however this will not be mandated in legislation and will fall under the general powers held by CQC to appoint NEDs) we expect the impact of the removing the Chief Investigator role to be minimal.

The new function in CQC will not be expected to provide a separate annual report to parliament. However, the unit will report on its logistics and running of its functions (rather than the contents of its investigations) to CQC, which will then be included within CQC's annual reporting process. The discrete investigation function of CQC will continue HSSIB's legacy to be a centre of excellence for investigations.

The Secretary of State for Health and Social Care (Secretary of State) can already request a review of CQC's performance at any time, which will apply to the new investigation function once established. The Department for Health and Social Care (DHSC) will provide funding to CQC for the running of the investigation's unit. Subject to business planning it is anticipated that funding will be ringfenced via Grant in Aid. This is similar to how CQC is funded for its current activity that cannot be recovered through fees charged to registered providers, such as enforcement activity for breach of regulations and monitoring the Mental Health Act.

As well as bringing a more strategic approach to the commissioning of safety investigations, merging HSSIB into CQC will also result in better planning and utilisation of financial resources, and there will be economies of scale savings, such as from removing the costs of the HSSIB Board, and potentially corporate services (like finance and HR).

Following the proposed changes in this bill, members of the public, providers and commissioners will still be able to make referrals. CQC will issue communications to the public, providers and commissioners. The new investigation function will continue with the role of scanning the system for patient safety concerns and incidents.

However, as recommended by the review, the National Quality Board (NQB) will provide stronger direction on the investigations carried out by the investigation function using the powers that already exist for the Secretary of State to direct investigations. The review states that '*each of these national bodies, inquiries and reviews considers different elements of safety, sometimes in response to previous problems and cases of unsafe care. However, the disparate nature of them results in the lack of a coherent national message, and a lack of ownership*.' And recommends that '*HSSIB should collaborate with DHSC (through NQB) to agree the scope of any investigations it carries out.*'

Additionally, in line with recommendation 1 of the Dr Dash review and the commitments of the 10 Year Health Plan, the NQB has been revamped, with its role significantly enhanced. As part of this revamp, the NQB (on behalf of Ministers) will strategically direct the new investigation arm of CQC for the vast majority of its investigations to focus on issues of importance for the wider NHS. The NQB will be responsible for the prioritisation of any recommendations generated by these investigations. This will form part of the wider clearing-house function of NQB to manage the response to other inquiries and quality (including safety) related recommendations.

The improvements relating to NQB do not require legislation so are happening separately to this bill and are not assessed in this impact assessment. The NQB was re-established in September 2025 and will be further strengthened in order to work with the new investigation arm when it is established. The investigation unit will retain discretion to initiate its own investigations too. With the NQB providing clear direction to the new investigation unit, it is aimed that the unit will be used in a more strategic way, better aligned to the agenda of the NQB, and minimising the number of commissioned reviews and inquiries. The investigation unit will also be able to continue to perform its education function, strengthening its role in advising and supporting best practice in local investigations. Sharing learning and retaining its role in upskilling local health organisations to perform their own investigations.

To oversee the operational actions required to close and transfer the functions of HSSIB a task and finish implementation board will be established, with membership from CQC, DHSC and HSSIB to manage the transition, consider potential transitional costs, ensure risks and issues are logged and mitigated; and develop and implement a communication plan for staff. Details of this board are to be determined and will be in line with any legislative timetable.

Monetised and non-monetised costs and benefits of each option

The costs and benefits have only been quantified and set out for the preferred option as this section focusses on the differences between the business-as-usual option and the preferred option.

This impact assessment provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HM Treasury (HMT) Green Book guidance[5].

Option 1: business as usual

In line with HMT's Green Book guidance, the costs of business as usual have been quantified in absolute terms to compare to the preferred option.

