Summary: Intervention & Options

Department /Agency:	Title:	
DH	Impact Assessment of a Code of Practice for Health & Adult Social Care & Guidance - plus care home information	
Stage: Final	Version: 1	Date: 8 December 2009

Related Publications: i-Code of Practice for health & adult social care on prevention and control of infections and related guidance ii-Prevention & control of infection - care homes

Available to view or download at:
http://www.dh.gov.uk/en/Consultations/index.htm

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

The current Code of Practice & related guidance only apply to NHS bodies. During 2010, NHS bodies & providers of adult social care & independent healthcare, will be registered against the same registration requirements, which includes infection control. The new Code & its related guidance, and the supporting practical information for care homes, take account of this. Infections can spread and impose costs on other parties, including the NHS, and best practice guidance is a public good which is most efficiently produced once rather than multiple times; both these support a role for government.

What are the policy objectives and the intended effects?

To ensure that best practice is consistently applied in all sectors so that the number of infections can be reduced and benefit service users. The aim is to ensure the application of the Code of Practice (CoP) is proportionate.

What policy options have been considered? Please justify any preferred option.

1. Produce a CoP without related guidance/care home advice leaving it to registered providers and the Care Quality Commission (CQC) to interpret the CoP. This option has been rejected. 2. Produce a CoP and related guidance emphasising flexibility for providers of regulated activities. This allows local determination based on risk assessment and proportionality and will act as a guide to interpretation of legislation and compliance. 3. Do nothing: the assessment uses this as the baseline.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? Review of the effectiveness of the CoP and guidance will be part of the CQC inspection process. [Their impact will be evaluated by 2015.]

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

..... Date: 14-12-09

Summary: Analysis & Evidence

Policy Option: Option 2	Description: A Code of Practice and related guidance plus supporting practical information for care homes

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ 11.5 million	1
Average Annual Cost (excluding one-off)	
£ 1.1 million	

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

Costs will fall, predominately, on adult social care, in terms of reviewing current practices, keeping records and making information available as required by the Code. See Impacts and Costs section.

Total Cost (PV) **£ 20.8 million**

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

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ 0	1
Average Annual Benefit (excluding one-off)	
£ 2.9 million	

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

Benefits monetised here are potential benefits from preventing cases of infections amongst patients and care home residents. See Benefits section.

Total Benefit (PV) **£ 24.7 million**

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

Improved quality of life from reduced infections. Since the Code, and its related guidance, formalises best practice in many instances, any further benefits have not been explicitly identified.

Key Assumptions/Sensitivities/Risks

There are uncertainties around the amount of time needed to review current practices, about the extent of current compliance, and about the impact on infections. Hence there is a risk that the overall net impact may diverge from our estimates by perhaps around 50%.

Price Base Year 2009	Time Period Years 10	**Net Benefit Range** (NPV) **£ 2 to 6 million**	**NET BENEFIT** (NPV Best estimate) **£ 3.9 million**

What is the geographic coverage of the policy/option?			England	
On what date will the policy be implemented?			Apr/Oct 2010	
Which organisation(s) will enforce the policy?			CQC	
What is the total annual cost of enforcement for these organisations?			£ 0 nil additional	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			N/A	
What is the value of the proposed offsetting measure per year?			£ 0	
What is the value of changes in greenhouse gas emissions?			£ 0	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small **-£50**	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ xxx Decrease of £ xxx **Net Impact** £ xxx

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

Introduction

1. The Health and Social Care Act 2008 introduces a new registration framework for all providers of regulated activities in health care and adult social care in England. The framework will provide independent assurance of the safety and quality of care and these providers will need to register with the Care Quality Commission (CQC) and meet the same essential levels of safety and quality.

2. The full set of these essential levels, described as 'registration requirements' will be set out in Regulations. The 2008 Act enables the Secretary of State for Health to issue a Code of Practice relating to health care associated infections ('the Code'), and the CQC will assess compliance with the registration requirement related to infections by reference to the Code.

3. The NHS currently complies with an existing Code of Practice. The new Code is simply a restructuring of the same information. Therefore, for NHS bodies it will not require any significant changes in practice or increased costs or burdens.

4. We recognise there may be additional one-off costs in the independent health care sector and adult social care sector in ensuring that local policies and activities are meeting the requirements of the new Code. The impact will become more evident from the responses to this consultation.

