| Title: | Impact Assessment (IA) |
|---|---|
| **Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery** | **IA No:** 8009 |
| **Lead department or agency:** Department of Health | **Date:** 23/11/2010 |
| **Other departments or agencies:** | **Stage:** Final |
| | **Source of intervention:** Domestic |
| | **Type of measure:** Primary legislation |

# Summary: Intervention and Options

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

The Health and Social Care Act 2008 (the 2008 Act) established the Office of the Health Professions Adjudicator (OHPA) to undertake the adjudication process of Fitness to Practise (FTP) procedures instead of the General Medical Council (GMC) and General Optical Council (GOC), to address the perceived lack of independence of the adjudication process from the investigative process. The problem under consideration is whether the creation of OHPA offers the most appropriate solution. Government intervention is necessary to amend the relevant provisions in the 2008 Act in order to proceed with the Government's preferred option.

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

The objective is to provide a system of adjudication for FTP cases that is more independent. Having reviewed the case for OHPA, the Government is not persuaded that the creation of another body is necessarily the most appropriate and proportionate way forward, and the Government's preferred option is to enhance the current GMC processes (and subsequently review the position for other health regulators), rather than proceeding with OHPA. The intended effect is a better utilisation of resources and will involve repealing OHPA's enabling legislation, winding up the transitional organisation, and reflecting the learning of the process of the OHPA project through changes to legislation and ways of working with the GMC (and, as appropriate, the other health regulators) in terms of adjudication.

**What policy options have been considered? Please justify preferred option (further details in Evidence Base)**

1. Proceed with OHPA implementation as previously planned - do nothing option* (*This option has been labelled as "do nothing" as it is essentially continuing with pre-existing policy, though it is recognised that this option would require some further work in the form of legislation to fully implement);

2. Repeal legislative provision relating to OHPA and, in separate legislation, take forward steps to enhance independence of adjudication and modernise existing processes at the GMC (and subsequently review whether to also do so for the GOC and other health regulators) - this is the preferred option. The Government considers that it offers a way to achieve more independent adjudication that is more proportionate than the other proposals.

| | |
|---|---|
| **Will the policy be reviewed? It will be reviewed**<br>**What is the basis for this review? duty to review** | **If applicable, set review date 2013/14**<br>**If applicable, set sunset clause date** |
| **Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?** | Yes |

**SELECT SIGNATORY Sign-off** For final proposal 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 SELECT SIGNATORY: ..... Date: 26/11/2010

# Summary: Analysis and Evidence

Policy Option 2

**Description:**

Repeal legislative provision relating to OHPA and, in separate legislation, take forward steps to modernise existing processes at the GMC

| Price Base Year 2010 | PV Base Year 2010 | Time Period Years 5 | Net Benefit (Present Value (PV)) (£m) | | |
|---|---|---|---|---|---|
| | | | **Low:** 45.1 | **High:** 59.5 | **Best Estimate: 52.3** |

| COSTS (£m) | Total Transition (Constant Price) | Years | Average Annual (excl. Transition) (Constant Price) | Total Cost (Present Value) |
|---|---|---|---|---|
| **Low** | Optional | | Optional | **Optional** |
| **High** | Optional | | Optional | **Optional** |
| **Best Estimate** | 0 | | 0.8 | **3.7** |

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

Additional GMC costs to enhance current adjudication process, via set up of independent board within GMC - funded by GMC registrants

(GMC operating costs are equal to those incurred by OHPA under Option 1, excluding OHPA overheads)

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

| BENEFITS (£m) | Total Transition (Constant Price) | Years | Average Annual (excl. Transition) (Constant Price) | Total Benefit (Present Value) |
|---|---|---|---|---|
| **Low** | 24.0 | 1 | 10.1 | **48.8** |
| **High** | 38.4 | | 13.0 | **63.2** |
| **Best Estimate** | 31.2 | | 11.6 | **56.0** |

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

Avoidance of OHPA transition costs - saving for Department of Health

Avoidance of GMC transition costs - saving for Department of Health

Reduction in operating costs by avoiding OHPA overheads - saving for GMC registrants

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

Enhanced public confidence in adjudication of FTP cases as delivered by an independent body.

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

Baseline has been provided by the current, pre-operational form of OHPA. Comparison against this baseline assumes accurate projections of future costs and activities by OHPA.

The total costs and benefits figures shown comprise an opportunity cost of 2.4 times cash price where cost or benefit falls to the Exchequer (ie Department of Health)

| Direct impact on business (Equivalent Annual) £m): | | | In scope of OIOO? | Measure classified as |
|---|---|---|---|---|
| **Costs:** | **Benefits:** | **Net:** | **No** | **IN/OUT** |

# Enforcement, Implementation and Wider Impacts

| | | | | | |
|---|---|---|---|---|---|
| What is the geographic coverage of the policy/option? | | | United Kingdom | | |
| From what date will the policy be implemented? | | | 01/07/2011 | | |
| Which organisation(s) will enforce the policy? | | | General Medical Council | | |
| What is the annual change in enforcement cost (£m)? | | | | | |
| Does enforcement comply with Hampton principles? | | | Yes | | |
| Does implementation go beyond minimum EU requirements? | | | No | | |
| What is the $CO_2$ equivalent change in greenhouse gas emissions? (Million tonnes $CO_2$ equivalent) | | | **Traded:** | | **Non-traded:** |
| Does the proposal have an impact on competition? | | | No | | |
| What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable? | | | **Costs:** | | **Benefits:** |
| Annual cost (£m) per organisation (excl. Transition) (Constant Price) | **Micro** | **< 20** | **Small** | **Medium** | **Large** |
| Are any of these organisations exempt? | No | No | No | No | No |

# Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

| Does your policy option/proposal have an impact on…? | **Impact** | **Page ref within IA** |
|---|---|---|
| **Statutory equality duties**[1] Statutory Equality Duties Impact Test guidance | No | 17 |
| **Economic impacts** | | |
| Competition Competition Assessment Impact Test guidance | No | 22 |
| Small firms Small Firms Impact Test guidance | No | 22 |
| **Environmental impacts** | | |
| Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance | No | 22 |
| Wider environmental issues Wider Environmental Issues Impact Test guidance | No | 23 |
| **Social impacts** | | |
| Health and well-being Health and Well-being Impact Test guidance | No | 23 |
| Human rights Human Rights Impact Test guidance | No | 23 |
| Justice system Justice Impact Test guidance | No | 23 |
| Rural proofing Rural Proofing Impact Test guidance | No | 23 |
| **Sustainable development** Sustainable Development Impact Test guidance | No | 23 |