The cost to continue business as usual is represented by the cost of continuous HSSIB funding via a grant-in-aid. This was £5.9 million in the financial year 2024 to 2025[14]. HSSIB employs 44 full time equivalent (FTE) staff and as an entirely remote organisation with no physical offices has no costs to maintain estates. HSSIB is governed by a board, with a chair, a chair of the Audit and Risk Assurance Committee, a chief executive officer and 5 NEDs alongside the directors of the 2 branches: investigation and insight, and business services.

Additional costs to the public arise from families', carers', patients' and staff participation in HSSIB's investigations; these costs would be very challenging to quantify and vary from investigation to investigation. Given that investigations will continue under the preferred option the difference between these costs under BAU and the preferred option are likely to be negligible.

Option 2: Transfer of HSSIB functions into CQC

Monetised Costs

Transition costs: digital, data and technology

There will be one-off transition costs associated with the integration of digital, data and technology. These costs have been estimated by CQC's IT department and include CQC

[5] HMT (2026), The Green Book - GOV.UK (viewed February 2026)

personnel resource, external IT supplier work package costs, and hardware and migration tool licensing costs. The estimated total cost of this transition ranges from £175,000 to £221,000 (excluding VAT). Any ongoing CQC IT support for the investigative arm has not been included in these transition costs but would be expected to be absorbed within CQC's Grant in Aid.

Non-monetised Costs

Transition costs

The costs of short term productivity loss are uncertain and carry associated risks which are addressed in the risk section. Creating a new organisation may impact on productivity as the working arrangements and cultures of two organisations are brought together. The impact on productivity could pose as a delivery risk for the new investigation unit's investigations.

In 2019, the Institute for Government noted the potential for high costs in lost productivity resulting from mergers.[6] There is also the potential for reduced employee satisfaction, if the transition is prolonged. A survey by the National Audit Office (NAO) found that following reorganisations in central government, three-fifths of respondents reported short term declines in staff morale and a third reported a short term decline in staff productivity.[7]

Continued staff engagement and consultation with unions aims to minimise this cost.

There may be some additional transitional costs (like associated data transfer and legal), however their precise scale will be determined through the task and finish board discussed above. These are expected to be relatively small. CQC have the flexibility to appoint a NED for patient safety. This role would be fulfilled without increasing the total number of CQC NEDs. Although CQC will fulfil the corporate functions of the investigations unit, there may be a small financial cost associated with recruitment. This cost has not been estimated in this impact assessment as there is uncertainty surrounding the recruitment of a NED, which will be a future operational decision by CQC.

Monetised Benefits

Recurrent pay savings

Non-staff members of HSSIB's board will not move over to CQC. This includes the chair, the 5 NED's, the Assurance and Risk Committee chair and the CEO. They are employed on fixed-term appointments which will come to an end as part of HSSIB's transition into CQC. Therefore, no redundancy costs will apply but recurrent pay savings[15] of around £281,000 per year (in 2026 to 2027 prices) are expected.

Table 1: Annual pay savings from HSSIB leadership, in 2026 to 2027 prices. All figures shown in £ thousands. Due to rounding figures may not sum to the totals.

Role	Annual pay saving, thousands (£)
CEO (1)	164
Chair (1)	64
Assurance and Risk Committee Chair (1)	13
NEDs (5)	40

[6] National Audit Office (2024), Progress with the merger of the FCO and DFID - NAO report, page 44 (viewed September 2025)
[7] National Audit Office (2010), Reorganising central government - NAO report, page 13 (viewed September 2025)

Total	281

Non-monetised Benefits

Streamlined patient safety landscape

As a result of HSSIB functions transferring to CQC, a reduced number of organisations will operate in the patient safety landscape. Patients will be able to contact one organisation (CQC) to raise any issues which lead to investigation, simplifying patient engagement with the system. This simplification, alongside other changes being made to the patient safety landscape such as an enhanced role for the NQB, aims to reduce the number of unimplemented recommendations from inquiries and investigations.

Improvements in patient safety

The aim is for the patients' experience to be similar to now. The functions of HSSIB will be lifted into CQC. Therefore, patients will follow the same process to raise concerns with the new investigative function within CQC and the outcomes will be reported to them in the same way as currently. The simplification of the patient safety landscape and a reduction in the number of unimplemented recommendations is intended to improve safety for patients and service users.