5. This final stage impact assessment considers three options for introducing the Code for health and adult social care regulated activities on the prevention and control of infections and related guidance, under the Health and Social Care Act 2008.

6. The three options relate specifically to the need to introduce this Code, but offers the options:

   - a minimum approach, where we just introduce the ten specific compliance criteria of the Code, with no related guidance or supporting information for care homes;
   - our preferred approach, where we introduce the same ten compliance criteria but provide related guidance to assist the interpretation of these by providers of health and adult social care, and the CQC, plus the supporting information *"Prevention and control of infection in care homes"* which is effectively a practical guide for care homes; or
   - do nothing; this option acts as the baseline for our assessment of costs and benefits.

Background

7. The Health and Social Care Act 2008 established the CQC in place of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission to regulate health care and adult social care in England.

Reasons for intervention

8. Under this Act, from 2010, the Government will introduce a new registration framework for all providers of regulated activities in health care and adult social care in England. The framework will provide independent assurance of the safety and quality of care and these providers will need to register with the CQC and meet the same essential levels of safety and quality. The full set of these essential levels, described as 'registration requirements' will be set out in Regulations.

9. The Health and Social Care Act 2008 enables the Secretary of State for Health to issue a Code of Practice relating to health care associated infections ('the Code'), and the CQC will assess compliance with the registration requirement related to infections by reference to the Code.

10. There is already a Code of Practice in current use *"The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance"* but this only applies to the NHS. This came into force in April 2009, and is used by the CQC to assess compliance with the registration requirement on 'cleanliness and infection control'.

11. However, independent healthcare and adult social care are brought into registration under the Health and Social Care Act 2008 from 2010 onwards. As a result, this new Code is being produced to cover all settings.

12. There are externalities in infection prevention and control (eg practice in one setting may have implications elsewhere, for example for the NHS which may need to deal with the consequences of an avoidable infection), and the provision of guidance has public good attributes and is best produced centrally to avoid duplication of effort, and both of these factors suggest a role for government.

Prevention and control of infection in care homes

13. The other document in our consultation is an update of our existing publication *"Infection Control Guidance for Care Homes"*, which was published in June 2006. The new publication, *"Prevention and control of infection in care homes"* will provide supporting information as a sort of 'how to manual' to help providers of adult social care services and staff from acquiring infections in care homes, and should be read alongside the new Code. It has been revised to reflect changes in the roles and responsibilities in line with the new Code and the underlying legislation, and reflects current best practice.

Developing the new Code of Practice

14. A draft illustrative version of the new Code of Practice and its related guidance was produced in April 2009. This was discussed extensively with a wide range of stakeholders from the NHS and independent health care sectors and adult social care, at a day-long stakeholder meeting at the Royal College of Physicians in London.

15. In May 2009 we held a further stakeholder meeting with the social care sector, to go through the new Code of Practice and its related guidance line by line. This meeting was requested by that sector at our stakeholder meeting in April. We have also considered a wide number of comments and suggestions from stakeholders sent to us by e-mail.

16. In addition and in light of comments from a number of specific policy areas within the Department of Health, we have also made amendments to the new Code of Practice and its related guidance, with a view to bringing it up to date to reflect current best practice and advice. The Code and the Impact Assessment have been further amended in the light of responses to the consultation, which was held from August to November 2009.

Policy Objectives

17. The aim of introducing the Code of Practice is to ensure that good practice is consistently applied in all sectors so that the number of infections can be reduced and benefit service users. The aim however is to ensure the application of the Code is proportionate. Clearly the risks differ according to the settings and unlike a small care home, an acute trust will need specialist staff and facilities.

18. A reduction in infections amongst users of these services will reduce the number of people whose lives are made less comfortable from these conditions. Individuals as well as groups of individuals will benefit as transmission of these diseases between service users and staff will be reduced.

19. Our policy objective is to ensure that good practice is consistently and proportionately applied in all sectors so that the number of infections can be reduced and benefit service users. The supporting information for care homes supplements this by providing practical information to ensure a clear understanding and implementation of the Code by all providers and the CQC.

Impacts and Costs

20. The NHS currently complies with the existing Code of Practice. The new Code is simply a restructuring of the same information. Therefore, for NHS bodies it will not require any significant changes in practice or increased costs or burdens.

