Title: Extension CQC Ratings **IA No: 6118** **RPC Reference No:** **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 04/08/2017 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact for enquiries:**

Summary: Intervention and Options

RPC Opinion: Pending

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANDCB in 2014 prices)	**One-In, Three-Out**	**Business Impact Target Status**
£-0.0172m	£-0.0172m	£-0.002m	In scope	Not a regulatory provision

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

Clear and accurate information is crucial for individuals to make effective and properly informed decisions about their choice of health or social care providers. The 2014 Care Act introduced a duty for CQC to carry out performance assessments of providers of health and social care services, to be summarised in the form of a rating. The CQC have established a ratings methodology which is applied to many but not all providers of health and social care sectors. For ratings to be an effective way of providing useful information to service users, ratings information should be applied to all providers of health and social care services consistently, and the information must be easily accessible and available to the public. Health and social care providers with poor ratings have an incentive to conceal ratings information from service users. Government intervention is required to compel all providers to display the results of their rating.

What are the policy objectives and the intended effects?

To extend the scope of performance assessment ratings to include providers of Cosmetic Surgery, Substance misuse, Independent Ambulances, Termination of Pregnancy, Dialysis Units, and Refractive Eye Surgery, and in so doing require providers of these services to publicly display their rating. This will ensure service users in these additional sectors (already subjected to CQC's inspection regime) are aware of the quality of the services they use and will enable users to make better informed decisions about their care provision. Overall, increased transparency and availability of information on provider quality will drive greater competition between healthcare providers and ultimately result in the delivery of better quality care and a more responsive service for the public.

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

1. Do nothing
   Service users will not have full information or be aware of the quality of health and care services in Cosmetic surgery, Substance misuse, Independent Ambulances, Termination of Pregnancy, Dialysis Units and Refractive Eye Surgery.
2. Extending CQC ratings to additional sectors, including requirement to publicly display ratings
   Introduced via secondary legislation, extending CQC's rating of providers to Cosmetic surgery, Substance misuse, Independent Ambulances, Termination of Pregnancy, Dialysis Units, and Refractive Eye Surgery providers, so that service users are made aware of ratings displayed on premises and websites.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 01/2022

Does implementation go beyond minimum EU requirements?		No		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:**	**Non-traded:**	

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

Signed by the responsible Minister: Philip Dunne Date: 12th September 2017

Summary: Analysis & Evidence

Policy Option 1

Description: Do Nothing

FULL ECONOMIC ASSESSMENT

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

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

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

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

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

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

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

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

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

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline. The do nothing option would mean members of the public may have less access to information that would allow them to make informed decisions about the quality of care they might receive from a provider.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 0	**Benefits:** 0	**Net:** 0	

Summary: Analysis & Evidence

Policy Option 2

Description: Extending CQC ratings to additional sectors, including requirement to publicly display ratings

FULL ECONOMIC ASSESSMENT

Price Base Year 2016	PV Base Year 2017/18	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** £-0.0172m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low			Optional	**Optional**
High		3	Optional	**Optional**
Best Estimate	£0.014		£0.001	**£0.0172m**

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

The main cost is the cost to providers of displaying their (initial and subsequently amended) rating on their premises and on their webpage.

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

Extending the rating of providers to these additional sectors will raise awareness of the rating, and this may have knock on effects for the provider's business. This is more likely to change the distribution (rather than the level) of demand across providers, since the total level of demand is likely to remain driven by underlying health and care needs. Furthermore, these impacts are judged to be indirect as they depend on what action service users choose to take in response to the rating.

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

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

All benefits are unquantified.

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

Improved availability and accessibility of information on provider's performance will benefit the public by improving transparency within the health and social care sector. Current and prospective service users will benefit from being more aware of the quality of the services that they use, and this will enable them to make more effective and informed decisions about the choice of health and social care provider. Providers with good ratings will also benefit from this being publically known, at the expense of providers rated less highly.