[1] Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

# Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

### References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

| No. | Legislation or publication |
|---|---|
| 1 | Trust, Assurance and Safety (February 2007) |
| 2 | Partial Regulatory Impact Assessment of Trust, Assurance and Safety (February 2007) |
| 3 | Health and Social Care Bill – Impact Assessment (2007) |
| 4 | Health and Social Care Act 2008 |

**+ Add another row**

### Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

### Annual profile of monetised costs and benefits* - (£m) constant prices

| | $Y_0$ | $Y_1$ | $Y_2$ | $Y_3$ | $Y_4$ | $Y_5$ | $Y_6$ | $Y_7$ | $Y_8$ | $Y_9$ |
|---|---|---|---|---|---|---|---|---|---|---|
| **Transition costs** | 0 | 0 | 0 | 0 | 0 | - | - | - | - | - |
| **Annual recurring cost** | 0 | 1 | 1 | 1 | 1 | - | - | - | - | - |
| **Total annual costs** | 0 | 1 | 1 | 1 | 1 | - | - | - | - | - |
| **Transition benefits** | 24-38 | 0 | 0 | 0 | 0 | | | | | |
| **Annual recurring benefits** | 3.9 | 6.8 | 5.3 | 5.3 | 5.3 | | | | | |
| **Total annual benefits** | 28-42 | 6.8 | 5.3 | 5.3 | 5.3 | | | | | |

* For non-monetised benefits please see summary pages and main evidence base section

NB. Policy evaluated over 5 years only. Figures included 2.4 times adjustment for opportunity costs to the Exchequer.

Use the following headings and add or delete as appropriate:

## A. What is the problem under consideration? Summary of analytical narrative

**Fitness to Practise Adjudication for Health Professionals:**
**Assessing different mechanisms for delivery**

## i. Explain the problem under consideration and underlying causes (*Ætiology*)

### Problem Under consideration

1. The problem under consideration in this IA is the perceived lack of independence of the adjudication process from the investigative process within the GMC's FTP procedures, and whether the creation of OHPA offers the most appropriate solution to this issue.

2. The development of policy surrounding OHPA stems from the 5th Report of the Shipman Inquiry[2], authored by the Rt Hon. Lady Justice Smith, which recommended that consideration be given to taking responsibility for adjudication on FTP matters relating to doctors from the GMC, and entrusting such matters to an independent body.

3. The previous Administration's White Paper *Trust Assurance and Safety* set out proposals for how this might be achieved. This document recommended separating the adjudication of FTP matters relating to health professionals and the establishment of a separate independent body. That is, whereas at present the relevant regulatory body investigates and arranges for the adjudication on FTP matters, it was proposed that an independent body took on this adjudication function to ensure public and professional confidence in the system of adjudication. It was estimated that creation of this independent body would cost c. £4.05m over two years, with estimated running costs being £11.95m per annum[3]. It would deal with FTP cases involving doctors initially, with proposals to extend this remit to registrants of the GOC later, with the intention to widen this scope to cover other health professionals in due course.

4. Policy proposals for the creation of this independent body in the form of OHPA were included within the provisions of the 2008 Act. This received Royal Assent on 22 July 2008. From that date, work was undertaken to create OHPA in relation to the GMC and put in place a transitional team to manage its affairs to enable it to be operational from 1 April 2011. OHPA became a legal entity on 25 January 2010 and, since then, has been working on developing operational rules to enable it to adjudicate on FTP matters from 1 April 2011.

5. However, since this time, alternative options have become available to address the issue of adjudication independence in a potentially more proportionate and cost effective manner.

6. The 2008 Act also provides for OHPA to take on FTP adjudication functions for the GOC. However, a date for transfer of the adjudication function of the GOC to OHPA has not been fixed and the same steps as have been taken in the GMC's case towards implementation have not been taken. Similar data taking into account the GOC is therefore not available. However, the GOC's FTP caseload is substantially smaller in scale and would not significantly alter the underlying analysis. As the legislation is not yet in place to provide for OHPA to take on adjudication for the other health regulators it is not possible to be clear which of them, if any, would become subject to OHPA's adjudication processes in the future. There is therefore, at this stage, no reliable data relating to them that can be factored into this IA.

[2] See: "Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future". Published 9 December 2004, Command Paper Cm 639. Accessible from: http://www.the-shipman-inquiry.org.uk/fifthreport.asp

[3] See: "Partial regulatory impact assessment: Trust, assurance and safety and Safeguarding patients". Accessible from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073190.pdf

## B. What are the policy objectives and the intended effects?

**Rationale for intervention**

7. The Government has been reviewing the progress towards full implementation of OHPA. In particular, it has been keen to scrutinise whether another body could deliver its activities and benefits more proportionately. As part of this consideration, the Government has revisited the problem which policy development on OHPA intended to address.

Changes at the GMC since the 5th Report of the Shipman Inquiry

8. In her report, Lady Justice Smith was critical of the performance and approach of the GMC in FTP matters. She did not believe, at that time, that the culture of the organisation was conducive to changing and improving extant processes, including those relating to adjudication on FTP matters.

9. The 5th Report of the Shipman Inquiry questioned the desirability of the same body investigating and then making decisions on FTP matters. Analysis of legal challenge to GMC decisions enables assessment of such concerns to be carried out (see paragraphs 15-22 below). Since Lady Justice Smith's report, the GMC has carried out work to separate out the investigation and adjudication of FTP matters. It also has proposals to enhance this still further, which are described below (see paragraphs 37-44).

10. Evidence of further changes, which suggest that the GMC has changed culturally and can deliver good regulation, can be derived from the independent assessment of the organisation conducted by the Council for Healthcare Regulatory Excellence (CHRE). Notably the GMC's governance has changed. From 1 January 2009 the GMC moved to a smaller, independently appointed governing Council comprised of equal numbers of lay and professional registrant members. Appointment to the Council is based upon skills and abilities, and is conducted through fair and open competition. The parity of lay membership is material because, as Lady Justice Smith noted in the 5th Report to the Shipman Inquiry, lay members are key to ensuring that regulatory bodies stay focussed on their core public protection duties, as opposed to being seen as acting in the interests of the profession they regulate.