Wider considerations

Estates costs

HSSIB operates as an entirely remote organisation[16], CQC allows for home working, hybrid, and office working[17]. As of November 2025, staff are expected to retain their current working arrangements including the option to work fully remote. Therefore, this impact assessment does not assess costs regarding estates, although some employees may wish to change their working arrangements and if they did the cost implications would be very small.

Redundancy costs

While this legislation enables HSSIB functions to transfer to CQC, it does not directly lead to reductions in headcount. Following the transfer of functions, CQC would be able to consider the structure and size of the new investigation unit, however that would be a future decision outside the scope of this assessment. Depending on their length of service there may be redundancy costs for senior staff members. Any financial implications of any changes to the structure would I need to be agreed with DHSC.

Direct costs and benefits to business calculations and impact on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and mitigations

Loss of institutional knowledge

The process of transferring staff may lead to higher attrition rates than business-as-usual operations. Previous experience of mergers has been that a high turnover of senior leadership slows progress and risks the loss of corporate knowledge and expertise.[8] This means the CQC could lose institutional knowledge from expert employees currently working in HSSIB.

[8] National Audit Office (2024), Progress with the merger of the FCO and DFID - NAO report, page 27 (viewed September 2025)

Loss of institutional knowledge and experience risks affecting the new investigation unit's ability to perform its functions effectively. This is because it takes time to train new staff and inefficiencies could arise.

This risk aims to be mitigated through staff engagement and consultation with unions to make the transition as smooth as possible for staff. Knowledge management processes are in place to mitigate against the risk of losing organisational knowledge in the process. Should there be an unexpected high rate of staff turnover, this could impact on completion of investigations. A transformation board will be set up to facilitate and oversee the transition, ensuring risks are effectively mitigated. However, the details of this transformation board are to be determined.

Delivery risks

CQC itself is undergoing changes following the Review into the operational effectiveness of CQC[18]. Further reform, with HSSIB merging into CQC may create a delivery risk for CQC to deliver its' functions. However, the impact of the overall transformation of CQC on the delivery of its' functions will be closely monitored by DHSC. DHSC will gain assurance that CQC is fit and ready to take on HSSIB functions in advance of the point of transfer.

Reputational loss

HSSIB's "global reputation"[19] may be impacted as it transfers to CQC. The intention is to ensure that the global reputation as a centre for excellence is protected and enhanced as it moves to become a discrete unit within CQC.

Loss of independence

There is a risk that the investigation unit of the CQC will not be perceived to be as independent for providers as HSSIB currently is. The legislation will make clear that the investigations unit has operational independence within CQC to continue to fulfil the current functions of HSSIB. This will include the same legislative provisions to continue the 'safe space' arrangements that are so important to successful safety investigations. The investigation unit will retain discretion to launch investigations into areas it considers important, alongside direction via the NQB, and will continue to be able to make recommendations to all parts of the NHS system, CQC and DHSC.

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.

Final stage impact assessment

Title: Care Quality Commission (CQC): extending the statute of limitation

Type of measure: Primary Legislation

Stage: Final

Source of intervention: Domestic

Department or agency: DHSC

Other departments or agencies: consulted with Ministry of Justice and the CQC

IA number: DHSCIA9719

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

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

- Prosecution may be used by CQC to hold registered health and social care providers to account for serious breaches of required standards, for operating a service without proper registration, or for obstructing inspections or providing false information in registration applications.
- The current three-year statutory limitation period for the CQC to conduct investigations and commence proceedings for an offence is, at times, inadequate.
- Government intervention is required as changes are required to primary legislation to extend the current 3-year statute of limitation in the Health and Social Care Act 2008.

What are the policy objectives of the action or intervention and the intended effects?