21. The new Code brings together current good practice and represents the standards of care already applying within the NHS. Discussions with stakeholders indicate that a proportion (we assume 75% for illustrative purposes) of independent healthcare and adult social providers are already using the current code and guidance and they are broadly content with the draft of the new Code and find the related guidance helpful.

22. We recognise, however, that in the independent healthcare and adult social care sectors there may be additional one-off costs in ensuring that local policies and activities are meeting the requirements of the new Code. We have estimates, obtained from stakeholders in the field, that perhaps 5 days may be needed by the manager (deputy or other) of the independent healthcare or adult social care establishment on a) appraising themselves of the standards; b) auditing the organisation against all the standards; c) writing, obtaining or amending policies, standards and systems in the organisation to bring them in line with the Code; and d) implementing the changes. We have applied this time input to the 25% who are not familiar with current guidance, whereas for those who are more familiar we have assumed the time input needed is about 2 days. For domiciliary care providers we have assumed that 2 days would be needed. The cost of this time has been estimated by stakeholders at £22 per hour (including the cost of salary, employer overheads, etc – note that this is a similar hourly cost to that estimated in the *Admin Burdens Costing Exercise* in 2006 for a manager working in an adult social care home). Assuming an average working week of 37.5 hours gives a total one-off cost of complying with the Code, per establishment, of £825 if a full week is needed or £330 if only 2 days is needed. CQC estimates that, in 2007-08, there were 18,541 care homes in England, 5,897 domiciliary care providers, and 1,700 independent healthcare providers in England who will face these one-off costs in complying with the Code. This suggests that there is a one-off cost to adult social care and to independent healthcare providers of about £11.1 million.

23. There may well be further one-off costs. Following the responses to the public consultation we have now added in a further cost of training for some providers. For example, they might make use of training resources such as the HPA DVD. Again we assume that the majority of providers already provide adequate training, but that a quarter of providers will increase training for six staff for one hour each, at a staff time cost of around £11 per hour. This would increase the total one-off costs by £0.4 million to £11.5 million.

24. Indications from our stakeholder events are that the main change will be one of a "culture change". The current infection control standards under the Care Standards Act 2000 are prescriptive and providers will now need a systems approach with an assessment on the infection control practice they already have, and to document it and act upon it as necessary.

25. Additional regular costs that have been identified by stakeholders relate to changes in the presentation of data on infections and making information available to service users and relatives. We estimate that the time required to report on any outbreaks and make information on infection control available to service users and relatives as a result of the Code, will be perhaps 2 hours per year. Again, we assume the cost of a manager's time in order to fulfil these requirements to be £22 per hour. Using the estimates for the number of adult social care providers and independent healthcare organisations as outlined in paragraph 21, we have a total estimated annual cost of about £1.1 million.

26. We also consider the potential impact on the regulating body, the Care Quality Commission, on implementing the Code and its guidance in its inspections of adult social care establishments. Since it is already the responsibility of the CQC to regulate under current policy as set out under the *Care Standards Act 2000*, all that the Code and its associated guidance should do is help to clarify precisely what they should be assessing in inspections. We, therefore, assume that the Code and its guidance will not require any additional work by the CQC, but will slightly change the nature of the work that they do. There may be some initial, low cost in revising the inspection regime, but we have not attempted to monetise this here.

27. To summarise, the following table details the one-off and annual costs and savings that we have estimated to illustrate the impact of the Code on adult social care providers and independent healthcare organisations.

	£million
One-off costs	**£11.5**
Costs of a) appraising standards; b) auditing the organisation against all the standards; c) writing, obtaining or amending policies, standards and systems in the organisation to bring them in line with the Code; d) implementing the changes; and e) increasing training.	£11.5
Annual costs	**£1.1**
Changes to presentation of infections information and information for service users etc	£1.1

Annual benefits	**£2.9**
Reduced HCAI infections, eg gastroenteritis	£2.9

Benefits

28. Individuals, as well as groups of individuals, will benefit from improved infection control, as transmission of infectious diseases between service users and staff will be reduced. A reduction in infections amongst users of these services will reduce the numbers of people whose lives are made less comfortable from these conditions: this leads to a potential increase in *Quality Adjusted Life Years* (QALYs) from preventing illness and death. It also leads to savings in staff time in social care, and length of stay in healthcare, for example.