11. In its latest performance review of the health regulators[4] CHRE examines the impact of these changes, in the context of the GMC. The report states:

> "The GMC said that the change in the structure and membership of the Council has been managed well and that there are good levels of trust between the Council and the executive. In 2009 the GMC produced a new Governance Handbook which is designed to ensure that there are clear lines of accountability and developed a Corporate Strategy which sets out what the Council aims to achieve over the next four years…."

12. CHRE then go on to consider the GMC's performance in terms of good regulation:

> "…We consider that the GMC has a real and transparent commitment to evidence based policy development. This commitment is underpinned by a variety of research and engagement activities. These include independently commissioned academic projects, collaborative research initiatives, surveys of doctors, public and discussion forums and listening to the views of its stakeholders gathered informally and formally during the course of its work. The outcomes of this work are shared by the GMC internally to ensure

[4] See "Performance review report 2009/10. Enhancing public protection through improved regulation." CHRE. July 2010. Accessible at: https://www.chre.org.uk/_img/pics/library/100701_Performance_review_report_2009-10.pdf

that the learning is taken into account in its work and externally to enhance public accountability."

13. The CHRE report concludes:

> "The GMC has continued to perform well, demonstrating excellence in several areas across its functions in a year of significant change. It is impressive that the GMC has maintained its commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation."

14. The independent assessment of the GMC conducted by CHRE suggests that the scale of change in culture at the organisation is significant. The GMC has moved from an organisation resistant to change (as characterised in the 5th Report to the Shipman Inquiry) to an organisation demonstrating a strong commitment to improvement, even in areas where performance is good already. This change is important because it may be indicative that an approach by which adjudication is maintained by the GMC, but involves the taking of steps to modernise existing legislation and provisions, is one that (on the evidence above) is likely to be successful and deliver real benefits.

Sustainability of GMC FTP Decision-making

15. The 5th Report of the Shipman Inquiry questioned the desirability of the same body investigating and then making decisions on FTP matters. The previous Administration, when proposing OHPA, highlighted the issue of perceptions. That is, when investigation and adjudication functions were undertaken by a single body, there was the potential for that body to be vulnerable to accusations that it is either too lenient on the profession that it regulates, or unduly harsh in pursuing professionals. Analysis of legal challenge to GMC decisions enables assessment of such concerns to be carried out.

16. In 2006/07 GMC conducted 2,480 FTP hearings. All of these decisions were challengeable in the Higher Courts. There were 46 such appeals, of which 10 were wholly or partially successful. Therefore, only 0.4% of decisions were successfully challenged[5].

17. In 2008/09 there were been 3,334 FTP hearings. All of these decisions were challengeable in the Higher Courts. Of this number, there have been 58 appeals, of which 11 have been wholly or partially successful. Therefore, less than 0.5% percent of decisions were successfully challenged.[6]

18. These figures suggest that the public and professionals can be confident in the GMC's capacity to make good quality decisions that are robust and withstand judicial scrutiny.

19. In addition, data from the CHRE is also instructive on this point, especially from public perceptions/public protection standpoint as to whether the GMC are acting too partially towards doctors.

20. CHRE have powers to review all final stage FTP decisions made by the regulators' committees and panels, and can refer outcomes to the Higher Courts for scrutiny if they believe that decisions are unduly lenient. Table 1 sets out statistics on such cases:

[5] Source: GMC's evidence to Commons Committee during passage of the 2008 Act.
[6] Source: GMC

**Table 1: CHRE statistics on referred decisions**[7]

| Year | Total Decisions referred to CHRE (all regulators) | GMC Decisions referred to CHRE | Total Decisions Referred to Higher Courts by CHRE (all regulators) | Total GMC Decisions Referred to Higher Courts by CHRE | Percentage of Higher Court Referrals (all regulators) | Percentage of Higher Court Referrals (GMC) |
|---|---|---|---|---|---|---|
| 2004/5 | 590 | 217 | 8 | 5 | 1.36 | 2.30 |
| 2005/6 | 763 | 301 | 10 | 7 | 1.31 | 2.33 |
| 2006/7 | 915 | 389 | 3 | 0 | 0.33 | 0.00 |
| 2007/8 | 1231 | 379 | 5 | 1 | 0.41 | 0.26 |
| 2008/9 | 1370 | 382 | 5 | 1 | 0.36 | 0.26 |

21. Since publication of the 5th Report of the Shipman Inquiry in 2004 the percentage of GMC case outcomes which CHRE considered to be unduly lenient has dropped significantly and, where once GMC case referrals were disproportionately higher in relation to other regulators, CHREs referral rate of GMC cases to the Higher Courts is now lower than that of other regulators – with very small volumes of decisions referred in any event

22. These statistics further suggest that both the public and professionals can be confident in GMC decision making.

Costs and Regulatory Burden

23. The expectation, as expressed to Parliament during the passage of 2008 Act, was that the cost of transition to establish OHPA would be in the region of c. £3-4m over two years. This estimate was developed by the Department with assistance of an external consultancy organisation. OHPA's Transition team now estimate that the range of expected cost to Government for the establishment of OHPA is to be between £10 and £16m. The lower end of this estimate also presents risks in relation to availability of contingency funds for a start-up operation.

24. OHPA is projected to deliver costs savings in the future through streamlining adjudication processes and, ultimately, delivery of economies of scale if, and when, it were to take on adjudication for other health regulators. However, the financial impact of this change will not be realised in the short-term and there are changes that the GMC have indicated they can also deliver to achieve some or all of these benefits in the context of their operations.

**Policy Objective**

25. The objective is to provide a system of adjudication for FTP cases that is more independent, in as proportionate a manner as is possible. The intended effect is better alignment of resources.