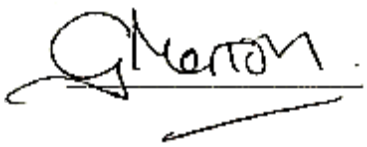
- Extending the statutory period to five-years enables the CQC to review all relevant information, including evidence from coroner inquests, police investigations and statutory notifications.
- The extended period will enable the CQC to potentially pursue few more prosecutions than it would have otherwise before the three-year period ran out.
- This aims to ensure families whose loved ones have suffered serious harm, are able to get justice and closure.

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

- **Option 1 (business as usual):** maintain the status quo at the 3-year statute of limitation.
- **Option 2 (remove the limitation period entirely):** having no limitation period would not achieve timely improvements that DHSC aims to achieve to ensure patient safety and quality of care.
- **Option 3 (preferred option):** extend the statute period from 3 to 5 years.
- The preferred time period of 5 years is based on advice from the CQC and to see timely improvements and justice for families harmed. There are examples of other bodies who investigate and conclude over a 5-year period, for example, the General Medical Council (GMC), although it does not have powers to pursue prosecutions.
-

Will the policy be reviewed? It will be reviewed. If applicable, set review date: TBC				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		Traded:	Non-traded:	

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: 8-9-2026

Summary: Analysis & Evidence

Policy Option 3

Description: Care Quality Commission (CQC): extending the statute of limitation

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

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

There are 2 monetised costs:

- The increased cost of investigations and enforcement to the CQC (£4.3m over 10 years), and
- The cost of additional cases in the Magistrates Court (£0.02m over 10 years).

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

There are 2 non-monetised costs:

- cost to CQC to prosecute an additional 2-3 cases per year.
- costs to defendants who are found 'Not Guilty'.

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				

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

- An increase in prosecutions would be expected to lead to a proportionate increase in the fines and victim surcharges paid by those found guilty (£2.7m over 10 years).
- The additional fines have no overall economic benefit to society. The cost of the fine is equal to the revenue benefit to Government, and so they do not make society as a whole better or worse off. They are presented for completeness.

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

- The non-monetised benefits of this policy are securing justice and holding a service provider to account by an independent regulator on behalf of families impacted by poor standards of care, resulting in serious damage to health or premature death.
- Prosecution is an alternative means to accelerate improvement in poor standards of care and provide learning opportunities for providers to give better care.

Distributional impacts N/A		
Key assumptions/sensitivities/risks	Discount rate	N/A
• Costs and benefits are in 2026 to 2027 prices and have not been discounted. • The costs and benefits are assumed to occur from 2029 to 2030 onwards, as the increase in the statute of limitation will take effect on incidents which occur from the enactment of the Bill onwards. • CQC enforcement and investigation costs are demand led. The cost estimates presented here are initial, based on the activity data currently available. • The implementation of the policy, without additional opportunity costs, would rely on CQC's future Grant in Aid increasing proportionately, which will be a matter for a future Spending Review.		

Business assessment (Option 3)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

When the Care Quality Commission (CQC) finds evidence of a breach of regulations and fundamental standards under the Health and Social Care Act 2008, and associated regulations, it follows its enforcement policy and decision tree to determine appropriate action. This may include civil enforcement to protect service users and criminal enforcement to hold providers accountable, provided the latter meets the 2-stage test from the Code for Crown Prosecutors.

The statutory limitation period for CQC offences is set out in Section 90(2) of the Health and Social Care Act 2008. It also provides that proceedings for a Part 1 offence must be brought within 12 months from the date evidence sufficient to warrant proceedings came to the prosecutor's knowledge, and no more than 3 years after the commission of the offence.

Problem under consideration

Prosecution may be used to hold individuals to account for serious breaches of required standards, for operating a service without proper registration, or for obstructing inspections or providing false information in registration applications[1].

Due to delays in receiving statutory notifications from providers of deaths and serious incidents of harm, and challenges in gathering information and evidence while conducting regulatory investigations, CQC can 'run out of time' to bring a prosecution against a provider. Although the CQC requires that deaths of people using services be reported "without delay"[2], delays still occur which can hinder proceedings. NHS trusts may also carry out internal investigations, for example under the Patient Safety Incident Response Framework[3], before sharing findings with CQC.

