Title:	Impact Assessment (IA)
REGULATION OF HEALTH AND SOCIAL CARE PROFESSIONS (Consultation Paper)	**Date:** 01/01/2012
IA No: LAWCOM0015	**Stage:** Consultation
Lead department or agency:	**Source of intervention:** Domestic
LAW COMMISSION	**Type of measure:** Primary legislation
Other departments or agencies:	**Contact for enquiries**: Tim Spencer-Lane

Summary: Intervention and Options

RPC: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£241.0m	£0	£0	No	NA

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

The regulation of 32 different health and social care professional groups is carried out by 10 regulatory bodies. A complex legislative landscape has evolved over 150 years resulting in a wide range of inconsistencies in the powers, duties and responsibilities of each of the regulators. The law could be improved to ensure it provides for a system of professional regulation that is responsive to the needs of modern regulation, proportionate to the risks involved and clear about the purpose of ensuring public protection. Accordingly, it would be beneficial to reform the legal framework and this will require primary legislation.

What are the policy objectives and the intended effects?

The policy objectives are: (1) the simplification of the legal framework to allow the law to be easier to understand for the public and professionals; (2) consistency of powers between the regulatory bodies, which would allow the public and professionals to be clearer about what to expect from the regulatory scheme; (3) increased flexibility and autonomy for the regulators to keep pace with changes in health and social care; (4) clear accountability mechanisms for regulation and (5) enabling cost efficiencies.

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

Option 0: Do nothing

Option 1: Simplification and reform of the health and social care professional regulation legislative framework (the preferred option). In general terms, this option involves consolidating existing legal provisions and establishing a more efficient and effective legal structure.

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

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** **No**	**< 20** No	**Small** **No**	**Medium** **No**	**Large** **No**
What is the CO2 equivalent change in greenhouse gas emissions? (Million tonnes CO2 equivalent)			**Traded:** 0	**Non-traded:** 0	

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 Chief Executive: ..... Date: 1 March 2012

Summary: Analysis & Evidence

Policy Option 1

Description: The preferred option is to reform the law to create a more flexible, transparent and efficient legal framework for the regulation of health and social care professionals.

FULL ECONOMIC ASSESSMENT

Price Base Year 2011	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: 161.5	**High:** 405.5	**Best Estimate:** 241

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	4.0	1	0.1	**4.8**
High	7.0		0.4	**10.3**
Best Estimate	6.0		0.3	8.5

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

Key monetised costs would fall on the health and social care professional regulators.
Transitional costs: Cost of re-training (£350,000) in first year; cost of creating/implementing new rules (£5.4 mn (best estimate)).
On-going costs: Extra activity arising due to clarifying access to the regulators' fitness to practise mechanism (£254,000 (best estimate)).

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

None identified.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	0	20.0	**166.3**
High	0		50.0	**415.8**
Best Estimate	0		30.0	249.5

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

Key monetised benefits would fall on the health and social care professional regulators and government. Registrants may also derive monetised benefits if the regulators reduced registration fees.

On-going benefits: efficiency savings at the regulators (£30,000,000 (best estimate)); decreased costs for government (£1,523,000 (best estimate)).

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

Key non-monetised benefits would fall on the public, patients and service users, and registrants.

On-going benefits: reduced risk to the public and increased confidence in the professions.

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

Assumptions: there are 1,423,277 registered health and social care professionals in the United Kingdom.

Sensitivities: between 5% - 15% (best estimate 10%) efficiency savings at the regulators.

Risks: More complaints may be received by the regulators once access is clarified.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

EVIDENCE BASE

This is an initial impact assessment which is produced as part of our consultation process. The consultation process is the first stage in our project as we work towards producing a final report. At that stage, we will publish a final impact assessment.

This version of the impact assessment is intended to describe the background to the project, to provide detail of the options considered and to identify the key themes of the potential impacts of our preferred option. The figures contained in this impact assessment are our initial estimates based on the figures available. We will be working with stakeholders in order to gather further evidence. We welcome any additional views and evidence as part of our consultation process.

Part 1: Introduction

Background to the problem

The regulatory scheme for health and social care professionals consists of a number of different statutory regulators. There are 10 regulators within the scope of this project. They are:

1. General Chiropractic Council;
2. General Dental Council;
3. General Osteopathic Council;
4. General Medical Council;
5. General Optical Council;
6. General Pharmaceutical Council;
7. General Social Care Council;
8. Health Professions Council;
9. Nursing and Midwifery Council; and
10. Pharmaceutical Society of Northern Ireland.

The health and social care regulators maintain professional registers, set standards for education and practice, and ensure that professionals are fit to practise. Collectively, the regulators are responsible for the standards of practise of almost 1.4 million professionals. It should be noted that the General Social Care Council is due to be closed in July 2012. Subject to the successful passage of the Health and Social Care Bill, the regulation of social workers will become the responsibility of the Health Professions Council, which will be renamed the “Health and Social Care Professions Council”.

Statutory regulation of health and social care professions can be traced back over the last 150 years, since the establishment of the General Medical Council in 1858. Over time, different health care professions have become regulated by statute. Each of the separate professions was made subject to statutory regulation one-by-one. This has meant that the legislative structure of health and social regulation has developed on a piecemeal basis and the regulators operate within a wide variety of legal frameworks. These frameworks have been agreed and amended by Parliament in different ways and at different times over the past 150 years. A complex legislative landscape has evolved resulting in a wide range of idiosyncrasies and inconsistency in the powers, duties and responsibilities of each of the regulators.

There are currently 10 pieces of governing legislation which govern the 10 regulatory bodies. These have all been amended extensively by 16 Orders made under the Health Act 1999 and a range of Acts of Parliament over the last 10 years. We have estimated that there are 194 pieces of secondary legislation which specifically address the regulators.

The current system is also expensive and requires continuous Government input for its maintenance. The regulators have powers to make rules and regulations concerning their operating procedures but the requirement of Privy Council approval imposes burdens on the Department of Health, as the Department with policy responsibility. In practice, the Privy Council defers to the Department’s policy officials and legal group when it is required to act. Constraints on Government resources mean that only the most

pressing matters are taken forward, thereby restricting the regulators' ability to instigate reforms and modernise their legal frameworks.

In summary, the current legal framework is highly complex, inflexible, inconsistent and expensive to maintain. Accordingly, there is a strong case for reform. This need has been recognised by the regulatory bodies as well as the Department of Health.

For these reasons, the Department of Health suggested a project to review the legal framework for health and social care professional regulation (this does not include social care professional regulation in Scotland or Northern Ireland). The purpose of the proposals made in the consultation paper is to address these problems by establishing a simple, consistent, flexible, accountable and **efficient** modern legal framework (see *policy objectives* below).

The problem under consideration

Complexity of the legal framework

The statutory schemes exist in a wide variety of forms which have been agreed and amended by Parliament in different ways and at different times over the past 150 years. A complex legislative landscape has evolved on a piecemeal basis resulting in a wide range of idiosyncrasies and inconsistency in the powers, duties and responsibilities of each of the regulators. There are currently seven separate Acts of Parliament and three Orders made under section 60 of the Health Act 1999 which govern ten individual regulatory bodies. These have all been amended extensively by various Orders and statutes over the last ten years. This complex legal framework would benefit from reform in order to emphasise the overall purpose of regulation in this context: to protect the public.

Inconsistencies in the legal framework

As a consequence of the complex legal framework, inconsistencies have developed. For example, in fitness to practise proceedings, some regulators have powers to establish systems of case management, while others do not. Some are able to screen allegations of impaired fitness to practise, while others must refer all complaints to an investigation committee. The powers to take action against practitioners whose fitness to practise is impaired also varies.

Inflexibilities in the legal framework

The regulators' governing legislation is difficult to alter and keep updated. Consequently the legal frameworks can often be out of step with the regulatory demands of their registrants. The main legislative vehicle for altering the governing legislation is an Order made under section 60 of the Health Act 1999. However, the section 60 orders can take two years to be implemented once the proposal has been agreed. Legislative reform would facilitate a more flexible system that better meets the needs of modern professional regulation.

Costs of the legal framework

The current legal framework gives rise to a significant cost burden on the regulators and the Government. In the White Paper *Enabling Excellence*, it is estimated that the total expenditure on health and social care professional regulation is more than £200 million per year, with the operating costs of the regulators met through fees paid by registrants themselves. The legal framework may also restrict the regulators from achieving efficiencies. Law reform presents an opportunity to create a legal framework to address this.

Furthermore, the current system requires continuous Government input for its maintenance. Each of the regulators has powers to make rules and regulations concerning their operating procedures but the requirement of Privy Council approval imposes burdens on the Department of Health, as the Department with policy responsibility. In practice the Privy Council defers to the Department's policy officials and legal group when it is required to act. Constraints on Government resources mean that only the most pressing matters are taken forward, thereby restricting the regulators' ability to instigate reforms and modernise their legal frameworks. By creating a flexible legal framework, there is an opportunity to significantly reduce departmental expenditure on health and social care regulation.

Rationale for intervention

The above discussion of the problem under consideration demonstrates a compelling case for reform this area of law. The complexity, inflexibility and cost of the current legal framework are causing inefficiency and may be frustrating the delivery of Government policy. On this basis, there is a strong case for reform of the law. Given that the regulation of health and social care professionals relies on a legislative structure, it follows that the only mechanism for intervention is through reform of the law, which requires Government intervention and Parliamentary time.

Policy objectives

There are five policy objectives:

Simplification

The purpose of reform would be to develop a legal structure that replaces the current position of dense and complicated law with a clearer and more cohesive framework. This would enable the law to be more easily understood by the public and registrants, thereby promoting confidence in the regulation of health and social care professionals. Furthermore, a simplified legal framework would make the law easier to use for the regulators by clarifying their legal powers and duties.

Consistency of powers

A key objective of reform is to establish consistency in the powers and functions of the regulators. A consolidated statute would provide a single source of law in an area that suffers from its basis on inconsistent pieces of primary legislation. This would have benefits for service users and registrants as they would be clearer about what to expect from the regulators. The regulators would feel benefits themselves by being able to make decisions in parity with other regulators and thereby develop shared learning points through which performance could be improved.

Flexibility

Reform of the legal structure is required to give the regulators greater flexibility. Under present arrangements, the regulators are straight-jacketed in their ability to provide regulatory solutions. A legal framework that enables regulators to create their own rules using streamlined processes, such as with less input from the Department of Health, should help produce a system which benefits the public and registrants, by providing a regulatory scheme which matches developments in the health and social care arenas.

Accountability

The need for proper modes of accountability is an important factor behind our proposals. Currently the role of the Privy Council is illusionary and in reality the Government holds the regulators to account. Our scheme aims to clarify the proper role of the Government in this regard. The regulators would also be open to scrutiny from the Council for Healthcare Regulatory Excellence and from the public through consultation requirements.

Cost efficiencies

An express aim of this proposed reform is to achieve cost efficiencies in professional regulation. Under present arrangements, resources are used inefficiently by requiring the Department of Health to oversee changes to the regulators' rules and regulations. The costs associated with this include drafting and legal advice, as well as delays. A feature of our proposals would be the transfer of costs from the Department of Health on to the regulators who would be required to undertake the consultation and drafting associated with a change in rules. However, it is anticipated that there are significant overall efficiencies to be had by moving the responsibility for changes from the Department of Health on to the regulators themselves. This would include efficiencies associated with having fewer layers in the change process. The public would benefit from a system which requires reduced expenditure from central Government. Furthermore, the public and registrants would benefit since the regulators would be able to introduce a more streamlined and efficient service.

Intended effects

The intended effect of reform is to create a clear, flexible, modern and efficient system for health and social care professional regulation, which sets out the legal powers and duties of the regulators in a manner which is accessible to the public and registrants.

Underlying causes of the problem

As noted above, the legislative framework for health and social care professional regulation in the UK has developed in a piecemeal fashion over the past 150 years. Each regulator has its own separate legal framework which has been introduced and reformed by Parliament throughout this period.