29. To illustrate the potential benefit, we consider reductions in HCAIs such as gastroenteritis. It is difficult to estimate the impact of improved practice, but it seems reasonable to assume that reviewing practice could prevent an average of one case of gastroenteritis in each care home per year. The illness could be due to *Clostridium difficile* or a food poisoning organism. The length of these illnesses varies but it will be a minimum of three days and we assume an average of four days. During the illness staff would have to clean commodes or toilet areas around 6 times a day, pay extra attention to hand hygiene and the use of personal protective equipment (aprons & gloves), change and clean linen (sheets etc) and monitor fluid intake and general well-being. We estimate that this would divert at least 3 hours of staff time from normal duties per day. If the staff costs are around £11 per hour the saving in staff time would be at least £132.

30. In addition, the Scottish NHS calculated the costs of HCAIs in NHS hospitals in 2007, in the "NHS Scotland National HAI Prevalence Survey" as set out in the Table on the following page. This suggests a cost of a case of HCAI in the healthcare sector of between £2,100 and £3,000 per case. So, for the independent healthcare sector, even if each institution only had one fewer case every 10 years they would save, on average, perhaps £250 pa per institution.

31. £132 per care home, when multiplied by 18,541 providers, comes to £2.45m. £250 per independent healthcare provider is multiplied by 1,700 providers, which comes to £0.43m. This gives an overall total of about £2.9m.

32. Thus, even reducing infections by one case can offset a significant proportion of costs in reviewing compliance with the Code. Preventing infections also has the benefits to service users as they are not ill and may save other medical costs but we have not attempted to quantify these.

33. We can also illustrate a net ongoing impact on the social care sector. In paragraph 25 we estimated an ongoing time cost for information provision, worth perhaps about £44 per provider. Above we have estimated a time saving from reduced time dealing with infections, worth perhaps £132 per provider. Hence, the net impact could be a time saving worth £88 for care homes – or perhaps around £50 per provider per year when averaged over domiciliary care providers too. For the independent healthcare sector, there could be ongoing time costs worth perhaps £44, but savings from fewer infections worth perhaps £250, giving a net saving worth over £200 per provider per year. Consequently, there are no net new burdens for local government arising from these proposals.

Table 8-3: *Comparison of economic estimates of cost of HAI estimated by previous studies*

	HAI %	Added stay days	Added cost £	Total cost £million
Scottish Office 1999 (60)	9	2	314	22
Plowman 1994 (3) (Incidence)	7.8	11	2 917	101
Walker 2001 (13)	9.2	11	2 244	186
This study 2007	9.5	6.6	2 105	183
This study 2007 using the full average cost per stay	9.5	6.6	3 003	262

Source: http://www.documents.hps.scot.nhs.uk/hai/sshaip/publications/national-prevalence-study/report/full-report.pdf

34. We have not attempted to monetise any further benefits of improved infection control here. However, the benefits to patients of healthcare providers and clients of social care providers are likely to be more wide ranging than has been illustrated here.

Specific Impact Tests

Health Impact Assessment

35. We have decided a health impact assessment is not needed for this particular Code of Practice and its guidance or for the supporting information for care homes. The main impact assessment above is about health and how we expect better regulation to have an improvement in health through reducing the number of adverse incidents to service users of health and adult social care.

Equality Impact Assessment

The evidence base

36. It is anticipated that the new system of regulation and the Code of Practice and its related guidance outlined above, as well as the supporting information for care homes will lead to a general improvement in the quality and safety of health care and adult social care services. There are two major categories of benefits:

- The new regulations will have an impact on the quality of providers already registered with the existing Commissions, which will benefit service users; and

- The inclusion of new providers into the registration system will have an impact on the quality of provision of some providers, especially those that are not currently meeting what we consider to be essential levels of quality.

37. The regulations and the Code of Practice and its related guidance, plus the supporting information for care homes will improve the quality of service provision for all users of health care and adult social care services, and the case in support of this is set out in the broader consultation stage impact assessment. It is reasonable to assume that this benefit will be felt most strongly by groups who are more frequent users of health and adult social care services. The following analysis takes this as its starting point and seeks to identify which groups are more likely to use the regulated activities and are therefore the most likely to experience improvements in safety and quality arising from the new system of regulation.

