Title:
The Professional Standards Authority for Health and Social Care (Fees) Regulations 2014
IA No:
Lead department or agency:
Department of Health
Other departments or agencies:
Non Applicable

Impact Assessment (IA)

Date: 03/10/2014

Stage: Consultation

Source of intervention: Domestic

Type of measure: Secondary Legislation

Contact for enquiries:
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Summary: Intervention and Options

RPC Opinion: Not Applicable

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, Two-Out?**	**Measure qualifies as**
-£0.5m	-£13.8m	£1.3m	No	N/A

What is the problem under consideration? Why is government intervention necessary?
Secondary legislation is necessary to realise the policy intention set out in the Health and Social Care Act 2012. The Authority's fees need to be compulsory (i.e. set out in legislation), to prevent any actual or perceived compromise of the Authority's independence from regulators and from Government. This is particularly important in view of the Authority's role in providing assurance that professional regulation is performed in a way that protects people who use services and other members of the public.

What are the policy objectives and the intended effects?
The recommendations of the ALB review formed part of the wider reforms to reduce the cost and number of public bodies. The change to the Authority's funding will generate annual savings to the taxpayer. It also reflects the long-standing principle that regulators should be operationally independent of both Government and those they regulate.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)
Option 1 – Do nothing.
Option 2 – Introduce secondary legislation giving the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees, based on the number of registrants each regulator oversees.
Option 3: Introduce secondary legislation giving the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees. Fees to be based on a fixed fee charged to all regulators to cover the Authority's activities from which they benefit equally, with the remainder of the costs apportioned according to number of registrants overseen by each regulator.

ll the policy be reviewed? It will be reviewed. **If applicable, set review date:** 2019

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes	**< 20** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

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

Signed by the responsible SELECT SIGNATORY: _____

Summary: Analysis & Evidence

Policy Option 1

Description: Do nothing: The Authority remains an ALB of the DH and therefore continues to be funded by Grant in Aid.

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
2014	2014	10	**Low:** 0	**High:** 0	**Best Estimate:** 0

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

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

Zero. This is the do nothing option and consequently no additional costs will be incurred by any party.

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

Zero, please see above.

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

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

Zero. This is the do nothing option and consequently no additional benefits will accrue to any party.

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

Zero, please see above.

Key assumptions/sensitivities/risks

Discount Rate N/A

Risk that the independence of the Authority may be questionable if it remains reliant on government funding. This may have negative reputational impacts on the Authority (thereby limiting its perceived effectiveness) and foster lower public confidence in the healthcare sector.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	N/A	N/A

Summary: Analysis & Evidence

Policy Option 2

Description: Introduce secondary legislation giving the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees based on the number of registrants each regulator oversees. This is the preferred option.

Price Base Year 2014	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -0.3	High: -0.7	Best Estimate: -0.5

COSTS (£m)	Total Transition (Constant Price)	Year	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0.008		3.9	**33.7**
High	0.008	1	8.5	**70.3**
Best Estimate	0.008		5.8	**48.6**

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

On-going costs: Financing the majority of the Authority's annual budget plus wage costs of one additional staff member to undertake work generated by the policy for the Authority. Assuming 100% pass through of costs; these will ultimately be borne by healthcare professionals registered with a regulator.

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

None identified.
Transition Costs: Recruitment costs for one Authority staff member to undertake work generated by the policy. Assuming 100% pass through of costs; this will ultimately be borne by healthcare professionals registered with a regulator. The figure was too small to be presented in summary but has featured in other calculations.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		3.9	**33.4**
High	0		8.4	**69.6**
Best Estimate	0		5.7	**48.1**

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

No transition benefits anticipated.
On-going benefits: Ongoing benefit to the Department of Health equal to the value of the total fees paid to the Authority by all regulators, as DH will no longer be responsible for funding the majority of the Authority's budget.

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

There is potential for the public's confidence in the Authority as an independent regulator, and thereby the healthcare provision sector in general, to increase once it is no longer reliant on government funding.
Reputational benefits to the Authority are possible as its independence and impartiality would be confirmed.

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

Authority funding requirements are largely driven by the number of Section 29 cases they must process in a given year. However, it is not possible to accurately forecast this figure, necessitating assumptions to be made regarding the future growth in funding requirements to finance the Authority.
No official data is available regarding the proportion of regulators' registrants that are classed as businesses and so estimates for this were compiled from the best available sources.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 1.3	**Benefits: Non-Monetised**	**Net: -1.3**	No	Not Applicable

Summary: Analysis & Evidence

Policy Option 3

Description: As option two but fee split in to an equal, fixed fee charged to all regulators to cover Authority activities from which they benefit equally, with the remainder apportioned by the number of registrants overseen by each regulator.

Price Base Year 2014	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -0.3	**High:** -0.7	**Best Estimate:** -0.5

COSTS (£m)	Total Transition (Constant Price)	Year	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value, 2014)
Low	0.008	1	3.9	**33.7**
High	0.008		8.5	**70.3**
Best Estimate	0.008		5.8	**48.6**

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

On-going costs: Financing the majority of the Authority's annual budget plus wage costs of the staff member detailed above. Assuming 100% pass through of costs; this will ultimately be borne by healthcare professionals registered with a regulator.
These are the same as in option two – the difference between the options is in how the fee is apportioned which will not alter the overall costs of the policy.

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

Transition Costs: Recruitment costs for one Authority staff member to undertake work generated by the policy. Assuming 100% pass through of costs; this will ultimately be borne by healthcare professionals registered with a regulator. The figure was too small to be presented in summary but has featured in other calculations.
These are the same as in option two – the difference between the options is in how the fee is apportioned which will not alter the overall costs of the policy.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	N/A	3.9	**33.4**
High	0		8.4	**69.6**
Best Estimate	0		5.7	**48.1**

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

No transition benefits anticipated.
On-going benefits: Ongoing benefit to the Department of Health equal to the value of the total fees paid to the Authority by all regulators, as DH will no longer be responsible for funding the majority of the Authority's budget.
These are the same as in option two – the difference between the options is in how the fee is apportioned which will not alter the overall benefits of the policy.

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

There is potential for the public's confidence in the Authority as an independent regulator, and thereby the healthcare provision sector in general, to increase once it is no longer reliant on government funding.
Reputational benefits to the Authority are possible as its independence and impartiality would be confirmed.
These are the same as in option two – the difference between the options is in how the fee is apportioned which will not alter the overall benefits of the policy.

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

Authority funding requirements are largely driven by the number of Section 29 cases they must process in a given year. However, it is not possible to accurately forecast this figure, necessitating assumptions to be made regarding the future growth in funding requirements to finance the Authority.
No official data was available regarding the proportion of regulators' registrants that would be classed as businesses and so estimates for this were compiled from the best available sources.
These are the same as in option two, how the fee is apportioned does not alter the sensitivities or risks.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 1.3	**Benefits: Non-Monetised**	**Net: -1.3**	No	Not Applicable

Evidence Base (for summary sheets)

The Professional Standards Authority for Health and Social Care (Fees) Regulations

Issue under consideration

1. The complexity of the work performed by health and social care professionals means that it can be difficult for employers and members of the public to discern the quality and safety of the care they provide. For this reason, independent statutory bodies regulate certain professions to ensure professionals meet required standards of training, competency, performance and conduct. There are currently nine health and social care professions regulators in the UK. These are:

   General Chiropractic Council
   General Dental Council
   General Medical Council
   General Optical Council
   General Osteopathic Council
   General Pharmaceutical Council
   Health and Care Professions Council
   Nursing and Midwifery Council
   Pharmaceutical Society of Northern Ireland

   Through its scrutiny of these regulatory bodies, the Professional Standards Authority (the Authority) provides assurance that this regulation is performed in a way that protects patients and the public.