Key assumptions/sensitivities/risks

Discount rate (%) 3.5

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: £0.002m	**Benefits:£m**	**Net:£-0.002m**	

Evidence Base

Policy Background

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care providers in England and has a key responsibility in the overall assurance of safety and quality of health and adult social care services.
2. Following the recommendations of the Public Inquiry into Mid Staffordshire NHS Foundation Trust, the 2014 Care Act introduced a duty for the CQC to carry out performance assessments of providers of health and adult social care services, to be summarised in the form of a rating.
3. The Government wanted the CQC to develop its ratings methodologies for all provider types and test its new approach in a controlled way. Therefore the scope of the performance assessment ratings was initially limited to NHS Trusts, NHS Foundation Trusts, Social Care providers, Independent Hospital providers and GP practices through The Care Quality Commission (Reviews and Performance Assessments) Regulations 2014, which came into force on the 1st of October 2014.
4. The current regulations focus the CQC's duty to undertake performance assessment ratings on those services where it would have the greatest benefit in informing patients, the public and commissioners, and where the CQC had sufficient evidence on which a system of robust, comparable performance ratings can be based.
5. As the CQC have continued to develop their ratings methodology and gained more experience in applying ratings to the above provider types, the CQC will expand the scope of ratings to other health providers. The sectors listed below have been identified where service users would benefit from being rated and where the CQC's growing evidence and expertise would support the production of a robust rating:

    - **Cosmetic Surgery Providers**
      The consultation document[1] stated the rationale for proposing providers of cosmetic surgery to be included in the scope of the ratings regulations is due to the concerns about safety and quality of providers in this sector since the publication of the report into PIP breast implants in June 2012. Extending ratings of providers to this sector combined with the requirement to display the rating (regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014), is intended to meet the recommendation of Sir Bruce Keogh's review of the regulation of cosmetic interventions. Sir Bruce's review recommended that 'Providers should be required to notify the public on their websites of any CQC inspection concerns or notices'.[2]
    - **Independent Ambulance Services**
      Although there are a small number of providers of independent ambulance across England, the number of providers is sufficient for patients to be presented with a degree of choice depending on where they live. Ratings will help users of these services to choose the best patient transport service for them. Ratings will also help commissioners when deciding who to contract services from which will encourage providers to deliver good quality care and make improvements in the quality of their services
    - **Independent Dialysis Units**
      There are a number of NHS Trusts that have links with independent dialysis centres, which provide services to their patients. These Trusts retain overall responsibility for the safety and quality of care that these patients receive. Allowing the CQC to apply ratings for these units will assist NHS Trusts in making decisions about which of these service providers to contract with.
    - **Refractive Laser Eye Surgery**
      Rating these providers is consistent with the proposal for ratings of other types of cosmetic surgery set out above. Ratings would also provide information about the quality of services for potential service users in a competitive market.

[1] Department of Health, Scope of Performance Assessments of providers regulated by the Care Quality Commission, August 2016

[2] Department of Health, Review of the regulation of Cosmetic Interventions: Final Report, April 2013

- **Substance Misuse Centres**
  Ratings of services in this sector would provide clear information on the quality of services for individuals seeking help with drug or alcohol misuse problems and for commissioners of services. Ratings may also encourage improvement by providers.
- **Termination of Pregnancy Services**
  Seeking advice on termination of pregnancy and access to further services leading to a termination can be a very difficult experience. Whilst the NHS provides these services, individuals may prefer to go to an independent provider.