Main stakeholders

1. The public, patients and service-users;
2. The registrant health and social care professionals;
3. The statutory regulators;
4. Unions and representative bodies;
5. Department of Health;
6. Privy Council;
7. Legal advisers; and
8. Wider justice system.

Scale and Scope

The following sets out the scale and scope of the health and social care professional regulatory sector that is within the remit of our project. In the main, we rely on figures from the regulators' publicly available information. This is primarily found in their recent annual reports and accounts. The detail of the information provided by the regulators in their accounts varies. Accordingly, the tables set out below vary in their data sets. For example in the case of governance costs only six regulatory bodies had the relevant cost information.

We will be working with the Council for Healthcare Regulatory Excellence, which will be gathering information from the regulators during our consultation period, to develop our data sets. We welcome any additional evidence as part of our consultation process.

Number of regulators/registrants

There are approximately 1.4 million professionals registered with the health and social care regulators. The regulators regulate 32 different health and social care professions. These numbers are not evenly distributed, with the number of registrants dependant on the number and size of professions within the remit of each regulator. For instance, the General Medical Council regulates a single, relatively large profession (doctors) whilst the Health Professions Council currently regulates 18 relatively small professions. When the Health Professions Council begins to regulate social workers (subject to the successful passage of the Health and Social Care Bill), it will become the second largest regulator.

Other regulators might regulate professions associated with its core profession. For instance, in addition to dentists, the General Dental Council regulates dental hygienists, dental therapists, clinical dental technicians, orthodontic therapists, dental nurses and dental technicians. Table 1 sets out the regulators in order of size:

Table 1: Regulatory bodies and registrants, 2011

Regulator	Number of Registrants
Nursing and Midwifery Council	665,132

General Medical Council	239,270
Health Professions Council	215,000
General Social Care Council	104,469
General Dental Council	97,087
General Pharmaceutical Council	68,500
General Optical Council	24,628
General Osteopathic Council	4,442
General Chiropractic Council	2,658
Pharmaceutical Society of Northern Ireland	2,091
Total	1,423,277

Source: Nursing and Midwifery Council, *Annual Report and Accounts 2010 – 2011* (2011); General Pharmaceutical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Dental Council, *Annual Report and Accounts 2010* (2011); General Medical Council, *The state of medical education and practice in the UK 2011* (2011); General Social Care Council, *Annual Report and Accounts 2010 – 2011* (2011); Health Professions Council, *Annual Report and Accounts 2010 – 2011* (2011); General Optical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Osteopathic Council, *Annual Report and Accounts 2010 – 2011 (*2011); General Chiropractic Council, *Annual Report and Accounts 2010* (2010); Pharmaceutical Society of Northern Ireland, *Annual Report and Accounts 2009 – 2010* (2010).

In the White Paper *Enabling Excellence*, it is stated that **28%** of registered health and social care professionals work in the private sector. As such, we can estimate that approximately **72%** of the total number of registrants work in the public sector.

Annual expenditure by the regulators

The White Paper *Enabling Excellence* states that approximately £200 million is spent by the regulators on an annual basis. The amount spent by the regulators is also unevenly distributed, with the General Medical Council spending significantly more than any other regulator. Table 2 sets out the regulators in order of their annual expenditures:

Table 2: Annual expenditure and per registrant (average) expenditure by regulatory body, 2011

Regulator	**Per registrant Expenditure (£)**	**Total expenditure (£)**
General Medical Council	£365	£87,342,000
Nursing and Midwifery Council	£ 67	£44,716,000
General Dental Council	£272	£26,477,000
General Social Care Council	£183	£19,146,000
General Pharmaceutical Council	£243	£16,678,000
Health Professions Council	£75	£16,257,000
General Optical Council	£209	£5,156,909
General Osteopathic Council	£683	£3,034,747
General Chiropractic Council	£1,117	£2,971,547
Pharmaceutical Society of Northern Ireland	£405	£846,918

Total		£222,626,121

Source: Nursing and Midwifery Council, *Annual Report and Accounts 2010 – 2011* (2011); General Pharmaceutical Council, *Annual Report and Accounts 2010 – 2011* (2011) [figure scaled up to reflect indicative annual expenditure]; General Dental Council, *Annual Report and Accounts 2010* (2011); General Medical Council, *Annual Report 2010* (2011); General Social Care Council, *Annual Report and Accounts 2010 – 2011* (2011); Health Professions Council, *Annual Report and Accounts 2010 – 2011* (2011); General Optical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Osteopathic Council, *Annual Report and Accounts 2010 – 2011* (2011); General Chiropractic Council, *Annual Report and Accounts 2010* (2010); Pharmaceutical Society of Northern Ireland, *Annual Report and Accounts 2009 – 2010* (2010).

This table demonstrates that the even where a regulator has a large number of registrants, this does not mean that more money is necessarily spent. Indeed, the approximate average spent per registrant across all the regulators is £361. At the General Medical Council, the approximate average spend per registrant is £365; whilst at the Health Professions Council, the approximate average spent per registrant is £75. A suggested conclusion from these figures is that that certain regulators are more efficient and / or benefit from increased economies of scale.

Annual expenditure by government on the regulators

An important aim of the review is to reduce the role of Government. Currently, the Department of Health has a central role in changes to the rules and regulations of the regulators. Expenditure primarily includes legal costs associated with developing policy with regulators, providing legal advice and oversight and drafting new rules and regulations.

Presently, we do not have information on exactly how many resources within the Department of Health are allocated to this process. We hope to explore this further with the Department of Health during our consultation process. However, we do have indicative figures which arise from the plans to implement the Office for the Health Professions Adjudicator (OHPA). The estimated costs for legal, policy and communications were £587,448 for 2011, £604,884 for 2012 and £620,631 for 2013.

We understand that these figures were specific to the context of OPHA which was a single body. The Department of Health engages in the process of rule formulation and development with nine regulatory bodies (in Northern Ireland, the Department of Health, Social Services and Public Safety Northern Ireland works with the Pharmaceutical Society of Northern Ireland on this issue). Accordingly, the Department of Health will benefit from significant economies of scale. Accordingly, whilst the OHPA figures are indicative of the general annual costs that are associated with changes to rules and regulations, we are aware that they may be too high. Accordingly we propose to calculate the figures by applying a reduction of 30%.

As a result, the figure we arrive at is **£3,807,222**. We take this figure to be the overall cost to the Department of Health for maintaining the legal framework for the health and social care regulators.

Governance costs

In general terms, governance costs relate to the costs of running a General Council and committees. This can include the expenses of the members of the Council and committees, as well as administrative costs. The governance costs associated with each Council depends on the size of the Council as well as the different governance structures that exists at each regulator. See table 3 below showing the governance costs of the regulators:

Table 3: The governance costs of selected regulators, 2011

Regulator	Average governance cost per registrant (£)	Total cost (£)
General Chiropractic Council	£56	£146,130
General Dental Council	£32	£2,985,000
General Medical Council	£36	£8,685,000
General Optical Council	£9	£209,308
General Pharmaceutical Council	£5	£310,000

Nursing and Midwifery Council	£6	£3,771,000

Source: General Chiropractic Council, *Annual Report and Accounts 2010 – 2011* (2011); General Dental Council, *Annual Report and Accounts 2010 – 2011* (2011); General Medical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Optical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Pharmaceutical Council, *Annual Report and Accounts 2010 – 2011* (2011); Nursing and Midwifery Council, *Annual Report and Accounts 2010 – 2011* (2011).

Using these figures, the average cost of governance per registrant is **£24**. Scaling this figure up, the estimated overall cost of governance across health and social care regulation is **£33,528,000**.

Costs of registration

In order to practise a chosen profession, a professional must register with the relevant regulator. For most professionals, their first contact in the regulatory system is at the point of registration. At this point, the regulator will check that the potential registrant has the relevant qualifications and experience to practise. See table 4 below for the average cost per registrant and the total costs to the regulators:

Table 4: The registration costs of selected regulators, 2011

Regulator	**Average registration cost per registrant (£)**	**Total cost (£)**
General Dental Council	£40	£3,790,000
General Medical Council	£53	£12,745,000
General Optical Council	£5	£125,836
General Pharmaceutical Council	£11	£626,000
Nursing and Midwifery Council	£10	£6,400,000

Source: General Dental Council, *Annual Report and Accounts 2010 – 2011* (2011); General Medical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Optical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Pharmaceutical Council, *Annual Report and Accounts 2010 – 2011* (2011); Nursing and Midwifery Council, *Annual Report and Accounts 2010 – 2011* (2011).

The average cost of registration per registrant is **£22**. Scaling this figure up, the estimated overall cost of registration across health and social care regulation is **£30,734,000**.

Costs of education and standards-setting

An important part of the work of the regulators is the approval of courses provided by educational institutions such as universities or colleges, as well as ongoing, post-qualification education such as continuing professional development and revalidation. The regulators also set practice standards by developing and publishing guidance for the professions. The following figures are available on the education costs of the regulators:

Table 5: The education and standard-setting costs of selected regulators, 2011

Regulator	**Average education cost per registrant (£)**	**Total cost (£)**
General Chiropractic Council	£8	£19,567
General Medical Council	£32	£7,672,000
General Optical Council	£18	£427,325
General Pharmaceutical Council	£9	£534,000
Nursing and Midwifery Council	£89	£5,215,000

Source: General Chiropractic Council, *Annual Report and Accounts 2010 – 2011* (2011); General Medical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Optical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Pharmaceutical Council, *Annual Report and Accounts 2010 – 2011* (2011); Nursing and Midwifery Council, *Annual Report and Accounts 2010 – 2011* (2011).

Using these figures, the average cost of education and standards-setting per registrant is **£31**. Scaling this figure up, the estimated overall cost of education and standards-setting across health and social care regulation is **£43,307,000**.

Costs of fitness to practise

When a professional falls below the standards set by the regulator, the regulator may take action to protect the public. This is the purpose of the fitness to practise procedures at the regulators. This function requires the regulator to perform an adjudicative role that entails requirements of procedural fairness such as independence and impartiality. This can entail significant legal costs, as well as the costs associated with the expenses of panel members, renting and maintaining appropriate premises and the general case management required to handle a case effectively. Furthermore, many regulators are currently unable to recover costs from registrants who are found to have impaired fitness to practise.

Accordingly, fitness to practise costs form a significant element of the regulators' expenditure. For instance, at the Nursing and Midwifery Council, fitness to practise accounts for **54%** of their overall expenditure. See table 6 below for figures showing the fitness to practise costs of the regulators:

Table 6: The fitness to practise costs of selected regulators, 2011

Regulator	**Average fitness to practise cost per registrant (£)**	**Total cost (£)**
General Chiropractic Council	£408	£1,062,927
General Dental Council	£133	£12,460,000
General Medical Council	£225	£53,834,000
General Optical Council	£40	£984,592
General Pharmaceutical Council	£24	£1,435,000
Nursing and Midwifery Council	£39	£26,108,000

Source: General Chiropractic Council, *Annual Report and Accounts 2010 – 2011* (2011); General Dental Council, *Annual Report and Accounts 2010 – 2011* (2011); General Medical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Optical Council, *Annual Report and Accounts 2010 – 2011* (2011); General Pharmaceutical Council, *Annual Report and Accounts 2010 – 2011* (2011); Nursing and Midwifery Council, *Annual Report and Accounts 2010 – 2011* (2011).

It should be noted that the figures of the General Chiropractic Council are unusually high due to an unexpected increase in the number of allegations of impaired fitness to practise. However, the process of averaging out the figures should take this into account. Using these figures, the average cost of fitness to practise per registrant is **£145**. Scaling this figure up, the estimated overall cost of fitness to practise across health and social care regulation is **£202,565,000**.

Costs of other litigation

Built into the statutory schemes of all of the regulators is an entitlement to appeal fitness to practise decisions to the High Court. There are also costs associated with the renewal of certain interim sanctions which can require an order from the High Court. There are similar arrangements in Scotland and Northern Ireland.