2. The Authority is currently an Arm's Length Body (ALB) of the Department of Health (DH) and is funded by the Department and the Devolved Administrations. In 2010, the Department of Health conducted a review of its ALBs. *Liberating the NHS: Report of the arm's length bodies review* (July 2010), recognised the importance of the work of the Authority (then the CHRE), but found no compelling reason for it to continue to be funded through general taxation, and recommended that it instead be funded through a compulsory fee on the regulatory bodies it oversees.

Policy objective

3. The recommendations of the ALB review formed part of the wider reforms to reduce the cost and number of public bodies. The change to the Authority's funding will generate annual savings to the taxpayer. It also reflects the long-standing principle that regulators should be operationally independent of both Government and those they regulate.

Rationale for intervention

4. Secondary legislation is necessary to realise the policy intention set out in the Health and Social Care Act 2012. The Authority's fees need to be compulsory (i.e. set out in legislation), to prevent any actual or perceived compromise of the Authority's independence from regulators and from Government. This is particularly important in view of the Authority's role in providing assurance that professional regulation is performed in a way that protects people who use services and other members of the public.

Options Considered

5. **Option 1:** Do nothing.
6. **Option 2:** Introduce secondary legislation giving the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees, based on the number of registrants each

regulator oversees. This is the preferred option as all policy objectives are achieved, the fee structure is simple and would be easily understood and the smaller regulatory bodies would not be disproportionally impacted.

7. **Option 3:** Introduce secondary legislation giving the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees. Fee to be based on a fixed fee charged to all regulators to cover the Authority's activities from which they benefit equally, with the remainder of the costs apportioned according to number of registrants overseen by each regulator. Although it was considered, there is currently insufficient management information available that could be used as a suitable proxy for this scenario. This is consequently not a viable option to pursue.

Alternatives to Regulation

8. Both policy options (i.e. the options that are not 'do nothing') involve laying a piece of secondary legislation and consequently there are no options which propose an alternative to regulation. This is because the Authority's actions are governed by the relevant legislation, so it is not possible to furnish them with new powers in the absence of a legislative change, and therefore a regulatory policy is required. However, the cost savings expected to accrue to the Department and the unquantified benefits to the Authority and the public justify regulatory action in the absence of possible alternatives.

9. An option making the legislation as 'light touch' as possible (i.e. giving the Authority broad powers to set fees without specifying the mechanism) is not deemed suitable for the following reasons:

   - A key component of the policy objective is to strengthen the Authority's reputation as an entirely independent and impartial organisation and thereby increase the public's confidence in the regulation of healthcare practitioners. Were the fee structure not fixed, it would leave open the possibility for individual regulators to assert that the allocation of fee between regulators had been biased by other factors. Such assertions could serve to impact the public's confidence in the Authority and the regulation of healthcare generally. Consequently, the policy objective may not be achieved to a full extent.
   - Pressure could potentially be exerted on the Authority by individual regulators in less favourable financial positions to reduce their cost burden for the year by charging them a lower fee. This equates to cross-subsidisation and as such is in contravention of recommendations laid out in HM Treasury's 'Managing Public Money' document[1].

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf

- Finally, it was considered that having a legislated fee structure would help to maintain the level of stability within the regulation of healthcare professionals sector, whereas leaving the structure open may have increased the risk of frequent changes to how the fee was charged. Frequent changes to how the fee was apportioned between regulators could raise uncertainty for the regulators in terms of their financial planning and the optimal level of fees to charge registrants. Registrants would also face potentially higher levels of uncertainty if their fees became more volatile as a result of frequent changes to how the Authority apportioned fees between the nine regulatory bodies it oversees.

Costs and Benefits of the Options

10. This section details the monetised and non-monetised costs and benefits expected to be generated by implementing the policy options under consideration. The evaluation of the monetary impacts will be followed by a discussion of the non-monetary impacts it was estimated the policy would generate for each policy option.

11. The DH liaised with the Authority who provided the baseline figures that have been utilised in this document (as shown in table one). These formed the basis for the calculations contained in this assessment. Please note that all the assumptions applied and adjustments made to these baseline figures have been made by the DH, not the Authority.

12. It may be noted that the overall monetised costs, benefits and therefore Net Present Values (NPV) of policy options two and three are equal and so they are dealt with in tandem in this section. This is due to the only difference between the options being how the fee will be apportioned between the regulatory bodies overseen by the Authority, which does not alter the underlying costs and benefits. The costs to business generated by the two options are not equal, and consequently the options are presented separately in that section.

Option One: Do Nothing

13. As directed by the guidance for impact assessments, zero costs and benefits are allocated to the do nothing option. Throughout, the do nothing option provides the baseline against which the impacts of policy options two and three can be assessed as marginal changes.

Options Two and Three

Option two is the Department's preferred option, however this is not based on its Net Present Value (NPV), as the NPV is identical in options two and three. Rather, option two enables the policy objectives to be met whilst ensuring the fee structure could be easily understood and the smaller regulators would not be disproportionately impacted. Furthermore, there is currently insufficient management information available that could be used as a suitable proxy for the methodology suggested in option three. This is consequently not considered a viable option to pursue.

14. This section will begin by setting out the monetary costs and benefits along with the resultant NPV of the policy, before moving on to detail the estimated non-monetary impacts.

15. A full methodology is presented at annex B whilst the narrative here provides a summary of the method, as well as specifying any areas of potential risk, uncertainty and or where assumptions have been made.

16. Table 1 below presents the best estimate monetary impacts in a single year of implementing option two or three, and states which stakeholder group will be impacted in each case. The figures were provided by the Authority and represent the cost of the Authority's activities relating to regulatory oversight functions, standards and quality (note that the figures do not relate to matters of public policy; advice to, and investigations for, government; accreditation of voluntary registers or advice provided to other organisations) in 2014/15.

Table 1: Unadjusted Costs and Benefits Expected to Arise in a Single Year as a Result of Policy Implementation, £m

Accruing to:	**Transition Cost**	**Transition Benefit**	**Ongoing Annual Costs**	**Ongoing Annual Benefits**
Authority	0.0	0.0	0.0	0.0
Government	0.0	0.0	0.0	3.6
Regulators	0.008	0.0	3.6	0.0

(Source: Baseline figures provided by the Authority)

14. The ongoing benefit to Government arises from the fact that the Department will no longer be responsible for providing funding for the Authority's budget. However, it should be noted that the savings to government estimated here will be reduced by a given proportion due to the tax deductible nature of the fees paid to the regulatory bodies by healthcare professionals. An increase in the amount of fees paid by healthcare professionals to their regulators will cause a marginal fall in the amount of taxable pay received by these individuals. This will therefore result in a fall in tax revenue, however, this effect has not been quantified here for the following reasons:

- The earnings, and therefore tax bands, across the various types of healthcare professionals can significantly differ from one another. In order to quantify the impact of potential lost tax revenues, it would have been necessary to assign an average tax band to each profession to estimate the proportion of the £2.47 fee rise per person would have been paid in tax. This per person figure would then have been applied across the estimated number of individuals practising in each profession to produce an aggregate figure. The uncertainties and necessary assumptions associated with this calculation would be highly likely to preclude the production of a robust result. Additionally, this was not deemed to be a proportionate approach taking in to account the small numbers in question.