6. Access to clear information about the quality and safety of the above services will be of considerable help in making an informed choice. The Department of Health consulted on the expansion of ratings between August-October 2016. The consultation also included a proposal to include the broad sector of independent community healthcare services. However, we found that certain types of providers in this category are difficult to define and we have concerns that the consultation exercise may therefore have failed to engage them fully. This sector has therefore been left out of the first set of regulations (which are the subject of this Impact Assessment). A second set of regulations, accompanied by a separate Impact Assessment, will seek to bring independent community healthcare services within scope.
7. We believe it would be beneficial to broaden the scope of the CQC's ratings regulations to include all providers of regulated services, with the exception of services already rated by other agencies or where it is not feasible to rate sectors because of operational constraints. Alongside independent community healthcare services, this will include independent doctors – who provide a diverse range of regulated activities. To avoid delay with those areas on which we have already satisfactorily consulted, we are therefore proposing to move ahead with our plans for regulations to cover them, but will introduce consolidating regulations to pick up these additional areas following a further period of consultation.
8. As at 31 December 2016, the CQC have given ratings to more than 26,000 locations and providers, and carried out more than 30,000 individual inspections overall (including re-inspections). The CQC are also carrying out more enforcement actions (1,462 in 2016; 1,073 in 2015).[3]
9. There is evidence of wide-ranging and positive changes following CQC inspections. By the end of 2016:
   - 79% (492 out of 622) of adult social care services originally rated inadequate had improved their overall rating.
   - Out of 11 hospital providers or locations originally rated inadequate, 6 had improved to requires improvement and 3 had been re-rated as good.
   - 78% (91 out of 116) of general practices rated inadequate had improved their rating – 56 moved to good and 35 moved to requires improvement.[4]
10. The evidence base for this impact assessment is structured as follows:
    - Section A: Problem identification and rationale for government intervention
    - Section B: Policy objectives and intended effects
    - Section C: Description of the options
    - Section D: Costs and benefits assessment
    - Section E: Conclusions

[3] CQC, Review of CQC's impact on quality and improvement in health and social care, April 2017

[4] CQC, Review of CQC's impact on quality and improvement in health and social care, April 2017

Section A: Problem Identification and rationale for government intervention

Problem Identification

11. Information is an essential component of the NHS and social care infrastructure. Better quality information and the sharing of information is critical to modernising the NHS and care services. Information can be used to improve the quality of care, improve our health and care outcomes, reduce inequalities and increase productivity and efficiency.

12. While there is a significant amount of information available on organisations providing health and social care in England, prior to CQC ratings, there was no aggregated assessment or 'rating' to summarise and compare the performance of organisations or the services provided by them. This limited the ability of individuals to make effective and properly informed decisions about their choice of health or social care provider, thus limiting the degree of competition between providers and meaning that the inherent information asymmetries between providers and service users were not addressed.

Rationale for government intervention

13. Government intervention is required to address these information issues and ensure that the information about ratings is as easily accessible and readily available to the public as possible, and that there is consistency in the rating of all health and care providers.

14. Bringing the additionally proposed sectors within the scope of the ratings regulation will simultaneously require providers in these sectors to display their rating.

Alternatives to legislation and options

15. Alternatives to regulation have not been considered as legislation is required in order for the CQC to be able to publish a performance rating for the sectors in paragraph 5. Although all health and social care providers are already subject to the CQC's new comprehensive inspection regime (which forms a key part of the information used to give providers a rating), the CQC are unable to issue a performance rating for providers who are not described in The Care Quality Commission (Reviews and Performance Assessments) Regulations 2014.

16. Since providers brought within the scope of these regulations are automatically required to publicly display their rating, the option of giving CQC the power to rate providers whilst leaving the display of such ratings as subject to the discretion of providers is not a practically feasible option. Therefore, for the purpose of this Impact Assessment, any discussion of the impacts of including the additionally proposed sectors within the scope of The Care Quality Commission (Reviews and Performance Assessments) Regulations 2014 cannot and should not be separated from impacts of requiring providers in these sectors to publicly display their rating.

Section B: Policy objectives and intended effects

17. The intended policy effect will be to ensure that service users in the additional sectors (listed in paragraph 5) are aware of the quality of the services that they use, which will enable them to make better informed decisions about their care provision. Overall, it is intended that this will in turn drive greater competition between healthcare providers and ultimately, result in the delivery of better quality care and a more responsive service for the public.