It is difficult to estimate the exact costs of litigation because the elements of each case vary. For instance, the length of the hearing and number of lawyers involved may vary. Furthermore, where a regulator is successful, the professional will normally bear the costs of the appeal.

The data available on appeals focuses on the General Medical Council. Between 2006 – 2009, **1.8%** of decisions of the General Medical Council's fitness to practise panels were appealed. Of these, **0.45%** were successful. Therefore, in 0.45% of appeal cases, the General Medical Council would have incurred associated litigation costs. See table 7 below for the number of final fitness to practise decisions from the regulators between 2010 – 2011.

Table 7: Number of Fitness to Practise Decisions, 2011

Regulator	Decisions
General Chiropractic Council	391
General Dental Council	106
General Osteopathic Council	14
General Medical Council	322
General Optical Council	20
General Pharmaceutical Council	28
Health Professions Council	504
Nursing and Midwifery Council	1,294
Pharmaceutical Society of Northern Ireland	4

Source: Council for Healthcare Regulatory Excellence, *Performance Review Report 2010 – 2011* (2011).

Scaled up, the estimated total number of final decisions is **2,892**. This equates to approximately **52** appeals across health and social care regulatory system. Of these, an estimated average of **13** appeals would be successful.

Taking a sample of High Court appeals where there is a discussion of cost awards, the average cost award is in the region of £10,000 - £20,000. For the party paying the costs, this figure must be doubled because they will also be bearing their own costs. This gives a range of £20,000 - £40,000, with an average of **£30,000**. However, it is important to note that the discretion to award costs within rule 44 of the Civil Procedure Rules can mean that cost awards do not reflect the true costs of litigation. With that caveat, we can assess the cost of appeals across the regulatory system as being **£390,000**.

Costs of the Council for Healthcare Regulatory Excellence

The Council for Healthcare Regulatory Excellence is currently an arms-length body. It performs a meta-regulatory role which means that it supervises the health and social care regulators, provides common regulatory standards and, where necessary, can take action against poor regulatory practice.

The current funding level of the CHRE is £2,750,000, which comes from the Department of Health. However, it is proposed in the Health and Social Care Bill that CHRE will cease to be directly funded by the Department of Health and will instead be funded by the regulators.

However, given that 72% of the registrants within health and social care regulatory system are within the public sector, and the fees of those registrants fund the regulators, the indirect costs of the CHRE to the public sector will be **£1,980,000**.

Options description

Two options have been considered:

- Option 0 – do nothing
- Option 1 – simplification and reform, as proposed in the Consultation Paper.

Initially, we also considered another option which was to retain and amend the governing legislation of the regulators. We did not proceed to develop this option because we concluded that this option would not fulfil our policy objectives of establishing a simple, consistent, flexible, accountable and efficient modern legal framework.

Option 0 – Do nothing

This option would mean retaining the existing legal structure for professional regulation. Some of the key features of the current law, which give rise to the issues identified earlier, are:

- The governing legislation for each regulator is extremely detailed and highly complex. This option would maintain this legislation as the legal source of the regulators' powers and duties.
- Taken as a whole, the current legislative framework contains inconsistencies between the different regulators in terms of their powers and duties. This option would maintain a situation whereby the regulators would have access to limited legal powers.
- The content of some of the regulators' key powers and duties are provided for in primary legislation. It may be argued that this creates an inherent inflexibility. This option would maintain a system whereby changes to those provisions require a section 60 Order to be passed through Parliament and approved by the Privy Council unless a suitable Bill was available. Some powers and duties are also set out in secondary legislation. However, changes in this regard also usually need to be passed through Parliament and approved by the Privy Council.
- The present arrangements require changes in legislation and rules to be passed through the Privy Council. However, it is the Department of Health which in fact approves the form and content of such Orders. Under this option, this lack of clear lines of accountability would remain.
- The structure of the regulators' legislation does not make the purpose of health and social care regulation clear as the wording of the main duties varies between the regulators. Under this option, this lack of clarity would persist without the necessary focus on patient safety.
- The present regulatory system is expensive for the regulators to operate and expensive for the government to maintain. Under this option, the inefficiencies which have developed in the regulatory framework would remain.
- The practice of modern health and social care is increasingly defined by joint working and professional interrelationships. Furthermore, the interfaces between regulation, the higher education sector and mainstream health services are increasingly sophisticated. However, the present legal architecture does not recognise this. Were this option to be adopted, the current disjuncture between sectors that interact with the regulatory scheme would persist.

Option 1 – Simplification and reform, as proposed in the consultation paper

The main provisional proposals as set out in the consultation paper are detailed below.

Structure of reform and accountability (Part 2 of the Consultation Paper)

Part 2 considers a number of preliminary matters which concern how the new legal framework should be structured and how the health and social care professional regulators should be made accountable for the exercise of their powers.

Our proposed structure would consist of a single Act of Parliament to provide the legal framework for all the regulators (provisional proposal 2-1). Under our reforms, there would be consistency across the regulators where it is required in the public interest or the Government would be given regulation-making powers to determine such matters. Otherwise the regulators would be given greater autonomy to adopt their own approach to regulation in the light of their circumstances and resources (provisional proposal 2-2). This would include broad powers to make or amend rules concerning the exercise of their functions

and governance without any direct oversight, including Privy Council approval and Government scrutiny (subject to certain safeguards) (provisional proposal 2-3).

There would be a requirement on the regulators to consult widely whenever issuing or varying anything which is binding, anything which sets a benchmark or standard, and a competency (provisional proposal 2-7) and a requirement that each regulator must provide information to the public and registrants about its work (provisional proposal 2-11). The requirement that each regulator should be required to lay copies of their annual reports, statistical reports, strategic plans and accounts before Parliament would be maintained and extended to include the devolved assemblies (provisional proposal 2-12).

The role of the Government would be clarified. Accordingly, the formal role of the Privy Council would be removed (provisional proposal 2-8) and the order-making power in section 60 of the Health Act 1999 would be repealed. Instead the Government would be given regulation-making powers on certain issues (provisional proposal 2-14). The Secretary of State should be given formal powers to make decisions on matters that require a political policy decision to be made (provisional proposal 2-10). Default powers would be given to the Government where a regulator has failed or is likely to fail to perform any of its functions (provisional proposals 2-17 and 18). The House of Commons Health Committee and the devolved assemblies are encouraged to consider holding annual accountability hearings with the regulators (provisional proposal 2-9).

Main duty and general functions of the regulators (Part 3 of the Consultation Paper)

Part 3 considers the main duties and general functions of the regulators, and how they should be provided for in our proposed statute.

The statute would set out a single paramount duty which would apply to all the regulators and the Council for Healthcare Regulatory Excellence. The wording of this duty is the subject of a consultation question and is based on the existing main duties which require the regulators to protect, promote and maintain the health, safety and well-being of the public (question 3-1).

Further questions are asked in Part 3. They are whether the statute should include guiding principles to assist with decision-making (question 3-3) and whether there should be a general power for the regulators to do anything which facilitates the proper discharge of their functions (question 3-4).

Governance (Part 4 of the Consultation Paper)

Part 4 of the consultation paper considers the governance arrangements for the regulators and how this should be provided for in the new statute.

In terms of the structure of each Council, we ask whether the statute should encourage Councils to become more board-like, whether a statutory executive board should be established or whether there should be unitary board structure (question 4-1).

Our proposed reforms would require that each Council must be constituted by rules issued by the regulators (provisional proposal 4-3). The regulators would be required to issue rules on composition of Councils (provisional proposal 4-4). However, in most areas the regulators would be given broad rule-making powers to determine their own governance arrangements (provisional proposal 4-9). The exceptions to this being the size of the Council and proportion of lay and registrant members (question 4-6).

Registers (Part 5 of the Consultation Paper)

A key statutory function of the regulators is to establish and maintain a register. Registration refers to the compilation of a list of individuals (and sometimes businesses) who have satisfied a regulator that they are qualified and fit to practise. Registration may be voluntary or mandatory. Part 5 considers the registration of individual professionals.

Our reforms would mean that the statute should set out a core duty on all the regulators to establish and maintain a professional register (provisional proposal 5-1). However, the regulators would not be required to appoint a Registrar (provisional proposal 5-2). The statute would specify which registers must be established by the regulators, including any different parts and specialist lists. The Government would

be given a regulation-making power to add, remove or alter parts of the register and specialist lists (provisional proposal 5-3). The Government would have regulation-,aking powers to introduce compulsory student registration in relation to any of the regulated professions (provisional proposal 5-4). Questions are asked about whether student and voluntary registration should be provided for in the statute, and what form they might take (questions 5-5, 5-6 and 5-7).

The form of registration that would be required would include registration on a full, conditional or temporary basis. The regulators would also be given powers to introduce provisional registration if they wish to do so (provisional proposal 5-9). The statute would require the regulators to communicate expeditiously with registrants and potential registrants. The regulators would be given broad rule-making powers concerning the processing of registration applications (provisional proposal 5-15). There would also be a requirement to establish an appeals process for when registration applications are refused, decisions relating to fraudulently procured or incorrectly made entries and in relation to decisions concerning restoration applications. The regulators would have broad powers to decide the precise process it wants to introduce (provisional proposals 5-16, 5-19 and 5-21). These processes would be supplemented by a further right of appeal to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland (provisional proposal 5-17, 5-20 and 5-22).

On other matters, such as the upkeep, publication and content of the register, the regulators would have broad powers to establish rules (provisional proposal 5-18 and 5-25). This is subject to certain exceptions, such as a requirement that all current fitness to practise sanctions must appear in the public register (provisional proposal 5-27).

The current schemes of protected professional titles and functions would be maintained and specified in the statute. The Government would have powers to add to or remove any of the protected titles and functions (provisional proposals 5-31 and 5-32). The regulators would continue to have powers to bring private prosecutions to enforce the protection of professional titles and functions, except in Scotland (provisional proposals 5-34).

Education, conduct and practice (Part 6 of the Consultation Paper)

One of the key functions of the regulators is to ensure proper standards of practice throughout a professional's career. To achieve this, the regulators oversee the quality of pre-registration and post-registration education and training in order to equip students with the skills and knowledge they need for practice. They also issue guidance such as codes of conduct, standards of proficiency and ethical guidelines which set out the values and principles on which good practice is founded. In addition, the regulators require registrants to keep their knowledge and skills up to date throughout their working life and to maintain and improve their performance. Part 6 considers how the new statute should enable the regulators to carry out these roles.

Our proposed system includes duties for the regulators to make rules on approved qualifications, the approval of education institutions, programmes and/or environments, rights of appeals, and systems of visitors (provisional proposal 6-2). There would also be a duty on the regulators to establish and maintain a published list of approved institutions and/or courses, and publish information on any decisions regarding approvals (provisional proposal 6-3).

There would be a duty on the regulators to issue guidance for professional conduct and practice (provisional proposals 6-9). The statute would provide for two tiers of guidance on which there would be clarity about their legal status (provisional proposals 6-10). There would be a duty on the regulators to ensure ongoing standards of conduct and practice, including the ability to make rules on continuing professional development and revalidation (provisional proposals 6-12).

Fitness to Practise (Parts 7, 8 and 9 of the Consultation Paper)

Fitness to practise attracts a significant amount of public and media attention and is undoubtedly the most high profile aspect of the regulators' work. The cost of running a fitness to practise system also takes up a substantial proportion of the regulators' resources. Parts 7, 8 and 9 of the consultation paper consider the fitness to practise process, and how it should be provided for in the new statute. Part 7 considers how impaired fitness to practise should be defined. Part 8 considers the investigation process. Part 9 deals with the adjudication of fitness to practise matters.

Impairment (Part 7 of the Consultation Paper)

Part 7 considers how impaired fitness to practise is determined. It is asked whether the statute should: (1) retain the existing two-stage approach for determining impaired fitness to practise; or (2) implement the recommendations of the Shipman report; or (3) remove the current statutory grounds which form the basis of an impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined) (question 7-1).