38. The registration requirements that care provider's will need to meet have been developed with a specific regard to human rights. In developing the registration requirements, we have identified how the principles of human rights provisions might be reflected in principles underpinning the provision of health and social care services. It is anticipated that drawing up registration requirements in this way will help to embed equality issues as a basic consideration in the regulation of service providers. How the registration requirements relate to human rights provisions is described below.

39. Finally, in carrying out the registration system and its other regulatory functions the CQC can consider 'the requirements of any other enactment which appears to the Commission to be relevant'. (Health and Social Care Act 2008). This means that the CQC will be able to consider how care providers are complying with the requirements of the Human Rights Act 1998 and equality legislation. It will be able to address equality, respect for diversity and other human rights in reaching decisions on registration.

What the evidence shows

Age

40. England is an ageing society. Since the 1930s the number of people aged over 65 has more than doubled and today a fifth of the population is aged over 60. The oldest age group (80 and over) is the fastest growing group[1]. This age group accounted for five per cent (2.7 million) of the population of the UK in mid-2007 and has increased by more than 1.2 million between 1981 and 2007[2].

41. Older people are heavier users of both health and social care services. Hospital Episode Statistics show that in 2007-08 more than one-third, 36%, of total episodes of hospital care were provided to people aged over 65[3].

42. A similar pattern applies to users of adult social care services. Provisional figures for 2007-08 show that of the 1.8 million adults receiving services, 1.2 million (68.8 per cent) were aged 65 and over. The proportion of older people receiving residential care is greater still. In 2007-08, 81.6 per cent of people receiving residential care were aged over 65[4].

43. We anticipate that the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance, and the supporting care homes information will result in overall improvements in health and adult social care services across England. Given the relatively heavier use of these services by older people, we anticipate that older people will feel these benefits more strongly.

[1]http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066

[2]www.statistics.gov.uk/pdfdir/popest0808.pdf

[3]http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=193

[4]http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/community-care-statistics-2007-2008:-referrals-assessments-and-packages-of-care-for-adults-england--national-summary-%5Bns%5D

Disability

44. Disabled people are also likely to be heavier users of both health and social services. Research carried out for the Office for Disability Issues found that fewer than one in five disabled people described their health as good, compared to two in three of the general population. A third of disabled people felt their health had worsened in the last twelve months. More than nine out of ten disabled people had used a health service in the past three months, which is significantly higher than the general population[5].

[5] (Experiences and expectations of Disabled People – Executive Summary; Office for Disability Issues, Department for Work and Pensions, July 2008).

45. Given the relatively heavier use of health and adult social care services by disabled people, we anticipate that the benefits of the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance, plus the care homes information, will be felt more strongly by disabled people.

Gender

46. There is good robust information on admissions and deaths and we know more women are going into hospital and into care homes. For example, the literature (Carman et al., *Effects of influenza vaccination of health-care workers on mortality of elderly people in long-term care: a randomised controlled trial*) suggests that 30% of elderly patients in long-term health care establishments are male, whilst 70% are women.

Race

47. There is no evidence to suggest that the Code of Practice will differentially affect ethnic groups. However, as the prevalence of diabetes is higher in BME populations, especially those with an Asian or Afro-Caribbean background and diabetes is increasing, they may benefit from a reduction of diabetes-related infections in the future. Infections, especially foot ulcers, are a serious medical problem for diabetics. Reducing exposure to healthcare associated infections could result in a reduction of the incidence of these infections.

Religion or belief

48. There is no direct evidence to suggest that use of health and adult social care services is different according to people's religion or belief. Although, the membership of particular religious communities does appear to have some bearing on health and wellbeing, with the British Muslim community having the worst reported health, closely followed by the Sikh community, this is not necessarily a direct cause and effect, but it is more likely compounded with other factors such as housing and economic and social status[6].

[6]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093133

49. There is therefore no reason to believe that there would be a significant positive or negative impact on specific religious or belief groups as a result of the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance or the care homes information. However, if any changes were felt, it is likely that they would be most beneficial to the Muslim and Sikh communities.

Sexual orientation

50. There is no reason to believe that there would be a significant positive or negative impact on specific sexual orientation groups as a result of the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance or the care homes information.

Challenges and opportunities

51. The new regulatory framework has not been set up with the aim of addressing inequalities in any single area. It is to improve the quality and safety of health and adult social services available to all service users. Older people and disabled people are more likely to use health and adult social care services than the general population and therefore that the benefits arising from the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance are likely to be felt more strongly among these groups.