Section C: Description of options

Option 1: Do nothing

18. Under the do nothing option, users of services provided by organisations listed in paragraph 5 would continue to have to make their own judgements about a provider's quality of care, despite ratings already being available for the majority of health and social care providers. Even if CQC could publish their ratings of providers in the additional sectors on the CQC website alongside the provider's inspection report, there is a risk that there will be low public awareness of the availability of this information, or that some key groups (such as the elderly) will find it difficult to access the information.

19. As a result, the do nothing option is not preferred.

Option 2: Extending CQC ratings to additional sectors, including requirement to publicly display ratings

20. CQC would be given the power to apply ratings to providers in the additional sectors, including the requirement for providers to publicly display their rating, via secondary legislation. Where practical this would be through display of their ratings on their premises and on the providers' website.

21. The CQC have produced a set of easy-to-use tools to help providers display their ratings to ensure they meet the requirements.

Section D: Costs and benefits assessment

22. The CQC inspect a provider as part of their regulatory activity and generate a rating following inspection. Regulation of health and social care has been in place in England for just over a decade, although regulation of NHS services only commenced in 2010. The CQC regulates all providers of health and social care, inspection is now a necessary condition of being allowed to operate under the Health and Social Care Act 2008. The Care Act 2014 includes a provision which gives CQC the legal power to conduct performance assessments of providers and concluding in the publication of a rating.

23. This policy will expand the scope of the CQC ratings to the health and social care sectors listed in paragraph 5, all of whom are already subjected to CQC's inspection regime. The CQC have developed their ratings methodology to providers listed in the Care Quality Commission (Reviews and Performance Assessments) Regulations 2014.

24. The CQC have produced a set of easy-to-use tools to help providers display their ratings to ensure they meet the requirements.[5] The tool provides ready-made ratings display solutions for poster and widget for web page.

Costs

25. The costs associated with mandatory publication of ratings for additional providers can be categorised into those that are one-off – e.g. concerned with developing the rating framework or applying it for the first time – and those that are recurrent; and into those that are borne by CQC and those imposed on the providers.

One-off costs

CQC

Developing a rating framework and training inspectors

26. The Impact Assessment for the initial introduction of provider ratings left the cost of developing the rating framework unquantified. In the discussion of development costs it included an estimate of £4m for the cost to CQC of developing the Annual Health Check of NHS Providers – a prior assessment framework – but opted not to include this in the quantified costs because of key differences between the prior and proposed rating frameworks, such as the fact that the Annual Health Check was applied only to the NHS (not to social care or independent providers of healthcare) and was not based on information collected via inspections.

27. In contrast to the situation in 2014, a framework for rating a diverse range of health and social care providers already exists. The challenge for CQC is to ensure the existing framework can be adapted in a way that, on the one hand, is consistent with how the framework is applied to providers already within scope and, on the other hand, is sensitive to the particular context of the sectors being added.

28. Successfully meeting this challenge will likely impose additional costs on CQC. It has not been feasible to estimate these costs, suffice to say that any such costs will need to be met from within CQC's existing budget and therefore represent an opportunity cost.

[5] http://www.cqc.org.uk/get-involved/consultations/ratings-display-toolkit

29. The CQC will also need to train inspectors to rate providers in these additional sectors, which they already inspect. Without knowing how the existing rating framework will be applied to these additional sectors, it has not been possible to quantify the costs of training inspectors. Given that a framework already exists and that the ratings will be based on information already collected through inspections, such costs are anticipated to be small.

Applying an initial rating to all additional providers brought within scope of the regulations

30. The CQC will need to provide an initial rating for all providers in the additional sectors. CQC have confirmed that they expect the ratings to be based on information gathered via the inspections they already carry out in these sectors. Furthermore, they do not anticipate that the frequency of inspection will change as a result of bringing these sectors within the scope of the rating framework. It has therefore been assumed that the additional costs of applying the rating, once the rating framework has been adapted to the additional sectors, will be small or negligible.

Providers

Familiarisation costs

31. There may be some familiarisation costs for providers who are now subject to ratings. However, given that the process of ratings is now well established in the health and social care sector, these costs are expected to be minimal or none.