Investigation (Part 8 of the Consultation Paper)

The regulators' governing legislation establishes detailed processes that must be followed when considering fitness to practise cases. Part 8 considers the beginning of the process which is the investigation of allegations of impaired fitness to practise.

There is an initial question about whether the statute should remove the concept of an allegation entirely and instead give the regulators broad powers to deal with all information and complaints in such manner as they consider just (question 8-1). It is then proposed that the statute should provide that all the regulators would be able to consider any information which comes to their attention as an allegation and not just formal complaints (provisional proposal 8-2). Additionally, there would be no set format for allegations (provisional proposal 8-3).

All the regulators would have the ability to establish a formal process for the initial consideration of allegations, such as screeners (provisional proposal 8-5), as well as the power to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel (provisional proposal 8-7). Furthermore, the test for all referrals to a Fitness to Practise Panel across the regulators would be the real prospect test (provisional proposal 8-15).

Flexibility would be promoted by giving the regulators broad powers concerning how and by whom an investigation is carried out (provisional proposal 8-10) and the statute would not require the regulators to establish an Investigation Committee (provisional proposal 8-9). The statute would give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question, including by the registrant themselves (provisional proposals 8-11 and 8-13).

The statute would consolidate the availability of certain decisions and outcomes at the investigation stage. This means that the regulators would have powers to issue or agree at the investigation stage: (1) warnings; (2) interim orders; (3) undertakings; (4) voluntary erasure and (5) advice. Exactly how this is implemented would be left up to the regulators (provisional proposal 8-16).

The statute would also provide a consistent template for the right to initiate a review of an investigation decision not to refer a case for an investigation following initial consideration; not to refer the case to a Fitness to Practise Panel; to issue a warning; or to cease consideration of a case where undertakings are agreed (provisional proposal 8-22). The right to initiate a review would be available to anyone interested in the decision (provisional proposal 8-23). Grounds for a review would be that new evidence has come to light which makes review necessary for the protection of the public or that the regulator has erred in its administrative handling of the case and a review is necessary in the public interest (provisional proposal 8-24). On all other matters, there would be broad rule-making powers (provisional proposal 8-25).

Adjudication (Part 9 of the Consultation Paper)

Adjudication is a formal process whereby the regulators consider evidence normally relating to whether the registrant's fitness to practise is impaired.. This often involves a formal hearing before a Fitness to Practise Panel but adjudication can also be undertaken by other bodies such as a Health Committee or an Interim Orders Panel. Part 9 deals with matters arising from adjudication.

An initial question is asked concerning whether the statute should require the regulators to ensure that they establish a structure which is compliant with Article 6 of the European Convention on Human Rights without taking into account the role of the higher courts (question 9-1). In addition, it is asked whether the new legal framework ensure the separation of investigation and adjudication (question 9-2) and whether the statute should allow for the option of the regulators' adjudication systems joining the Unified Tribunals Service (question 9-3).

The regulators would have a broad power to establish rules for case management (provisional proposal 9-4) as well as providing that the overriding objective of the Civil Procedure Rules – that cases must be

dealt with justly – is made part of the regulators' fitness to practise procedures (provisional proposal 9-5).

Fitness to practise panels would be required to be established by the regulators and would need at least three members and the panels would be appointed by a process which is separate to the Council, not include Council members and investigators and always have a lay member (provisional proposals 9-6 and 9-7) However, other than these matters, the regulators should have broad powers to make rules on the constitution of their Fitness to Practise Panels (provisional proposal 9-8).

Most procedural elements of adjudication would be subject to broad rule-making powers (provisional proposal 9-9). However, certain procedural aspects would be defined in our proposed statute. These include: the application of the civil rules of evidence (provisional proposal 9-11); enabling Panels to admit evidence which would not be admissible in court proceedings if this is fair and relevant (provisional proposal 9-12); the application of the civil standard of proof (provisional proposal 9-13); a requirement that all hearings must be held in public unless one or more of the exceptions in the Civil Procedure Rules apply (provisional proposal 9-14); and a central definition of a vulnerable witness (provisional proposal 9-15).

The statutory right of appeal against the decision of a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland and the High Court of Justice in Northern Ireland would be maintained (provisional proposal 9-35).

The regulators would be required to establish a system for imposing and reviewing Interim Orders (provisional proposal 9-17). On most procedural matters the regulators would have broad rule-making powers (provisional proposal 9-21). However, there would be certain mandatory elements such as a single test for imposing an order which would be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession) (provisional proposal 9-20). The right of appeal against an Interim Order to the High Court in England and Wales, the Court of Session in Scotland and the High Court of Justice in Northern Ireland would be maintained (provisional proposal 9-23).

There would be parity in the range of sanctions available to the regulators. All the regulators would be able to impose: (1) erasure from the register; (2) suspension; (3) conditions; and (4) warnings. The Government would also have regulation-making powers to introduce financial penalties and cost awards (provisional proposals 9-24 and 9-25). The test for imposing any of the sanctions would to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession) (provisional proposal 9-28). The regulators would have broad powers to make rules in relation to the available sanctions and the Government would be given powers to add new sanctions and to remove any sanctions (provisional proposals 9-29 and 9-30).

The regulators would be required to have a system of review hearings. The regulators could also extend review hearings for warnings and undertakings if they wished (provisional proposal 9-32). The regulators would have broad powers to establish the procedures for hearings (provisional proposal 9-33).

Council of Healthcare Regulatory Excellence (Part 10 of the Consultation Paper)

The Council for Healthcare Regulatory Excellence (CHRE) currently oversees the work of the nine UK health care regulators. It is an overarching body whose roles include supervising and scrutinising the work of the regulators, sharing good practice and knowledge with the regulators, and advising the four UK government health departments on issues relating to the regulation of health professionals.

A general question is asked about the effectiveness of the CHRE in performing the role of scrutinising and overseeing the work of the regulators (question 10-1). However, in our scheme the current powers and functions of the CHRE would be maintained in our statute as far as possible (provisional proposals 10-2 and 10-4). Appointments to the CHRE's General Council would be made by the Government and by the devolved administrations (provisional proposal 10-3).

A further question is asked about the CHRE's power to refer cases to the higher courts. It is asked whether the power should (1) be retained and exercised alongside a regulator's right of appeal, in cases when the regulator's adjudication procedure is considered to be sufficiently independent; or (2) be removed when a regulator's right of appeal is granted in such circumstances; or (3) be retained and rights of appeal should not be granted to regulators, although regulators should have a power to formally request the CHRE to exercise its power. This question is asked in light of the proposed right of appeal for the General Medical Council from its own tribunal service (question 10-7).

Business regulation (Part 11 of the Consultation Paper)

Some regulators have powers to regulate businesses with the aim of ensuring that the infrastructure supports proper standards of practice. Part 11 considers how commercial settings may affect the regulatory task and how the legal framework should approach the task of business regulation.

An initial question is asked about the extent to which regulation in a commercial context make a difference to how the regulators approach the task of professional regulation and whether the law provide adequately for professional regulation in a commercial context (question 11-1).

Our system would maintain and where appropriate reform the existing provisions for business regulation that some of the regulators have. These regulators are the General Pharmaceutical Council, the Pharmaceutical Council of Northern Ireland, the General Dental Council and the General Optical Council (provisional proposal 11-2). However, we also propose that the Government would be given regulation-making powers to extend systems of business regulation to any regulator (provisional proposal 11-6).

Overlap issues (Part 12 of the Consultation Paper)

Health and social care professional regulation does not exist in a vacuum. The functions of the regulators frequently cross organisational and legal boundaries. Often the same function or a similar function is undertaken by different organisations, and in recent years there has also been growing emphasis on achieving greater integration and co-operation between all the relevant agencies. Part 12 considers how our proposed statute should facilitate joint working.

Initial questions are asked about the ways in which the legal framework could establish clearer interfaces between the various regulatory systems (question 12-1) and whether there are practical difficulties when there are parallel criminal and fitness to practise proceedings, or when the regulators attempt to work jointly with another body (questions 12-2 and 12-3).

Our reforms would include a permissive statement to the effect that each regulator may carry out any of its functions in partnership with another organisation and moreover the statute would enable formal partnership arrangements to be entered into to deliver this (provisional proposals 12-4 and 12-5).

Furthermore, there would be two concurrent duties to cooperate – a general duty and a specific duty (provisional proposals 12-6 and 12-8). The general duty would require each regulator to make arrangements to promote cooperation with other relevant organisations or other persons, including those concerned with the (1) employment of registrants; (2) education and training of registrants; (3) regulation of other health or social care professionals; (4) regulation of health or social care services; and (5) provision/supervision/management of health or social care services. The specific duty to cooperate would apply when a regulator in question is considering registration applications and renewals; undertaking the approval of education and training; ensuring proper standards of practice and conduct; and undertaking an investigation into a registrant's fitness to practise. The requested authority would be requested to comply with a formal request made by a regulator unless they have good reasons not to, which myust be provided in writing.

Cross border issues (Part 13 of the Consultation Paper)

The management of cross border issues is an important activity for the health and social care professional regulators with a significant number of overseas-qualified practitioners wishing to register in the UK. In addition, the work of the regulators impacts on those outside the borders of mainland UK. In Part 13, we explore the issues that arise from this.

In terms of overseas applicants, the statute would require the regulators to specify in rules which qualifications would entitle an applicant to be registered, including overseas qualifications (provisional proposal 13-1). In terms of overseas applicants from the European Economic Area, the regulators would be given primary responsibility for ensuring compliance with the Qualifications Directive. However, there would also be default powers for the Government to allow for interventions in cases where there has been or is likely to be a failure to implement the Qualifications Directive properly (provisional proposal 13-2). Similar powers would be given to allow for the recognition of applicants from beyond the European Economic Area (provisional proposal 13-3). In addition, the regulators would be given an express power to approve and accredit overseas education institutions and courses (provisional proposal 13-6).

Cost benefit analysis

This impact assessment identifies both monetised and non-monetised impacts of intervention, with the aim of understanding the overall impact on society and the wider environment. The costs and benefits of each option are measured against the "do nothing" option. Impact assessments place a strong emphasis on valuing the costs and benefits in monetary terms. However there are important aspects that cannot sensibly be monetised. These might include impacts on equity and fairness, either positive or negative, or enhanced (or diminished) public confidence. A screening document which considers equality issues have been produced and accompanies this impact assessment.

The impact assessment process requires that we make an assessment of the quantifiable costs and benefits even when there is insufficient material on which to base those calculations. Where possible we have spoken to the regulators and to practitioners to inform our view of the likely impact of our proposals and have used this as the basis for our calculations. Where it has not been possible to obtain a rough indication of numbers in this way we have had to make a realistic estimate. In such cases we have taken a conservative approach and have tended to use figures that we considered likely to under-estimate benefits and over-estimate costs.

When calculating the Net Present Values (NPVs) for the impact assessment we have used a time frame of ten years, with the current year (2012) being year 0. We have assumed that the transitional costs and benefits occur in year 0, and ongoing costs and benefits accrue in years 1 to 10. A discount rate of 3.5% has been used in all cases in accordance with Treasury guidance. Unless stated, all figures are in 2010-11 prices, and have been uprated using the GDP deflator.

The following rounding convention has been applied to the final cost/benefit monetised values:

- values below £1m - rounded to the nearest £0.1m
- values below £10m - rounded to the nearest £1m
- values above £10m - rounded to the nearest £5m
- values over £30m and under £250m - round to the nearest £10m
- values over £250m - rounded to the nearest £50m

Option 0: Do nothing

Option 0 is the base case against which our other options are measured. Because the do-nothing option is compared against itself, its costs and benefits are of course zero, as is its NPV. While there would not be any additional costs, current costs incurred would continue to be incurred. These are discussed below to provide context for the assessment of the other options.

Costs

The do-nothing option would leave the existing system unchanged. It is not a cost-free option. Unnecessary and inefficient costs associated with the current legal system would persist. Conversely, there would be no transitional costs.

Benefits

Doing nothing will avoid the costs of reform, including the development of new rules and regulations.