## C. What policy options have been considered?

**Description of Options considered**

26. Two options are presented in this IA. Option 1 covers proceeding with the implementation of OHPA. Options 2 focuses on utilising and adapting current mechanisms to achieve the benefits expected from the introduction of OHPA in a more proportionate manner. The options are as follows:

[7] Source: Data for this table is taken from CHRE statistics published at: http://www.chre.org.uk/practise/79/

**OPTION 1:** Proceed with OHPA implementation as previously planned - do nothing option* (*This option has been labelled as "do nothing" as it is essentially continuing with pre-existing policy, though it is recognised that both of these options would require some further work in the form of legislation to fully implement);

**OPTION 2:** Repeal legislative provision relating to OHPA and, in separate legislation, take forward steps to enhance independence of adjudication and modernise existing processes at the GMC (and subsequently review whether to also do so for the GOC and other health regulators) - this is the preferred option. The Government considers that it offers a way to achieve more independent adjudication that is more proportionate than the other proposals.

27. A full public consultation took place between 9 August and 11 October 2010, the highest volume of respondents indicated that they are in favour of the Government's preferred option. The main theme arising out of their views was that the abolition of OHPA would be cost effective and sensible as the healthcare regulators already have the means and resources to operate fitness to practise adjudication hearings to adequately protect public and patient safety.

28. Having considered the responses and for the reasons given in the Consultation Report published alongside this IA, the Government has decided to proceed with option 2.

## D. Option 2 Impacts, Costs and Benefits *(Analyst support required)*

**Cost and Benefits of Each Option**

***OPTION 1: Proceed with OHPA implementation as previously planned - do nothing option.***

29. It is the present intention of OHPA to deliver a smooth transition at the point of proposed take over of responsibility for adjudication by "adopting and adapting" existing GMC processes. This approach is attractive as it allows for continuity to ensure that the important task of adjudicating on FTP matters is not compromised at a time of great change (e.g. the transfer of adjudication functions to another body). It also provides an opportunity to use the process of consulting on the adopt and adapt procedures to signpost much more significant intended future change, to secure buy in from external bodies and allowing them to shape future change. Any such future change would also be subject to requirements for further formal consultation.

30. OHPA have provided the department with a range of costs by which they can deliver independent adjudication, the lowest of which removes contingencies put in place to ensure against risk of over-spend. These costs relate to set-up of the organisation:

Transitional (set-up) costs in 2010-11[8]

**Table 2: Minimum projected transition costs under Option 1**

| **Item** | **£m** |
|---|---|
| Information Technology | 3.3 |
| Estates | 1.6 |
| Board, Executives and other staffing | 0.9 |
| Policy, Legal and Rules | 0.6 |
| HR Related Activities | 1.0 |
| Mandatory Operational Running Cost | 0.4 |
| Known Committed Cost to August 2010 | 1.0 |
| **Total funding requirements** | **8.6*[9]** |

**Table 3: Maximum projected transition costs under Option 1**

| **Item** | **£m** |
|---|---|
| Information Technology | 4.2 |
| Estates | 3.3 |
| Human Resources | 3.2 |
| Policy, Rules and Legal | 1.1 |
| OHPA Board including Chair and CEO private offices and other work streams (e.g. finance & procurement and communication) | 1.7 |
| Programme and Management Office including other corporate business processes and other projects | 1.1 |
| **Total funding requirements** | **14.6*[10]** |

31. In addition to these figures, and resulting from commitments given to Parliament by the previous Administration during passage of the 2008 Act, the Department has previously undertaken to meet costs unavoidably incurred by the GMC following establishment of OHPA, being estimated by the GMC as £1.37m[11]. These are one off costs anticipated to fall due mostly in 2011, being:

**Table 4: Estimated costs to GMC for transition to OHPA system[12]**

| **Item** | **£K** |
|---|---|
| Accommodation | 516 |
| Business preparation | 21 |
| Communications and stakeholder management | 4 |
| Finance | 12 |
| Human Resources | 140 |
| IT | 563 |
| Project management | 114 |
| Rules | £2 |
| **Total** | **1,372*[13]** |

Recurring costs (ongoing cost of OHPA managing adjudication)

32. OHPA's estimates of initial ongoing costs of managing the adjudication process from 2011-2013 are shown in Table 5. These include an appreciation of the benefits to be derived from the OHPA project (discussed below). These include substantial changes to the panel and

[8] Source: Date provided by OHPA to the Department
[9] (*Numbers may not add due to rounding)
[10] (*Numbers may not add due to rounding)
[11] Source: GMC
[12] Source: Date provided by GMC to the Department
[13] (*Numbers may not add due to rounding)

assessment costs by 2013. In Table 5, the ongoing costs are presented in the cost section, and the benefits of the development work planned by OHPA are presented in the benefits section.

**Table 5: Ongoing costs under Option 1**[14]

| OHPA Indicative Adjudication Costs | | 2011 £ | 2012 £ | 2013 £ |
|---|---|---|---|---|
| Panel and Assessment costs | | 14,788,496 | 14,123,249 | 5,187,947 |
| Adjudication Staff Costs | | 3,516,288 | 3,604,193 | 3,694,300 |
| Adjudication Office Support Costs | | 3,663,884 | 2,517,848 | 530,0794 |
| Total Adjudication Costs | | 21,968,668 | 20,245,292 | 9,413,041 |
| Corporate Overhead | | | | |
| | Estate Costs | 2,775,893 | 2,845,290 | 2,916,422 |
| | Board and Senior Mgt | 1,418,572 | 1,454,036 | 1,490,387 |
| | Human Resources | 357,903 | 366,851 | 376,022 |
| | Finance | 262,844 | 269,415 | 276,150 |
| | Information Technology | 1,478,750 | 1,515,719 | 1,553,612 |
| | Legal/ Policy/.Communications Costs | 587,448 | 604,884 | 620,631 |
| Total Corporate Overhead | | 6,881,410 | 7,056,195 | 7,233,225 |
| Total Operating Costs | | 28,850,077 | 27,301487 | 16,646,265 |

33. OHPA will seek to recover monies incurred in relation to these operating costs from GMC registrants, in the form of a contribution paid to OHPA from the GMC funded by the registration fees that it collects from doctors. At present, the GMC would incur some or all of these costs, and pass these on to its registrants, through its current management of adjudication (see discussion around costs of Option 2 below). If OHPA were to provide adjudication for GOC and the other health regulators a contribution from them towards OHPA's operating costs would also be sought in the same way.

Benefits

34. **Enhanced public confidence in adjudication as delivered by an Independent Body:** This benefit is non-quantifiable, as there is no reliable baseline to compare benefits against. However, public confidence in the system of adjudication is seen as a key benefit arising from ensuring that the system is independent of investigative activities, in line with other forms of adjudication.