Incident notification also comes from other sources such as coroners, local authority safeguarding, police, whistleblowers and family members of deceased patients and service users. Based on the intelligence provided by CQC, this information often arrives late, meaning that CQC are limited in what they reasonably can do in the time remaining before limitation expires.

As a general principle, and to avoid duplication of process, inquests are typically suspended pending the completion of any associated investigations. This is also a statutory requirement where related criminal proceedings are underway.

Evidence to support intervention

The CQC stated that there have been many cases, although exact numbers had not been recorded, where they have been unable to gather sufficient evidence to make a charging decision before the statute limitation period expired.

There are several reasons why investigations could be delayed. Police and coroner parallel processes can be lengthy. For example, coroner statistics state that in 2024, 18% of inquests took over a year, with certain coronial regions, such as Lincolnshire, averaging over 40 weeks

[1] Care Quality Commission (2025), Holding providers and individuals to account - Care Quality Commission (viewed in August 2025)
[2] Care Quality Commission (2025), Regulation 16: Notification of death of service user - Care Quality Commission (Viewed in August 2025)
[3] NHS England (2015), Serious Incident Framework - supporting learning to prevent recurrence (viewed in August 2025)

for the time taken to process an inquest suggesting lengthy timelines[4]. Moreover, police investigations can also delay proceedings, as the CQC may be unable to access critical evidence or witness statements indicating provider-level failure. While police and Crown Prosecution Service data for early 2025 relating to all prosecutions, not just CQC, suggest median case times of 26 days (no victim) to 39 days (victim-based), more complex cases can extend for several years[5].

Occasionally, the CQC have less than 3 years from the date of an incident to start an investigation. Evidence from CQC states that the enforcement team needs at least 9 months remaining on the limitation clock to investigate fully, meaning that investigations could start within 2 years and 3 months of the incident, increasing the potential for delays. There have been exceptions, some cases have proceeded with only 4 or 8 months left, and one was presented to CQC's criminal panel with just 7 weeks remaining following a coroner's ruling. However, the current 3-year time constraints put significant pressure on CQC's legal and enforcement teams, and investigations may conclude at or near the limitation date.

Importantly, delays can also deny families the justice they deserve. Research into the long-term impacts faced by patients and families after harmful healthcare events suggests that medical errors can leave 'psychological scars' that can last over 10 years for patients and families as a result of medical errors[6]. While inquests can play a role in restoring a sense of justice, the 'Voicing Loss' study highlights the need for greater support and meaningful involvement of bereaved people through these proceedings[7]. For many, closure is vital to the grieving process[8]. Ensuring a legal framework that allows prosecutions to proceed despite unavoidable delays is therefore essential to delivering justice and helping families move forward. An extended statutory period would enable CQC to conclude more investigations and support families in drawing closure.

Rationale for intervention

It is felt that the current period results in injustices in cases where a prosecution could not be brought within 3 years. The 10 Year Health Plan for England does not stipulate the period for an extension to the limitation, however, it commits the government to making a change:

> *We will change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider, to allow more cases to be comprehensively reviewed and acted upon. We know that the current 3-year restriction has caused considerable concern to some individuals and families who have suffered harm. We hope this change will provide assurance and help bring victims confidence we have learnt from their experience to improve the system for families seeking justice in the future.*

Government intervention is required as primary legislation must be changed to extend the current 3-year statute of limitation. Extending the statutory period to 5 years would allow other investigations to conclude, provide time to gather and analyse evidence from multiple sources, and ensure that serious breaches can be pursued effectively. This will support greater transparency and learning from failures in quality of care.