Net present value

Because the do-nothing option is compared against itself its NPV is £0.

Option 1 – simplification and reform, as proposed in the Consultation Paper.

The *preferred option* is to simplify and reform the existing system as set out in the Consultation Paper.

A key feature of the proposed programme of reform is increased autonomy for the regulators. The principal method achieving autonomy is by giving the regulators *enabling powers* which would allow them to develop their own rules and regulations in whichever manner they consider would deliver their regulatory objectives in the most efficient and effective manner. Indeed, 53 of the 131 provisional proposals contained give the regulators such enabling powers (40%).

We are unable to predict with certainty which powers the regulators will use and whether they will use these powers in a way that produces costs or benefits. However, we are able to estimate that it is highly

probable that (a) the regulators will continue to perform their functions and (b) a rational regulator is likely to seek efficiency savings to the fullest extent, subject to this not impacting on the overarching duty to promote and protect public safety. We hope to gather more data on the areas in which the regulators consider that they will be able to make efficiency saving during our consultation process. However, we consider that an average range of 5% - 15% (best estimate 10%) level of efficiency savings is plausible across the regulatory framework.

Costs

The costs of option 1 are either the costs of change or of new activities the regulators choose to adopt. It is important to note that our proposals do not focus on adding to the work of the regulators in substantive terms. Instead the emphasis is on the implementation of our proposed scheme on the ground.

The primary costs associated with our proposed scheme can be grouped into three cost themes. These include:

1. Costs of retraining fitness to practise panels;
2. Costs of implementing new rules and regulations; and
3. Extra activity arising due to clarifying access to the regulators' fitness to practise mechanism (widened systems / information).

Transitional costs

1. Retraining fitness to practise panels

There may well be one-off costs associated with retraining panel members at the regulators. We do not consider that there would be an added on-going burden because of the embedded training schemes that already exist within the regulators.

Figures available indicate that there is an estimated need for 1000 fitness to practise panel members across all the regulatory bodies. The predicted costs of retraining are set at **£350,000** (source: Department of Health, *Trust, Assurance and Safety – Partial Regulatory Impact Assessment* (2007)).

2. Creating and implementing new rules and regulations

Under our proposed scheme, the regulators will be required to provide for certain specified matters in either rules or regulations. In addition, the regulators will be given powers to create rules and regulations on certain matters. As a result, were our scheme to be implemented the regulators would undertake the task of creating several sets of rules and regulations. Our assumption is that this will occur at least once, although the regulators may choose to make changes after that first year.

There are eight broad areas where the regulators will be required to make rules or, in our view, it is highly likely that they would make rules. These are rules in relation to:

1. The constitution of councils, including size.
2. Establishing a committee/panel structure
3. Processing applications and application appeal processes
4. The upkeep, publication and content of the register
5. Education including required qualifications (including EEA and non-EEA applicants), approval of educational institutions, rights of appeal, quality assurance and appointment of visitors.
6. The investigation process, including rules on reviews of decisions made during an investigation.
7. Case management.
8. Fitness to practise, including interim order rules, sanctions rules, and sanctions review hearings rules.

The costs associated with the creation of rules include: developing policy, legal advice and drafting. Although there may be costs associated with the consultation process, it is our view that these costs are nominal and would be accommodated by current resource allocations.

We draw figures for the rule changes from the envisaged costs associated with the Office for the Health Professions Adjudicator. The analogy is viable because the Office also had to set up its internal mechanisms by way of rules. It was predicated that there was a range of possible costs associated with policy, legal and rules between £0.6 million and £1.1 million (best estimate **£0.85 million**). However, we are aware that the OHPA figures may be too high. Accordingly we propose to calculate the figures by applying a reduction of 30%. This gives us a range of £420,000 – £770,000 (best estimate **£595,000**).

Adopting these figures, we can calculate the costs over the entire regulatory system [excluding the General Social Care Council which will be abolished July 2012] which is £3.78 million to £6.93 million (best estimate **£5.36 million**).

The assumptions we make in relation to these rule changes are that each rule change will use a similar level of resources and that separate rules will be created within the eight categories listed above. It is possible that rule-making could be consolidated which may achieve cost synergies.

On-going costs

3. Extra activity arising due to clarifying access to the regulators' fitness to practise mechanism (widened systems / information).

Part of our scheme includes a requirement on the regulators to clarify how an allegation of impaired fitness to practise can enter the regulatory system. In particular, there would be no restrictions on the content of information received, format of an allegation or time limit within which an allegation could be brought.

We envisage that this may lead to a small increase in the numbers of allegations that enter the fitness to practise system, as we do not believe that many allegations are screened out on technical grounds. We predict that there would be an increased spend of between 1% - 5% (best estimate 3%).

The only available indicative figures on how allegations are received and whether they are taken forward are from the General Chiropractic Council. In 2010, £215,035 was spent on investigating allegations. During that period 718 cases were considered. This amounts to a rounded indicative cost of considering an allegation of £300. The predicted increase in allegations considered at the GCC would amount to an increased cost of £2,150 – £10,770 (best estimate £6,460).

We can scale up this figure to represent the entire regulatory system. We do this by take the predicted increase in cost at the GCC and calculating the percentage of GCC registrants within the regulatory system (0.19%). Scaling this up to 100% and thereby representing the entire regulatory system, the estimate cost of clarifying access would be: £212,000 - £1,060,000 (best estimate £636,000). However, caution needs to be exercised in relation to the GCC's figures from the sample period due to an extraordinarily high number of complaints received during 2010. For previous years the annual number of complaints received averaged 30. We proposed to apply a reduction of 60% for the figures calculated. By doing this, we arrive at figures of: £84,800 – £424,000 (best estimate **£254,400**)

We also proposed that the regulators should be required to provide information about their work. All of the regulators have sophisticated publication schemes. Accordingly, we do not consider that this would incur extra costs.

Table 8: Summary of main costs

	Low estimate (£)	Best estimate (£)	High estimate (£)
Transitional			
Retraining	£ 350,000	£ 350,000	£ 350,000
Creating rules	£3,780,000	£5,360,000	£6,930,000
Total transitional* (Year 0)	£4,000,000	£6,000,000	£7,000,000
On-going			

Clarifying access	£ 84,800	£254,400	£424,000
Total ongoing* (Years 1 – 10)	£100,000	£300,000	£400,000

* values have been rounded

Allocation of monetised costs: Transitional and on-going costs would fall on the regulators.

Benefits

On-going monetised benefits

The benefits associated with our proposed scheme can be grouped into two primary benefit themes. These include:

1. Efficiency savings for the regulators.
2. Decreased costs for government / public expenditure.

1. Efficiency savings for the regulators

A key element of our proposals is the possibility of allowing the regulators to introduce their own rules in a variety of different areas. These areas can be grouped into: fitness to practise, governance, registration and education / standards-setting.

An assumption made in this impact assessment is that a rational regulator would only undertake substantive changes to their current rules if this would entail some efficiency savings, although we acknowledge that other change incentives exist. We estimate a range of savings being between 5% - 15% (best estimate 10%)

Applying these proportions to the overall spend indicated in tables 2 – 6, yields the following efficiency savings to regulators, see table 9 below.

Table 9: Annual efficiency savings made by regulatory bodies

	Low estimate (5%)	Best estimate (10%)	High estimate (15%)
A. Governance	£1,676,400	£3,352,800	£5,029,200
B. Registration	£1,536,700	£3,073,400	£4,610,100
C. Education and standards setting	£2,165,350	£4,330,700	£6,496,050
D. Fitness to practise	£10,128,250	£20,256,500	£30,384,750
E. Total efficiency savings* (A+B+C+D)	£15,000,000	£30,000,000	£50,000,000

* values have been rounded

2. Decreased costs for government / public expenditure

We have estimated above that the government is likely to allocate **£3,807,222** to the maintenance of the health and social care professionals regulation. Under our proposed scheme, some of this role would be removed. Therefore, there are savings to be made in this area.

This would amount to savings on legal advice associated with policy formulation, drafting costs of initial proposals, internal departmental correspondence, approval procedure with the Privy Council,

departmental submissions to the Secretary of State for Health in his or her capacity as a Privy Counsellor and laying procedures in Parliament (which requires drafting and publication of Explanatory Memoranda and any impact assessments).

We envisage a savings range of 30% - 50% (best estimate 40%) to government expenditure in this area.

This would amount to the following savings: £1,142,167 – £1,903,611 (**best estimate: £1,522,889**)

Table 10: Summary of main savings

	Low estimate (£)	Best estimate (£)	High estimate (£)
Efficiency savings	£15,000,000	£30,000,000	£50,000,000
Government costs*	£1,000,000	£2,000,000	£2,000,000
Total*	£15,000,000	£30,000,000	£50,000,000

* values have been rounded

Allocation of monetised benefits: efficiency savings will benefit the regulators; savings on government costs will benefit the government.

Non-monetised benefits

Significant features of our proposed scheme are the non-monetised benefits associated with a simple, consistent, flexible, accountable and efficient legal structure. In particular, there are two key themes which are apparent throughout our proposals:

1. Reduced risk to the public
2. Increased public trust and confidence

Reduced risk to the public

The primary purpose of the health and social care regulatory framework is to reduce the risks associated with clinical interventions. Where there are better standards of practise, the public will be exposed to fewer risks when encountering a health or social care professional. Our framework seeks to promote this primary purpose through the imposition of a *paramount duty* (see Part 3 of the consultation paper). This proposed duty requires the regulators to protect, promote and maintain the health, safety and well-being of the public by ensuring proper standards of practice in the relevant profession.

Furthermore, our scheme is intended to provide for a more flexible regulatory structure which would allow for the regulators to adapt to changes in the professions which they regulate. A more dynamic legal structure will allow regulators to respond to new technologies and treatments, thereby allowing for an improved regulatory response to evolving clinical contexts.

In our view, the benefits of our proposed legal framework will be felt primarily at the level of the regulators themselves. However, this will have an impact on the techniques and practises of the regulated professionals. Accordingly, the benefits of our proposals will be indirect. However, we envisage that they will be significant.

Increased public trust and confidence

A further non-monetised benefit of our scheme will be increased public confidence in the regulatory system. This is a benefit because where there is increased public confidence in the quality and competence of health and social care professionals, members of the public are more likely to seek medical assistance rather than leaving it too late. Increased public confidence in the professions has long been recognised as a key objective of the regulatory scheme.

A legislative framework that promotes this will have benefits in terms of those members of the public who feel able to trust that the professional they are encountering is competent and safe. As above, we believe that the benefits of our proposals will be indirect. However, we envisage that they will be significant.

Summary of cost benefit analysis

This impact assessment has sought to identify some of the key costs and benefits that may be associated with our proposed scheme. This impact assessment accompanies a consultation paper. Accordingly, we expect more evidence to become available over time. However, based on the figures presented we can summarise the envisaged best estimate position as follows in table 11 below:

Table 11: Summary costs/benefits in £million constant prices over a ten year period

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Costs												
Transitional	6.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.0
On-going	0.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.0
Total	6.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	9.0
Benefits												
Transitional	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
On-going	0.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	300.0
Total	0.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	300.0
Net benefit	-6.0	29.7	29.7	29.7	29.7	29.7	29.7	29.7	29.7	29.7	29.7	291.0

Direct costs and benefits to business calculations (following OIOO methodology)

We do not anticipate any costs to business. Law Commission projects are out of scope of the one in, one out rules.

Part 3: Specific impact tests

An impact assessment must consider the specific impacts of a policy option upon various groups within society. These specific tests are carried out below and refer to the implementation of Option 1.

Statutory equality duty

We have conducted a screening exercise to determine whether a full Equality Impact Assessment is necessary. We concluded that it would be unnecessary to conduct a full Equality Impact Assessment at this stage. The screening document is appended to this impact assessment.

Competition

According to Office of Fair Trading guidance, the competition assessment must consider whether in any affected market, the proposal would directly or indirectly limit the number or range of suppliers, limit the ability of suppliers to compete, or reduce suppliers' incentives to compete vigorously.