35. **Future ambitions:** Over and above the changes delivered by "adopt and adapt", OHPA's ambitions for more substantive change also provide the opportunity to deliver more efficient, cost effective case management of hearings, delivered through a number of policy initiatives:
    i. Introduction of active case management and preliminary hearings;
    ii. Creation of costs management sanctions;
    iii. Legally qualified chairs to drive efficient and effective case management of cases;
    iv. Enhance hearing locations – leading to improved experiences for vulnerable witnesses and greater flexibility to hold hearings outside London & Manchester;
    v. Hearing styles – to only hold hearings when necessary, and to move closer to a Tribunal model;

[14] Source: Date provided by OHPA to the Department

vi. Specimen charging – to reduce the number of allegations charged to the most important matters, and to restrict to those needed to achieve the sanction sought;
vii. Replace transcribers with audio recording;
viii. Use Electronic Notice of Hearings;
ix. Reduce the Number of Panellists required for long hearings - changing the definition of a long hearing (increase from 11 days +) and/ or change the policy to deploy 5 panellists at such hearing to 3 to protect quorums;
x. Panel Development and Empanelment Strategies – to minimise need to travel to hearing centres;
xi. Overhauled expenses policy (Panellists and staff); and,
xii. Remove paper-based communications/ notification in the longer term, using electronic means to communicate.

36. It is anticipated that these measures will deliver savings for the parties involved in adjudication (the GMC, health professionals, defence unions that represent them, etc) due to shorter, more efficient proceedings. In terms of the innovations viii-xii, these could represent savings of c. £3.9 million per annum, without the need for legislation to deliver. The impact of delivery of the remaining innovations could deliver savings, as estimated by OHPA, of up to £15.3m subject to necessary legislation being introduced.

37. **Economies of scale**: the intention during creation of OHPA was that, over time, it would take on the role of adjudicating on FTP matters in relation to other health regulators[15] (non-quantifiable for the reasons given in paragraph 6 above).

Summary of costs and benefits of Option 1

38. Table 6 summarises the costs and benefits of Option 1, described in the sections above. The net cost of this option is the baseline against which Option 2 is compared.

**Table 6: Summary of costs and benefits of Option 1[16] (constant prices)**

| | 2011/12 Year 0 | 2012/13 Year 1 | 2013/14 Year 2 | 2014/15 Year 3 | 2015/16 Year 4 | Total costs | Average annual costs |
|---|---|---|---|---|---|---|---|
| **Costs** | | | | | | | |
| OHPA Transition costs (Government) | 8.6-14.6m | 0 | 0 | 0 | 0 | 8.6-14.6 | 1.7-2.9 |
| OHPA Operating costs (GMC registrants) | 28.9m | 31.2m | 31.9m | 31.9m | 31.9m | 155.8 | 31.2 |
| GMC transition costs (Government) | 1.4m | 0 | 0 | 0 | 0 | 1.4 | 0.3 |
| **Total cost (including opportunity cost)** | 52.9-67.3 | 31.2 | 31.9 | 31.9 | 31.9 | 179.8-194.2 | 36.0-38.8 |
| **Benefits** | | | | | | | |
| Enhanced adjudication process (GMC registrants) | 0m | 3.9m | 15.3m | 15.3m | 15.3m | 49.8 | 10.0 |
| **Net cost** | 52.9-67.3 | 27.3 | 16.6 | 16.6 | 16.6 | 130.0-144.4 | 26.0-28.9 |
| **Net cost (present value)** | 52.9-67.3 | 26.4 | 15.5 | 15.0 | 14.5 | 124.2-138.6 | 24.8-27.7 |

[15] In addition, during passage of the 2008 Act the previous Administration undertook to make payments to OHPA regarding IT costs incurred should they take over FTP adjudication for other regulators

[16] Assumption that steady state costs will recur from Yr 3. The previous Administration considered that OHPA would take on adjudication for other regulators in due course but there is no firm schedule of dates agreed and, in any event, this principle would be subject to ratification by the new Government.

***OPTION 2: Repeal legislative provision relating to OHPA and, in separate legislation, take forward steps to enhance independence of adjudication and modernise existing processes at the GMC (and subsequently review whether to also do so for the GOC and other health regulators) - this is the preferred option.***

39. The GMC have worked closely with both the Department and OHPA following the passing of the 2008 Act. This engagement has helped them to refine their thinking about how they could deliver adjudication separately, in a more independent manner than at present, if Option 2 is implemented.

40. The GMC plan to take steps to implement changes to their current processes almost immediately. Such steps would include (subject to consultation with affected parties): review of the quorum for adjudication panels, further changes to GMC expenses policies, and greater use of electronic communication.

41. In addition, subject to Parliament approving the dissolution of OHPA, the GMC are committed to working with the Department to develop proposals for more substantive legislative change.

42. Most notably, the GMC would propose to establish a "Tribunal" style model of hearings through the creation of an independent “Medical Disciplinary Tribunal”. This would be headed by an independently appointed President who will have overall responsibility for appointing and training lay and medical panellists, case managers, legal assessors and specialist advisers, and would be responsible for the quality of work undertaken by panels. This new structure would strengthen the ability of the GMC to deliver adjudication in a more independent manner, and would build on the reforms that the GMC has already implemented.

43. The GMC also consider that they can deliver the vast majority of the benefits that OHPA have propounded, as discussed above regarding Option 1. Implementation of the changes, especially those requiring legislative change, would be accompanied by appropriate consultation and IA.

<u>Transitional (set-up) costs</u>

44. The main cost incurred would relate to the creation of the Tribunal structure and the appointment of the President and other members of the governing committee. Detailed costs are not yet available, however these are estimated to be in the region of £1m per annum.

<u>Recurring costs (ongoing cost of managing adjudication)</u>

45. These are described in Table 7 below. In essence, recurring costs for the GMC reflect their assessment of costs incurred should they retain adjudication. There are some savings to be made due to the avoidance of incurrence of corporate costs, due to the fact that the GMC exists as a body at present, these are shown as benefits through avoiding OHPA overheads.