Cost of displaying an initial rating

32. Based on the most recent inspection activity, the CQC estimate the following numbers of additional providers that would be subject to ratings as a result of this policy.

Sector	Number of providers
Substance Misuse	Between 130 and 470
Independent ambulances	200
Cosmetic Surgery	100
Termination of pregnancy	121
Dialysis units	70
Refractive eye surgery providers	95
Total No Of Providers	**Between 716 and 1,056**

33. The impact of displaying ratings was calculated in a previous IA 'Display of Ratings: "Scores on the Doors"'. The assessment found the additional impact of requiring a provider to display the results of a CQC inspection is simply the cost associated with a provider taking the time to put up and display a certificate or poster with their rating on, and in updating their website with the same information.

34. Based on consultation responses for the previous impact assessment, it was considered 15 minutes of staff time were required to physically display the poster of the ratings, and there would be a similar time requirement to display the rating on a website.

35. The previous impact assessment assessed the cost of displaying ratings to be £7.50 which was based on a median gross hourly wage for all employees working in Human Health and Social Care Activities (Standard Industrial Classification 2007). Using the 2016 SIC for Human Health and Social Care Activities hourly wage of £15.09 and uplifting by 30% for on-costs, results in a gross wage of £19.62. Assuming 15 minutes for displaying the poster and 15 minutes for updating the website, we estimate a cost of £9.81 to providers for displaying ratings. To note, the CQC tools to display ratings should ease the burden on providers but it is difficult to estimate the associated time saving, so this has been left unquantified.

36. Multiplying the cost of displaying ratings by the estimated number of providers - as many providers in these sectors are micro or small businesses (see paragraph 47), we have assumed single premises per provider - implies a total estimated cost of up to ***£10,358*** for all providers to display their initial rating.

37. As stated above, CQC do not expect to be able to rate all additional providers within one year. This Impact Assessment assumes that it will take the CQC three years to initially rate all additional providers.

Recurrent costs

CQC

Re-rating of providers

38. As already stated above, CQC expect the rating of providers to be based on information gathered via the inspections they already carry out in the additional sectors. Furthermore, they do not anticipate that the frequency of inspection will change as a result of bringing these sectors within the scope of the rating framework. It has therefore been assumed that the additional costs of applying the rating framework on an ongoing basis will be small or negligible.

Monitoring and enforcement of compliance with display of ratings legislation

39. The Impact Assessment for the initial display of ratings legislation ("Scores on the Doors") stated that the costs to CQC of monitoring compliance are, 'expected to be negligible as they would be able to do this as part of their existing inspection processes', and any such costs would be offset to some degree by the power to collect a maximum penalty for not displaying a rating of £500, with the possibility of an additional £100 penalty notice in lieu of prosecution.

Providers

On-going costs of displaying a rating

40. As described above, the cost to providers of displaying an initial rating is estimated to be up to £10,358. In line with CQC's current inspection regime, it is assumed that CQC will focus their re-inspection resources on those providers receiving the bottom two ratings – i.e. those rated as 'Requires Improvement' or 'Inadequate' (some 22% of ratings issued to providers already within the scope of the regulations as at Q4 2016/17, according to CQC's Annual Report and Accounts 2016/17).

41. Clearly, providers will only incur on-going costs of displaying their rating where their initial or current rating changes as the result of a re-inspection. According to CQC's Annual Report and Accounts, re-inspection of 'inadequate' providers undertaken in 2016/17 led to a change in rating in 71% of cases and re-inspection of 'requires improvement' providers led to a change in rating in 58% of cases.

42. Assuming the same distribution in ratings in the additional sectors as those sectors already rated by CQC implies that around 15% of providers will need to display an amended rating on a recurrent basis, imposing recurrent costs equivalent to £1,362 per annum. (For simplicity, we have assumed that the proportion of providers rated as 'requires improvement' or 'inadequate' stays constant at 22%, despite there being some evidence that risk-based re-inspection has succeeded in CQC reducing this percentage over time).