- The overall net figures will not be affected by this as it is essentially a transfer of savings from government to the healthcare professionals.

17. The Authority will be funded instead by the regulators generating a cost saving (benefit) for government. Forecasts have been produced, based on the figures above, over a ten year period to estimate the overall costs, benefits and net costs (benefits) arising from policy implementation as presented below in table 2:

Table 2: Estimated Overall Costs and Benefits of Policy Implementation Forecast to Ten Years, 2014 Prices, £ million

Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Cost	3.6	4.2	4.8	5.6	5.9	6.3	6.7	6.7	6.8	6.9	57.5
Benefit	3.6	4.1	4.8	5.5	5.9	6.2	6.6	6.7	6.7	6.8	56.9
Net Cost	0.04	0.04	0.05	0.05	0.06	0.06	0.07	0.07	0.07	0.07	0.57

(Source: DH Analysis of Authority Baseline Figures)

18. In order to produce the best estimate forecast, the following adjustments were applied: Firstly, a one percent (real terms) year on year increase was applied to the baseline budget supplied by the Authority to account for rises in staff and accommodation costs, as well as rising charges for legal fees, with the workload held constant. Secondly, an adjustment was required to account for the potential changes in the Authority's workload over the period. This was the highest area of uncertainty regarding estimating forecasts for the Authority's budget as a large proportion of the

increase in the Authority's activities in recent years has been due to the number of Section 29 cases[2] they review and at what stage the review is concluded.

19. Given this uncertainty, the workload related year on year adjustment to the baseline budget was set at: 15% rise year on year between the first three annual periods; 5% year on year rise between the following three annual periods; and zero growth in workload between the final three years. As the benefits of the policy are equal to the Authority's running costs (which in the do nothing option would continue to be funded by the Department) the benefits were adjusted by the same amount as the costs.

20. The rationale for these assumptions lies in that we recognise the increases seen in Section 29 cases over recent years (although the rate of change has been volatile such as growth of 8% between 2011-12 and 2012-13 followed by 30% growth between 2012-13 and 2013-14). The drivers for these increases are unclear, but changes in public and employer expectations, and efforts by the NMC to reduce their fitness to practice case backlog, have contributed. It seems likely that these trends will continue over the next few years, but we expect to see growth slow, and eventually the number of cases to reduce in number, over the period covered by this IA. The following may be factors contributing to the overall trends in Section 29 cases and the resulting workload of the Authority:

    - Earlier disposal of cases by the regulatory bodies as a result of legislative change and improved processes.
    - Improvements to the quality of decisions by the regulatory bodies
    - Other regulatory changes (e.g. systems regulation becoming more effective, increased focus on CPD for health care professionals).
    - Increasing cost pressures from registrants.

21. Returning to the costs that will be generated by policy implementation: The total costs calculated will be split between the regulators depending on number of registrants (option two – preferred) or through a fixed, equal fee charged to each regulator and the remainder of the costs split by number of registrants (option three, considered but deemed not viable due to lack of supporting management information). The estimated costs expected to accrue to each of the nine healthcare professionals regulators therefore differ, and tables 3 and 4 below provide the breakdown for options two and three respectively:

Table 3: Estimated Total Costs Split by Regulator of Option Two, Forecast to Ten Years, 2014 Prices, £ million

Year	1	2	3	4	5	6	7	8	9	10	Total
PSNI	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.08
GCC	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.11
GDC	0.25	0.29	0.34	0.39	0.41	0.44	0.46	0.47	0.47	0.48	4.00
GMC	0.6	0.7	0.9	1.0	1.1	1.1	1.2	1.2	1.2	1.2	10.2
GOC	0.06	0.07	0.09	0.10	0.11	0.11	0.12	0.12	0.12	0.12	1.02
GOSC	0.01	0.01	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.19
GPhC	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.7
HCPC	0.8	0.9	1.1	1.2	1.3	1.4	1.5	1.5	1.5	1.5	12.7
NMC	1.7	1.9	2.2	2.6	2.7	2.9	3.1	3.1	3.1	3.2	26.5
Total	3.6	4.2	4.8	5.6	5.9	6.3	6.7	6.7	6.8	6.9	57.5

[2] The National Health Service Reform and Health Care Professions Act 2002 provides the legislative power at Section 29 for Professional Standards Authority for Health and Social Care (then called The Council for the Regulation of Health Care Professionals) to refer a fitness to practise decision by a regulatory body to the High Court where this seems to it to be desirable for the protection of the public. When such a case is referred to the High Court, the Court has the power to substitute its own decision for the one referred to it, or if it preferred to refer the case back to the regulatory body for re-hearing. Existing Court Rules protect the rights of the professional whose case is being heard by ensuring that he or she becomes a "respondent" in the appeal, that is, they have a right to be represented at the appeal hearing.

(Source: DH Analysis of Authority Baseline Figures. Totals may not sum due to rounding.)

Table 4: Estimated Total Costs Split by Regulator of Option Three, Forecast to Ten Years, 2014 Prices, £ million

Year	1	2	3	4	5	6	7	8	9	10	Total
PSNI	0.009	0.010	0.012	0.014	0.015	0.016	0.017	0.017	0.017	0.017	0.14
GCC	0.01	0.01	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.18
GDC	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	4.0
GMC	0.6	0.7	0.9	1.0	1.1	1.1	1.2	1.2	1.2	1.2	10.2
GOC	0.07	0.08	0.09	0.11	0.11	0.12	0.13	0.13	0.13	0.13	1.08
GOSC	0.02	0.02	0.02	0.02	0.03	0.03	0.03	0.03	0.03	0.03	0.26
GPhC	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.8
HCPC	0.8	0.9	1.1	1.2	1.3	1.4	1.5	1.5	1.5	1.5	12.6
NMC	1.6	1.9	2.2	2.6	2.7	2.9	3.0	3.1	3.1	3.1	26.3
Total	3.6	4.2	4.8	5.6	5.9	6.3	6.7	6.7	6.8	6.9	57.5

(Source: DH Analysis of Authority Baseline Figures. Totals may not sum due to rounding.)

22. The forecast figures were then adjusted using a 3.5% discount rate to produce an estimate of the 'present value' of the future impacts of the policy. The term 'present value' refers to the fact that economic analysis has found that rational individuals place a lower value on a potential monetary impact the further in to the future it is expected to occur. So, individuals would rather receive a monetary benefit as soon as possible and pay a monetary cost as far in to the future as possible. The 3.5% discount rate is the standard rate for a ten year forecast, to convert future impacts in to the estimated value a rational individual would place on the specified impact if it were to occur today. The present value of the figures presented above in tables 2, 3, and 4 are shown below in tables 5, 6, and 7:

Table 5: Present Value of Estimated Overall Costs and Benefits of Policy Implementation Over Ten Years, 2014 Prices, £ million, 3.5% Discount Rate

Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Cost	3.6	4.0	4.5	5.1	5.2	5.3	5.4	5.3	5.2	5.0	48.6
Benefit	3.6	4.0	4.5	5.0	5.1	5.2	5.4	5.2	5.1	5.0	48.1
Net Cost	0.04	0.04	0.04	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.48

(Source: DH Analysis of Authority Baseline Figures. Totals may not sum due to rounding.)