[4] Ministry of Justice (2025), Coroners statistics 2024: England and Wales - GOV.UK (viewed in August 2025)
[5] Criminal justice system (2025), Crime recorded to police decision - CJS Dashboard (viewed in August 2025)
[6] Ottosen, M., Sedlock, E., Aigbe, A. and others (2021), Long-Term Impacts Faced by Patients and Families After Harmful Healthcare Events - PubMed (viewed in August 2025)
[7] P7Locating bereaved people within the coronial process, Voicing Loss, Policy Brief No2 (viewed April 2026)
[8] Home Office (2025), Learning from loss: ensuring the lessons from domestic homicide reviews lead to change (accessible) - GOV.UK (viewed in August 2025)

Description of options considered

As the approach set out in the 10 Year Health Plan was not specific on the approach to changing the CQC time limit, an additional option has been set out below. This includes rationale as to why this option was not deemed preferred.

Option 1: business as usual

This option retains the 3-year statute of limitation.

This was not the preferred option based on CQC's information about barriers (timely notifications and access to information) to bring prosecutions within the existing 3-year limitation period. It was investigated how long it takes on average for the police and the coroner to conclude their investigation and the statistics (see page 6) suggest only a small number of police investigations or coroner inquests could be a barrier to CQC's timely investigation and prosecution. However, it cannot be ruled out that timely notification of serious incident to the CQC, could be a factor because of the number of sources that notifications come from.

Option 2: remove the statute of limitation period entirely

This option removes the statute of limitation period entirely.

The 3-year limitation was originally intended so that service providers would address failings identified by the CQC and make timely improvements to ensure patient safety and quality of care. The difficulty of budgetary planning was considered, for costs incurred by the CQC for enforcement activity and prosecutions, of removing the limitation period entirely. CQC is required to follow the principles in HMT's guidance *Managing Public Money* that does not allow costs of prosecutions and enforcement activity to be recovered through income from provider fees.

Option 3 (preferred option): extend the statute of limitation period from 3 years to 5 years

The preferred option is to extend the statute of limitation period from 3 years to 5 years.

The preferred time period of 5 years is based on advice from the CQC. There are examples of other bodies who investigate and conclude over a 5-year period, for example, the General Medical Council, although it does not have powers to pursue prosecutions.

In addition, an extension to 5 years, rather than 10 years or repealing the limitation altogether, also takes into account that historical breaches of regulations or failures would hang over service providers or staff during that period. The unintended consequences of extending to 10 years or a limitless period could impede improvements in poor care and families could wait longer to get due justice and closure.

Policy objective

The extension from 3 years to 5 years is to ensure that CQC have sufficient time to access all the information to inform and conclude its independent investigations, pursue prosecution where tests are met (by following the Code for Crown Prosecutors), accelerating improvement, and learning lessons by all concerned. The extended period from 3 years to 5 years will give the CQC a better rate of success with prosecutions that meet the threshold, where previously the 3-year period has been a limiting factor.

In line with the ambitions of the 10 Year Health Plan, this change will provide assurance and help build victims' confidence to improving the system for families seeking justice in the future. The intended policy objective is to reduce possible injustice by extending the period in which the CQC can bring proceedings for the relevant offences.

CQC's primary function remains to prioritise quality and safety which this provision supports. This change will allow more cases to be comprehensively reviewed. A provider being subject to a more robust enforcement process, will provide assurance to victims that a provider has learnt and acted upon their experience to improve the service for better patient outcome and experience, which is a key aim of the 10 Year Health Plan.
While CQC is not part of the 17 most economically significant regulators in the government's Regulatory Action Plan[9], it is included in the expanded scope and CQC have outlined their plans (with timings) for reviewing and simplifying duties to make them more growth focused.

Summary and preferred option with description of implementation plan

Under the preferred option, Section 90 of the Health and Social Care Act 2008[10] would be amended to extend the absolute limitation period from 3 years to 5 years. Section 90 has existed in its current form since commencement of the act in January 2009; therefore this measure will be extending an existing provision. No amendments have been sought to the 12-month limitation (that prosecutions must be brought within 12 months of facts warranting prosecution being known). The dual limitation encourages prompt action once credible evidence emerges (within 12 months) and sets an outer cut-off of 5 years from the offence to promote fairness and legal certainty. Additionally, removing it entirely would put providers at risk of enforcement for historic incidents.