Costs to providers of enforcement action

43. The costs to business of complying with the display of ratings regulation is based on 100% compliance, even though in practice some providers may choose not to display their rating. Furthermore, any fines or charges associated with non-compliance have been excluded from the net cost to business.

Costs of improving quality or expanding capacity in response to a given rating

44. The ultimate aim of extending the rating of providers to the additional sectors is, through the market signal it transmits, to improve the average quality of care experienced by service users.

45. This could occur either because providers rated as anything other than outstanding improve their quality because they fear the loss of users (and associated revenue) to providers rated more highly than them or because users vote with their feet and choose to be treated in more highly rated providers than would otherwise have been the case had ratings not been displayed. (We assume that this can only ever affect the distribution of users to providers rather than leading to an overall increase in the level of demand).

46. Since there is no general relationship between improving quality and costs – i.e. some quality enhancing measures save money – and since any such effects are indirect, they have not been

quantified in this Impact Assessment and are, in any case, excluded from the net direct cost to business.

Cost Summary

Overall Net Present Value			Year 0 2017/18	Year 1 2018/19	Year 2 2019/20	Year 3 2020/21	Year 4 2021/22	Year 5 2022/23	Year 6 2024/25	Year 7 2025/26	Year 8 2026/27	Year 9 2027/28	Year 10 2028/29	Total
Description of costs	CQC	Developing a rating framework	Unquantified											-
		Training Inspectors	Unquantified											-
		Providing initial ratings	None/Minimal											-
		Re-rating	None/Minimal											
		Enforcement	None/Minimal											-
	Business	Familiarisation of ratings	None/Minimal											-
		Display of initial ratings		3,453	3,453	3,453								10,358
		Display of ratings following reinspection					£1,362	£1,362	£1,362	£1,362	£1,362	£1,362	£1,362	
		Cost of quality improvement	Unquantified											-
Total Costs (undiscounted)			£0	£3,453	£3,453	£3,453	£1,362	£1,362	£1,362	£1,362	£1,362	£1,362	£1,362	£19,892
Discount adjustment			1	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	0.71	
Total Costs (discounted)			£0	£3,336	£3,223	£3,114	£1,187	£1,147	£1,108	£1,071	£1,034	£999	£966	£17,185
Description of benefits	Providers	Improved competition	Unquantified											
	Patients/Public	Improved awareness and health	Unquantified											
Total Benefits (undiscounted)			£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Discount adjustment			1	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	0.71	
Total Benefits (discounted)			£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Net present value (NPV)			£0	-£3,336	-£3,223	-£3,114	-£1,187	-£1,147	-£1,108	-£1,071	-£1,034	-£999	-£966	-£17,185
Equivalent Annual Net Direct Cost to Business (EANDCB)														-£2,047

47. The summary table above shows that the total NPV cost of this policy over 10 years is estimated as £17,185, all of which is estimated to be borne directly by business. The EANDCB (in 2014 prices) is estimated as being around £2,000 per year.

Benefits

Benefits to providers

48. Providers in these additional sectors with 'good' or 'outstanding' ratings are likely to benefit from increased public awareness of these ratings. However, on the flip side, providers with 'requires improvement' or 'inadequate' ratings may lose business if the public become more aware of these ratings. Overall it is not possible to quantify these impacts as we do not know how the public will respond to the ratings information.

Benefits to patients and the public

49. Improved availability and accessibility of information on providers' performance will benefit the public by improving transparency within the health and social care sector. Current and prospective service users will benefit from being more aware of the quality of the services that they use, and this will enable them to make more effective and informed decisions about their choice of health and social care provider.

50. In the long run, increased transparency is expected to improve competition between providers and incentivise them to make further quality improvements in order to receive a higher rating. This will further benefit the public by increasing the overall quality of care.

51. The previous impact assessment provided some illustrative examples of the potential benefits to patients using the EQ-5D framework for valuing improvements in general health status[6]. It found, if one service user is able to avoid one month's worth of less than perfect health due to poor quality care, there would be at least a 0.008 QALY gain. Based on a societal willingness to pay of £60,000 per QALY, this would equate to a societal benefit of at least £480 per patient. Although it is not possible to know how many users of these additional sectors might be affected in this way due to the introduction of ratings, if 36 users were to receive these modest health gains over the first 10 years, then the policy would break-even.