23. As previously, the discounted cost figures presented above in table 5 are shown below split by regulator in tables 6 and 7 for options two and three respectively.

Table 6: Estimated Total Costs Split by Regulator of Option Two, Forecast to Ten Years, 2014 Prices, £ million, Discounted at 3.5%

Year	1	2	3	4	5	6	7	8	9	10	Total
PSNI	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.06
GCC	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.10
GDC	0.2	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	3.4
GMC	0.6	0.7	0.8	0.9	0.9	0.9	1.0	0.9	0.9	0.9	8.6
GOC	0.06	0.07	0.08	0.09	0.09	0.09	0.10	0.09	0.09	0.09	0.86
GOSC	0.01	0.01	0.01	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.16
GPhC	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.2	0.2	2.3
HCPC	0.8	0.9	1.0	1.1	1.1	1.2	1.2	1.2	1.1	1.1	10.7
NMC	1.7	1.9	2.1	2.3	2.4	2.4	2.5	2.4	2.4	2.3	22.4
TOTAL	3.6	4.0	4.5	5.1	5.2	5.3	5.4	5.3	5.2	5.0	48.6

(Source: DH Analysis of Authority Baseline Figures. Totals may not sum due to rounding.)

Table 7: Estimated Total Costs Split by Regulator of Option Three, Forecast to Ten Years, 2014 Prices, £ million, Discounted at 3.5%

Year	1	2	3	4	5	6	7	8	9	10	Total

PSNI	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.12
GCC	0.01	0.01	0.01	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.15
GDC	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	3.4
GMC	0.6	0.7	0.8	0.9	0.9	0.9	1.0	0.9	0.9	0.9	8.6
GOC	0.07	0.08	0.08	0.09	0.10	0.10	0.10	0.10	0.10	0.09	0.91
GOSC	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.22
GPhC	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.2	0.2	2.3
HCPC	0.8	0.9	1.0	1.1	1.1	1.2	1.2	1.2	1.1	1.1	10.6
NMC	1.6	1.8	2.1	2.3	2.4	2.4	2.5	2.4	2.4	2.3	22.2
TOTAL	3.6	4.0	4.5	5.1	5.2	5.3	5.4	5.3	5.2	5.0	48.6

(Source: DH Analysis of Authority Baseline Figures. Totals may not sum due to rounding.)

24. As shown in the bottom right hand cell of table 6 above, the monetary estimates produce a negative NPV overall, i.e. a net cost. However, a pivotal objective of the policy is to prevent any actual or perceived compromise of the Authority's independence from regulators and from Government. This objective will produce significant non-monetary benefits as outlined briefly below:

Non-Monetary Benefits Arising from Implementation of Options Two or Three

25. The Authority is currently an Arms-Length Body (ALB) of the DH[3] and as such is funded by the DH along with contributions from the Devolved Administrations (DAs). There is potential that the Authority could be perceived to be making decisions that are biased in favour of the public sector as a result of their being entirely government funded. Implementing policy option two or three would remove this possibility, and thereby positively impact the reputation of the Authority as a truly impartial organisation.

26. In turn, we may expect the above reputational impacts to have a positive impact on the public's perception of the regulation of healthcare professionals. This could result in a higher level of confidence in the system as a whole if the public feel more reassured that regulators' decisions regarding professionals are properly scrutinised, and will be challenged where failings or discrepancies are found. Overall, it seems reasonable to expect that higher confidence in the Authority's role in providing assurance that professional regulation is performed in a way that protects people who use services and other members of the public, may contribute to reducing anxiety regarding consuming healthcare.

27. Taking in to account the scale of the negative NPV estimated to result from the monetary impacts of implementing option two or three, the value of the non-monetary benefits are considered to be sufficient to entirely, or more than, compensate for the value of the negative NPV.

Estimating the Costs to Business of Policy Implementation

28. The effect of implementing policy option two or three will be a requirement for the Authority to raise the majority of their budget (excepting specific government commissions and public good work) through charging fees to the nine regulatory bodies it oversees. A key assumption that has been made throughout this consultation stage impact assessment is that the regulatory bodies will in turn pass 100% of these additional costs on to their registrants by raising their registration fees. This will not necessarily be the case and indeed the rate of pass-through may vary across the regulators. However, as the principal source of the regulators' funds are registration fees paid by their registrants it seemed prudent in the first instance to make this assumption.

29. It was also acknowledged that a proportion of the regulators' registrants will practise in the private sector and would therefore be classified as businesses. This impact assessment therefore contains an initial estimate of the costs to business that will arise as a result of policy implementation. Annex B

[3] In that it is funded from the DH's ALB finance.

details the full methodology through which the estimates were produced as well as detailing the relevant figures and calculations, whereas a summary version is included here.

30. Estimating the potential costs to business of the policy options required figures showing what proportion of each regulators' registrants practise in the private sector and would therefore count as businesses. This type of information is not collected by the regulators and so a bespoke breakdown of the Office for National Statistics Annual Population Survey dataset was requested. The data depicts the number of individuals employed in healthcare occupations (as defined by four digit standard occupation classification (SOC) codes) split by whether they work in the public or private sector and the number of employees against the number of self-employed individuals. Employment data was deemed the most appropriate for this analysis and used throughout as the impacts will be on individual healthcare professionals, rather than on businesses as a whole.

31. The number of people employed were allocated to the nine regulatory bodies according to the profession they were classified under. The data did not cover all the relevant healthcare professions necessitating assumptions and adjustments to be made in some cases. These are detailed fully in annex B and it is acknowledged that wherever assumptions are made they can increase the level of risk associated with the estimates.

32. The percentage of people employed in the private sector for each regulator was then calculated either from the available data or as outlined in paragraphs 49 to 51. Table 8 below presents the results:

Table 8: Percentage of Registrants Employed in the Private Sector, Split by Regulator, 2013

Regulator	Total Employment	Private Employment	Public Employment	% All Registrants in Private Sector
PSNI	N/A	N/A	N/A	67%
GCC	N/A	N/A	N/A	56%
GDC	124,143	84,867	39,276	68%
GMC	246,028	64,149	181,879	26%
GOC	28,030	25,764	2,266	92%
GOSC	N/A	3,848	962	80%
GPhC	76,346	50,972	25,374	67%
HCPC	388,944	121,773	267,171	31%
NMC	639,646	96,458	543,188	15%

(Source: DH Analysis of ONS APS Data)

33. The costs of policy implementation per regulator (shown at tables 4 and 5) were then multiplied by the percentage of registrants practising in the private sector for that regulator and summed to produce the total estimated costs to business. The estimated costs to business are detailed below in table 9:

Table 9: Estimated Costs to Business Arising from Implementation of Options Two and Three, 2014 Prices, £ million, Undiscounted and Discounted at 3.5%