<u>Benefits</u>

46. The OHPA project has generated valuable ideas about how the process of adjudication could be delivered differently. These same innovations and benefits could be achievable through the GMC’s proposals to deliver more independent adjudication at arms-length, described above. As such, the types of changes and the benefits derivable are those discussed in the benefits section for Option 1. Of course, any future benefits of economies of scale through OHPA adjudication on FTP matters for other regulators would be lost.

Costs and benefits of Option 2.

**Table 7: Summary of costs and benefits of Option 2, as compared to Option 1**

| | 2011/12 Year 0 | 2012/13 Year 1 | 2013/14 Year 2 | 2014/15 Year 3 | 2015/16 Year 4 | Total costs | Average annual costs |
|---|---|---|---|---|---|---|---|
| **Costs** | | | | | | | |
| Additional GMC costs to enhance adjudication (GMC registrants) | 0 | 1 | 1 | 1 | 1 | 4 | 0.8 |
| **Benefits** | | | | | | | |
| Avoidance of OHPA transition costs (Government) | 8.6-14.6 | 0 | 0 | 0 | 0 | 8.6-14.6 | 1.7-2.9 |
| Avoidance of GMC transition costs (Government) | 1.4 | 0 | 0 | 0 | 0 | 1.4 | 0.3 |
| Reduction in operating costs by avoiding OHPA overheads (GMC registrants) | 3.9 | 6.8 | 5.3 | 5.3 | 5.3 | 26.6 | 5.3 |
| Total benefit (including opportunity) | 27.9-42.3 | 6.8 | 5.3 | 5.3 | 5.3 | 50.6-65.0 | 10.1-13.0 |
| **Net benefit as compared to Option 1** | 27.9-42.3 | 5.8 | 4.3 | 4.3 | 4.3 | 46.6-61.0 | 9.3-12.2 |
| **Net benefit as compared to Option 1 (present value)** | 27.9-42.3 | 5.6 | 4.0 | 3.9 | 3.7 | 45.1-59.5 | 9.0-11.9 |

## Risks and Assumptions

47. The risks to be considered and assumptions that have been made in preparing the options in this IA are as follows:

- All legislation required to proceed with implementation of OHPA (or otherwise to implement procedural changes at the GMC) has been subject to public consultation and, depending on its nature, scrutiny by Parliament
- Potential government funding available to support delivery is subject to the outcomes of the forthcoming Spending Review for 2011-2014
- Assumption that benefits described, and their scale, are realisable
- Costs incurred by both OHPA and GMC regarding adjudication would be subject to fluctuation dependent on supply of FTP cases to adjudication stage

## Administrative Burden and Policy Savings Calculations

48. As described above, proceeding with the preferred option will lead to a reduction of transitional (set-up) costs for OHPA generating policy savings and an enhanced costs/benefits ratio.

## Wider Impact

49. An equalities impact assessment screening is available in relation to this document (Annex 2).

## Summary and Preferred Option with Description of Implementation Plan

50. Table 9 compares the net benefit of Option 2 against the 'do nothing' option.

**Table 9: Comparison of options 2 with option 1, £m**

| Net benefit compared to Option 1 | 2011/12 Year 0 | 2012/13 Year 1 | 2013/14 Year 2 | 2014/15 Year 3 | 2015/16 Year 4 | Total net benefit | Average annual net benefits |
|---|---|---|---|---|---|---|---|
| Option 2 (constant price) | 27.9-42.3 | 5.8 | 4.3 | 4.3 | 4.3 | 46.6-61.0 | 9.3-12.2 |
| Option 2 (present value) | 27.9-42.3 | 5.6 | 4.0 | 3.9 | 3.7 | 45.1-59.5 | 9.0-11.9 |

51. Following public consultation, the preferred option commended is Option 2, as it delivers the benefit expected from the implementation of OHPA, but at a lower cost, giving the greatest net benefit overall. This option is QIPP[17] compliant as it yields net cash savings by 2014 without compromising the benefits.

52. Subject to Parliamentary approval, legislation will be taken forward at the next appropriate opportunity to remove provisions in the 2008 Act relating to OHPA, and make consequential amendments to other legislation. Along similar timescales, action will be taken to scale back OHPA's operations until a decision from Parliament is given on such repeal. The Department will, in due course, take forward proposals to modernise the GMC's legislation that will be subject to further public consultation, separate impact assessment and (ultimately) parliamentary debate and scrutiny.

[17] QIPP: Quality, Innovation, Productivity and Prevention. – see the Government's White Paper *Equity and excellence: Liberating the NHS*

# Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

# Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

| |
|---|
| **Basis of the review:** [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];<br>The Department intends, in conjunction with the GMC, to review the outcomes of modernised adjudication within three years of full implementation |
| **Review objective:** [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]<br>The purpose of such review would be to understand whether there are was any benefit/learning to be applied to FTP adjudication processes of other health regulators |
| **Review approach and rationale:** [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach]<br>Comparison of present adjudication costs against future, assessment of stakeholder reaction to changes, etc. Detail to be agreed with the GMC as the main affected party. |
| **Baseline:** [The current (baseline) position against which the change introduced by the legislation can be measured]<br>As set out in this impact assessment. |
| **Success criteria:** [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]<br>More independent adjudication processes and more efficient handling of FTP cases, shorter case times, less expensive unit costs, fewer or equivalent levels of legal challenge to decisions. |
| **Monitoring information arrangements:** [Provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]<br>To be agreed with the GMC. |
| **Reasons for not planning a PIR:** [If there is no plan to do a PIR please provide reasons here]<br>N/A |

Annex 2: Equality Impact Assessment Screening Template

| **Title of policy:**<br>**Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery** |
|---|

**Short description of policy:**
Provision was made within the Health and Social Care Act 2008 for the establishment of the Office of the Health Professions Adjudicator (OHPA), to ensure the separation of the adjudication of FTP cases from the investigation of those registered with General Medical Council (GMC) and, in time, the other healthcare regulatory bodies (commencing with the General Optical Council (GOC)). This was in response to a recommendation made in the 5th Report of the Shipman Inquiry.

The previous Administration believed that the creation of OHPA would ensure "public and professional confidence in the independence of the decisions made by the adjudicator".