While the CQC does have enforcement powers, including prosecuting providers who fail to meet required standards, their main function is regulation and inspection rather than prosecution alone. Extending the statute of limitation will provide the CQC with sufficient time to gather information from other investigations (including provider internal investigation, coroner inquest, police). Providers will be held to account for their failures and learn from serious incidents to make improvements to their services to ensure the public receive safe care. It will also give bereaved families assurance that time limitation will less likely be a factor in whether CQC pursue a prosecution or not.

Monetised and non-monetised costs and benefits for each option

The costs and benefits have only been quantified and set out for the preferred option as this section focusses on the differences between the business-as-usual option and the preferred option.

The increase in the statute of limitation will take effect on incidents which occur from the enactment of the bill onwards. It is assumed that no costs or benefits are incurred in the first 3 years after commencement. Costs and benefits are shown as occurring from 2029 to 2030 onwards.

[9] HM Treasury (2025), New approach to ensure regulators and regulation support growth (HTML) - GOV.UK (viewed March 2026)
[10] Legislation.gov.uk (2010) Health and Social Care Act 2008, section 90 (viewed March 2026)

Table 1 below provides a summary of the monetised costs and benefits. The figures have not been discounted and are in 2026 to 2027 prices.

Table 1: Summary of quantified costs and benefits (£m)[11]

Annual Costs (£m)	From 2026 to 2027 up to 2028 to 2029	From 2029 to 2030 up to 2035 to 2036	**Total (£m)**
Additional CQC Costs	0	0.6	**4.3**
Additional Magistrates Court Sittings	0	0.003	**0.02**
Total	0.0	0.6	**4.3**

Annual Benefits (£m)	From 2026 to 2027 up to 2028 to 2029	From 2029 to 2030 up to 2035 to 2036	**Total (£m)**
Fines & Victim Surcharge	0	0.4	**2.7**

Monetised costs

There are 2 monetised costs:

- The increased cost of investigations and enforcement to the CQC, and
- The cost of additional cases in the Magistrates Court.

CQC enforcement and investigation costs

CQC have provided an indicative cost estimate of **£0.6m per annum** for the additional investigation and enforcement activity associated with this change. Enforcement activity is inherently demand-led, meaning the actual number of investigations and their duration can fluctuate year-on-year. This figure represents the *best available assessment* based on current activity levels and cost assumptions.

The following caveats apply to this indicative cost:

- the increase in costs above is an initial estimate based on the activity data currently available
- the overhead cost and non-pay used to produce this initial estimate are based on CQC averages
- further work is needed to understand exactly what type of activities will be undertaken

  the enforcement activity is demand led, therefore the indicative estimates are based on current activity levels

Magistrates Court costs

The CQC estimate that this change will result in 2 to 3 additional prosecutions per year, which are generally heard in the magistrate's court. For simplicity, it is assumed that 3 additional

[11] Totals do not add due to rounding

cases are heard in the magistrates each year. The Ministry of Justice (MoJ) estimate that the cost of these additional cases, in total, will be £2,500 per annum 2026 to 2027 prices.

Non-monetised costs

Cost of additional prosecutions

There will be a cost to CQC to prosecute an additional 2 to 3 cases per year. However, the cost to the CQC of prosecuting individual cases varies widely, depending on the individual circumstances of the case. Analysis of the prosecution cost schedule presented by CQC to court in 5 cases, showed CQC costs ranging from £8k to £80k per case.

CQC have a very low trial rate, and a high early guilty plea rate (around 93%). If matters go to trial, or if defendants try to challenge the prosecution on legal technicalities, then costs of bringing the cases to court will be far higher.

The average cost awarded by the court between 2009 to 2010 and 2024 to 2025 was £20k (in 2026 to 2027 prices). However, the range of costs awarded by court over this period is wide, from £500 to £140k. This reflects differences in the complexity of individual cases.

The cost awarded by the court do not include the full cost of all activity undertaken on a case by CQC operational colleagues (for example inspectors or senior specialists or national advisors), national investigators, and legal colleagues (see monetised costs on page 8). They represent a proportionate estimate of cost to put before the courts.