Year	1	2	3	4	5	6	7	8	9	10	**Total**
Option 2	1.0	1.2	1.4	1.6	1.7	1.8	1.9	1.9	1.9	2.0	16.4
Option 2 Discounted	1.0	1.1	1.3	1.4	1.5	1.5	1.5	1.5	1.5	1.4	13.8
Option 3	1.0	1.2	1.4	1.6	1.7	1.8	1.9	1.9	2.0	2.0	16.6
Option 3 Discounted	1.0	1.2	1.3	1.5	1.5	1.5	1.6	1.5	1.5	1.5	14.0

(Source: DH analysis of ONS APS data and Authority baseline figures)

34. Finally, the Equivalent Annual Net Cost to Business expected to arise from the implementation of option two or three was calculated as outlined in the Better Regulation Manual by applying the formulas:

$$EANCB = PVNCB/a_{t,r}$$

$$a_{t,r}=\left(\frac{1+r}{r}\right)*(1-\left(\frac{1}{1+r^t}\right))$$

Where:

EANCB = Equivalent Annual Net Cost to Business

PVNCB = Present Value of Net Costs to Business

$a_{t,r}$ = Annuity Rate

t = Time period covered in the policy appraisal

r = Discount rate

35. The present value adjustments were made with a base year of 2010 (the year one in/one out began) and then converted in to 2009 prices using HM Treasury's GDP deflators. The resulting EANCB values for each option are shown below:

    EANCB Option Two = £1.28 million

    EANCB Option Three = £1.29 million

36. The EANCB figures were the final step in the calculations required for this impact assessment and thus represent the conclusion of the costs and benefits section for options two and three.

One-In, Two-Out Assessment

37. The Department would assert that this policy lies outwith the scope of the One-In, Two-Out requirements on the basis that the costs to business generated by the policy will be entirely indirect. The regulators are not required to pass the costs on to their registrants in the form of higher fees; it remains entirely at their discretion whether to do so or not. The regulators will also be able to decide whether or not to absorb a proportion of the costs (up to the full amount) instead of passing these on to their registrants. The options considered therefore qualify for exemption from One-In, Two-Out under the condition laid out in section 1.9.8 i of the Better Regulation framework. Furthermore, there is no expansion or reduction in the scope of regulatory activity, either from the Authority or the regulators it oversees, so any uplift in the fees may also be considered exempt under section 1.9.8 vii of the Better Regulation Framework. Under the two conditions outlined above, the proposals qualify as out of scope of One-In, Two-Out.

Small and Micro Business Assessment (SaMBA)

38. Small and micro businesses have not been exempted from the impacts of the policy options as:

- Firstly, the policy relates to the regulatory bodies paying fees to finance the majority of the Authority's budget, any exemptions for small or micro businesses would contravene the cross-subsidisation aspect of HM Treasury's Managing Public Money Guidance.
- Secondly, the preferred option will result in an equal increase in registration fees for all healthcare professionals. This will be applied as a flat rate per professional and so will not disproportionately impact small or micro businesses. Additionally, the vast majority of private sector healthcare enterprises are small or micro and it would therefore not be feasible to exclude registrants working within them when apportioning the cost burden.

Public Sector Equality Duty

39. We do not envisage that there will be an adverse impact on equality as a direct result of the regulations for the Authority's fees. To ensure this is the correct assessment we are including a question in the consultation document for the draft Fee regulation.

Timing of implementation

40. The Impact Assessment for the Health and Social Care Bill assumed that the Authority would become self-funded from 2013/14. However due to the need to agree a suitable fee structure, it is envisaged that the Authority will become self-funding from April 2015.

Annex A: Authority fees – components and methodology

41. Functions to be Covered by the Fee

Section*	Title
25 (2)	**The Professional Standards Authority for Health and Social Care** i) promote the interest of patients and other members of the public in relation to the performance of the regulatory bodies ii) promote best practice in the performance of professional regulation functions iii) formulate principles of good professional self regulation and encourage regulatory bodies to conform iv) promote co-operation between regulatory bodies
25A (5)	**Funding of the Authority** Process for determining the periodic fees to be paid by the regulatory bodies
25B	**Power of the Authority to advise regulatory bodies etc.** Advice to the regulatory bodies in relation to their statutory functions This excludes advice provided by the Authority for which a separate fee may be charged
25C (2)(a)	**Appointments to regulatory bodies** The Authority may assist the Privy Council with any of its appointments functions in relation to a regulatory body.
26 (1) and (2)	**Powers and duties of the Authority: General** The Authority may do anything which appears to it to be necessary or expedient for the purpose of or in connection with the performance of its functions to the extent that such functions are exercised in relation to the regulatory bodies. It may: i) investigate and report on the performance of each regulatory body ii) where a regulatory body performs functions corresponding to those of another, investigate and report how the performance of those functions compares ii) make recommendations to a regulatory body to change the way it performs its functions
26B (1) and (4)	**Duty to inform and consult the public** i) publication of information about the authority and the exercise of its functions ii) seek views of members of the public and organisations which appear to represent the interests of service users on matters relevant to the functions of the Authority
27 (2) and (4)	**Power to make directions requiring regulatory body to make**

	rules.
28	**Complaints about regulatory bodies** Regulations may make provision as to the investigation of complaints about regulatory bodies. (**Note this section has not yet been commenced)**
29 (4)	**Reference of disciplinary cases by Authority to court** The Authority may refer a case to the relevant court if it considers certain decision about a practitioners fitness to practise are unduly lenient or should not have been made
Schedule 7, paragraphs 15(1)-(4), 16(1), (1B) & (2)*	**Governance functions** Accounting, reporting and planning requirements imposed on the Authority. **These functions are only included to the extent to which they relate to the regulatory bodies.*
Schedule 7, paragraphs 16(3) and (4)*	**Parliamentary accountability** If required to do so, the Authority must lay a report on any matter as requested by the UK Parliament, the Northern Ireland Assembly, or the Scottish Parliament. **These apply only in so far as such work related to regulatory bodies.*

* Note: Section numbers relate to those in the NHS Reform and Health Professions Act 2002 (as amended)

42. Provisions in the Act also prevent certain other functions of the Authority being funded through the fee. These are set out in the table below.

Functions Excluded from the Fee

Section	Title
25G	Power of the Authority to accredit voluntary registers
25H	Accreditation of voluntary register: impact assessment
25I	Functions of the Authority in relation to accredited voluntary registers
26A	Powers of Secretary of State and devolved administrations (to request advice etc)

Section 25B empowers the Authority to provide advice or auditing services to the regulatory bodies, or to bodies with functions that correspond to those of the regulatory bodies, whether or not these relate to health or social care. Where it does so, a compulsory fee, determined by the Authority, will be paid by the bodies to which it provides advice or auditing services. However, the Authority may only provide advice or auditing services under this section if doing so would assist it in the performance of its functions (apart from its function of providing advice, reports or investigations to the Secretary of State or the devolved administrations under section 26A).

Annex B: Costs and Benefits Calculations – Detailed Methodology, Assumptions, Uncertainties and Risks

43. For the purposes of estimating the potential costs and benefits that could arise from the Professional Standards Authority (the Authority) moving to a self (rather than government) funded finance model, several calculations were required. To begin, data was sourced from the Authority on the amount of government funding agreed for the relevant workstreams in the Authority's 2014-15 budget. This figure represented a large proportion of the costs expected to accrue as a result of policy implementation and the entirety of the expected benefits.