OHPA became a legal entity on the 25th January 2010 and the intention, at that time, was that it would commence operational activities in relation to 'adjudication of fitness to practise cases referred by the GMC' from April 2011, (and subsequently from the GOC at a date not yet determined). Until then, the final adjudicating stage of the FTP process was to remain with the respective regulator.

The Government has reviewed plans for the full implementation of OHPA, in light of developments at the GMC since the Shipman Inquiry. It is not persuaded that there is need, on current available evidence, for a separate adjudication body. There are two Options:

**OPTION 1:** Proceed with OHPA implementation as previously planned - do nothing option* (*This option has been labelled as "do nothing" as it is essentially continuing with pre-existing policy, though it is recognised that both of these options would require some further work in the form of legislation to fully implement); and

**OPTION 2:** Repeal legislative provision relating to OHPA and, in separate legislation, take forward steps to enhance independence of adjudication and modernise existing processes at the GMC (and subsequently review whether to also do so for the GOC and other health regulators) - this is the preferred option. The Government considers that it offers a way to achieve more independent adjudication that is more proportionate than the other proposals.

It is the Government's preferred option to seek to repeal OHPA's enabling legislation and instead work with the GMC to enhance their legal powers. In doing so, the current intention is that the learning derived from the OHPA project would be collated and shared with the GMC, with a view to initiating a programme of modernisation of its legislation on fitness to practise adjudication (the Medical Act 1983 and GMC rules that take their powers from this). It is intended that the vehicle to deliver such modernisation would be amendment to the Medical Act by way of an Order under s.60 of the Health Act 1999.

**Overall policy Intent**
In terms of the Government's preferred option, the intention is to:

(i) Repeal OHPA's enabling legislation;
(ii) Wind up the transitional organisation, and,
(iii) Reflect the learning of the process of the OHPA project through changes to the Medical Act 1983.

The precise scale of such changes will need to be confirmed and will be subject (in some part) to the drafting of s.60 legislation to modernise the GMC's enabling legislation.

There are rigorous checks and balances in place governing exercise of s.60 powers, to ensure that the views of the public and Parliament are appropriately considered before any legislation can be made. These include:

- A requirement for any draft legislation to be published;
- A requirement that a public consultation on the terms and effects of legislation be conducted for at least three months; and,
- Parliamentary debate on any legislation.

As part of the consultation process the Government would propose to publish an assessment of the economic and equality impacts of the legislation and, similarly, the GMC would intend to consult on, and assess the impact of, such proposals in advance of any s.60 Order.

**Identified stakeholders -** Patients and the public, witnesses and those affected by the performance, conduct and behaviours of practitioners, practitioners, legal representatives and advisers, GMC, other regulators and tribunals, Adjudication Justice and Tribunals Council, OHPA Board and staff, contractors and associates.

| **Negative impact** |
|---|
| How could the policy have a **significant** negative impact on equality in relation to each area? |
| **Age**<br><br>None identified (see General Comments below) |
| **Disability**<br><br>None identified (see General Comments below) |
| **Race and Ethnicity**<br><br>None identified (see General Comments below) |
| **Gender (including trans-gendered people)**<br><br>None identified (see General Comments below) |
| **Religion or belief**<br><br>None identified (see General Comments below) |
| **Sexual orientation**<br><br>None identified (see General Comments below) |
| **Socio-economic groups**<br><br>None identified (see General Comments below) |
| • Will the policy create any **problems** of **barriers** to any community of group?<br>None Identified (see General Comments below) |
| • Will any group be **excluded** because of the policy? and<br>• Will the policy have a negative impact on **community relations**?<br><br>**No evidence to suggest this:**<br>See General Comments below |
| • Will the policy have a negative impact on **human rights**?<br><br>**No evidence to suggest this:**<br><br>The GMC's current management of adjudication matters are subject to the provisions of the Human Rights Act and there is no substantive evidence (e.g. Court decisions) to suggest that they are not compliant.<br><br>The position should be similar for the GOC and other health regulators because their processes should also be compliant with the Human Rights Act where applicable. |

**General comments:**

The impact of the policy is that FTP adjudication will remain with the GMC. As a statutory public body the GMC is subject to compliance with existing equality and diversity legislation. The GMC addresses compliance with these obligations through it Equality Scheme[18]

In relation to this scheme the GMC state that the:

*"GMC promotes equality and values diversity. While all doctors must meet the minimum competency standards, we want a profession that is able to accommodate people with a range of ambitions, ages, different faiths and backgrounds, those from different racial groups, and those with a disability, not least because varied perspectives will make valuable contributions to the profession and the population it serves.*

*We have prepared our equality scheme, activities action plan and our equality impact assessment action plan, as part of our business planning process so that all items are monitored as part of our business planning processes. We have also ensured that Directors consider the diversity implications of all objectives and activities when preparing their Directorate Plans to ensure that we identify impact on diversity at an early stage".*

The GMC also and has in place an Equality and Diversity Reference Group to advise it on action it needs to undertake to meet commitment to valuing diversity and promoting equality. The Reference Group's advice is also used to ensure that equality and diversity is embedded in the development and review of policies and procedures across the GMC.

There are no identified negative (or positive) impacts surrounding retention of adjudication by the GMC given it maintains the situation currently in place. However, it is expected that revamp of the GMC's processes through a section 60 Order would lead to impacts that would be subject to a separate equality impact assessment.

The position should be similar for the GOC and other health regulators because they are also subject to equality and diversity legislation.

**Positive impact**

Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist?
Not in itself. However, the major impact of the policy is that FTP adjudication will remain with the GMC, who have an equality scheme already in place.
The position in this respect and in respect of the each of the duties specified below should be similar for the GOC and other health regulators because they are also subject to equality and diversity legislation.
Explain how will it meet our duty to:

**1.** Promote **equal opportunities**

GMC Equality Scheme contains provisions to ensure that equal opportunities matters potentially affected by its processes are monitored and identified.

**2.** Get rid of **discrimination**

GMC Equality Scheme was implemented following a review of GMC processes to ensure that these were fair, objective, transparent and free from discrimination.

**3.** Get rid of **harassment**

GMC Equality Scheme contains provisions to enable harassment to be eliminated as far as is possible.

**4.** Promote **good community relations**

The GMC EQIA process described in its Equality Scheme is designed to promote good community relations.

**5.** Promote **positive attitudes** towards disabled people

GMC Equality Scheme contains provisions to enable promotion of positive attitudes to disability matters

**6.** Encourage **participation** by disabled people

As above.