Given the very small, expected number of prosecutions each year, and the wide range of costs per case, it is not possible to monetise this cost.

Costs to defendants who are found "Not Guilty"

This measure will increase the number of investigations by CQC. Impact assessments do not assess the costs of being investigated and prosecuted for those who are found guilty. However, it is possible that an increase in the number of cases investigated by CQC will increase the costs for those found not guilty.

This cost has not been monetised, as it would be disproportionate to do so. However, for some context, between 2009 and 2025 the CQC took forward 113 prosecutions, of which 112 were successful and one was found not guilty. Across these prosecutions, 164 charges were considered, 163 charges were found guilty, and one not guilty.

Monetised benefits

An increase in prosecutions would be expected to lead to a proportionate increase in the fines paid by those found guilty. Fines are primarily there to act as an incentive to adhere to CQC regulations, but they also transfer revenue back to central government and increase the amount available through the victim surcharge. To note, fines do not form direct income retained by CQC, they are passed on to the Secretary of State for Health and Social Care as per section 86 of the Health and Social Care Act 2008[12].

[12] Legislation.gov.uk (2009), Health and Social Care Act 2008 - Section 86 (viewed March 2025)

Between 2009 to 2010 and 2024 to 2025 the average fine paid was £130k and the average victim surcharge was £150 (all in 2026 to 2027 prices). This impact assessment assumes the changes are applied only to incidents which occur after commencement, which is estimated to lead to 3 additional prosecutions per year from 2029 to 2030 onwards. As a result, the increase in fines and victim surcharges paid by guilty defendants would be in £390k per year, and a total of £2.7million in the first 10 years of the policy.

Table 2: Monetised benefits

Annual Benefits	From 2026 to 2027 up to 2028 to 2029	From 2029 to 2030 up to 2035 to 2036	**Total (£million)** [13]
Fines & Victim Surcharge per annum (£million)	0	0.4	**2.7**

However, this is an uncertain estimate as it is expected that there would be 2 to 3 cases per year and in the calculations, it is assumed that there are 3 cases per year. Furthermore, the value of fines varies widely between cases, for example, the average fine paid in 2009 to 2010 was £2,400 whereas the average fine paid in 2022 to 2023 was £410,000 (all in 2026 to 2027 prices).

These additional fines have no overall economic benefit to society, as the cost of the fine is equal to the revenue benefit to the government, and so they do not make society as a whole better or worse off (as stated in HMT's Green Book[14]). The estimate of additional fine revenue is presented here for completeness.

The wider benefits of this policy have not been monetised.

Non-monetised benefits

The non-monetised benefits of this policy are securing justice and holding a service provider to account by an independent regulator on behalf of families impacted by poor standards of care, resulting in serious damage to health or even an early death.

A prosecution is an alternative means to accelerate improvement in poor standards of care, as well as a learning point for providers, to give better care.

Direct costs and benefits to business calculations and impact on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and mitigations

Risk of reduced focus on the wider determinants of health at system level

[13] Totals do not add due to rounding
[14] HM Treasury (2026), The Green Book (2022) - GOV.UK, section 6.3 (viewed March 2025)

The implementation of the policy, without additional opportunity costs, would rely on CQC's future Grant in Aid increasing proportionately, which will be a matter for a future spending review.

The work CQC has underway on making improvements to their internal processes will mitigate against risks of the 5-year extension being insufficient to complete investigations and bring legal action against providers. The work to make improvements includes increased engagement and improved relationship management with coroners, local police services and the Crown Prosecution Service.

The creation of a dedicated National Enforcement Team within the CQC has built up expertise and together with the Operations Team, a pilot is testing the process when the Operations Team receive notification of a specific incident, investigators in the National Enforcement Team carry out an initial assessment and triage of that information to determine whether there is the potential for a specific incident that needs to be progressed via CQC's enforcement policy. The pilot will be evaluated to determine what changes are required to CQC's internal processes for efficiencies.

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.