Having regard to these tests, we do not believe our recommendations will have any significant negative impact on competition. In particular, in the health and social care market, the regulatory burden is shared equally between competitors. Therefore, any tightening of regulatory standards would not put market actors at any relative competitive disadvantage.

Small firms

Many health and social care professionals operate as small businesses. In particular, chiropractors, dentists, osteopaths, opticians and pharmacists are generally micro enterprises and typically operate either as high street enterprises or on a self-employed basis. However, we do not believe our proposals will affect adversely small business, their customers or competitors. Our recommendations focus on the means by which health and social care professionals are regulated, rather than the specific services they provide.

We have proposed a power to allow Government to enable regulators to regulate business premises. Although there may well be implementation costs associated with such an innovation, we believe that these would be off-set by improvements in standards and efficiency. However, an extension of business regulation would be the decision of the Government – following their own impact assessment.

Environmental impact and wider environmental issues

We do not foresee any impact on carbon emissions or on wider environmental issues.

Health and well-being

Our proposals are expected to have a positive impact on health and well-being. A key objective of the proposals is to build a simplified and effective legal framework for the regulation of health and social care professionals. This will benefit public health and safety in all clinical contexts.

Human rights

The human rights dimension of our proposals is most apparent in relation to our proposed reforms of the adjudication of fitness to practise cases. We have adopted the position that the regulators should be responsible for compliance with the Convention rights on a case-by-case basis. We believe that the maintenance of a full jurisdiction right of appeal will strengthen this.

In our view, our proposals in relation to the composition of fitness to practise panels satisfy the requirements of impartiality and fairness required by Article 6 (ECHR), even without the right of appeal. We also consider our proposals in relation to the public nature of hearings will comply with Article 8 ECHR, as fitness to practise panels will have the discretion to hold a hearing in private. Such a decision must be lawful and therefore must comply with Article 8 ECHR.

Our proposed reforms would comply with the objectives of promoting and protecting human rights under the Human Rights Act 1998.

Justice system

The impact on the justice system of our proposals is considered throughout this impact assessment. In summary, our proposals do not envisage any substantive new rights or duties which would significantly increase the number of cases before the courts. In particular, we are maintaining the well-established routes of appeal to the High Court in England and Wales, the Court of Session in Scotland and the High Court of Justice in Northern Ireland.

We acknowledge that, in light of the 3% anticipated increase in complaints, there is a low level of risk that there may be more High Court appeals from fitness to practise panels. However, we consider that this would be at a level which is so low as to be not statistically relevant. This is because it does not follow that 3% more complaints will lead to an equally large increase in final fitness to practise decisions.

In general our proposals are consolidations and simplifications of existing law and do not represent new duties. In most of those areas where we have put forward new duties, we have recommended that these be implemented through the introduction of regulations, if the Secretary of State wishes to do so. Therefore, it will be the decision of the Government – following their own impact assessment – whether to introduce new duties.

Accordingly, we do not envisage that our proposed reforms will impact the justice systems.

Rural proofing

We do not foresee any differential impact on rural areas.

Sustainable development

We do not foresee any implications for sustainable development.

Appendix

Equality Impact Assessment: Initial Screening

The Equality Act 2010 requires public authorities to perform their functions with due regard to reduce inequalities for those with certain protected characteristics. To determine whether a full Equality Impact Assessment is necessary, an initial screening is conducted which seeks to identify the scope of those who may be affected and the proposals which may have an equality impact.

1. Name of the proposed new or changed legislation, policy, strategy, project or service being assessed.

Regulation of Health Care Professionals: Regulation of Social Care Professionals in England (2012) Law Com No 202; Scot Law Com DP No 153; NI Law Com No 12.

2. Individual Officer(s) & unit responsible for completing the Equality Impact Assessment.

Tim Spencer-Lane, Law Commission, Steel House, 11 Tothill Street, London, SW1H 9LJ

3. What is the main aim or purpose of the proposed new or changed legislation, policy, strategy, project or service and what are the intended outcomes?

Aims/objectives	**Outcomes**
(1) The simplification of the legal framework;	(1) A simplified legal framework which allows the law to be more easily understood by the public and professionals;
(2) Consistency in the ability of each regulatory body to undertake the task of regulation;	(2) A framework which provides consistency of powers between the regulatory bodies, thereby allowing the public and professionals to be clearer about what to expect from the regulatory scheme;
(3) Increased flexibility and autonomy for the regulators;	(3) A more flexible and autonomous legal framework for the regulators, thereby allowing the regulators to keep pace with change;
(4) Clear accountability; and	(4) A framework which enhances and provides clear accountability mechanisms for the regulators; and
(5) Enabling cost efficiencies.	(5) A legal framework which enables cost efficiencies to be achieved by the regulators.

4. What existing sources of information will you use to help you identify the likely equality impacts on different groups of people?

Our starting point is the statutory equality duty contained within section 149 of the Equality Act 2010. Section 149(1) requires public authorities to have due regard to the need (1) to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act; (2) to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and (3) to foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Section 149(3) which requires public authorities to have due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to (a) remove or minimise disadvantages suffered by

persons who share a relevant protected characteristic that are connected to that characteristic; (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it; and (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

Section 149(5) which requires public authorities to have due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to (a) tackle prejudice, and (b) promote understanding.

Section 149(7) identifies the following relevant protected characteristics: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

To identify the relevant equality impacts we considered the following:

(1) The estimated numbers of registered health and social care professionals with protected characteristics; and
(2) The provisional proposals within the consultation paper that may have an impact on those registrants with protected characteristics.

(1) The numbers of registered health and social care professionals with protected characteristics

The provisional proposals we make in our consultation paper focus on how the health and social care professional regulators operate in relation to their regulatory functions. Given that these functions directly impact on the health and social care professional workforce, this is the stakeholder group that we primarily seek to identify.

(a) Age

The NHS Health and Social Care Workforce Census of 22 March 2011 provides the following in relation to the age profile of medical and dental staff employed within hospital and community health services:

	All Ages	**Under 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70 and over**
All Staff	103,912	22,765	18,390	16,941	13,843	11,595	9,163	6,482	3,722	794	217
Consultant (including Director of Public Health)	37,752	5	790	5,728	8,889	8,171	6,566	4,613	2,431	443	116
Associate Specialist	3,810	-	24	200	486	814	819	715	592	132	28
Specialty Doctor	4,998	91	705	1,205	1,000	818	515	323	262	65	14
Staff Grade	1,432	18	95	223	293	301	213	142	110	26	11
Registrar Group	38,158	11,390	14,828	8,535	2,413	697	221	54	17	3	-
Senior House Officer	1,566	573	493	271	125	55	27	12	10	-	-
Foundation Year 2	6,101	5,109	666	197	95	26	8	-	-	-	-
House Officer and Foundation Year 1	6,240	5,484	478	171	70	28	6	3	-	-	-
Other	139	2	20	15	26	27	28	20	1	-	-

Doctors in Training											
Hospital Practitioner/ Clinical Assistant	2,464	23	124	232	300	455	536	404	244	102	44
Other Staff	1,816	101	237	235	229	285	326	256	100	36	11

Not all the regulators publish information regarding the age of their registrants. However, the General Chiropractic Council collects data in relation to age and states that it has data for all registrants across the UK. In its Annual Report and Accounts 2010 (at page 22 – www.gcc-uk.org), the Council states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of age, although it is noted that numbers involved are too small to be statistically relevant. The Pharmaceutical Society of Northern Ireland in its Annual Report and Accounts 2010/11 provides a graphical depiction of the age profile of registrants in Northern Ireland. Most registrants appear to fall in the age range 26-35 (over 900), whilst the least appear to fall in the age range of 66-70.

(b) Disability

We have only been able to identify information regarding the disability profile of those working as doctors between 2005 and 2007. This data is contained in the British Medical Association's Equal Opportunities Committee report *Disability Equality in the Medical Profession* (2007). It is based on whether or not those surveyed identified themselves as being disabled.

	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06
Total surveyed	6,090	4,392	4,601	9,337	14,747	20,469	13,636	10,034
Disabled	16	22	36	59	71	128	109	112
Not disabled	6,058	4,367	4,560	9,266	14,647	20,317	13,515	9,905
Undisclosed	16	3	5	12	29	24	12	17
Total disclosed	6,074	4,389	4,596	9,325	14,718	20,445	13,624	10,017
% Disabled	0.26%	0.50%	0.78%	0.63%	0.48%	0.63%	0.80%	1.12%
% Not Disabled	99.47%	99.43%	99.11%	99.24%	99.32%	99.26%	99.11%	98.71%
% Undisclosed	0.26%	0.07%	0.11%	0.13%	0.20%	0.12%	0.09%	0.17%

	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07
Total surveyed	6,329	12,220	20,406	16,582	13,125	12,311	4,958
Disabled	53	77	135	93	64	111	28
Not disabled	6,261	12,122	20,259	16,474	12,988	12,121	4,837
Undisclosed	15	21	12	17	73	79	95
Total disclosed	6,314	12,199	20,394	16,567	13,052	12,232	4,865
% Disabled	0.84%	0.63%	0.66%	0.56%	0.49%	0.90%	0.56%
% Not Disabled	98.93%	99.20%	99.28%	99.35%	98.96%	98.46%	97.56%
% Undisclosed	0.24%	0.17%	0.06%	0.10%	0.56%	0.64%	1.92%

However, information has been made available regarding the disability profile of health care professions working in Northern Ireland. The following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a breakdown of disability amongst health care professionals employed in that Trust. Again, this is based on whether or not the individual self-identified as being disabled:

Profession	Disability – no	Disability – yes	Not disclosed	Total
Doctor	1195	12	547	1754
Nurse	4373	86	1983	6442
Occupational Therapist	180	2	54	236
Optometrist	26	-	3	29
Pharmacist	93	-	3	96
Physiotherapist	264	4	68	336
Podiatrist	42	-	23	65
Radiographer	234	3	81	318
Speech and Language Therapist	100	1	28	129

The Northern Trust also provided information in relation to its workforce as at January 2012:

Profession	Disability - no	Disability - yes	Not Known	Total
Medical and Dental	66.5%	0.3%	33.2%	100%
Nursing and Midwifery	86%	1.3%	12.7%	100%
Occupational Therapist	88%	1%	11%	100%
Orthoptist	100%	0%	0%	100%
Pharmacist	89.4%	1.1%	9.6%	100%
Physiotherapist	82.1%	3.2%	14.7%	100%
Podiatrist	95.3%	0%	4.7%	100%
Radiographer	90.4%	2.4%	7.2%	100%
Speech and Language Therapist	88%	0.9%	11.1%	100%

Within the Southern Health and Social Care Trust, within the Medical and Dental, Nursing and Midwifery and Allied Health Professions, 69 staff are living with a disability, 3,356 staff are not living with a disability and it is not known whether 1,035 staff are living or not living with disability.

Not all regulators publish data in relation to disability amongst their registrants. However, the General Chiropractic Council does collect such data and states that it has data for 79% of its registrants across the UK. In its Annual Report and Accounts 2010 (at page 22 – www.gcc-uk.org), the Council states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of disability, although it is noted that numbers involved are too small to be statistically relevant.

As noted below, we will be working with stakeholders – including the Department of Health, the devolved governments/executives and groups who represent disabled people – in order to gather further information.

(c) Gender reassignment

We have been unable to locate any direct statistical information on the numbers of health and social care professionals who have undergone or are in the process of undergoing gender reassignment. The Equality and Human Rights Commission in its report *A Review of Access to NHS Gender Reassignment Services (England only)* (2011) states that "there are no reliable figures available on the size of the trans population in the UK or in England. Nor is there any central data on how many people request or receive gender

reassignment services in England."

If it was possible to have an indicative figure of the number of individuals in the UK who have undergone or who are in the process of undergoing gender reassignment, and we assume that this figure could be applied to health and social care professionals, we would be able to estimate the number of registrants with this protected characteristic. We will be working with stakeholders – including the Department of Health and the devolved governments/executives – in order to gather further information.