44. The Department also liaised with the Authority to ascertain whether they expected to incur any additional costs or savings as a result of ceasing to be a government funded body. The Authority responded that they anticipate recruiting one further member of staff as a result of the policy and provided an approximate ongoing cost figure comprised wage costs (including national insurance, pension contributions etc.). Additionally, a transition cost occurring in year one was estimated to account for the costs of recruiting the additional staff member. These figures are presented below in table B1:

Table B1: Costs and Benefits Expected to Arise as a Result of Policy Implementation

Accruing to:	**Transition Cost (£000's)**	**Transition Benefit (£)**	**Ongoing Annual Costs (£m)**	**Ongoing Annual Benefits (£m)**
Authority	0.0	0.0	0.0	0.0
Government	0.0	0.0	0.0	3.6
Regulators	0.008	0.0	3.6	0.0

(Source: Authority Estimates Baseline Figures)

45. As demonstrated in table B1, the policy is cost neutral for the Authority under the assumption that all of the costs will be passed on to the nine regulatory bodies overseen by the Authority. All the costs are therefore assumed to accrue to the regulators as opposed to the Authority. The ongoing benefit to government of £3.6 million is equal to the agreed Authority budget for the relevant workstreams in 2014-15. This arises from the fact that government will no longer be responsible for funding the Authority's budget.

46. As standard, the ongoing impacts of policy implementation were forecast out for ten years, with transition costs being incurred in year one. Low, 'best' and high estimates were produced by applying different assumptions regarding how the costs (benefits) presented in table one would change over time. The three approaches taken to estimate the change in impacts over the ten year timeframe are presented below in table B2:

Table B2: Range of Annual Changes in the Costs and Benefits Arising as a Result of Policy Implementation

Years	**1 - 2**	**2 - 3**	**3 - 4**	**4 - 5**	**5 - 6**	**6 - 7**	**7 - 8**	**8 - 9**	**9 - 10**
Low	5%	5%	5%	0	0	0	-5%	-5%	-5%
Medium	16%	16%	16%	6%	6%	6%	1%	1%	1%
High	27%	27%	27%	12%	12%	12%	7%	7%	7%

(Source: DH Assumptions)

47. The rationale for these assumptions lies in that we recognise the increases seen in Section 29 cases over recent years (although the rate of change has been volatile such as growth of 8% between 2011-12 and 2012-13 followed by 30% growth between 2012-13 and 2013-14). The drivers for these increases are unclear, but changes in public and employer expectations, and efforts by the NMC to reduce their fitness to practice case backlog, have contributed. It seems likely that these trends will

continue over the next few years, but we expect to see growth slow, and eventually the number of cases to reduce in number, over the period covered by this IA. The following may be factors contributing to the overall trends in Section 29 cases and the resulting workload of the Authority:

- Earlier disposal of cases by the regulatory bodies as a result of legislative change and improved processes.
- Improvements to the quality of decisions by the regulatory bodies
- Other regulatory changes (e.g. systems regulation becoming more effective, increased focus on CPD for health care professionals).
- Increasing cost pressures from registrants.

46. Additionally, in the best and high estimates an adjustment was included to capture a potential rise in staff costs (including wages, National Insurance and pension contributions), charges for legal fees and accommodation, with workload held constant, of 1% and 2% respectively. The low, 'best' and high cost and benefits estimates forecast out for a ten year period are presented below in tables two and three respectively:

Table B3: Low, 'Best' and High Costs Estimates Forecast out to a Ten Year Time Horizon, in Constant Prices, £m

Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Low	3.6	3.8	4.0	4.2	4.2	4.2	4.2	3.9	3.7	3.6	39.2
Best	3.6	4.2	4.8	5.6	5.9	6.3	6.7	6.7	6.8	6.9	57.5
High	3.6	4.6	5.8	7.4	8.2	9.2	10.3	11.1	11.8	12.7	84.6

(Source: DH Analysis of Authority baseline figures)

Table B4: Low, 'Best' and High Benefits Estimates Forecast out to a Ten Year Time Horizon, in Constant Prices, £m

Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Low	3.6	3.7	3.9	4.1	4.1	4.1	4.1	3.9	3.7	3.5	38.8
Best	3.6	4.1	4.8	5.5	5.9	6.2	6.6	6.7	6.7	6.8	56.9
High	3.6	4.5	5.7	7.3	8.2	9.1	10.2	10.9	11.7	12.5	83.8

(Source: DH Analysis of Authority baseline figures)

47. The figures in tables B3 and B4 were then combined with a view to estimating the net present value[4] (NPV) of the policy option. In line with HM Treasury Green Book guidance[5] a 3.5% discount rate was applied to the net costs associated with each level of estimate out to year ten. The resulting annual NPVs, as well as the overall total NPVs for years one to ten inclusive are presented below in table B5, with no adjustment for opportunity costs incorporated:

Table B5: Low, 'Best' and High Estimates of the NPV of Policy Implementation, Constant Prices £m, Discounted at 3.5%.

Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total NPV**
Low	-0.04	-0.04	-0.04	-0.04	-0.04	-0.03	-0.03	-0.03	-0.03	-0.03	-0.34
Best	-0.04	-0.04	-0.04	-0.05	-0.05	-0.05	-0.05	-0.05	-0.05	-0.05	-0.48
High	-0.04	-0.04	-0.05	-0.06	-0.07	-0.08	-0.08	-0.08	-0.09	-0.09	-0.69

(Source: DH Analysis of Authority Baseline Figures)

[4] Economic theory indicates that individuals place a higher value on a cost or benefit incurred today than they would on the same cost or benefit incurred at some point in the future. To account for this, future impacts are discounted in order to present their 'present value'.

[5] Page 100: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf

48. It can therefore be observed that the overall NPV of policy implementation from year zero to year ten (inclusive) is expected to lie within the range of approximately -£0.34m and -£0.69m with the best estimate being -£0.48m. The net costs are entirely made up of the additional costs arising from the Authority recruiting and retaining one additional staff member. This is due to the cost to regulators of funding the Authority being exactly offset by an equal benefit to government from no longer funding the Authority. The Department expects that the value of the non-monetary benefits that will accrue to the Authority and the public will outweigh the negative monetised NPV of the policy.

Calculating the Potential Impacts of Proposed Policy Changes to Healthcare Businesses.

49. Having completed the estimated the overall NPV of policy implementation, it was next necessary to estimate the expected impacts on businesses only from the Authority moving to a self-funding mechanism.

50. In order to accurately reflect the expected impacts on business of the proposed measure, a bespoke dataset was requested from ONS Annual Population Survey (APS) data. The figures presented a breakdown of the number of individuals employed in the public and private sectors[6] for each healthcare profession covered by a four digit Standard Occupation Classification (SOC) 2010 code[7]. It should be noted that not all the regulated healthcare professionals are allocated SOC codes which is a weakness relating to utilising this approach. However, it appears this data is from the most robust and detailed source available and consequently was utilised as outlined below. A further breakdown showing how many individuals were employees and how many were self-employed in both the public and private sectors was also provided to help inform the SMBA assessment[8].