52. To put this figure in context, according to the British Association of Aesthetic Plastic Surgeons' (BAAPS) Annual Audit 2017, representing just one of the additional sectors (cosmetic surgery) there were 31,000 surgical procedures performed in Great Britain in 2016. Even allowing for the fact that the ratings regulation will be extended only to those services provided in England, 36 users is likely to represent a very small proportion of the total annual number of users across the six additional sectors.

[6] http://www.euroqol.org/

Value for money

53. This Impact Assessment is concerned with the costs and benefits of extending CQC's rating of providers to additional sectors, as an important intermediate step in ensuring that users of health and social care services can benefit from the consistent and comprehensive rating of all providers.

54. Since these sectors are already within the scope of CQC regulation and inspection, the costs to CQC of bringing these sectors within the existing rating framework are expected to be small.

55. Furthermore, since the basis for providing a rating is expected to continue to be based primarily on information that is already collected through inspections, and given that CQC do not expect the frequency of inspection to increase as a result of bringing the additional sectors within the scope of rating, the costs to business are expected to relate solely to the costs of displaying their initial and subsequent ratings (where a re-rating results in a change to a provider's current rating).

56. The EANDCB is estimated at around £2,000 per year, which would require just 4 people a year to benefit from a moderate improvement in health as a result of the extended ratings for them to prove worthwhile.

Risks

Policy risks

57. There is a risk of low compliance from the additional sectors from displaying ratings suggesting the benefits discussed will not be realised. This risk will be mitigated through the CQC's inspections process which tests users' knowledge and awareness of a particular provider's ratings.

Section E: Conclusions

Conclusion

58. The impact of bringing the additional sectors (Cosmetic surgery, Substance misuse, Independent Ambulances, Termination of Pregnancy, Dialysis Units, Refractive Eye Surgery) into the scope of the ratings for CQC is likely to be minimal as providers in these sectors already undergo the CQC's inspection regime. This policy proposal is assessed to be a regulatory proposal with a small net cost to business.

Section F: Summary of specific impact tests:

Equality Impact Assessment

59. This policy proposal impacts all CQC registered health and adult social care providers. The costs will not impact service users or any group of individuals. The benefits of improved quality of care through increased accessibility and transparency of ratings information will be realised by users of health and adult social care services equally. This policy will not disproportionately affect any one demographic or social group. In general, the users of healthcare services tend to be people from older age groups, lower income distribution and those with disabilities or long term conditions.

Competition

60. In any affected market, would the proposal:

- Directly limit the number or range of suppliers?
  No. The proposals do not involve the award of exclusive rights to supply services, procurement will not be from a single supplier or restricted group of suppliers.

- Indirectly limit the number or range of suppliers?
  No. The CQC ensure that only providers who have made a legal declaration that they meet the standards of quality and safety are allowed to provide care. The proposed policy will increase the standards that providers must meet before they are able to enter the market.
- Limit the ability of suppliers to compete?
  No. This duty is not expected to have any impact on suppliers. All CQC registered providers of health and adult social care who receive a performance assessment from CQC will be affected equally.
  This duty does not limit the scope for innovation for the introduction of new products or supply existing products in new ways. It does not limit the sales channels a supplier can use, or the geographic area in which a supplier can operate. It does not limit the suppliers' freedoms to organise their own production processes or their choice of organisational form. It does not substantially restrict the ability of suppliers to advertise their products.
- Reduce suppliers' incentives to compete vigorously?
  No. The proposal does not exempt the suppliers from general competition law. It does require providers to be more open and honest with service users about the quality of services provided. Where this information would otherwise not be available, competition is likely to increase as information asymmetries are reduced.