52. The emphasis on human rights in the registration requirements and the capacity for the CQC to take into account the requirements of human rights and equality legislation establishes mechanisms for ensuring that services better respond to individual needs.

Reflecting human rights provisions

53. Central to the new framework are the regulation requirements that providers of registered activities must meet. These have been drawn up in order to focus on the outcomes that are provided to service users in a way that respond to their individual needs. In particular, in developing the registration requirements the Department of Health has identified how the spirit of human rights provisions might be reflected in the principles underpinning the provision of health and social care. The successful application of these registration requirements by the CQC will result in a pattern of service provision, which recognises and responds to individual needs.

54. In particular, the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance, plus the care homes information reflect two of these human rights provisions in the following way:

• **The right to life** – the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance, with the care homes information ensure that the right to life is not compromised by failure to manage hygiene and spread of infection.

• **The right to respect for private and family life** – the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance and the care homes information ensure that the right to privacy is not compromised by healthcare associated infection and attitudes by staff and other residents to their consequences.

55. In addition to the consideration of human rights requirements in developing the registration requirements, the CQC is able to consider the requirements of other enactments in operating the registration system and carrying out its other regulatory functions. This will enable the Commission to consider whether care providers are meeting the requirements of the Human Rights Act and equality legislation in providing regulated activities. The CQC will be able to consider enforcement action where care providers do not meet the requirements of these pieces of legislation.

Equality Impact Assessment

56. An adverse impact is unlikely. On the contrary, there is potential to reduce barriers and inequalities that currently exist. The registration requirements and the new Code of Practice for health and adult social care services on the prevention and control of infections and related guidance and the supporting care homes

information have been designed to produce a fairer playing field across all areas of health and adult social care, reducing any inequalities that exist.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	Yes	Yes
Small Firms Impact Test	Yes	Yes
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	No	No

Competition Assessment & Small Firms Impact Test

Introduction

We have estimated the impacts of the Code and Guidance and their costs and benefits in the main part of the Impact Assessment. From these calculations we estimate that the main impact is likely to be on the provision of social care. Overall our estimate is that there should be a net saving to the sector. This is composed of a small initial time cost to apprise themselves of the new Code and Guidance and checking and ensuring compliance; and over the longer term there are likely to be savings in time costs (and perhaps some material costs) owing to better prevention and control of infections; as well as improvements in the quality of care for vulnerable people.

The costs set out above are very small in comparison with overall expenditure in this sector. For example in the care homes sector, the costs might be less than 0.06% of overall expenditure in the first year, and the savings in subsequent years perhaps a quarter of that. In the domiciliary care sector we have estimated a yet smaller impact – of the order of 0.04% of expenditure in the first year and one eighth of that in subsequent years. So, for example, supposing fees per place in a care home of, say, £500 per week, the initial impact might be equivalent to 30p per place per week, with subsequent savings equivalent to 7p per place per week.

The above calculations have informed our assessment of competition and small firms impacts.

Competition Assessment

1. The proposal would not be likely directly to limit the number or range of suppliers. Rather it sets a common platform on which suppliers can compete.
2. The proposal would not be likely indirectly to limit the number or range of suppliers. It is not likely to affect costs significantly.
3. The proposal would not be likely to limit the ability of suppliers to compete. In fact the proposal is more likely to increase the ability of suppliers to advertise their products on the basis of a common set of standards applied to all registered suppliers (and there are many thousands of suppliers in the sector).
4. The proposal would not be likely to reduce suppliers' incentives to compete. It is more likely, for example, to enhance consumer and commissioner choice and ability to switch suppliers, based on the knowledge that the same standards apply to all.

Small Firms Impact Test

1. The proposal would affect independent suppliers, some of which are small businesses – for example some care homes.
2. The proposal sets a common platform on which suppliers can compete on equal terms. The standards deliberately do not favour either small businesses or large businesses.
3. Enforcement by the CQC will be risk-based and take a proportionate approach.
4. We have taken soundings from businesses and stakeholders and this has informed our assessments of impacts.
5. The proposal is not likely to affect suppliers' costs significantly. Given that the cost impacts are so small they are unlikely to be appreciably more significant for small businesses than for large ones.