51. The figures by profession were aggregated up by the Department to form estimates of private sector employment in each regulator, and what proportion of total employment overseen by each regulator this equated to. A summary of the results is provided below at table B6:

Table B6: Key Figures on Regulators' Registrants, 2013 – ONS Annual Population Survey Data Unless Otherwise Stated

	Number of Registrants*	Total Employment	Private Employment	Public Employment	% All Registrants in Private Sector
PSNI	1,932	N/A	N/A	N/A	67%***
GCC	2,890	N/A	N/A	N/A	56%***
GDC	101,594	124,143	84,867	39,276	68%
GMC	259,777	246,028	64,149	181,879	26%
GOC	24,350	28,030	25,764	2,266	92%
GOSC	4,810	N/A	3,848**	962**	80%**
GPhC	69,231	76,346	50,972	25,374	67%
HCPC	322,021	388,944	121,773	267,171	31%
NMC	673,567	639,646	96,458	543,188	15%

*As per figures from regulators' websites/reports, various points in time from 2012-14.
**Calculated from figures on GOSC website.
***Calculated as per assumptions/adjustments below.

52. As demonstrated above, there were no figures available from the APS data for the professions regulated by the PSNI, GCC and GOSC. This necessitated the application of a series of assumptions

[6] It was confirmed by ONS that when allocating individuals in to public or private sector employment, this was based on whichever sector the majority of the individual's work too place in. Therefore, there is no risk that an element of double counting may have biased the data set.
[7] A full list of the professions for which data was available is included at annex C
[8] The method for calculating % total employed in SMEs estimates is provided at a later point in this section.

and adjustments (outlined in the following section), in order to produce similar estimates for these three regulators.

53. Once the proportion of registrants operating within the private sector had been estimated for each regulator, this was then multiplied by the costs expected to accrue to each regulator in the low, best and high cost estimate scenarios for both fee structures under consideration. The individual regulator's figures were then summed to produce the total estimated cost to business arising from the Authority moving to become a self-funded regulatory body as presented in tables B7 (undiscounted) and B8 (discounted):

Table B7: Low, Best and High Estimates of the Monetary Impacts on Business Arising from the Authority Becoming Self-Funding, Constant Prices £m, Undiscounted.

Year		1	2	3	4	5	6	7	8	9	10	Total
Option 1	Low	1.0	1.1	1.1	1.2	1.2	1.2	1.2	1.1	1.1	1.0	11.2
	Best	1.0	1.2	1.4	1.6	1.7	1.8	1.9	1.9	1.9	2.0	16.4
	High	1.0	1.3	1.6	2.1	2.3	2.6	2.9	3.1	3.4	3.6	24.1
Option 2	Low	1.0	1.1	1.1	1.2	1.2	1.2	1.2	1.1	1.1	1.0	11.3
	Best	1.0	1.2	1.4	1.6	1.7	1.8	1.9	1.9	2.0	2.0	16.6
	High	1.0	1.3	1.7	2.1	2.4	2.7	3.0	3.2	3.4	3.6	24.4

(Source: DH Analysis of Authority baseline figures and ONS APS data)

Table B8: Low, Best and High Estimates of the Monetary Impacts on Business Arising from the Authority Becoming Self-Funding, Constant Prices £m, Discounted at 3.5%.

Year		1	2	3	4	5	6	7	8	9	10	**Total**
Option 1	Low	1.0	1.0	1.1	1.1	1.0	1.0	1.0	0.9	0.8	0.7	9.6
	Best	1.0	1.1	1.3	1.4	1.5	1.5	1.5	1.5	1.5	1.4	13.8
	High	1.0	1.3	1.5	1.9	2.0	2.2	2.4	2.5	2.6	2.6	20.0
Option 2	Low	1.0	1.0	1.1	1.1	1.0	1.0	1.0	0.9	0.8	0.8	9.7
	Best	1.0	1.2	1.3	1.5	1.5	1.5	1.6	1.5	1.5	1.5	14.0
	High	1.0	1.3	1.6	1.9	2.1	2.2	2.4	2.5	2.6	2.7	20.2

(Source: DH Analysis of Authority baseline figures and ONS APS data)

Assumptions and Adjustments Regarding Calculating Costs to Businesses for the Regulators Not Covered by the APS Data (PSNI, GOSC and GCC):

54. Throughout, figures for the PSNI were assumed to be equal to the data available for the GPhC as the coverage of the APS does not extend to the whole of the UK[9]. This approach was taken as the Department was not aware of a reason why the structure of the pharmaceutical sector in Northern Ireland should fundamentally differ from its equivalent in England.

55. The GOSC's website[10] provided the figure for the total number of individuals they are responsible for regulating and what proportion of clients pay for osteopathic services. It was deemed reasonable (in the absence of any alternatives) to assume that the proportion of clients paying for services would provide a reasonable proxy for the proportion of practitioners operating in the private sector. It was noted that this method may yield an over-estimate as not all individuals registered will necessarily be practising. No adjustment was made to the figures to compensate for this as an over-estimate would be preferable to an under-estimate and this may serve to offset the risk of an under-estimate, arising from the uncertainty surrounding the former assumption and how it may have impacted the figures.

[9] The APS data covers Great Britain as opposed to the whole of the UK.

[10] http://www.osteopathy.org.uk/resources/Research-and-surveys/Statistics/

56. There was no information available, either from the APS or the GCC's website that would have informed a robust estimate of the equivalent figures for the chiropractic sector. In order to produce an estimate, the total number of registrants was sourced from the GCC's website[11]. This was then multiplied by the mean proportion of total registrants estimated to practise in the private sector calculated from the other eight regulators' data.

Estimated Impacts on Small and Micro Enterprises (SMEs) Arising as a Result of Policy Implementation

57. In order to estimate the potential impacts on small and micro enterprises (SMEs) data on the size structure of enterprises within the private healthcare sector[12] was sourced from ONS Annual Business Survey (ABS). To try and maintain comparability, the figures utilised related to employment by sizeband with small and micro businesses defined as businesses in the employment sizeband one to 49. The employment numbers for these size bands were added together before being divided by the total employment figure for the sector, to give an estimated proportion of employment in the private healthcare sector that is in small or micro businesses.

58. Returning to the figures sourced from the APS, all self-employed individuals in the private sector were automatically categorised as working in an SME. The proportion calculated from ABS data was then applied to the private sector employee figures for each of the regulators, estimated from the APS data to produce approximate SME employment figures.

59. The PSNI data was again assumed to be equal to the GPhC's with the same underlying assumption as previously (aware of no reason why the structure of pharmacy in Northern Ireland would differ significantly from the rest of Great Britain). There was no data available with which to produce an equivalent estimate for the GOSC. With the aim of minimising the risk of under-estimating the costs to business arising from policy implementation, it was assumed that all of the osteopathic employment was in a micro or small enterprise.

60. As with the GOSC figures, in the absence of any further information, it was assumed that all estimated private sector practitioners regulated by the GCC were employed by or owners of small or micro enterprises. Table B9 below presents the results.

Table B9: Employment Estimates for Private Sector SME's

Regulator	Number Employed in Private Sector SMEs****	Percentage of Total Employment in Private Sector SMEs
PSNI	N/A	28%
GCC	1,618*****	56%*****
GDC	49,793	40%
GMC	54,416	22%
GOC	11,046	39%
GOSC	3,848*****	80%*****
GPhC	21,380	28%
HCPC	88,262	23%
NMC	31,927	5%

(Source: DH Analysis of ONS ABS and APS data)

****SMEs here referring to small and micro businesses.
*****To ensure no under-estimate of costs where no data is available it was assumed all private employment is in SMEs.