Small and Micro Business Assessment

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

- The proposed requirement would apply equally to providers of all sizes, and no exemptions are proposed for small and micro businesses as doing so would undermine the objective of the policy, which is to maximise public awareness of ratings and ensure that this information is as easily accessible and available to the public as possible. By exempting small providers from this requirement, we would expect that not all small providers would voluntarily choose to display their rating, meaning that only those members of the public who are already aware of ratings, know that the information is available from the CQC website, and have access to a computer would be able to access the information. This suggests that the public would not have a complete picture of ratings information, and there is a risk that this may skew public perception about the quality of services available. This would be a significant problem because, as demonstrated below, the vast majority of CQC regulated providers can be classed as a small or micro provider.
- The 2016 UK Business Population data suggests 99% providers in the Human Health and Social Work Activities are considered small or micro businesses (less that 50 employees). This would suggest the large majority of private providers registered with CQC will be small or micro businesses.

TABLE 5 UK Sections

Number of businesses in the private sector and their associated employment and turnover, by number of employees and industry section, UK, start 2016

	Number			Percent		
	Businesses	Employment thousands	Turnover [1,3] £ millions	*Businesses*	*Employment*	*Turnover [1,3]*
Q Human Health and Social Work Activities						
All businesses	347,700	1,757	75,535	*100.0*	*100.0*	*100.0*
All employers	62,770	1,460	65,659	*18.1*	*83.1*	*86.9*
With no employees (u	254,085	266	7,537	*73.1*	*15.1*	*10.0*
With no employees (n	30,845	31	2,338	*8.9*	*1.8*	*3.1*
1	5,370	11	616	*1.5*	*0.6*	*0.8*
2-4	20,355	61	3,546	*5.9*	*3.5*	*4.7*
5-9	12,010	91	4,887	*3.5*	*5.2*	*6.5*
10-19	12,145	183	9,547	*3.5*	*10.4*	*12.6*
20-49	8,930	284	14,585	*2.6*	*16.2*	*19.3*
50-99	2,490	170	7,882	*0.7*	*9.7*	*10.4*
100-199	860	116	4,919	*0.2*	*6.6*	*6.5*
200-249	155	35	1,448	*0.0*	*2.0*	*1.9*
250-499	265	89	2,805	*0.1*	*5.1*	*3.7*
500 or more	190	421	15,426	*0.1*	*24.0*	*20.4*

Legal Aid/Justice Impact

62. The following have been considered in the main impact assessment above and in the Ministry of Justice impact test provided alongside this document:
    - Will the proposals create new civil sanctions, fixed penalties or civil orders with criminal sanctions or creating or amending criminal offences? *No*
    - Any impact on HM Courts services or on Tribunals services through the creation of or an increase in application cases? *No/Minimal*
    - Create a new right of appeal or route to judicial review? *No*

- Enforcement mechanisms for civil debts, civil sanctions or criminal penalties? *No*
- Amendment of Court and/or tribunal rules? *No*
- Amendment of sentencing or penalty guidelines? *No*
- Any impact (increase or reduction on costs) on Legal Aid fund? (criminal, civil and family, asylum) *No*
- Any increase in the number of offenders being committed to custody (including on remand) or probation? *No*
- Any increase in the length of custodial sentences? Will proposals create a new custodial sentence? *No*
- Any impact of the proposals on probation services? *No*

Sustainable Development

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

Health Impact

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

    - The potential impacts on health have been considered above in the cost benefit analysis of this impact assessment, see Section D above.
    - There are no expected health risks in association with, diet, lifestyle, tobacco and alcohol consumption, psycho-social environment, housing conditions, accidents and safety, pollution, exposure to chemicals, infection, geophysical and economic factors, as a result of the proposals.

Rural Proofing

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

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

Wider Impacts

66. The main purpose of the proposed requirement is to increase public awareness of provider ratings and ensure that this information is as easily available and accessible for the public as possible. It is intended to help patients make better and more informed choices about the health and social care services that they use.

Economic Impacts

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

Environmental impacts and sustainable development

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

Social impacts

69. No impact has been identified in relation to rural issues or the justice system.