**7.** Consider **more favourable treatment** of disabled people

As above.

[18] Accessible at: http://www.gmc-uk.org/about/equality_scheme.asp

**8.** Promote and protect **human rights**

The GMC's current management of adjudication matters are subject to the provisions of the Human Rights Act and there is no substantive evidence (e.g. Court decisions) to suggest that they are not compliant. Any proposed steps to refine their processes would be subject to an assessment of Human Rights compliance.

**Evidence**

**What is the evidence for your answers to the above questions?**
Available evidence from the GMC and independently from the Council for Healthcare Regulatory Excellence (CHRE) indicates that such steps are effective.

Legislation confirms that the GOC and other regulators are also subject to duties in respect of equality and diversity.

**What does available research say?**
The following 6 page document sets out the GMC's achievements in this area from 2007-2009:
http://www.gmc-uk.org/Equality_Scheme_2010_Annex_C__Key_achievements_2007___2009_.pdf_29613274.pdf

The following document sets out the GMC's programme of EQIA's for 2010, covering c.25 strands of work, and its ongoing Action Plan on equality and diversity can be accessed at:
http://www.gmc-uk.org/about/equality_scheme.asp

The above demonstrates a clear commitment to equality and diversity, and that appropriate action is being taken to deliver. Independent verification of this is available from CHRE. They note, in their latest annual performance review of the GMC that:

*"We consider that the GMC has a real and transparent commitment to evidence based policy development. This commitment is underpinned by a variety of research and engagement activities. …The outcomes of this work are shared by the GMC internally to ensure that the learning is taken into account in its work and externally to enhance public accountability… The GMC has also undertaken a significant amount of work to embed equality and diversity principles in its work. It established a work programme following an independent review of its policies, practices and attitudes to equality and diversity issues. The programme included the creation of an internal equality and diversity champions network and hosting a seminar to engage with black and ethnic minority doctors. The GMC has also appointed a head of diversity. We note that the GMC is also currently considering the outcomes of its research programme which included looking at why doctors from some backgrounds are more likely to be referred forward to the final stages of the GMC's fitness to practise procedures than doctors from other backgrounds. We are pleased with the GMC's commitment to seeking to ensure that its procedures are free from discrimination".*

This independent verification of activities demonstrates expertise by the GMC in this area.

The CHRE report is accessible from:
https://www.chre.org.uk/_img/pics/library/100701_Performance_review_report_2009-10.pdf

Legislation confirms that the GOC and other regulators are also subject to duties in respect of equality and diversity.

**What further research or data do you need to fill any gaps in your understanding of the potential or known effects of the policy?**
The learning derived from the OHPA project will be collated and discussed with the GMC with a view to initiating a programme of modernisation of its legislation on fitness to practise adjudication (the Medical Act 1983 and GMC rules that take their powers from this). It is intended that the vehicle to deliver such modernisation would be amendment to the Medical Act by way of an Order under s.60 of the Health Act 1999.

Research and data collection about the impact of this change (retention of adjudication by the GMC under enhanced processes) will be progressed through this vehicle. Consideration can then also be given as to whether to take the same approach in the case of the GOC and other health regulators.

**Have you thought about commissioning new data or research?**
Yes. See above.

**Screening assessment**

Now that you have looked at the evidence, do you think that the policy needs a **Full EqIA**? **No**

## Specific impact tests

## Competition Assessment

Using the checklist of impacts from the Office of Fair Trading website[19] the following questions are considered:

*1) Would the policy directly limit the number or range of suppliers?*

*2) Would the policy indirectly limit the number or range of suppliers?*

*3) Would the policy limit the ability of suppliers to compete?*

The answer to each is 'No'. For this reason, a full Competition Assessment is not necessary

## Small Firms Impact Test

The Small Firms Impact Test (SFIT) considers any impacts on small businesses or their customers as a result of government policy. Specifically, the SFIT asks whether "the proposal affect[s] small business, their customers or competitors[20]" where a small business is defined as a business with a headcount of less than 50.

The abolition of OHPA would have no impact on small firms. For this reason, a full Small Firms Impact Test is not necessary

## Health Impact Assessment

The Department of Health guidance on health impact assessments[21] focus on three screening questions:

*1) Will your policy have a significant impact on human health by virtue of its effects on the following wider determinants of health? Income, Crime, Environment, Transport, Housing, Education, Employment, Agriculture, Social cohesion*

*2) Will there be a significant impact on any of the following lifestyle related variables?*Physical *activity; Diet; Smoking; Drugs; Alcohol use; Sexual behaviour; Accidents and stress at home or work*

*3) Is there likely to be a significant demand on any of the following health and social care services?Primary care; Community services; Hospital care; Need for medicines; Accident or emergency attendances; Social services; Health protection and preparedness response*

The answer to each is 'No'. For this reason, a full Health Impact Assessment is not necessary

## Greenhouse Gas Assessment

The Greenhouse Gas Assessment considers the impact this policy will have on greenhouse gas emissions.

This is not relevant to healthcare regulation. For this reason, a full Greenhouse Gas Assessment is not necessary

[19] Link: http://www.oft.gov.uk/shared_oft/reports/comp_policy/oft876.pdf
[20] Link: http://www.bis.gov.uk/files/file49614.doc
[21] Link: http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Healthassessment/DH_4093617

## Wider Environmental Issues Assessment

Using guidance from DEFRA, we do not believe this policy will have a negative impact on any environmental issues. For this reason, a full Environmental Impact Assessment is not necessary.

## Human Rights Assessment

Using guidance from the Ministry of Justice, we conclude the policy analysed in this Impact Assessment does not contravene the Human Rights Act 1998 and is compatible with all domestic and European legislation.

## Justice Impact Assessment

After consideration of the questions using the guidance on the Ministry of Justice website we do not believe this policy will have any impact on the justice system and hence a full Justice Impact Assessment is not required.

## Rural Proofing Test

Having considered the guidance from the Rural Proofing Toolkit, we do not believe there will be a disproportionately adverse effect on rural areas and hence a full Rural Proofing Test is not required.

## Sustainable Development Test

We do not believe there will be any environmental impacts of our policy proposal therefore a full Sustainable Development Test has not been completed.