[11] http://www.gcc-uk.org/UserFiles/Docs/Registrations/Report%20on%20the%202013%20registration%20year.pdf
[12] Defined in the data as: Human health and social work activities excluding NHS Trusts, Local Authorities and Central Government Bodies

61. Once the proportion of registrants operating within private sector SMEs had been estimated for each regulator, this was then multiplied by the costs expected to accrue to each regulator in the low, best and high cost estimate scenarios, for both fee structures under consideration. The individual regulator's figures were then summed to produce the total estimated cost to SME's arising from the Authority moving to become a self-funded regulatory body as presented in tables B10 (undiscounted) and B11 (discounted):

Table B10: Low, Best and High Estimates of the Monetary Impacts on SME's Arising from the Authority Becoming Self-Funding, Constant Prices £m, Undiscounted.

Year		1	2	3	4	5	6	7	8	9	10	**Total**
Option 1	Low	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.6	0.6	0.6	6.5
	Best	0.6	0.7	0.8	0.9	1.0	1.0	1.1	1.1	1.1	1.1	9.5
	High	0.6	0.8	1.0	1.2	1.4	1.5	1.7	1.8	1.9	2.1	13.9
Option 2	Low	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.6	0.6	6.5
	Best	0.6	0.7	0.8	0.9	1.0	1.0	1.1	1.1	1.1	1.1	9.6
	High	0.6	0.8	1.0	1.2	1.4	1.5	1.7	1.8	2.0	2.1	14.1

(Source: DH Analysis of Authority baseline figures plus ONS ABS and APS data)

Table B11: Low, Best and High Estimates of the Monetary Impacts on SME's Arising from the Authority Becoming Self-Funding, Constant Prices £m, Discounted at 3.5%.

Year		1	2	3	4	5	6	7	8	9	10	**Total**
Option 1	Low	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.5	0.5	0.4	5.6
	Best	0.6	0.7	0.7	0.8	0.9	0.9	0.9	0.9	0.9	0.8	8.0
	High	0.6	0.7	0.9	1.1	1.2	1.3	1.4	1.4	1.5	1.5	11.6
Option 2	Low	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.5	0.5	0.4	5.6
	Best	0.6	0.7	0.8	0.8	0.9	0.9	0.9	0.9	0.9	0.8	8.1
	High	0.6	0.7	0.9	1.1	1.2	1.3	1.4	1.4	1.5	1.5	11.7

(Source: DH Analysis of Authority baseline figures plus ONS ABS and APS data)

Calculating the Equivalent Annual Net Cost to Business (EANCB)

62. The EANCB is calculated through populating the following two formulae with the appropriate figures:

$$EANCB = PVNCB / a_{t,r}$$

$$a_{t,r} = \left(\frac{1+r}{r}\right) * \left(1 - \left(\frac{1}{1+r^t}\right)\right)$$

Where:

EANCB = Equivalent Annual Net Cost to Business

PVNCB = Present Value of Net Costs to Business

$a_{t,r}$ = Annuity Rate

t = Time period covered in the policy appraisal (10 years)

r = Discount rate (3.5%)

63. In this case, the policy appraisal covered a ten year time period and a 3.5% discount rate was applied throughout, giving an annuity rate of:

$$\left(\left(\frac{1.035}{0.035}\right) * \left(1 - \left(\frac{1}{1.035^{10}}\right)\right)\right) = 8.6$$

64. In accordance with the available guidance, the PVNCB was then calculated with the base year of 2010 for the present value adjustment. In order to achieve this, the assumption was made that year one would be 2015. Year one was then discounted utilising the 'year five' multiplier to show what the present value of the cost incurred in 2015 would have been in 2010. Year two was discounted using the multiplier for year six, year three using the multiplier for year seven and so on up to year ten using the multiplier for policy year 14 (which it would have been if it were 2010 today). The resulting figures for each year of the policy are detailed below in table B12:

Table B12: Range of Estimates for the PVNCB, Base Year 2010, Constant 2014 Prices

	Year	1	2	3	4	5	6	7	8	9	10	**Total**
Option 1	**Low**	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.7	0.7	0.6	8.1
	Best	0.9	1.0	1.1	1.2	1.2	1.3	1.3	1.3	1.2	1.2	11.7
	High	0.9	1.1	1.3	1.6	1.7	1.9	2.0	2.1	2.2	2.2	16.9
Option 2	**Low**	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.7	0.6	8.2
	Best	0.9	1.0	1.1	1.2	1.3	1.3	1.3	1.3	1.3	1.2	11.8
	High	0.9	1.1	1.3	1.6	1.7	1.9	2.0	2.1	2.2	2.2	17.0

(Source: DH Analysis of Authority baseline figures)

65. The base year 2010 present value figures above were then converted in to 2009 prices using HM Treasury's Gross Domestic Product (GDP) deflators[13] and divided by the annuity rate to produce the following range of estimates for the EANCB of implementing policy option two or three:

- Low EANCB Option Two: £0.89 million.
- Best EANCB Option Two: £1.28 million.
- High EANCB Option Two: £1.85 million.
- Low EANCB Option Three: £0.90 million
- Best EANCB Option Three: £1.29 million
- High EANCB Option Three: £1.87 million.

Annex C: Healthcare Professions with Associated SOC Codes, Allocated to their Responsible Regulatory Bodies, 2013.

		Private		Public	
		Employee	Self-Employed	Employee	Self-Employed*

[13] https://www.gov.uk/government/publications/gdp-deflators-at-market-prices-and-money-gdp-june-2014-quarterly-national-accounts

PSNI	N/A	N/A	N/A	N/A	N/A
GCC	N/A	N/A	N/A	N/A	N/A
GDC	Dental Practitioners	3,964	28,468	6,228	N/A
	Medical and Dental Technicians	13,443	7,021	15,519	N/A
	Dental Nurses	31,971	*	17,529	N/A
GMC	Medical Practitioners	13,702	50,447	181,879	N/A
GOC	Opthalmic Opticians	16,234	5,043	2,266	N/A
	Dispensing Opticians	4,487	*	-	N/A
GOSC	N/A	N/A	N/A	N/A	N/A
GPhC	Pharmacists	26,049	9,312	14,997	N/A
	Pharamaceutical Technicians	15,611	*	10,377	N/A
HCPC	Podiatrists	959	6,894	5,868	N/A
	Health Professionals NEC	7,209	2,643	28,298	N/A
	Health Associate Professional NEC	8,898	26,147	11,928	N/A
	Occupational Therapists	3,175	1,284	30,526	N/A
	Paramedics	3,187	*	19,869	N/A
	Physiotherapists	6,336	9,005	38,542	N/A
	Speech and Language Therapists	1,102	731	11,421	N/A
	Social Workers	9,738	4,513	79,693	N/A
	Psychologists	3,451	3,971	26,781	N/A
	Therapy Professionals NEC	3,123	19,407	14,245	N/A
NMC	Nurses	89,538	5,609	498,107	N/A
	Midwives	1,311	*	45,081	N/A

(Source: DH analysis of ONS APS Data)