(d) Pregnancy and maternity

We have been unable to locate any direct statistical information on the number of pregnant health and social care professionals there are on an annual basis. However, Hospital Episode Statistics (www.hesonline.nhs.uk) provides maternity data. Using the figures for the year 2010 -11, it can be calculated that the total number of reported pregnancies was 722,357. We can calculate the proportion of pregnancies in relation to the overall UK population of 62,218,761, as estimated by the World Bank (0.0116).

The White Paper *Enabling Excellence* states that there are 1,400,000 health and social care professionals. Applying the figure derived above, we can estimate that there are 16,254 pregnancies each year within the health and social care professions.

We will be working with stakeholders – including the Department of Health and the devolved governments/executives – in order to gather further information.

(e) Race

The NHS Health and Social Care Workforce Census of 22 March 2011 provides the following in relation to the race profiles of medical and dental staff employed within hospital and community health services:

	Ethnic Group Categories							
	White	**Black or Black British**	**Asian or Asian British**	**Mixed**	**Chinese**	**Any Other Ethnic Group**	**Not Stated**	**All Groups**
All Staff	56,856	3,493	27,420	2,346	2,102	4,014	7,524	103,912
Consultant (including Director of Public Health)	24,895	1,014	7,476	578	607	1,254	1,840	37,752
Associate Specialist	1,586	184	1,401	78	21	312	207	3,810
Specialty Doctor	1,764	262	2,125	117	41	334	337	4,998
Staff Grade	487	87	601	31	9	113	100	1,432
Registrar Group	17,598	1,434	12,024	1,044	945	1,466	3,628	38,158
Senior House Officer	532	82	656	49	23	84	139	1,566
Foundation Year 2	3,566	163	1,313	208	203	193	455	6,101
House Officer and Foundation Year 1	3,637	201	1,247	200	215	200	540	6,240
Other Doctors in Training	102	5	23	1	2	-	6	139
Hospital Practitioner/ Clinical Assistant	1,754	34	398	21	15	61	177	2,464
Other Staff	1,285	41	285	29	27	32	115	1,816

In addition, the Northern Ireland Health and Social Care Trusts collect information regarding the ethnic profile of their staff. The following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a breakdown of the racial group to which health care professionals employed in that Trust belong:

Profession	White	Black African	Filipino	Indian	Other	Unknown	Total
Doctor	1246	13	-	68	92	335	1754
Nurse	5091	12	199	189	61	890	6442
Occupational Therapist	207	-	-	-	-	29	236
Optometrist	28	-	-	-	-	1	29
Pharmacist	122	-	-	-	2	5	129
Physiotherapist	299	-	-	-	4	33	336
Podiatrist	46	-	-	-	-	19	65
Radiographer	304	-	-	-	1	13	318
Speech and Language Therapist	111	-	-	-	-	18	129

Not all the regulators publish information in relation to the ethnicity of their registrants. However some information is available.

For example, research has been commissioned by the General Medical Council to examine whether doctors who have qualified outside of the UK are more likely to experience onerous outcomes or high impact decisions as a result of fitness to practise procedures – see C Humphrey et al, *Clarifying the factors associated with progression of cases in the GMC's Fitness to Practise process* (ESRC End of Award Report, RES-153-25-0101, 2009). This research found that decisions reached at fitness to practise proceedings about doctors who qualified *outside the UK* are more likely to result in harsher sanctions than decisions reached about their UK-qualified counterparts. However, the research determined that it was not possible to reach a conclusion regarding the cause of the difference as there was insufficient evidence to determine whether real differences exist in fitness to practise between groups of doctors or whether the process tends to discriminate against certain groups of doctors. Further studies were carried out to investigate the meaning and significance of the findings. This further research identified challenges in four key areas: medical education and professional practice; the circumstances of doctors' working lives; their personal circumstances outside work; and the attitudes and behaviour of other people towards them. However, there was no direct evidence about whether or how such challenges might influence performance or fitness to practise. It has been considered by the General Medical Council that the lack of research directly investigating the relationship between ethnicity or place of qualification and possible performance problems means that there is no good basis as yet for drawing firm conclusions. (See General Medical Council "Fitness to Practise Factsheet 2010 "Ethnicity"" and www.gmc-uk.org).

The General Chiropractic Council collects data in relation to ethnicity and states that it has data for 79% of registrants across the UK. In its Annual Report and Accounts 2010 (at page 22 – www.gcc-uk.org), the Council states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of ethnicity, although it is noted that numbers involved are too small to be statistically relevant.

(f) Religion or belief

We have been unable to locate any direct statistical information on the numbers of health and social care professionals who identify themselves as having a religious faith. However, data available from the Office for National Statistics provides the following table in the report *Focus on Religion* (2004):

Population of Great Britain: by religion, April 2001

Great Britain

	Total population		Non-Christian religious population
	(Numbers)	(Percentages)	(Percentages)
Christian	41,014,811	71.82	n/a
Muslim	1,588,890	2.78	51.94
Hindu	558,342	0.98	18.25
Sikh	336,179	0.59	10.99
Jewish	267,373	0.47	8.74
Buddhist	149,157	0.26	4.88
Any other religion	159,167	0.28	5.20
No religion	8,596,488	15.05	n/a
Religion not stated	4,433,520	7.76	n/a
All non-Christian religious population[1]	3,059,108	5.36	100
All population	57,103,927		100

We can adjust these figures for the current UK population, which is estimated by the World Bank to be 62,218,761. This gives us estimated current figures of:

Christian	44,688,508
Muslim	1,731,207
Hindu	608,353
Sikh	366,291
Jewish	291,322
Buddhist	162,517
No religion	9,366,475
Religion not stated	4,830,630
All non-Christian religious population	3,333,112

The White Paper *Enabling Excellence* estimates that there are 1,400,000 health and social care professionals in the UK. We can use this figure to calculate an estimate of how many health and social care professionals belong to particular faith groups:

Christian	1,027,836
Muslim	39,817
Hindu	13,992
Sikh	8,425
Jewish	6,700
Buddhist	3,738
No religion	215,429
Religion not stated	111,104
All non-Christian religious population	76,662

Information has been made available regarding the religious beliefs of healthcare professionals working in Northern Ireland. The Health and Social Care Trusts collect information regarding the section 75 profile of their staff. The following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a

breakdown of the religious affiliation of health care professionals employed in that Trust:

Profession	Protestant	Catholic	Other or Not Known	Total
Doctor	761	631	362	1754
Nurse	2843	3194	405	6442
Occupational Therapist	127	104	5	236
Optometrist	21	8	-	29
Pharmacist	45	80	4	129
Physiotherapist	193	131	12	336
Podiatrist	28	34	3	65
Radiographer	152	158	8	318
Speech and Language Therapist	60	62	7	129

The Northern Trust also provided statistics in relation to the religion of staff employed in that Trust area as of January 2012:

Profession	Protestant	Catholic	Other or Not Known	Total
Medical and dental	42%	30.6%	27.4%	100%
Nursing and Midwifery	48.8%	43.8%	7.4%	100%
Occupational Therapist	51.2%	44.5%	4.3%	100%
Orthoptist	50%	12.5%	37.5%	100%
Pharmacist	58.5%	34%	7.5%	100%
Physiotherapist	65.8%	25.8%	8.4%	100%
Podiatrist	60.9%	31.3%	7.8%	100%
Radiographer	64%	31.2%	4.8%	100%
Speech and Language Therapist	56.4%	37.6%	6%	100%

In the Southern Health and Social Care Trust, within the Medical and Dental, Nursing and Midwifery and Allied Health Professions, 1,659 staff are Protestant, 2,469 are Catholic and the religious belief of 332 staff is unknown.

(g) Sex

The NHS Health and Social Care Workforce Census of 22 March 2011 provides the following in relation to the gender profiles of medical and dental staff employed within hospital and community health services:

	All Staff	
	No.	**%**
Male Staff	59,255	57
Female Staff	44,657	43
All Staff	103,912	100

The Northern Ireland Health and Social Care Workforce Census of 31 March 2011 provides the following information in relation to the gender profile of the health care professions workforce in Northern Ireland:

Medical and Dental	2039	1877
Qualified Nursing and Midwifery	1064	14948
Dietician	-	228
Occupational Therapist	-	800
Orthoptist	-	34
Dietetic/Orthoptic/Speech and Language Therapist	11	-
Physiotherapist	126	875
Podiatrist	57	203
Radiographer	63	671
Speech and Language Therapist	-	421
Pharmacist	85	337
Clinical Psychologist	73	108
Dental and Dental Support	-	53
Optometrist	-	25

It appears that the regulators do not all publish data in relation to the gender profile of the registrants who face fitness to practise processes.

The General Medical Council does publish such data, although it is collected on a UK-wide basis. For example, in 2009, the General Medical Council Fitness to Practise Fact Sheet 2009 "Gender" provides a breakdown by gender of fitness outcomes. In relation to case examiner outcomes, 32% of decisions about female doctors resulted in no further action, 32% resulted in closure with advice, 12% resulted in a warning and 8% in undertakings. The remaining 16% resulted in a referral to a Fitness to Practise Panel Hearing. This represents 0.05% of all female doctors currently registered. In relation to male doctors, 29% of case examiner decisions resulted in no further action, 28% resulted in closure with advice, 15% resulted in a warning and 6% in undertakings. The remaining 22% resulted in a referral to a Fitness to Practise Panel Hearing. This represents 0.2% of all male doctors currently registered. Fitness to Practise Panel Hearings in 2009 resulted in 73% of referred female doctors being found to be impaired and 74% of male doctors. Six female doctors and 62 male doctors were erased from the register in 2009. This represents 0.01% of all female doctors with current registration in that year and 0.05% of all male doctors.

The General Chiropractic Council collects data in relation to gender and states that it has data for all registrants across the UK. In its Annual Report and Accounts 2010 (at page 22 – www.gcc-uk.org), the Council states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of gender, although it is noted that numbers involved are too small to be statistically relevant.

The Nursing and Midwifery Council states in its Annual Fitness to Practise Report 2010-2011 (see page 13 – www.nmc-uk.org) that the collection of data in relation to age, gender, religion, ethnicity, sexual orientation and disability was commenced in 2009. As yet, there has been limited cross-reference to fitness to practise data. However, some information is available in relation to gender. In 2010-2011, across the UK, 3012 females were referred to the Nursing and Midwifery Council (72% of referrals) and 986 males (23% of referrals). Out of a total of 506 interim orders made in 2010-2011, 67.19% were in relation to females and 32.81% in relation to males. Out of a total of 256 cautions, conditions of practice or suspensions imposed, 75% were made in relation to females and 25% in relation to males. Of the 198 registrants removed or struck off the register, 62% were female and 38% were male. It should be noted that 114 of the nurses or midwives complained about were from Northern Ireland, which is 2% of the total number of complaints received (see page 18 – www.nmc-uk.org).

The General Dental Council states in its Annual Report and Accounts 2010 that 22215 male and 16164 female dentists are registered across the UK (see page 13 – www.gdc-uk.org). Where dental care professionals are concerned, 6204 males and 51000 females are registered across the UK.

The Pharmaceutical Society of Northern Ireland in its Annual Report and Accounts 2010/11 reports that 64% of registrants are female and 36% are male.

(h) Sexual orientation

We have been unable to locate any direct statistical information on the sexual orientation of health and social care professionals. We are aware that the Office for National Statistics collected information as part of its Integrated Household Survey in 2010. It found that more than 480,000 people consider themselves to be gay or lesbian and a further 245,000 people say that they are bisexual. However, the overall sample size was small.

In respect of Northern Ireland, the following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a breakdown of the sexual orientation of health care professionals employed in that Trust:

	Heterosexual	**Lesbian, gay, bisexual and transgender**	**Not disclosed**	**Total**
Doctor	780	16	958	1754
Nurse	2235	61	4146	6442
Occupational Therapist	101	2	133	236
Optometrist	17	-	12	29
Pharmacist	47	1	81	129
Physiotherapist	149	6	181	336
Podiatrist	20	-	45	65
Radiographer	125	3	190	318
Speech and Language Therapist	72	1	56	129

In the Southern Health and Social Care Trust, within the Medical and Dental, Nursing and Midwifery and Allied Health Professions, 1,580 staff are attracted to the opposite gender, 23 to the same gender, 1 is attracted to both genders and the sexual orientation of 2,856 staff is unknown.

We are not aware that any of the regulators collect data regarding sexual orientation. We will be working with stakeholders – including the Department of Health and the devolved governments/executives – in order to gather further information.

(2) The provisional proposals within the consultation paper that may have an impact on those registrants with protected characteristics.

To identify the provisional proposals within the consultation paper that may have an impact on those with protected characteristics we considered our proposals *generally* and *specifically*.

In general terms, the overriding theme of the consultation paper is that we are making provisional proposals to change the *structure* of the legal framework for the regulation of health and social care professionals. In the main, we are not proposing that certain decisions must be made by the regulators. This would continue to be a matter for the regulators to decide taking into account their individual circumstances and resources. Rather, we are seeking to reform the existing legal position in order to achieve our law reform objectives of simplicity, consistency, flexibility, accountability and efficiency. However, we accept that our proposals will give the regulators additional powers and discretion to make regulatory decisions, and that therefore the potential for decisions to be made which affect those with protected characteristics will increase.

Furthermore, we have proposed to give the regulators autonomy to create their own rules and to remove their

dependence on the Privy Council (and through it the Department of Health). We have not made provisional proposals in relation to the content of these rules which would be a matter for the regulators to decide. However, arguably the scrutiny process currently undertaken by the Department of Health may help to ensure that the regulators are compliant with the Equality Act 2010. If this is correct, then the regulators will need to take additional care to ensure that they ensure compliance. Such further work might include further research and policy work in order to determine the numbers of registrants who have one or more of the protected characteristics, whether such people are affected disproportionately by the decisions taken by the regulator and the development of policies to promote equality of opportunity.

In addition, there are some specific proposals that may have a direct impact on those with protected characteristics. We have identified the following:

(1) We have proposed the removal of the general requirement of "good health" in order for a practitioner to be registered (see paragraph 5.60 and provisional proposal 5-11). In our view, this requirement suggests some general state of health that is required for registration and obscures the primary issue for the regulators of whether these matters affect a professional's fitness to practise. Moreover, the Disability Rights Commission in its 2007 report *Maintaining Standards: Promoting Equality* (2007) provided evidence that such requirements can impact negatively on disabled people, often leading to unwillingness to disclose a disability which in turn reduces the availability of reasonable adjustments in law and individual support.

(2) The removal of the default position at some regulators that health cases should be heard in private (see paragraphs 9.51 to 9.52 and 9.66 to 9.70) and the adoption of rule 39.2 of the Civil Procedure Rules (provisional proposal 9-14). However, we do not envisage that this would have an impact on disabled people, given that in most health cases it is likely that hearings would be in private on the basis that it involves confidential information, notwithstanding that rights under Article 8 of the European Convention on Human Rights would be engaged (see *E v UK* (2001) 34 EHRR 529 at [39]).

(3) The introduction of a single definition of a "vulnerable witness" across the regulators modelled on the Youth Justice and Criminal Evidence Act 1999 (provisional proposal 9-15). Where a person is classified as being a "vulnerable witness", special measures can be introduced to assist the giving of evidence. Most regulators' rules define who is a vulnerable witness by reference to whether the person has a mental disorder, impaired intelligence or physical disabilities, the allegations are of a sexual nature or the witness has been intimidated. Some regulators are required to treat any witness under 18 as being a vulnerable witness, whilst for others the age is under 17. At the General Chiropractic Council and General Osteopathic Council there are no express provisions for vulnerable witnesses. In our view, the statute should establish a central definition of a vulnerable witness. It is not acceptable that some regulators do not have any express provision for vulnerable witnesses. Furthermore some of the definitions we have reviewed are outdated and potentially discriminatory; for example some establish that all disabled people are automatically *vulnerable* and will require special arrangements. Our proposed definition would ensure that disabled people would receive support and assistance if the quality of their evidence is likely to be diminished without it.

(4) A duty on the regulators to specify in rules which qualifications would entitle EEA applicants to be registered (provisional proposal 13-1) and powers to determine the registration requirements for applicants beyond the EEA (provisional proposal 13-3). At present, the provisions for overseas applicants are highly detailed and vary considerably between the regulators. We believe that these provisions should be provided at a level where such detail is more appropriate, such as in rules or regulations made by the regulators. Indeed, it is highly unlikely that the new statute could consolidate all these provisions effectively, whilst at the same time recognising the different aspects that apply to the various regulated professions. These proposals represent changes in the structure of how applicants are registered, rather than setting any different substantive requirements. Accordingly, whilst we acknowledge the relevance of the protected characteristic of race, we do not envisage any impact.

5. Are there gaps in information that make it difficult or impossible to form an opinion on how your proposals might affect different groups of people. If so what are the gaps in the information and how and when do you plan to collect additional information?

Note this information will help you to identify potential equality stakeholders and specific issues that affect them - essential information if you are planning to consult as you can raise specific issues with

particular groups as part of the consultation process. EIAs often pause at this stage while additional information is obtained.

As indicated above, there are currently significant gaps in the information available to us in relation to the numbers of people within the protected characteristics of gender reassignment, pregnancy and maternity, and sexual orientation. In relation to the protected characteristics of age, disability, race, religion or belief and sex we only have partial information.

However, we do not consider that these gaps make it impossible to form an opinion on the equality impacts of our provisional proposals. As we conclude at the end of this screening assessment, it is our view that our provisional proposals do not suggest any adverse equality impact.

As stated above, we will work with stakeholders – including the Department of Health and the devolved governments/executives – to develop these figures. In addition, we welcome further evidence during the consultation process.

6. Having analysed the initial and additional sources of information including feedback from consultation, is there any evidence that the proposed changes will have a <u>positive impact</u> on any of these different groups of people and/or promote equality of opportunity?

Please provide details of who benefits from the positive impacts and the evidence and analysis used to identify them.

In our view, two of our provisional proposals will have a positive impact on groups with a protected characteristic. We welcome evidence on these issues.

(1) The removal of the requirement that "good health" is a pre-requisite to registration (paragraph 5.60 and provisional proposal 5-11) would we believe have a positive impact on disability equality. As noted above, this requirement suggests some general state of health that is required for registration and obscures the primary issue for the regulators of whether these matters affect a professional's fitness to practise. Moreover, the Disability Rights Commission in its 2007 report *Maintaining Standards: Promoting Equality* (2007) provided evidence that such requirements can impact negatively on disabled people, often leading to unwillingness to disclose a disability which in turn reduces the availability of reasonable adjustments in law and individual support.

Our provisional proposal will have a positive impact for disabled people since registration could only lawfully be refused in cases where the applicant's fitness to practise is impaired, and not on the basis of a general requirement of good health.

(2) A consistent definition of a "vulnerable witness" modelled on the Youth Justice and Criminal Evidence Act 1999 (provisional proposal 9-15) would we believe have a positive impact on disability equality. As noted above, the current position is not acceptable, whereby some regulators do not have any express provision for vulnerable witnesses. Furthermore some of the definitions we have reviewed are outdated and potentially discriminatory; for example some establish that all disabled people are automatically assumed to be *vulnerable*. . Our proposed solution is that the statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing or if the Fitness to Practise Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. We think that this reform will discourage an attitude that disabled people are less capable than anyone else in society of giving evidence, while also ensuring that assistance is provided where there is a need to provide it.

This proposal will we believe have a positive impact on equality of opportunity for young people who will be eligible for assistance since it will offer young witnesses valuable protection whilst giving evidence before such a fitness to practise hearing.

7. Is there any feedback or evidence that additional work could be done to promote equality of opportunity?

If the answer is yes, please provide details of whether or not you plan to undertake this work. If not, please say why.

During the consultation process, we will be working with stakeholders – including the Department of Health and the devolved governments/executives – to identify if additional work is needed in order to promote equality of opportunity and if so what work is needed. We will also endeavour to seek the views of the Equality and Human Rights Commission. We welcome further evidence on this issue.

8. Is there any evidence that proposed changes will have an <u>adverse equality impact</u> on any of these different groups of people?

Please provide details of who the proposals affect, what the adverse impacts are and the evidence and analysis used to identify them.

As stated above, the majority of our provisional proposals seek to change the structure of professional regulation, rather than requiring a certain course of action by the regulators. . However, we accept that our proposals will give the regulators additional powers and discretion to make regulatory decisions, and that therefore the potential for decisions to be made which affect those with protected characteristics will increase.

Furthermore, there is a risk of an adverse equality impact because under our proposed scheme the regulators would be given greater powers to create their own rules without direct oversight and scrutiny from the Department of Health. This may lead to a greater risk that such rules are not created in compliance with section 149 of the Equality Act 2010. However, to some extent this risk may be offset by our proposed duty to consult when a regulator is considering making rule changes minimises such risk (provisional proposal 2-7). Furthermore, all of the regulators have developed Equality and Diversity Schemes to guide their decision-making on equality issues. Accordingly, our provisional view is that the risk described is minimal. We welcome further views on these risks.

9. Is there any evidence that the proposed changes have <u>no equality impacts</u>?

Please provide details of the evidence and analysis used to reach the conclusion that the proposed changes have no impact on any of these different groups of people.

We highlighted above two provisional proposals that have relevance to the protected characteristics. They are:

(1) The removal of the default position at some regulators that health cases should be heard in private (see paragraphs 9.51 to 9.52 and 9.66 to 9.70). We propose the adoption of rule 39.2 of the Civil Procedure Rules (provisional proposal 9-14).

We do not envisage that this would have an impact on disabled people, given that in most health cases it is likely that hearings would be in private on the basis that it involves confidential information, notwithstanding that rights under Article 8 of the European Convention on Human Rights would be engaged (see *E v UK* (2001) 34 EHRR 529 at [39]).

(2) A duty on the regulators to specify in rules which qualifications would entitle EEA applicants to be registered (provisional proposal 13-1) and powers to determine the registration requirements for applicants beyond the EEA (provisional proposal 13-3). At present, the provisions for overseas applicants are highly detailed and vary considerably between the regulators.

These proposals represent changes in the structure of how applicants are registered, rather than setting any different substantive requirements. Accordingly, whilst we acknowledge the relevance of the protected characteristic of race, we do not envisage any change in impact.

During our consultation process we will welcome any views on the above issues and whether we have omitted to mention a provisional proposal that may impact those with a protected characteristic.

10. **Is a full Equality Impact Assessment Required?** Yes ☐ No ✓

If you answered 'No', please explain below why not?

We do not consider that at this stage a full Equality Impact Assessment is required. However, this may alter as a result of evidence received during consultation.

We have assessed the size and nature of the health and social care professions and we have assessed our provisional proposals in relation to them. We were able to identify two provisional proposals that might have positive equality benefits, and two provisional proposals that are likely to have no equality impact. As for the remaining provisional proposals, whilst most can be described as structural or technical, we acknowledge that the potential for decisions to be made which affect individuals with a protected characteristic will increase.

We will be testing our provisional proposals during our consultation period. We hope to engage with relevant stakeholders and we welcome further evidence to inform our consideration of the equality impacts, or otherwise, of our proposals. The Law Commission complies with the Government's Code of Practice on Consultation (see page iv of the Consultation Paper).

11. Even if a full EIA is not required, you are legally required to monitor and review the proposed changes after implementation to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor evaluate or review your proposals and when the review will take place.

The Law Commission is not responsible for monitoring the effect of recommendations that are implemented as a result of the final report, which we intend to publish in 2014. This role is the responsibility of the implementing Department and the devolved governments/executives.

12. Name of Senior Manager and date approved

Name: Richard Percival
Department: Law Commission
Date: 1 March 2012